QUEENSLAND NETWORK OF ALCOHOL AND OTHER DRUG AGENCIES LTD.

Recovery and Harm Minimisation

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The re-conceptualisation of recovery oriented systems within the AOD sector is currently being debated following implementation of 'new recovery' in the United States of America and the United Kingdom.

In the Australian context, consideration of 'new recovery' should be weighed against the long established principle of harm minimisation (which we would argue is inclusive of recovery) and viewed against the backdrop of the significant reform of the broader health system and its' implications for future models of care, key performance measures and funding arrangements (including significant austerity measures).

The concept of recovery within an Australian context is not new, nor do we question its importance within the AOD treatment sector however, the current debate provides the opportunity to for us to consider current views and whether this new paradigm could enhance treatment and prevention approaches. We also acknowledge that a proportion of the AOD sector have expressed the concern that this 'new recovery' paradigm is a cosmetic shift in terminology, which provides cover for an abstinence only agenda.

What is recovery?

Whilst the term 'new recovery' is bandied about, there does not appear to be a definitive definition. Recognition of the place of recovery in the Australian context is embedded in the *National Drug Strategy 2010-15* -

> *Recovering from drug dependence can be a long-term process in which individuals need support and empowerment to achieve independence, a healthy self-esteem and a meaningful life in the community*.

The policy framework from which Australian drug policy has developed is one of harm minimisation (*National Drug Strategy 2010-15*). To achieve this ultimate goal, both policy and action have been built upon three pillars – demand reduction, supply reduction and harm reduction. Recovery is explicitly included within demand reduction, however, that is not to say that it is not also an outcome achieved through the other pillars, in particular harm reduction strategies.

The question then arises – does 'new recovery' conflict with our current understanding of recovery and detract from the overall objective of harm minimisation? To answer this a number of questions could be considered including –

- Is abstinence the ultimate goal of treatment?
- If so, does this exclude harm reduction measures such as pharmacotherapy?
- If the client considers they are recovered or in recovery - is this enough?

It is in the *application* of 'new recovery' in the USA and UK where a tendency towards thinking the goal of addiction treatment can and should be for people to be 'cured' through complete abstinence. Whereas in Australia, drug treatment systems operate within a framework of harm minimisation, but every treatment intervention can help reduce the harms caused by substance misuse[1].

Theoretically, all definitions of recovery within the AOD sector, including in the USA, do not expressly exclude harm reduction, nor do they aim to detract from the important role of harm reduction measures, such as pharmacotherapy maintenance.

Therefore we recommend that:

Within Australia, the primary goal of treatment and prevention policy should continue to be harm minimisation. This is an inclusive and flexible approach to addressing the harms associated with alcohol and other drug misuse.

The term recovery, if construed as implying an outcome of complete abstinence, has the potential to exacerbate the stigma experienced by those seeking treatment. Applied without clear understanding of the idiosyncrasies of the use of the term, this has the potential to restrict treatment options for clients who do not select abstinence as their goal.

Implications for service delivery and models of care

Despite the argument that new recovery is not that new, nor diametrically opposed to current treatment and prevention approaches, the UK AOD sector's experience indicates some caution should be exercised.

In Australia, Victoria has recently sought to re-invigorate recovery as the central concept within their reform agenda, the *Roadmap to Recovery*. The policy touches upon 'new recovery', and proposes recommissioning the service system to one that arguably is structured to preference 'full' recovery

[1] Queensland Health, 2010

through abstinence. Whilst harm reduction measures are not excluded, suggestions that these are valuable only as a 'bridge to treatment' are concerning.

We recommend that:

A diversity of measures, including harm reduction and abstinence based treatment approaches as selected by individual clients, are necessary to achieve the policy of harm minimisation.

With greater effort also being applied to integrate AOD and mental health services, it is also necessary to consider the potential for the definition of recovery within the mental health sector to be applied without question to the AOD sector. Treatment models within the AOD sector and the mental health sector are sufficiently different so as to warrant a continuing distinction.

A treatment system developed on a one-size fits all basis does not best serve the interests of those seeking treatment.

We recommend that:

Individuals should be supported to make treatment choices and select outcomes that are appropriate to their individual circumstances.

Key performance indicators

This conversation about recovery is occurring in the context of governments at all levels seeking to refocus service level agreements from quantifying inputs to contracts for service seeking particular outputs and outcomes. Some would argue that current key performance indicators applied within the AOD sector do not sufficiently take into account the ongoing nature of treatment, regardless of the treatment goal (ie reduced or controlled use, or abstinence). As the pillar of demand reduction acknowledges the ultimate goal is one of reconnection with family and social structures and providing a mechanism by which one can again contribute to society.

We recommend that:

That success in the AOD sector is measured not by the number of individuals who exit the system 'cured', but rather by the number that are supported to reduce their use of substances to a level where it no longer impacts negatively on their lives.

Financial Implications

The capacity of the AOD sector to achieve success (whatever the form) is hindered by the failure of government to recognise the importance of continuing care. The sustainability of the NGO AOD sector will continue to be challenged if outcome-based funding models don't recognise harm

reduction measures as success. If funding is to be based upon the achievements of outcomes, financial models should ensure that the outcomes by which they are determined include an assessment of each treatment approaches contribution to harm minimisation.

We recommend that:

> **Harm-reduction and continuing care are both critical and vital elements of the treatment milieu and should be acknowledged as such in funding models.**

Regardless of whichever definition of recovery is adopted (if any), this is only a part of the equation. 'Full' recovery does not negate the need for a significantly increased investment in supporting services to support an individual, including housing, meaningful employment and social inclusion.

We recommend that:

> **Current and future funding models must include increased investment in the critical support services that assist an individual to reduce ongoing harm.**