



Australian drug policy:

harm reduction and 'new recovery'

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Executive Summary

The concept of “recovery” within alcohol and other drug treatment is far from new, and features in the demand reduction section of the Australian National Drugs Strategy.

Recent ‘recovery-oriented systems of care’ is a US-born concept that is shaping drug treatment policy in the United Kingdom, and is now in the early stages of being promoted in Australia. Leading proponents of the new recovery rhetoric do not claim it has a strong evidence base at the systems level.

Resourced properly, new recovery could build upon harm minimisation and harm reduction programs that have been so successful in Australia. Such programs have managed to control the spread of disease and have opened up opportunities for treatment, thus making a positive contribution to public health promotion in this country.

Recovery systems most prominently promoted in the US appear to now value some harm reduction interventions such as pharmacotherapy, but link its value to abstinence, including even from alcohol. It would be unpopular and counter-productive if that narrow United States conceptualisation of recovery processes and outcomes was to take hold in Australia.

If new recovery was to become an agreed strategy, it should only evolve over many years at the frontline. Transformation toward new recovery approaches would require large-scale investments.

A lesson from the United Kingdom is that the new recovery philosophy is driving policy, but no additional resources required for systems-level transformation are forthcoming. If that was to be replicated in Australia it would most likely be highly disruptive and create harm that our public health approach seeks to prevent.

New recovery recognises that interventions to combat complex behavioural difficulties need more holistic responses, and far better co-ordination of a range of government and community services, particularly at grass-roots levels.

Recovery pathways are contingent upon matters such as housing, work, access to education, child welfare, protection of vulnerable people, health services more generally and the ability to meaningfully participate in communities.

As such, to use an Australian colloquialism, if it is to be fairdinkum then it has to be far more than merely a re-badging of harm minimisation, which has served various governments and the community well for more than 25 years.

"Recovering addicts repay their debt to the community through acts of restitution, by returning to productive roles in their families and workplaces, and by putting resources into the community rather than taking resources out of the community. The recovery movement offers the challenge of redemptive service: 'You have been part of the problem; now be part of the solution!'" – New recovery movement advocate William White [1].

Introduction

Australia's national drug strategy is based on principles of harm minimisation. It stresses the importance of harm reduction as well as assisting people to "recover" from problematic alcohol and other drug use. Undefined, the term "recovery" appears throughout the document [2].

"Recovery" is an innocuous word. The Australian cricket team experiences recovery from a batting slump, economies go through recoveries from economic crises, a community experiences recovery following floods and political parties hope for recovery from poor polls. We barely notice the prolific use of the word.

The concept of "recovery" within alcohol and other drug treatment is far from new, with many vehicles claiming this as the aim over many decades and even as far back as at least the 19th century [3-7]. The emergent "new recovery" paradigm is more contemporary however [8]. It emerged in the mid-to-late 1990s, largely from the United States in areas such as Connecticut, Vermont and in Philadelphia under the auspices of the Department of Behavioural Health and Mental Retardation Services. The emergent concept of Recovery-Oriented Systems of Care (ROSC) is already associated with consumer- and carer-oriented mental health treatment and promotion [9-11].

New recovery is now becoming a more prominent part of the alcohol and drug treatment lexicon. Its exponents overtly describe it as a social movement. New recovery rhetoric is concerned with drug treatment and post-treatment outcomes, which in the Australian setting functions in the 'alcohol and other drugs' silos that also cover harm reduction.

"Recovery" is now official policy in the United Kingdom [12], including in Scotland [7]. In its recent "road map to recovery" statement, the UK Government stated that its "treatment system" would be based on three principles: wellbeing, citizenship, and freedom from dependence [12].

An atmosphere of budget cuts has established a context for concerns that this policy position could result in both an overall reduction in investment in the sector and a diversion of resources from the proven effectiveness of harm reduction principles and programs. It is notable that "harm reduction" as a term has been all but relegated to a footnote in the UK drugs strategy [13].

Associate Professor David Best, who established the United Kingdom Recovery Academy is one of the most prominent recovery-oriented research academics in the UK. He is now based at

Turning Point Alcohol and Drug Centre in Victoria, where he is promoting the new recovery paradigm and, with others, has also established a Recovery Academy in Australia.

Many stakeholders in the drug and alcohol sector are justifiably concerned that the new recovery approach may be at the expense of proven harm reduction measures, and the UK experience does not provide comfort on this score. For example, in February 2012 the UK Government announced that the strategy was for greater emphasis on individuals in treatment entering “Full Recovery”, and while recognising that entire systems transformations will be required, did not commit extra funding that would be required to achieve the transformation [12]. Within funding that is declining in real terms, 20 percent has been tied to a payment-by-results system in which services may receive payment for people who complete treatment and do not re-present for at least six months.

Stakeholders in the harm minimisation sector have voiced major concerns about the emphasis on “new recovery” creeping into Australia’s public health approach to alcohol and drugs.

The Australian National Council on Drugs (ANCD) recently sponsored and promoted a United States 'new recovery' advocate to Australia for a speaking tour. At least one Australian state, Victoria, appears to be moving toward a drug and alcohol system that places more emphasis on recovery. This is evident in the Victorian Government’s development of its Whole of Government Alcohol and Drug Strategy [14: 13].

It is clear that in Australia a period of increasing budget austerity on the part of all governments lies ahead. It can be expected that all opportunities to reduce public expenditure will be carefully examined by governments over the next few years.

The policy directions mentioned above may also make embracing of the new recovery agenda by governments more likely than may be the case in a less austere climate. The combined effect of these forces is to expose effective harm reduction policies and programs to a risk of de-emphasis and diversion of existing resources (to new recovery, or simply to budget savings).

Any shift toward new recovery paradigms as organisational principles in Australia must reflect our various alcohol and other drug policy frameworks, our history, values, our socio-economic realities and of course our culture. These are distinct from the United States and the United Kingdom from where the paradigm is being imported.

It is therefore timely to initiate an informed debate, one that takes what has emerged in other countries and considers how it may apply throughout Australia’s various – and changing – community welfare and health structures. Already in Australia there is considerable concern that the new recovery paradigm is a cloak for abstinence-only agendas. Without clarification of this in the Australian setting there is a distinct possibility that the emergence of the rhetoric, and application of it at policy levels, will be highly polarising. Examination of this issue is therefore warranted.

What does 'new recovery' mean?

Not all people who use alcohol and or illicit drugs need assistance. Some function with occasional to frequent consumption and do not feel they have issues from which they need to “recover”. This is particularly the case with alcohol where social norms in most countries do not perceive moderate and responsible alcohol consumption to be problematic. Conversely, while a range of views exist, it is reasonable to suggest that the prevailing view in most societies is to regard any use of illicit drugs as problematic in one way or another.

New recovery advocates state that “Recovery Management” and “Recovery-Oriented Systems of Care” (ROSC) are best suited to people with severe, chronic Alcohol or Other Drug (AOD) problems and who possess limited “recovery assets and resources” [6: 306]. This establishes that in theory at least, the new recovery paradigm is primarily concerned with people seeking, and willing, to begin a recovery “journey” rather than those who are, for whatever reason, not at that stage.

A stand-out feature of the new recovery paradigm is a claim to be an evolution of the pathology-based acute illness/care model, to one viewing substance addiction as a chronic illness and therefore requiring a sustained care framework. With less emphasis on acute interventions, it encourages “addiction treatment services to provide pre-recovery identification and engagement, recovery initiation and stabilisation, long-term recovery maintenance and quality of life enhancement for individuals and families” [9].

Debate amongst the new recovery movement, particularly in the United States, has displayed some difficulty with the question of whether or not abstinence is a pre-requisite for a person being considered as being in recovery or having recovered [15].

The Betty Ford Institute (BFI) has been influential in the shaping of the new recovery movement in the United States. Perhaps not surprisingly given its history, in 2007 the Institute wrote:

“recovery from substance dependence is a voluntarily maintained lifestyle characterised by *sobriety*, personal health, and citizenship” [16: emphasis added].

BFI revisited the issue in 2009 and reaffirmed the position that sobriety is complete abstinence [17]. Prominent new recovery activist and writer William White considers this to have critically restrictive implications for what has been described as Recovery-Oriented Methadone Maintenance (ROMM) [18].

A more detailed *proposed* definition of recovery has been put forward as “the experience (a process and a sustained status) through which individuals, families, and communities impacted by severe alcohol and other drug (AOD) problems utilise internal and external resources to voluntarily resolve these problems, heal the wounds inflicted by AOD-related problems, actively

manage their continued vulnerability to such problems, and develop a healthy, productive, and meaningful life" [19: 236].

One of the most commonly referred to examples of a recovery- oriented community-based network evolution comes from the Connecticut Community for Addiction Recovery (CCAR). Founders and participants wrestled with attempted definitions, wondering "Is abstinence a requirement? What about medication? What about methadone? Should there be an amount of clean time required for participation and/or membership?" [20].

Finally, they concluded that "you are in recovery if you say you are." That very open and inclusive quasi-definition is, however, not yet reflected in the prevailing mainstream new recovery paradigm. In the United States, from where this paradigm is still being driven, an emphasis on abstinence remains evident.

How comprehensive is the new recovery evidence base?

Effective public policy should be based on evidence. This is particularly the case in the field of illicit drug use because of its susceptibility to fear-based exploitation. It is standard procedure in health policy for new drugs or treatment regimes to be tested against simple criteria such as safety, and effectiveness.

Writing in 2000, White pointed to the paucity of evidence about what constitutes recovery journeys:

"We know a great deal about addiction and that body of knowledge grows daily, but we know very little about recovery. We have elaborate systems to measure the incidence and prevalence of AOD use, and AOD problems, but virtually no comparable systems that can tell us the number or characteristics of those who have found enduring solutions to these problems. We study the status of people a few months or a few years following a treatment episode, while we know virtually nothing about people whose recovery is measured not in weeks or months but in decades" [1].

Eleven years later, he restated that the effectiveness of recovery-oriented treatment systems was not yet supported by evidence beyond small-scale local case studies [6]. It is apparent therefore, that at the services systems and overarching policy level, new recovery remains an unproven aspiration [7: 8, 21].

For example, a 2009 review of the evidence by the United States' Substance Abuse and Mental Health Services Administration claimed "the literature is scant". It states:

"Although States and communities are implementing a variety of services and activities to create recovery-oriented systems, there is minimal research in peer-reviewed journals that examines the framework and the effectiveness and outcomes of this framework" [11].

In preparation for a 2009 symposium to address a lack of scientific rigour behind the new recovery movement, Laudet said long-term recovery was virtually uncharted territory. “How can we effectively promote something we poorly understand and have not adequately examined?” [22].

Australians should reflect on this when considering wholesale or even cosmetic shifts toward adopting the new recovery agenda. A review of recovery literature conducted for the Scottish Government published in 2010 concluded there was little UK-based research:

“The international evidence base on recovery is limited by three factors: 1) much of the evidence is dated; 2) much of it is based on alcohol rather than illicit drugs; and 3) almost all the evidence originates from the United States” [7].

Even though “new recovery” has become official treatment system mantra and policy in the UK, there are no agreed standards or metrics by which to measure its failure or effectiveness [23].

This contrasts with the evidence base for the effectiveness of harm reduction programs. For example, the value of NSPs is proven [24, 25]. A large body of peer-reviewed studies have repeatedly demonstrated the health and subsequent economic benefits of such programs to be safe, and most certainly effective [24]. Beyond their communicable disease role, the NSPs provide the most frequented interface with current injecting drug users not in treatment and so provide a cornerstone for evidence-based funding and program enhancement.

Search for consensus

There is a view that it is not necessary to canvass potential definitions for an Australian understanding of new recovery rhetoric as it applies to the alcohol and other drug sector. The newly created Victorian-based Recovery Academy is promoting the minority Connecticut Community for Addiction Recovery view of “if you say you are you are”. While that may be a valid conceptual endpoint, it is inconsistent with the Australian practice of clear, and evolving, definitions. Avoiding clarity, definitions or principles is also out-of-step with what those in alcohol and other drug policy and practice are currently seeking.

Definitional imprecision presents risk for Australia’s long-established harm minimisation system, (including the pillar of harm reduction). A lack of clarity generates a consequential degree of “wriggle room” for policy and decision makers to generate poorly thought through policy resulting in sub-optimal program outcomes, generating poorly targeted cost shifting and cutting opportunities potentially in tandem with political populism. No one can carefully consider an amorphous “new recovery”, but evidence-based policy making requires rigorous conceptual clarity.

The United Kingdom Recovery Federation has developed a consensus position which reflects the “if you say you are” self-determinative spirit [26]. It includes the following statements:

1. Recovery transcends, whilst embracing, harm reduction and abstinence-based approaches and does not seek to be prescriptive.
2. Recovery exists on a continuum of improved health and well-being.
3. There are many pathways to Recovery and no individual, community or organisation has the right to claim ownership of the 'right pathway.'
4. Recovery involves a continual process of change and self-redefinition for individuals, families, organisations and communities.
5. Recovery is supported by peers, families and allies within communities.
6. Recovery lies within individuals, families and communities and is self directed and empowering.
7. Recovery lies within our 'connectedness' to others, is holistic and has many cultural dimensions.
8. Recovery involves the personal, cultural and structural recognition of the need for participative change, transformation and the building of recovery capital.

The United Kingdom Drug Policy Commission described the process of recovery as “voluntarily-sustained control over substance use which maximises health and well-being and participation in the rights, roles and responsibilities of society” [26: 6].

In late 2011 the US Substance Abuse and Mental Health Services Administration (SAMHSA), following consultation, adopted the following “working definition” for both “mental disorders and substance use disorders”: “a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential” [27]. In March 2012 the working definition was amended to place greater emphasis on abstinence [28].

In summary, proponents of new recovery have struggled to define with any great precision exactly what it means. In the United States, which has the capacity to greatly shape international drug policy agendas, the reference to abstinence remains firmly within the mainstream conceptualisation of new recovery definitions.

Role of mutual aid groups and communities

The new recovery paradigm emphasises that mutual aid groups are a vital and successful element for creating social environments to help people reduce and eliminate alcohol and other drug addiction. Alcoholics Anonymous is one prominent example. Mutual aid groups can take other forms such as Narcotics Anonymous and the trademarked SMART Recovery programs.

Sometimes referred to as Recovery Community Organisations (RCOs), they have been loosely

defined as independent, non-profit organisations led and governed by representatives of local communities of recovery. They may organise policy advocacy, carry out recovery-focused community education and outreach programs, and/or provide peer-based support services [5, 6, 29-32].

The new recovery movement envisages the development and diffusion, in a contagion-like manner, of mutual aid groups. This has been visible in the UK over recent years. In 2004 White warned that if it became a “commercialised” system featuring “an ever-growing recovery support services industrial complex, this experiment will have failed horribly” [5]. Interestingly, the key new recovery advocates at this time in Australia are professionals working in the government funded drug treatment sector.

With a population of 302 million, it was estimated in 2007 that there were “more than 175”, RCOs in the United States at the time [30], suggesting that new recovery rhetoric aside, scale remains a major challenge

Where do harm reduction and new recovery sit in the Australian context?

Australia has a well established, three-pillar approach to drug harm minimisation on which successive National Drugs Strategies have been based – supply, demand and harm reduction.

The National Drugs Strategy 2010-2015 includes: “support people to recover from dependence and reintegrate with the community [2]”. Emergent new recovery-oriented care and treatment principles would most clearly align with the “demand reduction” pillar.

Recovery-oriented measures may also be in accordance with harm reduction given that reducing drug injection frequency, as well as temporary or permanent cessation of illicit drug use (abstinence) also reduces the risk of contracting a blood borne virus [33]. In its position statement Harm Reduction International (formerly International Harm Reduction Association) explicitly acknowledges that abstinence is a desirable option:

“The objective of harm reduction in a specific context can often be arranged in a hierarchy with the more feasible options at one end (e.g. measures to keep people healthy) and less feasible but desirable options at the other end. Abstinence can be considered a difficult to achieve but desirable option for harm reduction in such a hierarchy” [34].

As of 2010 there were an estimated 46,000 people on some form of opioid replacement/substitution pharmacotherapy in Australia [35]. Can people participating in such programs to either reduce or cease illicit opioid use, be considered to be in recovery within the emergent new paradigm?

A prolific and influential advocate associated with the emergent recovery agenda is US writer William White, who was once of the view that methadone clients were outside the definition of

recovery. He is now clear that new recovery paradigms can and should include people on pharmacotherapy [36], stating that “denying medically and socially stabilised methadone patients the status of recovery is a particularly stigmatising consequence” [1]. He suggests a term which is now emerging as part of the recovery discourse, “medication-assisted recovery” [37], and more recently, Recovery-Oriented Methadone Maintenance (ROMM) [18].

White warns recovery activists, and mutual aid groups, against creating a form of elitism in which people on pharmacotherapy were seen as “less than full members of local recovery communities” [37].

While the recovery movement in the US now appears to endorse pharmacotherapy, intense debate has occurred for many years as to whether or not people stabilised on methadone were genuinely in recovery [15]. White now argues they *can* be welcomed into the recovery community, but in doing so, repeats the criterion that “methadone maintenance” “helps the patient abstain from the use of alcohol and other intoxicating drugs” [18: VI]. This again underscores the continuing undertone of abstinence in the debate.

Under this scenario, which is firmly in line with the BFI consensus position, it would effectively mean that a person who has been stable on pharmacotherapy for 10 years, and had not used any other illicit drug or licit drug for non-medical purposes, but drinks alcohol (at any level) does not meet the first criterion for being in recovery or having recovered. Furthermore, a person who had been on methadone to become abstinent from heroin, and had consumed neither for 10 years, but who moderately drank alcohol, is also outside the BFI definition of what constitutes recovery.

Such a restrictive and arguably puritanical and discriminatory definition is the current position expressed in much of the US-based new recovery movement literature. It is distinctly at odds with Australia’s mixed-methods approach to drug policy, and can be expected to be roundly criticised by the Australian public health community.

Various authors argue that harm reduction and recovery should not only co-exist in the policy and practice space, but are mutually complementary and enhance each other [see 38].

For instance, Neale argues that “harm reduction has a very important role to play when drug users say they want abstinence” and “the harm reduction field will likely find that it has more in common with abstinence-oriented services and the broader recovery agenda than it might otherwise have imagined” [39].

This is supported by Hunt, who told the 2011 International Harm Reduction Conference that, based upon developments and emerging concepts of recovery in the UK, “certainly the understanding of recovery that I had a few years ago should be put in the dustbin because it is foolish – it does not recognise a lot of the opportunities and possibilities that currently exist” [40].

Programs which provide injecting drug users with access to sterile needles and syringes, as well

as referrals to other health and social services, are a leading example of a harm reduction-based response and a vital element of harm minimisation.

While there has been little detailed consideration of where precisely needle and syringe programs sit within recovery-oriented paradigms, Best has stated that:

“there is nothing incompatible about harm reduction and recovery models ... there is no incompatibility between needle exchanges or the provision of naloxone to prevent overdose fatality and the recovery agenda” [3: 139], and in addition, “harm reduction and recovery are predicated in the same basic principles of community-based interventions” [41].

It can clearly be seen that work by needle and syringe programs in reducing blood borne virus transmission risks, and making referrals to other social services, remains an important dimension of drug policies and practice. White lists “needle exchange programs” as a valid recovery component particularly as NSPs can have referral functions [9], and clearly states:

“my position has been pretty clear that the abstinence/harm reduction dichotomies/service silos are counterproductive and that all Recovery Management or Recovery-oriented Systems of Care sites need to integrate harm reduction, and all harm reduction strategies need to have recovery as a visible option” [42].

Pickard, who manages an established Australian recovery-oriented service, states that we should not:

“...think that recovery is only at the shiny end where people are publicly speaking about change transformation. That’s fabulous, but there are also valuable recovery content in a person who is visiting a needle and syringe/primary health care service” ... “particularly when able to also have some healthcare needs addressed” [43].

This view is echoed by prominent UK new recovery movement activist Stephen Bamber, who wrote that:

“The real-world benefits of NSPs are overwhelmingly positive. As a corollary of promoting harm reduction goals of safer using, stabilisation, 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” [44].

We can conclude from the foregoing that, far from being at odds with the new recovery model, harm reduction policies and programs should be regarded as being in harmony with current thinking in the new recovery space. Harm reduction policy and programs should continue to feature in an integrated, coherent and effective response to the challenges of illicit drug and problematic alcohol use in Australian society.

New recovery role model and HIV prevention performance

Notwithstanding these indications that opinion leaders in the new recovery model readily conceive of the mutual complementarity with harm reduction programs, consideration of a US case study is cause for concern about the actual reality on the ground.

Connecticut is held up as a ROSC model by the new recovery movement [3, 23, 29]. According to the Connecticut Department of Health, it has an active outreach-based Drug Treatment Advocacy (DTA) program. The stated mission of the DTA program is to: “prevent the spread of the HIV/AIDS virus through intervention and facilitation of clients into drug treatment programs that lead to recovery” [45].

The Connecticut outreach workers are instructed to engage in motivational interviewing, co-planning on a client-by-client basis and to establish strong community partnership with relevant support services (eg: legal, housing, employment, job training etc) [45]. Connecticut HIV prevention outreach guidelines say “start where the client is: not all clients are ready for treatment”. They then urge workers to “*motivate clients* to seek treatment: DTA should help clients address crises that may impede treatment” [45: emphasis added].

Most notably however, the DTA guidelines for HIV prevention amongst people who inject drugs make no reference to what are universally recognised as being essential to HIV prevention amongst those populations: interventions such as sterile needle provision, education on safer needle use and disposal, overdose avoidance, condom provision and health promotion more broadly [45].

An indication of where more conventional HIV prevention amongst injecting drug users is prioritised in a reportedly role-model new recovery-oriented health system is to consider its coverage and scale of sterile injecting equipment provision. The extent to which Connecticut practises needle exchange is an indicator of the degree to which the function of new recovery is complemented by harm reduction. The population of Connecticut is approximately 3.6 million. By comparison, the population of Queensland is approximately 4.6 million.

Connecticut has only four needle exchange sites [46]. People are ‘enrolled’ in a needle exchange program, and it is reported that 175,786 “syringes” were distributed for the 2009-2010 financial

year. More than seven million sterile needle and syringes were distributed in Queensland in 2007/2008, and more than 10 million in 2010.

The state of Connecticut's sterile needle and syringe distribution is roughly equivalent to just one medium-sized integrated primary needle and syringe program outlet in Victoria in the same year.

It is reported that in Connecticut 75 new HIV infections were attributed to drug injection in 2008 and 100 new infections were reported for the 2008-2009 financial year, although that is down from the several hundred earlier in the decade [47, 48]. By comparison, in Australia there were no new HIV infections attributed to drug injection in 2008 as reported by the 2009 annual surveillance report [49]. Obviously the epidemiological settings, shaped by history of HIV prevention responses, are different.

There does not appear to be any substantial discussion of needle exchange programs and HIV rates when the 'role model' Connecticut case study was discussed in the new recovery literature. This is indicative of the general lack of discussion about HIV prevention or hepatitis management within new recovery literature more generally, and points to an obvious challenge for policymakers and health services in Australia. The Connecticut academic, Professor Merrill Stringer, who has extensive experience in HIV prevention research, said the Connecticut's recovery approach has "never been in conflict with harm reduction or the needle exchange program" [50].

The existence of high rates of HIV transmission amongst injecting drug users in the celebrated new recovery Connecticut case study illustrates that new recovery advocates have not adequately considered important public health priorities in relation to drug use. Lives may be lost if a new recovery focus was to evolve alongside devalued harm reduction approaches.

Reconfiguration and resources

Governments forming the view that a reconfiguration of the overall service system in the drug and alcohol field to one based largely on new recovery principles will be simple, quick and generate significant savings would be misguided. The available evidence suggests the contrary, and to take significant steps down this path on the basis of such unfounded assumptions is likely to inevitably invite further negative findings such as those in a recent report of the Victorian Auditor General [51].

Any shift to recovery-oriented programs and systems "requires a fundamental change in the culture and attitudes of professionals and communities" [23]. Building communication and trust, as well as shifting the power balance toward consumers of treatment services, is at the heart of envisioned ROSC [23, 32].

Changes in attitude and practice must be far more than rhetoric:

“achieving both a recovery-oriented system of care and the implementation of a recovery management philosophy requires substantial changes in treatment philosophies, purchase-of-care strategies, regulatory policies and monitoring protocols, clinical and support service menus, service relationships, the roles of the service professional and service consumer, the training and supervision of staff and volunteers, and intra- and inter-organisational relationships” [9: 18].

Elements that may feature in a “recovery management model”, it has been argued, could include: multi-agency, multi-disciplinary service teams, integrated or aligned funding streams, cross-training and frequent case conference that include clients and families, coordinated and consistent communication of client/family expectations across all service organisations, an integrated assessment process, use of a single service plan across agencies and rigorous monitoring and “early re-intervention” [9, 52].

A conclusion from one case study was that re-orienting a state treatment system: “requires changes at the system, program, and practitioner levels as well as redefinition and innovation in the service content, delivery/infrastructures, finance mechanisms and outcomes” [53: 232].

Another case study stressed that organisations’ cultures and staff attitudes needed to change, and while shifting to new recovery was possible it was found to be “really, really hard” [54: 255].

For recovery to become the “dominant model”, it is argued, would require “strategic vision and *bravery*” [3: 99, emphasis added]. The concept of a need for boldness or “bravery” has political implications, from the service manager through to government decision makers tasked with improving public health outcomes within political and budgetary constraints.

The consensus is that it takes five to 10 years for organisations/systems to shift toward recovery [6]. In Liverpool, which is regarded as being somewhat down the recovery path, “the speed of transition is slow, and there are on-going cultural issues about the extent of transition to a recovery-oriented approach” [3: 127], leading to the conclusion that “there is little evidence that the overall treatment system has evolved sufficiently to maximise these benefits” [3: 130].

Investment implications

It is lazy to recommend policy shifts in isolation from such key questions as: how much will it cost and can the costs be justified based on the evidence? This is particularly relevant at this juncture in the Australian funding environment, with governments seeking to reduce overall spending.

Rickwood, who has substantial experience in the Australian mental health policy shifts toward recovery principles, has stated:

“The experience from the mental health sector shows that evolving toward a more recovery-oriented approach is a considerable task. Mental health reform has been taking place over the past 20 years in Australia, and there is still much more to be done. A recovery-oriented system of integrated services, which support the changing needs of consumers over time, requires deep systems-level transformations, and tens of millions of dollars in additional government investment. It’s not a cheap quick fix ... investment needs to be commensurate with the substantial disease burden attributed to mental and substance use disorders” [55].

With limited international evidence demonstrating the effectiveness of the new recovery paradigm in the drug treatment sphere, such a re-orientation has major implications for the investment required to bring it about with maximum effectiveness.

Re-orienting and re-tooling an entire system toward an overt US-inspired ROSC is a challenge in any economic environment. White recognises this, questioning how it could be achieved “in an environment of tightening resources” [9]. The rise of the new recovery paradigm in the US occurred ahead of the 2008 global financial crisis which has been followed by budgetary cutbacks. England’s government implemented recovery policy simultaneously with significant budget realignment.

It has been noted, based upon the limited UK data to date, that “switching to recovery systems” involving “specialist recovery groups” was much more expensive and difficult than treating “lots of clients in outpatient opiate substitution programmes” [3].

Best told the *Anex Bulletin* in 2011 that it ultimately need not be a more expensive approach. He says that after some initial “pump priming” “governments and politicians like this agenda because it is cheaper in the long term” [41]. However, there does not appear to be the evidence-base required to understand whether or not transforming treatment systems in accordance with the new recovery paradigm would require less investment, let alone a better return on investment.

Transformations toward recovery-oriented systems in the mental health field in Australia indicates that not only is it difficult, time-consuming and requiring fundamental changes, it is an expensive exercise. The harm reduction sector has suffered from severe under investment in Australia. Redressing this problem should be a challenge for all interested in Australia’s public health success.

An environmental conceptualisation

The structural changes required should not be under-estimated. There is fertile ground upon which to situate recovery-oriented systems within the ‘risk environment’ approach associated with Professor Tim Rhodes [25, 56-58]. Such a structural analysis seeks to emphasise that

structural responses, building of social cohesion, social capital and 'solidarity' are required [7, 58]. A structural approach to HIV prevention, it is argued, regards risk environments as

“the space, whether social or physical, in which a variety of factors exogenous to the individual interact to increase vulnerability”, and “much of the most needed 'structural HIV prevention' is unavoidably political in that it calls for community actions and structural changes within a broad framework concerned to alleviate inequity in health, welfare and human rights” [57].

In attempting to better understand factors that assist recovery, its prominent proponents have noted something similar:

“More attention also needs to be given to the role of the environment where substance misuse and remission unfold; the role of environment safety, opportunity for leisure, access to services have been neglected thus far as research typically focuses on individual-level domains to elucidate a psychosocial process” [59].

It is apparent then that harm reduction and new recovery paradigms both need to be concerned in understanding broader questions of social inclusion, especially including employment and housing, community development as well as causes and consequences of inter-generational alcohol and other drug misuse [57, 60].

Therefore, a new recovery-oriented alcohol and other drug policy cannot positively affect any community without also addressing social problems such as those contributing to poor physical and mental health, sub-standard housing, employment (paid or unpaid), and of course the availability and proximity to substances [57, 60].

One of the fundamental premises underpinning a person's potential for 'recovery' is their 'recovery capital' [21, 22, 59]. Three recovery-oriented sites in the UK describe recovery capital and people's potential readiness as being:

- Abstinent from use of crack cocaine and heroin (for a month prior);
- No acute housing problems reported;
- A form of structured activity (at least one day of employment, training or formal education in the last month).

It was found that even when only those three basic criteria were applied, only “one in 12 individuals in the participating sites would qualify as ready for their recovery journeys” [3: 117].

Given that workforce participation is one indicator of a person being in recovery or having recovered [12, 31, 61, 62], recovery on a community-wide impact level is unachievable without the participation of the private sector where most employment, employment loss, workplace stimuli and trauma occurs. This is one of the lessons described in the Connecticut Community

for Addiction Recovery case-study, where volunteer recovery 'counsellors' were trained in assisting people find employment [20].

However, as has been documented in the UK, there are extremely complex and deeply embedded structural barriers preventing many people with problematic substance use histories entering the workforce, one of which is insistence by employers to conduct drug testing and criminal record checks on job applicants [61, 62].

Australia's employment support system has been regarded by some commentators as not serving the particular needs of those whose barriers to employment include a disability, injury or other health conditions which should, but is generally not understood to include addictions. The current system encourages and rewards employment service providers for relatively quick interventions and early placement into employment, "easy wins". It does not encourage or support more holistic and supportive case management of a client's whole set of circumstances to bring about a long term, sustainable change in those circumstances.

A large scale move to new recovery-oriented approaches should not be undertaken in isolation from much wider consideration of other elements of government activity and policy that may impact on the effectiveness of such a move. This has very significant ramifications for the speed and scope of any such re-orientation of drug and alcohol policy.

In conclusion

We know new recovery in the form that is spreading from the United States to Australia via the UK has a particular philosophy and meaning attached to it when used in the context of drug policy. It has a philosophy and meaning that could see it become a tool that undermines the support for, and therefore the value of, Australia's evidence-based harm minimisation policies and approaches.

In particular, there is a natural suspicion that policy shifts toward a systems-level recovery-oriented paradigm could threaten the backbone of the needle and syringe programs and opioid replacement treatment systems. This remains to be seen, but indeed may turn out to be the case if new recovery becomes a rushed operating paradigm without investment in the necessary *additional* resources required to implement it.

Recovery models and rhetoric should not be used to either mask or justify erosion of the lifesaving and cost effective approach of harm reduction throughout Australia. Some prominent new recovery leaders purportedly support the mutual complementarity of harm reduction and recovery programs. However, new recovery has rarely championed harm reduction programs. A simple new recovery adoption will therefore likely erode the lifesaving Australian harm minimisation approach.

Given the weak evidence-base, wholesale shifts toward the new recovery paradigm as it is currently framed involves significant risks. In a contemporary context of government budget pressures, this risk is heightened.

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