Producing the 'problem of drugs': A cross national-comparison of 'recovery' discourse in two Australian and British reports

Kari Lancaster[1], Karen Duke[2] & Alison Ritter[1]

[1]Drug Policy Modelling Program, National Drug and Alcohol Research Centre, UNSW Australia

[2]Drug and Alcohol Research Centre, School of Law, Middlesex University, London, UK

Corresponding author:

Kari Lancaster

Drug Policy Modelling Program

National Drug and Alcohol Research Centre

UNSW Australia

Sydney NSW 2052

Australia

k.lancaster@unsw.edu.au

+61 (0)2 9385 0476

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Highlights

- This paper critically examines how the problem of drugs was constituted in a British and an Australian report on the place of 'recovery' in drug policy.
- The problem of drugs was represented as 'dependence' alone in both documents, with the implication that not all illicit drug use is problematic.
- People who use drugs problematically were constructed as either 'responsibilised' (Britain) or 'patientised' (Australia).
- Conditional citizenship, associated only with treatment and recovery, is reinforced in both documents.
- The perceived authority of the UKDPC and ANCD was critical to the recovery debates at the time the reports were produced.
- As 'recovery' discourse continues to evolve, discussing its contested meanings and effects will be an ongoing endeavour.

Abstract

The notion of 'recovery' as an overarching approach to drug policy remains controversial. This cross-national analysis considers how the problem of drugs was constructed and represented in two key reports on the place of 'recovery' in drug policy, critically examining how the problem of drugs (and the people who use them) are constituted in recovery discourse, and how these problematisations are shaped and disseminated. Bacchi's poststructuralist approach is applied to two documents (one in Britain and one in Australia) to analyse how the 'problem of drugs' and the people who use them are constituted: as problematic users, constraining alternative understandings of the shifting nature

of drug use; as responsibilised individuals (in Britain) and as patients (in Australia); as worthy of citizenship in the context of treatment and recovery, silencing the assumption of unworthiness and the loss of rights for those who continue to use drugs in 'problematic' ways. The position of the organisations which produced the reports is considered, with the authority of both organisations resting on their status as independent, apolitical bodies providing 'evidence-based' advice. There is a need to carefully weigh up the desirable and undesirable political effects of these constructions. The meaning of 'recovery' and how it could be realised in policy and practice is still being negotiated. By comparatively analysing how the problem of drugs was produced in 'recovery' discourse in two jurisdictions, at two specific points in the policy debate, we are reminded that ways of thinking about 'problems' reflect specific contexts, and how we are invoked to think about policy responses will be dependent upon these conditions. As 'recovery' continues to evolve, opening up spaces to discuss its contested meanings and effects will be an ongoing endeavour.

Keywords:

Recovery, Drug policy, Australia, Britain, Problematisation, Carol Bacchi

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Introduction

The proposition that policies do not react to pre-existing problems which exist 'out there' waiting be solved, but rather *create* particular kinds of problems is particularly challenging in a field like drug policy, where the notion of 'drug problems' is so embedded. As Goodwin (2012, p.27) observes, "[t]he suggestion that 'social problems' are brought into being, rather than simply existing, waiting to be solved, corrected or addressed by government can be unsettling for those who spend a good deal of their time attempting to have situations regarded as oppressive, intolerable, or simply untenable 'addressed'." Nonetheless, as previous research has argued, interrogation of the construction of concepts such as 'drug use' and 'addiction' (and their 'causes' and 'effects') is essential if the stigmatising and marginalising effects of laws and policies are to be disrupted (Seear & Fraser, 2014). Such scrutiny is important not only in relation to well-established policies and practices (as have been examined in previous drug policy research: Fraser & Moore, 2011b; Lancaster & Ritter, 2014; Seear & Fraser, 2014), but also as a way of critically reflecting on contemporary and emerging ideas about the governance of drug problems. 'Recovery' is one such idea.

Although the notion of 'recovery' is not new (Berridge, 2012), in recent years recovery has become the focus of drug policy in Britain (HM Government, 2010; Inter-Ministerial Group on Drugs, 2012; Scottish Government, 2008) and the subject of polarised discussion in Australia (AIVL, 2012; ANCD, 2012a; Anex, 2012; Best, 2013). Drug policy scholars have begun to examine the emergence, meaning and implications of 'recovery' debates in Britain (Duke, 2013; Duke, Herring, Thickett, & Thom, 2013; Duke & Thom, 2014; McKeganey, 2014; Monaghan, 2012; Monaghan & Wincup, 2013;

Neale, 2013; Neale, et al., 2014; Neale, et al., 2015; Wardle, 2012), but there has been no analysis to date in the Australian context.

Despite having been formally embedded into national drug policy in Scotland (Scottish Government, 2008) and in England (HM Government, 2010), and into treatment services in one Australian state (State of Victoria Department of Health, 2012; Victorian Government Department of Human Services, 2008), the notion of 'recovery' as an overarching approach to drug policy remains controversial. As Neale et al. (2014, p.310) note, "concerns and differences of opinion persist, with recovery routinely described as a contested concept". In particular, there has been ongoing concern about the implications of this shift in emphasis for the continued provision of harm reduction interventions and pharmacotherapy treatment (AIVL, 2012; McKeganey, 2012, 2014; Stimson, 2010). Aside from these debates, a widely accepted definition of recovery within the drug policy field also remains elusive (Neale, et al., 2014). Indeed, recovery is often put forward as a term which seemingly eschews definition. It has been said that recovery can be defined in a myriad of ways (Laudet, 2007; White, 2007), and that "as an ideological term, it has a variety of definitions and can mean different things to different people" (MacGregor, 2012, p.351).

It is in this context of diffuse and multiple definitions that 'recovery' lends itself to analysis. As the recovery debate continues to unfold and gain prominence internationally, critical examination of how the problem of drugs (and the people who use them) are constituted in recovery discourse, and how these problematisations are shaped and disseminated, is imperative.

International comparative policy analysis can help to reveal the ways in which *ideas* about the problem of drugs, and how it could be managed, are dependent on context. Thus through a critical lens, cross-national comparisons can help us recognise "that certain ways of thinking about 'problems' reflect specific institutional and cultural contexts and, hence, that problem representations are contingent" (Bacchi, 2009, p.14). By applying Bacchi's (2009) poststructuralist approach, we consider how the problem of drugs was constructed and represented in two key

British and Australian reports on the place of 'recovery' in drug policy. Our purpose in doing so is not to 'define' or better understand what recovery "really means" (Bacchi, 2009, p.181). Rather, in using this form of analysis, we aim to investigate the emergence of the meanings produced by recovery discourse in Britain and Australia, and interrogate the processes and taken-for-granted assumptions which have made this thinking possible.

Method

Bacchi's (2009) 'What's the problem represented to be?' approach is a poststructuralist mode of policy analysis grounded in the concept of 'problematisation'. Bacchi (2009, p.30) uses the term 'problematisation' in two ways: firstly, to signal the need for critical interrogation of taken-for-granted assumptions; and secondly, to refer to the ways that issues are put forward and thought about as 'problems' in policy, as a way of identifying the thinking behind particular forms of rule (for further discussion see: Bacchi, 2012b).

Central to the approach is the proposition that policy is *productive*; it constitutes and gives shape and meaning to 'problems' rather than merely addressing them. Bacchi (2009, 2012a) argues that because policies by nature make proposals for change, every policy contains implicit representations of what may be considered 'problematic' and how these 'problems' ought to be thought about. By observing that problems are "endogenous – created within – rather than exogenous – existing outside" policy processes, Bacchi (2009, p.x) challenges the 'problem solving' paradigm which dominates many conventional modes of policy analysis. As an alternative, Bacchi (2009; 2012a, p.23) makes the case for a new "problem-*questioning*" paradigm as a "critical form of practice". This shift from the conventional 'problem solving' paradigm to one of 'problem questioning' means scrutinising the ways in which 'problems' are thought about, rather than simply accepting "the shape they are given" in proposals for change (Bacchi, 2009, p.46). In saying this however, the approach is not concerned with identifying the intentional framing of political arguments. Instead, the aim is to illuminate the underlying presuppositions and conceptual premises which lodge within

problem representations and make a particular policy intervention possible. Bacchi argues that this mode of critical analysis is crucial, because how 'problems' are thought about and represented in policy matters greatly. Problem representations have real and important effects for "what can be seen as problematic, for what is silenced, and for how people think about these issues and about their place in the world" (Bacchi & Eveline, 2010, p.112), that is, "for what gets done or not done, and how people live their lives" (Bacchi, 2012a, p.22). Using Bacchi's (2009) questions as tools for analysis (see Table 1), we systematically interrogated the problem representations contained within two documents ("practical texts": Bacchi, 2009, p.54): the United Kingdom Drug Policy Commission Recovery Consensus Group 'Vision of Recovery' report (UKDPC, 2008) and the Australian National Council on Drugs '1st Recovery Roundtable' report (ANCD, 2012a). Bacchi (2009, p.54) notes that text selection is in and of itself an interpretive exercise. We acknowledge that we have taken a focussed approach by limiting our analysis to these two documents. These documents were selected as they were both produced following formal meetings which brought together invited stakeholders with multiple perspectives at particularly significant points in recovery drug policy discussions in the two jurisdictions, with both seeking to articulate a position on 'recovery' at that time. As will be discussed below, both documents emerged following heated debate in Britain and Australia, and aimed to bring clarity to an increasingly divided field.

The nine-page UKDPC report provides a detailed background to the reasons for convening the Recovery Consensus Group, lists the members of the group, and describes the processes undertaken. The report ends by outlining 'next steps' for continued discussion. A list of references is also provided. The three-page ANCD report is comparatively brief. Although it lists the Roundtable attendees, it provides little information about why the group was brought together, or the processes leading to the generation of the points contained within the report.

Our analysis of these two documents emphasised questions 1, 2, 4 and 6 in Bacchi's approach, with a focus on identifying the assumptions and conceptual premises which lodge within the identified

problem representations, critically considering their limits and silences, and reflecting upon the processes and means through which these problem representations have been produced, disseminated and defended. Before examining the themes identified in detail, we first provide some background to the two documents analysed.

Background to UKDPC Recovery Consensus Group 'Vision of Recovery' Report

In July 2008, the UKDPC (a self-described independent body that provided objective analysis of the evidence concerning drug policy and practice: see http://www.ukdpc.org.uk/) published a report which put forward a 'vision for recovery' based on the work of a Consensus Group. Their work was a response to the growing polarisation within the drugs field between harm reductionists and abstentionists around the definitions of 'recovery' and the role of substitute prescribing, particularly methadone maintenance, within a recovery-oriented treatment system. Historical analyses of British drug policy have illuminated the longstanding conflicts between abstinence versus harm reduction in the development of drug treatment policy at various junctures (Berridge, 1991; Mold, 2008). During the period from 2005 to 2010 however, these conflicts became vitriolic and more public than in the past. In 2006 and 2007, the right wing Centre for Social Justice led by the Conservative politician, Ian Duncan Smith, published reports which were highly critical of Labour drugs policy (Centre for Social Justice, 2006, 2007). The 2007 report argued that the Labour drugs policy of harm reduction had failed and produced "entrenchment" and "intergenerational cycles" of addiction (Centre for Social Justice, 2007, p.10). An alternative approach based on total abstinence was proposed by the Centre which stirred debate regarding the goals of drug treatment. The media also became involved in questioning treatment outcomes. Using National Treatment Agency statistics, Mark Easton, a BBC journalist, highlighted that only 3% of clients had exited treatment 'drug free' (Easton, 2008). This opened up a public debate which began to question the harm reduction consensus that had operated within drug policy following concerns about HIV in the 1980s. It provided a window of

opportunity for those advocating abstinence-based treatment to put forward their views (Duke, et al., 2013; Duke & Thom, 2014).

Some key stakeholders referred to the division within the drugs field at this time as an "abstinence versus maintenance civil war" (Hayes & Dale-Perera, 2010, p.9). The UKDPC's view was that the debate was becoming "divisive, with little reference to the evidence on treatment effectiveness which indicates that a treatment system should be composed of a range of different services to meet different needs" (UKDPC, 2008, p.2). There were also fears that support and funding for drug treatment would be undermined. Thus, the establishment of a Consensus Group was an attempt to locate the debate in a 'rational' framework. There was a lack of agreement surrounding the goals of treatment and a lack of clarity regarding the term 'recovery'. The task of the UKDPC Consensus Group was "to identify the common-ground and develop a clearer understanding of recovery that could be applied to *all* individuals tackling problems with substance misuse, and *all* services helping them, without reference to particular treatment modalities" (UKDPC, 2008, p.2, emphasis original).

The Consensus Group consisted of sixteen people representing a wide range of demographics, types of treatment (e.g. rehabilitation, substitute prescribing, GP care, and support groups), disciplines (e.g. GP, psychiatry, psychology, nursing, management and lay people) and perspectives (e.g. consumers, families, practitioners, commissioners and researchers). They were invited to participate as 'individuals' rather than as 'representatives' of their respective organisations. The group met initially for two days. The commencement point for the group was the report of the Betty Ford Institute Consensus Panel convened in the US, which defined recovery as "a voluntarily maintained lifestyle characterised by sobriety, personal health and citizenship" (Betty Ford Institute Consensus Panel, 2007, p.222). The group was also influenced by the work on recovery in the mental health fields and in Scotland. Their discussions were facilitated by Thomas McLellan, a recovery advocate from the US, who had played a key role in the Betty Ford Institute Consensus Panel. The focus for the Consensus Group was on outcomes for the individual, not the treatment services required to

achieve these outcomes. It was acknowledged that a 'consensus' might not be achieved through this process, but the goal was to identify specific areas where there was agreement. The group identified and agreed to a number of key features of recovery and developed these into a statement which was put forward as a 'vision', rather than a 'definition'. The group then consulted with the 'wider field' through meetings and presentations to ascertain whether this statement and key features accorded with others' views and to identify areas for clarification and amendment. After this period of consultation, the group met again to agree minor changes to the wording of the statement. There are no details in the UKDPC document of what particular amendments were made and who requested these. However, the UKDPC (2008, p.4) stressed that the "core points identified at the initial two-day meeting have withstood this scrutiny well and remain largely unchanged." The vision statement agreed by the group is as follows:

> "*The process of recovery from problematic substance use is characterised by voluntarily-sustained control over substance use which maximizes health and well-being and participation in the rights, roles and responsibilities of society*" (UKDPC, 2008, p.6, emphasis original).

Background to the ANCD 1st Recovery Roundtable Report

In June 2012, the ANCD (then, the principal advisory body to the Australian Government on drug policy: see http://www.ancd.org.au/) convened the '1st Recovery Roundtable' in Canberra. This meeting was conducted under Chatham House Rules with the purpose of "bringing together a number of stakeholders in the alcohol and other drug sector to discuss the concept of recovery" (ANCD, 2012a, p.1). In the context of the changing drug policy landscape in Britain, the increasing popularity of the notion of recovery in the local mental health sector, the arrival of an influential recovery advocate (David Best) in Australia, and intensifying discussion of whether recovery was relevant in an Australian drug policy context, the Roundtable aimed to "explore and understand the concept of recovery within the alcohol and other drug field" (ANCD, 2012a, p.1).

Similar to Britain, there was a perception at this time of a growing division within the alcohol and other drug (AOD) sector in Australia as debates about what was meant by the term 'recovery' ensued. There was concern about what recovery could mean for Australian drug policy and the 'harm minimisation' framework which had provided its foundation since 1985. The National Drug Strategy 2010-2015 approved by the Ministerial Council on Drug Strategy had reiterated 'harm minimisation' as the overarching approach for Australian drug policy, despite the challenges mounted under the previous government by those advocating for more abstinence-based and 'zero tolerance' approaches (for discussion see Bessant, 2008; Lancaster & Ritter, 2014; Mendes, 2001, 2007; Rowe & Mendes, 2004). Contrary to the very public and political debates about drug policy which had occurred in the media and parliamentary inquires during the conservative Howard Liberal-National Coalition's time in government, emerging discussion about the 'New Recovery' movement remained mainly internal to the AOD sector. In early 2012 documentation arising from the British recovery drug policy experience and discussion papers were circulated in the Australian AOD field (e.g. AIVL, 2012; Anex, 2012; Best & Lubman, 2012). These papers generated significant combative debate within the sector and in online discussion forums (such as the Alcohol and Other Drugs Council of Australia's email lists) in the months prior to the Roundtable being convened. The ANCD saw its role as "[e]stablishing a collaborative approach with key stakeholders in the AOD sector to appropriately define and describe the place of 'Recovery' within the Australian framework of supply, demand and harm reduction given that this is Australia's strategic response to drug and alcohol problems" (ANCD, 2012b).

In total, eighteen people attended the one-day Recovery Roundtable meeting. The format of the day included a series of short presentations "to promote discussion on the history, definition, purpose, international experiences, goals, advantages, and disadvantages that are potentially associated with the use of the term recovery in alcohol and other drug policy, programmes and practices" (ANCD, 2012a, p.1). These short presentations were followed by in-depth discussion. The invited attendees represented a range of stakeholders including professional organisations, advocacy groups (including

harm reduction, family support, and consumer advocates), peak bodies, researchers, and treatment services.

In contrast to the UKDPC process which aimed to "identify the common ground" (UKDPC, 2008, p.2), the ANCD Roundtable was exploratory and "not intended to achieve an agreed position or resolution at the first meeting" (ANCD, 2012a, p.1). It was noted that the "views of participants were diverse and discussion was robust and informative" (ANCD, 2012a, p.1). According to the report, the definition of recovery was "a key contention" for the group and "views ranged from existential to empirically-based opinions and information, including opposition to the use of the term at all and questioning its legitimacy if it could not be defined" (p.1). It is not stated how the list of consensus points and issues contained within the report was generated, and who participated in the writing of the public report. Although a second Recovery Roundtable bringing together a wider range of stakeholders was intimated in the report, to date we are not aware of further steps in this regard.

In comparing the background and contexts of these two documents, both similarities and differences can be identified. Perhaps the most significant difference to note is the positioning of the recovery paradigm within these processes. While the British process adopted an expansive understanding of recovery and aimed to "identify the common-ground and develop a clearer understanding of recovery that could be applied to *all* individuals tackling problems with substance misuse, and all services helping them" (UKDPC, 2008, p.2, emphasis original), in the Australian context, 'recovery' itself was constituted as problematic. In the Australian document, recovery was viewed as a politicised, disruptive and destabilising idea which "should not be the sole basis for a national drug strategy" (ANCD, 2012a, p.2). Below, we consider how the conceptual logics underpinning the problematisations produced through these two documents contribute to these differences, despite the apparent similarities in the processes which led to the documents' creation.

Themes

In applying Bacchi's questions, four themes emerged from the texts: (1) 'recovery' and 'problematic drug use'; (2) 'recovery' and the 'responsibilised' or 'patientised' individual; (3) 'recovery', well-being and the worthiness of the lives of people who use drugs; and (4) contesting or legitimising 'recovery'. The first three of these themes emphasise Bacchi's first, second and fourth questions, while the final theme focuses on question six (see Table 1).

'Recovery' and 'problematic drug use'

To begin, Bacchi's approach leads us to ask: how is the problem of drugs represented in the two documents? Throughout the UKDPC (2008, pp.3-9) report, terms such as "problematic substance use" and "problems with substance misuse" are used. The ANCD (2012a, p.1) report similarly refers to "people with alcohol and other drugs problems" or "dependence". There is only one instance across both documents, in the ANCD report, where drug use is referred to in an unqualified way ("history of drug and alcohol use" p.2). Hence the focus of both documents is squarely directed towards 'problematic' or 'dependent' drug use (and not drug use per se), thus producing drug use as a particular kind of policy problem: one of 'dependence' or 'addiction'. This highly specific use of language, common to both documents, invokes a particular drug using subject, and produces a dichotomy between drug use behaviour which is regarded as 'problematic' (and therefore should be ameliorated through recovery and treatment) and 'non-problematic' drug use. It is important to consider how this binary distinction shapes how drug use (and the 'problem of drugs') may be thought about. By focusing only on 'problematic' drug use, it is implied that not all illicit drug use is necessarily problematic. In doing so, these documents seemingly eschew the moralising discourse which often lodges within discussions of illicit drug use. Indeed, it is explicitly stated that substances could potentially be used "in a way that is not problematic for self, family or society" or in a "consistently moderate" way (UKDPC, 2008, p.5).

However, as Bacchi (2009, p.xii) argues, problematisations "necessarily reduce complexity". We suggest that the invocation of a binary distinction between 'problematic' and 'non-problematic' use

constrains an alternative understanding of the transient or shifting nature of use between those two states over time, and in various settings, within the experiences of one individual. That is, the notions of a 'continuum of use' and of drug use as a complex sociocultural practice are silenced. Moreover, while there is acknowledgement that "recovery will differ between individuals" and that there will be "variation in the causes and extent of the problems associated with problematic substance use" (UKDPC, 2008, pp.4-5), silence about what constitutes 'problematic drug use' suggests that this concept is fixed, known and incontrovertible (an assumption which has been challenged: see Fraser & Moore, 2011a). While it is stated that it was difficult to "define a single-end point that satisfactorily captured the diversity of experiences of recovery", the starting point of 'problematic substance use' was not questioned. The silences here signal taken-for-granted assumptions about what the characteristics and effects of "problematic substance use" or "dependence" may be.

'Recovery' and the 'responsibilised' or 'patientised' individual

By delving deeper, and interrogating the presuppositions underlying the problematisations identified, we begin to see the ways in which the reports offer two distinctly different views despite both being focused on 'problematic substance use' or 'dependence'. In the UKDPC report, the notion of recovery as being "characterised by voluntarily-sustained control over substance use" (UKDPC, 2008, p.6) (defined as meaning "comfortable and sustained freedom from compulsion to use", p.5) emphasises individual agency whereby people who use drugs are responsible for their own lives. Here, 'recovery' from 'problematic substance use' becomes the responsibility of the individual who is expected to take control of her or his own health, presumably by seeking and engaging with drug treatment and "mak[ing] the *choice* to use a substance in a way that is not problematic for self, family or society" (p.5, emphasis added). In this way, the UKDPC recovery statement represents individual drug using subjects as responsible, rational, self-controlled and autonomous people.

Responsibility has become a key construct in neoliberal forms of governance, underpinned by an emphasis on self-regulation, self-discipline, self-motivation, control and rationality. In terms of citizenship, there has been a shift away from 'rights' to a focus on 'responsibilities', as well as a movement away from collectivised risk management to an "individualisation of risk" where individuals, families and local communities are expected to "take upon themselves" responsibility for more aspects of their lives (Rose, 1999, p.247). This shift can be observed in the context of health, and drug policy in particular. As Race (2009, p.15) observes, "what is striking about the neoliberal context is that health is now deemed to be a goal actively embraced by autonomous subjects."

However by constructing individuals as rational agents who are capable of control over their 'problematic' drug use, the UKDPC statement also implicitly attributes responsibility for the 'problem of drug use', 'problematic use' or 'dependence' to individuals themselves. That is, people who have not 'chosen' to use drugs in a 'non-problematic' way (that is, those not 'in recovery') are constructed as being responsible for their own problems. This construction has significant implications, as it stigmatises and 'marks' a targeted minority group. Through these "dividing practices" (Foucault, 1982, p.777) this group is characterised as deviant or incapable. This in turn serves a broader governance objective by encouraging desirable behaviour (self-regulation and responsibility) among the rest of the population who seek to avoid this stigma (an observation which has also been made in the context of policies addressing 'excessive' gambling: Bacchi, 2009). This subjectification arguably has profound effects for how this group perceives themselves, and what they can and should expect from government (Lancaster, Santana, Madden, & Ritter, 2014).

The construction of the 'responsibilised' individual in the UKDPC recovery statement also delimits the ways that drug use can be thought about. It silences perspectives such as those focused on the 'social determinants of health', which acknowledge the social, economic and cultural conditions which influence health outcomes and direct prevention efforts towards societal and institutional interventions (rather than towards the individual) (Munro & Ramsden, 2013). The emphasis on

"freedom from compulsion to use" (p.5) also invokes binary categories of 'choice' and 'compulsion,' thus silencing alternative accounts of drug use practices. For example, 'controlled loss of control' has been documented by researchers as a social phenomenon in weekend drinking sessions (Fraser, Moore, & Keane, 2014; Measham & Brain, 2005).

The individual subject is invoked differently in the ANCD Recovery Roundtable report. Here, rather than being 'responsibilised', the individual is 'patientised'[1]. In sharp contrast to the neoliberal discourse of the UKDPC report identified above (where non-problematic substance use and the avoidance of harm are deemed to be within the control of autonomous individuals), the Australian report invokes a medical discourse. Throughout the ANCD (2012a, pp.2,3) report, there is a focus on treatment and interventions provided by "the drug and alcohol sector" and provision of "programs, and effective treatment options and interventions" (p.3). Terms such as "serious adverse outcomes" (p.2) and "continuity of care" (p.2) reinforce the medical discourse underpinning the document. This emphasis produces 'dependence' as a medical problem, to be addressed through a range of specialist services. Whereas the UKDPC statement emphasises individuals' choice and agency, the language of "care" (p.2) and "support" (p.1, 2) in the ANCD report constructs people experiencing drug "dependence" (p.1) more passively as 'patients' in need of 'help'. Recovery discourse is not granted a place in this 'patientised' problematisation (unlike the place granted within the 'responsibilised' construction identified in the British document, which is underpinned by individual rationality). The dominance of medical discourse and the privileging of the expertise of treatment services in the Australian document stands in contrast to the UKDPC statement which, by stating that "neither 'white-knuckle abstinence' […] nor being 'parked' on prescribed drugs […] constituted recovery" (UKDPC, 2008, p.6), challenges the discourse of both medicalised pharmacotherapy treatment and self-help movements.

[1] While 'medicalised' is a more commonly used term, we have chosen to use the term 'patientised' here. We suggest that being constituted as a 'patient' suggests something distinct and more specific than being produced as a medicalised subject.

Similar to the dividing practices at work in the UKDPC statement, by positioning "people with alcohol and drug problems and their families" (p.3) as having "needs" (p.3) which require "help" (p.2) "assistance and support" (p.1), the ANCD report discursively divides populations into two groups: those in the general population who can responsibly manage their own health, and others who are 'at risk' and therefore targeted for intervention and 'help' by services. In the ANCD report's summary, it is noted that "[p]articipants agreed that people want harm to self and the community to be minimised (including reducing or eliminating use) but that this requires a range of programs, and effective treatment options and interventions to be readily available" (ANCD, 2012a, p.3). The consensus expressed in this statement illustrates that despite the apparent contestation between those advocating for recovery-oriented systems and those advocating for harm minimisation and the existing treatment system (including pharmacotherapy), both positions in their Australian context produce individual drug using subjects as being in need of curative intervention.

'Recovery', well-being and the worthiness of the lives of people who use drugs

Following from this analysis of the conceptual logics underpinning problem representations, and particularly the people categories produced, we may also consider the political implications of these subjectivities. The UKDPC report says that "recovery is more than reducing or removing harms caused by substance misuse as it must also encompass the building of a fulfilling life" (UKDPC, 2008, p.6). Here, recovery inextricably links drug using behaviour with the worthiness of the lives of people who use them. By stating that "their relationship with the wider world (family, peers, community and wider society) is an intrinsic part of the recovery process" (p.6), recovery itself becomes the very means through which these people may be regarded as truly worthy citizens. Until a "fulfilling life" (p.6) is achieved, these people are, by implication, represented as somehow separate from "the wider world" (p.6) in which they live. The focus is not on drug use behaviour (or harms arising from it) but on the actual lives of the individual drug using subjects. Drug use is not represented to be a

distinct problem to be managed (for example through reducing the harms associated with use) but rather is tied to the attainment of a meaningful existence for these citizens.

The concept of individual responsibility for one's drug use, health and well-being is closely related to ideas about citizenship, productive roles, and what it means to make a meaningful contribution to society. In the UKDPC (2008, p.6) statement, "control over substance use" is linked to "maximis[ing] health and well-being and participation". Here, control over substance use necessarily *precedes* well-being which is said to encompass "both physical and mental good health", as well as "a satisfactory social environment" (p.6). 'Uncontrolled drug use' then is produced as the problem underlying poor health and social relations. It is not entirely clear what a 'satisfactory social environment' refers to in this context, but the implication is that its attainment is contingent upon reducing or ceasing drug use and "mov[ing] on" from treatment which is, in turn, required to "achieve lives that are as fulfilling as possible" (p.6). Aspiring to, and 'achieving', a fulfilling life is therefore predicated on an individual's capacity to 'attain' good health. This construction fails to problematise multiple barriers which may contribute to poor health outcomes and lack of participation such as poverty, equity of access, stigma and discrimination.

The final strand of the UKDPC group's vision for recovery focuses on an individual's "participation in the rights, roles and responsibilities of society" (p.6). This social dimension underscores the emphasis placed on wider 'citizenship' issues, particularly relating to employment, productivity and 'contribution' to society. The UKDPC group noted that 'rights' were included in order to acknowledge the stigma and discrimination "often associated with problematic substance use" (p.6). The ANCD document also points out that "there is a need to eradicate stigma and discrimination so that people can talk more openly about their drug and alcohol use" (ANCD, 2012a, p.2). Despite these statements, the pairing of 'rights' with 'roles' and 'responsibilities' nonetheless suggests that such rights are conditional upon making a contribution, being fit for work and 'productive'. Inclusion and "re-entry into society" (p.6) is dependent on this productivity and process of restitution. Issues

surrounding stigma and the reluctance of employers to employ people 'in recovery' are not addressed. Moreover, the emphasis placed on a particular set of neoliberal norms surrounding work and responsibility fail to acknowledge that recovery may be culturally, socially and personally specific. There is silence around the impact or consequences for different groups. For example, Thom (2010) argues that the emphasis on individual responsibility and ownership of recovery silences the differences in the social and normative contexts of men and women's lives, and therefore the differential impacts of mental health and substance use.

Similar to the UKDPC statement, in saying that Australia's National Drug Strategy "already has an objective to support people to recover from alcohol and drug dependence and assist their *reconnection* with the community" (p.1, emphasis added) the ANCD report implies that people who are drug dependent are 'outside' of the community, effectively producing them as 'separate' or 'non-citizens'. The assumptions underpinning this 'other-ing' construction of the drug using subject in many ways silences a counter-discourse in which the problem of drugs could be thought about differently: for example as a broad population health issue or one in which social factors may play a role in determining the health of a community.

Contesting or legitimising 'recovery'

Bacchi's (2009) approach encourages consideration of the practices and processes through which problem representations emerge and achieve legitimacy. In this section we focus on Bacchi's sixth question to analyse how the UKDPC and ANCD produced, disseminated and defended the constructions examined above.

The UKDPC operated from 2007 to 2012, commissioning research and collecting evidence on issues relating to drug policy and practice. It was a charity that aimed to "provide *independent* and *objective* analysis of drug policy; and to ensure this was used by UK governments when considering policy, and by the media and the public to encourage a wider, informed debate" (UKDPC, n.d.,

emphasis added). The UKDPC (n.d.) was self-described as "independent of government and special interests, both in its funding and work programme. It was not a campaigning body and did not come from any particular standpoint". The 'independence' of the UKDPC may be considered particularly important in dealing with the heated debates around 'recovery' which emerged from 2005 onwards. Their respected position within the drug field ensured that the representation of recovery put forward by the Consensus Group was promoted, legitimised, and most importantly defended in the event of any challenge. The ANCD, similarly, held a respected and privileged position within the drug field in Australia, reporting directly to the Prime Minister. From 1998 to 2014, the ANCD (n.d.) provided "*independent*, strategic advice to government" (emphasis added). The ANCD (n.d.) saw itself as representing members from government and non-government sectors across "treatment, medicine, research, law enforcement, Indigenous health, local government, education, mental health, consumers, and the magistracy from around Australia" and claimed to have the capacity to access "an extensive range of expertise". In this way, the ANCD was positioned as an authoritative 'opinion-leader' in drug policy in Australia.

The processes surrounding the UKDPC's vision statement and the ANCD's Recovery Roundtable were both responses to perceptions of increasing division and lack of unity within the drug field. Both reports can be viewed as documents of appeasement which attempted to reach a middle ground between those advocating an abstinence-only treatment policy and those wishing to maintain a harm reduction ethos within drug treatment. Both the UKDPC and the ANCD were seen as legitimate arbitrators of this debate, with the authority and means to bring together a range of stakeholders from across the respective sectors. The UKDPC aimed to ensure that the interests of all stakeholders were taken on board and concessions were made to both sides of the debate within the final drafting. In the UK, the timing of the publication of the vision statement in 2008 was important and ensured that this representation of recovery was embedded into the field prior to the election in May 2010. This helped to pave the way for the development of the recovery-oriented drug policy in England under the Coalition Government (HM Government, 2010). It is clear from the Australian

report that such consensus was not possible, and ongoing discussion in the form of a second Roundtable was intimated. It could be argued that the report released by the ANCD did little to progress discussion, or indeed change dominant ways of thinking. But by engaging in the process, the concerns and agendas of various stakeholders were given a 'legitimate' forum, thereby providing a moment of articulation for drug policy discussion in Australia. However, it is worth critically considering the range of effects produced by processes which aim to reach a 'middle ground'. The notion of 'middle ground' assumes that this kind of compromise is both achievable and desirable, which is not in itself a neutral position. Indeed, what it means to be neutral or objective in the context of drug policy is itself a complex and contested question. In addition, the language of 'middle ground' constructs critics and those who resist dominant problematisations as being somehow extreme or unreasonable, thus shaping the field of debate (that is, making it difficult to "think differently": Bacchi, 2009, p.16)[2].

Applying a critical lens to these processes, the legitimacy of both organisations rests on their ability to project themselves as rational, independent, apolitical bodies providing 'evidence-based' advice. These organisations are good examples of institutions which become 'enlisted' in the task of governing "through the knowledges they produce" (Bacchi, 2009, p.157). Paired with this is the dominance of 'evidence-based policy' discourse in nations such as Britain and Australia, which has been embraced with gusto by the drug policy field (for discussion see Lancaster, 2014). The recovery discussions thus provide fertile ground for critically examining what gets to count as valid knowledge in drug policy debates, and which voices may be heard. Both the UKDPC and ANCD processes selectively brought together specialised knowledge producers, many of whom were researchers, clinicians and sector representatives. Both reports positioned research as having a particular privileged status, either through citing research papers or explicitly mentioning the need for 'knowledge translation' and 'research investment'. These organisations secure positions of influence by claiming a position of 'objectivity' through deploying scientific evidence-based policy discourse.

[2] We thank one of the anonymous reviewers for their thoughtful comments on this point.

It is worth further reflecting on the way 'policy knowledge' was constructed in these recovery debates. Given their commitment to the importance of 'scientific evidence' and 'rationality' in drug policy debates, it is noteworthy that the UKDPC and the ANCD became involved in trying to develop consensus in an area with very little evidence on what constitutes recovery in the drugs field and the effectiveness of recovery-oriented treatment systems. The Scottish review of recovery literature concluded that there was a paucity of British research on recovery and that the international evidence base was limited by being out-of-date, based on alcohol rather than illicit drugs, and almost exclusively American (Best, et al., 2010). The review identified three areas which required significant research commitment (recovery-specific research, treatment and interventions, and prevention and public policy) to ensure that innovations in recovery practice were evidenced for the future (Best, et al., 2010). However, this merely speaks to the way particular kinds of knowledge come to be rendered valid or useful in policy discussion, highlighting the contested and constructed nature of policy-relevant knowledge in different contexts (Lancaster, 2014). The singular focus on producing evidence of 'what works' in drug treatment eschews a range of prior questions about how things may be 'known' and how the 'problem' to be 'solved' by drug treatment may be understood.

Conclusion

By applying Bacchi's approach we have identified similarities and important distinctions in the way that the problem of drugs has been shaped in two specific recovery policy discussions in Britain and Australia. The institutional and cultural contexts of the recovery discussions in the two jurisdictions allowed particular problem representations to emerge at particular points in time. While the reports have been compared as products of two separate processes, they are also overlapping and intersecting. The context in which the Australian debates took place was in many ways contingent upon the problematisations produced in 'recovery' discourse in the British context. It appears that it was in response to the meanings produced in the British debates that the proposal of 'recovery' *itself* was constituted as problematic in the Australian context, where recovery was not granted a

place within the dominant medical discourse. In many ways, the positions put forward in the two reports raise a mirror to each other: the British 'vision for recovery' problematises a particular way of thinking about drug treatment; while the vigorous defence of the existing treatment system proffered in the Australian context constitutes recovery as a threat. What we can conclude from this observation is that the problem of drugs is not fixed, but rather malleable and shaped by contextual factors; it is constituted by the very processes which seek solutions.

By unpicking the presuppositions underpinning the problem representations contained within the two documents, we identified distinctions in the ways that people who use drugs have been constructed as 'responsible agents' and 'patients' in need of curative attention, through the respective neoliberal and medical discourses at play. The potentially stigmatising effects of the dividing practices embedded within these constructions, and the silencing of alternative accounts of drug use practices and alternative social paradigms of health is important. The analysis here in many ways accords with previous research which has examined notions of 'responsible' and 'irresponsible' drug use within drug policy (see Bacchi, 2009, p.83). Our analysis now extends this to recovery discourse, which we suggest stands in contrast to the biomedical discourse of some contemporary neurobiological accounts of addiction as a 'chronic relapsing brain disease' by emphasising that people who use drugs have agency in their lives. Constituting people who use drugs in this way as rational and controlled neoliberal subjects may have intuitive appeal insofar as it apportions to people who use drugs the same respect and capabilities afforded to other citizens who, too, are expected to take responsibility their health. However, as Moore and Fraser (2006) have noted, engaging with and perpetuating such neoliberal constructions is not without risk and must be understood as a political decision. In weighing up the desirable and undesirable political effects, in the context of the ongoing recovery debate one approach may be to acknowledge the "strategic value of adopting the status of neo-liberal subject while remaining sceptical of it" (Moore & Fraser, 2006, p.3045).

Fraser et al. (2014, p.55) have argued that although the brain disease model produces addiction "as a physiological rather than psychological phenomenon, as incontrovertible, concrete and physically present in the body as heart disease" it simultaneously relies on the social and behavioural assumptions which underpin both psychological and popular notions of 'drug dependence' and 'addiction'. This too is evident in the documents analysed, insofar as what it means to 'recover' from 'dependence' was also intertwined with morally-weighted concepts of what it means to live a 'productive life'. The inclusion of social and life-style factors assumes that a 'satisfactory social environment' or 'connection with the community' cannot co-exist with drug dependence or addiction (see also Keane, Moore, & Fraser, 2011). Moreover, inextricably linking 'recovery from alcohol and drug dependence', health and well-being with the attainment of a meaningful and productive existence problematises people who use drugs *themselves*, and not just their drug using behaviour. In this sense, recovery is not a wholly new way of thinking about drug policy insofar as it reproduces many of the assumptions and conceptual logics underpinning dominant drug-related public discourse.

Policy processes create communities which produce and constitute ideas about drug policy, and institutions become 'enlisted' in the task of governing through the knowledges they produce and deploy. There is a lack of transparency about who actively participated in the writing of the UKDPC and ANCD reports, and how disagreements about language and conceptual logics were resolved. Such practices aim to communicate neutrality and a position unbiased by individual interests, thus privileging the authority of the expert group or committee and distributing responsibility (Fraser & Moore, 2011b). The perceived authority of the UKDPC and ANCD was critical to the recovery debates at the time these reports were produced. The analysis here illuminates the ways in which these organisations secured positions of legitimacy and influence through the deployment of 'evidence-based policy' discourse. By seeking 'evidence of effectiveness' of recovery interventions, or indeed by seeking consensus about how to define, implement and measure the outcomes of recovery-

oriented systems of care, the processes assumed that the problem of drugs was fixed, known and uncontroversial.

To our knowledge, this is the first time Bacchi's approach has been applied to international comparative policy analysis in the drug policy field. As Bacchi (2009, p.209) argues, "[a]sking how the 'problem' is represented in select contexts allows us to identify 'discursively constructed practices' that extend beyond singular geographical sites while keeping space open to reflect on contextual variation […] [T]he focus is on how these issues are conceptualised and with what effects in different sites." As noted in other analyses of this kind (see Bacchi & Eveline, 2010), it must be recognised that the documents were produced and analysed at a fixed time, while recovery discourse continues to evolve in different constantly changing contexts (consider, for example, the re-orientation of drug treatment services from 'rehabilitation' to 'recovery' in Ireland: Keane, McAleenan, & Barry, 2014; or the ongoing efforts to generate new 'measures' of recovery: Neale, et al., 2014). These were also complex documents, capturing the outcomes of contested discussion and a range of perspectives, and thus do not contain a single meaning. It is not unusual for policies to contain more than one problem representation within them and, as Bacchi (2009, p.4) notes, at times they may conflict and even contradict each other. This analysis has teased out some of the multiple representations in the two documents. There are other elements which have not been analysed here and which could be examined in future research. For example, what does it mean to use the language of 'a vision' for recovery? Or what fails to be problematised as a result of the 'consensus' process itself? How is the problem of drugs constituted in recovery discourse in other geographic and temporal sites? Finally, in making these observations, we are not suggesting that participants in the processes analysed (or indeed others engaged in wider drug policy discussions) have been in any way intentional or manipulative in their particular use of language and how it constructs the problem of drugs. As Bacchi (2009, p.91) notes, "[t]here is no suggestion of conspiracy in this kind of analysis".

The meaning of 'recovery' and how it could be realised in policy and practice is still being negotiated. By comparatively analysing how the problem of drugs was produced in 'recovery' discussions in two jurisdictions, at two specific points in the policy debate, we are reminded that ways of thinking about 'problems' reflect specific contexts, and how we are invoked to think about policy responses will be dependent upon these conditions. As 'recovery' continues to evolve, opening up spaces to discuss its contested meanings and effects will be an ongoing endeavour.

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Tables

Table 1 Bacchi's (2009, p.2) 'What's the problem represented to be?' approach to policy analysis

1. What's the 'problem' represented to be in a specific policy? 2. What presuppositions or assumptions underlie this representation of this 'problem'? 3. How has this representation of the 'problem' come about? 4. What is left unproblematic in this problem representation? Where are the silences? Can the 'problem' be thought about differently? 5. What effects are produced by this representation of the 'problem'? 6. How/where has this representation of the 'problem' been produced, disseminated and defended? How could it be questioned, disrupted and replaced? Apply this list of questions to your own problem representations.