Recovery programmes for intervention about substances abuse disorders: european good practices

Los programas de recuperación en la intervención de los trastornos por abusos de sustancias: buenas prácticas europeas

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Abstract

a) Introduction: addictive behaviours recovery-oriented programmes have advanced from traditional therapeutic communities to actual interventions integrated in social and health networks and developed by multidisciplinary professional staff. This evolution has not been systematic until XXIst century, with the beginning of "Science of Recovery". b) Aims: to analyse the development of recovery programmes, especially the theoretical models and good practices actually in development into European programmes. c) Development of the topic: they have been analysed four theoretical models and two good practices about recovery, from a scientific perspective and experiences previously documented. d) Conclusions: the "Science of Recovery" is advancing to validated, replicable and measurable models and programmes. It´s still necessary to adapt recovery-oriented programmes to needs and particularities of people under treatment and specific groups.

Keywords

Good practices, Recovery, "Science of Recovery", Theoretical models, European programmes.

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Resumen

a) Introducción: los programas basados en recuperación de conductas adictivas han evolucionado desde las comunidades terapéuticas tradicionales hasta las intervenciones actuales, integradas en las redes sanitarias y sociales, desarrolladas por equipos multidisciplinares profesionales. Esa evolución no ha sido sistemática hasta el siglo XXI, con la aparición de la "Ciencia de la Recuperación". b) Objetivos: analizar el desarrollo de los programas de recuperación, especialmente los modelos teóricos y las buenas prácticas que se desarrollan actualmente en los programas europeos. c) Desarrollo del tema: se analizan cuatro modelos teóricos, relacionados con la recuperación desde una perspectiva científica y previamente documentados, relacionados con buenas prácticas. d) Conclusiones: la "Ciencia de la Recuperación" está avanzando hacia modelos y programas validados, replicables y medibles. Sigue siendo necesario adecuar los programas basados en recuperación a las necesidades y particularidades de personas y grupos específicos.

Palabras clave

Buenas prácticas, Recuperación, "Ciencia de la Recuperación", modelos teóricos, programas europeos.

1. INTRODUCTION: RECOVERY-BASED PROGRAMMES: THE "RECOVERY" CONCEPT

Within the intervention programs about addictive behaviors, different elements and factors are used that go beyond the mere presence or absence of substances or behavioral problems (Hall, Carter & Forlini, 2012). There are different explanatory models, ranging from the purely biological model to ecological and social models (Deacon, 2013). To develop the actions, comprehensive approaches are usually integrated with the participation of multidisciplinary teams applying protocols and common action plans (Molina, González, Montero and Gómez, 2015), within the so-called biopsychosocial model. These addiction intervention programs are fundamentally divided into Harm Reduction programs and Recovery-based programs. Harm reduction programs aim to minimize the main negative consequences of drug addiction, especially the aftermaths of associated infections and criminal behavours related with substances use (Laespada and Iraurgi, 2009), while "Recovery" is a concept used to contextualize a process of treatment, addiction rehabilitation and subsequent social reintegration (Yates, 2010). Sometimes is used interchangeably as "Rehabilitation", but there are differences between both concepts as the next ones:

- "Rehabilitation" is defined as that process whose overall goal is to help people with some type of handicap or difficulty (such as physical problems, addictions and / or psychiatric problems) to reintegrate into the community and improve their psychosocial functioning, in a way that allows them stay in their social environment in the most normalized and independent conditions possible (Klingemann and Sobell, 2007).
- "Recovery" involves the development of personal autonomy, the performance of socially valuable roles, maintaining

significant socio-affective relationships and living together with the symptoms that allows the person a level of socio-community integration to develop a relatively satisfactory life (McGregor, 2012). Recovery implies not only reducing or eliminating drug use, as could even be achieved by spontaneous remission (Carballo, Fernández-Hermida, Secades-Villa, Sobell, Dum, and García-Rodríguez, 2007), called in some cases "natural recovery" (Moos, & Finney, 2011), but to become an active member of the Society (Yates, 2010).

According to Hernández (2017), rehabilitation is promoted by professionals, while recovery arises from those affected themselves, being one of their main differences. Therefore, it implies a component of participatory action and social context in the ability to reintegrate people into society in a broad sense. Recovery is a process with evolutions and involutions. This process includes three more concepts related to Recovery (Best, 2012):

- Contagion / contagion: understood as the ability to influence in the social context.
- Connection / connections: for the construction of communities and society.
- Homophily / homophilia: term linked with the tendency to associate with people similar to ourselves.

In addition, within the intervention based on Recovery, it is very important to consider the increase in social participation activities: employment, civil action, volunteering, social networks, etc. Some studies specifically include the ability to participate in activities such as leisure and free time, especially sports leisure, due to the factors involved (Best, 2012), specifically:

- Positive identity, which includes a sense of self-efficacy.
- Physical health and well-being.
- Positive social networks.
- Social learning and modeling.
- Sense of hope and positive vision of the future.

This concept, on many occasions, has been linked to therapeutic communities for drug addicts (Molina, Saiz, Cuenca and Gil, 2020) or to strategies such as Alcoholics Anonymous, the Minnesota model and mutual aid groups. Currently, it refers more to programs whose objective is Recovery than to the traditionally called "drug-free programs" (Molina, Saiz, Cuenca, Gil and Goldsby, 2020). Within the Recovery-based programs, exchange and Reciprocity are facilitated, based on the concept of "social support" (Stevens, Jason, Ram and Light, 2015). Recovery, in this way, consists of going from being part of the problem to becoming part of the solution, in going from being "an individual versus a group" to "an individual within a group" (MacGregor, 2012). Active participation in social activities implies progress in the recovery process (Best, 2012). It is very important in recovery processes to consider the increase in social participation activities: employment, civil action, volunteering and social networks (MacGregor, 2012).

2. THE SCIENCE OF RECOVERY

Since 2012, various studies have been developed that raised the extent to which Recovery was a local problem for specific populations or if one could speak of a "Science

of Recovery" (Groshkova, Best and White, 2012). One of the elements evaluated has been the Recovery capital, which refers to the connections between personal and social networks, as well as the competences, reciprocal norms and the capacity for trust and bonding generated between the person in treatment and their reference groups (Putnam, 2000). The concept of "Recovery capital" has become operational in various areas, especially personal, social and community (Groshkova and Best, 2011). This "Recovery capital" can be divided into different types (Best, 2012):

- Persona Recovery capital, which includes the skills and capacities recovered / empowered during the rehabilitation process, especially emotional capacities (Aujoulat, d'Hoore and Deccache, 2007).
- Social Recovery capital, which takes into account the impact of recovery on the social groups of reference, especially family and social networks (Granfiedl and Cloud, 2001).
- Collective Recovery Capital: The Impact generated in a social context by the recovery of people with addiction problems, especially taking into account the cost / benefit balance it entails (Best, 2012). When talking about benefits, we must mention both the direct economic benefits derived from the socio-labor reintegration of a person and the reduction in costs derived from the departure of a person from the care, legal-criminal, health emergency circuit. To calculate this cost / benefit balance, we have to consider all the investments made during the Rehabilitation process (inputs) and balance the benefits received during and after said process (outputs). When speaking of benefits, we must mention both the direct economic benefits derived from the socio-laboral reintegration of a person and the reduction of costs derived from the departure of a person from the health-care, legal-criminal or health emergency circuit (MacGregor, 2012).

To understand the relevance of Recovery Capital, it is more productive to analyze the individual situations and the special health, social and psychological needs of the people involved (Boyle and Johnstone, 2014), in this case people with addiction problems (European Monitoring Center for Drug Dependance and Addiction, 2017). Groshkova, Best, and White (2012) presented the Recovery Capital Assessment as a way to measure recovery progress as part of treatment milieu. Subsequent studies have shown three common elements in Recovery programs at the international level: 1) the connection between the reduction in drug use and the improvement of skills with the reduction of criminal behavior (Best and Aston, 2015), 2) the importance of family bonding (White, 2012) and 3) the positive effects of bonding to treatment and the influence of the peer group (Tiburcio and Kressel, 2011). Social support (Stevens, Jason, Ram & Light, 2015) has also been found to be relevant in long-term maintenance in treatment and recovery processes (Tiburcio & Kressel, 2010).

3. SYSTEMATIZATION OF RECOVERY: MODELS OF INTERVENTION

Now they will be showed the main theoretical models in wich are sustained the recovery intervention programmes.

3.1. The Biopsychosocial Model

The biopsychosocial model applied to substance use and other addictive behaviors (APH, 2015) aims to understand the reality of health problems, including addictive behaviors, through the study of three different variable types: biological, psychological and social. The biological variables would refer to the standard configuration that each person presents, and may be affected by other variables (such as epigenetic factors). These variables have been the subject of multiple studies, the vast majority of them inconclusive despite the determinism that exists when analyzing their influence on addictive behaviors (Molina, Gil and Cuenca, 2018). The psychological variables would refer to the expression in another way of the forces and needs of each individual, through behaviors, beliefs, emotions, lifestyle habits, etc. that each person presents. The evaluation of this variable allows us to better understand the reality regarding the impact that dependency patterns are producing on the person. Finally, the social variables would be found. These variables would be raised in order to know the interactions and relationships that people establish with their environment and not only includes people, but also identities, stereotypes, prejudices, stigmas and values. Integrating them in an open way through a non-linear relationship principle, the model assumes that to a greater or lesser extent all of them can influence both health and the development of a possible disease on the part of people (APH, 2015). Thus, the model is also governed by the principle of multi-causality. Within the interconnection of all these variables, it is necessary that there be a series of risk factors in the absence of protective ones so that problematic behavior patterns can develop, until they lead to addiction, on the part of the person.

Another very important element that the biopsychosocial model raises is that the substance, the consumption, the uncontrolled behavior, do not suppose the problem in itself. All this is understood as a symptomatology of something much deeper, focusing on the possible social and psychological needs that can be found behind said symptomatology. It is a comprehensive psychosocial model that includes a multitude of psychotherapeutic and social support elements that have made it a comprehensive treatment model with room for the introduction of medical-pharmacological and psychiatric treatments (APH, 2015). Among other elements, it includes relapse prevention techniques, cognitive-behavioral techniques and a motivational therapeutic style, distributed in an intensive therapy temporarily adapted to the demands and needs of the people, to which the necessary continuation and follow-up treatment is added. It provides multivariate sessions (individual, family and couple, educational group, therapeutic group and social support) that provide the educational and clinical basis (teaching and practice of coping skills and stress inoculation to alleviate withdrawal syndrome and help maintenance abstinence goals, and participation in self-help groups). It is structured by standardizing the sessions, but, at the same time, with the flexibility to offer other additional sessions according to the needs of the person under treatment. Among the fundamental components for the design and implementation of the intervention, the following stand out (APH, 2015):

- Establish a motivational, positive and collaborative therapeutic relationship with the person.
- Development of an individualized, comprehensive and realistic approach

and treatment plan, with the participation of all the people involved (family member, user, etc.).

- Carry out psychoeducational work with users, their relatives, friends and other people from their social network.
- Teaching, modeling and training in specific techniques.
- Positive reinforcement of desirable behaviors.
- Family involvement in the process.
- Participation in self-help groups.

This model delves into the field of Social Incorporation, understood as a personalized and flexible socialization process, made up of actions and interventions that seek to actively involve, hold, promote and facilitate people's autonomy, development and social well-being, participation and critical capacity. with their environment and aimed at recovering the self-concept of citizen.

3.2. Model of Planification Centered in the Person/PCP (O´Brien y O´Brien, 2000)

John O'Brien applied the principles of normalization and the valorization of the social role to the design of services, ensuring that these achieve "five essential achievements" (O'Brien, 2003):

1. Presence in the community, that is to say that they are accessible services and that they are close to the population.
2. Choice, which implies offering people the option of choosing the type of intervention they will receive, allowing them to participate in the decision-making processes that affect them (as for example in the case of a person who does not have fixed place of residence, you are allowed to choose which type of accommodation offered by social services best suits your characteristics.
3. Competence (experience of acquiring new skills and participating in meaningful activities with the necessary support). (Aujoulat, d'Hoore and Deccache, 2007).
4. Respect, which in relation to this issue implies not being treated as a second-class citizen, but as a citizen with full rights who makes a rational use of public or private resources destined to improve the quality of life of the population.
5. Community participation, which leads to closer ties with community members, neighbors and acquaintances (Bovaird, 2007).

Based on these principles, O'Brien (2003) designed his Planning model centered on the Person / PCP, whose objective is the full integration of every individual in society and avoid individualism in social action. Its application in programs for homeless people with addictions and / or mental illness has been frequent, generalizing the individualization of recovery processes as a general intervention strategy (Molina, Saiz, Gil, Cuenca & Goldsby, 2020).

3.3. Model CHIME: Framework of psychosocial support elements for personal recovery (Leamy, Bird, Le Boutillier, Williams y Slade, 2011)

The CHIME model is a model based on Recovery evaluated and reviewed in several countries (Best, 2012: Vanderplasschen,

2017), which is based on two psychosocial variables: perceived social support and people's use of resources and capacities. available. CHIME is the acronym for the different resources included in the model:

Conectedness (Connection and social support networks)

Hope (Hope / Motivations)

Identity (Social and personal identity)

Meaning (Meaning that the person gives to this social support network)

Empowerment (Empowerment / personal and social competences)

To achieve these objectives it is necessary:

1. Be oriented toward promoting recovery rather than eliminating disease. 2. Build on the person's own goals and aspirations.
2. Articulate the role of the person and the role of others (support person) to help them achieve their own goals.
3. Focus and work on the abilities, strengths and interests of the person.
4. Emphasize the use of community resources rather than segregated resources or programs.
5. Allowing uncertainty, setbacks, and disagreements as inevitable steps on the path to greater self-determination.

It is an optimistic model, in which people with mental health problems do not need to be "cured" to lead productive, fulfilling and meaningful lives. It is a less hierarchical approach where professionals, affected people and families work collaboratively. It takes into account the person in their family, social and cultural context. There are European experiences of working with these processes in a standardized way (Leamy, Bird, Le Boutillier, Williams and Slade, 2011; Best, 2012; Vanderplasschen, Vandevelde and Brockaerst, 2014), developing the concept of "Recovery cities" (Best, 2012), as has been implemented in cities such as Ghent (Belgium) and Goteborg and Stockholm (Sweden).

3.4. The Model HERMESS (Barzanti et al., 2017)

The project "HOME / 2014 / JDRU / AG / DRUG / 7092-Triple R: Rehabilitation for Recovery and Reinsertion" (Barzanti, Blixt, Carrena, DiRenzo, Franzen and Molina, 2017a) had as its main axis the standardization of intervention models in addiction recovery, especially peer learning and subsequent social reintegration, promoting entrepreneurship and social employment.

The objective of the project was to improve the rehabilitation of people with drug problems, through the development and exchange of innovative approaches aimed at recovery and social reintegration (especially, socio-labor integration), the exchange of information on relapse prevention and psychosocial intervention models, to promote the identification and dissemination of good practices in this area. Differential gender aspects were integrated throughout the project (Bird and Rieker, 2008). Its main activity consisted of documenting peer learning practices and social entrepreneurship strategies, presented as effective and relevant in the recovery of people with addiction problems in Europe (EMCDDA, 2017).

This project was coordinated by the Italian association San Patrignano, together with four other EU countries: Spain, Belgium, Sweden and Croatia. The concepts of Rehabilitation, Recovery and Reintegration (the three Rs of the project title) applied to people with addiction problems at the European level were the axis of the documentation. The practices were selected by a panel of experts and included in the manuals "Manual on rehabilitation and recovery of drug users" (Barzanti, Blixt, Carrena, DiRenzo, Franzen and Molina, 2017b) and "Handbook on social reintegration of recovered drug users" (Barzanti et al., 2017a). A third manual related to the legal-criminal aspects of addictions was published.

The project was structured in two phases:

- 1st phase of visits to centers and compilation / validation of Good practices.
- 2nd phase of transfer of experiences

This second phase was developed in specific national contexts, such as the Croatian network for intervention in addictive behaviors. In Croatia, since the 1990s, the main problem has been opiate users, especially Hepatitis c and HIV infections, for which a methadone and brupenorphine dispensing network was designed, considered one of the most effective of Europe. For years, the Croatian intervention network has been orienting itself towards other types of complementary programs for opiate substitutes, such as prevention programs for adolescents, motivational intervention, and job training and guidance. In the evaluation of the Croatian strategy to combat drugs, one of the significant elements was the need to move from a purely social-health approach to a perspective that integrates and facilitates all kinds of programs, from harm reduction to labor incorporation.

The objective of the study and the second phase of the Triple R project was to carry out a treatment network proposal for the Croatian Anti-Drug Strategy 2018-2022, detailing both the identification of transferable practices and the design of interventions proposals. Within the Triple R project, it was developed an intervention model based on peer learning and socio-emotional development called the "Triple R HERMESS" model on rehabilitation and recovery. The "Triple R HERMESS" model presents the key concepts that emerged from the exchange of good practices during the Triple R project. The theoretical bases of HERMESS are the Empowerment model, the Competences model and Social Learning. The acronym HERMESS stands for:

H-human centered / people-centered.

E-empowerment aimed / directed at Empowerment.

R-reintegration oriented / Reintegration oriented.

M-motivational driven / driven towards (internal) motivation.

E-educational embedded / inserted education.

S-self sustainability focused / focused on self-sustainability / personal autonomy.

S-social need oriented / oriented to social needs

A summary of the recovery models documented in the Triple R project is found in Table 1.

Figure 1. Model HERMESS

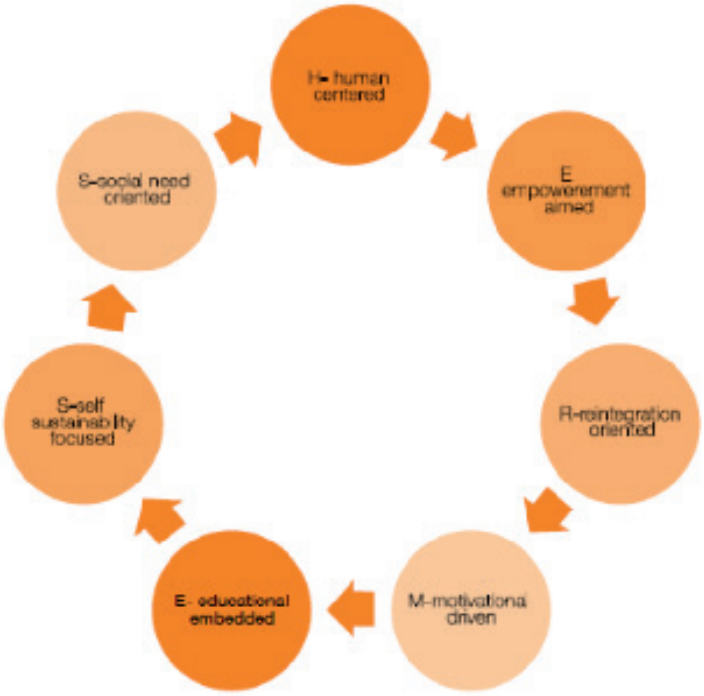

Table 1. Resume of Models of Recovery

Model	Country/es	Framework	Tools	Programmes	NGO
Biopsycho-social	Spain (international)	Models medical,psychological and social (environmental)	Motivation, behavioural change, emotional modulation, social capital	Outpatient and residential facilities	Proyecto Hombre, CEIS.
PCP	EEUU, Canadá (international)	Sociological Model Skills model, Empowerment, "Housing First"	Motivational interview, Design of case, Action plan, Social capital	Focused to social reintegration	Dianova, Institute Pulla
CHIME	Belgium, United Kingodm and Sweeden	Skills model, Empowerment, environmental model	Social support, services network, motivation, social capital	Commnitty Intervention	EURAD, Popov.
HERMESS	Belgium, Croatia, Spain, Italy and Sweeden	Skills model, Empowerment,	Motivation, behavioural change, training in skills, preproffesional training	Therapeutic communitties, social reintegration enterprises, entrepeneurship	San Patrignano, BASTA, Stijena.

4. WHAT IS WORKING AND WHAT IS NOT IN RECOVERY PROGRAMMES

At present, the Recovery concept has been reintegrated within the main axes of the psychosocial intervention of addictions (Goethals, Vanderplasschen and Vandevelde, 2012), related to empowerment programs for the rehabilitation and social integration of people with addiction problems. addiction (López-Goñi et al., 2010). This reintegration has occurred both at the technical and political levels (Best, Grushkova, & White, 2012), promoting structured and validated recovery-based programs within public addiction intervention networks (Vanderplasschen, Vandevelde, & Broekaert, 2014). In this line, we consider that the development of intervention models based on psychosocial factors for people who consume alcohol or cocaine (and not only programmes designed for opiate users) can contribute to the so-called Science of Recovery (Molina, Saiz, Gil and Cuenca, 2021).

Regarding intervention in drug use, the current ethics of intervention, which has been implemented throughout Europe since the 1990s (Molina, Saiz, Cuenca, Gil & Goldsby, 2020), avoids categorizing drugs as "good" or "bad", pointing out the advantages and disadvantages of the use of each substance and its interaction with the personal aspects of each consumer. Especially relevant has been the role of actual generation of professionals in overcoming the "PLD Vs PRD" duality, which had become a real dead end in the design of intervention plans and programs. The broader and more global vision, based on public health, respectful of people's rights and with a strong ethical component, has changed the institutional vision of substances, consumers, their causes and consequences (Morgan and DiZiglio, 2007).

The use of a harm reduction approach in the intervention should never be considered a problem (Laespada and Iraurgi, 2009; Bumbarger and Campbell, 2011). The fact that this approach does not allow accessibility to other treatments and programs such as those based on Recovery, especially for certain subgroups such as women with addiction problems or other non-binary gender identities, the LGTBIQ+ collective, how intersectionality is applied in programs, whether or not the intersectional approach is taken into account in the design and execution of programs… should be considered as lacks of the addiction care system itself (Best, Bliuc, Iqbal, Upton and Hodgkins, 2017).

The need to carry out continuity of care programs for people with drug addictions, combining pharmacotherapy, psychotherapy and recovery for, for example (it seems evident) people with alcohol and/or cocaine consumption problems. Recovery in the areas of social integration, leisure and free time activities, training and job orientation is especially important (Vanderplasschen, Vandevelde and Brockaerst, 2014). In addition to improving the active participation of people with substance abuse disorders in their reference social context (Best, Bliuc, Iqbal, Upton, & Hodgkins, 2017), this approach serves to increase social support (Uchino, 2004) and improve recovery, both in the reduction of risk situations due to mental illness and/or drug use and associated problems, especially crime and socio-health emergencies, as well as to improve coexistence and citizen participation (Best and Aston, 2015). It is about developing models based on scientific evidence applied

to the recovery of people who have problems with addictive behaviors (Bumbarger and Campbell, 2011). In addition, to improve the intervention, the need to act on the stigma of the "addict" social identity is made explicit (Kulesza, Matsuda, Ramirez, Werntz, Teachman, & Lindgren, 2016), a markedly psychosocial aspect that needs to be specifically addressed to achieve an active incorporation into the social context (Saiz, 2008). In this sense, programs based on social support (Uchino, 2004) and the use of "Recovery capital" (MacGregor, 2012) seem necessary to help in this psychosocial intervention.

The use of validated good practices, such as the HERMESS recovery model (Barzanti, Blixt, Carrena, DiRenzo, Franzen and Molina, 2017), or the Recovery Capital Assessment (ARC) through the "Life in Recovery" questionnaire (Best, Vanderplasschen and Nisic, 2020), can), can help improve the relevance and suitability of Recovery-based programs as health and social responses to problems with addictive behaviors (EMCDDA, 2017). Identifying the strengths and barriers of such treatments may also be appropriate for identifying individuals and groups most likely to be successful in recovery programs (Best, Vanderplasschen, & Nisic, 2020).

5. CONCLUSIONS

There seems to be a consensus on the idea of focusing on a comprehensive treatment model capable of diversifying their responses, while considering a great individualization in treatment through work plans that can be more adapted to each person. Different intervention programs (including Recovery-based programs) seem necessary, because there are differences between the profiles and patterns of drug use, especially in epidemiological and social factors. Also in addition to these aspects, it seems necessary to avoid reductionism in research and treatment, whether reductionism towards the neuropsychological, the genetic or the psychotherapeutic. Although we understand that the availability factor is essential to explain the massive consumption of certain addictive behaviors in our society, we think that the simple mention of the extensive commercial distribution of products is insufficient to understand their abusive use in certain individuals or social groups. We must look for multifactorial and non-linear explanations, avoiding the one cause-one effect sequence.

For the correct development and implementation of programs, research and detection of risk groups and the adaptation of interventions to their needs and problems is currently essential. The more concrete and precise we are, the more effective the interventions will be and the better prognosis we will be able to offer these people. It is necessary to overcome the reductionism of the debate on "Harm Reduction programs" and "Recovery programs". Both types of interventions are necessary and can be developed in an intervention circuit.

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