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The HERMESS model for addictive behaviors recovery

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Funding: Funding for this study was provided by “HOME/2014/JDRU/AG/DRUG/7092 Triple R: Rehabilitation for Recovery and Reinsertion project”. Triple R Project was funded with support of the European Commission. This publication reflects only the views of the author and the European Commission cannot be held responsible for any use which may be made of the information contained therein. European Commission had no role in the study design, collection, analysis or interpretation of the data, writing the manuscript, or the decision to submit the paper for publication.

Potential competing interests: No potential competing interests to declare.

Abstract

Addictive behaviors treatment networks are composed of harm-reduction services and recovery-oriented programs. Recovery is a perspective in addictive behavior intervention based on the empowerment, competencies, and life skills of a person with addictive behaviors. Recovery-oriented programs have advanced from traditional therapeutic communities to actual integral services, which are integrated into main international standards and manuals about addictive behavior interventions. There are different experiences valid to define proper recovery treatments. Different methodologies have been used to study addictive behavior recovery programs, either quantitative or qualitative strategies. The main conclusions are: recovery-oriented programs must be integrated and connected with harm reduction networks, social services, health systems, and employment services; recovery is based on empowerment and peer social support, so it's necessary to develop structured programs for these topics; it's also necessary to create specific actions for several collectives, as develop evaluation systems to validate efficiency and adequacy of recovery-oriented programs. As a main conclusion, the HERMESS recovery model was developed to be a reference for new recovery-oriented programs.

Keywords: Addictive behaviors, recovery, good practices, transference, treatment network

1. Recovery into addictive behaviors treatment network

Drug treatment policies and intervention practices in addictive behaviors are based on harm reduction, recovery, and sustainable livelihoods (UNODC, 2012). International consensus is clear regarding the need to broaden these problems using the biopsychosocial perspective (Hall, Carter & Forlini, 2015) and any kind of intervention should include topics such as 'recovery' (Yates& Malloch, 2010) and 'social support' (Uchino, 2014) to be effective in the long-term (UNODC, 2012).

Recovery (Yates& Malloch, 2010) is an important concept regarding the treatment and rehabilitation of addictive behaviours. It means not merely reducing or eliminating the use of drugs (including alcohol) (Moos & Finney, 2011), it

means to become an active member of society (Yates & Malloch, 2010). Moreover, it also does not mean a process of 'natural recovery' by which the addicted individuals (Moos Finney, 2011).

2. Recovery: keys and concepts

Best, Bliuc, Iqbal, Upton, and Hodgkins (2017) define the following three concepts linked to recovery: 1) Contagion is the capacity of a person in recovery to influence his/her social context; 2) Connection is the capacity to build community and society; and 3) Homophily is a tendency to relate to and bond to individuals that are similar to us.

Granfield and Cloud define 'recovery capital' as the following: "... the breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery from AOD [alcohol and other drugs] problems" (Granfield & Cloud, 2001). There are three phases to recovery capital (RECCAP): 1) Scientific assessment of strengths and weaknesses; 2) Planning the individual's care in relation to their strengths'; 3) The recovering individual having strong and solid links with groups and activities oriented to recovery.

From White and Cloud (2008, p. 23):

"Recovery capital constitutes the potential antidote for the problems that have long plagued recovery efforts: insufficient motivation to change AOD use, emotional distress, pressure to use within intimate and social relationships, interpersonal conflict, and other situations that pose risks for relapse. (...). Strategies that target family and community recovery capital can elevate long-term recovery outcomes as well as elevate the quality of life of individuals and families in long-term recovery".

For these authors, there are three phases for the identification of recovery capital (RECCAP): 1) Support screening and brief intervention (SBI) programs; 2) Assess recovery capital on an ongoing basis; and 3) Use recovery capital levels to help determine the level of care placement decisions. In this sense, Best (MacGregor, 2012) divides this "recovery capital" into three aspects:

- Personal Recovery Capital: skills and abilities recovered/empowered during the rehabilitation process, especially emotional skills.
- Social Recovery Capital: Impact of recovery in social groups, especially family and social networks.
- Collective Recovery capital: Impact of Recovery in a social context, especially cost/benefit balance (MacGregor, 2012).

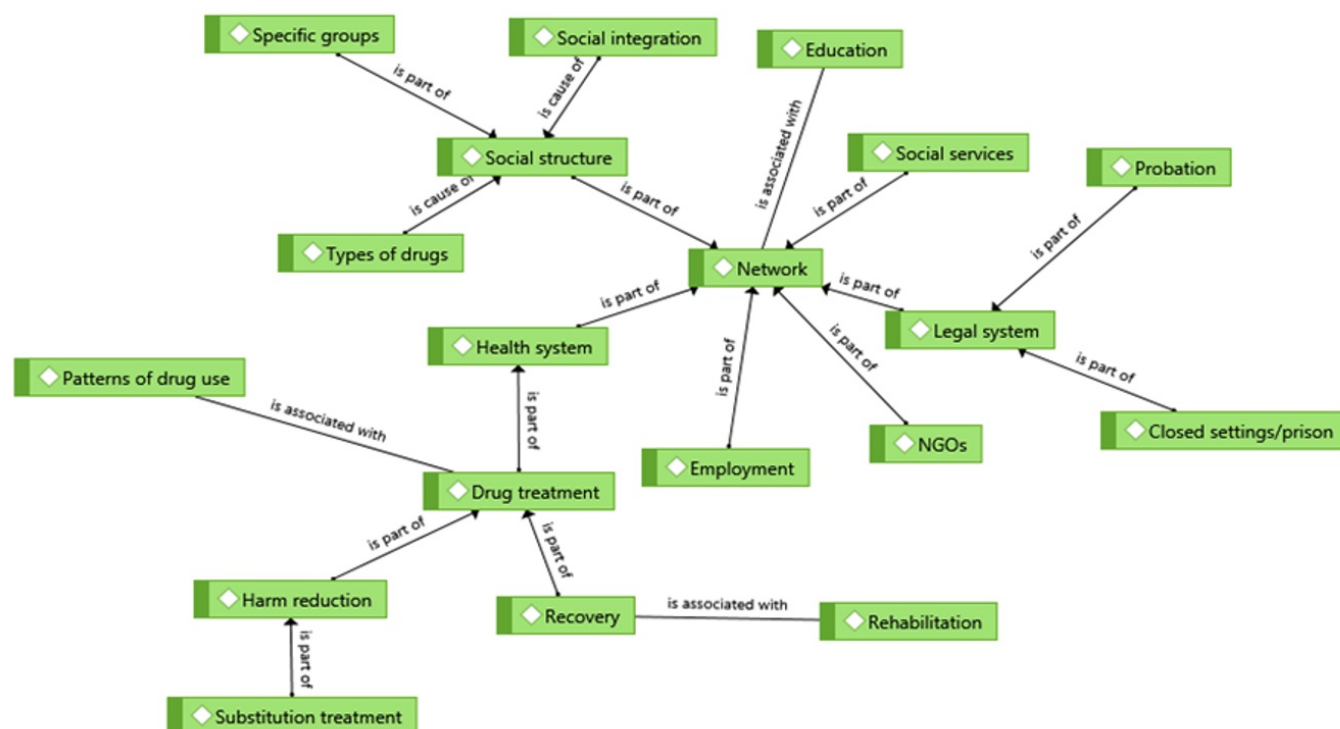


Figure 1. Addictive behaviors treatment network (including Recovery) map of categories.

3. Models and international experiences

The coordination between the health system (especially pharmacological treatments and substitutes, as well as medical protocols) and other services that participate in social intervention in addictive behaviors is another aspect to which attention needs to be paid (Bumbarger & Campbell, 2012). This coordination, which is perceived as very beneficial and clearly improves the efficiency of networks and services, requires professionals who are used to working in multi-disciplinary situations (Molina, Montero, González y Gómez, 2016).

There are programs that are already working with these problems in a standardized way, such as the programs in the city of Ghent that use the “*CHIME Model: Framework of elements of psychosocial support for personal recovery*” (Leamy, Bird, Le Boutillier, Williams & Slade, 2011), in collaboration with the University of Ghent (MacGregor, 2012; Vanderplasschen, Vandeveldel & Brockaerst, 2014). This model is based on the perceived social support and the degree of usage of available resources and capacities. CHIME is the acronym for the various resources included in the model:

- Connectedness (Connection and social support networks)
- Hope (Hope and motivation)
- Identity (Social and personal identity)
- Meaning (Meaning that the person gives to the social support network)
- Empowerment (Empowerment; personal and social skills)

Another experience in health promotion is the development of social recovery models, “Recovery cities” (MacGregor,

2012). The “recovery cities” models are already being utilized in cities such as Goteborg and Stockholm (Sweden) in reducing risk situations due to drug use and associated problems (especially crime and socio-health emergencies), as well as to improve coexistence and citizen participation (Best, Bliuc, Iqbal, Upton & Hodgkins, 2017).

Another experience that emerged from the project “*HOME/2014/JDRU/AG/DRUG/7092-Triple R: Rehabilitation for Recovery and Reinsertion*” (Barzanti, Blixt, Carrena, DiRenzo, Franzen & Molina, 2017) was the named “*Triple R HERMESS model*”. HERMESS presents the key concepts selected from the process of transfer from good practices during the Triple R project. The acronym HERMESS stands for:

- **H-human centered**
- **E-empowerment aimed**
- **R-reintegration oriented**
- **M-motivational driven**
- **E-educational embedded**
- **S-self sustainability focused**
- **S-social need oriented**

The image below is presenting the key elements as a Visual Chart, highlighted as lessons learned that could help professionals, practitioners, and policymakers interested in knowing more about the essence of the rehabilitation programs.

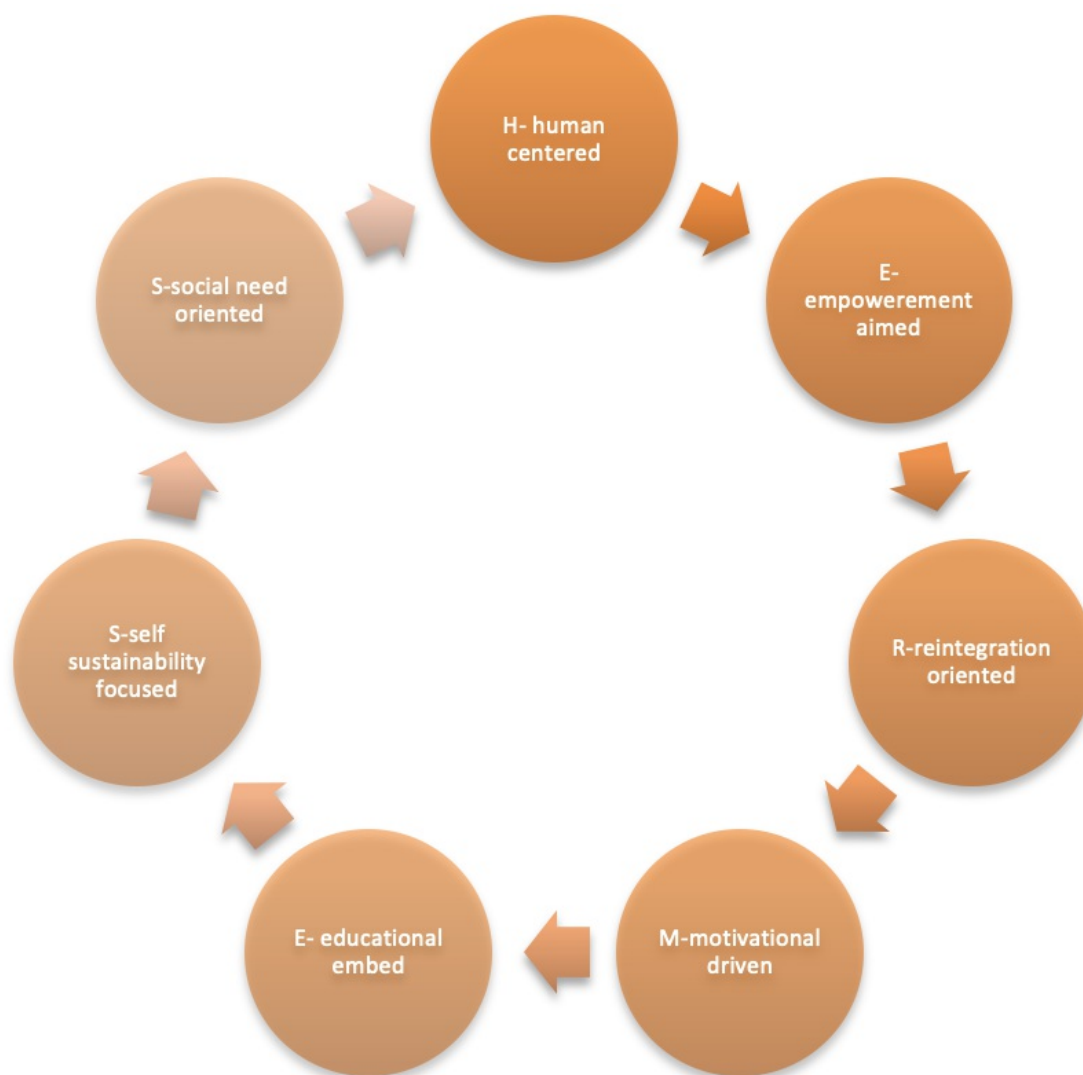


Figure 2. HERMESS model visual chart.

Human-centered

A successful recovery program is one that assesses and addresses individual needs and finds the best way toward rehabilitation and recovery. Human beings and not the substance or drug of choice should be seen as the core center of the program. Working on the root causes or the co-causes that led people into addiction is the key to helping out those who decided to quit their addiction. One other key aspect of human life is time. Although in some cases the rehabilitation program needs to follow a timeline, due to the public contributions or the funds to run the rehabilitation center, it emerged clearly from the project lessons learned that after years of addiction, a true recovery takes time, and the program should be a long term one. Different options have been shown on how to make projects self-sustainable and allow the person in recovery to stay longer in the community setting if needed, in order to be ready for social reintegration. Allowing time for behavioral change is also a very important component of the individualized process recovery programs strongly recommend.

Empowerment aimed

The ultimate purpose of recovery is to empower people and to provide ex-drug users with the necessary self-esteem, life, and professional skills they have been lacking due to drug addiction. HERMESS sees recovery as a personal journey, where the individuals are actors for change, overcoming their fears and leading the foundation of a new drug-free life. Different ways or methods have been explored in order to achieve empowerment or autonomy, as some of the partners also call it. Some approaches are more focused on work, professional training, and learning by doing, some others prefer psychological therapy, both individuals or in groups.

Reintegration oriented

HERMESS shows how the recovery path is intrinsically connected with the social reintegration. All the study cases presented underlined the importance of seeing the continuum between rehabilitation and social reinsertion. Social reintegration is considered the farther step of the recovery. Social reintegration is also embedded in the planning, and the activities carried out in the rehabilitation are functional to the achievement of successful reinsertion.

Motivational driven

Recovery has been defined as a personal journey where motivation is the trigger for change at the beginning of the program. It is also the force that keeps people in treatment going facing the challenges of rehabilitation and boosting self-esteem while an initial change is achieved. Motivation plays a role in learning about ethics and in taking the right decision, abandoning shortcuts, and embracing commitment while getting a profession, a career, and building up a better future for oneself and the beloved ones.

Educational embedded

HERMESS model insists on the role to be played by education in recovery programs. Interrupted studies are not enough to face the challenges of today's demanding labour markets and earn a living. Formal, non-formal, and informal education, professional training, learning foreign languages and IT programs, and getting degrees, are all important aspects to be included in the rehabilitation program and should be an integral part of it and not as an appendix. Education is an investment for the future, exactly as recovery and they will mutually benefit from each other, being included in the rehabilitation programs.

Self-sustainability focused

According to each organization's peculiarity, ways have been recognized to enhance self-sustainability. Securing public funds, private donations, or having services and goods to be purchased in the market are options to be looked into while offering a rehabilitation program. For this reason, HERMESS suggests that self-sustainability should be included in the long-term goal of the organization and provide inspiration on how to shape activities and services toward achieving

operational autonomy of the organization. In doing so, each rehabilitation center would secure the opportunity to provide the best services and have the final say on the duration and the implementation of the recovery programs offered, making the program sustainable for their residents and clients as well.

Social need oriented

In the HERMESS model emerges repeatedly the necessity and the call to go far beyond addiction. New forms of interventions could be created, merging also approaches or target populations, to create innovative solutions for the organizations and their beneficiaries and the community as a whole.

4. Conclusions

People in addictive behavior treatment don't need only pharmacotherapy or psychosocial support. They want to find a job, to be active members of society, and to participate in their communities. To be persons again (Cañas, 2003). An adequate socio-health and psychosocial intervention is important to reduce these problems (Boyle & Johnstone, 2014), with social support (Uchino, 2004) and specific attention to the very profile of a person with addictive behaviors problems (Bumbarger & Campbell, 2012). It seems appropriate to adapt the current programs to the various populations at risk, in addition to evaluating the limitations presented by the current programs on addictive behavior in order to adequately address and understand the needs and problems of people who could utilize these services. To go far beyond the substance, to find a way to help the person. This is the recovery pathway (Yates & Malloch, 2010).

Acknowledgment

The author wishes to thank T.C. San Patrignano, Triple R project partners, as well as Mirjana Vojinović, Darko Condic, and Sinisa Panic for their collaboration during the study.

Funding

Funding for this study was provided by "HOME/2014/JDRU/AG/DRUG/7092 Triple R: Rehabilitation for Recovery and Reinsertion project". Triple R Project was funded with the support of the European Commission. This publication reflects only the views of the author, and the European Commission cannot be held responsible for any use which may be made of the information contained therein. European Commission had no role in the study design, collection, analysis, or interpretation of the data, writing the manuscript, or the decision to submit the paper for publication.

Conflict of Interest

The author has disclosed no potential conflicts of interest, financial or otherwise.

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