RECOVERY

OUR COMMON GOAL

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FOREWORD

BORISLAV GOIC

Drug addiction and drug demand reduction are rather controversial topics not only in the drug policy field but also in the area of implementation. Over the past 25 years, radical attitudes, such as glorifying harm reduction programs or exclusive drug-free programs, have led to many disagreements and isolation. This has caused severe consequences mostly for the individual who was seeking help - the individual addicted to drugs. The fact that the responsibility for the progress in achieving maximum potential lies with each individual, but also in the system which supports him, to some extent has convinced me that we need to address the drug addiction problem differently. A common goal must be set, and old ideologies and false dichotomies forgotten, because in front of us is someone to whom we are the last straw for salvation. Years ago, I was part of that story myself, and timely information was the key to diagnosis and direction to my personal wellbeing.

The question is, what is our goal? What do we as people who directly or indirectly approach people with addiction problems ultimately want for them? What is our goal for them, on what knowledge and foundations do we base our approach? Would we do anything different in our day-to-day work, and in our decision-making, if the person we deal with was our spouse, brother, sister, or child?

Addiction recovery is not a new term. In America, recovery is referred to with optimistic hope in every segment of the debate. In the UK, every step from the problematic drug use is recovery. In our region, recovery is experienced by a minority of those who have escaped from the hell of addiction. The question is, do we even properly understand that magic word- recovery. What is recovery for me and what does it mean for you? There are also many different approaches lined to recovery. While for recovery from a fractured arm, every effort will be made to help the arm properly heal and to be functional again, in addiction recovery it seems as if there is a lack of willingness to help a person recover and return to how he/she was before the illness. In spite of the scientific evidence and foundation for such a pessimistic approach and factors that certainly contribute to people with addiction problems staying in pain, there are certainly factors in the recovery process that can lead to progress, empowerment and a shift towards hope.

This publication is designed to help us better understand what lies behind the term "recovery". I would like to thank the authors who wrote the papers contained in this publication, who have selflessly contributed and prioritised our region, with the aim to share their knowledge and examples of good practices, so all of us can have benefits for ourselves and our work. The collected papers may contribute to making the drug abuse problem a priority, launching joint debates, and setting a common goal. A goal that can support many individuals who feel isolated and stigmatized. A goal that supports them in returning to how they were before, because no one is born as someone who uses drugs and it does not have to stay like that forever. A goal that will help individuals achieve their maximum potential. A goal called recovery.

REDISCOVERING RECOVERY IN THE TREATMENT OF DEPENDENT DRUG USE

NEIL MCKEGANEY

Within the last few years there has been an enormous change in the world of drug dependency treatment consisting in the rediscovery of recovery as the achievable goal of treatment. For at least the last fifteen years the treatment of drug dependency within many countries has been influenced by one idea more than any other -namely that drug dependency is a chronic relapsing condition from which the individual, once affected, never fully recovers. That view was articulated most powerfully by Professor Tom McLellan and colleagues in 2000 when, after having reviewed a wide range of studies evaluating drug treatment initiatives, they concluded that:

Our review of treatment response found more than 100 randomized control trials of addiction treatments, showing significant reductions in drug use, improved personal health, and reduced social pathology but not cure.
(McLellan et al 2000: 1693)

According to McLellan and colleagues, drug dependency has more in common with other chronic illnesses such as Type 2 Diabetes Mellitus, Hypertension and Asthma than it does with other more acute illnesses. Specifically McLellan and colleagues suggested that drug dependence is best characterised as a chronic illness for the following three reasons, first there is a significant genetic component in the development of addiction (to the extent that there is a generic component of dependence this is not going to be changed by

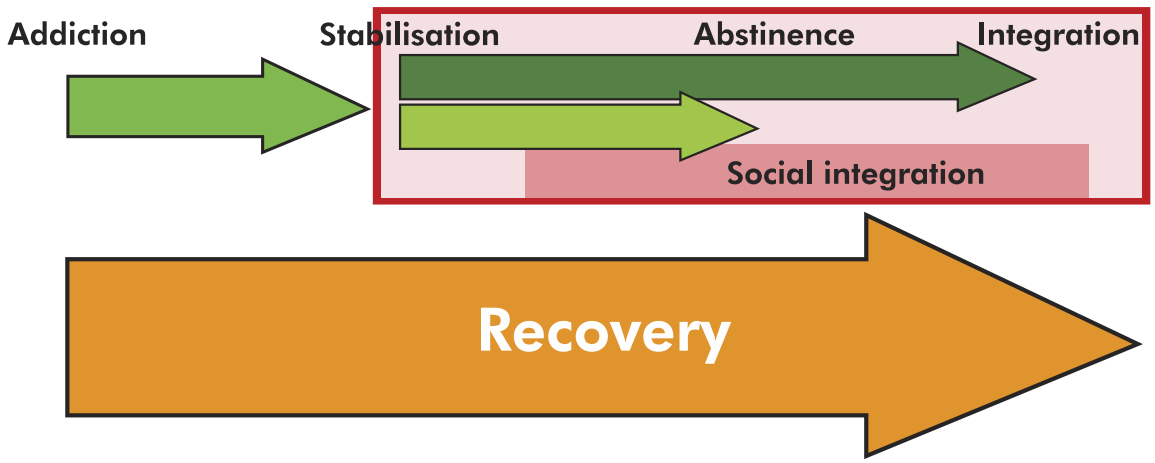
environment or individual motivation towards recovery. Second, the consumption of alcohol and other drugs produces physical changes in the individual's brain that persist even after the individual has ceased consumption thereby placing the individual at risk of relapse even if they have not consumed alcohol or drugs for a protracted period. Third, whilst it is recognised that there is a significant element of personal choice on the part of the individual as to whether to consume specific substances, in fact the element of apparent free will may itself be influenced by genetic and environmental factors acting beyond the individual's own volition. According to Mcellan and colleagues, just as Type 2 Diabetes, Asthma and Hypertension are seen as lifelong illnesses that require life long treatment, so too should it be recognised that drug or alcohol dependence is a chronic illness for which "there is no reliable cure…" and for which treatment itself is likely to be long term possibly life-long (McLellan et al 2000:1693). "The best outcomes from treatment of drug dependence have been seen among patients in long-term methadone maintenance programmes and among the many who have continued participating in AA support group (McLellan et al 2000:1694).

It would be impossible to overestimate the influence that these ideas have had on the world of drug and alcohol treatment producing a set of assumptions around the perceived goals of treatment (to reduce harm rather than to facilitate abstinence or cure), and to encourage individuals to remain in treatment on a long term basis, often with little or no expectation that they will ever reach a point

where they do not need some level of treatment and support. **The perception of drug dependency as being a chronic relapsing condition, requiring life long treatment, and in the case of opiate addiction the long term prescribing of substitute opiate drugs, very much resonated with the view of drug use as a normal behaviour promoted by those who favoured some form of legalisation or decriminalisation of drug use. From within this perspective drug use (whether prescribed or illicit) was seen as a socially acceptable lifestyle choice such that it would be quite wrong to exhort individuals through treatment to cease their drug consumption or to prosecute those who were purchasing their drugs on the street.**

ing that drug treatment services are focussed not so much on reducing the harm associated with individuals continued drug use but on the individual's full recovery. In 2008 for example the Scottish Government announced a new drug strategy that placed recovery at the very centre of drug dependency treatment:

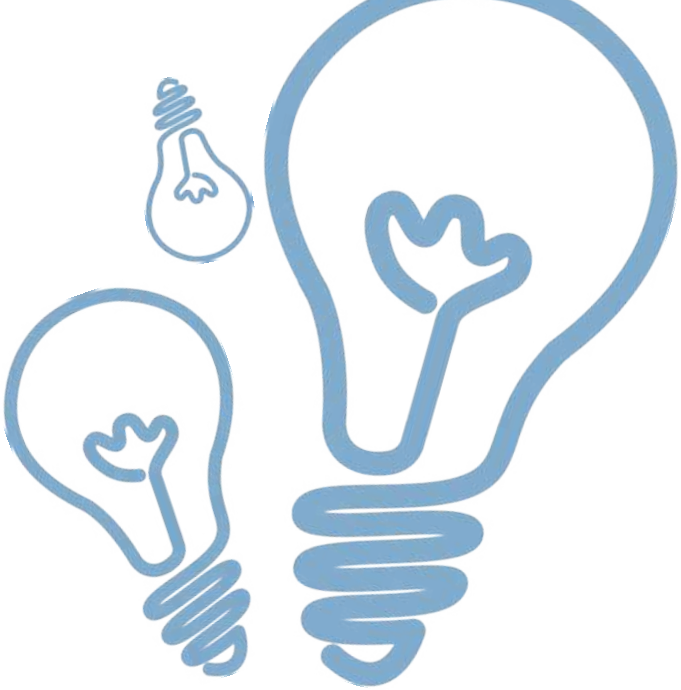
In the government's view recovery should be made the explicit aim of services for problem drug users in Scotland. What do we mean by recovery? We mean a process through which an individual is enabled to move on from their problem drug use, towards a drug free life as an active and contributing member of society. (Scottish Government 2008:23)



Whilst hugely influential in shaping drug treatment policy, and provision, the notion of drug and alcohol dependence as a chronic relapsing condition requiring life-long treatment has been reassessed more recently in a growing focus on the importance of ensur-

Similarly, the UK National Treatment Agency in 2007 identified the primary aim of drug treatment services in the following way:

In the year ahead all of us in the field face this challenge to focus our efforts on the out-



comes of treatment, to enable more addicts to become drug free (National Treatment Agency 2007)

Within the United States the widely respected Betty Ford clinic organised a consensus panel to produce an agreed definition of recovery that services could use in seeking to focus their efforts on the new recovery agenda:

Recovery from substance dependence is a voluntarily maintained lifestyle characterized by sobriety, personal health and citizenship (Betty Ford Consensus Panel 2007:221).

Within the UK, the influential UK Drug Policy Commission produced its own definition of recovery illustrating how central the notion of recovery had become in thinking about the goals of drug treatment services within the UK:

The process of recovery from problematic substance use is characterised by voluntarily-sustained control over substance use, which maximises health and wellbeing and participation in the rights, roles and responsibilities of society. (UKDP, 2008:6)

Whilst these definitions vary in part (for example one emphasises sobriety whilst the other stresses the importance of voluntary sustained control over substance use) both clearly indicate a move way from the notion of drug and alcohol dependence as a condition from which there is no cure and with which the individual will have to live for the remainder of his or her life.

David Best and Alexandre Laudet have offered a different and in a way more holistic and less medicalised view of recovery than either the Betty Ford consensus panel or the United Kingdom Policy Commission:

The essence of recovery is a lived experience of improved life quality and a sense of empowerment; that the principles of recovery focus on the central ideas of hope, choice, freedom and aspiration that are experienced rather than diagnosed and occur in real life settings rather than in the rarefied atmosphere of clinical settings. Recovery is a process rather than an end state, with the goal being an on-going quest for a better life (Best and Laudet, 2010:2

Within those areas where the recovery agenda has gained momentum drug treatment services, and those shaping drug

treatment policy, have had to reshape many aspects of their work. Within the UK new guidelines were sent to drug treatment services by the National Treatment Agency encouraging services to move away from the notion of drug dependency treatment being a life-long process. Rather than seeing the engagement with drug treatment services as being an end in itself the goal now was to view treatment as a process leading to recovery within which individual's engagement with drug treatment services was time limited rather than life-long:

> **Ensure exits from treatment are visible to patients from the minute they walk through the door of your service. This means giving them enough information to understand what might comprise a treatment journey, even if their eventual exit appears some way off. And make visible those people who have successfully exited by explicitly linking your service to a recovery community, or employing former service users or using them as a volunteer recovery mentors and coaches. (National Treatment Agency 2012:7)**

THE REDISCOVERY OF RECOVERY IN DRUG TREATMENT

The development of a focus on ensuring that drug treatment services are focussed on recovery rather than simply ensuring that drug users remain in drug treatment for many years has been influenced by a number of factors. First there has been a concern that in many instances drug users prescribed substitute opiate drugs as part of a methadone maintenance programme may have been "parked" on their substitute medication for many years without any real encouragement or expectation from prescribing clinicians that they may move on from their reliance on prescribed medication (Easton 2009). **The concern was that treatment for to many drug users had become an end in itself rather than a route to recovery and that at least part of the reason for this has been a lack of ambition on the part of prescribers in seeking to maintain the momentum towards**

recovery that may have infused drug users at the point at which they were initially contacting drug treatment services:

The ambition for more people to recover is legitimate, deliverable and overdue. Previous drug strategies focussed on reducing crime and drug related harm to public health, where the benefit to society accrued from people being retained in treatment programmes as much from completing them. However, this allowed a culture of commissioning and practice to develop that gave insufficient priority to an individual's desire to overcome his or her drug or alcohol dependence. This has been particularly true for heroin users reducing OST(opiate substitution treatment), where the protective benefits have too often become an end in themselves rather than providing a safe platform from which users might progress towards further recovery (National Treatment Agency for Substance Misuse, 2012:4)

Second, research has shown that many drug users contacting drug treatment services are looking for assistance in becoming drug free. In 2004 McKeganey and colleagues published the findings of research on drug users aspirations from drug treatment services. This study, which was based on structured interviews with 1007 drug users initiating a new episode of drug treatment in Scotland in 2002, found that 56.6% of those questioned identified the goal of becoming drug free as their sole reason for having contacted drug treatment services. By contrast only 7.4% of those questioned said that they were seeking to stabilise their continued drug use and less than 1% (.7%) said they were looking for advice on how to use their drugs with greater safety (McKeganey et al 2004).

Alongside the research showing that many drug users contacting drug treatment services

were seeking to become drug free, there has also been a growing body of evidence showing that treatment services, configured in the right way, can assist a substantial proportion of drug users in becoming drug free. In 2007 Dawe and colleagues reported the results on long term abstinence on the part of drug users included in the Australian Treatment Outcome Study (Darke et al 2007). Based on interviews with 429 heroin use, followed up over a three years period, the study showed that at the 36 month follow up interview 40% of drug users had been abstinent for the preceding 12 months. In looking at the characteristics of those drug users who had been able to maintain a period of sustained abstinence the researchers on this study identified some surprising findings including that:

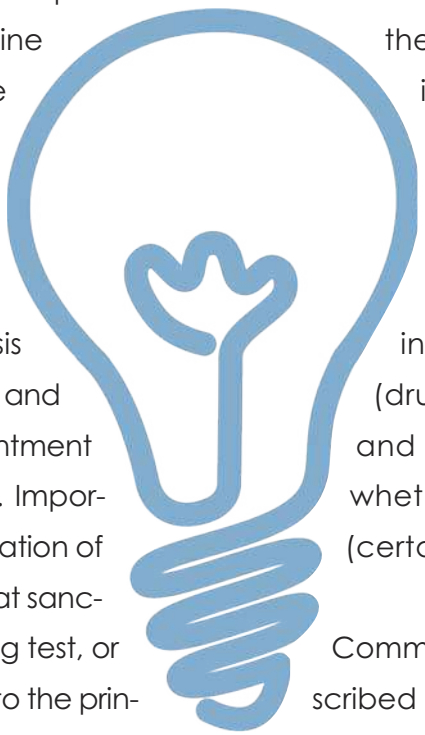
The abstinent were significantly less likely to be currently enrolled in treatment. In fact, two thirds of the abstinent were not enrolled in treatment at 36 months. It would appear that this group had successfully emerged from a longer, more stable treatment experience in the first year of follow-up, having made long-term change to their drug use which they were able to maintain (Darke et al 2007:1904).

In effect then "more treatment" did not necessarily equate to better outcomes from treatment -although the researchers on this study stress the likely value of stable

treatment. Other studies have also shed light on both the extent to which those who have become drug or alcohol dependent can achieve sustained abstinence, and the characteristics of treatment services that may be most likely to produce such an outcome. McLellan and colleagues, for example, have reported on the experience 904 addicted doctors admitted to the US physician health care programmes. Just over half of the doctors studied had a primary diagnosis of an alcohol problem, and 35% had an opiate problem. The treatment itself largely consisted of an abstinence based, 12-step i.e. Alcoholics Anonymous type programme coupled with some element of residential care where needed and regular drug testing. In total 81% of those completing the treatment programme remained drug or alcohol free over the study period (confirmed by urine testing) whilst 19% relapsed at least once over the five year study period (McLellan et al 2008). Those are impressive proportions indicating that abstinence can be achieved by a very large number of those engaged in treatment.

One objection that may be directed towards the McLellan study is that doctors are likely to be highly motivated towards recovery and abstinence because their continued licence to practice depends on such a positive outcome. Other research with what many would regard to be less highly motivated treatment samples has also identified

similar positive outcomes where abstinence is identified as an important goal of the treatment provided. The Hawaii Opportunity Probation with Enforcement (HOPE) is a community based probation programme for methamphetamine users. The HOPE programme places particular emphasis on individuals remaining drug free during the period of their probation with individuals tested on a regular basis and "…every positive drug test and every missed probation appointment (being) met with a sanction". Importantly, the authors of the evaluation of the HOPE programme stress that sanctions resulting from a failed drug test, or missed appointment, adhere to the principles of being swift, certain, and proportionate. The evaluation of the HOPE programme showed that the proportion of participants in the study group producing a positive drug tests reduced from 53% to 4% over a 12 month period compared to a reduction of 22% to 19% amongst the comparison group (Harken and Kleiman 2009). **The learning produced from these two evaluations appears to be that where treatment providers place importance on individuals remaining drug free, and where those services either reward abstinence or punish transgressions, services can achieve very substantial rates of improved behaviour.** Importantly the sanctions as shown by the HOPE evaluation do not need to be excessive indeed the authors of this study emphasise that what makes the sanctions so influential is the fact that they are swift, certain, and proportionate. In other words sanctions are proportionate to the transgression (for example an individual may spend a short time hours or days in prison following a positive drug test), the punishment happens very quickly following on from the transgression (drug use, failed appointment) and there is no ambiguity about whether the punishment will occur (certainty).



Commenting on what they have described as a new treatment paradigm Du Pont and Humphreys and have observed that:

> One distinctive feature of these … interventions is the intense leverage that is used to sanction substance use and to reward abstinence. In the case of the PHP's the leverage is the threat of removal from practice and ultimately the loss of the physician' medical license; the reward is continuing to practice in a prestigious and well-paid profession. For HOPE…. immediate brief incarceration is the sanction and freedom in the community is the reward. (Du Pont and Humphreys 2011:4)

Mandatory abstinence used in this new paradigm contrasts sharply with programmes that make treatment mandatory but do not impose meaningful consequences for any continued substance use. The ….programs for offenders sharply contrast with the far more common approach in the criminal justice system where consequences for non compliance, including continued substance use, are long delayed, uncertain, and when applied are-often after many violations-draconian. (Du Pont and Humphreys 2011:4)

In contrast to these examples of treatment initiatives that have successfully prioritised abstinence there are many examples of the much more modest outcomes of treatment systems that have not prioritised abstinence. Within Scotland in 2008 the Scottish government announced a new drug strategy that required drug treatment services to be focussed on ensuring that drug users were assisted to become drug free. However prior to this focus on recovery drug treatment services within Scotland were very much focussed on retaining clients in long term treatment without any clear expectation of recovery- treatment was in this sense seen more as an end in itself rather than a route to abstinence based recovery. During this period the proportion of drug users becoming drug free on the basis of even long term contact with drug treatment services was very modest. McKeganey and colleagues followed a sample of drug users starting a new episode of drug treatment in 2002. Despite the fact that this study had shown that the majority of drug users in treatment were looking to become drug free on the basis of their contact with treatment services in fact after 33 months of contact with treatment services only:

> Although becoming drug free was the expressed goal of the majority of drug users recruited into the Drug Outcome Research in Scotland study at 33 months following recruitment only 5.95 of females and 9.0% of males had been totally drug free (excluding alcohol and tobacco) for the 90-day period in advance of being interviewed. (McKeganey et al 2006:537)

In a treatment system where abstinence is not prioritised and where concurrent illicit drug use is not sanctioned it is perhaps hardly surprising that even after extensive contact with drug treatment services only a tiny minority of individuals managed to remain drug free for even a relatively modest period (90 days).

One of the by-products of a treatment culture within which long term contact with treatment services is seen as the primary goal in itself (rather than the progress individuals can make towards recovery) is that individuals may not only remain in contact with drug treatment services for much longer but they

may also remain drug dependent for longer as a result of the opportunities for recovery not having been fully exploited. In a study carried out in Edinburgh, Scotland to identify the impact of long term methadone provision on drug users risks of premature death the researchers identified that those drug users who had been prescribed methadone were significantly less likely to die than those who had not been prescribed the drug:

For each additional year of opiate substitution treatment the hazard of death before long term cessation fell 13% (95% confidence interval 17% to 9%) after adjustment for HIV, sex calendar period, age at first injection and history of prison and overdose.(Kimber et al 2010)

However the study also identified an inverse relationship between the provision of long term opiate substitution treatment and the likelihood of individual's achieving long term cessation in their drug use. Drug users who were prescribed methadone on a long-term basis remained drug dependent for substantially longer than those who were not prescribed the drug:

Opiate substitution treatment was associated with an increased duration of injecting (that is time to long term cessation): for each year of treatment before adjustment duration was increased by 11%..... for patients who did not start opiate substitution treatment the median duration of injecting was five years (with nearly 30% ceasing within a year) compared with 20 years for those with more than five years of exposure to treatment..)

In effect then a treatment system which is focussed on providing methadone on a long term basis, and which has priorities remaining in treatment over recovery (long term cessation), is much less likely to achieve full recovery on the part of the drug users being treated. The situation within Scotland in advance of the new drug strategy focussing on recovery was very similar to the situation of some methadone programmes within the United Stated described by Du Pont and Humphreys:

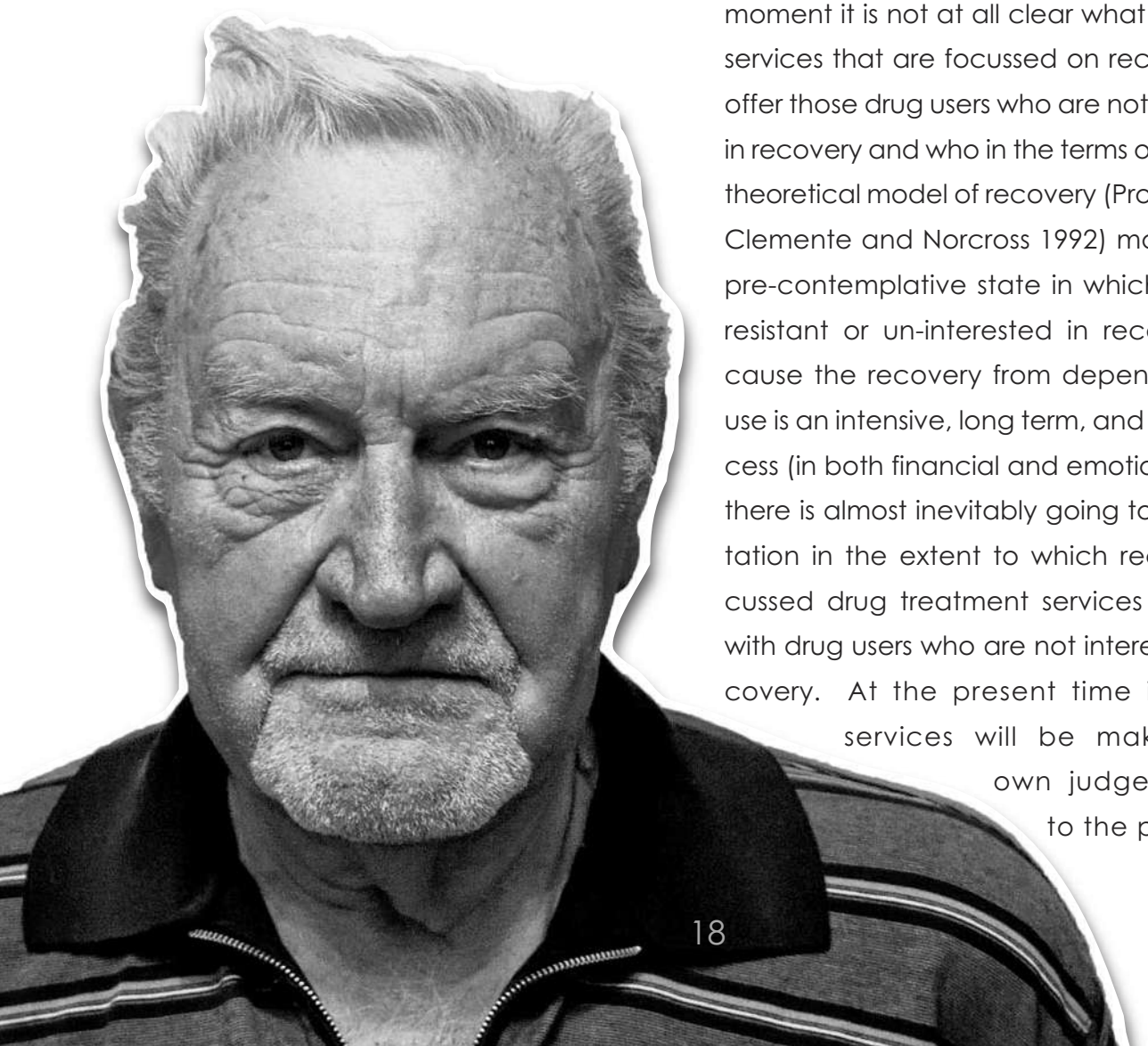
This contrasts with the pattern among some methadone programmes today that do little or no drug testing and are not concerned in any meaningful way with continued alcohol and other drug use, relying instead on the hope that with some methadone, heroin addicts will use a bit less heroin and commit somewhat less crime. That permissive type of methadone programme may affect those indicators modestly, but those programmes do not start many people on the path way to recovery. (Du Pont and Humphreys 2011:5)

The recovery focus that is now a characteristic of many drug treatment systems in different countries has also thrown up many challenges that in many ways demonstrate the paucity of the available ev-

idence that might otherwise have usefully guided practice.

THE CHALLENGE OF A RECOVERY FOCUSSED DRUG TREATMENT SYSTEM

Embracing the idea of recovery, and encouraging drug treatment services to focus on recovery, is an important first step in reconfiguring the world of drug dependency treatment. However there are many challenges that flow from the attempt to realise a commitment to ensuring that drug treatment services are working towards individual's recovery. Research has to date only partly contributed to answering some of those questions.



WHAT DO YOU OFFER DRUG USERS IN TREATMENT WHO ARE NOT INTERESTED IN RECOVERY?

Whilst research has shown that the majority of drug users in contact with drug treatment services are looking for assistance in becoming drug free it is certainly not the case that all drug users in contact with treatment services are motivated in this way. At any one time there will be a proportion of drug users in contact with drug treatment services who are not interested in recovery and who will have contacted drug treatment services for a variety of other reasons -including in some instances having being required to do so on the basis of court ordered treatment. At the moment it is not at all clear what treatment services that are focussed on recovery can offer those drug users who are not interested in recovery and who in the terms of the trans-theoretical model of recovery (Prochaska, Di Clemente and Norcross 1992) may be at a pre-contemplative state in which they are resistant or un-interested in recovery. Because the recovery from dependent drug use is an intensive, long term, and costly process (in both financial and emotional terms) there is almost inevitably going to be a limitation in the extent to which recovery focussed drug treatment services can work with drug users who are not interested in recovery. At the present time individual services will be making their own judgements as to the proportion

of recovery motivated and recovery unmotivated clients they can work with. Those judgements, however, are difficult to make since we know very little about the factors that may increase or decrease the likelihood of an individual shifting from a stage when they are uninterested in recovery, to a stage where they are willing to focus on recovery. We know that individuals with higher levels of recovery capital (individual family and social/community resources) will progress more rapidly into a state of sustained recovery, but at the present time we are not able to easily differentiate between those individuals for whom recovery is a realistic goal and those for whom recovery is a very distant, and in some instances unconsidered, goal.

Drug treatment services working within a recovery climate will need to determine how much of their services, and what kinds of services, they can offer to those drug users who are not interested in recovery – balancing the goals of abstinence and harm reduction (McKeganey 2005). For some individuals it may be most appropriate to provide information on how to use their drugs more safely; for example, encouraging a shift from injecting to non-injecting forms of drug use, whilst for others the goal may be to encourage the individual to cease his or her drug use entirely for increasingly long periods. **Although at a superficial level it may seem straightforward for drug treatment services to combine these contrasting goals, in reality it can be very difficult for a service focussed on abstinence to encourage its staff to provide harm reduction advice to drug users just as it can be very difficult for the staff working within a harm reduction service to encourage clients to embrace the goal of abstinence.**

Although at the moment many services may claim to be effectively combining the different goals of abstinence and harm reduction we know relatively little in research terms as to how that is being achieved in practice. There have been concerns, nevertheless, that the focus on recovery within drug treatment services in some areas has resulted in some drug users being prematurely expelled from treatment with significant adverse effects (White et al 2005)). Where this occurs it suggests that service providers have been unable to find a way of balancing the needs of those drug users who are focussed on recovery with those who committed to continuing their drug use.

HOW LONG SHOULD INDIVIDUAL'S REMAIN IN TREATMENT?

Research has shown that the outcomes from drug treatment are more likely to be positive where treatment itself is provided over an extended period of time. That evidence would caution against drug treatment being provided for only short periods of time or for treatment being prematurely interrupted, for example, temporary cessation of an individ-

ual's opiate substitute prescription. **However, there is a real danger that either through overly cautious judgements on the part of staff, or anxiety on the part of clients, that individuals may build up a dependence on drug treatment services thereby potentially extending the length of time they are engaged with services beyond the point at which that engagement is necessary.** Once again the evidence base on how drug treatment services may be guided in establishing how long individuals can or should remain in treatment is far from extensive beyond the broad guidance that better outcomes arise from longer treatment. Research has not been able to show at what point individual treatment or combinations of treatment move from making an effective to an ineffective contribution in facilitating an individual's recovery. As a result we know very little within the drug or alcohol dependency field about how long an individual should ideally remain in treatment. Indeed in many instances the length of time an individual is engaged in treatment will be determined by extraneous factors such as the level of funding for a treatment services or the extent of any waiting list of clients hoping to access a service.

WHOSE DEFINITION OF RECOVERY SHOULD APPLY?

Whilst there has been a growing commitment to ensure that drug treatment services are working towards facilitating recovery it is less clear how the definitions of recovery offered by some of the national organisations, and contained within national drug strategies, can be operationalized at an individual level. Some commentators have suggested that the definition of whether one is in recovery should be very much determined by the individual involved in contrast to that judgement being imposed by drug treatment professionals. Recovery in this sense becomes an individually determined state. Whilst defining recovery in this way ensures that recovery is seen as a process that is maximally inclusive it also raises the deeper question of whether the process of recovery can ever end i.e. whether the recovered state can actually ever be reached or whether recovery is itself seen as a potentially life long process. This question is important since it leads into the issue of how long individuals may be expected to remain "in treatment". Part of the way in which the focus on recovery has been distinguished from previous characterisations where simply being in treatment was seen as an end in itself, is the importance given to ensuring that drug treatment services are maximising individual's momentum towards recovery. If recovery is being seen as something that is largely determined by the individual him or herself then it raises the prospect that an individual could see themselves, and expect to be seen by others, as engaged in recovery even

though they are not in any significant sense progressing to the point where they no longer require contact with drug treatment services. Proposing that recovery is entirely determined by the individual could create a situation of life long engagement with treatment that was very much a criticism of the view that engaging with drug treatment services is an end in itself. A further difficulty with adopting a purely individual view of recovery of course is that it becomes very difficult to challenge individuals in terms of either their commitment towards recovery or the pace of their progression in recovery leading ultimately to a situation in which drug treatment services may find themselves being overly determined by those in recovery.

The alternative scenario in which drug treatment services largely determine the components of recovery, deciding when an individual has recovered enough to cease his or her contact with drug treatment services, may result in the individual feeling excluded from his or her own recovery. At an operational level then, in terms of how drug treatment services engage with clients, there will be a need to balance the capacity of individual's to define their own recovery with the constraints (including funding constraints) that services are operating under in determining to determine how much treatment or support an individual can receive for how long, and with what level of intensity.

HOW TO COMBINE PROFESSIONAL TREATMENT SERVICES WITH FAMILY, COMMUNITY, AND VOLUNTARY SERVICES?

Within the current recovery climate there is a growing recognition that the contribution of statutory or privately funded drug treatment services towards recovery is relatively modest, compared to the contribution of friends, family, and the wider community. To an extent this is to be expected since in the simplest of terms the amount of time an individual engages with drug treatment services is only ever likely to be a fraction of the time they are engaged with family, friends and the wider community. **Where an individual is surrounded by positive supportive influences in their home life there is an increased likelihood that their recovery will be positive. Equally, where an individual is surrounded by influences pulling them back into a pattern of dependent drug or alcohol use, there is indeed a greater likelihood of their relapse and the resumption of a pattern of chaotic and harmful drug or alcohol use.**

Whilst there is now a growing awareness of the important contribution of family and friends, and of the wider community -often characterised as family/social/community recovery capital- in individual's recovery (White and Cloud 2008), there is much less clarity with regard to establishing how these various influences can best be made to work together for maximum positive impact. Relatively little is known, for example, about how professional or statutory drug treatment staff can work most effectively with family members in facili-

tating an individual's recovery i.e. what information to share about the individual's recovery, past drug use, past criminality. Equally we know relatively little about how best to moderate or ameliorate those influences within an individual's social world that may increase the likelihood of relapse- hampering rather than furthering the individual's recovery. This is an area where research in relation to other conditions has been able to make a positive contribution. For example in early studies into the factors influencing the recovery from schizophrenia researchers and clinicians identified that the patients who received the most visits from family members, when they were hospitalised, were often the patients that took the longest time to recover. The reason for this was that part of the psychpathology they were demonstrating was arising from the dysfunctional family relationships in which the individual was involved. The upshot of this research is that where individuals are hospitalised for certain mental health problems, family visits in the early stages of the individual's recovery and hospitalisation are discouraged. It has also been shown that the nature of the family environment into which the individual is discharged at the conclusion of their treatment especially the emotional life of the family can have a significant impact on the nature and extent of the individual's subsequent recovery (Brown Birley and Wing 1972, Amaresha and Venkatasubramanian 2012). In the case of drug or alcohol dependency there may well be individuals in the patient's/clients social world that are more facilitative of their continued drug use than their recovery although at the present time we know relatively little about how best to limit those influences whilst enhancing those influences that are more positive. This too is an area where research is required.

CONCLUSION

The development of a recovery focus in drug and alcohol treatment has been an important recent development in drug treatment systems in a number of countries. Where previously addiction and dependency were seen as life long states, often requiring life long treatment, where simply being in treatment was seen as an important goal in itself there is now a growing commitment towards ensuring that drug treatment services are working towards maximising the opportunities for individual's recovery. Treatment in these terms is seen as a process with an end to it in which individual's move on from being in treatment to take up their responsibilities in the wider society. That shift in policy and practice has been driven in part by the evidence showing that most drug users contacting services are indeed looking for help in becoming drug free and no doubt in part also by the circumstances of economic austerity in many countries that has made life long drug dependency treatment an option that is too expensive to provide. The goal of ensuring drug treatment services are working towards enabling drug users to become drug free however contains within it many fundamental challenges to do with the nature of treatment its duration the definitions of recovery, the respective contribution of family friends and the wider community in facilitating recovery and crucially in determining what one offers those drug users who are not interested in recovery. Each of these are areas where research can make an important contribution guiding practice although at present many of these areas remain relatively unexplored.

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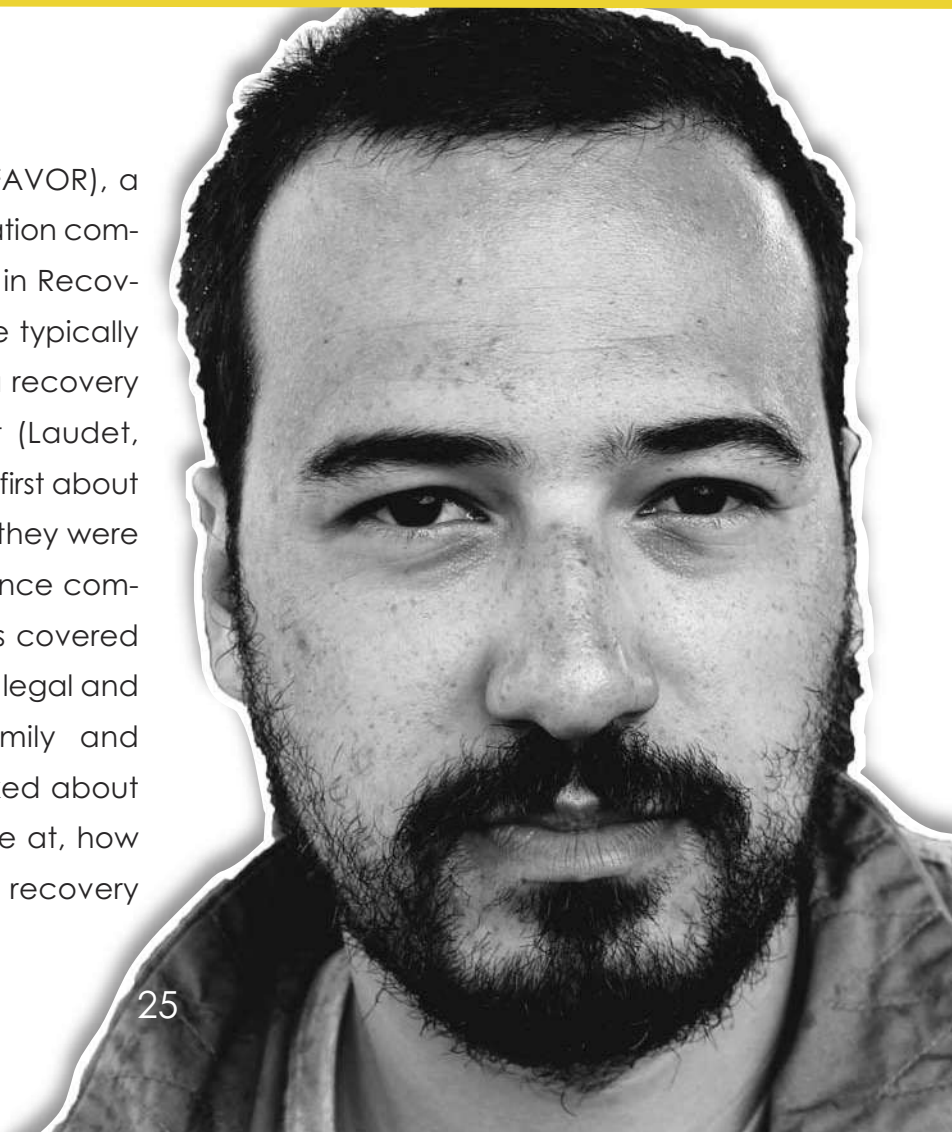
ANALYSIS OF THE BALKAN LIFE IN RECOVERY REPORT

DAVID BEST AND MULKA NISIC

What happens to people when they achieve and then stabilise addiction recovery? While there is a lot of scientific evidence about relapse and about the acute stages of addiction, we know relatively little about the success stories of people who manage to sustain their recovery journeys and what that means in terms of their lives. The study described below builds on an international body of work (and in particular on a European funded research study) to examine patterns of recovery in the Balkan countries and what life in recovery looks like in this setting.



1. BACKGROUND

Faces and Voices of Recovery (FAVOR), a large recovery advocacy organisation commissioned an online survey of Life in Recovery to chart what life domains are typically changed as a result of initiating a recovery journey. In this initial U.S. project (Laudet, 2013), 44 items were asked twice - first about life in 'active addiction' and then they were repeated to assess experiences since coming into recovery. These questions covered five core domains: work, finances, legal and criminal justice, social and family and health. Participants were also asked about what stage of recovery they were at, how they would describe their own recovery

status (eg as 'in recovery', 'recovered' and so on) and what recovery support services they were engaged with at the time of the survey. A total of 3,228 surveys were completed and returned. On average, the participants in the survey had an active addiction career of 18 years and had started their recovery journey at an average age of 36 years. However, the clear conclusion was that, across all of the domains measured, there was clear improvement when people transitioned to recovery, and also that the longer they were in recovery, the higher their wellbeing and functioning.

While the survey had a significant impact in the US (and there are currently discussions about whether it should be repeated), it has created a ripple effect that has meant that it has since been reproduced in a number of countries internationally, starting with Australia (Best, 2015) and the UK (Best et al, 2015), with participating samples of 573 and 802 respectively. While the overall patterns were the same with marked improvements reported in both countries across all five of the domains, there were interesting and important differences, reflecting slight differences in those who took part and in the social and cultural context in which recovery occurred. However, one common characteristic of the surveys was that they all produced roughly equal numbers of male and female participants suggesting that this is an optimal mechanism for accessing the hidden voice of women in recovery.

Since that point, and collated in a special issue of Alcoholism Treatment Quarterly in 2018, a further survey has been completed in Canada (McQuaid et al, 2017) and the survey adapted to create a family members' version reporting both on the addict and the family member's journey to recovery (Andersson et al, 2018).

In 2017, the ERANID REC-PATH project was funded by the respective health departments in Belgium, Netherlands, Scotland and England (Best et al, 2019). The aim of the project was to assess gender differences in engagement with different 'recovery mechanisms' and to track changes in recovery wellbeing and recovery support engagement over the course of one year. The project used the Life in Recovery Survey (Faces and Voices of Recovery, 2013; Best et al, 2015; Best, 2015) as a screening tool to recruit participants in the four main countries.

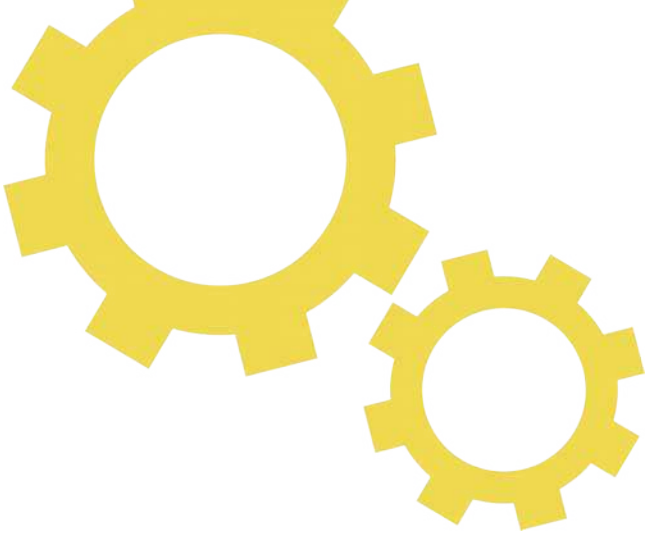
As an addition to the ERANID project, cooperation with Recovered Users Network (RUN) has been established and adapted version of the survey was distributed to its members to allow us to augment the international database and to look at wider experiences of recovery across Europe. The aim of this chapter is to outline those findings and to consider how they differ from the findings in the UK and other Anglo countries. One of the key objectives of undertaking this survey in multiple settings (with different cultures and processes) is to assess what aspects of recovery are consistent and which are specific to cultural, policy and treatment processes and models.

2. METHOD

A slightly adapted version of the instrument was circulated through the Recovered Users Network (RUN) following a process of back-translation to ensure both consistency and that it was meaningful to potential participants.

The Life in Recovery research project reported here is built on an already established research methodology and is part of data collection for the Balkan region. This has been funded and coordinated by NGO Proslavi Oporavak/Celebrate Recovery, a recovery organisation which aims to provide support and services to people in both active addiction and in recovery and help them achieve full recovery and their full potential, by among other things ensuring that policy and practice are developed on the basis of evidence and research.

This research has also relied on the support and participation of recovery organisations, therapeutic communities, communes and institutions providing various supports to people affected by drugs and those in recovery across the region. They played a significant role in the distribution of the survey among their service users and the sample should be regarded as a network of these organisations. However, member organisations of Recovered Users Network –RUN, Association Izlazak/ Exodus , Srbija; NGO Preporod/ Rebirth Crna Gora; Association Stijena/ Rock, Hrvatska and Association Proslavi Oporavak/Celebrate Recovery, Bosnia and Herzegovina, which are the coordinators for their respected countries, have played the most significant role in this research.



We cannot claim that the sample is representative and is opportunistic, yet it offers people in recovery the chance to describe their own experiences of change and to contribute to a growing evidence base around recovery barriers and enablers.

The surveys were completed by individuals who are in self-reported recovery, irrespective of how they understand recovery and what stage they are at on this journey. Additionally, people in recovery played a critical role in the distribution of the survey and circulated the survey amongst family members, friends and other individuals.

Procedure: The survey has been translated into the local languages of the countries involved and it ran for four months. The survey was available online as well as in hard copies and it was promoted regionally via organisations, social media, websites, TV shows and other partner agencies. Hard copies of the survey were also made available for those who did not have access to or were not comfortable completing the online version. The aim (as with other LiR surveys) was to start from known recovery groups and then snowball out to a more diverse group of potential participants.

The study rationale is based on a series of indicators that the participant endorses for two different stages of their life - as they are currently ('in recovery') and at the peak of their substance use ('in active addiction'). The five domains that the survey assessed were:

- **Finance**
- **Health**
- **Crime**
- **Family and social**
- **Employment and education**

3. RESULTS: OVERVIEW OF THE BALKAN POPULATION ONLY

3.1 Sample characteristics

There were a total of 263 completed returns. The Balkan sample were predominantly male 190 (72.2%) with 27.8% of the sample female, which is radically different from the roughly equal split in the previous LiR surveys in English speaking countries.

More than two thirds of the sample had lower levels of education, while the rest had a post-graduate or degree level education (23.6%), also differing from the English-speaking versions where respondents were typically more educated. Most participants (42.2%) were married at the time of the survey. 34.6 % reported being single and had never married and fewer people were divorced, separated or widowed. Of the 263 who completed the survey, 142 (46.0 %) reported having dependent children. They had an average of 1.75

children under the age of 18.

In terms of how they see themselves, 23.6% saw themselves as being 'in recovery'; 37.6% as 'recovered'; 17.9% as used to have a drug problem but don't now, 10.6% reported that they were in medication assisted recovery and 10.3% as having another status.

3.2 Addiction careers

Participants from the Balkan region typically started using at around 15 years of age and stopped at around 30 years, a using career of around 15 years. This is typically younger and earlier onset and exit than reported in most US and UK based studies. The average age of initially attempting to stop was 24.1 years and it had been an average of 7.2 years since participants used drug problematically, although they typically regarded the recovery window as slightly shorter, the mean was 6.7 years.

Compared to those from the other participating countries, those from the Balkans stopped using earlier and first sought help at an earlier age, and so were typically in recovery for longer at the time of the survey.

3.3 Basic pattern of change from active use to recovery

The main part of the analysis examines changes from active addiction to recovery across multiple domains: these are split into domains and in Table 1 we report this for health. In each of the sections we report only on those areas where there are important or significant results.

TABLE 1

HEALTH FACTORS IN ACTIVE ADDICTION AND IN RECOVERY

DID YOU:	IN ACTIVE ADDICTION	IN RECOVERY
EXPERIENCE UNTREATED EMOTIONAL OR MENTAL HEALTH PROBLEMS	77.2%	47.9%
VISIT EMERGENCY ROOMS FREQUENTLY	23.6%	6.8%
GET REGULAR DENTAL CHECK-UPS	17.1%	47.9%
USE TOBACCO PRODUCTS	87.8%	49.4%
TAKE CARE OF YOUR HEALTH	16.7%	76.0%

As with the previous surveys, there is a very clear transition from unhealthy to healthy behaviours with higher levels of dental health, and general health awareness in recovery. From an economic point of view, there is a much lower use of emergency services in recovery. There are also marked improve-

TABLE 2

LEGAL FACTORS IN ACTIVE ADDICTION AND IN RECOVERY

DID YOU:	IN ACTIVE ADDICTION	IN RECOVERY
DRIVE UNDER THE INFLUENCE OF DRUGS	66.2%	11.4%
DAMAGE PROPERTY	70.3%	14.1%
GET ARRESTED	63.9%	10.3%
HAD CRIMINAL CHARGES AGAINST YOU	54.8%	10.3%
SERVED A PRISON SENTENCE	31.2%	8.4%

ments in the use of tobacco and in untreated mental health or emotional problems although it is important to note that there are still around half of the sample using tobacco and with untreated mental health problems, suggesting that there is still some way to go to 'full recovery' for at least some of the sample.

In the next table (Table 2) we examine legal issues in active addiction and in recovery:

From a public health and safety perspective, the most marked changes are involvement with the criminal justice system - with huge drops in the rates of arrest, charge and imprisonment, while public safety is also markedly improved by the drop in driving while intoxicated. The saving to the public purse from these changes is enormous and the disruption to families and communities every bit as important. These findings are consistent with other countries other than the higher rates of ongoing criminal justice involvement in recovery. Table 3 below examines financial issues as the third core domain, where similar positive changes can be identified:

Table 3: Financial factors in active addiction and in recovery

What is clear from the table below is that the journey from active addiction to recovery is characterised by an increased stability and capacity to pay, although as with previous

TABLE 3

FINANCIAL FACTORS IN ACTIVE ADDICTION AND IN RECOVERY

WERE YOU:	IN ACTIVE ADDICTION	IN RECOVERY
UNABLE TO PAY YOUR BILL	66.9%	22.1%
SHAVE HAD DEBTS OR CREDIT	65.0%	12.9%
USUALLY PAY BILLS ON TIME	15.2%	66.2%
HAVE STABLE HOUSING	79.1%	87.8%

TABLE 4

EMPLOYMENT FACTORS IN ACTIVE ADDICTION AND IN RECOVERY

DID YOU:	IN ACTIVE ADDICTION	IN RECOVERY
REMAINED STEADILY EMPLOYED	36.9%	54.4%
GET GOOD JOB EVALUATIONS FREQUENTLY	31.2%	64.3%
MISS SCHOOL OR WORK	65.8%	6.5%
FURTHER YOUR EDUCATION OR TRAININGGET	31.2%	41.1%
FIRED OR SUSPENDED FROM WORK	44.5%	7.2%

domains, financial problems are not completely resolved. Also as is the case with the other domains, the change that is reported has significant benefits for society as well with increased payment of taxes and repayment of other debts and increased stability in housing which we know from the literature is a key prerequisite for recovery.

Table 4 charts work and study changes from active addiction to recovery:

While the levels of employment in recovery are lower than in some of the other LiR survey (for instance, in the 2015 UK Life In Recovery survey, over half were in stable employment in recovery) there are clear improvements in productivity, reliability and commitment to education and employment. The rate of people getting fired has dropped from around 45% to around 7% and there has been a similarly large reduction in absenteeism.

The final domain considered in the survey is around family and social life and that is outlined in Table 5 below:

There are marked changes in family functioning with much higher levels of active engagement in recovery and much lower levels of family violence. **However, these changes are not only within the family as there is almost a tenfold increase in volunteering and community participation,**

TABLE 5

FAMILY AND SOCIAL FACTORS IN ACTIVE ADDICTION AND IN RECOVERY

DID YOU:	IN ACTIVE ADDICTION	IN RECOVERY
PARTICIPATE IN FAMILY ACTIVITIES	33.5%	78.7%
PLAN FOR THE FUTURE	20.2%	80.2%
EXPERIENCE OR PERPETRATE FAMILY VIOLENCE	41.8%	8.7%
VOLUNTEER IN THE COMMUNITY	6.1%	52.9%

suggesting the importance of recovery for community engagement.

The conclusion from this overall analysis is that there are marked improvements in all five domains reported - that signify not only improvements in personal health and well-being, but also in family functioning and in active contribution to the community and to the wider society. While problems are not eradicated in this population, the improvements reported have huge benefits for the wellbeing and life expectancy of the individuals, and for all of their relationships and commitments, that are consistent with our definitions of stable recovery.

3.4 Comparison of people who are recovered compared to those in medication assisted recovery in the Balkans

The next section splits up the recovery group into those in abstinent recovery (who describe themselves as 'recovered') with those in medication assisted recovery, to test

TABLE 6

HEALTH FACTORS IN ACTIVE ADDICTION AND IN RECOVERY

DID YOU:	IN ACTIVE ADDICTION	IN MED- ASSISTED RECOVERY	RECOVERED
EXPERIENCE UNTREATED EMOTIONAL OR MENTAL HEALTH PROBLEMS	77.2%	46.4%	35.4%
FREQUENTLY USE HEALTH CARE SERVICES	30.4%	78.6%	19.2%
GET REGULAR DENTAL CHECK-UPS	17.1%	25.0%	62.6%
USE TOBACCO PRODUCTS	87.8%	89.3%	34.3%
DRIVE UNDER THE INFLUENCE OF DRUGS	66.2%	14.3%	7.1%
GET ARRESTED	63.9%	25.0%	3.0%
HAD CRIMINAL CHARGES AGAINST YOU	54.8%	14.3%	7.1%
COMPLETE A CONDITIONAL SENTENCE, SUCH AS PAROLE	39.5%	10.7%	7.1%
SERVED A PRISON SENTENCE	31.2%	10.7%	4.0%
REMAINED STEADILY EMPLOYED	36.9%	28.6%	70.7%
GET GOOD JOB EVALUATIONS FREQUENTLY	31.2%	50.0%	82.8%
MISS SCHOOL OR WORK	65.8%	10.7%	2.0%
FURTHER YOUR EDUCATION OR TRAINING	31.2%	35.7%	52.5%
GET FIRED OR SUSPENDED FROM WORK	44.5%	3.6%	2.0%
EXPERIENCE OR PERPETRATE FAMILY VIOLENCE	41.8%	17.9%	6.1%
VOLUNTEER IN THE COMMUNITY	6.1%	21.4%	79.8%

whether there is a consistent recovery benefit across all the participants in the study. The results are consistently showing better well-being in abstinent recovery, as shown in Table 6:

Although there are clear improvements in both populations, the extent of improvement is much weaker in the medication assisted sub-population who completed the survey with elevated rates of ongoing mental health problems, much greater use of health services and much more smoking. In contrast in the abstinent population, the rate of steady employment is much closer to that seen in the English-speaking LiR surveys.

The medication assisted group were eight times more likely to have been arrested, twice as likely to face criminal charges and more than twice as likely to go to prison. Medication assisted respondents were much less likely to be stably employed and were less likely to further their education. Finally they were much more likely to be involved in family violence and much less likely to volunteer in the community. **This may suggest that medication assistance can be seen as an early step to achieving the full benefits of recovery for the majority of its recipients**.

3.5 Sources of lifetime help-seeking

The study attempts not only to address the question of the extent to which people recover, but also what mechanisms of change have supported that journey. The proportion of people that have sought help from the following sources are shown in Table 7 below:

It is important to note that many individuals will have used more than one support mechanism, either consecutively or concurrently. These data are fascinating and very different from the position in the UK or Australia with low rates of mutual aid and very high rates of residential treatment, as well as elevated rates of engagement with spiritual organisations to support recovery.

TABLE 7

SOURCES OF LIFETIME HELP-SEEKING	
12-STEP	8.0%
PEER BASED RECOVERY SUPPORT SERVICES	9.1%
RESI REHAB, TC OR DETOX	63.9%
SPECIALIST OUT-PATIENT TREATMENT	53.2%
OTHER SERVICE (SUCH AS A CHURCH)	44.9%

Some key comparisons between different recovery pathways are shown in Table 8 below:

The differences are much slighter here with almost no statistically significant differences between these groups as indicated in Table 8. Those in 12-step recovery were slightly less likely to have ongoing emotional and mental health problems, to be homeless and to have been arrested, but were more likely to use health services, to smoke, to be in employment and to volunteer in the community. In other words there are some differences but no consistent pattern of benefit, and it is important to remember that there are significant overlaps in the group, and also that recovery is a personal and individualised process.

TABLE 8

COMPARISON OF RECOVERY OUTCOMES FOR 12 STEP COMPARED TO RESIDENTIAL TREATMENT PATHWAYS

DID YOU:	IN ACTIVE ADDICTION	12-STEP FELLOWSHIPS	REHAB, TC AND / OR DETOX
EXPERIENCE UNTREATED EMOTIONAL OR MENTAL HEALTH PROBLEMS	77.2%	42.9%	50.6%
VISIT EMERGENCY ROOMS FREQUENTLY	23.6%	14.3%	8.9%
USE TOBACCO PRODUCTS	87.8%	57.1%	49.4%
GET ARRESTED	63.9%	4.8%	8.9%
HAD CRIMINAL CHARGES AGAINST YOU	54.8%	9.5%	10.7%
SERVED A PRISON SENTENCE	31.2%	9.5%	7.7%
HAVE HAD DEBTS OR CREDIT	65.0%	23.8%	13.7%
HAVE STABLE HOUSING	79.1%	100.0%	89.9%
REMAINED STEADILY EMPLOYED	36.9%	61.9%	53.6%
GET GOOD JOB EVALUATIONS	31.2%	71.4%	64.3%
FURTHER YOUR EDUCATION OR TRAINING	31.2%	47.6%	42.9%
GET FIRED OR SUSPENDED FROM WORK	44.5%	4.8%	6.5%
DROPPED OUT OF SCHOOL OR UNIVERSITY	47.1%	0.0%	8.9%
LOSE CUSTODY OF CHILDREN	5.3%	0.0%	1.2%
REGAIN CUSTODY OF CHILDREN	-	0.0%	1.8%
EXPERIENCE OR PERPETRATE FAMILY VIOLENCE	41.8%	9.5%	8.3%
VOLUNTEER IN THE COMMUNITY	6.1%	71.4%	59.5%

TABLE 9

COMPARISON OF STAGES OF RECOVERY AND COMPARED TO ACTIVE ADDICTION

DID YOU:	IN ACTIVE ADDICTION	IN RECOVERY		
		EARLY	SUSTAINED	STABLE
EXPERIENCE UNTREATED EMOTIONAL OR MENTAL HEALTH PROBLEMS	77.2%	52.2%	62.9%	37.1%
VISIT EMERGENCY ROOMS FREQUENTLY	23.6%	7.2%	10.0%	4.8%
GET REGULAR DENTAL CHECK-UPS	17.1%	36.2%	45.7%	55.6%
DRIVE UNDER THE INFLUENCE OF DRUGS	66.2%	11.6%	15.7%	8.9%
DAMAGE PROPERTY	70.3%	8.7%	18.6%	14.5%
GET ARRESTED	63.9%	8.7%	14.3%	8.9%
SERVED A PRISON SENTENCE	31.2%	11.6%	7.1%	7.3%
USUALLY PAY BILLS ON TIME	15.2%	46.4%	61.4%	79.8%
PAID BACK TAXES	6.5%	18.8%	21.4%	26.6%
PAY TAXES ON TIME	8.4%	29.0%	32.9%	49.2%
REMAINED STEADILY EMPLOYED	36.9%	39.1%	50.0%	65.3%
GET GOOD JOB EVALUATIONS	31.2%	47.8%	55.7%	78.2%
FURTHER YOUR EDUCATION OR TRAINING	31.2%	29.0%	34.3%	51.6%
PARTICIPATE IN FAMILY ACTIVITIES	33.5%	69.6%	72.9%	87.1%
VOLUNTEER IN THE COMMUNITY	6.1%	29.0%	41.4%	72.6%

3.6 What is the impact of stage of recovery on these variables?

The key variables for life in addiction and recovery are reported for addiction by stage of recovery career, with strong evidence from previous surveys that recovery wellbeing improves with increased time in recovery.

What this table clearly indicates is that recovery is a complex phenomenon whose many aspects will resolve and improve gradually over time. For this reason, while there are clear grounds for further studying national variations and differences, it is important to bear in mind that these may reflect variations in the stage of recovery journeys people are at. The key findings in this area are shown in Table 9:

What is clear from Table 9 is that recovery is a process and not an event - given that while there are some immediate improvements within the first year (referred to as early recovery) others take much longer.

This is particularly evident in the area of employment where 39% of people in early recovery are in stable employment, rising to 50% in sustained recovery (between one and five years in recovery) and then rising to 65% in stable recovery. A similar picture emerges for positive job evaluations and volunteering and contributing in the local community where this is a stepwise approach. However, across many of the domains there is much less of a clear and linear pathway to recovery than has been seen in the previous surveys.

Where the findings do replicate the international evidence and provide strong support for the suggestion that recovery oriented treatment will only pay off for communities where support goes beyond acute clinical care to support people well into their recovery pathways, and that continuity of care and support is an essential part of sustaining change.

3.7 Comparison between Balkan and other countries

The study is a larger European project in which the Balkan sample has been embedded allowing us to undertake cross-country comparisons. The overall sample from each country is shown in Table 10:

TABLE 10

COUNTRY OF RESIDENCE

COUNTRY:	NUMBER	VALID %
UK	364	27.7%
NETHERLANDS	231	17.6%
BELGIUM	181	13.8%
BALKANS[1]	263	21.0%
REST OF EUROPE [2]	189	14.5%

[1] BOSNIA AND HERZEGOVINA (N=72), SERBIA (N=123), CROATIA (N=53), MONTENEGRO (N=15)
[2] SWEDEN (N=44), SPAIN (N=60), POLAND (N=79), PORTUGAL (N=6)

There were some significant differences in population profile by country. As shown in Table 11, there were variations in the gender balance across the five groups of countries:

This difference reached statistical significance ($x2 = 27.30$, $p<0.01$), with lower proportions of female participants in Belgium and the Balkan countries than in the other countries. There were also marked average age differences between the countries - with participants from the UK markedly older (mean age = 46.2

TABLE 11

GENDER BY COUNTRY

	UK	NETHERLANDS	BELGIUM	BALKANS	OTHER
MALE	59.6%	58.4%	73.5%	72.2%	61.4%
FEMALE	39.8%	41.1%	26.5%	27.8%	37.0%
OTHER	0.5%	0.4%	-	-	0.5%

years) than participants from the Netherlands (mean age = 40.0 years), Belgium (35.5 years), Balkans (37.1) and other European countries (37.7 years; F=53.39, p<0.001).

There were also marked differences in achieving educational attainment, with 70.9% of British participants having achieved higher education, compared to 40.7% in the Netherlands, 25.4% in Belgium, 23.6% in the Balkans (where 27.1% of the sample never achieved beyond a primary level of education), and 25.4% from the other European countries (x2 = 365.21, p<0.001).There are also differences in relationship status, with almost half of the Balkan participants married or co-habiting (49.2%), compared to 67.9% of UK participants, 36.0% of those from the Netherlands, 22.2% of those from Belgium and 24.6% of those from the other European countries. 46.0% of those from the Balkans reported that they had dependent children, compared to 33.8% of participants from the UK, 28.6% of participants from the Netherlands, 35.9% of participants from Belgium and 30.2% of participants from the rest of Europe (x2 = 20.39, p<0.01).

Table 12 shows the history of help-seeking from a range of sources by country of residence:

TABLE 12

HELP-SEEKING HISTORIES

	UK	NETHERLANDS	BELGIUM	BALKANS	OTHER	CHI
12-STEP FELLOWSHIP	74.5%	72.3%	26.5%	8.0%	10.4%	380.09***
PEER-BASED RECOVERY SUPPORT	50.3%	29.4%	24.3%	9.1%	36.1%	127.00***
RES. REHAB OR TC	57.1%	77.5%	75.7%	63.9%	83.1%	56.34***
SPECIALIST OUT-PATIENT	64.8%	73.2%	70.7%	53.2%	66.7%	25.63***
OTHER SUCH AS CHURCH	23.4%	17.3%	6.6%	44.9%	19.0%	101.83***

*** p< 0.001

There were marked differences in levels of help-seeking with participants in the UK most likely to use 12-step fellowships, which were rarely used in the Balkans or in the rest of Europe. Similarly, other peer organisations were more commonly used in the UK, and rarely in the Balkans. Residential rehab and therapeutic communities were most commonly used in Netherlands, Belgium and the rest of Europe and other supports, such as churches were most commonly used in the Balkans. **In other words, there is a very strong reliance on professional support and treatment, and much less engagement with peer-based approaches in the Balkans than has been reported elsewhere.**

There were also addiction and recovery career differences as shown in Table 13 below:

There were marked country differences in lifetime patterns of substance problems with alcohol most common in the UK and Netherlands, whereas heroin is most commonly a problem in the Balkans and cocaine powder and amphetamines most commonly a problem in Belgium. For opiate prescription drugs, lifetime problems for methadone and buprenorphine are higher in the Balkans than elsewhere, again emphasising the reliance on professional treatments in addiction and recovery.

There are few variations in health factors in recovery between the Balkans and other countries comparing addiction and recovery, but there are differences in legal factors. There are marked variations in arrest rates during active addiction from around

TABLE 13

NATIONAL VARIATIONS IN ADDICTION CAREER FACTORS

	UK	NETHERLANDS	BELGIUM	BALKANS	OTHER	F OR CHI, SIG
AGE OF FIRST ILLICIT USE	15.5	16.2	15.7	15.5	16.0	1.50(NS)
AGE OF LAST ILLICIT USE	36.9	35.0	32.7	30.5	33.0	20.23***
RECOVERY DURATION	9.0	5.4	4.0	5.9	4.0	22.43***

Participants from the Balkans typically stopped using at a much younger age yet the average length of time in recovery was low and onset age was around average for international participants in the survey.

40% in the Netherlands to 70% in the UK. In recovery, these rates drop markedly in all countries to less than 10% in four of the countries and just over 10% in the Balkans. This also applies to prison - with rates twice as high in Belgium and the Balkans for im-

prisonment during addiction (over 30% compared to 15%) with those variations matched in recovery where 1.3% of Dutch respondents reported prison time in recovery compared to 8.4% of those from the Balkans

6. DISCUSSION / INTERPRETATION / NEXT STEPS

This is hugely innovative work that is important in starting to paint a picture of how people in the Balkan countries go about achieving recovery – what is clear from the survey and its completion is that people can and do recover.

Findings from the LIR survey provide new evidence that address some previous gaps in knowledge about recovery experiences in the Balkan region, but this is only a starting point for understanding how and who recovers and what supports they need. It also provides a comprehensive understanding of what the different journeys of individuals living in recovery are, and an understanding of how prevalent recovery is. The key findings from the LIR survey include:

- **Balkan people in recovery reported an early age of first substance use (median age of 15 years) and addiction (median age of 15 years), yet we should be encouraged that recovery also typically happens at a relatively early age and with shorter addiction careers at least among those who do report recovery.**

- Respondents reported a number of negative effects during addiction on their health, finances, family and social life, and work and study, as well as many more legal issues. More than half of the participants reported criminal charges during their addiction and around one third had spent time in prison, while in recovery there were marked reductions (to under 10%) in both of these justice outcomes.

- Cannabis, reported by 81.1% of participants, was the most common substance used during active addiction, followed by heroin, prescription drugs and alcohol. The pattern of substances reported by participants from the Balkans was more focused on opioids than in the Western European countries.

- Respondents used a variety of pathways to initiate and sustain recovery, the most common recovery resources or programs used were Residential Rehabilitation, Therapeutic Communities or in-patient detoxification (63.9%). There is a clear reliance on professional services that is indicative of a lack of peer support organisations (both 12-step and other) that could support and empower a grass-roots recovery movement.

• **Compared with life during active addiction, when describing recovery respondents were more likely to report participating in family activities (78.7% versus 33.5%), remaining steadily employed (54.4% versus 36.9%), paying bills on time (66.2% versus 15.2%), regularly volunteering for community service activities (52.9% versus 6.1%), and planning for the future (80.2% versus 20.2%). These effects are particularly strong and clear for those who have achieved abstinent recovery.**

• **Although not quite as linear as in previous surveys, there is a clear cumulative benefit to recovery – with individuals in stable recovery having significantly higher rates of employment and education, volunteering and participation in family activities. In contrast, those with five years or more in recovery reported markedly lower levels of untreated mental health problems.**

• **41.8% of participants reported committing or experiencing family violence during active addiction, whereas only 8.7% reported this event during recovery, suggesting as is the case in previous studies, that family stability and participation is a crucial consequence of recovery; which can also be seen as a way of preventing the inter-generational transmission not only of addiction but also of trauma.**

The findings from this study should also be interpreted in light of its limitations. It is possible that respondents might have been more likely to report positive outcomes in recovery and negative outcomes when answering questions about addiction. Furthermore, there was a geographical sampling bias, where some states such as Serbia was overrepresented, while other, such as Montenegro underrepresented. The aim of the Life in Recovery model however is not representativeness but is highlighting what is possible and how. The study not only affirms the benefits of recovery it also starts to develop an understanding of what people need to support and sustain a recovery journey.

What is clear from the current findings is that the most important thing is time – people who sustain recovery for at least five years experience significant benefits personally but also for themselves and for society. Our findings are also clear that there are greater improvements reported with abstinent recovery than with medication-assisted recovery and it is extremely encouraging that recovery starts at a relatively young age on average in the Balkans. In contrast to this, and consistent with the low level of use of peer support, there is a relatively short duration of recovery that would suggest the Balkan countries are still at an early point in developing a supportive and engaging community resource for people struggling with addictions.

Future analyses with the existing LIR data to examine recovery pathways will be conducted in follow-up reports. Such work is significant and can help identify how pathways to recovery differ for particular groups, thereby informing the need for, for example, gender and age appropriate recovery support programmes. The work done will also contribute to the international efforts around understanding the processes and mechanisms of recovery.

CONCLUSION

The LIR data reveal that long-term recovery is attainable and sustainable even when addiction is marked by high severity and chronicity, but also that this kind of research is feasible and valuable in the region. The sample achieved (although not representative) is strong enough to identify core themes of consistency with previous LiR studies, but also factors unique to the Balkans, including the reliance on specialist services to support recovery pathways. There is clear need for policy support for more effective peer services and for adequate continuity of care into the community for those in residential treatment support.

These findings provide hope for individuals and families affected by addiction, and help inform professionals seeking to assist them. Moreover, the evidence of many individuals in recovery reporting to lead meaningful lives and contributing to their families and to society can be a landmark for policy makers considering the value of providing funding for targeted investments to address the system-level barriers to ensure more treatment and recovery programs are available and accessible for this population. Investing in recovery could significantly improve the lives of individuals struggling with addiction and beginning their recovery journey...

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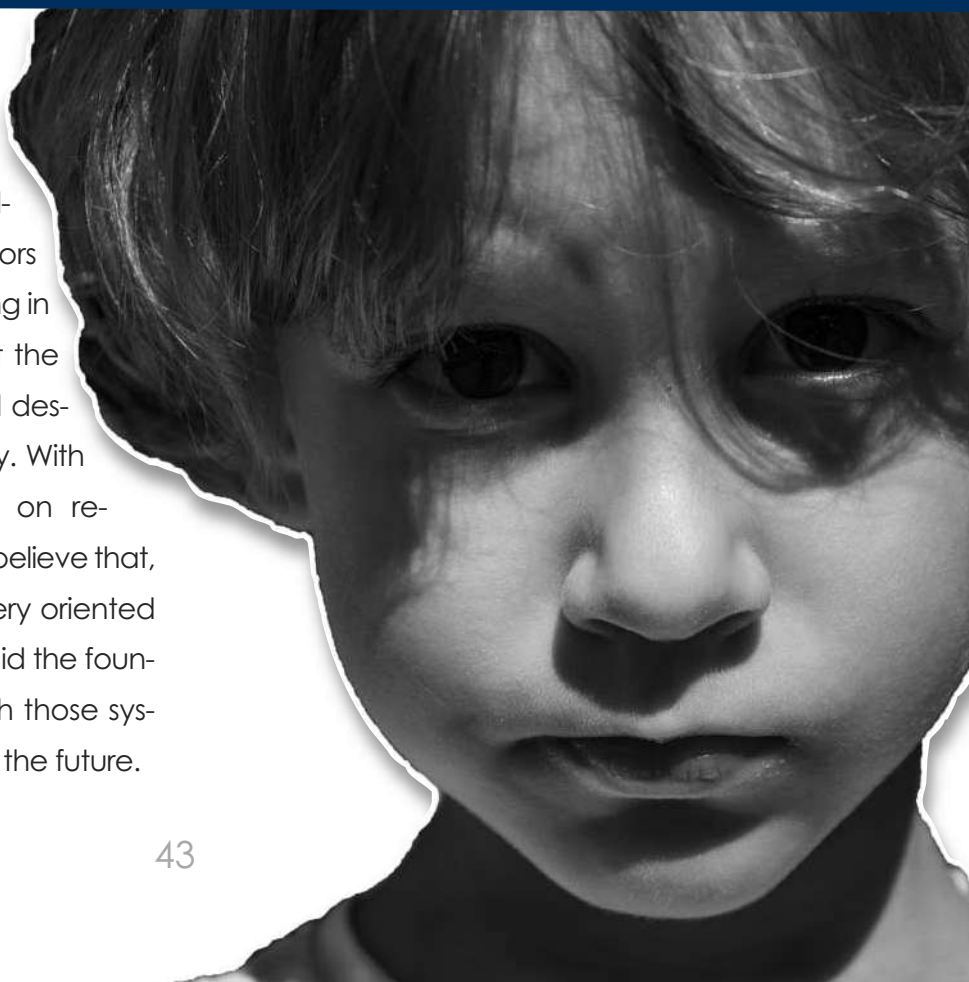
THE CHOOSE RECOVERY PROJECT - FROM NEEDS ASSESSMENT TO EFFECTIVE RESPONSES

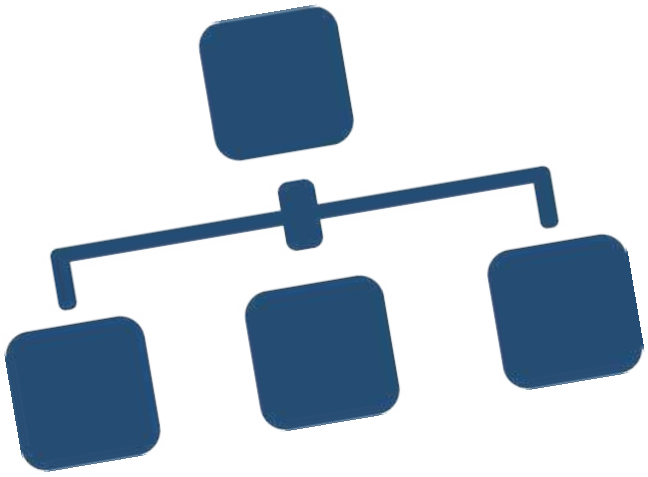
BORISLAV GOIC

If we consider the onset and factors that lead to the development of drug addiction, we certainly cannot single out just one thing. Likewise, if we think about how a person with an addiction problem can move towards a drug-free life and social integration, we can certainly see that there are more factors involved in that process, as well. Different institutions and organizations working in the field of drug addiction, provide maximum support within their capacities. However, the situation in the field of drug demand reduction in Bosnia and Herzegovina, Serbia and Montenegro is alarming.

The absence of a comprehensive system, which would focus on helping people with addiction problems to achieve their maximum potential, is recognized as a barrier in drug addiction treatment. From the perspective of a person with drug addiction problem or a person in some stage of recovery process, there is a lack of clarity and goals to which these systems lead.



With Choose Recovery project we wanted to address multiple segments, including: reaching out to the target group via helpline, development of cooperation with actors who are directly or indirectly working in the field, raising awareness about the consequences of drug abuse and destigmatization of people in recovery. With an innovative approach based on research and needs assessment, we believe that, if we did not establish new recovery oriented systems of care, then we at least laid the foundation that could help us establish those systems of care through joint efforts in the future.



ABOUT THE PROJECT PARTNERS

Civil society organizations, Proslavi Oporavak (Celebrate Recovery) from Sarajevo - established back in 2008, Izlazak (Exodus) from Belgrade - also established in 2008, and Preporod (Rebirth) from Niksic - which has been active since 2006. Partner organisations have been one of the very few organisations in the region, focused on reaching out to populations affected by drug addiction problem.

Main characteristic that makes project partners fundamentally similar, is that all three organizations have been founded by individuals who recovered from addiction. Initially, organisations have worked based on their enthusiasm and lived experience, but have also invested in capacity and knowledge building and increasing professionalism, so finally all three organizations gained significant credibility in their local communities as well as on regional levels, and the number of services they provided to people with addiction problem has been steadily increasing.

Sharing experiences on current and emerging trends in the field of drug demand reduction between staff was a form of cooperation that needed to be improved.

WHY CHOOSE RECOVERY

Our discussions were focused on our common goals - development of our services, establishing better cooperation with all relevant institutions and organizations directly or indirectly involved in the fight against drug abuse, as well as review of the old systems and possibly creating recovery oriented systems of care.

Considering that the situation in the drugs field has also changed (fewer new heroin addicts, younger population seeking help, systemic and institutional solutions exist, but are outdated), back in 2015 these three organizations launched the first regional project, entitled " 3Balkan ".

The project activities have been funded by the Swedish Forum Syd, in partnership with and supervision of WFAD (World Federation Against Drugs), and it lasted for one year. The main objective was to conduct a needs assessment in all three countries regarding the current situation in drugs field. At the end of the first phase, the needs assessment has shown the following:

- Lack of interest for the drug addiction problem
- Services are provided in isolation
- Decrease in number of NGOs dealing with this issue
- People struggling with addiction problems do not have information about the possibilities for recovery
- Rural areas have mostly been neglected

Throughout the first year the World Federation against Drugs has recognized the quality of work of the three partner organizations, so the project continued from 2017 through the next three years with all its extensive activities until the end of 2019.

The key goal for WFAD and Forum Syd, as a donor, was to improve the position of marginalized groups (individuals and families affected by drug addiction problem) and to achieve better results for all of the assessed need by developing cooperation, over a period of three years.

The project entitled "Choose Recovery" and all activities have been coordinated by the Association Proslavi Oporavak/celebrate recovery. Joint activities included:

- Raising awareness of drug addiction problem and recovery
- Developing better cooperation between relevant actors in the field
- Creating an ecology of recovery
- Focus on rural areas

OUTCOME 1:

ACHIEVEMENTS OF THE PROJECT CHOOSE RECOVERY

Improved capacities of counseling centers in all three countries

While in Bosnia and Herzegovina this was reflected in the expansion of capacity at its existing location in Sarajevo, in Belgrade, counseling center started its work at a new location in the city center, while Preporod from Niksic launched a new center in the Montenegrin capital, Podgorica.

Established free and anonymous helpline

Free helplines have been established in all three countries. To improve service delivery, employees have been additionally trained to provide phone counseling. Guidelines for more efficient phone counseling have been developed, as well as the monitoring system targeting progress of service users.

New methods of service delivery for individuals and families visiting counseling center have been developed

In Sarajevo, we started implementing Multidimensional family therapy program, which includes providing services both to drug users and their families. Individual and motivation counseling has been improved, and has continued to be an integral part of the counseling process in all three countries with particular emphasis and positive outcomes in Montenegro.

Organisations hosted a number of individual and multi-sector meetings with institutions and CSOs

Throughout the course of the project, one of the main goals was to bring together all actors which directly or indirectly work in drug addiction field. These meetings gathered representatives of ministries, mental health centers, social services, the police, various civil society organizations, representatives of municipalities and other relevant stakeholders.

The meetings have been organised with the aim to present the project as well as to conduct an assessment of the capacities of organizations/institutions. In some areas, the assessment has shown the lack of interest for further engagement in drug addiction field.

The meetings also included discussions around the need for multi-sector approach to treatment and recovery oriented systems of care, as well as the need for addressing the stigmatization and building responsiveness towards people struggling with drug addiction.

The meetings have shown different responses from key representatives from respective countries. While in Bosnia and Herzegovina police officers showed the highest level of willingness to cooperate, in Montenegro, representatives of relevant institutions providing treatment and offices for prevention expressed interest for greater involvement in the fight against drugs.

The project partner Izlazak from Serbia had a specific approach to organizing multi-sector meetings and the meetings have been orga-

COOPERATION WITH INSTITUTIONS/CSO

INDIVIDUAL MEETINGS	MULTI-SECTOR MEETINGS	CONFERENCES
157	31	7
NUMBER OF PARTICIPANTS	NUMBER OF PARTICIPANTS	NUMBER OF PARTICIPANTS
349	549	550

MEMORANDUMS OF UNDERSTANDINGS

59

nised in coordination with the Government Office for Combating Drugs. This approach has proven to be very effective as it has contributed to both the greater turnout rates of delegates and greater significance of guidelines adopted after the meetings.

Memorandums of Understanding

Memorandums of understanding have been signed with organizations/institutions which expressed their interest with the aim of promoting helpline but also cooperation at a greater extent. The chart clearly shows the overall outcomes and the significant number of meetings organisations conducted, including the number of participants.

In the future, Memorandums should serve as a platform for creating favorable circumstances for helping individuals with addiction problems achieve their maximum potential. Good cooperation among key actors can contribute to efforts for creating recovery oriented systems of care.

Conferences in three countries

The conferences had multiple aims, such as bringing together all stakeholders from multi-sector and individual meetings, provide a platform for the exchange of information about target group, discussions about outcomes and challenges that service providers have, and the exchange of best practices from countries across the region and Europe that have guided us through all three years of project implementation.

The large turnout rates, over 80% of invited delegates, has shown us that the interest of professionals working in the field has increased over the years, but also that there is a need for more similar conferences in the future.

We noted that there is a lack of expert conferences focused on drug addiction and recovery in the Balkan region. Therefore, the project partners have hosted annual conferences in all three countries and the First Re-

gional Forum in Belgrade, which has certainly contributed to increased awareness of and discussions around addiction and recovery.

Media representation and campaigns

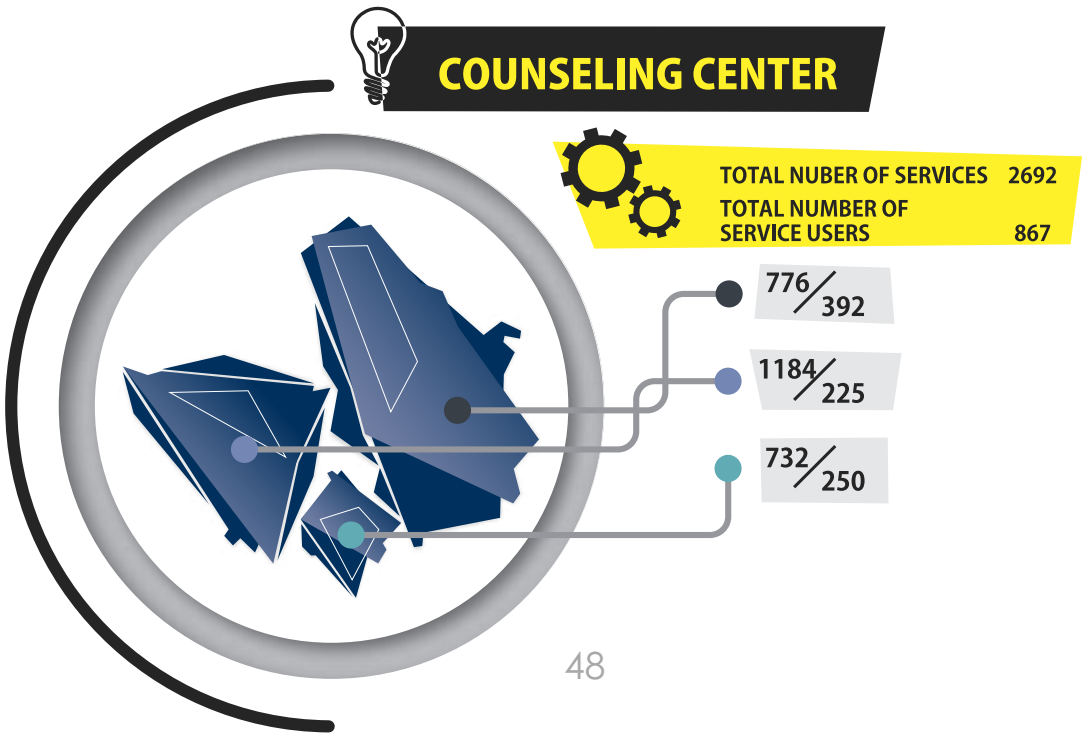
A continuing promotion of the project has been one of the ongoing activities throughout the project implementation. After undergoing a number of trainings in the area of promotion, building PR skills and learning about advocacy, organizations in all three countries promoted helplines in different ways.

Organization Izlazak created a video focused on the helpline promotion, which included hiring professional actors. The video was broadcasted in all three countries on various websites which promoted this video free of charge.

Organization Preporod has set up permanent billboard advertisements, which features the helpline number, located in high traffic frequency highways in Montenegro. Proslavi Oporavak, has developed a strong cooperation with private companies and has been able to place posters and citylight billboards featuring helpline number across the country, free of charge.

During the implementation of the project, organisations have been tasked to actively participate in state, local and private TV shows and initiate discussions about drug abuse and recovery. Unfortunately, these shows have been focused to inform the public about the harms of drugs, and not on the complexity of the issue about which viewers should be more informed.

We conclude that our efforts to be more present in the media have been successful but insufficient. Ongoing political debates in the countries of the region take the largest media interest, so it is clear to us that these topics are left with little media space. However, drug abuse with its consequences, not only for individuals, but also for the entire



families and society as a whole, must be adequately represented in the media.

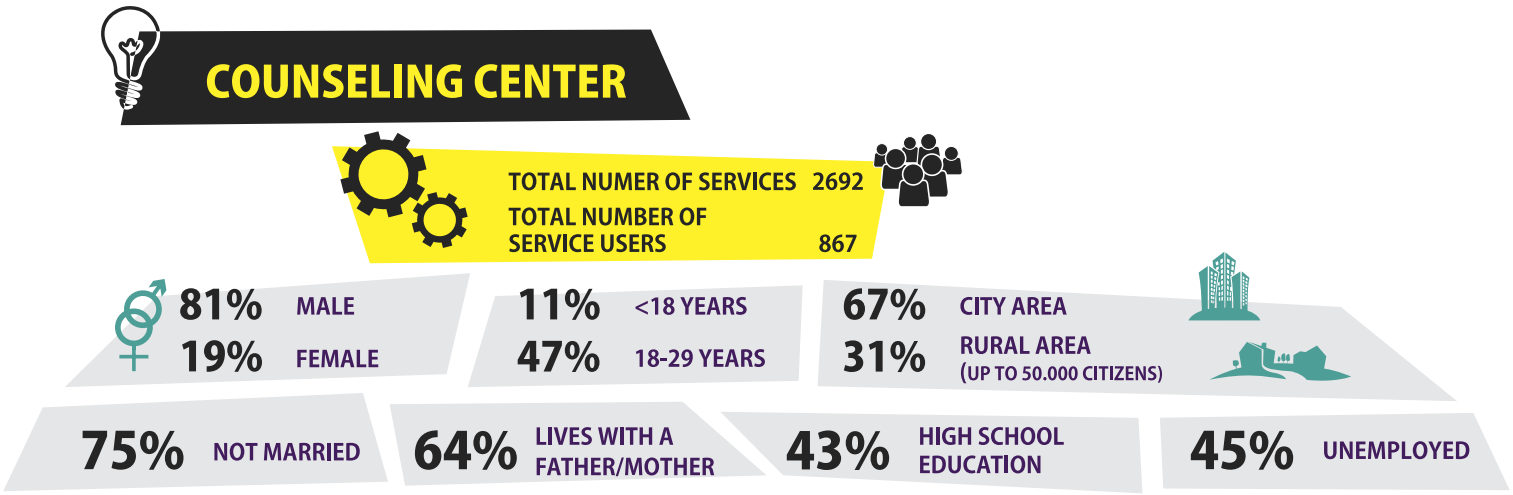
OUTCOME 2:

COUNSELING CENTERS DATABASE - A CLEAR SIGN FOR ACTION

After the establishment of the helplines and the media campaigns that followed the promotion of the counseling centers, the capacity of the counseling center in all three countries increased, as well as the number of provided services. After 28 months, analysis has shown the following data:

These results indicate the successful outreach for new service users in Serbia and Montenegro (250), but also that services available in the counseling center in Bosnia and Herzegovina have met the needs for continued recovery support for those who contacted the center.

Demographic data collected over the past 28 months have shown that 19% of individuals who seek help were females and that the majority of services have been provided to young people aged 18-29.



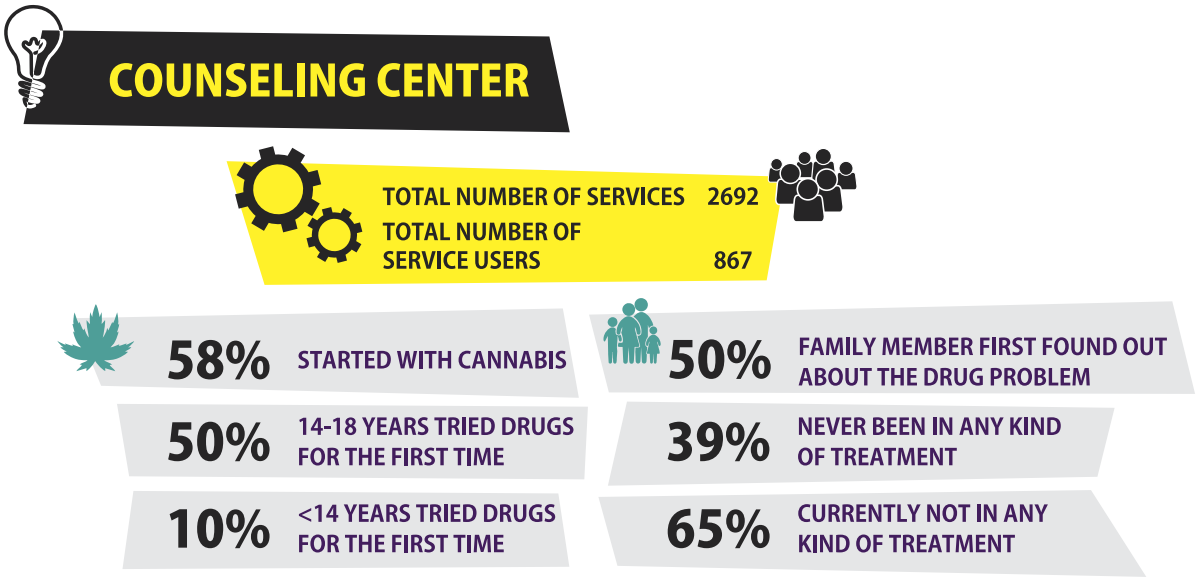
A total number of provided services (2692), analyzed on a monthly basis, increased by six-fold compared to the period before 2017, which confirms efficacy of counseling centers and their increased capacities. While Serbia has the highest number of service users (392), in Bosnia and Herzegovina, 225 service users have been visiting the center more and using services more frequently (on average around five services per user)

The fact that every 11th service has been provided to a young adolescent under the age of 18, is very worrying and requires additional analysis of the situation around drug use among this population. Also, these data reflect the need to adequately treat addiction among children, since comprehensive mechanisms for long term responses to the need of these population in these three countries have not been established yet.

Although one of the project objectives was to reach more people from rural areas, where the level of marginalization of people who use drugs is certainly higher, the database has shown that only one third of all provided services in all three countries have been delivered to individuals from rural areas, which is not ideal for all partner countries. In Montenegro, due to the majority of cities with a population of less than 50,000, the numbers show a greater number of services provided to users from rural areas. In the other two countries, there is still work to be done in terms of de-stigmatization of addiction, so people with drug related problems can seek help they need.

The reason service users called helpline is very significant for our analysis, and has shown that 60% of 2692 services have been provided to people who need treatment and who want to start the recovery process. Other services have been provided to individuals who needed some kind of information. Half of the services have been provided to a family member, demonstrating not only the importance of implementing a multidimensional approach, but also the need for continuous development of programs that can strengthen family as a key factor in motivating individuals to initiate the recovery process.

There are some interesting findings regarding gateway drugs, which indicate that more than half of the service users reported cannabis as the first drug they used. We consider this fact a very significant warning that, in spite of becoming increasingly available and accessible as well as socially acceptable, cannabis remains as a gateway drug number one

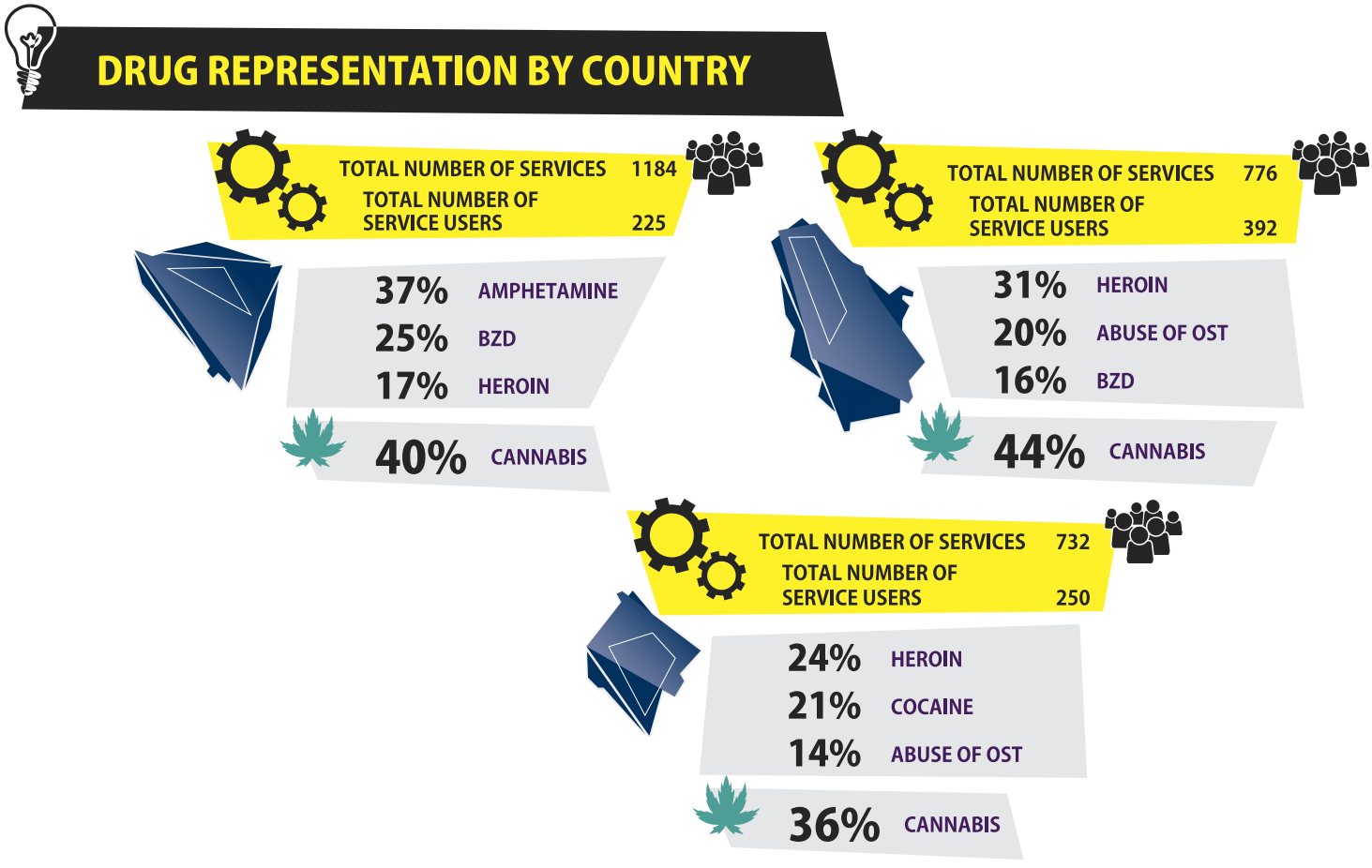


among those who are seeing help. Therefore, and in line with these findings, in the upcoming period, our plan is to engage in campaigns against social acceptability of cannabis use for recreational purposes.

Half of users of our services reported first trying drugs at the age between 14-18, while every tenth service user has tried drugs before the age of 14, which is certainly earlier compared to the period of 20-30 years ago. These data only confirms that prevention is necessary, not only for adolescents, but also in elementary schools where programs are needed to monitor the development of children and adequately respond to their relationship or attitude towards drug use and acceptability of drugs in general.

Perhaps the most important finding, which confirms the significance of the free helplines and development of available services provided in counseling centers, is the number of services provided to those who have never (39%) or are currently not (65%) engaged in any kind of treatment. Civil society organizations are hereby acknowledged as key and vital actors in reaching individuals who are not in the system. With these activities the NGOs complement the overall treatment efforts and contribute to availability of services which enable individuals who seek help to achieve their maximum potential.

Data related to the most frequently used drugs by service users, indicate that there are differences between countries and should serve for further development of programs in line with current and future trends. Heroin is still the main drug of choice in Serbia and Montenegro, while in Bosnia and Herzegovina am-



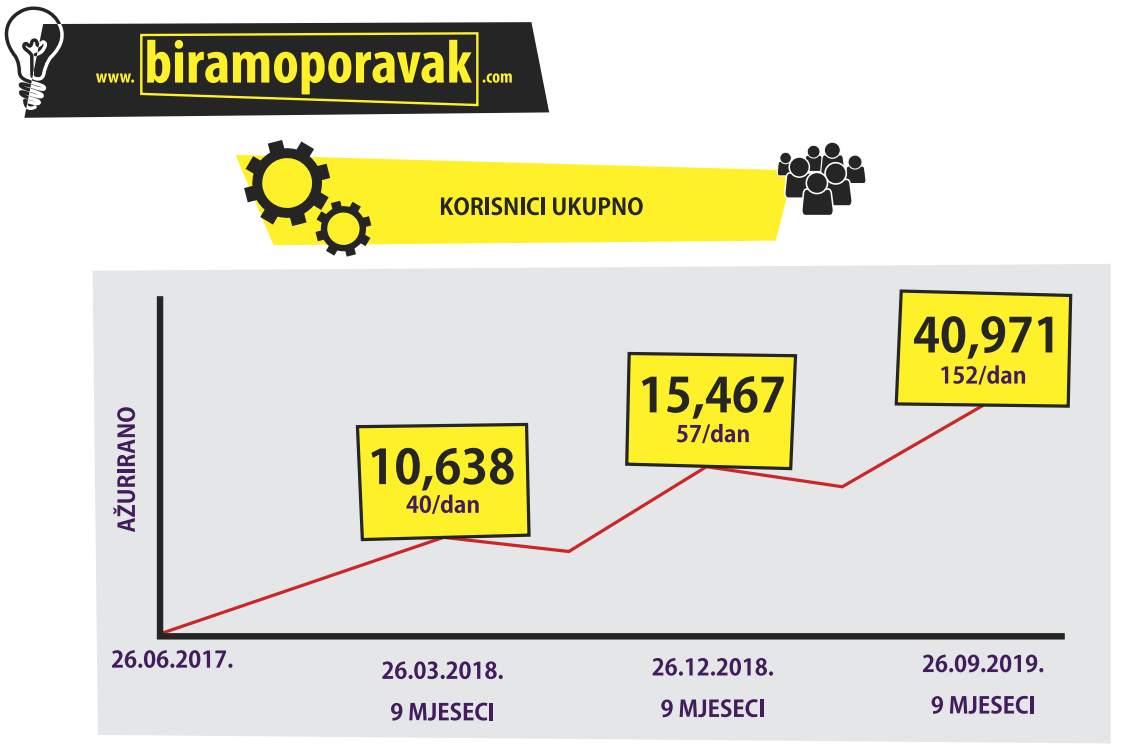
www.biramoporavak.com

phetamines have been abused by more than one third of individuals seeking help. What the analysis has also shown us is also the high prevalence of polydrug use among people who need help, while prescription drug abuse is an additional problem. The abuse of opiate substitution therapy (OST), especially in Serbia and Montenegro, and the consumption of cannabis, which is nearly the same in all three countries, indicate that there is a very serious situation in the region.

OUTCOME 3:

WEBSITE WWW.BIRAMOPORAVAK.COM

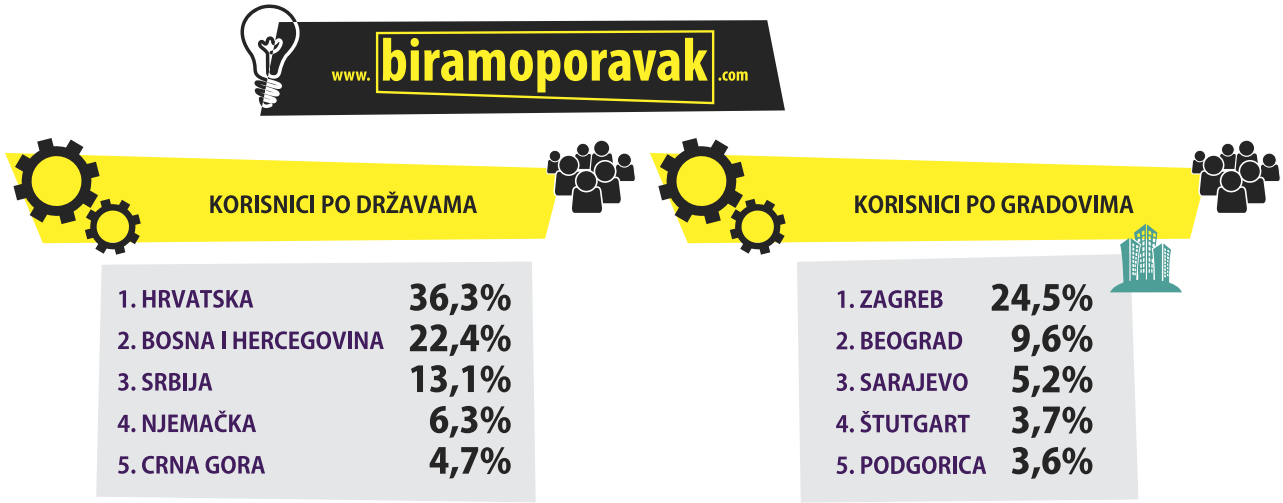
Symbolically, on the International Day Against Drug Abuse and Drug Trafficking, on 26 June 2017, we launched the website www.biramoporavak.com. In response to the lack of comprehensive guidelines available on the internet, about what one should do when addiction "comes into one's home", we have launched an informative website that refers people to services that offer help for addiction problems across all three countries. To facilitate access to services for people in need, the site contains contact information of all relevant actors working in this field. The website also provides other useful information, such as descriptions of different types of illegal and prescription drugs, symptoms and effects of drugs and drug use, and provides information on detoxification and treatment options, as well as possibilities for successful integration back to society. A special subpage on the website, entitled "Imate problem? ("Do you have a problem?"), contains recommendations for improving support for people with addiction problems, how to be



supportive and how to treat a substance dependent person who is a family member, a friend or an employee. One segment of the website is dedicated to news related to the activities of partner organizations which are implementing the project, as well as news from the addiction and recovery field.

Since its inception, the website traffic has been steadily increasing. However, the number of users has been increasing rapidly in the last 9 months of the analysis, in which google analytics shows that an average of 152 users visit the site on a daily basis, which is three times more than the average recorded in the end of 2018. We believe that continuous media campaigns in all three countries have contributed to the visibility of the website and, therefore, increased access to information for those who need it.

Although the project has been aimed at Serbia, Bosnia and Herzegovina, and Montenegro, analysis has shown that the majority of website audience live in Croatia and Zagreb, as well as other countries, which further indicates the im-



MOST FREQUENTLY VISITED PAGES – TOTAL OF 102 140 VISITS

1.ABUSE OF XANAX	10,876
2. ABUSE OF TRAMADOL	6,916
3. ABUSE OF ECSTASY	5,135
17. FACTS THAT EVERYBODY SHOULD KNOW ABOUT XANAX	1,517
62. PREVENTION	228
165. KOTOR	52
328. IRELAND: THE USE OF XANAX SHOULD BE TAKEN SERIOUSLY	23

portance of such a website which has reached out to readers beyond the borders.

Google Analytics has also shown data on the most visited pages, revealing that Xanax abuse subpage is the most visited, with 10% of all website users reading this article. The abuse of legal analgesics like Tramadol is second ranked, and the negative effects of ecstasy is the most visited subpage among illegal drugs. Not surprisingly, the article about prevention had only 228 visits, while news and current debates, such as cannabis use, had few entries.

The analysis of the website www.biramoporavak.com clearly shows that the website is important and very much needed, but also that the audience is superficially interested in real-world topics and better insights into current trends in drug abuse field. On the other hand, although we live in a fast-changing world characterised by the need for short information, the fact that articles about drugs such as Xanax and Tramadol have a large number of audience also indicates that there is a possibility of high rates of misuse of those drugs among website visitors. Although that cohort doesn't belong to our direct target group, in the future these users may represent an important factor in creating support systems for recovery.

OUTCOME 4:

WHAT DO CITIZENS SAY? - PUBLIC OPINION RESEARCHES 2017 AND 2019

To gain a better understanding of the public attitudes on drug addiction and recovery, we conducted a public opinion research in Bosnia and Herzegovina, Serbia and Montenegro. The Omnibus survey was conducted twice, in 2017 and again in 2019. The sample of 1,000 individuals per country has been surveyed on both occasions using the CAPI method. The overall objective was to examine to what extent the public was aware of the addiction problem, their views on drug use, the levels of stigma towards people who use or have been using drugs in the past as well as the knowledge around the recovery options available in the societies.

Main findings of the 2017 survey:

• The general negative attitude towards drugs and fear from drugs is prevalent among the respondents across the countries, and the associations expressed by the respondents on drugs or

psychoactive substance are markedly negative

• The majority of the population surveyed in Bosnia and Herzegovina, Serbia and Montenegro has expressed that they are against drug use

• The attitude of the public is that drug use, regardless of the type of drugs, must be banned and strictly controlled by the law

• The general view of respondents is that the health consequences of drug use are extremely negative

• A significant proportion of the general population in all three countries would support the legalization of marijuana for medical purposes and think that marijuana can be useful in treating a variety of diseases

• Approximately one in ten respondents across Bosnia and Herzegovina, Serbia and Montenegro would support the legalization of marijuana for recreational purposes

• Although respondents agree that drug addiction is a disease, a significant proportion of the population believes that addiction is a consequence of a personal choice of people addicted to drugs

• The vast majority of respondents have never used psychoactive substances

• Three to four in ten respondents know someone who uses drugs

• Public Attitudes on recovery from addiction are varied

• Respondents think that people addicted to drugs should, first and foremost, seek help from their family and then from doctors and addiction treatment clinics

• Demographic structure of respondents is more or less the same in all countries. Younger respondents, highly educated, those who are steadily employed, have high income and live in urban areas reported being less against drug use, more supportive of marijuana legalization for medical and recreational purposes and have more personal and / or indirect experience with the use of psychoactive substances. On the other hand, older adults, less educated, with lower income, those who are retired, and respondents who live in rural areas have opposite attitudes compared to the cohort indicated above.

• There were some significant differences in findings by country of residence, as shown in Table below:

WHICH OF THE FOLLOWING STATEMENTS ARE IN LINE WITH YOUR VIEWS?	BOSNIA AND HERZEGOVINA	SERBIA	MONTENEGRO
% OF CITIZENS OPPOSE TO DRUG USE	91%	91%	93%
% OF CITIZENS SUPPORT LEGALIZATION OF MEDICINAL MARIJUANA	46%	41%	31%
% OF CITIZENS SUPPORT LEGALIZATION OF RECREATIONAL MARIJUANA	10%	9%	8%
% OF CITIZENS HAVE TRIED/USED PSYCHOACTIVE SUBSTANCES	5%	8%	7%
% OF CITIZENS KNOW SOMEONE WHO IS USING DRUGS	30%	38%	43%
% OF CITIZENS BELIEVE THAT PEOPLE ADDICTED TO DRUGS CAN RECOVER COMPLETELY AND GET BACK TO NORMAL LIFE	45%	36%	34%

Main findings of the 2019 survey:

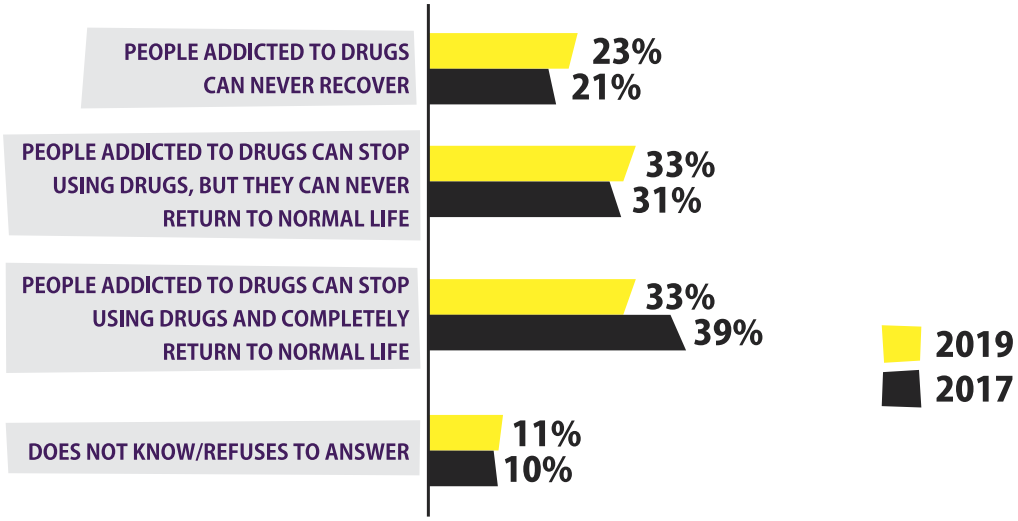
• One in four respondents reported knowing someone who was or still is addicted to psychoactive substances, while three quarters reported an acquaintance

• The proportion of people who know someone who was or still is addicted to psychoactive substances is statistically higher among young people and among those who are highly educated

• Two thirds of the region's population believe that people addicted to drugs can stop using drugs. Nearly a quarter of the sample were less optimistic about recovery

levels of stigma linked to drug addiction recovery. To this end, we repeated three questions from the first survey and compared the findings.

Although the implementation of the project and activities carried out in cooperation with the institutions and through media campaigns have led to increased visibility, there marked changes in reduction of the stigma associated with drug addiction recovery have not been found. Moreover, the proportion of respondents who believe that people with drug addiction problems can stop using drugs and fully return to normal life has decreased significantly



• The findings reveal a number of prejudices among general population towards people with drug dependence and people in recovery

• Drug consumption, regardless of the type of drugs, frequency and circumstances of use, is unacceptable for the majority of respondents

• Nine in ten respondents say they have never experienced any negative consequences from someone else's drug use.

One of the project goals was to reduce the

compared to the proportion of respondents recorded during the 2017 survey. No statistically significant changes have been found related to the two other repeated questions.

To conclude, although the project was visible and widely promoted, it has not decreased the stigma towards people in recovery among the general population. We believe that all institutions and organizations active in

this field need to be involved in more comprehensive efforts for breaking the stigma. This issue must have a greater media coverage and should be focused not only on the harms that addiction causes, but also on the benefits that the recovery brings, not only to the individual but also to families and communities.

By reducing the stigma and increasing awareness of drug addiction recovery, the number of people who will change the attitude towards this problem will certainly increase. The society must acknowledge its role in addressing one of the greatest plague nowadays which addiction for sure is. These findings do not give hope that the attitudes towards drug addiction disease and recovery from addiction will be treated differently in the future, with less stigma and exclusion, and with more hope and support that ultimately every human being seeks and deserves.

CONCLUSIONS

• Establishment of the free helpline has contributed to six-fold increase of number of services provided in counselling centres

• The cost-effectiveness of helplines has been demonstrated, among other, in terms of reaching people who are not involved in any kind of treatment

• The implementation of innovative programs for young people (under 25) has proven to be very successful

• Public institutions indirectly involved in addiction and recovery field are more interested in this area after 3 years of the project implementation

• Advocacy efforts through media about addiction and recovery have proven to be more than justified
• Multi-sector and individual meetings have had a positive influence on key stakeholders to perceive involved project partners as relevant and credible actors in the fight against drug abuse
• The conferences provided a platform for actors to share information about new insights, trends and good practices from the addiction and recovery field
• The stigma attached to addiction and recovery has not decreased in spite of continued efforts.

CHALLENGES

• A large proportion of public institutions lack a comprehensive assessment of the current needs (and goals) that should be addressed in the drug demand reduction field
• The Memorandums of Understanding do not guarantee joint action and continuation of cooperation
• The majority of service users find it difficult to take next steps and engage with other services
• Organizations have lack of capacity to respond to emerging needs
• Despite cooperation with key actors recovery oriented systems of care have not been established yet
• Creating a media landscape that would facilitate reduction of stigma surrounding drug addiction and that would promote potential resources for recovery.

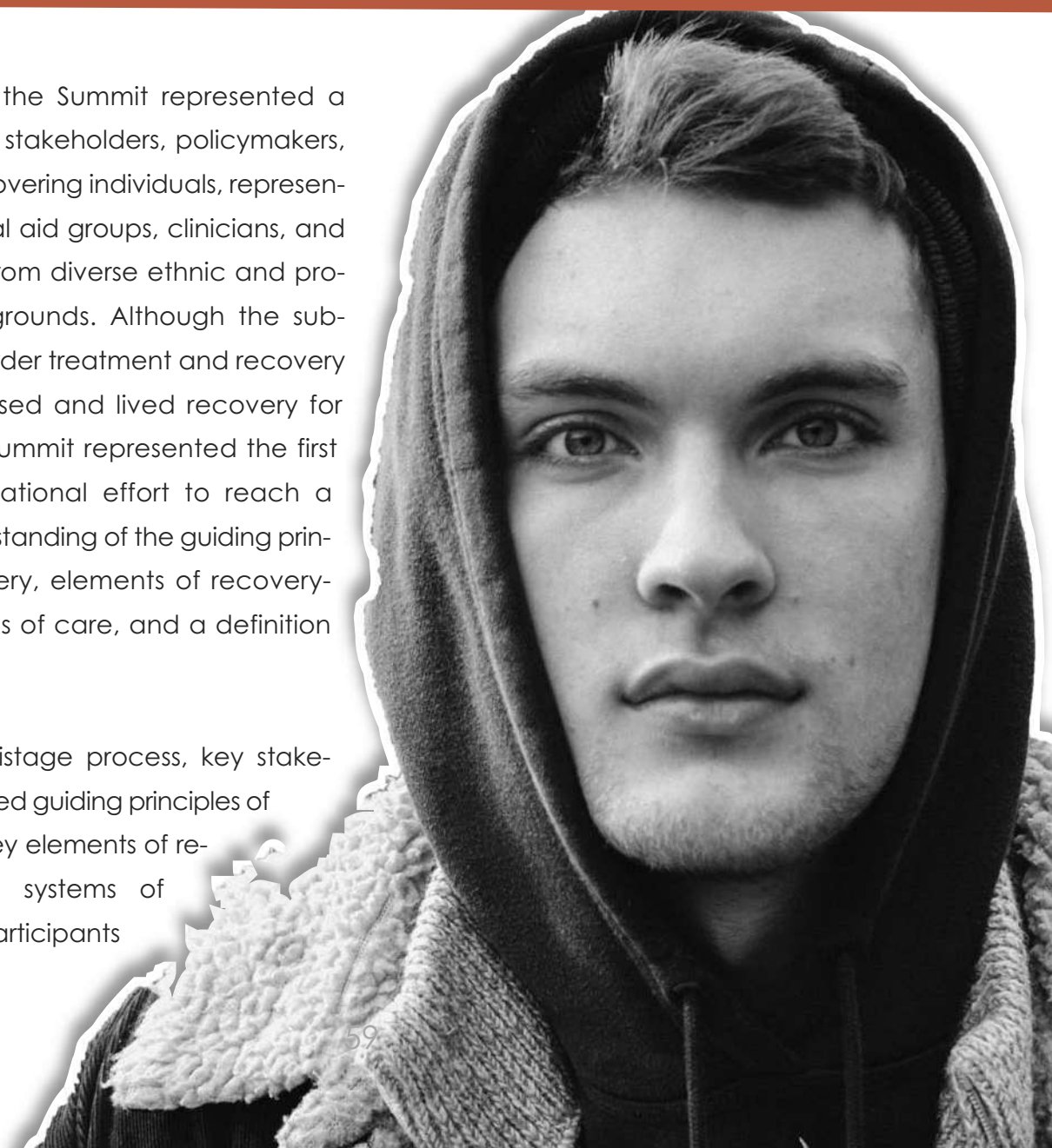
RECOMMENDATIONS

• The findings described in this evaluation should be included in relevant documents and considered in the process of analysis and decision-making towards development of comprehensive guidelines for drug supply and demand reduction
• Comprehensive guidelines should be an integral part of new national or local strategies that consequently should contribute to the establishment of recovery-oriented systems of care
• National drugs offices from all three countries should be involved in establishment of multi-sector teams, and should recognize the example of good practice from Serbia, and thereby decrease the isolation and enhance cooperation between stakeholders
• There is a need to recognize the importance of prevention and early interventions for young people, but also to ensure that addiction among young adolescents (aged 12-18) is adequately treated
• Events to reduce stigma and increase the visibility of recovery should be jointly organised by key stakeholders
• The measures to raise public awareness and influence public opinion on the dangers of cannabis for recreational purposes and reduce its potential social acceptability should be taken
• To increase the benefits to and wellbeing of both the project beneficiaries and all citizens of Serbia, Bosnia and Herzegovina and Montenegro, capacity building trainings of staff as well as funding for similar activities should be secured and supported based on this example of good practice.

APPROACHES TO RECOVERY-ORIENTED SYSTEMS OF CARE AT THE STATE LEVEL AND LOCAL LEVELS: THREE CASE STUDIES

SAMHSA

The concept of recovery lies at the core of the Substance Abuse and Mental Health Services Administration's (SAMHSA) mission, and fostering the development of recovery-oriented systems of care is a Center for Substance Abuse (CSAT) priority. In support of that commitment, in 2005 SAMHSA/CSAT convened a National Summit on Recovery.



Participants at the Summit represented a broad group of stakeholders, policymakers, advocates, recovering individuals, representatives of mutual aid groups, clinicians, and administrators from diverse ethnic and professional backgrounds. Although the substance use disorder treatment and recovery field has discussed and lived recovery for decades, the Summit represented the first broad-based national effort to reach a common understanding of the guiding principles of recovery, elements of recovery-oriented systems of care, and a definition of recovery.

Through a multistage process, key stakeholders formulated guiding principles of recovery and key elements of recovery-oriented systems of care. Summit participants

then further refined the guiding principles and key elements in response to two questions:

1) What principles of recovery should guide the field in the future? and
2) What ideas could help make the field more recovery oriented?

A working definition of recovery, 12 guiding principles of recovery, and 17 elements of recovery-oriented systems of care emerged from the Summit process. These principles and elements now provide a philosophical and conceptual framework to guide SAMHSA/CSAT and other stakeholder groups and offer a shared language for dialog.

Summit participants agreed on the following working definition of recovery:

Recovery from alcohol and drug problems is a process of change through which an individual achieves abstinence and improved health, wellness, and quality of life.

The guiding principles that emerged from the Summit are broad and overarching. They are intended to give general direction to SAMHSA/CSAT and stakeholder groups as the treatment and recovery field moves toward operationalizing recovery-oriented systems of care and developing core measures, promising approaches, and evidence-based practices.

The principles also helped Summit participants define the elements of recovery-oriented systems of care and served as a foundation for the recommendations to the field contained in part III of the National Summit on Recovery: Conference Report (CSAT, 2007).

Following are the 12 guiding principles identified by participants (for a complete definition of each of the guiding principles, see the National Summit on Recovery: Conference Report [CSAT, 2007]):

- **There are many pathways to recovery;**
- **Recovery is self-directed and empowering;**
- **Recovery involves a personal recognition of the need for change and transformation;**
- **Recovery is holistic;**
- **Recovery has cultural dimensions;**
- **Recovery exists on a continuum of improved health and wellness;**
- **Recovery emerges from hope and gratitude;**
- **Recovery involves a process of healing and self-redefinition;**
- **Recovery involves addressing discrimination and transcending shame and stigma;**
- **Recovery is supported by peers and allies;**
- **Recovery involves (re)joining and (re)building a life in the community; and**
- **Recovery is a reality.**

Participants at the Summit agreed that recovery- oriented systems of care are as complex and dynamic as the process of recovery itself.

Recovery-oriented systems of care are designed to support individuals seeking to overcome substance use disorders across their lifespan.

Participants at the Summit declared, "There will be no wrong door to recovery," and recognized that recovery-oriented systems of care need to provide "genuine, free, and independent choice" (SAMHSA, 2004) among an array of treatment and recovery support options. Services should optimally be provided in flexible, unbundled packages that evolve over time to meet the changing needs of recovering individuals.

Individuals should also be able to access a comprehensive array of services that are fully coordinated to support individual and unique pathways to recovery.

Participants identified the following 17 elements of recovery-oriented systems of care (for a complete definition of each of the elements, see the National Summit on Recovery: Conference Report [CSAT, 2007]):

- **Person-centered;**
- **Family and other ally involvement;**
- **Individualized and comprehensive services across the lifespan;**
- **Systems anchored in the community;**
- **Continuity of care;**
- **Partnership-consultant relationships;**
- **Strength-based;**
- **Culturally responsive;**
- **Responsiveness to personal belief systems;**
- **Commitment to peer recovery support services;**
- **Inclusion of the voices and experiences of recovering individuals and their families;**
- **Integrated services;**
- **System-wide education and training;**
- **Ongoing monitoring and outreach;**
- **Outcomes driven;**
- **Research based; and**
- **Adequately and flexibly financed.**

PURPOSE STATEMENT

This white paper has been developed as a resource for States, organizations, and communities embarking on systems-change efforts to develop recovery-oriented system. Each State, local government, community, and organization encounters a unique set of opportunities and challenges when it commits to developing recovery- oriented systems of care.

Nonetheless, there are many broadly applicable lessons that can be drawn from the experiences of other States and communities. Developing and implementing recovery- oriented systems of care are rewarding, difficult, and complex processes. This process is relatively new to the addictions treatment and recovery field, and minimal information is available to guide States, communities, and organizations wishing to develop recovery- oriented systems of care.

The case studies presented in this document provide examples of recovery-oriented approaches at various stages of development. By providing a range of examples, States and communities can explore approaches best suited to their circumstances. None provides a complete template or roadmap, since each State and community is unique, and since the development of recovery-oriented systems of care is a continuous process of systems and services improvement. Ultimately, each State, organization, and community will develop recovery-oriented systems of care based on individual needs and strengths.

Using the principles and elements as the framework, this white paper will highlight the activities and operations of two statewide systems and one city system that have taken steps toward the development of recovery- oriented systems of care. It will present case studies highlighting work under way in Arizona, Michigan, and the City of Philadelphia. The case studies will describe the following:

- Approaches to systems change;
- Systems and program models;
- Funding mechanisms;
- Challenges encountered, including workforce and training needs, regulatory and other systems barriers, and reluctance to change among key stakeholder groups;
- Research used to inform the approach; and
- Motivating factors and other elements critical to the implementation of recovery-oriented systems of care.

The City of Philadelphia: A Model of Systems Transformation

Historically, the City of Philadelphia's substance use disorders and mental health agencies provided traditional, institution-based addictions and mental health treatment that often reflected acute care intervention models. However, within that broader context, a subset of organizations had been piloting and developing recovery-oriented systems of care framework for many years.

These organizations recognized that individuals are capable, with some assistance and a network of supports, of managing their lives without alcohol and drugs. They understood that by providing a recovery-oriented systems of care framework individuals would "increase their capacity to participate in valued relationships and roles, and embrace purpose and meaning in their lives" (City of Philadelphia, n.d., p. 2)

Beginning in 2004, the City of Philadelphia embarked on a process to transform the city's behavioral health system to a recovery-oriented model in which coordination of services and continuity of care would be greatly enhanced. The City of Philadelphia stated the values that would drive its development of recovery- oriented mental health and addiction systems in a white paper developed to support the transformation process. Those values are shown in the box below.

• Values of Recovery-Oriented Mental Health and Addictions Systems.

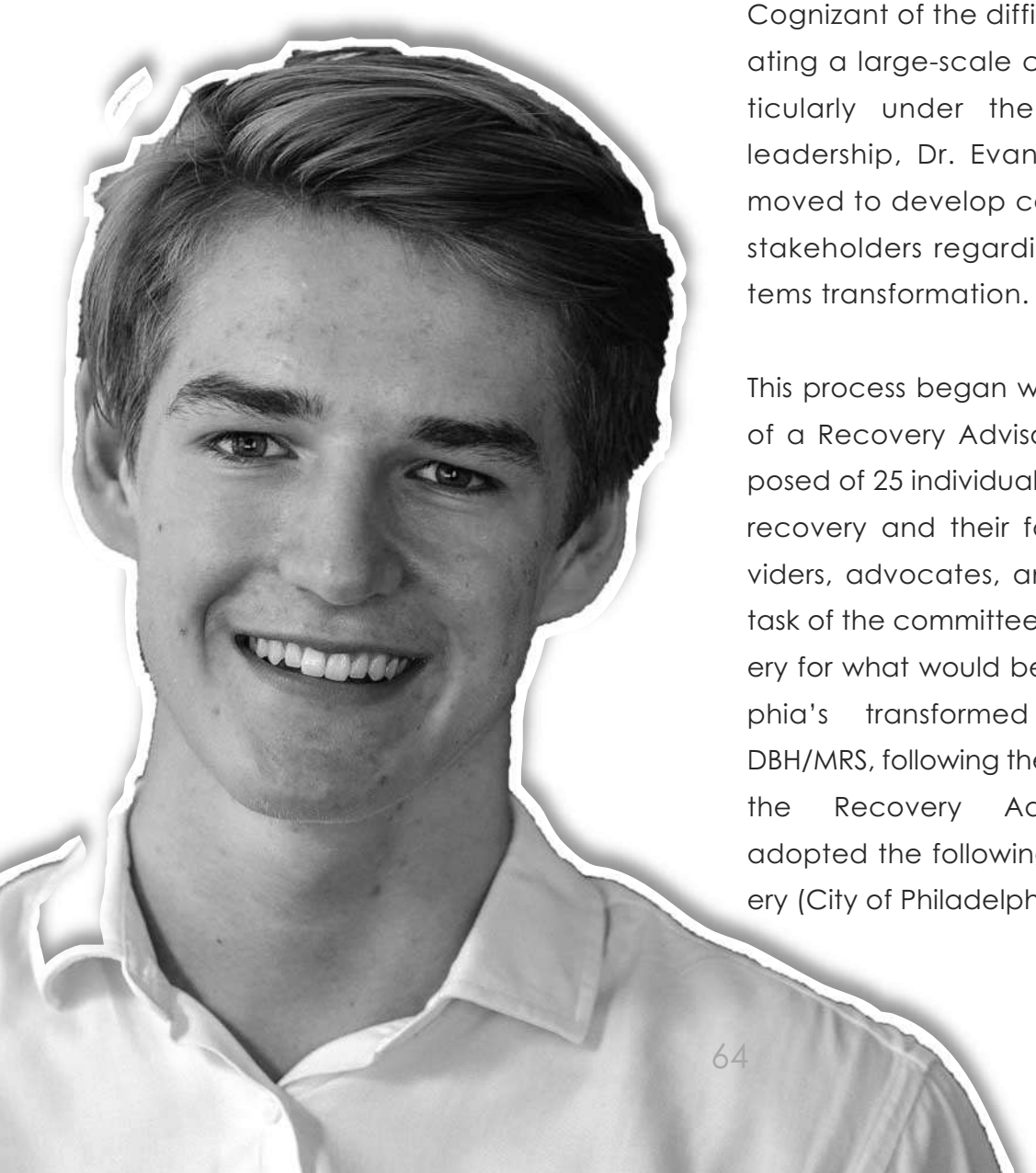
• The values of recovery-oriented mental health and addiction systems are based on the recognition that each person must either lead or be the central participant in his or her own recovery. All services need to be organized to support the developmental stages of this recovery process.

• Person-centered services that offer choice, honor each person's potential for growth, focus on a person's strengths, and attend to the overall health and wellness of a person with mental illness and/or addiction play a central role in a recovery-oriented system of care.

• These values can operate in all services for people in recovery from mental illness and/or addiction, regardless of the service type (i.e., treatment, peer support, family education).

TRANSFORMATION:
THE PROCESS OF SYSTEMS CHANGE

Systems transformation within the City of Philadelphia's Department of Behavioral Health and Mental Retardation Services (DBH/MRS) occurred after a change in leadership. The new director, Dr. Arthur Evans, had extensive prior experience transforming the State of Connecticut's behavioral health system to one focusing on a recovery-oriented systems of care framework. He led Philadelphia on a similar transformation process beginning in 2004.



DBH/MRS leadership dedicated the first few months of the transformation process to assessing the city's existing behavioral health system, getting to know providers, and identifying the needs of the system. Initial assessments revealed that the city lacked a collective emphasis on support for long-term recovery that included linkages between treatment providers, indigenous and faith-based organizations, and other community resources to ensure continuity of care through community supports and institutions that sustain long-term recovery.

Cognizant of the difficulty involved in initiating a large-scale change process, particularly under the direction of new leadership, Dr. Evans and his team first moved to develop consensus among key stakeholders regarding the need for systems transformation.

This process began with the development of a Recovery Advisory Committee composed of 25 individuals, including people in recovery and their family members, providers, advocates, and city staff. The first task of the committee was to define recovery for what would be the City of Philadelphia's transformed system. In 2006 DBH/MRS, following the recommendation of the Recovery Advisory Committee, adopted the following definition of recovery (City of Philadelphia, n.d., p. 23):

Recovery is the process of pursuing a fulfilling and contributing life regardless of difficulties one has faced. It involves not only the restoration but also continued enhancement of a positive identity as well as personally meaningful connections and roles in one's community. It is facilitated by relationships and environments that provide hope, empowerment, choices and opportunities that promote people reaching their full potential as individuals and community members.

The Recovery Advisory Committee also serves as a steering committee for several workgroups that have been formed as a part of the transformation process. These workgroups were charged with examining specific topics germane to the development of recovery- oriented systems of care.

These topics included trauma-informed services, cultural competence, evidence-based practices, and faith-based services. Under the leadership of the Recovery Advisory Committee, the workgroups were charged with ensuring that their work remains connected to the larger system vision and contributes to its realization.

Recognizing that the City's system had many strengths and that recovery-oriented systems of care framework existed in some areas, DBH/MRS set out to systematize the transformation to a recovery-oriented system of care through a shared vision and common direction (City of Philadelphia, n.d., pp.4-5).

Following development of the definition of recovery, advisory committee members went on to identify recovery values and principles within domains the group felt were important. Concurrently, DBH/MRS conducted a formal system-wide survey designed to identify community strengths and intended to serve as a tool in building consensus and buy-in.

The survey asked individuals in recovery, their family members, providers, and recovery advocates to identify recovery strengths within the community. This provided an opportunity for individuals and organizations to highlight their own recovery-oriented activities and afforded the city an opportunity to identify potential models for the rest of the system.

3000

More than 3,000 individuals responded to the survey. In addition, stakeholder meetings involving more than 450 individuals from all components of the behavioral health system were convened. The meetings provided city officials with a chance to gather direct feedback about the strengths and the needs of the system and to gather information on views regarding the priorities and staging of the system transformation process. Through this process, the Recovery Advisory Committee constructed a set of priorities for transformation.

The city's behavioral health leaders were committed to the creation of a shared vision and to guaranteeing conceptual clarity. Therefore, the city conducted frequent community forums, conferences, and workshops engaging individuals in recovery and their family members, as well as providers and advocates, in dialog about the vision and the transformation.

This principle of a shared vision and conceptual clarity would continue throughout the transformation process. As the process gained momentum, the city invited experts in recovery to present on their work.

For example, William White, senior research consultant on the Behavioral Health Recovery Management project, made presentations on the concepts of recovery management and on addiction as a chronic illness to DBH staff, recovering individuals, and providers.1 He also spoke with members of the broader community, including families and community-based organizations not a part of the DBH/MRS service system.

The Recovery Advisory Committee dedicated approximately nine months to the establishment of recovery values and priorities that flowed from them. Once these were established, efforts were focused on the development of the white paper, as well as a blueprint for change.

The white paper, Innovations in Behavioral Health: An Integrated Model of Recovery-Oriented Behavioral Health Care, discusses the concepts and history of recovery, general principles of recovery, and the shared need for a transformation to recovery-oriented care for both substance use disorders and mental health.

The blueprint, which was under development at the time this case study was written, presents the recovery-oriented vision for the system and describes the process through which the vision, shared goals, and systems priorities were developed.

It is intended to encourage DBH/MRS staff, providers, and other key stakeholders to begin thinking about how the priorities and goals of the transformed system will affect their services, organizations, and staff. Each entity involved in transformation will be asked what practice changes will be implemented, as well as what policies and administrative issues will be addressed.

TRANSFORMATION:
WHAT ARE THE NEXT STEPS?

Moving forward, the City of Philadelphia plans to develop implementation plans that will guide the city and its partners in creating a system that embodies the shared vision and conceptual framework and builds on the resources and models identified through the survey and the many public forums and meetings.

System-wide education and training is a top priority in the implementation of the transformed system. The city has developed recovery training to be delivered across the system. This is the first formal training that DBH/MRS staff, individuals in recovery and their families, and providers will participate in together.

People in recovery and their families will assist with facilitating the training. The 2- day session will lay the conceptual foundation of recovery and a recovery-oriented system of care upon which transformation efforts will be built.

Additionally, an advanced training session is currently under development. The advanced training will help individuals acquire the skills and knowledge necessary to operate within a recovery-oriented system of care. A workgroup is in the process of identifying the skill and knowledge sets critical for individuals providing services within a recovery-oriented system of care.

The city has also released requests for concept papers, asking providers to apply for $10,000 mini-grants to enhance and expand existing services to support recovery-oriented systems of care. The mini-grants will not fund new programs but will instead encourage providers to examine their systems and identify where and how they can infuse recovery-oriented principles and transform policies and practice.

The city is also encouraging community-based organizations other than treatment providers to apply for the mini-grants, recognizing that there are many pathways to recovery and that some individuals are more comfortable seeking assistance from faith-based or peer- based organizations or other natural supports.

Each of the mini-grant applicants must have an implementation team that includes recovering people. The hope is that these mini-grants will help to raise awareness, increase recovery capital in communities, and develop innovative approaches to system transformation.

As a follow-up to the mini-grants, the intent is to host a conference in which treatment and other community-based organizations make presentations on innovative systems transformation solutions. During the follow-up conference, the city intends to rely solely on the experience of stakeholders from its system for presentations on innovative systems-change efforts and lessons learned.

The city and stakeholders are discussing several other change efforts, including:

• Funding collaborations between providers and people in recovery to develop consumer-run businesses;
• Increasing the number of support groups (peer-run, consumer-run, self-help) around the city;
• Developing a cadre of peer specialists who can team with treatment providers to provide peer recovery services;
• Establishing employment and internship collaborations in which providers and local businesses provide employment and career opportunities for individuals completing treatment;
• Initiating collaborative efforts with Philadelphia community colleges to develop a leadership academy for individuals in recovery. Completion of the academy training would qualify recovering individuals to serve as advocates in the DBH/MRS or in a provider organization;
• Co-locating physical and behavioral health services within some of the city- run health clinics, focusing largely on areas with significant ethnic diversity;
• Sponsoring train-the-trainer programs for people in recovery to assist in continued efforts to disseminate the vision of systems transformation in the city;
• Creating family resource and support centers run by families of people in recovery; and
• Building on the strengths of existing programs that have:
- employed pretreatment support;
- demonstrated success by enhancing retention and treatment outcomes; or
- developed strong, long-term recovery maintenance supports.

Many of these ideas are in the early stages of concept development. However, the process through which they are evolving encourages innovative thinking among providers, community-based organizations, and city staff.

Through this process, the city is encouraging providers to think creatively in the creation and adoption of model programs to support recovery-oriented approaches. If an attempted approach is not successful, the providers will not be sanctioned for trying something new.

Instead, the city encourages providers to try different approaches based on lessons learned.

The City is not defining or proscribing program design, giving providers the flexibility to use their internal strengths to create programs and initiatives that will support the vision.

FUNDING SYSTEM TRANSFORMATION

Much of the funding for the current system transformation effort in the City of Philadelphia came from a surplus in Medicaid. DBH/MRS has relied on this surplus to fund many of the innovative programs that have been created.

Rather than funding startup or new programs (which can be costly), the city has focused on providing small amounts of money to enhance or shift existing programs to reflect the values and principles of the new system.

LESSONS LEARNED

The Philadelphia experience confirms that building trust and including all voices throughout the process is critically important to systems-change efforts. The city consistently demonstrated a willingness to listen and not make unilateral changes, aiding in the development of trust and system-wide buy-in from providers and organizations.

Though there are still providers and organizations that have reservations about the changes, the majority of the system stakeholders support the process and are active participants in the transformation effort. Additionally, the city felt it was important to inform stakeholders from the very beginning that the change process will evolve over time.

However, ambiguity can increase stress and resistance to systems change. It is critical to the success of these efforts that any issues that could impede the process be addressed as soon as possible in the planning process.

CHALLENGES

Agreeing on a common definition of recovery was the first challenge in the transformation process. Because people conceptualize the term "recovery" in many

different ways, it was both important and challenging to develop a broadly supported definition. Additionally, consensus needed to be developed and reached on the terms and principles of "recovery management" and "recovery- oriented systems of care."

Providers were initially anxious when the city—their primary funding source— proposed significant systems change and articulated new directions. Early in the transformation process, this manifested as resistance on the part of many organizations. The anxiety among treatment providers and other organizations heightened when the city discussed an all- inclusive process that would evolve over the long term but provided no clear timeframe.

Such an open-ended process left many providers uncertain and nervous about their place in the system. All of these challenges were overcome, however, by open communication, articulation of the shared vision at every opportunity, and ensuring that the planning, decision-making, and implementation processes remained inclusive.

SUMMARY

The City of Philadelphia has instituted an inclusive process of systems transformation that emphasizes building on existing resources to develop recovery-oriented systems of care.

The city's efforts generally reflect several of the elements of recovery-oriented systems of care developed through the National Summit on Recovery. However, there are areas where the convergence between the City of Philadelphia's work and the Summit's elements is particularly marked. They include:

Person-centered by making the individual in recovery the center of the transformation process. Recovering individuals have been central at each phase of planning and implementation, helping to design the city's recovery-oriented system of care. The city is also developing a menu of services that will meet the needs of the individual, whether the person is seeking support from a recovery- support provider, a community

organization, a treatment program, or a peer support specialist.

Family and other ally involvement by bringing families and other support networks to the table as a part of the transformation process. Families are an important part of the city's system, and that is reflected in the various roles they continue to play in the system and in the change process.

Individualized and comprehensive services across the lifespan by changing the system to enhance chronic care approaches and rely less on approaches that reflect acute care practices. The city has also focused on developing comprehensive services that are stage- appropriate and can be accessed by individuals at any point in their treatment or recovery.

Systems anchored in the community through the inclusion of community-based organizations. The city also supports community-based organizations in transformation efforts. This enhances the community support systems and makes them a viable and valued part of the system of care.

Continuity of care by identifying those organizations that are providing pretreatment and recovery support services and enhancing their programs through mini-grants in an effort to develop models for pretreatment and recovery maintenance.

Strength-based by redesigning the system to support treatment and recovery efforts that capitalize on an individual's strengths.

Culturally responsive by reaching out to ethnically diverse populations and supporting recovery in settings where they are most comfortable.

Responsiveness to personal belief systems by including faith-based organizations in the transformation process and in the request for proposals (RFP) process for mini-grants.

Commitment to peer recovery support services by including peer recovery support services in the principles of the transformation as well as by devising strategies to expand those services.

Inclusion of the voices and experiences of recovering individuals and their families by including them throughout the transformation process, as well as by training recovering individuals and their families in peer support and family support activities.

Integrated services by creating an integrated behavioral health care system and by exploring strategies for making behavioral health care available in city-run health clinics.

System-wide education and training through the provision of training and education opportunities from the outset of the process. System-wide education and training will continue as a part of the transformation efforts as the city brings together model programs for conferences and workshops, trains recovering individuals to partner with providers to create systems and services that embody the vision and the mission of the transformation, and provides education to recovering individuals and their families.

Ongoing monitoring and outreach by developing a system that is designed to reach out consistently to individuals and their families and to reengage them in the recovery process through training opportunities, education, and community-based support.

Arizona:

Statewide Systems Change Through Medicaid Expansion

Since the early 1990s, substance use disorders services in the State of Arizona have been provided as a part of a behavioral health Medicaid carve-out. Service eligibility is contingent upon financial eligibility for Medicaid.

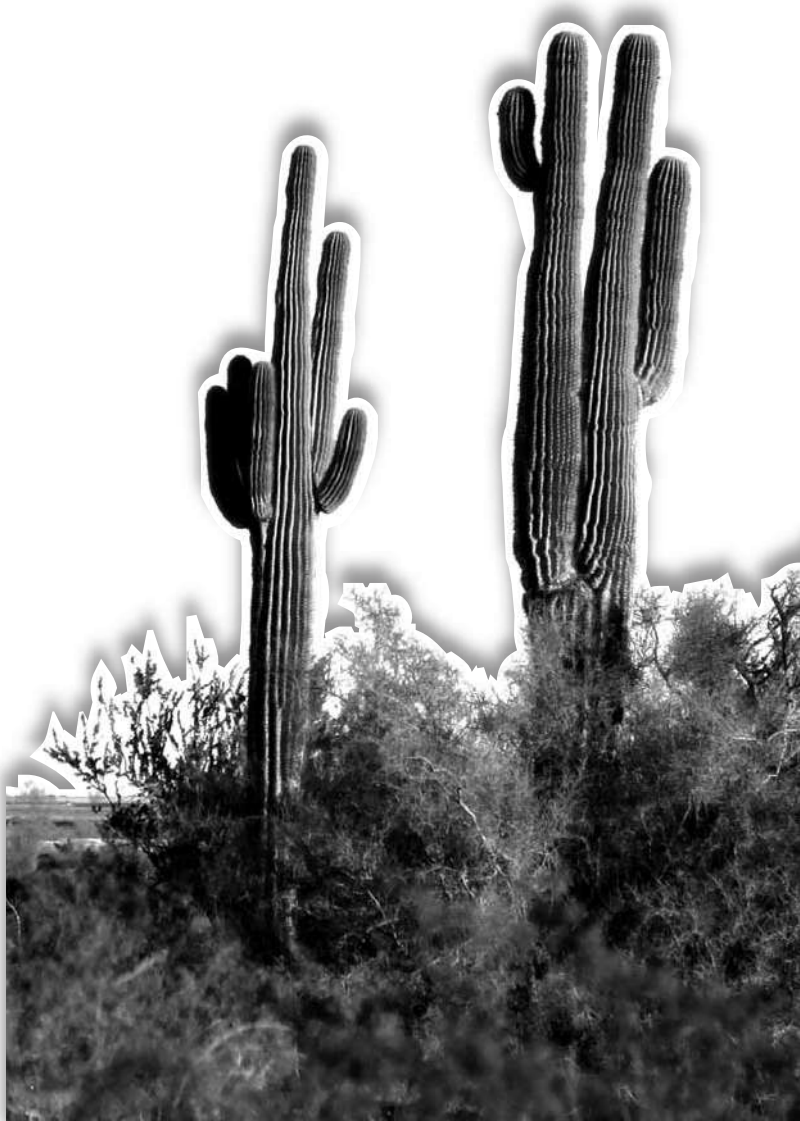
Coverage of all behavioral health services under Medicaid allows the State to offer the same level of services regardless of whether someone presents with a substance use disorder or a severe mental illness. In 2000, Arizona redesigned the State's behavioral health system to shift the provision of service from delivery solely in traditional treatment settings to delivery in treatment and other recovery-based community settings.

This system redesign included an expansion of person- and family- centered support and rehabilitation services. A number of factors motivated Arizona to undertake this systems-change effort, including:

- A Federal Medicaid waiver that allowed services to be defined and reimbursed in a new way;
- A statewide ballot initiative that significantly increased the number of individuals eligible for Medicaid; and
- A class action lawsuit settlement that required the State to substantially improve behavioral health services for children.

PEER AND FAMILY SUPPORT SERVICES

With an expanded array of services covered by Medicaid, Arizona was able to offer a full array of person- and family-centered, recovery- oriented services. Both recovering individuals and their family members were hired to work in the behavioral health system in a variety of capacities. Under Arizona's system redesign effort, recovering individuals play a critical role in providing peer support services (PSS).



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Arizona began offering PSS in 2000. Initial PSS efforts focused on services to individuals with serious mental illnesses. However, beginning in 2003, Arizona expanded the focus to create PSS positions to support those with substance use disorders. Peer support specialists serve as mentors and recovery coaches and team with alcohol and drug treatment providers to support individuals in their long-term recovery efforts.

A statewide training for peer support specialists was piloted in 2003 and expanded in 2005 to train 65 peer support specialists working in 17 agencies. In 2006, the State achieved its goal of doubling the number of peer support staff, and it continues to expand PSS.

Although the State does not require certification for peer support specialists, several training and certification programs exist. A new training program to expand PSS for people with co- occurring disorders provides training for both treatment providers and people interested in becoming peer support specialists.

The 2-day training for treatment providers serves as a guide for including peer support specialists on service teams and trains existing staff to work with peer staff on service teams. Other training targets individuals interested in becoming peer support specialists and provides a mechanism for earning college credit.

Family members are also an important part of the Arizona recovery support service redesign. Many family members are hired by community service agencies (CSAs), which may be nontraditional faith-based organizations and/or community-based organizations.

The CSAs provide support services (e.g., health promotion groups, living skills, other family supports) under the Medicaid waiver. Other family members (approximately 181 at this time) provide family and PSS in both licensed behavioral health agencies and CSAs statewide.

CSA

The CSAs were added to Arizona's funded continuum of care in 2001. They were created as part of the system redesign to expand access to recovery support services. The CSAs are not licensed and do not conduct assessments or provide treatment, but they are certified through an application process overseen by the Arizona Department of Health Services/Division of Behavioral Health Services, the Single State Authority for substance use services.

They are described in Arizona's Medicaid Covered Services Guide as a "natural community support" that uses

practical and informal approaches to provide support and rehabilitation services. While many of the services can be provided by a clinician, nontraditional providers often bring personal experience in recovery, shared cultural experience, and other assets that clinicians may not be able to offer.

The CSAs receive both block grant and Medicaid funding. There are currently 12 consumer- operated organizations providing peer services, including depression and alcohol screening, employment training, and educational services for behavioral health consumers and family members. Their efforts have reinforced the focus on recovery-oriented efforts, increasing awareness of what it takes for people to be successful in recovery.

RECOVERY-ORIENTED APPROACHES AT THE POINT OF ENTRY

Within the new system, Arizona implemented recovery-oriented approaches at the front door. In many agencies, when someone enters a treatment facility, the first person they see is a peer, not a clinician. This first contact can be instrumental in fostering engagement with the behavioral health system.

This approach has proved successful in Arizona's detoxification programs. Many detoxification clients come into the program with

no intention of staying longer than the 24 hours it will take to stabilize.

However, when the first person they meet is a peer, they find themselves in conversation and interaction with someone who can relate to what they are going through. This often leads to a discussion about what is next for them, and many find themselves talking about treatment and recovery as something they want or need in their life.

Arizona's person-centered approach to recovery-oriented services begins when an individual initiates contact with the system.

The assessment process also reflects recovery- oriented approaches. A uniform assessment and service-planning process has been adopted statewide. It concurrently assesses substance use and mental health issues and utilizes a team approach to develop a recovery plan, which reflects the individual's goals and focuses on building a system of support around him or her. The planning team focuses on helping individuals identify strengths and supports in their lives and also puts in place a plan to ensure that they will be able to attend the next appointment.

This same planning process is in place for adolescents, utilizing a child and family support team. The team may consist of a variety of social service providers, family members, or a guardian, who provide support for the adolescent. The child and family support team also identifies any urgent issues that must be addressed immediately, such as concerns about the child's safety or a need for prescription medication. There are about 14,000 child and family support teams operating in Arizona, serving a little over one-third of the adolescents in the system.

COMMUNITY REINTEGRATION

Ongoing recovery support also involves assisting individuals in locating housing and employment. The State of Arizona has worked with provider organizations to provide employment opportunities within the behavioral health system for recovering individuals.

It has also provided seed money for consumer-run businesses, including a candle-making company and a bee- keeping business. The State is also collaborating with the business community to create job development programs to support employment for individuals in recovery.

The State has developed methods to help individuals secure housing as well. If an individual cannot afford housing, the block grant will pay for supported housing for individuals and their families while they are participating in treatment. When an individual moves from residential treatment to outpatient services, the State covers the cost of an apartment for the duration of treatment.

PLANNING FOR RECOVERY-ORIENTED SERVICES

Initially, minimal strategic planning informed systems-change efforts in the adult substance use disorders service system. Systems change was driven by changes in Medicaid that expanded the service availability for eligible clients.

The change meant that providers had to provide reimbursable services to Medicaid-enrolled individuals. Providers were challenged with determining how to make available this expanded array of services. The State assisted by offering technical assistance, monitoring utilization rates, setting network goals, and assessing network capacity.

At the time this case study was written, Arizona State officials, consumers, providers, and advocates were in the process of developing a strategic recovery plan for adolescents. The document is currently in draft form. The systems-change process for the adolescent service system has been more structured than the effort to transform the adult system. The process includes the development of a plan with the support of stakeholder workgroups and defined goals.

IMPLEMENTING RECOVERY SUPPORT SERVICES

Through utilization review, the State learned that providers were not comfortable with PSS and therefore had not implemented them despite available funding. To increase utilization of PSS, the State convened eight providers to design a peer support model.

2003

In 2003, the State requested technical assistance from SAMHSA to help adapt the successful peer support model used for those with serious mental illnesses to a model that could be used for individuals with alcohol and drug use disorders.

The eight providers piloted the adapted model. The State highlighted the work of the eight providers by scheduling trainings and workshops in which they presented their work. The State also provided $650,000 to expand the availability of PSS, which then became Medicaid-covered services. Finally, the State developed a protocol for PSS designed to help organizations develop and implement their own PSS.

This creative and flexible approach to funding substance use disorders services has allowed the State to serve more than 89,000 people, up from only 8,000 in the late 1990s.

FUNDING RECOVERY-ORIENTED APPROACHES

Arizona has been able to successfully blend its block grant and Medicaid funding to provide a wide range of recovery-oriented services. While Medicaid accounts for over 75 percent of the Arizona substance use disorders budget, block grant funds cover critical components not covered by Medicaid, including transitional housing for individuals completing treatment.

According to State officials, Arizona had the ability through a waiver to expand their Medicaid service coverage since the early 1990s, but did not systematically identify gaps and explore how Medicaid funds could fill these gaps until 2000.

CHALLENGES AND BARRIERS

One of the greatest challenges Arizona encountered was dealing with clinicians' beliefs that they could control the treatment and recovery process. Medicaid-eligible services could no longer be denied for an individual deemed "not ready" for treatment.

Clinicians were accustomed to making many decisions regarding treatment for in-

dividuals, including whether or not an individual was ready for treatment. With the change to the Medicaid-covered services array, providers were now required to provide services for anyone eligible to receive them.

Ambivalence and hesitation among providers regarding the provision of peer services was also a significant challenge. Under the Arizona model, peer support specialists have access to clinical records and take part in clinical staffing. Some clinicians initially attempted to exclude them from the staff room and also attempted to prevent them from reviewing medical records.

Some clinicians also attempted to hold service-planning meetings at a time when the peer support specialist was unavailable. Additionally, in rural agencies, a challenge was encountered when a peer support specialist was receiving services at the same agency where they were providing peer support.

Previously there was nothing in a clinician's training that addressed overcoming some of the ethical and clinical issues that they were facing in dealing with peers/consumers as full and participatory members of the service delivery staff. In response to this, the State developed a protocol to help agencies and clinicians overcome these challenges.

LESSONS LEARNED

Other organizations attempting the same level and scope of system redesign must undertake the effort with recognition that change is a long-term and evolving process. A philosophical shift like Arizona's systems-change effort can be daunting for all parties involved and should be recognized as such.

Any major system shift should include input from all key stakeholders from the beginning. It is also important that all parties— the State, providers, advocates, and individuals in recovery—be flexible and at times accommodating as the process will be continuously revised and adjusted. Cultural barriers can also pose a challenge to systems change.

SUMMARY

The Arizona recovery-oriented change process is an example of how a State can develop innovative approaches to address the needs of individuals and can implement those changes through a long-term and evolutionary process involving multiple parties.

The State's efforts generally reflect several of the elements of recovery-oriented systems of care developed through the National Summit on Recovery. However, there are areas where the convergence between the State of Arizona's work and the Summit's

elements is particularly marked. They include:

Person-centered by implementing team-based recovery-focused approaches from an individual's initial contact with the system.

Family and other ally involvement by involving families in the recovery process from the point of assessment through recovery. Families provide support services and are valued members of organizational support staff.

Individualized and comprehensive services across the lifespan by making available an individualized, stage-appropriate, and flexible menu of options for adults and adolescents. The systems change reflected the knowledge that the system must change to meet the needs of the individual, as opposed to requiring the individual to change to meet the needs of the system.

Systems anchored in the community through involving CSAs in the recovery support process, as well as involving community members in community reintegration efforts.

Strength-based by developing an assessment that focuses on the strengths an individual brings to his or her own recovery.

Commitment to peer recovery support services by the creation and funding of CSAs.

Inclusion of the voices and experiences of recovering individuals and their families by giving peer support specialists a prominent role in the system, employing them in agencies where they are the first contact a client may have with the system, and by valuing their input in the system redesign.

Integrated services by implementing the use of an integrated behavioral health assessment. The Arizona system also focuses on assisting individuals in gaining access to community supports following treatment, including housing and employment.

System-wide education and training by making such efforts a cornerstone of the Arizona systems-change effort. The introduction of peer services required extensive training of provider organization leaders and managers, clinicians, and peers.

Adequately and flexibly financed by creatively expanding the range of Medicaid-covered services and the number of individuals eligible for Medicaid and using block grant funding to provide services not covered by Medicaid.

Michigan:
An Evolving Process to Implement Recovery-Oriented Approaches

Michigan's substance use disorders system is operated through a regional structure. The State offices for substance use disorders—the Office of Drug Control Policy and the Bureau of Substance Abuse and Addiction Services—contract with 16 regional coordinating agencies (CAs). The CAs in turn contract with providers in their region and manage the regional provider network. All direct services are provided by licensed community-based organizations.

In 2006, the State completed a 3-year restructuring process. This process culminated with the issuance of new administrative rules governing substance use disorders treatment services. The rule change was particularly significant because the State had not modified its rules since they were first promulgated in 1981.

Prior to the issuance of the revised administrative rule, State substance use disorders policy and regulation had been driven largely by the requirements of the Federal Substance Abuse Prevention and Treatment Block Grant, which was the primary funding source for substance use disorders services in the State.

IMPLEMENTING RECOVERY-ORIENTED APPROACHES

State officials began the systems-change effort by reviewing the substance use disorders services and infrastructure with the goal of expanding the service array for licensed provider agencies.

Prior to the rule change, the State funded outpatient, intensive outpatient, sub-acute residential, detoxification, residential, and methadone services.

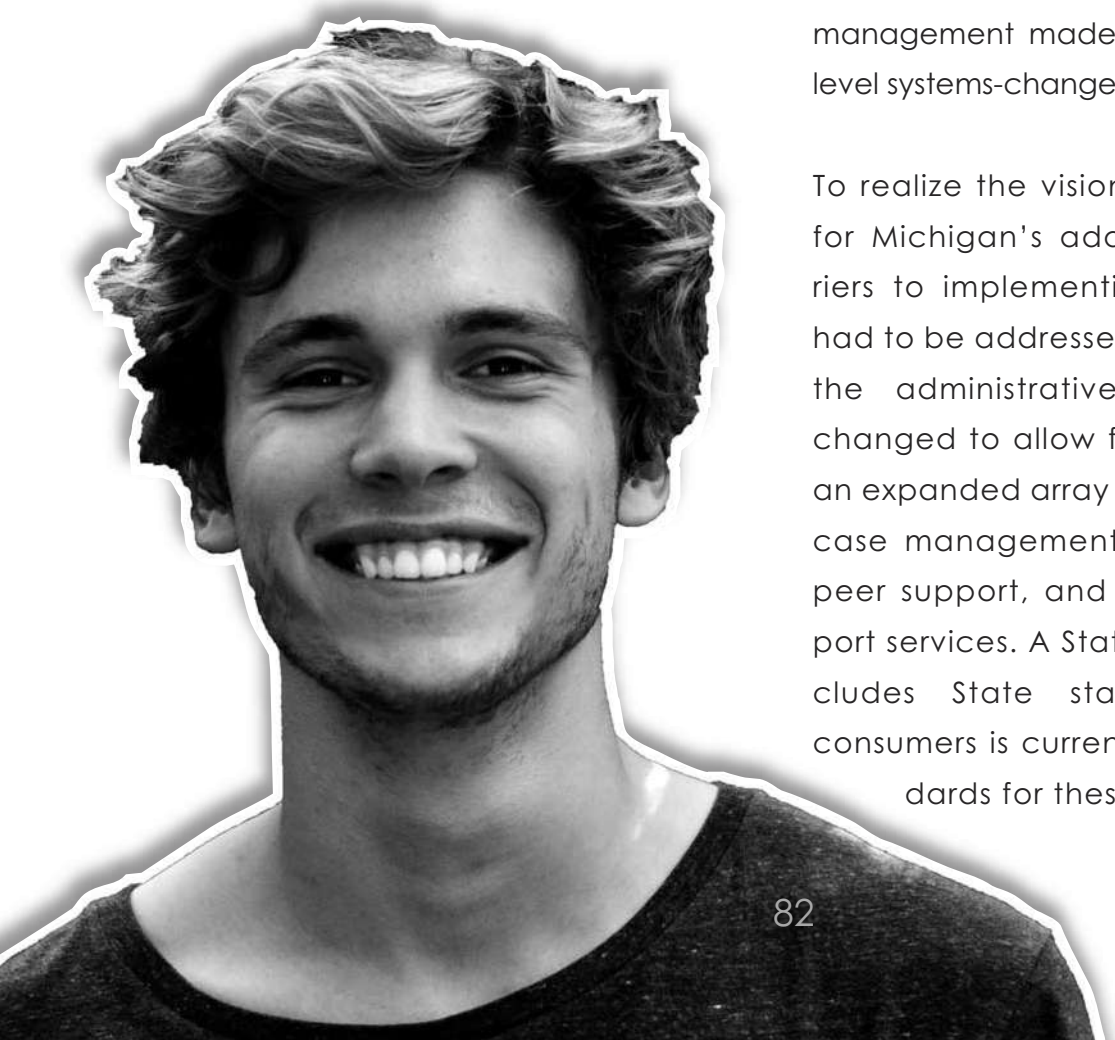
With the implementation of systems-change efforts, that standard service array was expanded to include case management, co-occurring mental illness, recovery, and PPS, as well as early intervention. (Previously early intervention only existed within the prevention system.)

The initial change process did not include a vision statement or plan for strategic systems change. The State's environment for the past several years had been one of little or no growth or change. However, community stakeholders pressed for systems evolution. Discussions began to move forward with modest goals.

A vision and a strategy began to emerge. When State officials convened a workgroup consisting of providers and other stakeholders to discuss improvements to addictions treatment, consensus emerged that the system needed to be strength-based and recovery-focused. From this consensus, the stakeholders developed values and principles to guide the State's vision and authored a plan to create such a system.

Although Michigan did not make a conscious decision to implement recovery management as defined by the Behavioral Health Recovery Management project and the work of William White, the principles and practices of this project informed the implementation process. Many providers and CAs across the State were familiar with White's work and the concepts of recovery management.

Through the multiple trainings he had conducted in the State, many of his ideas had caught on at the local level. Through discussions between the State, CAs, and local providers, the elements of recovery management made their way into State-level systems-change efforts.



To realize the vision that had emerged for Michigan's addictions system, barriers to implementing systems change had to be addressed. First and foremost, the administrative rule had to be changed to allow for reimbursement of an expanded array of services, including case management, early intervention, peer support, and other recovery support services. A State workgroup that includes State staff, providers, and consumers is currently establishing standards for these services.

In addition to designing standards for the State's expanded recovery-focused services, State officials have made a concerted effort to include strength-based and recovery-focused approaches and philosophies throughout the State system.

Planning guidelines and documents reflect this effort. Examples include proposed requirements that consumers and families be included in treatment and recovery planning and in decision-making processes at all levels. In addition, the State law governing the advisory council requirements for CAs has been updated to require greater consumer and family participation on the advisory councils.

Among the challenges the State of Michigan faced were fostering understanding and acceptance of new approaches and philosophies and managing the process of change through which they were implemented on a program and system level.

Training is a critical component of Michigan's systems-change efforts. It serves not only to equip clinicians, providers and other stakeholders to implement new practices but also to support them in adopting new philosophies.

Training is an important tool to secure widespread support of the change process. The State has funded several training opportunities for providers, including a motivational interviewing workshop with William White. As part of their ongoing training plan, State officials have requested support from the Great Lakes Addiction Technology Transfer Center (GLATTC).

GLATTC provides technical assistance and training on systems-change efforts and technology transfer and continues to work with the State, providers, and consumers on skills training to enhance and support systems-change efforts.

Finally, the State and providers are striving to close the gap between prevention and treatment in Michigan. Historically, prevention and treatment services existed in separate and distinct silos. However, several organizations across the State are working to break down those silos and capitalize on preventionists' community capacity–building skills to support community-focused recovery and relapse prevention efforts.

FUNDING SYSTEMS-CHANGE EFFORTS

Despite the efforts to create systems change in Michigan, State funding is not available to support new services. The State is asking providers to examine their business practices and identify creative ways to reallocate or more effectively fund recovery-oriented services.

Additionally, the State is developing strategies to address engagement and retention issues. They have discovered that a significant percentage of addictions treatment funding supports services provided to individuals who enter the system, receive limited treatment services, and then are discharged prior to treatment completion or without linkage to recovery support services.

Often a significant percentage of these individuals return within weeks or months. Such "revolving door" services cost the State money but typically do not result in positive outcomes.

Michigan recognized that systems could be put into place that would increase engagement and retention rates, reducing the number of clients cycling in and out of the system. To address these issues, the State has been involved in the Network for the Improvement of Addiction Treatment (NIATx) study to determine which combinations of services produce the greatest improvement in treatment services.

This involvement resulted in the State's establishing a policy to facilitate access to treatment by making the initial intake process less intensive and overwhelming for individuals seeking treatment.

By implementing practices to increase engagement and retention, thereby reducing the revolving door effect, Michigan believes that it will be able to reallocate resources that have historically funded repeat treatment episodes.

Many CAs have applied for grants to fund recovery support services, and one Michigan CA was awarded a Recovery Community Services Program (RCSP) grant. Providers and CAs will continue to apply for grants to fund recovery-oriented approaches in the State.

The State is also looking at how existing, non-traditional community services can be used to support recovery-oriented approaches. State officials believe that even if no new funds become available, changes can be made within organizations to support ongoing systems-change efforts.

LESSONS LEARNED

It is important to identify a vision for the system. Once a vision has been established, values and principles need to be articulated and a structure to support them needs to be developed. It is also important to identify and analyze regulatory, funding, and philosophical barriers to implementation of practices that reflect the new values and principles.

A plan should be developed to address specific barriers. The plan may require a multipronged approach that includes statutory and rule changes and statewide training efforts. Without such a plan, systems-change efforts may stall. Finally, the change process will require incremental steps over an extended period of time to implement.

BARRIERS AND CHALLENGES

Funding has been identified as the greatest barrier to implementing a recovery-oriented approach in Michigan. However, the State and providers have worked collaboratively to reallocate existing funds to support recovery- oriented services. Additionally, barriers created by the State's infrastructure and administrative codes were addressed through a collaborative process.

SUMMARY

Systems-change efforts in Michigan continue to evolve incrementally as State workgroups create recommendations to address gaps and barriers. Michigan's ongoing work is an example of systems-change efforts in support of a recovery-oriented approach. It demonstrates how a planning and change management process can become a feature of a State system, providing a mechanism for system improvement.

The State's efforts generally reflect several of the elements of recovery-oriented sys-

tems of care developed through the National Summit on Recovery. However, there are areas where the convergence between the State of Michigan's work and the Summit's elements is particularly marked. They include:

Person-centered by expanding the array of services to include a broader menu of choices. The service system now includes case management, recovery and PPS, and early intervention.

Continuity of care by closing the gap between early intervention and treatment.

Strength-based by infusing strength-based principles and concepts into all systems-change efforts.

Commitment to peer recovery support services by adding PPS to the array of covered services in the State system. Additionally, the State has developed a workgroup to design peer support standards.

Inclusion of the voices and experiences of recovering individuals and their families through administrative and regulatory changes. Recovering individuals and their families are now included in many of the decision-making and planning processes, including CA advisory councils.

Integrated services by including co-occurring disorders services in the new administrative rule. Providers are now able to provide these services to consumers in the substance use disorders programs.

System-wide education and training by providing training on systems change and technology transfer. Michigan also conducts a yearly statewide training conference that for the past 2 years has been focused on recovery- oriented approaches.

Ongoing monitoring and outreach by increasing retention rates. Michigan will be able to use money previously spent on "revolving door" clients on recovery-oriented approaches.

CONCLUSION

The three case studies presented here document innovative approaches that a city and two States have taken to implement recovery-oriented approaches. Systems- change efforts were motivated by different factors in the jurisdictions. In 2004, the City of Philadelphia hired a new director of the Department of Behavioral Health and Mental Retardation Services who transferred lessons learned from a similar effort in another jurisdiction.

The State of Arizona, in 2000, redesigned the State's behavioral health system based on several factors: a Federal Medicaid waiver that provided an expanded funding stream; a Statewide ballot initiative that increased the number of individuals eligible for Medicaid; and a class action lawsuit settlement requiring the State to improve behavioral health care for children.

In 2006, the State of Michigan began its change process by promulgating an administrative rule change, which expanded the service array. Further, a broader vision for systems change was inspired by community stakeholders.

Implementing recovery-oriented systems of care is an evolutionary process, and the city and States discussed in this paper are at different stages in that process. In each case, the city or State faced unique challenges and barriers which it was able to overcome by collaborating with key stakeholders, including consumers and their families, providers, and other community-based organizations.

Despite differences, all three studies concluded that collaboration among stakeholders was required for success. In each study the leaders were able to create buy-in for a common vision and a process for change by maintaining open communication and including multiple stakeholders in the planning and implementation process. The city and States found that entrenched attitudes and beliefs by those involved in the systems created barriers to change and had to be addressed immediately.

Leadership, innovative thinking, flexible planning, and analysis of existing system strengths and weaknesses emerged as key elements of each change process. Another theme that emerged was that change can begin with small amounts of funding or by reexamining current business practices.

Additionally, in each case, contributors stressed the need to recognize and commit to a long-term and often difficult process.

However, once that commitment is made and all parties recognize that the city or State is prepared to follow through with change efforts, momentum increases.

Despite the long-term nature of the process, these jurisdictions stated that their efforts to move people and systems toward a recovery orientation were worthwhile.

RECOVERY AS A SOCIAL AND COMMUNITY EXPERIENCE

DAVID BEST I MULKA NISIC

Although recovery is a term that is ages old in the addictions field, definitions have become more focused and precise as the term has increased in its clinical and political salience. There have been two consensus statements that capture many of the key elements of recovery with the Betty Ford Institute Consensus Panel defining recovery from substance dependence as a "voluntarily maintained lifestyle characterised by sobriety, personal health and citizenship" (2007, p. 222). The following year, the UK Drug Policy Commission statement characterised recovery as "voluntarily sustained control over substance use which maximises health and well-being and participation in the rights, roles and responsibilities of society" (2008, p.6).

In both documents, recovery is regarded as being more than just abstinence, although this may often be an essential first step, to include quality of life and well-being and introduce the idea of citizenship as making a meaningful contribution to the community and to broader society.

The Betty Ford statement also characterises recovery as a journey and outlines the ra-

tionale for thinking of this as typically a journey of around five years with the first year after the onset of abstinence characterised as 'early recovery'; between one and five years as sustained recovery and beyond five years as 'stable recovery'. This fits with longitudinal research by Dennis, Scott and Laudet (2014) who have argued that it is after five years that recovery becomes 'self-sustaining', while prior to that point external supports are required. This sets a clear objective for a recovery model (as opposed to an acute treatment model) in providing the structures, systems and supports that allow people the maximum chance of making five years. The aim of this paper is to outline some of the ways that this can be conceptualised and can be supported.

KEY CONCEPTS

There are three core concepts that will be used to provide the foundations of a social recovery model that are all predicated on the idea that other people, in particular other people who have made the same journey, have a critical role to play in supporting the transition from active addiction to recovery.

1. In reviewing the literature around mental health recovery, Leamy and colleagues (2011) introduced the notion of CHIME as an acronym for the notions of Connectedness; Hope; Identity; Meaning and Empowerment, which they saw as critical in providing the support needed for people in their journey to recovery from mental health problems. The basic idea was that programmes that were effective in supporting recovery

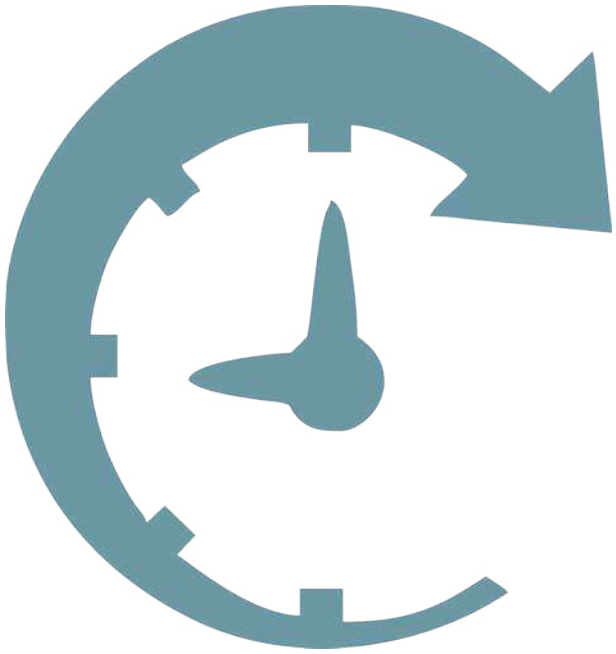
journeys were those that enabled and supported all five of these components. In my own translation of this to the addiction recovery area, there is a clear sequence to this work (Best, 2019) - human connection (particularly with those already in recovery) generates a sense of hope that change is possible. This hope is the fuel that drives a generative virtuous circle of meaningful activities, the development of positive identities and a growing sense of empowerment that manifests itself as self-esteem and self-efficacy. The implication of this model is that the key starting point of a recovery support service is to build connections to prosocial groups and individuals and in particular those who are already on their way to stable recovery.

2

2. The second core concept is around social identity and its role in sustaining and building recovery. The basic idea here is that the groups we belong to influences how we see the world and ultimately who we are. Social identities structure (and restructure) a person's perception and behaviour — their values, norms and goals; their orientations, relationships and interactions; what they think, what they do, and what they want to achieve (Tajfel & Turner, 1979; Haslam, Reicher and Levine, 2012). When this model is adapted to the addictions field - through the Social Identity Model of Recovery (SIMOR; Best et al, 2016) - the primary objective is around transitioning from groups that are supportive of addiction to groups that are supportive of recovery. In the section on implications below, we will outline what the practical steps are that can support this process

3

3. The final stage of this model is around the metric of how we measure where people are in their recovery journey. Recovery Capital was first described by Granfield and Cloud (2001) as the breadth and depth of resources available to a person to support their recovery pathway. Combining data from UK and US studies on recovery, Best and



Laudet (2010) categorised these resources into three domains:

1 **Personal Recovery** Capital refers to the internal qualities and skills: a person needs to develop and enhance including resilience, coping skills, self-esteem, self-efficacy and good communication skills

2 **Social Recovery** Capital refers to the size of positive social support and the individual's commitment to those positive and supportive individuals and groups in their networks. It is important to note that commitment to using and offending groups and a sense of belonging to them would constitute 'negative social recovery capital' (Cloud and Granfield, 2009). This reverse to the deficits that result from stigma and exclusion (negative community recovery capital), from either isolation or commitment to using and offending groups (negative social recovery capital) or high levels of impulsivity and sensation seeking and poor cognitive function or mental health problems (low personal recovery capital).

3 **Community Recovery Capital** refers to the resources available and accessible in the community that can support recovery pathways in terms of good quality treatment services, visible and attractive recovery groups and champions and effective pathways from medical treatments to community recovery groups. Community recovery capital would also include basic requirements for recovery including jobs, education and safe housing.

What is important to note about recovery capital is that it is amenable to change and we can count - with good sensitivity and accuracy - changes in the total resource and in the various sub-domains. The first measure in this process was the Assessment of Recovery Capital (Groshkova, Best and White, 2012), but this has more recently been embedded into a holistic approach to measurement and care planning called the REC-CAP (Cano et al, 2017). The REC-CAP assesses what strengths an individual has in personal, social and community domains and deploys these to build in areas where there are gaps. **This is a core part of a strengths-based approach which assumes that recovery happens in the community**

(and not in the clinic), that it is fundamentally relational (and not just a question of effort or willpower) and that it relies on the acceptance of recovery by communities and families as a core part of overcoming stigma and exclusion.

In the second half of the paper, we will talk about some of the practical implications for implementing a social recovery model and conclude with a beacon of hope for integrating recovery efforts across a range of European cities.

PRACTICAL IMPLICATIONS AND NEXT STEPS

In the largest ever study of addiction and recovery, based in the US, Project MATCH, Longabaugh et al (2010) found that the single strongest predictor of recovery from alcoholism was transitioning from a social network supportive of drinking to a social network supportive of recovery. However, this is easier said than done as people will often have lost all social support and access to resources during their active addictions (and may well have lost a lot of their own skills and capacities in the process too). For that reason, the steps proposed below are around creating treatment and recovery services and systems that allow people to make positive links, to access community resources and to gradually build their reserves of stable recovery capital. We are assuming that the five year journey to stable recovery involves accessing supports from communities and peers that affords the person the time and space to develop the personal resources to continue their recovery journey.

STEP 1:

CREATING A RECOVERY-ORIENTED SYSTEM OF CARE (SHEEDY AND WHITTER, 2009):

There is a very limited literature on what a service system looks like with the most impressive work outlined in a book edited by Kelly and White (2011) which talks about the 5-10 year window needed to generate a viable recovery oriented system of care. This was based in part on the work done by Sheedy and Whitter in 2009 for the Substance Abuse and Mental Health Services Administration, outlining 17 key principles for a recovery-oriented approach, including that services be person-centred, individualised and comprehensive, based in communities, inclusive of families, strengths-based, culturally responsive and involving adequate continuity of care. The model also involves a commitment to peer-based recovery support services, an integrated approach to service delivery with a high level of service user involvement, and a strong commitment to evaluation, research and to the evidence-base.

This approach is a gradual model of culture change involving not only professionals but the active engagement of peers. However, the overall goal is to create a 'therapeutic landscape for recovery' (Wilton

and DeVerteuil, 2006) in which families and communities are actively engaged in altering the space in which recovery can take place and in building the kind of community capital that is discussed in the conclusion to this article.

From this foundation, it is possible to create the strong recovery support systems and services, bearing in mind the evidence about what we know works in the recovery landscape.

STEP 2:

PROMOTING A PEER-BASED APPROACH

When asked to review the existing evidence for addiction recovery, Humphreys and Lembke (2013) concluded that there were three clear areas supported by a wealth of research evidence that used multiple approaches:

> **- Recovery housing (most commonly Oxford Houses)**
> **- Peer-based mutual aid groups (with the strongest evidence supporting 12-step mutual aid groups, in particular Alcoholics Anonymous)**
> **- Peer-delivered recovery support services.**

What all of those models have in common is a central role for peer-delivered, rather than professionally-delivered services. It is through the role of peers that a social contagion of

recovery emerges with recovery passing from one person to another as a result of positive role modeling and the active engagement and attraction of peer champions. Best and White (2019) have described this phenomenon as a 'recovery cascade' in which each growth in recovery "lowers the kindling point for initiation of future change - at personal, family, community and cultural levels" (p1). This is achieved not only through peers but peers will play a vital role in challenging exclusion and stigma and in promoting viable pathways to community and recovery resources. This is further generative through a process referred to as the 'helper principle' (Riessman, 1965) according to which it is not only the peer who receives benefit from the helping process but also the person who gives it.

STEP 3:

IDENTIFYING AND ENGAGING COMMUNITY ASSETS

The premise of recovery rests on the idea that, for most people in recovery, they are excluded from many of the assets in their local community through processes of stigma and marginalisation. What resources do exist (and that includes recovery groups) may be denied to them and they are unable to access the resources they need to support their recovery pathway. The idea of Asset Based Community Development (Kretzmann and McKnight, 1993) is predicated on the idea that all communities contain an abundance of assets in its people, its informal groups and associations and its formal institutions), and that the key is to promote and support the mobilisation of these resources. However, this will not be sufficient in its own right and it will be essential to identify 'community connectors' (McKnight and Block, 2010) who are the human bridges who will link excluded individuals to the assets that exist in their community.

To test this approach with the recovery community in Sheffield, UK, Edwards, Soutar and Best (2018) recruited and trained 21 people in long-term recovery to be community connectors and they were given six weeks to identify and positively engage with community recovery assets. In this period of time, they mobilised a total of 134 assets that could then be used to support meaningful recovery pathways. This path has to be individualised according to personal needs and preferences to ensure that the specifics of recovery stage and recovery needs are adequately addressed. This work has since been extended to helping prisoners engage in prosocial activities with family members trained to identify and engage relevant community assets (Hall et al, 2018), with equally positive results - the process spreads commitment and hope in the group and improves both access to new relationships and growing levels of community recovery capital.

CONCLUSION

Recovery is an incredibly diverse experience with people recovering through a number of different mechanisms and according to their own individualised and personal pathways. However, this does not mean that there is nothing can be done to support the process and to create the right culture that is therapeutic and embedded within a recovery-oriented system of care. As Braithwaite (1989) has argued in the context of social capital, the deployment of recovery capital does not diminish it (as would be the case for financial capital). The more you use recovery capital, the more of it exists in a community - in other words it is generative and results in the community being stronger as a result. This is a strengths based model in which connections build strengths and services and therapists start from the assumption of what is good and valuable, rather than what is broken or wrong.

This is the basis for a new initiative that is gathering momentum across Europe - that of Recovery Cities (Best and Colman, 2018). The aim of the recovery (and inclusive) cities model is to use the successes of a social model of recovery - social cascades and contagion, mobilisation of assets, social learning and social identity change - and to apply them more widely to increase connections and engagements across communities. While this work is in its early stages, the idea is to challenge exclusion, reduce isolation and loneliness and to promote recovery as a celebration of active citizenship and active community engagement.

Recovery is something that is worth celebrating and it is something whose celebration is creative and generative and has the capacity to improve the way we all live and the places we live in.

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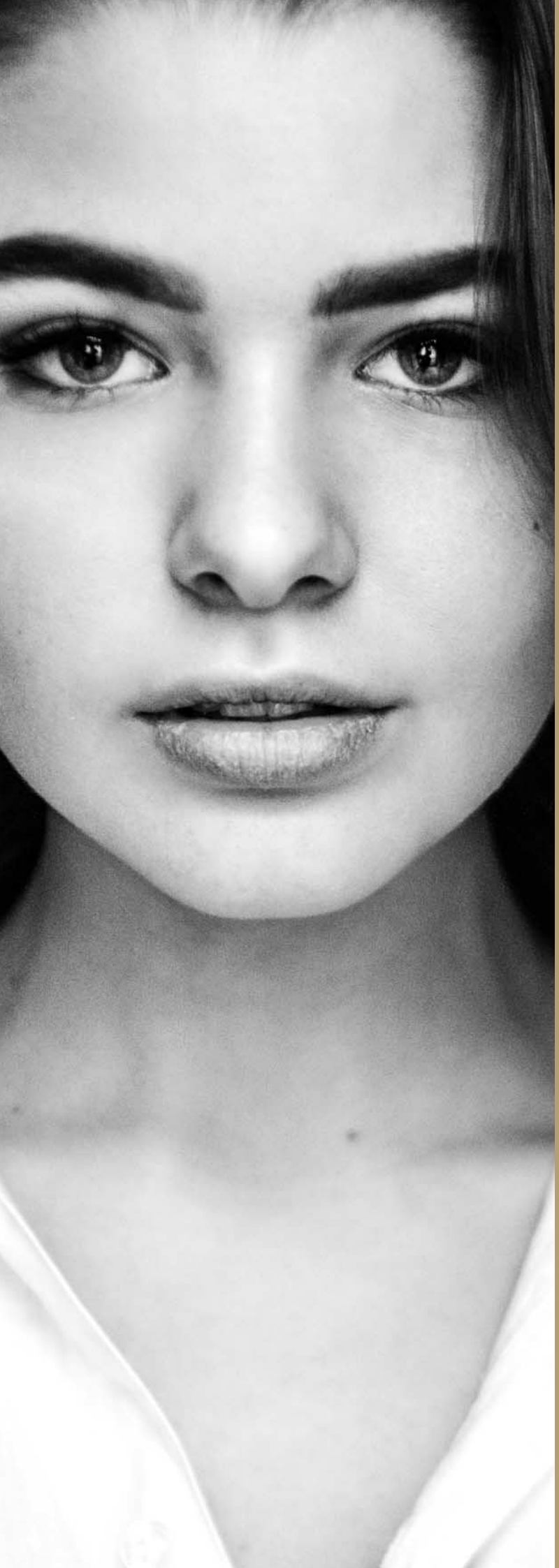
ASPIRE DRUG AND ALCOHOL SERVICE, DONCASTER – EXAMPLE OF GOOD PRACTICE

STUART GREEN

Aspire Drug and Alcohol Services which is a partnership between the NHS (RDASH) and registered charity The Alcohol and Drug Service in Hull. Aspire delivers harm reduction from needle exchange, BBV testing and vaccinations through to structured treatments such as opiate substitute Prescribing and inpatient residential rehabilitation to the population of Doncaster which is an ex-mining community in Yorkshire, UK. There are significant challenges around health and wellbeing, deprivation as well as poverty within the local area. Doncaster has a population of 350,000 and due to its heavy drinking culture there are approximately 4000 problematic alcohol users and around 2500 problematic substance misusers who have been identified through a strategic needs assessment.

Doncaster history is that it is a historic market town with a racecourse. It has three prisons in the local geography and has seen changes in its industry, moving to warehousing and distribution. The recent addition of an airport is seen as a central logistical operations centre for national and international companies.

Aspire as an adult service, has a current treatment population of 1600, made up of 1100 people on substitute prescribing and the remainder either on other drugs or alcohol.



Aspire is proud to be at the forefront of the Recovery Cities agenda. It is a keen contributor to visible recovery and collective learning through the Recovery College's and Recovery Games. Aspire also recognises and builds on the strengths within the local community seeing assets in the citizens that present as clients of Aspire Drug and Alcohol Service.

OVERVIEW

The UK appears to follow similar trends as the USA, although a few years behind. Currently the USA is in the grip of an opiate epidemic. This has led to the UK and Europe being one of the main consumers of cocaine at present. Cocaine prices in the UK have dropped and purity levels remain extremely high with the average price of £40 per gram. More worryingly the UK is seeing cocaine and alcohol in the night time economy which creates Coca-ethanol. Nationally alcohol related harms are on the way up which will has a further impact due to cocaine use and potential damage to the liver from excessive drinking.

The UK has clear guidance on its drug strategy (10 year plan) which has three key planks that are restrict supply, education and treatment. There is a moving groundswell in the harm reduction camps to look at decriminalisation as well as places where people can use drugs more safely such as supervised injecting centres. One success

which appears to be gaining a significant grip is drug testing at festivals, often run by organisations such as the Loop. This seems to work because festival goers are looking for recreational effects from drugs and have a willingness to dispose of drugs which are not what they thought they bought. One of the main reasons why the UK has not moved towards decriminalisation can be evidenced through the Overton window which presents a model of what is politically acceptable.

Recovery orientated practice is key to social integration and community building. This can be evidenced clearly in the Recovery Cities work. It is also evident in how the final stage of recovery is the community accepting people with previous addiction issues as valued citizens and contributors to the local economy and society "community returners" . In Doncaster we are proud to showcase visible attractive, community recovery, such as the Recovery Games, which brings together the full range of biopsychosocial interventions to enable recovery capital to be built on.

Recovery orientated practice in the field also recognises the assets and strengths the patient brings into the relationship and builds on these. This is key to independence rather than dependence on professionals and works on positive social capital building.

OVERVIEW FROM THE PRACTICAL STAND POINT – WHAT HAPPENS WHEN SOMEONE COMES IN FOR HELP?

Aspire in Doncaster, like many UK services, has many formal and informal pathways into treatment. The favoured pathway is self-elected presentation at the Single Point of Access part of the service. Other pathways into the service are through criminal justice, such as trigger offences. Professional referrals occur from acute services, secondary care, physical health services, mental health services and primary care such as GP Practices. A holistic, confidential assessment takes place. This includes reviewing history, current issues, drug and/or alcohol use, reviewing recovery capital and any pre-disposing risk factors such as route of use, for example injecting or safeguarding. From this a recovery plan is formulated which focuses on strengths and goals. The key in this process is to establish recovery capital across the biopsychosocial areas of somebody's life. The predisposing standpoint is from harm reduction stance, making sure that people are protected with informed choices around Alcohol or illicit drug use, offering needle exchange, Naloxone, brief interventions and making sure wider harm prevention to family and the community are considered.

When we look at personal capital building, it is important to look at social networks of support, both constructive and destructive as well as looking at substance misuse in-

cluding cues and triggers. The service aims to offer a triple track approach to social capital building, for example support groups, Narcotics Anonymous and Alcoholics Anonymous; medication; talking therapies; prescribing interventions including blockade medication. Talking therapies delivered by key workers or nurses, using techniques such as motivational interviewing, solution focussed and Cognitive Behavioural Therapy which can be 1-1 or in group work.

Digital self-help and other wrap around support including links to housing, gyms, and employment are also considered as part of an integrated approach to a person's circumstances. This may involve debt management and wider physical health and mental health issues such as registering with a GP Practice and dental practice.

RANGE OF DIFFERENT SERVICES

Aspire aims to offer interventions for all stages of the cycle of change in regards to use and behaviour and structures its service accordingly. It offers opportunities for people who are still using drugs or alcohol to reduce the harms. The pathway often leads clients from harm reduction to long-term talking therapies and substitute prescribing followed by detoxification and an abstinence based recovery programme. The service offers recovery check-ups post service discharge for ex-clients to help with continued support and prevention of lapse, Aspire also has access to a rehabilitation budget for residential treatment.

Aspire has specialist workers which include a midwife, wound care nurse, employment, training and education (ETE) workers who support some of the more dynamic health and social issues that clients present with.

PROFILE OF PEOPLE IN CONTACT WITH THE SERVICES

Aspire works with 0.5% of the 350,000 Doncaster population. This is an aging cohort as treatment has a protective factor. When profiling these clients the average age of the treatment population is slowly increasing and the ratio is four males to one female, predominantly White British. The main cohort has been in treatment for significant periods of time for opiate dependency and are on opiate substitution therapy (Methadone). A large group of clients have significant contact with children and issues with housing and employment. Poly drug and alcohol users with complex co-existing conditions often have other historic trauma

related conditions such as Post Traumatic Stress Disorder, childhood trauma, for example physical abuse/ neglect or poor mental health. Doncaster like a lot of towns in the UK is seeing problematic alcohol use which is resulting in increased hospital admissions for physical health issues. People who are drinking in excess of the recommended units are not routinely presenting at services for help and they are often resistant to change and functioning members of the community. Scotland has recently introduced minimum pricing to alcohol and evidence suggests this has reduced alcohol consumption. However there is a whole debate on whether people with problematic alcohol issues, as to whether introducing minimum pricing pushes people into poverty and associated behaviour relating to addiction further.

MEDICALLY – ASSISTED RECOVERY

A large cohort of patients within Doncaster is on substitute prescribing for Illicit opiate use. Currently the service is looking at clustering these into three groups. Those on long-term prescribing and are stable and living fulfilling lives are treated as any other long-term health condition. Receiving regular reviews and while the service recognises prescribing alone does not create change, these individuals have enough recovery capital to be considered as self-directed in terms of positive changes. There are regular reviews during the year to offer pathways into further interventions such as detoxification and group work.

The predominant offer for people with opiate issues continues to be methadone prescribing as a front line intervention with rapid entry into this e.g. post prison release/ hospital and continuity of prescribing from transfers or ongoing treatment. In Doncaster there is a recognised cohort which continues to use illicit opiates on top of the methadone. From a harm reduction point we consider whether a person is on optimum prescribing levels. If drug use is reduced and there are positive health benefits as a result of an individual is not procuring or using illicit drugs to the same level. Therefore the harms are reduced. The range of opiate prescribing tends to be between 40mg and 100mg for most individuals with initially supervised consumption on a daily basis to as a requirement at pharmacies to make sure concordant use.

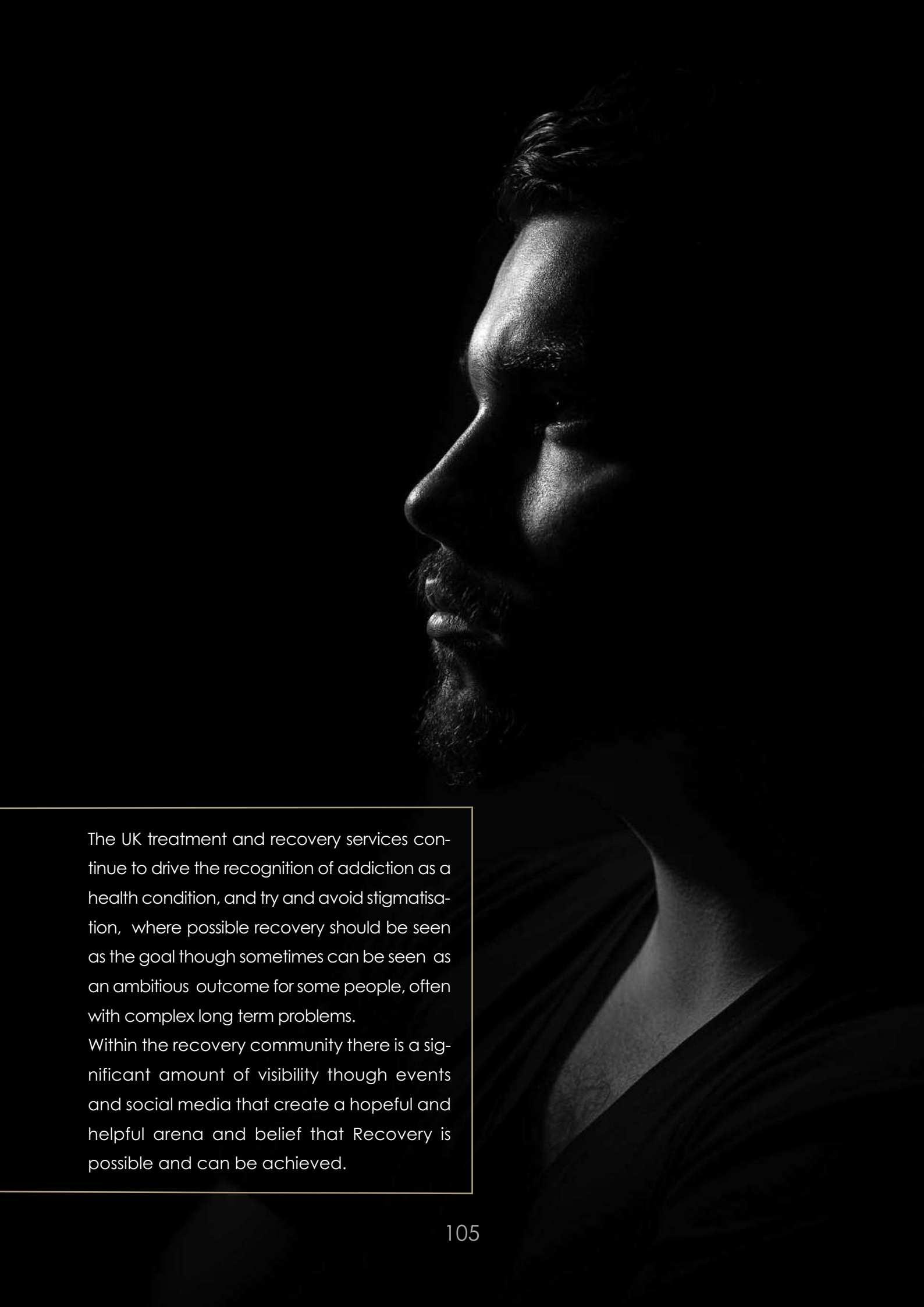
Within the treatment system there are a number of psychosocial groups and interventions which are suitable to support an individual to look at behavioural change these are laid out in NICE guidance. These include relapse prevention as well as motivational interviewing, mapping which would move people towards abstinence or treatment exit, and help them learn new ways of dealing with issues without the use of substances.

There is a famous saying, "dead people don't recover" so having methadone as a main plank in regards to substitute prescribing offer is key to engagement and working with an individual around changing behaviour but also recognising lapse is part of the process at times . Change is measured not by how low a dose someone is on but what positive capital they are building in their life such as work, family and happiness.

Doncaster is fortunate in that it has a bespoke ten bed inpatient detox unit and day rehab programme called New beginnings. This enables people to make the transition to abstinence based recovery for drugs or alcohol which then leads into meaningful activities such as volunteering, work, education or parenting. The programme offers a CBT approach in a therapeutic environment.

CURRENT CHALLENGES

In the background the supply of illicit drugs is being driven by organised crime groups (OCG's) which are becoming increasingly becoming more violent, better equipped using digital and other ways of communication such as the dark web. These OCG's are using children to move drugs across the country, 'county lines'. The bed rock of most OCG's often is the illicit activity of selling drugs which creates turf wars and potential arms race against rival OCG's.



The UK treatment and recovery services continue to drive the recognition of addiction as a health condition, and try and avoid stigmatisation, where possible recovery should be seen as the goal though sometimes can be seen as an ambitious outcome for some people, often with complex long term problems.

Within the recovery community there is a significant amount of visibility though events and social media that create a hopeful and helpful arena and belief that Recovery is possible and can be achieved.

RECOMMENDATIONS

Continued development of approaches such as the inclusive cities work, building on breaking down stigma and recognising addiction as a health condition within our communities on a health and social level is very much needed and will contribute to a long term positive change in this area.

There is also a need to continue to collaboratively work across Physical health services and mental health services focusing on where people often present outside of normal pathways requesting help such as Hospitals, Hostels and Prisons.

For the work with this client group- people affected by drug addiction- there needs to be strong clinical supervision and support for the staff. There also needs to be a degree a flexibility to meet people on their own terms and work across different settings such as primary care, hospitals as well as traditional outreach.

AUTHORS

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Dr. Best is Professor of Criminology at the University of Derby and Honorary Professor of Regulation and Global Governance at Australian National University. Trained as a psychologist and criminologist, he has worked in practice, research and policy in the areas of addiction recovery and rehabilitation of offenders. He has authored or co-edited five books on addiction recovery, and has written more than 180 peer-reviewed journal publications and around 70 book chapters and technical reports.

Mulka Nisic, *Regional Project Coordinator, Association Celebrate Recovery, Bosnia and Herzegovina*

Mulka Nisic holds a degree in Political Sciences from the University of Sarajevo, specializing in Social Work and has undergone a number of trainings in the field of Psychology, Recovery from addiction and Drug policy. Ms Nisic has been actively involved in recovery and drug policy field since 2015 when she started working as a Regional project Coordinator at the grassroots recovery organisation in her home country Bosnia and Herzegovina and as a Communication Officer at the European network for prevention, treatment and recovery - EURAD. She has represented the Western Europe region serving on the Civil Society Task Force on Drugs for the Ministerial Segment of the 62nd Commission on Narcotic Drugs in March 2019. The Task Force serves as the official liaison between the United Nations and civil society.

Neil McKeganey, *Director, Centre for Drug Misuse Research, UK*

Neil McKeganey holds a PhD in sociology and 1994 he set up the Centre for Drug Misuse Research at the University of Glasgow. 2011 he led the development of the Centre as an independent research group. Neil McKeganey is the author of over 150 peer-reviewed papers on aspects of addiction and drug use, and author of eight books. Current research underway within CDMR includes work on the impact of major drug seizures, the effectiveness of prison based drug treatment, the relative effectiveness of different drug treatment modalities, research on users experience of electronic cigarettes and the impact of nicotine policy.

Stuart Green, *Manager, ASPIRE Drug and Alcohol Service, Doncaster*

Stuart Green has worked in the field for over 16 years and he is also part of the Yorkshire and Humber Recovery Forum. Amongst his wide range of experience he has worked in a residential rehab setting in London, as a front line practitioner in Doncaster which then led him into developing an outreach programme and service within Stainforth. His key achievements have been supporting the initial launch and development of the New Beginnings Programme in 2005 which lead him onto managing the New Beginnings Service. Since November 2013 Stuart has been managing the Drug and Alcohol Service for Doncaster.

SAMSHA

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Borislav Goic, *President, Association Celebrate Recovery, Bosnia and Herzegovina*

Boro Goic has been actively involved in the drugs field since 2004. In 2008 he co-founded and became President of the NGO Celebrate Recovery and since then he has actively participated in work and establishment of similar organisations across Balkan Region. He is one of the initiators of the regional recovered users yearly conference in Sarajevo. 2012 Mr. Goic became a Chair of Recovered Users Network- RUN and a board member of the European network for prevention, treatment and recovery - EURAD. He was one of the members of the Working Group in the process towards creation of the new national drugs Strategy 2019-2023.

PROSLAVI OPORAVAK

NVO za resocijalizaciju bivših ovisnika.

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