International Journal of Drug Policy 73 (2019) 72–80

Contents lists available at ScienceDirect

International Journal of Drug Policy

journal homepage: www.elsevier.com/locate/drugpo

Research Paper

The movement and translation of drug policy ideas: The case of 'new recovery'

Natalie Thomas[a,b,*], Melissa Bull[c,b], Rachel Dioso-Villa[b], Kate Smith[b]

[a] Criminology, School of Humanities, Arts, & Social Sciences, University of New England, Armidale, New South Wales, Australia
[b] Griffith Criminology Institute, Griffith University, Brisbane, Australia
[c] Crime Justice and Social Democracy Research Centre, Queensland University of Technology, Brisbane, Australia

ARTICLE INFO

Keywords:
Policy transfer
Policy mobility
Recovery
Non-government organisations

ABSTRACT

Introduction: 'New recovery' can be conceptualised as both a social movement and a broader policy agenda to restructure treatment service systems towards 'recovery-oriented systems of care'. Emerging initially out of the United States, new recovery has gained currency as a policy agenda in other jurisdictions - perhaps most distinctly in the United Kingdom. In 2012, the ideas behind 'new recovery' were debated in the Australian alcohol and other drug field as the Victorian government sought to incorporate recovery principles into policy and service design. This paper uses the policy transfer and policy translation literature to understand how international policy ideas about 'new recovery' were negotiated in the Australian context, focusing specifically on the role of non-government actors in the process.

Methods: This paper draws on an analysis of policy documents, organisational documents and interviews with representatives from the Australian non-government alcohol and other drug sector to consider how new recovery was translated into Victorian drug policy.

Results: The interactions between organisations and actors — including bureaucrats, governmental agencies and policy entrepreneurs — facilitated the circulation and translation of policy ideas in the Victorian context. Despite this, the analysis suggests that policy transfer was largely a symbolic exercise: overall, some of the key features of new recovery policy from the United States and the United Kingdom, such as encouraging peer-led recovery and mutual aid, were not incorporated in the Victorian policy. NGOs resisted what they considered to be some of the more problematic elements of 'new recovery', and informed the local translation of the policy.

Discussion: The results have implications for understandings of the relationship between social movements, non-government organisations and the state, as well as the dynamics of knowledge transfer in drug policy.

Introduction

'New Recovery' can be understood as both a social movement to advance the interests of people who identify as being in recovery from problematic alcohol and other drug use, and a policy approach promoting recovery-oriented systems of care (Best, 2012; Humphreys & Lembke, 2014; White & Taylor, 2006; White, 2007, 2011). While the new recovery movement has largely focused on rights, citizenship, and empowerment for people who identify as being in 'recovery', in policy, the term has been controversial with critics pointing to its use by governments as a cost-cutting exercise or as an ideological shorthand to encourage abstinence-oriented services. The concept of 'recovery' has been increasingly mobilised in official drug policy discourse in a range of jurisdictions, as governments in places such as the United States (US) and the United Kingdom (UK) have incorporated the concept into drug policy and service design. During 2012, 'New Recovery' was the subject of debate in the Australian alcohol and other drug (AOD) sector, and recovery principles were adopted in Victorian drug policy. This article takes this apparent case of policy 'convergence' as a starting point, using the debate of recovery in the Australian AOD sector and the incorporation of recovery principles into Victorian drug policy as a vehicle for examining the politics of policy transfer.

Drawing on document analysis and interviews with people working in the Australian AOD sector, this paper presents an analysis of 'new recovery' as an example of cross-national policy learning. In the next section of the paper, we review the literature on the international development of 'new recovery', both as a social movement and how recovery has featured in policy in the US, the UK and Victoria. Following on from this, we discuss our overarching theoretical approach, and how the frameworks of policy transfer and policy translation informed our

* Corresponding author at: Criminology, School of Humanities, Arts, & Social Sciences, University of New England, Armidale, New South Wales, Australia.
E-mail addresses: natalie.thomas@une.edu.au, natalie.thomas@griffithuni.edu.au (N. Thomas).

https://doi.org/10.1016/j.drugpo.2019.07.013

study. We go on to outline the methods of data collection and analysis used in this research. We then present the results of the study, focusing first on some of the drivers of policy transfer in the Victorian context, particularly how non-state actors were influential in the circulation of new policy ideas, and how Australian non-government organisations (NGOs) responded to new recovery in the Victorian drug policy context. We argue that Australian NGOs acted as translators, negotiators and at times, in resistance, to recovery policy. Overall, we propose that whilst there is evidence that policy transfer did occur, it was largely symbolic, and lacked some of the features of 'recovery-oriented systems of care' characteristic of 'new recovery' in international jurisdictions — in particular, the government endorsement and encouragement (rhetorical and material) of community-based recovery-focused organisations.

Literature review

Although the concept of recovery is not 'new' (Berridge, 2012), the emergence of the 'new recovery advocacy movement' (NRAM) — as it has been called in the United States — can most definitively be traced back to a US government policy in the late 1990s, when the US Federal government introduced a grants program, the Recovering Community Support Program (RCSP) in 1998, to fund organisations led by people in recovery and their supporters (Humphreys & Lembke, 2014). Organisations oriented towards recovery from AOD problems (mutual aid and self-help groups for example) existed well before this, but the term 'new recovery' is used to "pay homage to earlier advocacy movements" of people in recovery, and also signpost the new direction taken by this movement (White, 2016a). William White (2007), a prominent recovery spokesperson in the US, explains that the new recovery movement, by virtue of its focus on solutions, is to be distinguished from earlier social movements:

> …which sought to alter public perceptions of and public policies towards those with AOD problems by redefining the problem ('alcoholism is a disease'), altering perceptions of those with the problem ('the alcoholic is a sick person') or promoting a particular intervention ('treatment works') (p. 700).

Policy is a key target of the movement. The core values and ideas of the movement centre on personal recovery as a platform for advocacy, the importance of 'authentic, grassroots representation' in drugs policy, recovery leadership, and the value of cultural diversity (White, 2007). The strategies of the NRAM centre around: building strong local recovery advocacy organisations; advocating for meaningful representation in policy processes for people in recovery and their family members; educating the public, policy makers and service providers on recovery; creating recovery support centres that deliver non-clinical, peer-based recovery support services; and supporting research that illuminates effective strategies and the processes of long-term recovery (White, 2007, pp. 700-701). Since its introduction in the US, the federal government has continued to be involved in supporting the 'new recovery' movement of people in recovery from alcohol and other drug use through funding peer-based recovery organisations (Humphreys & Lembke, 2014; Kaplan, Nugent, Baker, Clark, & Veysey, 2010).

In the late 2000s and the early 2010s, the ideas behind recovery-oriented policy spread to the United Kingdom and then to Australia. The focus on recovery in policy emerged in the UK in Scotland in 2008, when the Scottish Government released their drug strategy entitled "The Road to Recovery: A New Approach to Tackling Scotland's Drug Problem", which outlined a clear focus on treatment approaches encouraging recovery from problematic drug use through abstinence (Duke, 2013; Humphreys & Lembke, 2014; McKeganey, 2014). Following this, in 2010 the English Coalition Government introduced their drug strategy, *Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life* (HM Government, 2010). During 2012, 'new recovery' and recovery-oriented systems of care became the subject of debate in the Australian AOD sector, and recovery policy influenced the restructuring of the Victorian AOD treatment system (Lancaster, Duke, & Ritter, 2015). In what follows, we investigate the process and elements of policy transfer involved in the Victorian context and in the wider Australian context, comparing recovery organisations and recovery policy in the US, the UK and Australia to consider the politics of policy transfer and translation.

Approach

The study of cross-jurisdictional or cross-disciplinary movement of policy has been captured in a range of different conceptual models in the policy studies literature, including the ideas of 'policy transfer', 'policy diffusion', 'policy translation' and 'policy mobilities'. The concept of 'policy transfer' is most closely associated with the work of political scientists Dolowitz and Marsh (1996, 2000) as a rational choice model of policy-making. As Jones and Newburn (2007) note, however, in their study of policy transfer in crime control and penal policy between the United States and the United Kingdom, the study of policy transfer should also investigate "the apparent transfer of policy ideas/symbols/rhetoric, policy content, and policy instruments, and second, the various processes by which such transfer comes about (or is constrained)" (p. 35). Whilst policy transfer and policy diffusion studies tend to be associated with a rational choice model of policy making, the perspectives of policy translation and policy mobilities stem from the critical, constructivist and interpretivist literature on policy making (Lendvai & Stubbs, 2009; Longhurst & McCann, 2016; McCann & Temenos, 2015; McCann & Ward, 2013; McCann, 2008; Peck & Theodore, 2010).

The critical policy studies literature on 'policy mobilities' and 'policy translation' can help address some of the blind-spots of the 'traditional', rational choice policy transfer approach, in that it pushes attention towards the agency of actors, networks of power, critiques of resistance, and the role of symbolism, ideas and discourse in policy change (Newburn, Jones, & Blaustein, 2017). Whilst the policy transfer literature is rationalistic, the policy translation and mobilities literature encourages attention to the 'politics' of transfer, through "the ways in which policies (schemes, content, technologies and instruments) are constantly changing and emphasizes the interactions, the complexity, and the liminality of encounters between actors, sites, scales, and contexts" (Balen & Leyton, 2015, p. 103). The meaning of policy, and the agency of social actors in interpreting and changing these ideas in policy, particularly through language and representation, is central to policy translation (Balen & Leyton, 2015). The preference for the term 'translation' signifies the change that policies inevitably undergo when they are moved from one context to another. Newburn et al. (2017) highlight that work in these areas compliments the existing policy transfer literature, in that policy mobilities and policy translation studies apply constructivist and interpretivist approaches to studying policy mobility to extend on ideas from the policy transfer literature. At the heart of each of all of these approaches, however, is recognition that influences from other jurisdictions or other policy areas can often be a significant feature of the policy process.

The study of the movement of policy in the drug studies literature has highlighted some of the complexities involved in policy change drawing on cross-national policy ideas, for example in the context of the 2003 Afghan National Drug Control Strategy (Bewley-Taylor, 2014), the Dublin drug court (Butler, 2012), drug consumption rooms (Longhurst & McCann, 2016; McCann & Temenos, 2015; McCann & Ward, 2013; McCann, 2008), and the development of a legalised cannabis market in Uruguay (von Hoffmann, 2016). In a recent review of ideational and social constructionist work in the drug policy literature, Gstrein (2018) included several studies of policy transfer and mobility studies and called for further comparative studies to help advance understandings of policy development. Overall then, the study of cross-national policy convergence and the movement of policy provides an important avenue for drug policy studies, both in terms of understanding the processes behind

advancing progressive policy change and resisting negative or regressive policy changes. We draw on concepts from the policy transfer literature and policy translation literatures in this study by asking several key questions: 1. Why and how was new recovery transferred to the Australian context? 2. Who were the key agents involved in the transfer? 3. To what extent was policy transferred? and 4. How was 'new recovery' translated in the Australian context?

Methods

The analysis presented in this paper draws on data collected as part of a broader study investigating the role of NGOs in the Australian drug policy system (Thomas, 2017). As part of that study 'new recovery' was identified as an emerging point of policy discussion in the Australian AOD sector, and a number of NGOs had released their own position papers on the topic; based on this, the debate around 'new recovery' was selected as a case study for analysing how non-government organisations engaged with a particular policy issue, using a framework drawing on ideas from the policy transfer and policy translation and mobilities literature. Like most studies of policy transfer, the analysis for this case study is based on documentary analysis, and semi-structured interviews. The documents that were analysed for this study included government publications (State of Victoria Department of Health, 2012, 2013a, 2013b, 2013c), the report of the 1st Recovery Roundtable (Australian National Council on Drugs ANCD, 2012) and position statements released by non-government organisations (Anex, 2012a, 2012b; Australian Injecting & Illicit Drug Users League, 2012; Queensland Network of Alcohol & other Drug Agencies, 2012; UnitingCare ReGen, 2012).

Semi-structured interviews were conducted with 19 representatives from non-government organisations for the broader doctoral project. The following inclusion criteria were used for participants for the interviews: staff member of an NGO in NSW, ACT, VIC, or QLD, who as a part of their work engages in or assists with advocacy and policy work, or who has assisted with policy work in the past. Interviewees were based in Queensland (4), Victoria (6), New South Wales (5) and the Australian Capital Territory (4). Participants were drawn from a diverse range of organisations and generally held senior or leadership positions; all but one interviewee held a current role with an NGO involved in the AOD sector. The interviews were conducted between September 2014 and April 2015. All interviewees were asked their perspective on new recovery as part of the interview process. The majority of participants interviewed for the broader project were familiar with the context of the recovery debate happening in Australia during 2012 or had been involved in it, although five interviewees said that they were not familiar with it or did not comment on it. The data from these interviews were not included in the analysis presented in this paper, thus the final sample of interviews for this analysis was 14. Interviews lasted between 15 min and 1.5 h, with most being approximately an hour. An interview guide as used, covering topics relating to government/non-government partnerships, non-government organisations, drug policy, and new recovery (Thomas, 2017). Ethical clearance was obtained through Griffith University Office for Research, protocol number CCJ/43/13/HREC. All interviews were recorded, transcribed and de-identified by the first author.

This data is limited to the perspectives of people who worked in the non-government sector, and official documents. For the purposes of this project, the first author was not able to speak with government representatives that were involved in the development of recovery policy in Victoria. The non-government interviewees, however, had all been involved in policy work, and so were able to provide this perspective on policy for the purposes of this research. This study also focused particularly on the role of non-government organisations in the national debate of recovery policy. Reference to secondary literature and government publications has also been used to supplement and support the analysis presented in the paper.

Analysis

The approach to analysis was guided by a framework drawing on policy transfer and policy translation. Dolowitz and Marsh (2000) outline a series of questions to ask in any analysis of policy transfer, including: why transfer policy, who is involved in transfer, what is transferred, from where, what are the degrees of transfer, and what restricts or facilitates the policy transfer process? These questions served as an initial guide to analysis of the documents and interviews. Drawing on the policy translation and policy mobilities literature, we investigated several other lines of investigation during analysis, including how policies are contested, modified and adapted to their specific contexts; and the role of feedback from stakeholders in policy transfer. NVivo 10 and 11 was used to assist with the practical aspects of storing, managing and coding of the interview and documentary data.

Results

Why was recovery adopted, and who was involved?

Two key questions asked in the policy transfer literature is why the policy is transferred, and who were the actors involved. According to the accounts of participants, and the analysis of key documents, there were several factors that combined to provide the conditions that supported the adoption of recovery principles in Victorian AOD policy. Below we discuss three factors: the timely arrival of a key recovery advocate in Victoria, the work that was underway to reform the alcohol and other drug treatment service sector in that state and the attempt to align it with the mental health treatment sector.

Over the last thirty years the Victorian AOD sector has undergone several programs of reform (Ritter & Berends, 2016). According to Ritter and Berends (2016) since 1994 there have been 5 documents outlining policy change in the AOD service system in that state. In their analysis of these documents, they describe how the drivers of reform across these documents were generally consistent over time, and included concerns around poor integration of services, disconnections between AOD and broader health and welfare services, poor service planning and concerns about quality of care (Ritter & Berends, 2016). The reform of the AOD treatment service sector was a major driver of 'policy transfer', as was the alignment of AOD and mental health bureaucracies, as this interviewee explains:

> Yeah again it [new recovery] came out of predominantly the alignment between the drug and alcohol and mental health branches in the Department, and wanting to align some of the policy practices or elements that were going to — because the drug and alcohol and mental health services ended up being recommissioned and reformed at the same time, and there was a lot of work that was common that was going on in the department underlying that, and recovery in mental health had emerged as a real focus that was being driven by consumers, carers, and treatment providers. So it was raised and introduced with the sector.

The desire to reform the AOD treatment sector in Victoria provided an important policy window for policy actors to push recovery onto the reform agenda. The policy transfer and translation literatures emphasise the role of social agency in determining the uptake of policy ideas from other jurisdictions: "Because ideas do not travel by themselves, policy actors, experts, states, and non-state actors, as well as organized and non-organized citizens, play an important role in translation" (Balen & Leyton, 2015, p. 103). The interaction of recovery advocates and policy-makers appears to have been a key driver of policy transfer in the Australian context. This has similarities to the development of recovery policy in the UK. As Humphreys and Lembke (2014) note, there were a number of pre-conditions to the adoption of recovery policy in the UK, including a growing dissatisfaction with the existing

orientation of drug service systems, as well as contact with recovery advocates from the US.

In the US and the UK, the role of public intellectuals and advocates has been significant and influential. There have been a number of prominent spokespersons for the recovery movement, including William White, Betty Ford, Keith Humphreys, along with a number of others (White & Taylor, 2006; White, 2007). Academics, in particular, have been key in the promotion of 'new recovery' (Gilman, 2011; White, 2016b). There is significant international mobility, with recovery advocates travelling between different countries and presenting and holding recovery conferences (Roth, 2011). David Best (Best & Lubman, 2012) has been a spokesperson advancing recovery, in the UK and later in Australia (Fomiatti, 2017; Roth, 2011). He is the head of the 'Recovery Academy' in the UK, which is a group of clinicians and researchers working towards advancing recovery and recovery evidence. In 2011, David Best, travelled to Australia and began working at Turning Point in Victoria (Fomiatti, 2017). Turning Point is an important non-government organisation in the Victorian AOD field, providing treatment, research, policy advice and leadership in the field since it was established in 1994 (Turning Point, 2015). Through his position as an Associate Professor in Addiction Studies at Turning Point and Monash University, Best acted as a policy advisor to the Victorian government (Fomiatti, 2017). During his appointment, he was involved in the organisation of the '1st Recovery Roundtable' through the Australian National Council on Drugs in Canberra, which sought to bring together stakeholders from the Australian AOD sector to discuss recovery (Australian National Council on Drugs [ANCD], 2012). An 'Australian Recovery Academy' was also established, with Best as an advisor (Recovery Academy Australia, 2016). The Academy, however, gained limited traction in Australia as we describe in the following section. A number of interviewees specifically cited David Best as a key actor in the adoption of recovery principles in Victoria. One participant explained the adoption of recovery in Victoria in this way:

> Recovery came to town a few years ago, it is a trend that's occurred in America and the UK, and it sort of arrived with a vengeance in Victoria, largely due to a couple of individuals, one of whom was Dr — I mean I don't think I'm breaching any confidentiality by naming names — but one of the key players in Victoria was Dr David Best, who was one of the very vocal exponents of recovery in the UK, and he took a position at Turning Point, and he gave enormous impetus to the recovery, the whole issue, and quality and recovery. A small group of people established the 'Recovery Academy', and again it was a couple of key individuals who were just tireless in pursuing the recovery agenda.

This participant went on to explain how the presence of this key recovery advocate was influential in the incorporation of recovery ideas into the policy documents released at the time:

> What is interesting is that David Best has the ear of government, and that was largely how recovery found its way into the policies that were formulated during the reform period by the previous government…I mean he's now returned to the UK — Dr David Best has — so it was very much that coincidence of him being here at that particular juncture where policy was being reviewed and reformulated, and it is now part and parcel of the way treatment services have been, how they've been imagined and how they've been established, with recovery stuff.

The desire to reform the AOD treatment sector in Victoria provided an important policy window for international non-governmental policy actors to push recovery onto the reform agenda. This does not mean that there was a simplistic or wholescale uptake of recovery. In the next section, we discuss what was transferred, and the extent of the policy transfer.

What was transferred?

In this section, we discuss what was transferred in the Victorian context, and the extent of the transfer. In 2012, the ideas behind recovery-oriented policy influenced the restructuring of the AOD treatment system in Victoria. In 2012–2013, the Victorian Department of Health released several policy papers that incorporated principles of recovery (State of Victoria Department of Health, 2012, 2013a, 2013b, 2013c). In 2013, the Department of Health published 'Reducing the alcohol and Drug Toll: Victoria's Plan 2013–2017' outlining a 15-point plan which included 'care, treatment and recovery' as key principles (State of Victoria Department of Health, 2013c). They also released a set of new principles for the AOD treatment system, which incorporated recovery ideas: "The principles have as their foundation a philosophy of harm minimisation and a recovery orientation." (State of Victoria Department of Health, 2013c). Recovery is not considered to be in conflict with the principles of harm minimisation:

> Recovery-oriented approaches sit within the harm minimisation framework, acknowledging and building on people's own resilience and resources. Recovery-oriented approaches recognise that people come to treatment through many different paths and that their goals and journey towards recovery and wellbeing are individual and unique. These approaches are reflected in the new principles and across system reforms (State of Victoria Department of Health, 2013c).

The recovery-oriented principles adopted in the *Victorian alcohol and drug treatment principles* note that interventions can include a range of approaches: "Treatment includes a variety of biopsychosocial approaches, interventions and modalities oriented towards people's recovery" (State of Victoria Department of Health, 2013c, p. 4-5). Across the Victorian documents, 'recovery-oriented services' are linked with the idea of continuity of care and integrated and responsive services. Similarly, continuity of care has been emphasised in the US and UK policy contexts (Sheedy & Whitter, 2009). In the Victorian context, the 'reform' of the AOD sector included recommissioning services to be inline with the principles of the reform. "Person-centred, family and culturally inclusive, recovery-oriented treatment" is the first of these principles guiding reform of the Victorian AOD system, illustrating the influence of recovery on the reform (State of Victoria Department of Health, 2012).

The Victorian policy documents released during 2012–2013 also discussed experimenting with payment by results, but the reform has ultimately resulted in 'activity-based funding' and outcome-monitoring rather than 'payment by results' (Ritter & Berends, 2016; Savic & Fomiatti, 2016). Activity based funding pays services a fixed price for activities (Fomiatti, 2017; Ritter & Berends, 2016). As part of the reform, funding was provided for counselling, intake and assessment, care and recovery coordination, non-residential withdrawal, and planning (Fomiatti, 2017). A centralised intake and assessment system was implemented, where the screening and assessment tool was developed by Turning Point Alcohol and Drug Centre – the tool then used to allocate the service user to different levels of treatment (Berends & Ritter, 2014; Fomiatti, 2017). Berends and Ritter (2014) noted that the new service type of 'care and recovery coordination' was the source of confusion for stakeholders.

While grassroots new recovery organisations are key actors advancing the new recovery movement in the United States and the UK, these kinds of political mobilisations and organising were and continue to be noticeably absent in the Australian context. In the context of the US and the UK, non-government and community recovery organisations have been key to the recovery movement (Best, 2012). For example, in the United States, there is a wide range of non-government organisations

furthering the interests of people in recovery. Faces and Voices of Recovery (FAVOR) is one of these groups, and they are oriented towards political activity. The description from their website outlines an expressly political purpose, stating that they are:

> dedicated to organizing and mobilizing the over 23 million Americans in recovery from addiction to alcohol and other drugs, our families, friends and allies into recovery community organizations and networks, to promote the right and resources to recover through advocacy, education and demonstrating the power and proof of long-term recovery (Faces & Voices of Recovery, 2016b).

FAVOR engages in a number of activities to advance the interests of recovery organisations. The 'Recovery Voices Count' is a campaign that encourages the civic participation of people in recovery to vote and have representation on electoral issues (Faces & Voices of Recovery, 2016a). A similar organisation has emerged in the UK, named the Faces and Voices of Recovery UK (FAVOR UK) (Faces and Voices of Recovery UK, 2016). Like FAVOR in the US, FAVOR UK seeks to provide a voice for people in recovery, promote recovery activities (such as the Recovery Walk), and to work with other organisations to promote recovery (Faces & Voices of Recovery UK., 2016). In addition, in the UK and the US, there are organisations that exist to organise and represent recovery community support organisations – including the Association of Recovery Organisations in the US and in the UK the 'Recovery Federation' is a Scottish organisation focused on supporting the development and linking up of Recovery Networks (UK Recovery Federation, 2015).

There appears to have been limited mobilisation of civil society organisations advancing recovery in the Australian context. At this stage, there is no association or umbrella organisation of recovery organisations in Australia, and no organisation comparable to FAVOR. The most significant recovery organisation is the Recovery Academy Australia which was "founded as a voluntary association to promote and support activities that celebrate the reality of recovery from addiction — for individuals, their families, their communities and our wider society" (Recovery Academy Australia, 2016, p. 3). A key part of the movement is the 'recovery walks', which have been organised across the US and the UK (Knopf, 2013; Manchester welcomes UK Recovery Walk to the city, 2014), and also in Australia during 'Recovery Month' (September) (Best & Lubman, 2012; Stark, 2013). The Recovery Academy Australia took on responsibility for the 'recovery walks' in Victoria. Yet, following David Best's departure from Turning Point (discussed above), these walks have received little public attention.

In the US and the UK, governments have actively encouraged voluntary, self-help style recovery organisations. A key part of recovery policy in these jurisdictions is government support for 'recovery organisations' and the role of peer recovery support services. The Substance Abuse and Mental Health Services Administration (SAMHSA) provides policy leadership, conducting a range of activities related to supporting recovery organisations, and coordinating an online policy academy for jurisdictions interested in implementing the ROSC framework (Humphreys & Lembke, 2014; Substance Abuse & Mental Health Services Adminstration, 2015). The US Government is a sponsor of 'Recovery Month' and there are 'Recovery Month' materials on the SAMHSA website (SAMHSA, 2015). SAMHSA also provides funding for peer-based recovery community organisations (SAMHSA, 2015). Like the US government, the UK government supports recovery organisations and activities — although Humphreys and Lembke (2014) note that the UK government has not provided the significant material support for recovery organisations that the US government has. The UK Recovery Festival is co-organised by non-government and government sector (Humphreys & Lembke, 2014). In England, the National Treatment Agency for Substance Misuse under the National Health Service (now Public Health England) completed a body of work on mutual aid and recovery groups and released a series of documents co-produced with mutual aid groups, commissioners and service managers (National Treatment Authority, 2016).

The governmental focus on voluntary, self-help style recovery organisations has been far more constrained in the Victorian context. There is a preference in the Victorian context to refer to 'peer-workers' (State of Victoria Department of Health, 2012, p. 28). In the ANCD 1st Recovery Roundtable report, the role of recovery groups and mutual aid is implied in references to peer support. The strongest expression of this idea is: "that families and friends are very important in treatment and peer-support models are very effective, but are under-utilised and under-supported" (Australian National Council on Drugs [ANCD], 2012, p. 2). We could locate little evidence that the Victorian government had engaged in activities that supported recovery focused organisations, although as discussed above the Victorian government has provided funding to organisations for 'care and recovery co-ordination'. The recently released 'Victoria's alcohol and other drugs workforce strategy 2018-2022' (State of Victoria Department of Health, 2012) does discuss 'recovery-oriented care', and the 'expansion and support of the peer workforce' (p. 28), and establishing an 'AOD peer workforce network' (p. 28). At the time of writing, this area of work is still developing in the Victorian context.

Although grassroots mobilisation is integral to 'new recovery', in the Australian context, the policy change behind the adoption of recovery has largely been led from the 'top-down'; there has been less influence of organised grass roots recovery groups, and somewhat less support for the recovery concept from clinicians and AOD professionals in the Australian context. David Best discussed this in an interview with William White, noting the resistance to recovery ideas amongst professionals in the Australian AOD field.

> The embrace of the recovery concept has happened much, much faster by policymakers than by professionals involved in the treatment field. Many of the latter have been resistant to recovery ideas for a whole range of reasons. It's been very interesting to watch this happen in Victoria… (White, 2012, p. 7)

This relatively limited encouragement of and mobilisation of civil society organisations is one of the key avenues shaping the extent to which recovery policy was adopted in the Victorian context – with the nestling of recovery in the overarching approach of harm minimisation, a kind of 'hybrid' form of new recovery has been produced (discussed further below). In the next section, we discuss how actors from NGOs in Australia interpreted, resisted and critiqued recovery, contributing to the local translation of the policy.

Translating recovery policy

The policy translation literature encourages attention to 'how policies are contested, modified and adapted' to their local contexts. In the US, and the UK context, non-government actors and agencies have been central not only to the 'movement' of new recovery, encouraging policy learning about recovery — as described in the sections above — but also to the process of defining and debating the meaning of recovery, and thus translating recovery policy in their domestic contexts. As already discussed, a number of NGOs in the Australian context produced their own position statements on new recovery, and in June 2012, the ANCD convened the 1st Recovery Roundtable, which brought together a number of representatives from the AOD sector, including those from the non-government sector, to discuss recovery (Australian National Council on Drugs [ANCD], 2012). Below, we draw on these documents, as well as the interview data, to explore how non-government actors negotiated and at times resisted what were considered to be the more problematic elements of recovery policy, in particular the definition of recovery and the role of abstinence in relationship to the established Australian policy position of 'harm minimisation', and the economic implications of recovery policy.

Defining recovery: Abstinence or not?

A key concern in the negotiation and 'translation' of recovery policy in the Australian context was the very definition of recovery. The meaning of recovery in the AOD field is contested, with no one accepted definition of the term (Lancaster et al., 2015; Neale, Nettleton, & Pickering, 2011). A number of different definitions of recovery have been proposed. In the US, the Betty Ford Consensus Panel has been influential in providing a definition of recovery for the US context, publishing an article on the topic in 2007 (The Betty Ford Institute Consensus Panel, 2007). In the US, the idea of recovery was expressly linked with abstinence. The Betty Ford Institute (BFI) consensus document defines recovery as "a voluntarily maintained lifestyle characterized by sobriety, personal health, and citizenship" (The Betty Ford Institute Consensus Panel, 2007, p. 222), where sobriety is defined as "abstinence from alcohol and all other non-prescribed drugs" (Betty Ford Institute Consensus, P. et al., 2007). The idea of recovery is also expressly linked with abstinence for US recovery organisations. For example, the FAVOR site explicitly discusses 'abstinence-based recovery'. In the UK context, the influence of 'new recovery' on policy has been controversial because of its links with a perception of governmental preferences for funding abstinence and abstinence-oriented treatment programs over harm reduction programs, particularly methadone maintenance programs (Duke, Herring, Thickett, & Thom, 2013; McKeganey, 2012, 2014). As Duke (2013) notes, however, in England, the Coalition strategy document allowed for harm reduction techniques and methadone maintenance, concluding from her analysis of the strategy that "it would appear that the pragmatism that has characterized British drugs policy and treatment over history is likely to continue" (p. 51). Historically in US drug policy there has been a strong focus on abstinence, whilst in the UK and Australian policy harm minimisation and harm reduction have been embraced as guiding principles.

In the Australian context, the relationship between recovery policy and abstinence was the subject of particular controversy. The ANCD recovery roundtable noted that there was no agreed upon definition of recovery, and they did not agree to adopt one. The roundtable report notes that there was consensus that recovery does not equate to abstinence: "recovery does not mean that abstinence must be the goal for all people with alcohol and other drug problems" (Australian National Council on Drugs [ANCD], 2012, p. 1). Despite the advice in the ANCD 1st Recovery Roundtable Report that recovery does not have to equate to abstinence, interviewees reflected back that this had been an ongoing point of tension. For some Australian organisations, there was a concern that 'new recovery' lacked an evidence-base and was just a cover for a moralistic move towards abstinence-only services (Anex, 2012b; Australian Injecting & Illicit Drug Users League, 2012). AIVL released a paper that questioned New Recovery's conceptualisation of alcohol and other drug dependence as a 'chronic', 'relapsing' disease, and the harmful dichotomous categorisation of people 'in recovery' and those who are still actively using drugs (Australian Injecting & Illicit Drug Users League, 2012). They also raised objections regarding the novelty of the 'new recovery' approach, noting the strong history of recovery organisations in Australia and the traditionally 'pragmatic' Australian approach arguing:

> In this regard, the only genuinely 'new' element within the 'new recovery' agenda is that key new recovery advocates are seeking to replace our current pragmatic and evidence-based philosophy and practice with a focus on a largely ideological and moralistic agenda (Australian Injecting & Illicit Drug Users League, 2012, p. 5).

Some participants considered that 'new recovery' had created some unhelpful divisions in the drug and alcohol field, whilst harm minimisation allowed for a diversity of services under one framework. One participant stated:

> I think New Recovery is a barrier to progress. Because people are—no one—people don't want to talk about it, or if people do talk about it then it's really emotional. I mean what I said to you before around harm minimisation is that we represent a diversity of service providers who provide everything from abstinence-based to harm reduction services; and we believe our sector needs all of those approaches. I understand harm reduction organisations are reluctant to talk about it because of what happened in the UK, where abstinence was seen as the end goal. We don't ever want to see that here. I think what happened was that there was all this talk about 'New Recovery' but then it just kind of stopped, and I just think that this word now 'recovery' is a barrier to progressing drug policy. (Interviewee).

There was a clear preference in the Australian context to make room for a range of services — including harm reduction services — along the 'continuum' of recovery. The ANCD Recovery 1st Roundtable report likewise emphasised that people can take different pathways to 'recovery' and that recovery can take many forms, making continuity of care important (Australian National Council on Drugs [ANCD], 2012). A number of the participants interviewed for this study identified with this idea of recovery, and when asked about new recovery, the majority preferred the definition of recovery as a journey. The following participant highlighted how defining recovery in this way allows a place for a range of services along that journey:

> …if we say as they do that recovery is a journey then it's got to start somewhere and people have to be safe while they're starting the journey. So I would say in the early days for some people their recovery journey may involve in engaging with various harm minimisation strategies, and that's for injecting drug users, using needle and syringe programs or maybe it would be the methadone program, it could be a controlled drinking program for people with alcohol dependence; so there's a whole range of things.

Overall, most NGO responses advocated that harm minimisation should remain the overarching policy framework, even where they were receptive to new recovery. The ANCD Recovery Roundtable Report notes that it would not be appropriate for recovery to guide overarching policy in Australia. It states that "recovery, regardless of definition, should not be the sole basis for a national drug strategy, particularly as it would tragically undermine the gains available from both harm and demand reduction" (Australian National Council on Drugs [ANCD], 2012, p. 2). Similarly, other organisations emphasised the importance of retaining the 'harm minimisation' framework, and for 'recovery policy' to take account of the Australian context and for open discussion to occur about how recovery fits with the harm minimisation framework (Queensland Network of Alcohol & other Drug Agencies, 2012; UnitingCare ReGen, 2012).

On the whole, the AOD sector's discussion of New Recovery in Australia was particularly mindful of the lessons of the policy experience in the UK, and the need to retain harm minimisation as an overarching strategy. The non-government AOD sector's discussion of New Recovery in Australia highlighted the policy's problematic association with abstinence, and drew on some of the lessons of the policy experience in the UK to argue for the need to retain harm minimisation as an overarching strategy. Whilst recovery principles were adopted in the Victorian context, the over-arching approach of harm minimisation was retained. The Victorian policy framework incorporates recovery principles but sees them nestled still within the broader overarching harm minimisation framework (State of Victoria Department of Health, 2013a).

Economic concerns and mutual aid groups

Economic concerns about increasing the cost-effectiveness of services have been extremely influential in the reshaping of health funding systems across the US, the UK and Australia (Beeson & Firth, 1998; Coburn, 2004; Ritter, 2019). The synergy between 'new recovery' and

emphases on cost-efficiency and frugalism in public spending can be seen most clearly in two elements of recovery policy: 'results-based' or outcome-focused funding, and the idea of encouraging 'voluntary', 'community-based' and 'self-help' recovery organisations – these two elements were central sites of translation and contestation in the Victorian context.

The recovery focus in the drug policy documents has translated into a focus on outcome monitoring in drug treatment service systems, and funding processes designed to encourage a focus on recovery (Mason et al., 2015; Maynard, Street, & Hunter, 2011). How this has been expressed in each jurisdiction has varied. The interviewees for this study noted the concern that recovery-oriented policy would negatively impact on funding arrangements for AOD services. Here, for example, an interviewee noted their concern that 'new recovery' might lead to the preferential funding of abstinence-based services:

> I find it very concerning. The word 'recovery' in drug and alcohol basically means abstinence-based rehabilitation leading to total abstinence, a disease-model twelve-step — not that there's anything wrong with people going down those paths, but when it becomes public policy it's putting all the eggs into a very small basket which really isn't effective overall. If you take it to the degrees that someone like Bronwyn Bishop [a conservative Australian politician] might do, it might mean that unless your service was actively getting people to be drug free, then you wouldn't get funded. So perhaps services like ours would disappear.

Payment by results was a key element of recovery policy in the UK context, and a particularly controversial one at that (Duke, 2013). Interviewees for this project discussed the concerns around the payment-by-results framework that has been associated with recovery in the UK context. NGO representatives noted that Payment by Results could impact services' willingness to work with 'difficult clients', and thereby limit the services and options available to people who use drugs:

> I think what it means is, and what's happened in the UK, is that services are less inclined to work with the most chaotic of drug users because they want to work with people who have the most chance at stopping using so again it feels like the more vulnerable people are left behind.

The potential for payment by results to have these kind of unintended consequences is an example of 'Goodhart's Law' that states 'when a measure becomes a target, it ceases to be a good measure' (Eldridge & Palmer, 2009, p. 164). In this case, the concern is that performance-based funding in the drug and alcohol sector will not reflect the actual performance of providers, but rather their ability to make it look as if they are meeting targets by changing their practices and the kinds of clients they take on (Eldridge & Palmer, 2009, p. 165). Several position papers produced by Australian AOD NGOs responded to the problems associated with 'new recovery' and funding for AOD services, making recommendations that pay by results be avoided (Australian Injecting & Illicit Drug Users League, 2012; Queensland Network of Alcohol & other Drug Agencies, 2012). In national discussions about recovery, it was highlighted that recovery and payment by results were separate issues: the ANCD Recovery Roundtable concluded that "recovery does not explicitly or implicitly support a 'payment for results' policy" (Australian National Council on Drugs [ANCD], 2012). In the Victorian context, the policy that was implemented ended up being activity-based payment through tracking "episodes of care" rather than being based on payment for outcomes (Fomiatti, 2017; Fomiatti, Moore, & Fraser, 2017).

For some participants, the new recovery emphasis on peer support (Ostrow & Adams, 2012) could also be linked with pushes for economic efficiency in service funding. An interviewee noted that mutual aid groups are a cheaper option than methadone maintenance programs or other treatment programs. When asked about 'new recovery', the interviewee explained:

> Which is about the GFC and shifting stuff out of a government-financed sector to the self-help sector, isn't it? Dressed up in the rhetoric of 'the outcomes will be much better for the individual if they are better supported on exit from our treatment system by volunteers and mutual aid groups', which do it for free generally. You want me to comment on that? The cynical part of me says it's about getting stuff done on the cheap without the appropriate quality measure in place, often by well-meaning people, because the system either can't afford or has a different ideological bent to working with people with alcohol and drug issues.

Economic issues have been highlighted by drug policy scholars in the UK context. In her analysis of the shift to recovery policy in the UK, Duke (2013) notes the neat intersection between the recovery agenda's emphasis on peer support and the government's need to find efficiencies through public sector funding cuts: "it could be argued that drug policy has shifted its emphasis from harm reduction to crime reduction to resource reduction" (p. 49). As Duke (2013) notes, shifting some of the responsibility for support of people who use drugs onto voluntary and self-help groups is an attractive option for governments, because often these groups require little to no public funding. Thus, instead of needing to provide increased funding to costly professional services to fulfil the emphasis on continuous care for drug treatment clients, 'aftercare' services can instead be provided cheaply by voluntary, self-help groups. The discussion paper released by Anex also pointed to this tension in 'new recovery', noting that the lack of resources to support recovery policy in the UK should be a 'lesson' for Australia:

> 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 (Anex, 2012b, p. 1).

As already discussed, whilst grassroots mobilisation has been integral to 'new recovery' in the US and UK, in the Australian context, the policy change behind the adoption of recovery has largely been led from the 'top-down'. There has been less influence of organised grass roots recovery groups, and somewhat less support for the recovery concept from clinicians and AOD professionals in the Australian context (White, 2012). The context in which the 'transfer' occurred in Victoria — the policy change being led by 'policymakers' rather than grassroots organisations, or professionals in the field in Australia — could partly explain the relative lack of rhetorical and material attention to supporting recovery organisations in the Victorian policy context. Due to the funding environment in Australia, including cuts to public sector spending, the ANCD consensus document reflects economic concerns around the potential effect of recovery policy on resources in the AOD sector (Australian National Council on Drugs, 2012). The ANCD recovery roundtable report points out that the Australian AOD sector has been under-funded, and there was concern that recovery policy might lead to further under-funding as governments attempted to shift services on to mutual aid or self-help organisations that historically require less funding because they are staffed by volunteers (Australian National Council on Drugs [ANCD], 2012). This is another example of how non-government organisations highlighted some of the more problematic elements of recovery policy and encouraged their local translation in the Australian context.

Discussion

Lost in translation?

At the macro-level, the degree to which policy transfer occurred in the Australian context appears relatively limited. Like other studies of drug policy 'transfer' (for example, Bewley-Taylor, 2014, & Butler,

2012), this study also finds that symbolism and ideas were significant in the policy adopted in the Australian context. Recovery in the Australian context did not involve direct copying of the US or UK models of 'recovery-oriented systems of care'; it appears that the *idea* and symbol of recovery was more important in the policy change (State of Victoria Department of Health, 2012, 2013a, 2013b). Although the idea of recovery-oriented systems of care feature heavily in the Victorian documents (State of Victoria Department of Health, 2012, 2013a, 2013b), some of the key features of new recovery policy in the US and the UK — in particular, the government support for peer-based recovery organisations — have been less prominent in the Victorian context. Fomiatti et al. (2017) observe that the implementation of any concrete 'recovery-oriented' interventions as a result of the policy reform was relatively limited. As opposed to being a direct copy of the US and UK approaches, recovery policy in the Australian is an example of hybridisation — the most typical form of policy learning — because it combines aspects of programs in other settings to produce a policy that is still relevant to the local context in the recipient jurisdictions (Evans, 2009). As Stone (2012) notes, there are several dimensions of policy transfer, including the transfer of policy goals, institutions, regulatory, administrative or judicial tools, ideas and ideologies, and personnel. In the case of new recovery in Australia, it appears that the transfer of goals, ideas and ideologies were also important features in the process of policy transfer, whereas the other dimensions did not feature in the data.

At a micro-level, this article outlined how NGOs and the broad Australian AOD sector — those actors that are involved in implementing policy — negotiated elements of what is considered to make up recovery. The significance of 'local politics' has also been explored in the study of drug policy 'mobilities', which has largely developed in the urban planning and geographic studies literature. This literature explored the role of 'expertise', experts and 'truth' in the spatial and political circulation of policy knowledges (Longhurst & McCann, 2016; McCann & Temenos, 2015; McCann & Ward, 2013; McCann, 2008), the networked mobilisation of policy and practices such as drug consumption rooms and the political struggles and resistance to particular policy ideas (Longhurst & McCann, 2016; McCann & Temenos, 2015), and how people act as vehicles for policy change in various ways, for example by sharing knowledge at conferences (Temenos, 2015).

Mukhtarov (2014) advocates that policy translation should focus on how policy actors engage with the movement of policy ideas across contexts and jurisdictions "by framing, reframing and modifying the meaning of ideas that travel; engaging in constructing problems and solutions as pertinent to certain scales" (p. 76). NGOs promoted the learning of 'negative lessons' about recovery', cautioning against some of the negative consequences of recovery policy in the UK. The concerns in the Australian context reflect both ideological and practical concerns around abstinence and harm reduction, as well as funding for drug services. There was concern that with the introduction of new recovery policy, harm reduction services would no longer receive funding because they were not oriented towards getting clients 'drug-free'. Overall, the reaction of the Australian AOD NGO sector appeared to reaffirm the importance of harm minimisation as an overarching policy. Both the ANCD Roundtable and the 'Recovery Academy Australia' principles of recovery note that recovery does not require abstinence (Australian National Council on Drugs [ANCD], 2012; Recovery Academy Australia, 2016). Rather, what was considered important included continuity of treatment/services, having a range of approaches, and fighting against 'siloing' of services (Australian National Council on Drugs, 2012; Queensland Network of Alcohol & other Drug Agencies, 2012). In this way, non-government agencies and actors were key to *resisting* what they saw as the problematic elements of recovery policy and informing its local transformation.

Conclusion

The response to 'New Recovery' in Australia illustrates the importance of historical, political and social contingencies in shaping the process of policy transfer, and the role of non-government actors in translating and negotiating policy ideas. The pre-conditions for recovery in the Australian context included dissatisfaction and repeated attempts at recommissioning of the drug treatment service systems in Victoria (Ritter & Berends, 2016). The strong history of harm minimisation — including harm reduction approaches — in the Australian context meant that recovery policy was not accepted uncritically, and the debate amongst NGOs (evidenced in the ANCD roundtable) largely ended in reaffirming the importance of harm minimisation, and highlighting that new recovery could not serve as an overarching policy. Recovery principles were incorporated into the Victorian AOD treatment system, but were not seen to conflict with harm minimisation, which was retained as the overarching policy framework. Consistent with the policy translation literature, non-government organisations and actors played important roles in the circulation, transformation and negotiation of the meaning of recovery policy in the Australian context (Balen & Leyton, 2015; Stone, 2012). In particular, Australian NGOs highlighted some of the more problematic elements of recovery policy, including definitions of recovery and the role of abstinence, the economic ramifications of recovery policy in other jurisdictions, and the importance of the local context and framework of harm minimisation already in place in Australian jurisdictions. The findings, overall, illustrate the ongoing nature of the policy process and the continued relevance the policy translation and policy mobilities literature hold in viewing 'policy transfer' as a dynamic process where meanings shift and policy ideas are modified and adapted to their local context.

Declaration of Competing Interest

The authors have no conflicts of interest to declare.

Acknowledgements

The authors would like to thank the two anonymous reviewers who provided feedback on an earlier draft of the manuscript. Thank you also to Renae Fomiatti for also providing very helpful comments on an earlier draft. An earlier version of this paper was presented at the International Society for the Study of Drug Policy conference in Vancouver, 2018. The fieldwork and interviews that this study is based on was performed whilst Natalie Thomas was funded by an Australian Postgraduate Award. The fieldwork was also supported by Higher Research Degree funds from Griffith University. Parts of the analysis presented in this article are also presented in the PhD thesis for which this data was collected (Thomas, 2017).

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