Review of: "The HERMESS model for addictive behaviors recovery"

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Antonio Jesus Molina-Fernandez's article in *Qeios* provides a lovely introduction to the HERMESS model for addiction recovery in Europe. He describes a well-integrated and multidisciplinary biopsychosocial model for uniting harm reduction and recovery work. As a former worker in public health policy and a medical anthropologist working on addiction in China, with experience in the United States and Canada, the model sounds ideal, a proper integration that moves beyond mere detoxification programs. As specified in the article, the program makes rehabilitative sense, but what happens an ideal program is operationalized to apply to to real life situations on the ground? For example, how are all these services funded and integrated to provide someone with long-term recovery interventions over time? Indeed, in the United States, there is always a battle between privately funded services in the 'distress industries' and public health services for indigent members who are homeless/addicts living hand to mouth. It is well documented that homelessness exacerbates addiction as drugs become a means of coping with living on the streets. Anecdotal evidence from Montréal during the COVID pandemic found that providing stable housing for addicted COVID-positive individuals reduced their reliance on ETOH because they had a reliable daily source in line with harm reduction. However, I note that housing was temporary. It would be fruitful to hear more about the implementation of this project, thus demonstrating how a multi-factorial project works and how successful it was (or not). For example, in the State of Vermont, there are considerable gaps in similar wrap-around service models because of a lack of funding to meet addicts where they are and provide social services like stable housing, addiction counseling that does not rely on a Narcotics Anonymous model (where abstinence is a mandatory starting point), and addressing how one would coordinate these multidisciplinary teams, e.g., psychiatrists, peer educators, social workers, housing development specialists, and job counselors.

In the interest of dialogue, I have a couple of questions for the author. Molina-Fernandez states that a successful recovery program assesses/addresses individual needs and finds the best way forward, starting with root causes rather than the aftermath of addiction that requires long-term solutions. Since relatively accessible longer-term solutions, like those offered in therapeutic communities, seem to have gone with the West wind and in their place are nominal projects that only address one type of service, e.g., housing precarity or pharmaceutical access to Narcan/Methadone/Naltrexone provided by public health outreach workers and public clinics/hospitals, how would you plan to integrate these different levels of services across a wide-swathe of government bureaucracies in several different European countries? Also, there appears to be no mention of the role of the media in terms of outreach and allaying the fears of a jittery population that midunderstands the needs of addicts in recovery. To conclude, I would be interested in how this HERMESS system bypasses some of the work on abstinence-only addiction programs. Thank you.