recovery plus

How to help addicts into long-term enriched recovery

Recovery research

SPECIAL ISSUE GUEST EDITED BY JASON SCHWARZ
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WHAT'S ESSENTIAL FOR RECOVERY TO HAPPEN?
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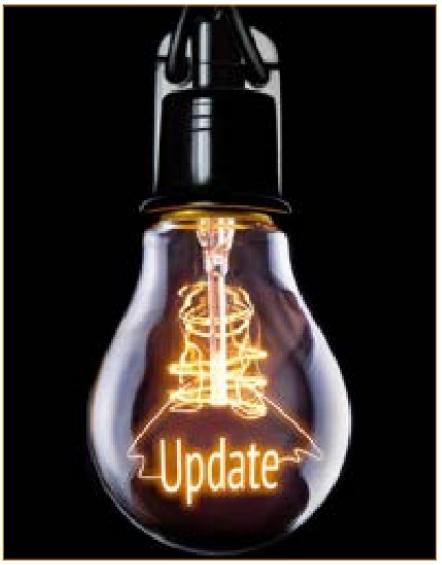
How to build trust



Research findings on addiction and recovery can often be confusing, unintentionally or not. Media reports and experts often make strongly worded statements that are contradicted by statements from other media sources and experts. Other times, they seem to negate or minimise the lived experience of people with drug or alcohol problems and their families. And often the research does not cover what matters to us.

For example, it's very common for press releases, media reports and, occasionally, researchers to make statements about a study demonstrating the effectiveness of a particular intervention. Other times, we hear people say something like, "science shows that [insert intervention] works." However, when we look closely at the study, we sometimes find that the outcomes don't fit our idea of "effectiveness" or "works". Further, the conditions and subjects don't resemble the real world.

This isn't confusing just for lay people, it's confusing for professionals and policy makers too. And, to make matters worse, many people are reluctant to question statements presented as science or evidence-based.

But this is essential when we advocate for funding to save lives.

For these reasons, this issue of *Recovery Plus* journal is dedicated to work by Jason Schwartz. He was our first guest editor in 2019 and now returns to share relevant recovery research with our readers.

He reminds us of questions to ask that will hopefully allow anyone to review a study and evaluate its relevance to their goals rather than relying on the reporting of others, who might see things through their own bias.

- What is the treatment or intervention being studied?
- Who were the subjects?
- How long was the study?
- What outcomes did the study measure? (How did they define success?)
- What were the study methods?
- What were the actual findings and does the authors' discussion accurately represent the findings?
- Were there any conflicts of interest (real or potential)?
- What questions does the study not answer?

Click on the orange button beside each article to be automatically brought to it.

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Participate in World Drug Day at Recovery Plus 25-26 June 2020, London.

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News: April 2021

Changing habits during a year of Covid

34.4% of people reported a change in their drinking habits over the past year, and of those 49.1% say they are currently drinking more alcohol compared to March/April 2020, University College London found as part of the Covid-19 Social Study.

In relation to this, the House of Lords debated a motion in Grand Committee, moved by Baroness Finlay of Llandaff: To ask Her Majesty's Government what assessment they have made of the report by the Commission on Alcohol Harm It's Everywhere—Alcohol's Public Face and Private Harm.

One in seven Brits admit they are drinking more alcohol than before – and there are other addictive habits developed over the past year, too, such as gaming, porn, playing the lottery and online shopping. So psychologist Sirin Atçeken explained how to deal with addictive habits developed in lockdown.

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'Right to rehab' plans

The scottish Conservatives will bring forward 'right to rehab' plans after recovery experts warned Scotland's drugs deaths figures will rise due to treatment delays. Scotland has the worst drugs death rate in Europe, about 3.5 times worse than England & Wales. Douglas Ross, leader of the Scottish Tories, wants to enshrine people's right to access residential rehabilitation services into law, to prevent denial of treatment.

Four reasons why your tolerance to alcohol can change

While some evidence suggests alcohol consumption increased during lockdown, other reports suggest that over one in three adults drank less – or stopped altogether. Either way, drinkers' alcohol tolerance can change, via several mechanisms. Here Sally Adams of University of Bath describes four ways that tolerance can develop and change: functional tolerance, environmental-dependent tolerance, learned tolerance and metabolic tolerance.

Signs of the times...

NHS INPATIENT UNITS OFFER INCOMPARABLE TRAINING FOR MEDICAL PROFESSIONS

NHS inpatient units provide the treatment that people with life-threatening addictions desperately need – and offer crucial on-the-job experience and training for medical and nursing trainees in the field of addictions that isn't available anywhere else, the NHS Addiction Providers' Alliance advocated.

SAMARITANS URGES GAMBLING INDUSTRY COMMITMENT TO SUICIDE PREVENTION

The Samaritans published its first best practice guidance for the gambling industry, in a bid to tackle the link between gambling and suicide: "Suicide is preventable and different industries need to address specific challenges in order to have effective suicide prevention practices in place," it explained.

LOCKDOWN: "I'M SEEING MORE ALCOHOLICS IN A&E THAN EVER"

"If there's one word on the A&E dashboard screen that really makes my heart sink, it's not "Covid" but "intoxicated" – and I'm seeing more and more of it," the 'secret medic' shared. Without proper investment in preventing alcohol abuse, the NHS will be left in the lurch for years to come.

News: April 2021

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Big Pharma money gets diverted

Addiction recovery agencies want to redirect big pharma settlement money. For example, New York State received $32million in a settlement with major pharmaceutical company McKinsey & Co but "$11million went into medically assisted treatment for those that are incarcerated, the other $21million went to a general fund, which is unacceptable". There are at least 11 more pending opioid lawsuits similar to the McKinsey suit, and lives could be at stake if the settlement money from them is not handled properly.

Fighting barriers to addiction care, this time insurance denials, the Kennedy Forum and the National Alliance on Mental Illness released The Health Insurance Appeals Guide: A Consumer Guide for Filing Mental Health and Substance Use Disorder Appeals. Patients go out of network over five times more often for behavioural health care than for physical health care.

More replacement drugs, less counselling

Biden administration guidelines mean doctors and other health workers will no longer need extra hours of training to prescribe buprenorphine – and they no longer have to refer patients to counseling services. The latter addresses causes, the former is a bandaid.

Exposure to drugs of abuse induce effects across generations

Notably, not all people who use addictive drugs develop a substance use disorder. Substance use disorders are highly heritable, but patterns of inheritance cannot be explained purely by Mendelian genetic mechanisms. Vulnerability to developing drug addiction depends on the interplay between genetics and environment. And evidence from the past decade has pointed to the role of epigenetic inheritance in drug addiction, University of Pittsburgh said as it showed that parental exposure to drugs of abuse has enduring effects that persist into subsequent generations.

Signs of the times...

WASHINGTON LAWMAKERS HAVE RE-CRIMINALIZED DRUG POSSESSION

On 24 April, Washington's state Legislature passed Engrossed Senate Bill 5476, a direct response to the Supreme Court's decision to decriminalize all drugs. The bill makes simple possession of controlled substances illegal again, as a misdemeanor rather than a felony.

DOCTORS PRESCRIBING OPIOIDS TO COVID 'LONG HAULERS' RAISE ADDICTION FEARS

Washington University et al found alarmingly high rates of opioid use among Covid survivors with lingering symptoms at Veterans Health Administration facilities, raising fears of addiction.

BETTY FORD CENTER: $30MILLION EXPANSION AND RENOVATION

The Betty Ford Center will break ground on a four-year, $30million project – to include three new buildings and updates to the grounds – in its California treatment center which was famously founded by former First Lady Betty Ford and former US ambassador Leonard Firestone in 1982.

News: April 2021

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WHO alcohol policies for Europe

The World Health Organization European Region had an overall fall in alcohol consumption levels – but this is linked to only a small number of countries. With a few notable exceptions, western European countries made little or no progress in the reduction of alcohol consumption. Alcohol is a psychoactive and dependence-producing substance classified as a Group 1 human carcinogen, along with other cancer-causing substances such as asbestos, radium and tobacco. It is recognised as a cause for over 200 diseases and injuries and, in the European Region alone, alcohol use leads to almost 1million deaths each year – about 2,500 deaths every day. WHO/Europe's research suggests that overall alcohol consumption will remain close to current levels in the next 10 years. "Alcohol is no ordinary commodity and should not be treated as one. It hits the most vulnerable," explained Dr Nino Berdzuli, a director at WHO/Europe.

Impact of Covid-19 on drug markets

During the 64th session of the Commission on Narcotic Drugs, the impact of the pandemic and the need to engage in joint efforts to recover better were discussed in both the plenary and side events. Click here to learn more from the United Nations.

Lockdowns, PTSD and eating disorders

Covid-19 and its resulting lockdowns have been linked to post traumatic stress disorder symptoms and other adverse outcomes among patients with eating disorders, two new studies – from Università Degli Studi Di Milano and University of Florence – show. The first study found that, during lockdown, eating disorder patients had significantly higher stress, anxiety, depression, PTSD- and ED-related symptoms, with only the last two easing after lockdown. The second study found similar harms and interference with the recovery process.Patients with early trauma or insecure attachment were particularly vulnerable.

In brief...

NETHERLANDS: 'LOGISTICS PROCESS WIDE OPEN TO DRUGS CRIMINALS'

Drugs gangs have the run of the logistics process at Rotterdam port – the Netherlands is the main european distribution centre for drugs and Rotterdam port is key because of widespread corruption.

IRELAND: 3,500+ ON WAIT LIST FOR A DETOX BED, 143 RESIDENTIAL BEDS CLOSED

Over 3,500 people were waiting for a drug or alcohol detox bed in Ireland, as of February, with over 2,200 on the waiting list for at least nine months – ascribed being due to "the necessary Covid-19 safeguards", according to the Department of Health.

RETRACTED: 'SCIENTIFIC' PAPER CLAIMING SMOKERS LESS LIKELY TO ACQUIRE COVID

A 'scientific' paper in the *European Respiratory Journal* claiming smokers are 23% less likely to be diagnosed with Covid-19 compared to non-smokers has been retracted, after it was discovered some of the authors had financial links to the tobacco industry.

REAPPRAISING ADDICTION IN LIGHT OF GENOME STUDIES

Genes initially studied in addiction genetics were chosen because they were the most "obvious". University of Toledo analysed how these and genome-wide approaches necessitated certain assumptions – which now appear to be incorrect.

MACRON CALLS FOR CHANGE IN LAW AFTER KILLER AVOIDS TRIAL

After a man who killed his neighbour successfully pled that he was unfit to stand trial because of a marijuana-induced psychotic episode, President Emmanuel Macron called for a change in France's legal system.

What's vital for recovery to happen?

We know mutual aid works to help people with substance use disorders achieve their goals. The recent Cochrane Review which analysed the evidence for Alcoholics Anonymous reported impressive results. John F Kelly, Keith Humphreys and Marica Ferri "determined that... most studies showed that AA participation lowered health care costs".

Although the focus of the research has been more on AA than other types of mutual aid, Humphreys said that their review was 'certainly suggestive that these methods work for people who use heroin or cocaine'. In fact, these days, in my practice, it's much more common to see people with problematic poly-drug use, so it would help to know more about the range of supports available.

So, we know that mutual aid works to help people achieve their goals, but how much do we know about how it works? In his 2008 review, Rudolph Moos identified 10 key 'ingredients' at the heart of the process in 12-step groups.

- Bonding
- Direction
- Structure
- Observation and imitation of norms and role models
- Expectation of positive & negative consequences
- Involvement in protective activities
- Effective rewards
- Identification of high risk situations & stressors
- Building self efficacy/confidence
- Developing coping skills.

So, it looks as if we know quite a bit about how it works too, but we are still learning new things.

Some of this new learning was captured in a recently published study from the UK. Hannah Rettie, Lee Hogan and Miles Cox wanted to know if such processes might also apply in non-12-step groups and if there might be anything else relevant that wasn't on the list. They had the sensible notion to ask the people who had experience of such groups how important they felt these components were.

Using social media, flyers and active recruitment through the groups, they attracted 151 participants from 30 groups, including 12-step, Smart Recovery and non-structured lived experience community groups. Participants had to be alcohol or drug free, with a previous history of dependence and regular attendees. On average, the subjects had been members for over two years and had a mean age of just over 42 years. 30% had previously had an alcohol problem, 20% a drugs problem and the rest had used both alcohol and drugs problematically.

They asked the participants to think about their group and to score how important each ingredient on the list was to them and how much that component was represented in the group they were a member of. They were also asked a couple of open questions. The researchers divided one of the ingredients (no. 4) into two – 'presence of role models' and 'following a sober lifestyle' and added another ingredient 'giving back to others'. They teased out five pertinent themes from the open-ended questions, as follows:

1. Perspective taking: e.g., getting a new angle on a problem through discussion with others

We know that mutual aid works to help people achieve their goals, but how much do we know about how it works? Dr David McCartney summarises some key research for us.

About the author

Dr David McCartney (@DocDavidM) is an addiction medicine specialist working in an NHS residential rehab (LEAP) in Lothian. He is chair of the Scottish Government's Working Group on Residential Rehabilitation. He blogs at Recovery Review.

Listen to David's recovery story here.

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2. Being connected to others: eg, strong bonds, reciprocal support, not doing it alone
3. Developing skills: e.g., coping skills, confidence, useful outside of the group too
4. The value of group activities: e.g., replacing using and drinking time, hobbies and areas of interest
5. A change in the self: e.g., from rock bottom to recovery, gaining hope, new lease of life.

These themes were apparent in both 12-step and non-12-step groups.

Testing out the list of key components of recovery success, the researchers found that, across the variety of groups, every ingredient was both offered by the group and rated highly by the group members. Interestingly, 'gaining rewards' was not rated as high as other factors. Type of group, length of membership and time in recovery did not influence the ratings.

The research team updated the original table of important components of recovery groups to look like this:

- Bonding and support
- Goal direction
- Structure to follow
- Following a sober lifestyle
- Available role models
- Expectations of positive and negative consequences
- Involvement in protective activities
- Effective rewards
- Identifying high-risk situations
- Building self-confidence
- Developing coping skills
- Giving back
- Presence of like-minded individuals
- Developing self-awareness and reflection skills.

Encouragingly, these findings suggest universal experiences in mutual aid and lived experience recovery organisations, though not if these experiences translate into longer term quality of life and sobriety outcomes relating to type of support. It's important to note that the authors acknowledge potential bias due to recruitment methods, so this might not be applicable to all recovery groups, though it rings true. I did wonder if there was crossover in the sample, given that people can be a member of a 12-step group, a Smart Recovery group and an activity-focussed recovery group at the same time.

I like the respect the researchers have for people with lived-experience – "true experts" – something that's not universal. Mutual and and wider lived experience recovery organisation research is quite rare in the UK. This really helps add to our understanding of what the important features in recovery groups are. It adds to our previous understanding. It also gives support to the 'many pathways to recovery' perspective.

Connection is at the heart of the recovery process. In my experience, many recovering people are members of more than one lived experience recovery organisation, including mutual aid. I believe that every extra recovery connection is likely to advance and support an individual's recovery and help them flourish, and that we should be promoting and actively connecting service users to a diverse range of groups offering the components in this article.

How can 'evidence' contradict facts?

This year, I've seen several people writing on the subject of substance use disorder treatment calling for us "to stick with the evidence" of what works. Research evidence should, quite rightly, inform policy and practice.

There's an assumption underlying this premise and it's a big one. The hierarchical ladder of research methodology is based on the scientific method and on the premise that it is possible to understand the world in which we live in terms of cause and effect. As it turns out, life's a bit more messy.

The randomised controlled trial (RCT).

In terms of effective research structures, the randomised controlled trial stands tall. It's the typical standard that researchers use to reassure us that an intervention is causing an effect. In my GP days, I was involved in RCTs exploring medications for various health conditions – they often shifted practice to improve treatment outcomes for patients.

Methodologies like the RCT provide results that can lead to evidence-based practice. In medicine this has been defined as: "the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients" (Sakett et al, BMJ 1996).
I'll draw your attention to the word "current". Here's the thing: we don't know what we don't yet know. We're even less likely to get to know it if we're not looking for it. The evidence base for interventions is undeniably not complete, which means when people say, for example, "there's no evidence that residential treatment works to help people achieve their goals", it doesn't mean that residential treatment does not help people achieve their goals. In fact as many have shown, there is evidence for residential treatment but it does need to be better developed. One might question why the evidence lags a bit. Is it because few are looking for it?

Recovery and the randomised controlled trial.

When the scottish government began to develop its previous drugs strategy in 2007 – The Road to Recovery – resistant voices claimed that there was "no evidence" to support recovery. They cited data to show that, in terms of the evidence base, opioid replacement therapy was the most solidly-based treatment for those with opioid use disorder.

There is generally agreement that those voices were right in terms of where the weight of the evidence lay. But the issues are more nuanced that they might first appear. If you look at the end points studied: reduction in illicit drug use, reduction in deaths, reduction in blood-borne virus transmission and reduction in crime, then the evidence for those things is there. But when you begin to examine quality of life outcomes, the evidence is less solid.

I believe in medication assisted treatment (MAT), but I'm also open to examining its shortcomings. In the British Medical Journal, Sanger and colleagues (2018) wrote: "Recent guidelines indicate there is little consistent evidence to evaluate the effectiveness of MATs. Reviews evaluating MAT effectiveness have found great variability in outcomes between studies, making

Why does research lag behind experience? Is effectiveness too hard to study? "Life is messier than the hierarchical ladder of addiction research methodology," Dr David McCartney explains.

it difficult to establish a real treatment effect. Each study measures a different set of treatment outcomes that define success in arbitrary or convenient terms".

The authors add that "This is a substantial limitation in addiction research that must be overcome to reach a consensus on which treatment outcome domains should be the goals. So even when the evidence appears strong, there are still issues to be resolved".

When it comes down to recovery research evidence, it's not only that the research focus is not on recovery – part of the issue is that it's also hard to pin down precisely what recovery means, which makes it difficult to study. Nevertheless, in 2010, the review of the evidence base – Research for Recovery – found that there was evidence to support recovery.

A problem with the evidence imbalance is that medicalised treatment is easier to study than complex, multiple-stranded psychosocial interventions. One lends itself to the RCT and one does not. And if all you study are medication-based interventions it's technically correct to say that's where the evidence lies (although, as before, there are legitimate questions about which end points you use to cite efficacy). But what matters to researchers and the public health agenda might not be what matters to patients.

RCT strengths and weaknesses.

In his book Circles of Recovery, Professor Keith Humphreys of Stanford University lays out the strengths and weaknesses of the RCT. He points out that it has high internal validity – a strength. This means we can make robust inferences about a treatment effect. He goes on to make the point that there are difficulties with generalisability and utility.

RCTs will usually have inclusion and exclusion criteria. In terms of the trial, who is allowed to join it will limit how far we can apply the findings in everyday practice. I've been involved in research using RCT methodology. Typically we will exclude people with major physical health problems (eg, hepatitis C) and major mental health disorders (eg, depression, self-harm, personality disorders, eating disorders, bipolar disorder, past history of psychosis etc). In other words, we exclude the sort of people we see every day in our work. Typical patients. This has an obvious impact on what happens when we apply the research to real-life practice.

Generally you need to get large numbers of people enrolled in RCTs to 'power' them. Large populations mean you establish 'central tendencies'. The evidence that is gathered might not be applicable to individuals – in other words to you and me: it's not necessarily 'externally valid'.

Then there's bias – pharmaceutically-funded studies tend to favour the medication being trialled, all of us have our own acknowledged or hidden biases and there are too many bits of research unpublished because they didn't show the 'right' results. Bias and spin can also affect what folk do with study evidence.

"Academics interviewed repeatedly acknowledged the urgent need for better research into the effectiveness of a whole range of treatments and interventions."

About the author

Dr David McCartney (@DocDavidM) is an addiction medicine specialist working in an NHS residential rehab (LEAP) in Lothian. He is chair of the scottish government's Working Group on Residential Rehabilitation. He blogs at Recovery Review.

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It's not hard to rubbish research and it's not hard to bend it to make it appear to say something it actually doesn't say or to fail to highlight uncomfortable findings.

Fortunately, RCTs are not the only way to get accurate results. Humphreys confirms that "the common conviction that RCTs always generate more accurate estimates of treatment effects is simply incorrect". But the grading of evidence is biased towards RCTs, meaning that other useful research can be inadequately considered or overlooked (Irving et al, 2017).

Opportunities and challenges.

So, in addiction and recovery research we need to be careful how we set up research and how we interpret and use it. Being overconfident can be harmful, just as ignoring the evidence can be. We need to be open to other ways of evidencing the impact of treatment and recovery community support and interventions.

We can get caught up in that catch 22 that the RCT is not the best methodology for studying recovery interventions and processes. Yet, we'll still look almost exclusively to RCTs or 'high rungs' on our evidence ladder for evidence to guide our practice.

Practice-based evidence.

One way of reframing evidence-gathering is to use the concept of practice-based evidence. In this approach, "the real, messy, complicated world is not controlled" (Swisher, 2010). "Patients are not controlled as research subjects, who must meet certain inclusion/exclusion criteria. Rather they are grouped together by factors they share. This type of research respects that people are complex, and don't readily fit the "cause and effect" model of science."

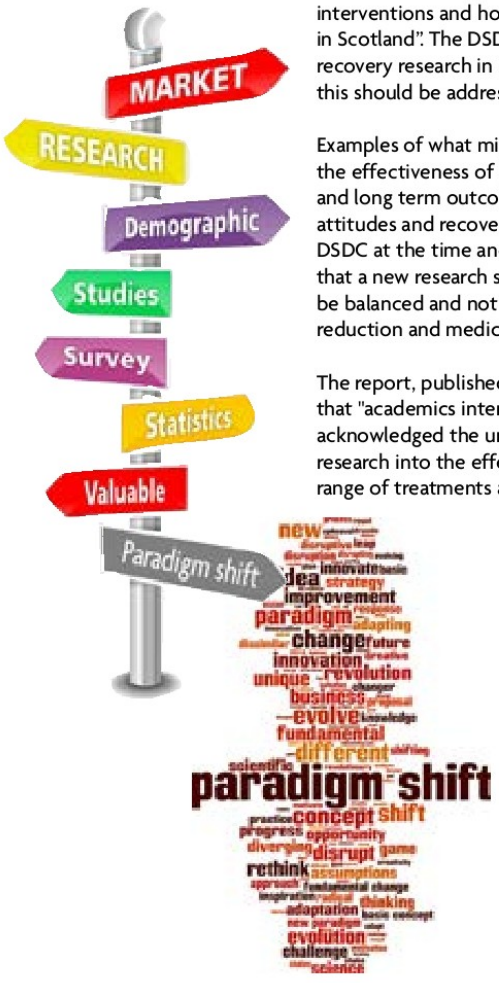
This answers a different question to "does X cause Y". This different question is more interested in what's happening with the individual and their world, however messy. On top of this, we should be involving patients in setting research outcome points and then measuring the intervention against what matters to the patient.

Here we go again.

After years of neglect, residential rehabilitation in Scotland has just had a significant increase in resource. Some are saying that this is an example of an intervention with a poor evidence base and suggesting that the resource would be better used elsewhere "in evidence-based interventions". What a blind spot we continue to have.

You see, the tragic thing is that we were asked to improve the evidence base in 2010 with a plea for research into longer term outcomes, after the scottish government published its review of the evidence base on recovery. Then in 2012 the chief medical officer at the time, Sir Harry Burns, asked the independent Drug Strategy Delivery Commission, an advisory group to government, to undertake a review of opiate replacement treatments but also to consider the concerns that had been raised: "In particular what research evidence existed to allow objective evaluation of the relative benefits of residential rehabilitation

"We must return to practice informing research, and research informing practice. They are an inseparable team and neither element is complete on its own".



interventions and how widespread was their use in Scotland". The DSDC identified the lack of recovery research in Scotland and suggested that this should be addressed.

Examples of what might be done were examining the effectiveness of abstinence programmes and long term outcomes – and examining staff attitudes and recovery. I was a member of the DSDC at the time and expressed my concern that a new research strategy for Scotland should be balanced and not mostly focussed on harm reduction and medical interventions.

The report, published in 2013, states that "academics interviewed, repeatedly acknowledged the urgent need for better research into the effectiveness of a whole range of treatments and interventions which may influence the development of or recovery from problematic substance use".

Neglect.

In terms of research, residential rehab, mutual aid, lived experience recovery organisations (LEROs) and community recovery programmes have been largely neglected.

We have generally seen neither a sense of urgency nor 'better research'. Recovery interventions and processes might be more complex and messy to study, but that doesn't mean we should not try. Just as we need balance in our treatment system, we need balance in addiction research.

As Swisher (2010) says, "We [must] return to practice informing research, and research informing practice. They are an inseparable team and neither element is complete on its own".

If we've not got that balance, interventions like residential treatment will continue to be unhelpfully branded as "not evidence-based" even as people are healed and lives are transformed within their walls.

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Recovery capital vs disenfranchisement

About the author

William Stauffer has been director of Pennsylvania Recovery Organization Alliance. He is in long-term recovery since age 21 and has been actively engaged in public policy in the recovery arena for most of those years. He is also an adjunct professor of Social Work at Misericordia University in Pennsylvania. He ran a recovery house taskforce that helped inform PA Act 59 of 2017. In 2018, he testified in front of the US Senate Special Committee on Aging on the opioid epidemic and older adults, and in 2019, he conducted a hearing with the PA House Human Services Committee to expand recovery opportunities for young people. He is co-chair of the public policy committee for Faces & Voices of Recovery and is the recipient of many recovery awards..

My organisation, PRO-A, recently joined 36 other state and regional recovery community organisations across the US and sent this letter to Congress to educate politicians on the woefully inadequate funding for grassroots recovery community organisations. Disparate funding is the norm even as billions of supplemental dollars flow out to the states. Even when these allocations specifically mention recovery community organisations, they consistently fail to get resources to recovery community organisations at any equitable level. The funds generally end up elsewhere. This must change.

Here in Pennsylvania, not one single dollar from the federal (SAPG) block grant is allocated for our statewide recovery community organisation. Not even one penny. Other statewide recovery community organisations are experiencing similar dynamics. The letter to Congress from our 37 recovery organisations states that: "Block grants require states to have consumer advisory committees, yet without supported statewide recovery community networks ensuring leadership, advisory structures become rife with tokenism. Funding, intended to support our efforts when passed through the SSA system more often than not go to large foundations, long-standing clinically focused providers, and academic institutions well connected and well poised to secure these funds yet with little or no insight into local recovery needs of communities."

We are experiencing systemic disenfranchisement. Millions of dollars goes to large foundations and politically connected groups, while recovery community organisations buy ink for their deskjet printers with social media-funded campaigns. Recent grant applications for recovery support services in our state include treatment programmes as eligible and have short turn around periods, which disadvantages small grassroot recovery community organisations and advantage large treatment organisations which can write grants quickly. These are dynamics that are unfortunately widespread across both the US and UK. We should have broad conversations about what gets funded, and what equitable means in respect to funding allocations that support grassroot recovery community organisations in meaningful ways.

The new recovery advocacy movement was founded by the recovery community and oriented towards inclusion of recovery communities, in all our diversity in all elements of care planning, provision and evaluation. Improving care and recovery rates cannot occur unless there is meaningful inclusion of our community in matters that impact us.

Last year, I wrote the following with recovery historian Bill White on recovery representation. "Supporting and strengthening long-term recovery across multiple pathways of recovery and diverse cultural contexts must remain a central focus of our efforts. This is 'the commons' of our movement for which we need deep, equitable, and inclusive representation in matters that effect our lives. *Nihil de nobis, sine nobis* is Latin for Nothing about us without us and has been a rallying cry for democracy and

$millions go to large foundations and politically connected groups – but not recovery community organisations. This must change, William Stauffer urges in this explanation.

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disenfranchised groups for over 500 years. It means that no policy should be decided without the full and direct participation of the people affected by that policy. We must ensure that our voices are included in all systems addressing alcohol- and other drug-related problems."

Recovery community organisations at national and local levels are vital to the kinds of systems changes we need. We expand recovery capital, not only on the individual level where most of our care systems are beginning to understand the role and function of recovery management, but also on the systems level in the community. These functions are critically needed and a foundational element of statewide recovery community organisations, yet they are not being systemically funded at a time when such infrastructure development has never been more vital. This must change.

We are not experiencing anything close to the level of inclusion we need to move our systems beyond the kinds of exclusionary policies and barriers that have plagued it over the last 50 years. No system can change without meaningful inclusion of the impacted community, including persons in recovery and recovery community organisations. Exclusion equals discrimination, there is no way to sugarcoat that.

The recovery movement came from the recovery community and occurred because are systems were not meeting the needs of people with addictions. We have not made enough progress on those goals. We need to keep our eye on the prize and insist that recovery community organisations at the state and local levels are funded in stable and equitable ways that allow them to do this vital lifesaving work.

Nihil de nobis, sine nobis – Nothing about us without us – means that no policy should be decided without the full and equitable participation of those affected by that policy. We must ensure that our voices are included in all systems addressing alcohol- and other drug-related problems. Anything less is unacceptable.

Click here too read more of Bill Stauffer's blogs.

Validate yourself

Coronavirus, lockdown and even returning to freedom take their toll. Tori Press draws a remedy.

facebook.com/revelatori instagram.com/revelatori

For inspiration...

We at *Recovery Plus* recommend Tori's first book: I Am Definitely Probably Enough (I Think): Revelations on the Journey to Self-Love.

Evolving views on harm reduction

About the author

Jason Schwartz LMSW, MAC is the founder of Recovery Review and has been an addiction professional and social worker since 1994. He started blogging in 2005 as the clinical director at Dawn Farm and is now the director of Behavioral Medicine at a community hospital, and a lecturer at Eastern Michigan University's School of Social Work..

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Click on the grey text and you will link to its related website.

In 2003, we wrote an article about harm reduction that articulated six values that guide our approach to services:

1. Drug use by addicts is bad and oppressive
2. Every addict must be treated with the belief that recovery is possible for him or her, and interventions must place supreme value on recovery from addiction
3. Any intervention must attempt to assess "aggregate harm" done to the addict, other interested persons and the community
4. Any intervention targeting addicts must communicate hope to both the individual and the community
5. Does the program reinforce the culture of addiction or the culture of recovery?
6. Stewardship of community resources must be integral to this dialogue.

We encouraged other providers to identify their values and hoped that this might lead to more productive dialogue and collaboration.

In 2006, I suggested that this article was really a call for recovery oriented harm reduction. In 2008, I proposed an outline of recovery-oriented harm reduction: "Recovery is all about freedom. The freedom to live one's life in the way one chooses without being a slave to addiction or being controlled by treatment or criminal justice systems... I've been thinking about a model of recovery-oriented harm reduction that would address the historic failings of abstinence-oriented and harm reduction services. The idea is that it would provide recovery (for addicts only) as an organising and unifying construct for treatment and harm reduction services. Admittedly, these judgments of the historic failings are my own, a recovery-oriented provider:

- an emphasis on client choice–no coercion
- all drug use is not addiction
- addiction is an illness characterised by loss of control
- for those with addiction, full recovery is the ideal outcome
- the concept of recovery is inclusive – can include partial, serial, etc.
- recovery is possible for any addict
- all services should communicate hope for recovery–recognizing that hope-based interventions are essential for enhancing motivation to recover
- incremental and radical change should be supported and affirmed
- incremental changes are validated and supported, but are not an end-point
- such a system would aggressively deal with counter-transference – some people might impose their own recovery path on clients, others might enjoy vicarious nonconformity through clients.

By this time, harm reduction was already moving toward the mainstream. But the opioid crisis and the overdose crisis accelerated the process. A result has been an effort to redefine recovery from a process involving "sobriety" to a process of improved wellness, effectively placing harm reduction inside that definition of recovery.

Why recovery-oriented harm reduction and not just recovery?

13 years ago, recovery-oriented harm reduction was thought of as a bridge between harm reduction and treatment or recovery. Today, in

The opioid crisis has elevated the visibility of harm reduction. This seems like time to revisit the concept of recovery-oriented harm reduction, Jason Schwarz writes.

some circles, it might invite questions about why one would want to maintain a distinction between harm reduction and recovery.

Defining harm reduction.

Harm Reduction International defines harm reduction as follows.

"Harm reduction refers to policies, programmes and practices that aim to minimise negative health, social and legal impacts associated with drug use, drug policies and drug laws. Harm reduction is grounded in justice and human rights – it focuses on positive change and on working with people without judgement, coercion, discrimination, or requiring that they stop using drugs as a precondition of support. Harm reduction encompasses a range of health and social services and practices that apply to illicit and licit drugs. These include, but are not limited to, drug consumption rooms, needle and syringe programmes, non-abstinence-based housing and employment initiatives, drug checking, overdose prevention and reversal, psychosocial support, and the provision of information on safer drug use. Approaches such as these are cost-effective, evidence-based and have a positive impact on individual and community health."

Defining recovery.

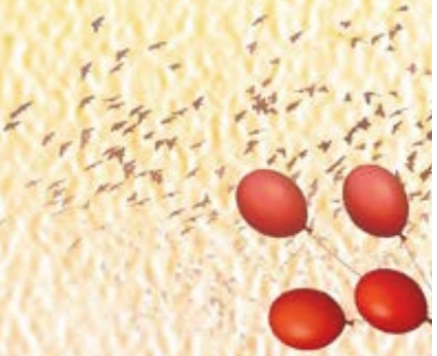
There have been several proposed definitions of recovery by academics, professional associations, panels and governments. The trend among these definitions is toward more porous conceptual boundaries and greater inclusion. The first wave of attempts to define recovery seemed to originate from a sentiment like the following,

"There are people out there who are doing what you call recovery. They just are not doing it in 12 step groups or they are using medication to assist their recovery. They are just using another pathway to get to the same destination (ie outcome). To exclude this people from the boundaries of recovery is inaccurate and wrong. And, by the way, you might want to wrestle with whether there are ways in which your thresholds are too low (eg tobacco use and other unhealthy behaviors). Recovery is less about the pathway and more about the destination/outcome."

The best example of a definition arising from this is from the Betty Ford Consensus Panel: "Recovery from substance dependence is a voluntarily maintained lifestyle characterized by sobriety, personal health, and citizenship."

The next wave of definitions seemed to arise from something like "What you've thought of as recovery is way too narrow. It shouldn't be confined to addiction. There's a whole spectrum of problems and changes within the context of those problems that constitute recovery. It's not a outcome at all. It's a process, and anyone engaged in a process to improve their wellness is in recovery. Recovery is the pathway not the destination/outcome." SAMHSA's definition is an example of this is type: "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential".

Another, more recent, example is from the Recovery Science Research Collaborative: "Recovery is an individualised, intentional,



dynamic, and relational process involving sustained efforts to improve wellness".

Long before researchers and scholars took an interest in recovery, recovering people described recovery as a process – as well as a destination/ outcome. Some might think of it as a process that leads to an outcome, while others might think of it as an outcome maintained by a process. Whatever the case, both elements are considered essential. The Betty Ford Consensus Panel definition integrates a lifestyle (destination) that is voluntarily maintained (process). However, the more recent wave of definitions emphasises a process and a direction ("improvement... striving... full potential" and "sustained efforts to improve wellness") rather than an outcome or destination. Does it matter? Yes, it does. A lot.

Bill White has observed that "Defining recovery also has consequences of great import for those competing institutions and professional roles claiming ownership of alcohol/ drug problems. Choosing one word over another can shift billions of dollars from one cultural institution to another, eg, from hospitals to prisons. Medicalised terms such as recover, recovery, convalescence, remission, and relapse convey ownership of severe AOD problems by health care institutions and professionals, just as words such as redeemed and reborn, rehabilitate or reform, and stop and quit shift problem ownership elsewhere. It is important to recognise that rational arguments for particular definitions of recovery can mask issues of professional prestige, professional careers, institutional profit, and the fate of community economies. The answer of who has authority to define recovery will vary depending on the question, 'define for what purpose?'. Given that defining recovery could generate unforeseen and harmful consequences, efforts to define recovery should include broad representation from: 1) individuals and family members in recovery, 2) diverse recovery pathways and styles, 3) diverse ethnic communities and 4) policy, scientific, and treatment bodies, including leaders of the major institutions that pay for behavioural health care services."

I imagine everyone believes that their definition will ensure more people recover or will protect recovery from a harmful erosion of its boundaries. In some cases, they wish to extend it to include mental illness and other problems. In other cases, they wish to include people who are taking steps toward change, but have not yet crossed into traditional notions of recovery. Others want to secure the status of MAT patients in the boundaries of recovery. Others see opportunities for stigma reduction and political action by enlarging the number of people in recovery. Others see opportunities to address the needs of people with lower severity problems. Others might see progress on stigma reduction benefiting people in recovery but neglecting people who still use alcohol and other drugs. Others see the concept of recovery as imbued with moral panic and wish to challenge that. There have been attempts to address some of these issues. Scott Kellogg, for example, proposed a model he calls gradualism which "seeks to create a continuum between the

"I believe that, if these new definitions take root, recovering people will feel a need to establish typologies of recovery or select a new word to convey the identity they share."

world of harm reduction interventions and the abstinence-oriented treatment field. Again, this approach differs from other calls for integration (Denning 2001; Marlatt et al 2001) because there is a much greater emphasis on making abstinence the eventual endpoint of most harm-reduction enterprises. This paradigm would combine the harm reduction emphases on outreach to the addicted, incremental change, and gradual healing with the abstinence-oriented therapeutic perspective that the use of substances in an addictive or abusive manner is antithetical to the growth and wellbeing of humans".

Bill White proposed the concept of precovery: Precovery is a recovery incubation period arising during active drug use that moves one from the center of addiction to the edge of addiction. Experiences within this stage prepare us for the potential break-up of the person-drug relationship and move us close enough to the recovery territory to feel its contagious pull. Brief sobriety experiments within this boundary region do not constitute sustainable recovery, but they have the potential to incrementally move us to the center of the recovery experience and the physical and cultural world in which that experience is nested. The center of recovery is a region of stability and safety within the recovery process".

These models embrace harm reduction, but not as recovery. They are a path *to* recovery.

Why does it matter if harm reduction is placed inside the definition of recovery?

- It defines recovery in a way that is contrary to the lived experience of cultures and communities that have identified with the concept
- This tension between professionally developed definitions and organic, indigenous definitions is likely to alienate communities of recovery rather than engage them
- These definitions fail to consider who "recovery" is important to and what its redefinition might mean to them
- "Recovery" is an attractive label for a reason. It's become associated with wellness, citizenship, and other positive attributes. It's clear that these attributes do not accurately described many people traditionally considered to be "in recovery" and can exclude others who do live up to those attributes. However, extending the label too far risks eroding positive associations that make "recovery" attractive in the first place.

I believe, if these new definitions take root, recovering people will feel a need to establish typologies of recovery or select a new word to convey the identity they share. They would likely be used to organise research and programming around each type. This means these typologies would be used in inclusion/exclusion criteria for everything from research to treatment to recovery housing to collegiate recovery programs to physician health programmes to state or unstated hiring practices. And, if there was success in establishing typologies, wouldn't that bring us back to our starting point?

So... we've explored why recovery and harm reduction should remain distinct constructs. This sets the stage to revisit and update the concept.

Latest views on harm reduction

What is recovery-oriented harm reduction? Recovery-oriented harm reduction seeks to address the historical failings of both abstinence-oriented treatment and harm reduction services. ROHR views recovery as the ideal outcome for any person with addiction and uses recovery (for addicts only) as an organising and unifying construct for treatment and harm reduction services.

Addiction is an illness. The defining characteristic of the disease of addiction is diminished and/or loss of control related to their substance use.

Drug use in addiction is not freely chosen. Because the disease of addiction affects the ability to choose, drug use by people with addiction should not be viewed as a lifestyle choice or manifestation of free will to be protected. It is not a expression of personal liberty, it is a symptom of an illness and indicates compromised personal agency.

All drug use is not addiction. There is a broad spectrum of alcohol and other drug use. Addiction is at the extreme of the problematic end of that spectrum. We should not presume that the principles that apply to the problem of addiction are applicable to other AOD use.

ROHR is committed to improving the wellbeing of all people with addiction. ROHR services are not contingent on recovery status, current AOD use, motivation, or goals. Further, their dignity, respect, and concern for their rights are important are not contingent on any of these factors.

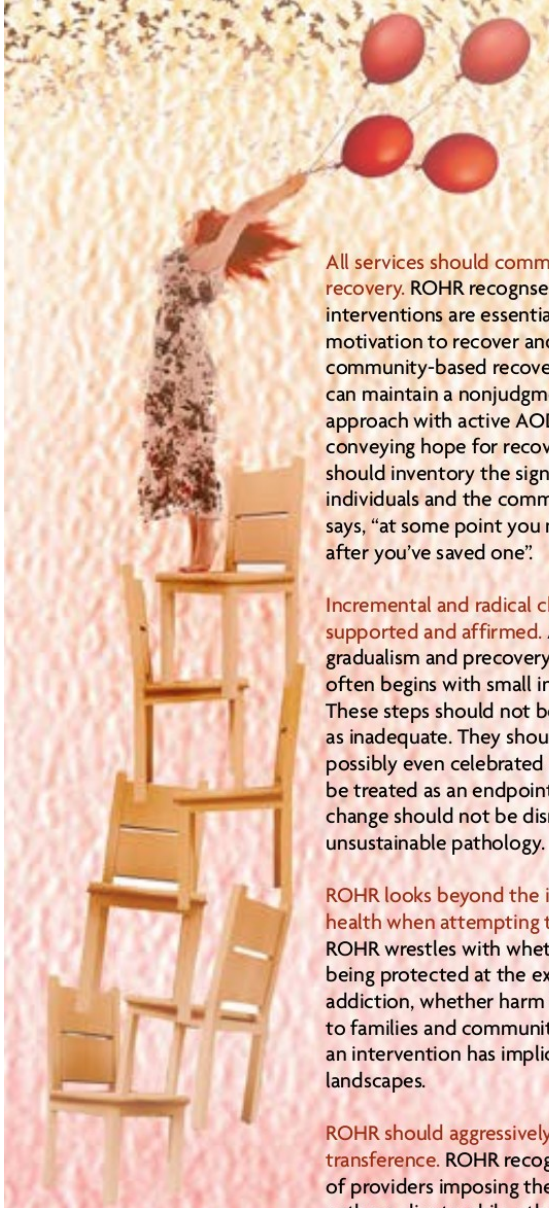
An emphasis on client choice: no coercion. Addiction indicates an impaired ability to make choices about AOD use, but service providers should not engage in coercive tactics to engage clients in services. Service engagement should be voluntary. Where other systems (legal, professional, child protection, etc) use coercive pressure, service providers should not participate in the disenfranchisement or stigmatisation of people with addiction.

For those with addiction, full recovery is the ideal outcome. People with addiction, the systems that work with them, and the people around them often begin to lower expectations for recovery. In some cases, this arises in the context of inadequate resources. In others, it stems from working in systems that never offer an opportunity to witness recovery. Whatever the reason, maintaining a vision of full recovery as the ideal outcome is critical – just as we would for any other treatable chronic illness.

The concept of recovery can be inclusive – it can include partial, serial, etc. While this article argues for a distinction between recovery and harm reduction, Bill White has described paths that can be considered precursors (precovery) to full recovery.

Recovery is possible for any person with addiction. ROHR refuses cultural, institutional or professional pressures to treat any sub-population as incapable of recovery. ROHR recognises the humbling experiential wisdom that many recovering people once had an abysmal clinical prognosis.

Jason Schwarz follows up his history of concepts of harm reduction with his latest recipe of ingredients vital for recovery-oriented harm reduction.



All services should communicate hope for recovery. ROHR recognses that hope-based interventions are essential for enhancing motivation to recover and for developing community-based recovery capital. Practitioners can maintain a nonjudgmental and warm approach with active AOD use while also conveying hope for recovery. All ROHR services should inventory the signals they send to individuals and the community. As Scott Kellogg says, "at some point you need to help build a life after you've saved one".

Incremental and radical change should be supported and affirmed. As the concepts of gradualism and precovery indicate, recovery often begins with small incremental steps. These steps should not be dismissed or judged as inadequate. They should be supported and possibly even celebrated and they should never be treated as an endpoint. Likewise, radical change should not be dismissed as unrealistic or unsustainable pathology.

ROHR looks beyond the individual and public health when attempting to reduce harm. ROHR wrestles with whether public health is being protected at the expense of people with addiction, whether harm is being sustained to families and communities, and whether an intervention has implications for recovery landscapes.

ROHR should aggressively address counter-transference. ROHR recognises a history of providers imposing their own recovery path on clients while others enjoy vicarious nonconformity or transgression through clients. These tendencies should be openly discussed and addressed during training and ongoing supervision.

ROHR refuses to be a counterforce to recovery. ROHR seeks to be a bridge to recovery and lower thresholds to recovery rather than position itself as a counterforce to recovery. Recognising that addiction/recovery has become a front in culture wars, ROHR seeks to address barriers while also being sensitive to the barriers that can be created in this context. When ROHR seeks to question the status quo, it is especially wary of attempts to differentiate from recovery that deploy strawmen, recognising that this rhetoric is harmful to recovering communities and, therefore, to their clients' chances of achieving stable recovery.

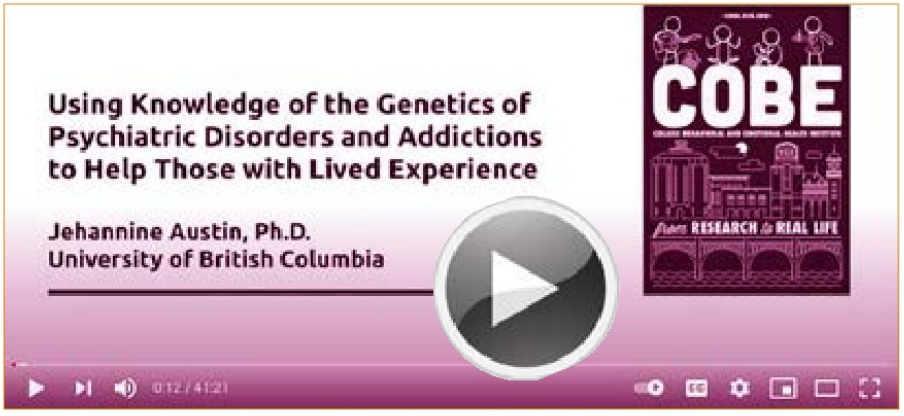
ROHR sees harm reduction as a means to an end. ROHR views harm reduction as strategies, interventions, and ideas to reduce harm. As such, it is wary of harm reduction as a philosophy or ideology, which sets the stage for seeing harm reduction as an end unto itself. The end we seek is recovery, or restoration or flourishing. Seeing harm reduction as a philosophy or ideology risks viewing it as "the thing" rather than "the thing that gets us to the thing".

ⓘ Recovery Review is a community of recovery-oriented experts on addiction and addiction recovery, started by Jason Schwarz when he worked at Dawn Farm and continued after he left in 2019. You can access more information and posts at www.recoveryreview.blog.

Essential learning

Recovery Review founder and our guest editor Jason Schwarz selects a top video and podcast.

A few years ago I had the pleasure of seeing Dr Jehannine Austin discuss how she approaches genetic counseling around psychiatric disorders and addiction. She she offers a helpful frame for thinking about genetics, environmental risk factors, and protective factors. It also helps illuminate the role of recovery capital and social determinants of health. Fortunately, her talk was recorded – click the link below to hear her on YouTube.



One of the outcomes of the opioid crisis is that physicians have been centered in addiction treatment and drug policy discussions. So I recorded an interview with Derek Wolfe, a new medical school graduate and future psychiatrist with a special interest in addiction.

Recognise moral injury in SUD care

About the author

William Stauffer has been director of Pennsylvania Recovery Organization Alliance. He is in long-term recovery since age 21 and has been actively engaged in public policy in the recovery arena for most of those years. He is also an adjunct professor of Social Work at Misericordia University in Pennsylvania. He ran a recovery house taskforce that helped inform PA Act 59 of 2017. In 2018, he testified in front of the US Senate Special Committee on Aging on the opioid epidemic and older adults, and in 2019, he conducted a hearing with the PA House Human Services Committee to expand recovery opportunities for young people. He is co-chair of the public policy committee for Faces & Voices of Recovery and is the recipient of many recovery awards..

The Wikipedia definition of moral injury "refers to an injury to an individual's moral conscience and values resulting from an act of perceived moral transgression, which produces profound emotional guilt and shame, and in some cases also a sense of betrayal, anger and profound moral disorientation". There are things that people working in our substance use disorder care workforce are forced to do that outsiders, including policy makers, have no frame of reference for. This must change.

Recently in medical and behavioural circles I hear discussions of "occupational moral injury". This article from 2020 in the British Medical Journal describes occupational moral injury as "arising during work such as armed combat or emergency response when people carry out, fail to prevent, or become aware of, human actions that violate deep moral commitments. Occupational moral injury is often associated with psychological distress, and moral responses including guilt, anger and disgust". The article goes on to say that "a moral wound can be experienced by anyone. It arises from sources that include injustice, cruelty, status degradation and profound breaches of moral expectations. The moral-philosophical version of moral injury associates it with moral and psychological anguish, and feelings such as bewilderment, humiliation and resentment. According to this formulation of moral injury, it could affect patients, service users, families and loved ones as well as care staff".

There is significant occupational moral injury associated with SUD care work. Looking through the literature, I see that people often confuse it with burnout. Recently, I hear about people who lost colleagues to Covid-19 and could not get personal protective equipment or ended up at lower status on vaccination protocols. For many, it goes into the mix, for others it was the last straw. I lost count of how many people I treated who died because I could not get them into the proper care because of barriers that emanate from our systems of care, each one a human who should have been valued enough to properly help. We need to honour them by accounting for these failings of our care systems.

According to this WebMD article, moral injury occurs when health care providers are "repeatedly expected, in the course of providing care, to make choices that transgress their long-standing, deeply held commitment to healing. The moral injury happens because they're frustrated and can't provide the care they trained for and promised to give". This type of triage care has been the norm for me over several decades of work in the SUD care field. I know I am not alone, it is the norm. This week a colleague confided in me that thoughts of suicide have entered her thinking process because of these very dynamics.

I joke that every month, unfunded mandates and new administrative burdens added 2% of effort to justify or document the work rather than actually do the work of helping people. Over a year, it means roughly a quarter of "extra" time to these areas of focus over three decades, it is 720%. Every minute of this takes away from the actual work of helping people.

There are things that people working in our substance use disorder care workforce are forced to do that outsiders have no frame of reference for. This must change, Bill Stauffer urges.

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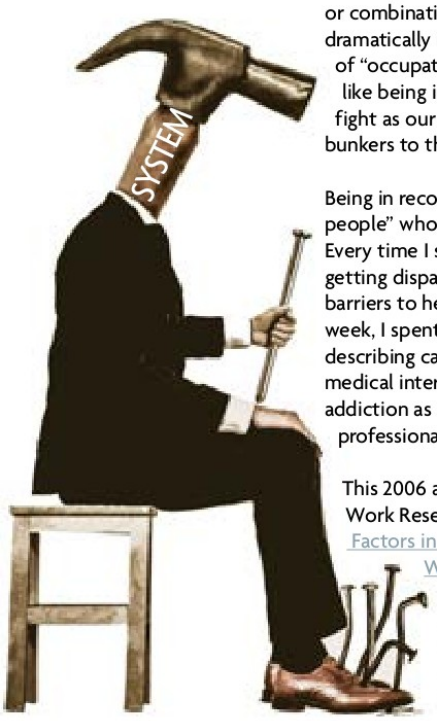


In 2013, PRO-A, my organisation conducted interviews and examined the SUD workforce in Pennsylvania. The counsellor version titled Systems Under Stress found all kinds of barriers to the work and a workforce leaving because they were spending less time helping people. Increased administrative burdens continue, even accelerate. More time spent justifying the work, less time doing it as death rates from addiction, including alcohol, stimulants and opioids or combinations of all of these substances dramatically increase. This is the very definition of "occupational moral injury". It starts to feel like being in the trenches fighting the good fight as our own officers pick us off from their bunkers to the rear of our own lines.

Being in recovery makes many of us "those people" who end up getting disparate care. Every time I see it, I recognise it could be me getting disparate care and insurmountable barriers to help. Every day this very long week, I spent time on the phone with people describing care denials of life sustaining medical interventions under the lens of seeing addiction as a moral failing by licensed medical professionals. It is normal. It hurts my soul.

This 2006 article from Journal of Social Work Research – Personal and Occupational Factors in Burnout Among Practicing Social Workers – found that in the helping professions there is a lifetime burnout rate of 75%. They suggest we examine individual factors that can influence resiliency. One way to do this is to address the moral wounds of systematic barriers to recovery. I have said often that we have built a system of care that provides less than what people need to get better because of implicit bias against people with addiction. As a society we have low expectations of persons with SUDs and this influences care design. We don't have care that offers the minimum effective dose of care. Marginalized communities get even less.

In 2019, it was the honor of a lifetime to receive the Vernon Johnson Award for individual advocacy at the America Honors Recovery Diner. In my speech, I reference the moral injury of this work. The body count continues to escalate. Sisyphus' rock up the mountain is heavy. But what alternative is there but to carry on?

According to this article by the Moral Injury Project at Syracuse University, "moral injury, then, is a burden carried by very few, until the "outsiders" become aware of, and interested in sharing it. Listening and witnessing to moral injury outside the confines can be a way to break the silence that so often surrounds moral injury". It recommends public dialogue and deepened understanding of the burdens carried by the few on behalf of society. Even in social services, there are few fields of work with the level of implicit bias and systemic barriers as the substance use care system. We should have such a process across our SUD care system. I suspect we will keep have unending workforce shortages without such an accounting. If we can address such dynamics here, we can fix a lot of things. The first step is acknowledging we have a problem, then we must do something about it.

Terminology and stigma: surprises

About the author

John Kelly BS Psychology (Summa Cum Laude) PhD is Harvard University's first professor in addiction medicine, president of the American Psychological Association Society of Addiction Psychology and associate editor for the journals Addiction and the Journal of Substance Abuse Treatment. He is also founder and director of the Recovery Research Institute at Massachusetts General Hospital, programme director of the Addiction Recovery Management Service and associate director of the Center for Addiction Medicine at MGH. He has served as a consultant to US federal agencies such as the White House Office of National Drug Control Policy, the Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Institutes of Health (NIH); to non-profits such as the Hazelden Betty Ford Foundation; and to foreign governments. Dr Kelly has published over 100 peer-reviewed articles, reviews, and chapters in the field of addiction.

Substance use disorders are among the most stigmatised conditions in the world, and words used to describe this condition affect the level of perceived stigma by healthcare professionals and the general public. For example, among the general public and mental health clinicians, exposure to the term 'substance abuser' tends to elicit a more punitive attitude whereas the term 'substance use disorder' tends to elicit a more treatment-oriented attitude.

Over the last decades, medical terminology to describe addiction was promoted in an effort to reduce stigma. But some argue that this medicalisation of addiction has unintended consequences, such as negatively impacting the public's perception that people with addictions can actually change and recover, as well as reducing the sufferer's own confidence in their ability to change. So I led a Recovery Research Institute study – A US national randomized study to guide how best to reduce stigma when describing drug related impairment in practice and policy – which used a rigorous design to examine if exposure to commonly used medical and nonmedical terms describing opioid-related impairment makes a difference in people's attitudes toward those with opioid use disorder.

We examined the impact on several dimensions of stigma, treatment need and belief that a person with opioid-related impairment could get better (prognostic optimism). We sought to inform practice and policy communication efforts what terms are optimal and under what circumstances these terms might be best used to reduce stigma and maximise help-seeking.

How was this study conducted?

This was a nationally representative study of adults from the US general population where over 3,500 participants were randomised to read one of 12 descriptive vignettes using six commonly used terms and different genders to describe someone with opioid-related impairment. Participants were then asked to answer questions that assessed attitudes across multiple dimensions of stigma and perceptions on likelihood of recovery. Terms used included:

- Chronically relapsing brain disease
- Brain disease
- Disease
- Illness
- Disorder
- Problem.

What did this study find?

Use of 'chronically relapsing brain disease' was associated with both benefits and drawbacks.

Compared with 'chronically relapsing brain disease', participants who were presented with any of the five other ways of describing someone with opioid-related impairment rated the person as significantly more personally to blame for their opioid impairment. The highest blame attribution was from 'problem' and 'disease', moderate blame attribution was from 'illness' and 'disorder', and lowest blame attribution was from 'brain disease' and 'chronically relapsing brain disease'.

At the same time, compared with the term 'opioid problem', participants presented with the term 'chronically relapsing brain disease' rated

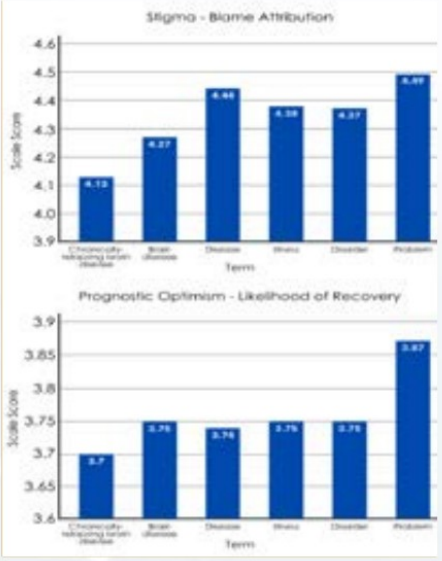
Describing addiction as a "chronically relapsing brain disease" is intended to decrease stigma, but might actually increase it, Harvard's Professor John Kelly shares.

References:

You will find research references for every statement and statistic in this article by clicking here.

the opioid-impaired person as being less likely to recover (decreased prognostic optimism) and as being more dangerous and having an increased need for continuing care.

Generally, participants attributed less blame when "Alex" was depicted as a man but simultaneously were more likely to want more social distance from a man and viewed a man as more dangerous. When looking at the effect of gender by terminology, decreased blame attribution toward males was only observed with the term 'chronically relapsing brain disease'. Of note is that the greater prognostic optimism linked with the term 'problem' compared with 'chronically relapsing brain disease' was present regardless of whether the subject was described as a man or a woman.



What are the implications of the study?

The study found that using the term 'chronically relapsing brain disease' to describe a person with opioid-related impairment produced the lowest blame attribution, with this effect more pronounced in men. However, using this exact same term also decreased the perceived likelihood that this person could recover and increased perceptions that the person was dangerous and should be socially excluded.

Study findings suggest that there is no single term to describe opioid-related impairment that can reduce all potential stigma biases. In other words, while some terms were very good at reducing certain types of stigma, these same terms increased other types of stigma, and vice versa. This indicates there can be tradeoffs to using different types of terminology to describe opioid-related impairment, and choice of terminology should be tailored according to the purpose of the communication.

Consistent with this study's findings, to reduce personal shame and blame that might inhibit treatment seeking, use of more medical terminology might be optimal (eg, 'chronically relapsing brain disease') - but if you want to increase confidence that the person can recover and is not dangerous, use of non-medical terminology could be best (eg, 'opioid problem').

For more information, click here.

Self-help groups

Contact details for mutual-aid groups, endorsed by the World Health Organisation and NICE.

UK contacts.
US contacts

Resources in other countries will be added.

Addictions Anonymous
020-7584 7383

Adult Children of Alcoholics
PO Box 1576, London SW3 1AZ
www.adultchildren.org

Al-Anon...
for families and friends of problem drinkers – including after they quit
...and Alateen
for people aged 12-20 affected by someone else's drinking.
www.al-anonuk.org.uk
www.al-anon.org

Alcoholics Anonymous
www.alcoholics-anonymous.org.uk
www.aa.org

Addicts Anonymous
www.alladdictsanonymous.org

Bullying*
& National Bullying helpline:
www.bullyonline.org

CITA* - Council for Information on Tranquillisers & Antidepressants
www.citawithdrawal.org.uk

Christians In Recovery
www.christians-in-recovery.org

Co-Anon
for families and friends of cocaine addicts
www.co-anon.org.uk
www.co-anon.org

Cocaine Anonymous
for cocaine/crack and other substances
www.cauk.org.uk
www.ca.org

Coda - Co-Dependents Anonymous
for people working to end patterns of dysfunctional relationships and develop functional and healthy relationships
www.codependents.org
http://coda.org

Computer Gaming Addicts Anonymous
cgaa.info

Cosa (was Codependents of Sex Addicts)
for recovery from sexual codependency
www.cosa-recovery.org

Cruse Bereavement Care*
www.cruse.org.uk

Crystal Meth Anonymous
www.crystalmeth.org
World meeting list: www.crystalmeth.org/cma-meeting/cma-meeting-directory.html

Debtors Anonymous
for problem debting, compulsive spending, under-earning & other money/work issues
www.debtorsanonymous.org

Depression Alliance*
Self-help groups, workshops & conferences.
www.depressionalliance.org

Depressives Anonymous*
0870-7744 320

DrinkLine*
0800-917 8282

Drug Addicts Anonymous
www.drugaddictsanonymous.org.uk
www.daausa.org

Eating Disorders Association*
www.edauk.com

Emotions Anonymous
www.emotionsanonymous.org
World meeting list: www.allone.com/12/ea

Families Anonymous
for relatives & friends of people with drug problems
www.famanon.org.uk
www.familiesanonymous.org

Food Addicts Anonymous
www.foodaddictsanonymous.org

Food Addicts In Recovery Anonymous
help with food obsession, bulimia, overeating or undereating.
www.foodaddicts.org

Gamblers Anonymous
for gambling problems
Gam-Anon
for relatives of those with gambling problems
For information on both:
020-7384 3040
www.gamblersanonymous.co.uk
www.gamblersanonymous.org

Heroin Anonymous
http://heroinanonymous.org/HAUK.html
www.heroin-anonymous.org

Heroin Helpline*
020-7749 4053 (office hours)

HIV Anonymous
www.hivanonymous.org

Internet & Tech Addiction Anonymous
www.netaddictionanon.org

UK contacts.
US contacts

Resources in other countries will be added.

Love Addicts Anonymous
www.loveaddicts.org

Marijuana Anonymous
for those who wish to stop using marijuana
www.marijuana-anonymous.co.uk
www.marijuana-anonymous.org

Muslim Youth Helpline*
confidential counselling service for young muslims in need; many languages spoken
www.myh.org.uk

Nacoa*
(National Association for Children of Alcoholics)
www.nacoa.org.uk
www.nacoa.org

Narcotics Anonymous
for drug problems
www.ukna.org
www.na.org

Net*
internet addiction in all forms
www.netaddiction.com

Nicotine Anonymous
www.nicotine-anonymous.org

Obsessive Eaters Anonymous
www.obsessiveeatersanonymous.org

OCD action*
information & support for people with obsessive compulsive disorder
www.ocd-uk.org

Online Gamers Anonymous
www.olganon.org/home

Overeaters Anonymous
for problems with food, including anorexia
www.oagb.org.uk

Pan fellowship
any dependency/codependency with emphasis on steps 4&10
7pm Fridays - Methodist Hall, Fulham Broadway, London

Pills Anonymous
www.pillsanonymous.org
World meeting list: www.pillsanonymous.org/meetings/find-a-meeting

Samaritans*
for anyone feeling low, depressed or suicidal
www.samaritans.org

S-Anon
for people affected by someone else's sexual behaviour
www.sanon.org
cardiffhopefortoday@yahoo.com

Sex Addicts Anonymous
www.sauk.org
https://saa-recovery.org

Sexaholics Anonymous
for those who want to stop their self-destructive sexual thinking and behaviour
020-8946 2436
www.sa.org

Sex & Love Addicts Anonymous
(The Augustine Fellowship)
www.slaa.uk.org
www.slaafws.org

Sexual Compulsives Anonymous
www.sca-recovery.org/

Shopping Overshopping*
www.overshopping.com

Spear*
Supporting people who self-harm
www.projectspear.com

Survivors of Incest Anonymous
www.siawso.org

Talking About Cannabis*
Supports families of cannabis users
www.talkingaboutcannabis.org

UK self-help*
website containing hundreds of listings
www.ukselfhelp.info

Underearners Anonymous
www.underearnersanonymous.org

Violence Initiative*
offering violent people a chance to change – meetings, one-to-one sessions, conflict resolution training
www.tviccv.org

Workaholics Anonymous
Celia 01993-878220
or George 020-7498 5927
www.workaholics-anonymous.org

* Resources other than 12-step groups – check if free of charge.

Treatment centres

Need help for yourself, a loved one, an employee or client? Start with this list of resources.

The addiction-treatment and recovery centres on these pages are based in the UK.

When you visit our sister online journal, you can click on photographs of each rehab to go direct to its website.

If you have specific requirements, such as gambling or eating disorders, a search facility will soon be available.

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Admissions: 01603 513091
Brand-new purpose-built 14-bed specialist addictions recovery clinic set in picturesque Suffolk, just one hour from London.
www.abbeycare.co.uk
Abbeycare Newmarket
Jeddah Way, Newmarket CB8 8JY

Admissions: 01603 513091
21 bed specialist addictions recovery clinic, discreetly situated near Glasgow - set in a castle on 45 acres of land.
www.abbeycare.co.uk
Abbeycare Scotland,
Murdostoun Castle, Wishaw
ML2 9BY

Admissions Team: 01723 371869
email form on website
Ark offers 1st-stage and 2nd-stage care and aftercare, using psychodynamic therapies, REBT, CBT, 12 steps, Gestalt, etc –
www.arkhouserehab.co.uk
15 Valley Rd, Scarborough, North Yorkshire YO11 2LY.

Admissions: 020 3553 5218
Respectful drug & alcohol rehab. If you think you or a family member has a problem with drug or alcohol addiction... we can help you – details at
www.blueskies-recovery.com
50 South Street, Farnham
Surrey GU9 7RN.

Admissions: 01443 226 864
email form on website
Only residential rehabilitation service in Wales with cognitive behaviour therapy at its core –
www.brynawel.org
Llanharry Road, Llanharan,
Pontyclun, Mid Glamorgan
Wales CF72 9RN.

Admissions Team: 01736 850006
info@bosencefarm.com
Bosence offers rehabilitation using the 12 step model, detox and stabilisation to anyone aged 18 or over – details at
www.bosencefarm.co.uk
69 Bosence Rd, Townshend, Hayle
TR27 6AN.

Admissions Team: 020 7323 4970
email form on website
Counselling and psychotherapy for addictions, eating disorders, trauma and family relationships – details at
www.charterharleystreet.com
162 New Cavendish Street
London W1W 6YS.

Admissions Team: 01603 439905
info@hebrontrust.org.uk
Looks at the multiple and complex problems which lie behind dependency, including past trauma – details at
www.hebrontrust.co.uk
10-12 Stanley Avenue, Norwich,
Norfolk NR7 0BE.

Admissions: 0845 053 1785
enquiries@promisclinics.com
Part of Promis, offers weekend assessment programme as well as 24-hour medical supervision, rehab and aftercare – details at
http://promis.co.uk/locations/promis-residential-clinic-hay-farm
Hay Lane, Deal, Kent CT140EE.

Admissions: 020-7701 8130
Kairos.bethwin@kairoscommunity.org.uk
Kairos Residential also links to detox, day programme, aftercare.
www.kairoscommunity.org.uk/treatment-services/residential-rehab
59 Bethwin Road, Camberwell,
London SE5 0XT.

Admissions: 020 3553 5218
21-bed drug and alcohol detox and rehabilitation facility set in a quiet and picturesque suburban street, with trained staff on site 24hrs a day –
www.libertyhouseclinic.co.uk
220 Old Bedford Road, Luton
Bedfordshire LU2 7HP.

Admissions: 01524 771500
lhtcadmissions@btconnect.com
LHTC offers 21st century addiction, trauma & wellbeing recovery & management with an unequivocal focus on recovery, quality of care and service delivery –
www.littledalehalltc.co.uk
Littledale, Lancaster LA2 9EY.

Treatment centres

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Admissions: 020 8769 7674
info@mountcarmel.org.uk
Offers residential, day and quasi-residential programmes and counselling; detox can be organised – details at www.mountcarmel.org.uk
12 Aldrington Rd, London SW16 1TH.

Admissions: 020 3553 5218
Offers two programmes, allowing tailored treatment and client choice: the Oasis Strengths programme and a 12-step programme – details available at www.oasisrecoverycommunities.co.uk
Bridge St, Runcorn WA7 1BY.

Admissions: 020 3553 5218
This state-of-the-art drug and alcohol rehab is located in a quiet residential location and provides a welcoming, caring and safe environment for recovery – details available at www.recoverylighthouse.com
Winchester Rd, W Sussex BN11 4DJ.

Admissions: 020 3553 5218
This treatment facility benefits from new management with combined knowledge of the UK's most experienced and respected addiction treatment counsellors and practitioners – www.sanctuarylodge.com
Hedingham Rd, Essex CO9 2DW.

Admissions Team: 01202 467 661
info@StreetScene.org.uk
Group includes Allington House, Cornerways, Francis House and Unity House – www.streetscene.org.uk
Allington House, 46 Dean Park Road, Bournemouth, Dorset BH1 1QA.

Headquarters: 020 3535 5218
Detox, rehab & therapy, spanning from luxurious rehabs with en suite rooms, gyms and full on-site medical nursing units to cost effective rehabs all across the UK – see five of our centres on these pages.
www.ukat.co.uk

The addiction-treatment and recovery centres on this page are outside the UK.

You can click on photographs of each rehab to go direct to its website.

If you have specific requirements, such as gambling or eating disorders, a search facility will soon be available.

To add your facility to these pages, email TheTeam@DBrecoveryresources.com

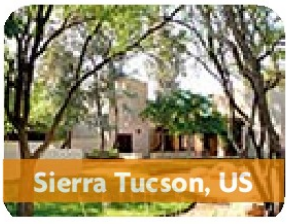
Admissions: +353 1 494 6358
info@rutlandcentre.ie
Ireland's best known addiction treatment centre provides safe, confidential and direct patient treatment for all addictions.
www.rutlandcentre.ie
Rutland Centre, Knocklyon Road, Templeogue, Dublin 16, D16 YV04.

Admissions: +27 (0) 44 5331752
(+27 (0) 73 7989699 after hours)
info@oasiscentre.co.za
Treats alcohol, drugs, self harm, sex addiction, eating disorders, gambling and more– details at
www.oasiscentre.co.za
PostNet Suite 27, Plettenberg Bay, South Africa 6600.

Admissions: +34 951 107 195
meena@caminorecovery.com
Treating substance and process addictions, co-occurring disorders, trauma, family/relational issues in an intimate setting,with dignity.
www.caminorecovery.com
Cortijo la Fortaleza, Velez-Malaga, 29700, Spain.

Admissions: +1 866.313.6310
info@ashleytreatment.org
Substance abuse programmes include: primary, relapse prevention, young adults and pain recovery programmes.
www.ashleytreatment.org
800 Tydings Lane, Havre de Grace, Maryland 21078.

Admissions: +351 919357186
email form on website
English speaking, individualised 12-step recovery treatment from professionals trained at the Priory – details at
www.novavidarecovery.com
Located 25 minutes' drive from the main airport at Faro.



Admissions: 1 877.959.8896
email form on website
Programmes cover addiction & co-occurring disorders, complex pain, trauma & PTSD, mood & anxiety and eating disorders – details at
www.sierratucson.com
Sierra Tucson, Arizona.

DB RECOVERY+ McLEAN DECONSTRUCTING STIGMA AWARDS DINNER 2021

The Awards ~ the 'Oscars' celebrating stars in the field of recovery from addictive behaviours ~ are open to all.
Your nomination can highlight the talent, dedication and innovation of an individual and/or organisation across all aspects of recovery life, showing us countless reasons to take pride in our field.
Join us in honouring the unsung heroes of recovery!

recoveryplusdb.com

What's next

Inspired to join us again / anew?

Network. Expand your knowledge and find solutions to problems.
Learn beyond your field or interest, as well as becoming more confident in your own field. Present your ideas and work to others. Get people to meet you.

Meet up with likeminded people and industry peers: DB Recovery+ Ukesad conferences bring together people from all different geographical areas who share a common discipline or field – all with the mission of lifesaving addiction-recovery work.

Don't miss out! The best available discounts end this month! Grab them while you can.

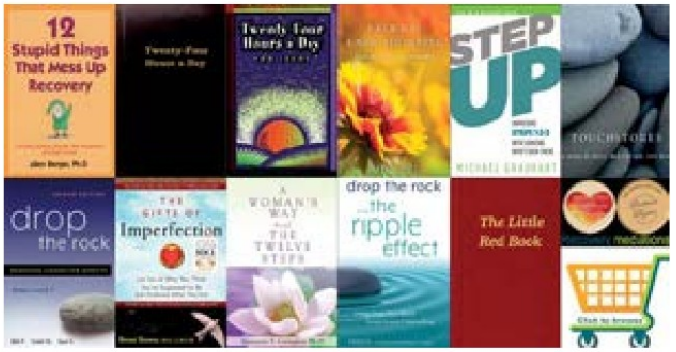
CLICK HERE FOR ONLINE BOOKING

IC&RC

Delegates will receive attendance certificates.
Delegates who complete/return Evaluation forms provided will be awarded internationally recognised 'gold standard' CEUs / CPDs from the International Certification & Reciprocity Consortium (www.icrcuk.org).

Helping addicts into long-term enriched recovery

RESOURCES for recovering people



TOP RESOURCES for loved ones

TOP RESOURCES for therapists

Hazelden addiction recovery guides

Choose from our Top Recovery Guides, in each of 3 categories:
>1 for people in or starting recovery from addictive behaviours
>2 for families/loved ones
>3 and for professionals: therapists, counsellors, rehabs, social workers, researchers.

Save on £ prices – and reduced p&p – by buying at $ prices in our special deal!

Bonus: All orders over £99 earn you a Directory or Classified advertisement in *Recovery Plus* journal, for 2 issues!

After you have ordered, simply confirm your free advertisement with TheTeam@DBrecoveryresources.com.

www.recoveryplusjournal.com/hazelden-addiction-recovery-guides

Hazelden Publishing

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EVIDENCE-BASED RESOURCES
WRITTEN BY LEADING ADDICTION AND BEHAVIOURAL HEALTH EXPERTS

Prevention
Intervention
Assessment
Treatment
Recovery Management