White, W. L. (2011). Professional service and recovery advocacy in England
An interview with Mark Gilman. Posted at www.facesandvoicesofrecovery.org and
www.williamwhitepapers.com.

Professional Service and Recovery Advocacy in England
An Interview with Mark Gilman, MA
Strategic Recovery Lead
National Treatment Agency for Substance Misuse

William L. White

Introduction

I have written extensively about the emergence of recovery as a new organizing paradigm within the alcohol and drug problems arenas and that this shift entails substantial realignment of national policies, treatment philosophies, treatment practices, and treatment financing models. The movement toward recovery-oriented systems of care has been most successful where there are recovery champions within key organizations who do the difficult work of translating this conceptual shift to the realities of frontline addiction treatment and recovery support. Mark Gilman is such a recovery champion. In the interview below, Mark reviews his career in addictions research and treatment, discusses his work with the National Treatment Agency, and shares his thoughts on recovery management and the state of the recovery advocacy movement in the UK. Please join me in this engaging discussion.

Bill White: Mark, how did you first become aware of substance use, substance use disorders, and recovery?

Mark Gilman: I was born and bred in a place called Bury in Greater Manchester, UK. I lived in a newsagents shop owned by my parents. This was a kind of convenience store in an area where about half of the customers lived in social housing. It was not a very poor area, but it was blue collar working class. I first became aware of drugs when some boys at my school were arrested for stealing amphetamines from pharmacy stores.

Amphetamines were used by people who stayed up all night dancing at 'Northern Soul' music clubs in and around Manchester in the 1960s and 1970s. I left school at the age of 16 and spent 9 years engaged in a variety of jobs and travelling around the world.

Free Festivals emerged as part of the alternative culture of the 1960s. One of these Free Festivals was in a place called Deeply Vale near Bury. I was 21 years of age when Punk Rock featured at the Deeply Vale Festival in 1977. At the time, I didn't think of people being involved in 'recovery support work'. Organisations like Lifeline offered informal assistance to people who were having bad LSD trips or had taken too many barbiturates. I think the relevance of these early experiences was that of ***self-help***. Free Festivals and Punk Rock were about people doing it for themselves. If you can't afford to go to Glastonbury, set up a free festival. If you can't afford a ticket to see Pink Floyd, start your own Punk Band. The same principle applied to drug and alcohol problems. The idea of asking for outside help was never mentioned. '*You've got yourself into this mess, sort yourself out and get back to work!'* Mass unemployment and brown powder heroin arrived in the early 1980s and changed everything. There was no work to go back to, and heroin was to prove very resistant to self-help.

Bill White: Another of your early involvements was working in a research project studying youthful heroin users in Northern England. What are the most important things you learned from that project?

Mark Gilman: In 1981 at the age of 25, I went to college in Bradford, West Yorkshire, as a 'mature student'. I graduated with a first degree in Organisation Studies in 1984 and started work as a researcher investigating the growth of brown powder heroin use amongst young people in the North of England. The most important lesson was the relationship between 'addiction', addictive behaviors, and time management. Mass unemployment created time vacuums in people's lives. Taking care of the business of a heroin addiction filled this time vacuum. Discovering Preble and Casey's 1969 paper "Taking Care of Business" and the subsequent work of Bruce Johnson was a revelation. This experience also highlighted the limitations of relying solely on 'evidence' derived from treatment settings and treatment populations.

On September 15th, 1985, I began work as Fieldworker and Manager of Trafford Community Drugs Team (near my spiritual homeland of Manchester United Football Club). In essence, Trafford Community Drugs Team was a methadone clinic. One of the first clients was someone I had

interviewed only months before for the heroin research. In that interview, he described his life as a street addict as if "Taking Care of Business" were a full-time and challenging occupation. But in the methadone clinic, I was faced with a completely different person telling a completely different story. The vibrancy and dark humour of the 'ripping and running' street addict narrative was gone. Instead, the same guy became Dickens' Uriah Heep. In the methadone clinic, he was a poor helpless victim laid low by the disease of addiction, ever so humble to be restored to life by a generous methadone prescription.

Whatever else happened in these exchanges, we lost a truth. Our treatment interaction thereafter lost any authenticity. This is why I remain wary of treatment evidence gathered by treatment professionals in treatment settings alone. Any self-report evidence gathered in this way needs to be triangulated by harder evidence such as body fluid testing and police arrest data. Ideally, I would always want to see a qualitative, ethnographic investigation running alongside any quantitatively derived data. The UK treatment sector is data rich but analysis poor. We are awash with numbers and spreadsheets. Our challenge is to be able to say what all this quantitative data means in real terms and real time for real people.

Bill White: In 1985, you were invited to work at The Lifeline Project Drugs Advice and Treatment Charity. What was Lifeline and how did this opportunity arise?

Mark Gilman: Starting work with Lifeline was great because I knew of them from the Free Festival and Punk days. They had a good reputation. They were a Manchester organisation, and people I respected said good things about Lifeline. They were there to help people with drug problems, and they knew what they were talking about. I interviewed Rowdy Yates for the heroin research and immediately knew he was a genuine, authentic human being who I wanted to work for. Lifeline was recruiting to the Community Drug Teams. I applied and was appointed to the Trafford position. In 1987, I was promoted within Lifeline to Prevention Development Officer for the North West of England Region and then to Director of Research for Lifeline in the mid-1990s. Since that time, Lifeline has grown into a significant not-for-profit provider of substance use disorder interventions.

Bill White: You remained at Lifeline for 14 years. What were some of your most memorable experiences there?

Mark Gilman: Being absolutely honest, I thought I had made a terrible mistake at first. We didn't have premises for the Trafford Community Drugs Team till January 1986. So, I was based at the Lifeline Day Centre for about four months. Here, I watched on bewildered as self-styled therapists practiced on working class 'addicts' in the name of treatment. Again, I had the challenge of knowing many of the 'clients' or 'patients' as real people outside treatment. I was as baffled by the treatment language as they were. 'Support' was something you did to a football team. When I was told that we would be 'supporting a client in court', I had images of standing in the public gallery cheering the defendant and booing the prosecution. Thankfully, Rowdy Yates was also disturbed by all this and soon sorted it out. Ian Wardle arrived in the late 1980s and became Chief Executive in the early 1990s. Rowdy, Ian, and I all remain good friends to this day. Harm Reduction was very much the organising principle at Lifeline. With cooperation and advice from our colleagues in Liverpool, we set up needle and syringe exchange programmes. We produced harm reduction literature in the form of adult comic books. "Smack in the Eye" and "Peanut Pete" are probably collector's items today. I attended and presented at the early International Harm Reduction Conferences in Liverpool, Barcelona, Melbourne, and Rotterdam.

Bill White: In 1999, you became a drug adviser for the UK Government's Home Office (Criminal Justice Agencies and Correctional Facilities). What did you do in this role?

Mark Gilman: As a Drug Prevention Adviser for the Home Office, I worked with the 22 Drug and Alcohol Action Teams in the North West of England. Our role was to ensure that responses to drug problems were strategic and informed by the best available evidence. The main purpose was to raise the profile of substance use interventions and demonstrate that they offered a value for money investment. Crime reduction and community safety became the organising principle for treatment interventions. Methadone maintenance is a very attractive, evidence-based intervention for those charged with crime reduction and community safety. When combined with public health and general harm reduction, the purpose of substance use disorder interventions becomes to keep people alive and out of prison. Getting people abstinent from drugs and alcohol was never a primary goal. Public health and safety was, and is, the reason for such significant and continued public investment in drug treatment. When I started with Lifeline,

they had a turnover of about £200,000. Today, this is nearer £20 million. The sector overall has enjoyed similar growth over the last 25 years. Demonstrating the value for money of this unprecedented public investment in substance use disorder interventions remains crucial.

Bill White: You later joined the National Treatment Agency for Substance Misuse serving as North East Regional Manager and then the North West Regional Manager. What were your primary responsibilities in this role?

Mark Gilman: Going to the North East of England was a challenge. I am very familiar with Manchester and Liverpool and the North West of England. Places like Newcastle and Middleborough had a very different substance use profile. The North West has been responding to working class heroin use since the early 1980s. The North East had been largely unaffected until the 1990s. It wasn't hard to be a success in the North East as we simply had to implement initiatives that were seen to have been successful in the North West. From 2001 through 2004, I was known in the North East as a great advocate of methadone maintenance. I never heard the word 'recovery' mentioned in the UK until I returned to the North West in 2004/5.

Bill White: When did you first became enamored with the idea of recovery as an organising concept for addiction treatment and pre- and post-treatment recovery support services?

Mark Gilman: I returned to the North West in 2004. After three years away, I started to become concerned at the lack of movement of people in methadone maintenance treatment. I don't know what I expected, but it simply didn't feel right. People seemed to be stuck in a lifestyle of methadone maintenance and welfare dependency. At one level, this was a success: they were alive and out of prison. But their quality of life was a real cause for concern. Many were drinking alcohol excessively and most smoked tobacco. This was also a time when the economy was booming and there were lots of minimum wage jobs available but they were not taken by our clients. Whilst people came to the UK from all over the world to do these jobs, most of our clients chose to remain on welfare benefit. I am a great believer in the therapeutic power of employment, paying your own way, and (borrowing from George De Leon) 'living right'. My fundamental belief is that recovery is a bridge to normal living and that involves working, paying bills, and doing the right thing.

Bill White: You have worked to establish Recovery Oriented Integrated Systems (ROIS) in the North West. Describe your vision and achievements in this area to date.

Mark Gilman: I have long been inspired by the work of George De Leon. It was in the work of George De Leon that I first came across the notion of Recovery Oriented Integrated Systems (ROIS). I set myself the challenge of trying to articulate or better still, establish, an ROIS in a geographically defined community. De Leon's work on community as method was crucial in my thinking. De Leon's proposition is that by coming together as part of a therapeutic community people can learn how to live right. In the past, places like Liverpool had sent significant numbers of people to residential rehabilitation centres far away. Northern regional accents could be heard in residential rehabilitation centres all over the South of England. If they did well, they stayed away from their hometowns and cities. If they didn't do so well, they relapsed and came home. So, North West commissioners of residential rehabilitation were exporting 'success' and importing 'failure'. I wanted to see if we could establish an ROIS in a North West community setting. Could people get well where they got sick? Can people learn how to live *right* in the same communities where they had been living *wrong*?

I am now convinced that the answer is yes they can. Liverpool now has a very large and growing network of Narcotics Anonymous (NA). Cocaine Anonymous (CA) and Alcoholics Anonymous (AA) have seen similar growth. Many very expensive residential treatment centres use the 12 steps as their treatment programme and their aftercare programme. One of the best kept secrets of our world is that the cost of a copy of the AA Big Book varies from hundreds of thousands of pounds to a couple of dollars. Another is that the best place to hide money from an alcoholic is in the Big Book.

Bill White: Can you describe the North West Recovery Forum and its activities to date?

Mark Gilman: The North West Recovery Forum began as the North West Abstinence Forum. In early 2005, we wanted to increase access to treatments that were based on abstinence as opposed to harm reduction or controlled use. A group of almost twenty commissioners, providers, and ex-users met in Manchester to face this challenge from a local perspective. The North West was where the UK heroin epidemic started and we had a disproportionately high drug-misusing population. We discussed the role of

abstinence- based treatment and how to move from a focus on quantity to an emphasis on quality. This group gave birth to the North West Recovery Forum, which has been exploring the ways that treatment can be organised to support recovery ever since. In practice, the North West Recovery Forum is a contact list of over 300 people who are committed to the promotion of recovery in and beyond the North West of England. We have organised meetings, training events, and provided speakers. We have widened our stakeholder groups to show how recovery can give a much better return on investment to the police service, probation service, prison service, and social services. For example, some of the leading recovery advocates in Liverpool were once prolific and priority offenders (PPOs). Their criminal activities in active addiction may have been reduced by methadone prescribing. In abstinence-based recovery, they do not commit any crime at all. They go to work, pay their bills and look after their children. Members of the North West Recovery Forum are able to articulate and demonstrate how investing in recovery is an exemplar of 'investing public money to save public money'.

Bill White: You have acknowledged the influence of John McKnight and others on your own work. What are some of the most important ideas or strategies you have taken from John?

Mark Gilman: By 2009, it was becoming clear that there was a piece of our recovery jigsaw missing. What happens to people in long-term recovery? Do they just stay in 12-Step and SMART Recovery meetings? Where else do they go and what do they do? We had come to believe that people in long-term recovery were 'better than well'. This is where the work of John McKnight and his colleagues fits into the UK recovery picture. Asset-Based Community Development (ABCD) has emerged as a way of responding to the challenges posed by general health and social inequalities. The most difficult and complex cases of addiction, presenting to public services for treatment, tend to emerge from, and are located in, the most impoverished communities. Treatment alone cannot provide a long-term answer to addiction that has its roots in intergenerational health inequalities.

As our treatment system prepares for the transition to a new public health system under the auspices of a new body to be called Public Health England, the NTA is already encouraging local areas to adopt asset-based interventions. Its action plan for 2011-12 makes clear this approach will enable partnerships to assess the recovery networks of their own communities as part of the local strategic planning process. Treatment that

is recovery-oriented and recovery that is asset-based can ensure that our sector plays a major role in our new public health system. People recovering from addiction in the same post codes in which they were sick are real community assets. They show that new and healthier identities can be forged by coming together and creating communities that foster recovery in the widest sense of the word. I am indebted to John McKnight for this insight.

Bill White: Are you witnessing growth in the size, diversity, and geographical dispersion of recovery mutual aid societies in the UK?

Mark Gilman: The growth and geographical dispersion of recovery mutual aid societies in the UK is fascinating. Narcotics Anonymous (NA) is growing fastest in Liverpool. I have been told that the growth of NA in Liverpool and Merseyside is second only to the growth of NA in Iran. In the UK, 12-Step mutual aid has always been most evident where there are 12-Step treatment centres. The growth of 12-Step facilitation is complementing this and spreading the recovery message to areas where there hasn't previously been a 12-Step mutual aid presence. Cocaine Anonymous (CA) has also grown and tends to have close links to Alcoholics Anonymous (AA). In the UK, cocaine is often taken in combination with alcohol. Abstinence is the treatment goal for stimulant-based problems: '*you've got to turn the water off to mend the plumbing'*. Abstinence is also the treatment goal for alcohol problems. What we are seeing is people detoxifying from cocaine and alcohol and throwing themselves into CA and AA meetings. In some places, there is a renewed interest in the Primary Purpose of 12-step mutual aid: 'To show other alcoholics *precisely how we have recovered* is the main purpose of this book.' (*Alcoholics Anonymous*, pg. xiii). In some parts of the UK, SMART Recovery offers an alternative to 12-Step mutual aid. For many professionals working in community drug treatment in the UK, SMART Recovery is an easier concept to embrace than 12-Step because of the overt focus on CBT. Time will tell how 12-Step and SMART Recovery develop in the UK. Thanks to your work with the late Lisa Mojer-Torres, there is also an interest in Medication-Assisted Recovery and Recovery-Oriented Methadone Maintenance.

Bill White: How would you characterise the stage of recovery advocacy and peer recovery support services in the UK?

Mark Gilman: I would argue that the North West of England is the epicenter of the contemporary UK recovery movement. Recovery has struck

a chord with the people of the North West and the recovery tune is now being heard all over the UK. George De Leon commented on a recent visit to Liverpool that we can 'put the tambourine down now'. We have got people humming the recovery tune. Now we need to teach them the words.

Bill White: What developments in these areas are you most excited about?

Mark Gilman: That's easy. Getting well where you got sick and indigenous recovery communities.

Bill White: Have things advanced to the point that we can talk about a UK Recovery Advocacy Movement?

Mark Gilman: Yes.

Bill White: What are some of the most critical issues facing this movement?

Mark Gilman: Unrealistic recovery expectations of treatment services. Most UK community treatment services are rooted in harm reduction. They are there to keep people alive and out of prison. In the main, they are not places where you will find long-term recovery. That's not what they were set up to do. They were set up to reduce harm, and they do a great job that we should all applaud. The job of orthodox treatment services is to get people into treatment quickly, keep them alive and out of prison. Then keep them long enough for the treatment to make a difference and discharge them as a Successful Completion. It then becomes the job of the recovery communities, peers, and mutual aid to pick up the person and walk with them along the path to long-term recovery. The other critical issues concern definitions and measurement of recovery.

Bill White: There has been some conflict between newly emerging recovery advocacy organisations. How do you view such conflict and its future?

Mark Gilman: I think some conflict is inevitable in building a recovery movement. These conflicts will work their way through and out of the system. We've never been here before. We have had recovery since 1935. We have had methadone maintenance and treatment since 1965. The worlds of treatment and recovery have existed in different worlds. For many they

are different things. We are building bridges between two worlds. These bridges take people both ways: from treatment to recovery and, for many, from recovery back to treatment. We are working out a new language and ways of communicating between these two worlds. This is more of a challenge for the UK then the US because of our relationship with 12-Step mutual aid. AA, NA, and CA are at the heart of US recovery communities, and I believe will be at the heart of UK recovery communities, but this will take time here because of our cultural differences.

Bill White: You have visited the US and seen many of our recovery advocacy and recovery peer support projects. What are the most vivid recollections and lessons learned from that visit?

Mark Gilman: In the summer of 1995, I was a guest of the United States Information Agency. This took me to Washington, Kansas, Montana, San Francisco, New Orleans, and New York. During that visit, I was struck by the number of people in recovery who were running treatment services and how closely aligned their efforts were to the 12-Step mutual aid groups. I didn't experience the same gulf between treatment and recovery in the US. It was in the US that I was also first introduced to the idea of getting well where you got sick. It was also where I had the difference between self-help and mutual aid explained. I used to think of AA as self-help until a guy in Kansas City took me to an open AA meeting and said 'this is not self help. If we could help ourselves, why would we need to come here? This is mutual aid. We come together to find a common solution to a problem we all share'.

Bill White: Do you feel the UK recovery advocacy/support movement will parallel the US movement or generate new ideas and strategies unique to the UK context?

Mark Gilman: The UK recovery advocacy/support movement will develop in a different way because of the cultural differences. The UK is a very secular society compared to the US. When I first became a student of recovery, I was most taken by a statement in Bill's Story in the Big Book where he talks about how he came to embrace spirituality and how it *'…melted the icy intellectual mountain in whose shadow I had lived and shivered many years'*. There is a long way to go before our icy intellectual mountains are melted.

In the meantime, we have things like SMART Recovery that sit easier in the shadows of the UK treatment mountain. Of course, there is always the

issue of social class in the UK. The contemporary UK recovery movement is primarily a working class entity. For historical purposes, it may be worth remembering Harold Wilson's view that the British Labour movement owed more to Methodism than to Karl Marx. The UK recovery movement will evolve out of our history and our culture. We are generating new ideas and strategies. For example, we are about to explore the idea of contemporary sober living campuses and sober living communities in partnership with the Quakers. The UK recovery movement has some answers to some of the big questions facing British Society at large. In many ways, substance use disorders and 'addiction' are a response to, and symptoms of, a more fundamental societal malaise. If people can get well where they got sick, they will become role models for right living and assets in some of the most disenfranchised communities in England.

Bill White: How do you think this movement will influence the future of addiction treatment and recovery in the UK?

Mark Gilman: The UK recovery movement has already contributed to a paradigm shift in addiction treatment. We can't go back. The future is one where treatment and recovery co-exist and work with each other and not against each other.

Bill White: Have you encountered strain in your dual roles as a visible recovery advocate and a manager for the NTA? How have you prevented or managed such tension?

Mark Gilman: There have been times when I have encountered strain in my dual roles as a visible recovery advocate and a manager for the NTA. I have managed these tensions by taking the time to remember that we are privileged to be well paid to try and make life better for the people who suffer from substance use disorders and 'addiction'. There is a real tension between treatment that is funded primarily to protect the public's health and safety and recovery that exists to help individuals get well. This does require that I am able to hold onto two ideas that may seem contradictory at the same time. For example, in early recovery, many ex-heroin addicts take on a fervent anti-methadone position: 'they kept me on methadone too long!' It may also be true that the methadone treatment kept people alive long enough to hear and receive the recovery message. The same applies when discussing crime reduction and community safety. Methadone maintenance is a cost effective crime reduction intervention. Most English Council's would not

want to conduct a social experiment in closing down the methadone clinics and risk a rise in crime. The challenge for recovery communities and recovery centres is that they have to exist alongside harm reduction. Most of those in long-term recovery realize that their primary purpose is to keep their side of the street clean. Recovery communities and recovery centres need to be ready, willing, and able to welcome people who have successfully completed treatment.

Bill White: You have had a long career working in the arenas of addiction treatment and recovery. How have your views about addiction, addiction treatment, and recovery evolved over these years?

Mark Gilman: I have only met people in recovery in the UK since 2005. I now know that people do recover and that a fundamental part of this recovery is spiritual.

Bill White: What do you feel best about as you look over your time in this most unusual of professional fields?

Mark Gilman: Finding the humility to realize that professionals are not the experts in recovery. Rather, it is the people who are recovering or have recovered who are the real experts. Paraphrasing John Sutherland from his great book 'Last drink to LA' – in the world of addiction, addiction treatment, and recovery, it is 'the guinea pigs who wear the white coats'.

Bill White: Mark, thank you for this interview, and thank you for all you do for people seeking and in recovery.