ReCovery Oriented Practice

Supporting Evidence

Understanding Recovery-Oriented Practice

What is it?

Recovery is typically described as a journey, a process of change in which a person seeks to overcome the impacts of alcohol and other drug (AOD) use on their lives. Given the nature of AOD dependence and the multiple, interconnected factors contributing to the process, the journey is usually a long one. Recovery literature often estimating a period of five-to-seven years before someone can expect to achieve sustained results (Sheedy & Whitter, 2009).

The concept of Recovery has existed for some time (White, 2012; Best, 2012; Anex, 2012). Adopted by a wide variety of groups, the concept is subject to ongoing debate amongst the loose association of groups that are often collectively referred to (by members and non-members) as the 'Recovery Movement' (Bamber & White, 2011).

While particular principles or points of emphasis (such as the importance of 'sobriety' and the acceptability of pharmacotherapies or harm reduction services can be hotly contested within the movement, there is general agreement on the broad understanding of Recovery premised on the following principles:

- Voluntary action – people undertaking long-term efforts out of a strong desire for change;
- Peer support – recognising the expertise with lived experience of AOD dependence and recovery to support the efforts of others;
- Recovery capital – strengthening the individual factors (e.g. motivation, confidence, physical and mental health, relapse prevention and mood management skills) community supports (e.g. housing, employment, service and support networks) to enable ongoing growth and personal development;
- Improved quality of life – including individuals' concept of self and positive changes in physical and mental health, relationships, social participation, employment etc.
- Citizenship – making amends for past behaviour through meaningful contributions to the Recovery community and wider society (BFI, 2007; Sheedy & Whitter, 2009; Best et al, 2010; Bamber & White, 2011; SAMHSA, 2011)

Describing AOD Recovery

It is generally recognised that there is a range of possible interpretations of the meaning of Recovery and that it is impossible to provide a clear definition beyond general principles (Neale, Nettleton & Pickering, 2012; Best et al, 2013). Even within the comparatively restricted domain of alcohol and other drugs, the context of ideas within the Recovery movement incorporates a wide philosophical spectrum,

from the original 12-step model to 'New Recovery' see below and concepts such as White and Kurtz's 'amplified recovery' (White, 2014) that seeks to reframe Recovery discourse away from a focus on undoing harm to highlighting the potential for people's capacity to make social contributions to be enhanced by their experience of dependence and Recovery.

For the sake of consistency, this document uses the term 'Recovery' to loosely capture the range of meanings inherent within the concept, in the context of alcohol and other drugs. Where necessary, 'New Recovery' is used when necessary to describe features particular to that approach and their relevance to Australian drug treatment and policy.

'New Recovery'

There have been broad efforts within the Recovery movement to expand the concept of recovery to incorporate additional ideas that will enhance its capacity to promote Recovery as unifying approach to the various responses to AOD-related harms at an individual, family and community level. These ideas include:

- Empowerment – working in equal partnership with people in recovery to identify, achieve and review their recovery goals;
- Positive reframing – turning AOD discourse from being problem and harm-focussed, towards messages of hope and wellbeing;
- Recovery advocacy – using personal stories of transformation to inspire others and challenge stigma;
- Policy change – establishing Recovery as an overarching philosophy for Government AOD policy and service delivery;
- Integrated, continuous care – developing closer ties between specialist treatment services and peer-based Recovery supports;
- Life-long support – providing a support framework that will assist people's recovery throughout various life stages (Sheedy & Whitter, 2009; White, 2000, 2008; Bamber & White, 2011, 2011a; Best, 2012).

'New Recovery' advocates call for a broadening of focus on individuals' Recovery to consider systemic and environmental factors that play a potentially powerful role in shaping people's individual Recovery journeys.

In recent years, New Recovery advocates (often referred to collectively as the 'New Recovery Movement'), have achieved significant successes in seeing Recovery-based models adopted as Government policy in the USA and UK (Scottish Govt, 2008; Sheedy & Whitter, 2009; IMGD, 2012; Duke, 2013).

While advocates such as White (& Mojer-Torres, 2010) and Best (et al, 2010; 2013) have recognised that there are various approaches to recovery, including use of pharmacotherapies or moderate substance use, there have been other marked examples of 'pushback' within the Recovery movement to reaffirm the primacy of abstinence as a requirement of recovery (SAMHSA, 2011, 2012).

Recovery-Oriented Practice

The term 'Recovery-oriented practice' describes policy and service systems for responding to AOD-related harms with Recovery as the 'organising construct' (Anthony, 2000) and a common approach to the application of Recovery principles.

In their review of the evidence base for Recovery, Best *et al* identify four general Recovery principles to be applied to the development Recovery-oriented AOD policy:

- A need for transformation of systems to a philosophy based on empowerment and hope;
- Recognition that Recovery is a long-term process that occurs, not in treatment settings, but in the community;
- There are variable pathways to Recovery but fixed predictors of success (strengths, not pathologies);
- The efforts of local Recovery champions and support groups will make a difference to the recovery experience (2010, p45).

There are clear benefits to a co-ordinated, holistic approach to supporting sustainable change (Pugh *et al*, 2013). The challenge of Recovery-oriented practice for policy makers and service providers is to develop a more integrated, long term approach. This challenge is discussed in more detail below.

Recovery in other contexts

In addition to its use in other contexts, the concept of Recovery is becoming increasingly adopted as the basis for policy and service delivery in the field of mental health. As with AOD Recovery, it is subject to a similar variety of interpretations in different countries and service systems (DoH, 2011). Based on similar principles to those outlined above, Recovery in mental health settings is sometimes divided into two interrelated components:

- Clinical Recovery – defined by mental health service providers, it involves working towards a reduction or cessation of symptoms and improved social functioning; &
- Personal Recovery – defined by the individual, it describes the personal process of growth, healing and self-determination (Slade, 2009).

While the mental health Recovery model has a particular emphasis on individual empowerment and achieving improved quality of life, regardless of any reduction in symptoms of mental illness, AOD Recovery is based on significant reduction (or, in many interpretations, total abstinence from) AOD use. As both models are subject to ongoing debate and reinterpretation within their respective movements, there are multiple potential points of distinction between their various elements. These will not be examined here.

Australia's approach: harm minimisation

National Drug Strategy

Since 1985, Australian AOD policy and treatment systems have been framed within a Harm Minimisation approach. Harm Minimisation is premised on the understanding that AOD use will always occur to some extent in Australia, but that there are a variety of responses that can minimise its negative impacts for individuals, families and the wider community.

The current National Drug Strategy (2010-2015) provides a policy framework for the multi-layered, complimentary interventions within Australia's Harm Minimisation approach. It is comprised of three key pillars:

- Supply Reduction – to prevent, stop, disrupt or otherwise reduce the production and supply of illegal drugs and control, manage and/or regulate the availability of legal drugs;

- Demand Reduction – to prevent the uptake and/or delay the onset of AOD use of, reduce AOD misuse in the community and support people to recover from dependence and reintegrate with the community;
- Harm Reduction – to reduce the adverse health, social and economic consequences of AOD use (MCDS, 2011).

Success of Harm Minimisation in Australia

Following the adoption of the Harm Minimisation approach, Australia became recognised as a world leader in the development of evidence-based public health programs (King & Richards, 2003; Dolan et al, 2005; Ritter et al, 2011; Ritter & Lancaster, 2014). Some of the key impacts of this policy framework include:

- Far fewer Australians are smoking and being exposed to second-hand smoke as a result of comprehensive public health approaches, including bans on advertising, bans on smoking in enclosed public spaces and significant investments in public education and media campaigns. The daily smoking rate among Australians aged 14 years and over has fallen from 30.5% in 1988 to 12.8% in 2013.
- Far fewer people are using illegal drugs. The 2007 National Drug Strategy Household Survey shows the proportion of people reporting recent use of illegal drugs fell from 22% in 1998 to 14.7% in 2013. The recent use of cannabis—the most commonly used illegal drug—fell from 17.9% in 1998 to 10.2% in 2013.
- Law enforcement agencies have continued to be effective in detecting and seizing illegal drugs to disrupt supply. The number of illegal drug seizures increased by almost 70 per cent between 1999–2000 and 2008–09, and the collective weight of seizures increased by about 116 per cent.
- The heroin shortage that began in 2000 has been sustained, with heroin use remaining at low levels since then.
- Harms associated with injecting drug use have also been reduced. It is estimated that from 2000–2009 needle and syringe programs, which ensure the safe supply and disposal of syringes to injecting drug users, have directly averted over 32,000 new HIV infections and nearly 97,000 hepatitis C infections.
- Since its introduction in September 2005 non-sniffable Opal fuel has contributed to a 70 per cent reduction in petrol sniffing across 20 regional and remote communities in Western Australia, South Australia, the Northern Territory and Queensland.
- Early intervention and diversion programs, which help prevent young people and adults apprehended for drug use from getting caught up in the criminal justice cycle by diverting them to treatment interventions, have become an established and successful part of the harm minimisation approach.
- Drink driving has become largely unacceptable within the general Australian population. There was a substantial reduction in alcohol-related road deaths between the mid 1970s and the early 1990s through mass breath testing of drivers, lower and nationally consistent driver blood alcohol content limits, zero limits for special driver groups, a system of penalties, mass public education and media campaigns and other road safety initiatives.
- Far more is known about what works in the treatment of alcohol and other drug dependence, including through brief interventions, detoxification, pharmacological and psychosocial *treatment approaches.* (MCDS, 2011; AIHW, 2014)

Harm Reduction

Harm Reduction is considered to be the most contentious of the three pillars of Harm Minimisation, particularly within public discussion of AOD policy. Its focus on reducing AOD-related harms to individuals and the broader community is sometimes misinterpreted as an endorsement of AOD use (Ritter & Cameron, 2005). In this context, Harm Reduction services are often considered to represent the philosophical antithesis of Recovery.

The benefits of Harm Reduction go beyond the individual using alcohol and other drugs to their friends, families, workplaces and wider society by reducing the transmission of HIV, viral hepatitis and other infections, preventing injury and early deaths.

An extensive body of research into the effectiveness of Harm Reduction services has consistently demonstrated their capacity to produce significant community benefits:

- Prevention of illness and improved public health
  - the prevention of overdose, the transmission of blood born viruses and sexually transmitted infections and other health impacts in Australia (Ritter & Cameron, 2005; NCHECR, 2009; Wodak & Maher, 2010)
- Return on investment

  By preventing the occurrence of future harms, services reduce the future burden of illness on the health system. Australian studies have shown that:
  - needle and syringe programs alone have saved Australia $1.28 billion in health costs in the past decade (NCHECR, 2009);
  - every dollar invested in needle and syringe programs, more than four dollars were returned in direct healthcare cost-savings in the short-term (ten years) with further cumulative long-term gains (DoHA, 2002; NCHECR, 2009).

Recovery and harm reduction: competition or collaborators?

Common Ground

Recovery and Harm Reduction have often been portrayed as opposing philosophies. In spite of their philosophical differences, they share enough common ground to be considered as members of the same community or at least different expressions of the same endeavour (ANCD, 2012).

While there will always be variances in the delivery of different Harm Reduction services, there are several key areas in which it shares priorities with Recovery:

- Positive orientation – Harm Reduction is an exercise in hope, minimising the negative impacts of current behaviour to maximise future capacity for change
- Person centred – One of the key strengths of Harm Reduction services is that they respect individuals' capacity to make informed decisions about their AOD use. They provide health information, supplies etc to support those decisions and offer opportunities to engage with other relevant services.
- Strengths-focussed – By supporting people to assert control over the conditions and potential impacts of their AOD use, Harm Reduction services can play an important role in empowering them to take control of other parts of their lives.
- Holistic – As a key point of engagement with the health system, Harm Reduction services typically respond to a variety of health needs in addition to those directly relating to AOD use.

- Advocacy – Because of the high profile and the extent of public scrutiny of key Harm Reduction services, they typically take on a strong advocacy role to improve public understanding of the needs of their clients, their programs' evidence base and their demonstrated public health benefits.

Critical Friends?

In spite of their shared concern for people experiencing AOD-related harms and the commonalities in their respective approaches, there remain differences that can either be seen as evidence of incompatibility or a combined capacity to support a greater diversity of individual, family and community needs.

The key point of difference has been the Recovery movement's longstanding adherence to the principle of 'sobriety' (or abstinence from alcohol and any other drugs) as an immediate and long-term goal and Harm Reduction's focus on people's immediate health and safety. Over time, this point of difference has become entrenched in the respective cultures of each grouping. Each has suffered the effects of the stigma generally associated with AOD use internationally and each has been targeted at various points for vitriolic attacks within an often uninformed public debate.

In considering the ferocity of debate within the Recovery movement, White highlights the tendency of disempowered and stigmatised groups to internalise judgemental attitudes and direct them at other members of their own community (Bamber & White, 2011). This, perhaps, goes some way towards explaining the oppositional (and occasionally vitriolic) tone in public debate between Recovery and Harm Reduction advocates on matters of AOD policy (Duke, 2013).

New Recovery advocates have made considerable progress in increasing the acceptance of 'non-abstinent' or 'medication-assisted' Recovery (White, 1996 & 2008; Best et al, 2010 & 2013; White & Mojer-Torres, 2010; Bamber & White 2011, 2011a). While far from a universally accepted principle – there have been noted examples of 'pushback' within the movement to reaffirm the centrality of 'sobriety' (BFI, 2010) – it should now be recognised that the gap between Recovery and Harm Reduction (real or perceived) is less than previously. As a consequence, there is now an increased capacity for the two approaches to provide consistent and integrated supports for people seeking to make sustainable changes to their AOD use.

New Recovery advocates have consistently stated their support for the view that Recovery and Harm Reduction (and specialist AOD treatment services in general) are compatible and complementary approaches to AOD-related harm (Futterman et al, 2004; White, 2008; Neale et al, 2010; Bamber, 2010; Bamber & White, 2011; Best et al, 2013). Recent Recovery literature also regularly recognises the established evidence base for the effectiveness of specialist treatment services (including key harm reduction interventions such as NSPs, supervised injecting facilities etc), noting their cost-effectiveness and demonstrated capacity to support significant individual, family and community benefits (Best et al, 2010; Bamber 2010). There is also a frank recognition of the gaps in the evidence base for Recovery as an approach (White, 2000; Laudet, 2007; Groshovka & Best, 2008; Best et al, 2010; Kelly & White, 2011; Berridge, 2012)

However, Recovery literature just as regularly criticises specialist treatment services for a variety of real or perceived failings, including:

- Variation in delivery of standardised treatments and differences in service quality between service providers (Best et al, 2010), in spite of the fact that local variation is considered a key strength of Recovery approaches (see below);
- Being too problem-focussed – 'subtracting the negatives' (Best et al, 2010, p31) rather than inspiring individuals' transformation. The presentation of dependence as a 'chronic, relapsing condition that

permits no escape' is too negative and generates pessimism amongst treatment providers and participants.

- Engaging with people only after they have already experienced significant AOD-related harms and when change is much more difficult to achieve.
- Providing comparatively short-term interventions, without the capacity for ongoing support;
- Not considering people's wider support needs e.g. housing, employment and family relationships;
- Failing to emphasise the importance of abstinence as a goal; &
- Providing people with insufficient support to engage with key Recovery supports such as mutual aid groups during and after their participation in treatment (Bamber, 2010; Best et al, 2010; White & Mojer-Torres, 2010; Bamber & White, 2011a).

The clear implication (and occasionally explicit position) behind these criticisms is the need for a reframing of all specialist treatment services within a Recovery-oriented system. The validity (or otherwise) of these criticisms will be discussed in more detail below.

Regardless of their validity, this apparent duality in the New Recovery discourse (being both friend and foe to specialist treatment services) has been a cause of significant concern within much of the Australian AOD treatment sector about its potential implications for future service planning and policy directions. These concerns range from frustration at a perceived attempt to simply 'rebadge' Harm Minimisation as Recovery to a genuine fear of losing the gains in public health made under Harm Minimisation in the context of a Recovery principles being used to justify a forced shift to abstinence-based approaches (Anex, 2012).

The initial outcomes of the Victorian AOD treatment reform process have gone some way towards allaying sector concerns about the extent of a shift in Australian AOD policy towards Recovery-oriented practice and its immediate impacts on the treatment systems. However, the adoption of a more comprehensively Recovery-oriented policy framework in the UK continues provide an example of the need for ongoing attention (Duke, 2013).

Recent policy documents (IMGD, 2012; CSJ, 2014) demonstrate the potential for Recovery-oriented policy to be a vehicle for undermining established, evidence-based treatment. The concept of 'full recovery' that underpins the UK model is premised on abstinence and a clearly stated intention to limit access to pharmacotherapy and repeated episodes of treatment (Daddow, 2012). The introduction of 'Payment by Results' service funding within this model has been identified as a driver of consumer disempowerment, with treatment providers and consumers feeling pressured to adopt abstinence-focussed goals that disregard consumers' wishes and impose arbitrary deadlines for 'full recovery' (NDEC, 2014).

Common arguments for & against Recovery-Oriented Practice

Recovery provides an all-inclusive model

Advocates for Recovery-oriented practice argue that AOD treatment services and current government policy frameworks fail to provide a comprehensive structure for supporting individual and systemic change (White, 2008; Best et al 2008). New Recovery is described as an overarching approach that incorporates the needs of all people affected by AOD use (Bamber & White, 2011a; Best et al, 2010). However, Bamber & White also recognise internal politics within the movement as an obstacle to establishing 'a truly inclusive culture of recovery' (2011, p9).

However, New Recovery advocates also recognise that Recovery-oriented practice is best suited to people with severe, chronic AOD concerns and who have limited 'recovery capital' (Kelly & White, 2011; Best & Laudet, 2011). Along with concerns about the focus of Harm Reduction services within a Recovery-oriented model (see above), this raises obvious questions about its inclusiveness of groups such as people engaged in non-dependent use: who constitute the great majority of people who consume alcohol and other drugs.

Recovery is predicated on the need to change behaviour. For many people, ceasing or reducing their use is neither desirable nor necessary (Dahl, 2014). A Recovery-oriented system would not appear to cater to their needs and could provide a barrier to future engagement. While there is a clear role for Recovery approaches to play in supporting people in their efforts to overcome AOD dependence , Australia's multifaceted Harm Minimisation Framework provides a more inclusive framework for responding to the various forms of AOD use (and the associated harms) across the country.

The apparent contradictions between the ideas of leading 'progressive' Recovery proponents (such as White, Bamber and Best) and examples of actual practice of Recovery approaches in the USA and UK (Anex, 2012) indicate that, while the concept has a definite role in expanding our development of meaningful and effective AOD services, it is not sufficiently established (and, conceivably, may never be) to be considered as an alternative to current policy frameworks.

New Recovery has a more positive focus than treatment services

New Recovery advocates highlight the movement's focus on using stories of individual transformation to build individuals' confidence in their capacity to change and challenge the stigmatisation of people in recovery (Bamber & White, 2011). This orientation is often presented as a contrast between treatment providers' approach, described as 'pessimistic' in its view of AOD dependence as a 'chronic relapsing condition' and seeking only to reduce, rather than eliminate, AOD use and associated harms.

While treatment providers are able to deliver targeted responses for people whose goals included continued use of one or more substances, abstinence is a common immediate and/or long-term goal. It is difficult to imagine any Australian treatment provider attempting to dissuade people from having abstinence as a long-term goal. Even those Harm Reduction services most commonly targeted with allegations of 'enabling' or 'endorsing' illicit drug use (e.g. NSPs and Sydney's Medically Supervised Injecting Centre) have been repeatedly shown to provide effective points of engagement with treatment services to support sustainable change (DOHA, 2002; KPMG, 2010).

In the case of treating opioid dependence, pharmacotherapies (such as methadone and suboxone) provide an effective and evidence-based support to achieving long term abstinence (Gowing *et al*, 2014). Best-practice treatment for opioid dependence will involve recommendations against immediate abstinence where such an approach would place a person at increased risk of harm. Recommendation of pharmacotherapy as part of a comprehensive, stepped treatment plan is not a rejection of abstinence as a worthy goal, but a key enabler of people's safe and sustainable progress towards that goal (Strang, 2012; ReGen, 2012a).

While there are always improvements that can be made to treatment services' capacity to support sustainable behavioural changes, the AOD sector has already achieved significant progress within Australia's Harm Minimisation Framework (see above). From its own experience within the Victorian sector, ReGen has a clear focus on continuing to develop its services (and service partnerships) to provide holistic responses to both the effects and the causal factors of AOD misuse.

In recent years, ReGen has also taken a greater role in public advocacy to increase community understanding of key AOD issues and reduce stigma. Along with other advocates, ReGen recognises the power of personal narratives to inspire and challenge prejudice and welcomes New Recovery's

contribution to the debate. However, it is also important to remember that some practises within the Recovery movement compound the stigmatisation of some of the very people the movement is intended to support.

For those whose efforts to achieve sustainable change do not fit particular definitions of Recovery (e.g. those using pharmacotherapies), their contact with mutual aid groups can be problematic. Many either report being overtly excluded from a potentially valuable support network or feeling that they need to withhold this information from their peers in order to 'fit in'.

Such exclusion from (or conditional acceptance within) the recovery community has done a disservice to the Recovery movement and, most importantly, undermined people's recovery journeys. While key New Recovery advocates are seeking to increase the inclusiveness of the movement, the ferocity of internal debate about abstinence appears to confirm that exclusive practices will continue within some recovery communities.

While inclusion presents an ongoing challenge to the Recovery movement, it is important to note that AOD treatment and other service providers need to continue to recognise the impact of stigma on the accessibility of their services (AIVL, 2012; Neale, Nettleton & Pickering, 2012) and as a potential barrier to recovery. It is essential for service providers to ensure that their own practice does not contribute to the stigmatisation of their consumers and that they effectively support the empowerment of individuals and families affected by problematic AOD use.

Recovery's flexibility means it is more responsive to community needs

The adaptability of Recovery principles to fit with local conditions and priorities is seen as a great strength of the movement, in that it promotes the development of local ownership of Recovery communities. The development of strong, vibrant Recovery communities is a key goal of New Recovery to provide both a wide network of meaningful Recovery supports and to challenge public perceptions (Best, 2012).

As an approach to community development, this flexibility serves the movement well. However, it also enables the development of exclusionary or damaging practices at a local level (Anex, 2012). In describing the challenges faced in trying to advocate for the acceptance of methadone maintenance within the Recovery movement, White highlights the potential pitfalls of localised control of peer-led groups:

> There is a tendency for all of us to extend our own experiential truth to the status of universal truth and to then define the differences between our own and others' experience in categories of inferiority and superiority. (Bamber & White, 2011 p6)

In addition to the difficulty of ensuring consistent application of Recovery principles within local Recovery communities, the ongoing contest of principles within the Recovery movement undermines the effectiveness of New Recovery to provide a clear and consistently interpreted basis for public policy. The subsequent capacity for governments and public advocates from across the political and philosophical spectrum to manipulate those principles for their own purposes (such as defunding treatment services in times of economic austerity and shifting responsibility to voluntary community groups, as seen in the UK) is a legitimate cause of concern.

Recovery approaches are more sustainable and, ultimately, more effective than treatment services

A key component of recent advocacy for Recovery-oriented practice has been the assertion that specialist AOD treatment services do not provide the best outcomes for individuals or the wider community and that a Recovery-based approach would be more effective. Some of the arguments have been addressed above, but one of the main distinctions made between the two approaches focus on treatment services as shorter-term, resource intensive interventions that focus on building

'individual recovery capital' and Recovery approaches as providing much longer-term, informal and life-integrated supports that build 'community recovery capital' (Kelly & White, 2011; Hunt, 2012).

In pursuing this line of argument, Groshovka & Best state that:

> While this does not mean that the effectiveness of specialist treatment is diminished in relevance, it would suggest that it is not sufficient to enable and enduring recovery journey. (2008, p33)

In ReGen's experience, no ethical provider of AOD treatment in Australia claims that participation in treatment services, on its own, can achieve sustainable changes in people's behaviour. Effective treatment focuses not only on the particular intervention provided, but works with individuals (and their families) to develop appropriate support networks to help them maintain the changes achieved as a result of engaging with specialist services. For many people, Recovery-based groups will provide a key component of their networks of support.

It is important to recognise that both specialist treatment and Recovery approaches play distinct, but essential roles in supporting sustainable life changes. Best's own research demonstrates that people recognise the difference between making change and sustaining it in the long term (Best et al, 2008). The intensive interventions provided by specialist treatment are best placed to maximise the benefits provided by what Best & Groshovka describe as 'windows of opportunity for change' and 'turning points in a developmental trajectory' (2008, p33). As part of a holistic approach to people's various treatment and support needs (amongst which, AOD use may not be the most pressing) such interventions enable significant cognitive and behavioural shifts (supported by the development of new skills to increase people's 'internal recovery capital') within a safe and structured service framework.

Effective post-treatment planning, including the utilisation of community Recovery supports, increases the sustainability of these interventions. However, due to the complex nature of the recovery process, it is likely that individuals and families may require additional treatment interventions following (or to prevent) relapse. Best et al recognise the important role that Recovery communities can play in promoting earlier re-engagement with treatment services and removing practical barriers to participation (2010, p28).

ReGen promotes and includes a range of recovery-oriented supports across its services. By strengthening links to ongoing supports and providing a holistic range of services to increase individual and community recovery capital, our programs support long-term behavioural change. While there are always opportunities to improve the effectiveness of our services, our experience has shown that minimising barriers to engagement (regardless of people's goals or identification with the Recovery movement) can be a powerful enabler of cumulative progress in both the medium and long term (Caraniche, 2011; ReGen, 2012b).

Recovery is cost-effective

While there will always be debate about the level of funding allocated to AOD treatment in Australia, each year State and Federal governments invest significant public funds in the maintenance of policy frameworks and professional treatment services. As with any area of public expenditure, it is beholden on governments to ensure that communities receive an appropriate level of public benefit from this investment.

The Recovery movement has traditionally been situated outside the scope of public policy, with a clear emphasis on volunteerism and community-generated activity motivated by a shared commitment to supporting change. Without returning to discussion of the relative merits of treatment services vs Recovery supports it is easy to recognise the potential appeal for policy makers of shifting costs from government to the community, particularly in the context of austerity measures.

However, a full commitment to promoting Recovery should extend well beyond the comparatively narrow confines of the AOD sector. Stable accommodation, employment, good physical and mental health are key enablers of Recovery. Any Recovery-oriented public policy that does not address systemic contributors to disadvantage is unlikely to achieve sustainable outcomes. As has been identified elsewhere, this would require a significant increase in Government expenditure in many policy areas (Anex, 2012; Duke, 2013). This highlights both the potential benefits of a genuinely holistic approach to Recovery and the potential risks of adopting Recovery-oriented policy as a purely cost-saving measure.

Summary – implications for Australia

In spite of the occasionally heated nature of the debate surrounding Recovery in Australia and internationally, it is clear that Recovery-based approaches effectively complement Harm Reduction services and other approaches within Australia's Harm Minimisation policy framework. The question at the core of the debate is to what extent Recovery principles should influence policy, service planning, funding and delivery.

There is much to be gained from a greater integration between specialist AOD treatment services and ongoing community-based supports. Improved connections with supportive networks can only improve the long-term impacts of treatment participation. The commitment to removing structural obstacles to sustainable change (e.g. access to stable housing, education, training and employment) would be a strong support to recovery outcomes but would also require a significant and sustained increase in public funding in these areas.

Language and philosophical principles are important and key influencers of policy and practice. It is essential to have an ongoing debate about how we can ensure the best outcomes for individuals, families and the wider community. However, while the debate rages in some quarters, it is important to remember that arguments between extremes are of little relevance to the majority of people directly affected, who recognise the need for holistic, person-centered approaches and are focused on finding meaningful and practical supports so they can get on with their lives.

The terms 'Harm Reduction' and 'Recovery' both carry historical baggage and will continue to hold negative connotations for various groups, regardless of future policy changes. If language is getting in the way of having an informed and respectful public debate, perhaps it is time to reframe the debate with new language. Neil Hunt (2012) suggests that both terms are now irrelevant and that future policy and service delivery will be best served by adopting an approach grounded in human development.

Influencing the current debate in Australia is the growing recognition that we are losing our status as a world leader in Harm Reduction approaches (Pennington, 2010; Ritter et al, 2011). The real or perceived threat to Harm Reduction as an integral component of Australian AOD policy has raised concerns amongst many in the Australian AOD sector, not only about our reputation on the world stage, but our capacity to minimise the various harms associated with AOD use and improve public health.

The current Victorian AOD treatment system reforms have gone some way towards allaying fears about a possible shift away from established AOD policy principles. However, there remains some uncertainty about the future place of Harm Reduction programs within AOD treatment settings and the capacity of specialist services to provide earlier interventions with individuals and families to prevent the escalation of AOD related harms.

There is a clear need for ongoing attention to future policy development to ensure that Australians have ready access to effective, evidence based supports and that our AOD treatment systems have the capacity to respond to emerging patterns of AOD use and related harms.

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Authorised by the Board of ReGen

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About ReGen

Our purpose is to promote health and reduce alcohol and other drug related harm.

ReGen is the lead Alcohol and Other Drugs (AOD) treatment and education agency of UnitingCare Victoria and Tasmania. ReGen is a not-for-profit agency, which has over 40 years experience delivering a comprehensive range of AOD treatment and education services to the community.

These services include Counselling and Support, Assessment and Intake, Community Outpatient, Home-based and Residential Withdrawal for adults and youth, Supported Accommodation, Drug Diversion programs, Youth and Family Services, an Intensive Playgroup, Alcohol Community Rehabilitation Program and AOD services at Port Phillip Prison. ReGen also delivers Education and Training programs nationally.

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