Strategies to Strengthen

RECOVERY
IN BRITISH COLUMBIA

The Path Forward

BRITISH COLUMBIA
CENTRE ON
SUBSTANCE USE
Networking researchers, educators & care providers

Table of Contents

In this document, we use the definition of *recovery* developed by the American Society of Addiction Medicine,[1] which is:

> "**Recovery** *is a process of sustained action that addresses the biological, psychological, social and spiritual disturbances inherent in addiction.*
>
> ***Recovery*** *aims to improve the quality of life by seeking balance and healing in all aspects of health and wellness, while addressing an individual's consistent pursuit of abstinence, impairment in behavioral control, dealing with cravings, recognizing problems in one's behaviors and interpersonal relationships, and dealing more effectively with emotional responses.*
>
> *An individual's recovery actions lead to reversal of negative, self-defeating internal processes and behaviors, allowing healing of relationships with self and others. The concepts of acceptance and surrender are also useful in this process.*
>
> *Since some prescribed and non-prescribed medications can interfere with recovery, it would be prudent to consult with an Addiction Specialist Physician in selected cases.*"[1]

The Path Forward

I t is time for a new path.

As is the case in most North American jurisdictions, British Columbia has long suffered because of the lack of an effective system to support individuals in and pursuing recovery from substance use disorders. Due to the need to address the all too common negative outcomes of untreated addiction, at times, this has meant that the overwhelming focus of the health system response has been on reducing the spread of disease (e.g., HIV infection) and saving lives through the implementation of public health measures such as sterile syringe distribution and take-home naloxone.

Without question countless lives have been saved through these essential programs and supports. While resources and emphasis on building effective public health programming is urgently required, British Columbia must also establish a full evidence-based continuum of care including building an effective and coordinated addiction treatment and recovery system that has traditionally been lacking. In the face of this longstanding unmet need, many working to establish effective services aimed at supporting long-term treatment and recovery from addiction have felt both stigmatized and marginalized.

This has been particularly problematic since individuals seeking to establish an effective recovery-oriented system of care are often individuals with lived experience in recovery who have themselves learned firsthand how to successfully achieve long-term remission from substance use disorders. That is, those with the essential expertise to create more effective programming have felt ignored and devalued when they are the specific population who should be informing and helping chart a course towards building the recovery-oriented system of care that British Columbia urgently needs.

British Columbia now has a Ministry of Mental Health and Addictions focused on building this new system and the support of a dedicated Minister who has committed to addressing historical stigma and building a full continuum of substance use services and supports including addressing the longstanding need to expand effective recovery services.

This report seeks to set this new path forward by articulating these needed services and supports and will be followed by dedicated working groups seeking to implement needed changes.

The time for a new path is here and the way forward is clear. With thanks to the many individuals and organizations who helped in developing this report, we welcome all British Columbians to join us as we seek to build and strengthen needed recovery services in the Province.

Dr. Evan Wood
Director
BC Centre on Substance Use

Marshall Smith
Senior Adviser for Recovery Initiatives
BC Centre on Substance Use

Recovery: An Attainable Reality

Because of stigma and other concerns, individuals with addiction are often devalued and written off by society as being "beyond help". This is costly, unethical and wrong. Research has clearly demonstrated that long-term recovery from substance use disorders and other addictions is not only possible, but is an attainable and sustainable reality for many individuals, regardless of the severity and duration of their addiction. In fact, the majority of individuals with substance use disorders are capable of making positive change, growing and becoming positively reconnected to their broader community.

Yet people in recovery, and the broader recovery community, often face institutional discrimination and social stigma. Many describe this experience as being reduced to a past diagnosis, stereotype or risk score. Respectful and non-discriminatory approaches that acknowledge the critical value of recovery services and highlight the dignity of individuals in recovery are essential for maintaining and strengthening the successes they have achieved in improving their health and wellbeing. More broadly, the provincial health and related social service systems must leverage the collective strength, experience and expertise of those in recovery and the broader recovery community to create a recovery-oriented system of care.

There are many paths to recovery and those on this journey need understanding, support and access to appropriate services in the community to achieve their goals. Recovery needs to be viewed positively by health care, legal and social services systems, as well as the broader community. It is vital to engage and support individuals in recovery through development of personalized recovery plans, based on the strengths and goals of that individual, and the severity, complexity and duration of their illness. Timely access to services that meet the highest safety and quality standards is also critical. Research demonstrates the importance of the availability of psychosocial supports for individuals in recovery for achievement of their education, housing, and employment goals, and to provide access to ongoing counseling (e.g., for the resolution of trauma).

It is also important that everyone with substance use disorders and other addictions, at all stages of their illness, be offered a diverse range of health services that always include options for abstinence-oriented recovery services. Everyone who has a substance use disorder should be aware of the variety of recovery-oriented services, addiction treatments, and harm reduction options that are available to them. They should be

able to access the appropriate type and stage of service and care, based on their illness status, as well as their personal strengths, choices and goals.

To this end, recovery must be recognized and encouraged as a realistic option, and offered to all those who enter the system of addiction care. Further, recovery-oriented services that are free of stigma and that emphasize emotional, mental and spiritual wellbeing must be made accessible to all people with substance use disorders. Families, loved ones and employers of people with substance use disorders and other addictions also require education, support and assistance in understanding recovery and supporting individuals who are on this path.

Addressing the experience of institutional discrimination and social stigma faced by the recovery community is essential. Fortunately, British Columbia is home to a wide range of successful recovery programs. Further, this province boasts a large and experienced population of people in long-term recovery, many of whom are active in supporting one another and the broader care system that addresses substance use and addictions.

By identifying, supporting and working with the recovery community, and by adapting best practice models for recovery programs to local contexts, we can make long-term recovery an attainable reality available to all British Columbians who are interested and able to pursue this path.

There are many paths to recovery

"It has been my learned experience that everyone needs healing. It's become my goal to provide those who suffer from addiction equal opportunity to recover."

—

Geri Bemister

What We Know

In 2017, the Canadian Centre on Substance Use and Addiction (CCSA) and the National Recovery Advisory Committee (NRAC) released the findings from the *Survey of Life in Recovery from Addiction in Canada*,[2] the first nationwide study to provide a comprehensive understanding of what life in recovery from addiction looks like. A total of 855 Canadians participated in the *Life in Recovery* survey; just under half resided in British Columbia (46%, n=391).

As with any survey-based research, there are some limitations of the *Life in Recovery* survey, for example, self-selection and response biases, and survey results might not be representative of all Canadians in recovery. However, it is noted that there was a high degree of consistency in overall survey results and major themes between the Canadian *Life in Recovery* survey and those administered in other countries (i.e., the U.S., the U.K., and Australia).[2]

The goals of this study were to inform health care services and to educate service providers, decision makers and the public regarding the strengths and positive attributes of people in recovery, as well to decrease stigma and misconceptions about people with substance use disorders.

The *Life in Recovery* survey provided a wealth of information about the experiences of individuals in recovery in Canada, and identified a number of very important trends. First, and most importantly, the study clearly shows that individuals in recovery can and do lead meaningful lives.

- Survey respondents viewed recovery as positive, achievable and sustainable, and more than half (51%) achieved stable recovery without experiencing a single relapse.
- Over time, an individual's journey in recovery was reflected as continued improvements across multiple dimensions of their lives, such as reconnecting with family, friends, and the community, and initiating or returning to school and/or work.
- Recovery journeys were unique to each individual, with many different pathways followed to achieve personal recovery goals.

- On average, individuals reported using six different recovery-oriented resources or programs throughout or at different stages of their recovery journey.
- Most individuals experienced challenges starting their recovery journey (>80%), such as barriers to accessing services, stigma and lack of support, among others.
- Over half of individuals (~55%) described not being ready, not believing they had a problem, or not believing the problem was serious enough, as a barrier to seeking help for their addiction.
- Once engaged in the recovery-oriented system of care, fewer individuals (~50%) experienced barriers to sustaining their recovery.

Leading Factors in Starting and Maintaining Recovery

	Starting	Maintaining
Quality of life reasons	69%	85%
Mental health or emotional reasons	68%	67%
Marital, family, or other relationship reasons	35%	64%
Physical health reasons	45%	57%
Employment reasons	37%	41%
Financial reasons	36%	40%
Legal reasons	17%	11%
Religious or spiritual reasons	16%	48%
Cultural reasons	3%	10%
Other	4%	6%

The most frequently reported reasons that individuals had for starting and maintaining recovery were similar:

- improve their quality of life
- mental and emotional health
- personal relationships
- physical health

Leading Barriers to Starting Recovery

Did not experience any barriers to starting recovery	17%
Not being ready, not believing you had a problem, or not believing the problem was serious enough	55%
Being worried about what people would think of you	50%
Not knowing where to go for help	36%
Lack of supportive social networks	30%
Long delays for treatment	25%
Lack of professional help for mental health or emotional problems	24%
Cost of recovery services	22%
Lack of programs or supports in your community	20%
Quality of services available in your community	20%

The most common barriers to starting recovery were:

- not believing they had a problem or not believing their problem was serious enough (denial) (55%)
- being worried about what other people would think (stigma) (50%)
- not knowing where to seek help (36%)

Of note, only 17% of surveyed individuals reported experiencing no barriers to starting recovery.

Leading Recovery Resources and Programs Used

12-step mutual support group	92%
Residential addiction treatment program	61%
Group or individual counselling by a psychologist or psychiatrist not specializing in addiction	57%
Group or individual counselling by an addiction professional	57%
Outpatient addiction treatment program	41%
In-patient detox program	35%
Therapeutic Community	35%
Program specific to dual diagnosis	32%
Support Recovery House	30%
Employee assistance program for addiction	26%

It is important to note that the majority of people with substance use disorders do not access formal programs to achieve recovery. Of the respondents who did, the top resources and programs used to support their recovery were:

- 12-step mutual support groups (92%)
- residential addiction treatment programs (61%)
- group or individual counselling (57%)

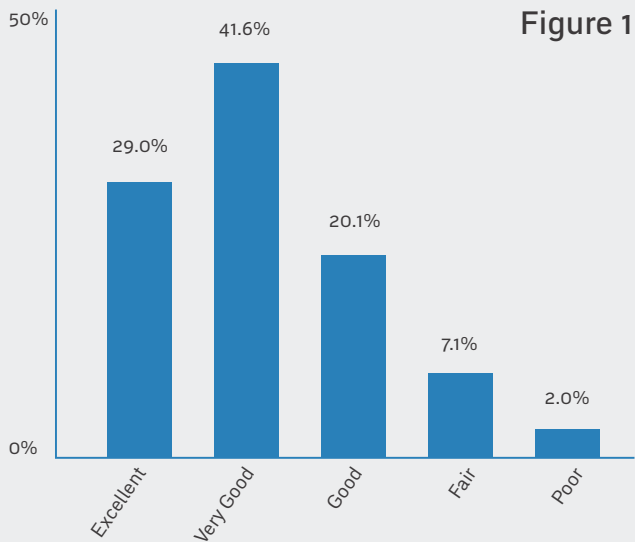## Leading Themes and Concepts in Respondents' Definitions of Recovery

Abstinence	52%
Good quality of life	14%
Using an addiction program	14%
Spirituality/religion	12%
Emotional health, coping, and well-being	10%
Physical health and well-being	8%
Absence of thoughts about or cravings for drugs	7%
Productive/functional member of society	7%

While most participants defined recovery as abstinence from alcohol and other drug use (52%), some defined recovery as achieving a good quality of life (14%), or actively participating in a treatment program (14%).
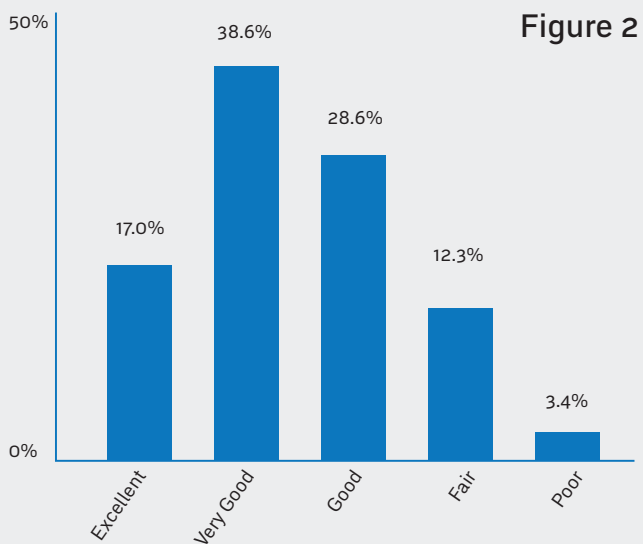
This highlights the unique and highly individualized perspectives on recovery that can exist within the recovery community, and underscores the importance of using language and terminology that is inclusive and respectful of the diverse perspectives held by those in recovery.

Self-Reported Ratings of Quality of Life & Mental Health

Individuals in recovery reported having an overall positive state of health and wellbeing. More specifically, the majority of individuals in recovery rated their overall quality of life (Figure 1), mental and emotional health (Figure 2) and physical health as "very good" to "excellent".

Figure 1

Rating	Percentage
Excellent	29.0%
Very Good	41.6%
Good	20.1%
Fair	7.1%
Poor	2.0%

Most respondents (90.7%) reported their quality of life as "good," "very good," or excellent

Figure 2

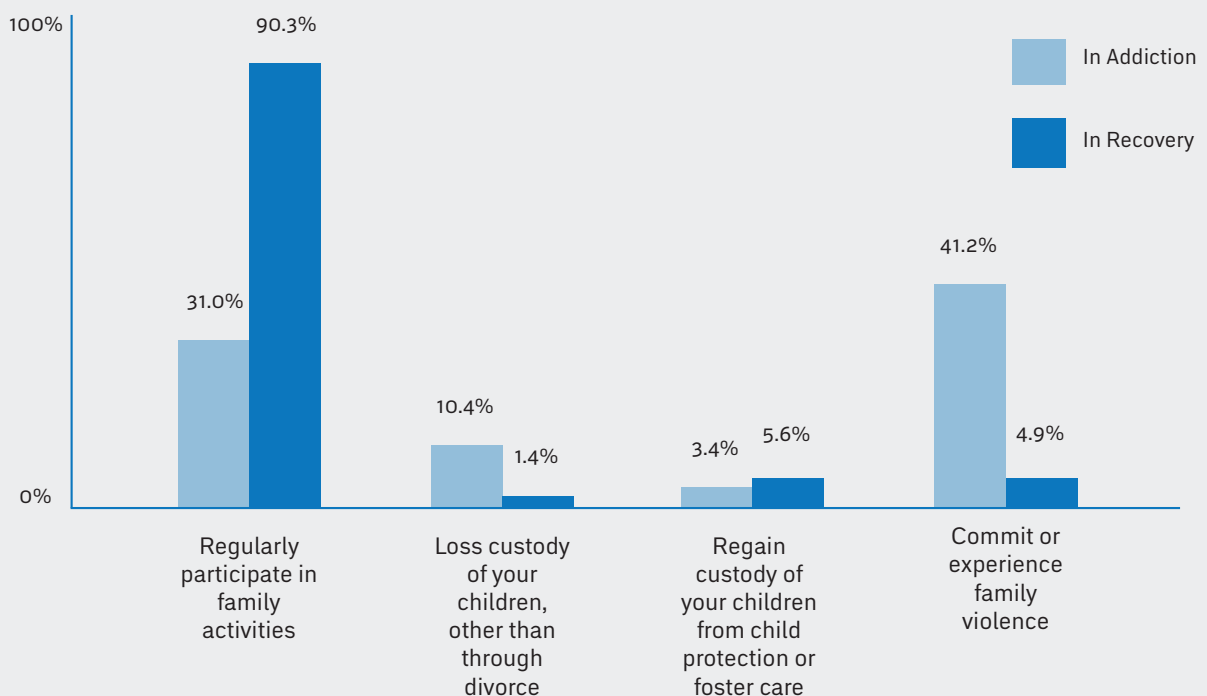| Rating	Percentage
Excellent	17.0%
Very Good	38.6%
Good	28.6%
Fair	12.3%
Poor	3.4%

84.2% of respondents rated their mental health as "good" or better

Reconnecting with Family

Compared to periods of active addiction, individuals in recovery reported higher rates of regularly participating in family activities, increased likelihood of maintaining custody of children and reduced involvement with child protective services (if applicable), and lower rates of committing or experiencing domestic violence (Figure 3).
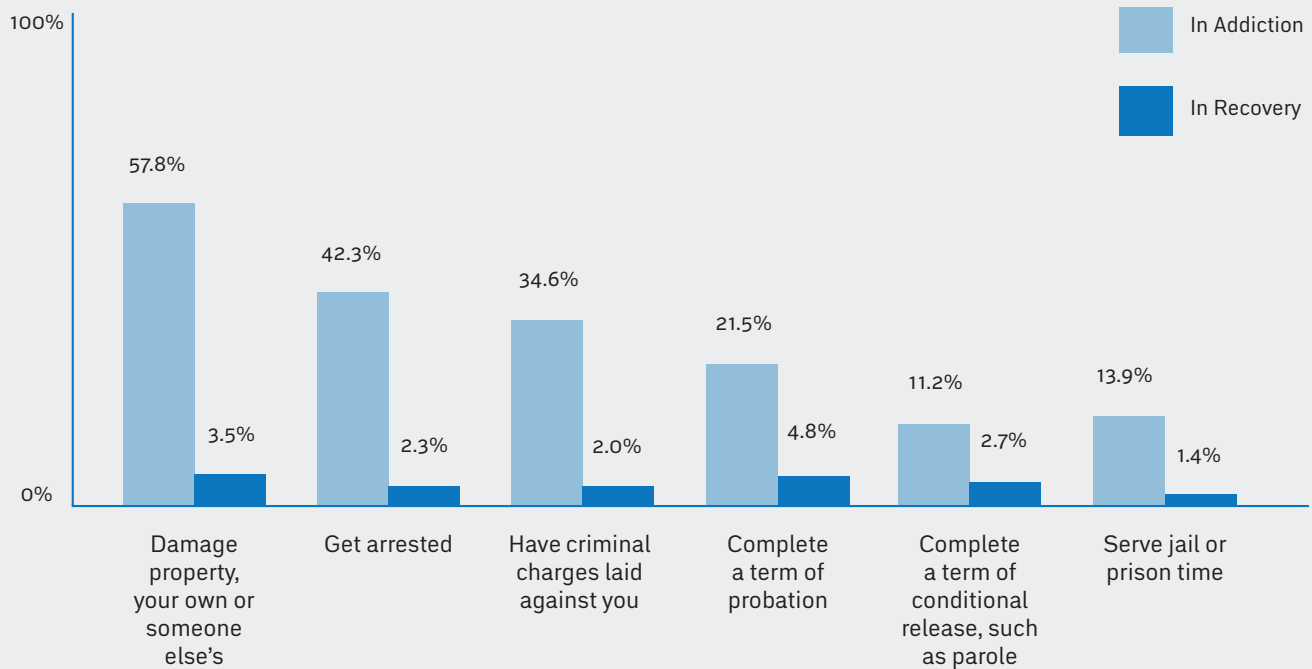
Figure 3

The *Life in Recovery* study demonstrated that Canadians in recovery experience positive changes across multiple dimensions of their lives that continue to build over time, such as family relationships, health and wellness, legal issues, employment and education, and personal finances.

Reducing Criminal Offences

Individuals in recovery reported substantially lower rates of involvement in criminal activity, and fewer encounters with the criminal justice system (Figure 4).

Figure 4

Legend:
- In Addiction (light blue)
- In Recovery (dark blue)

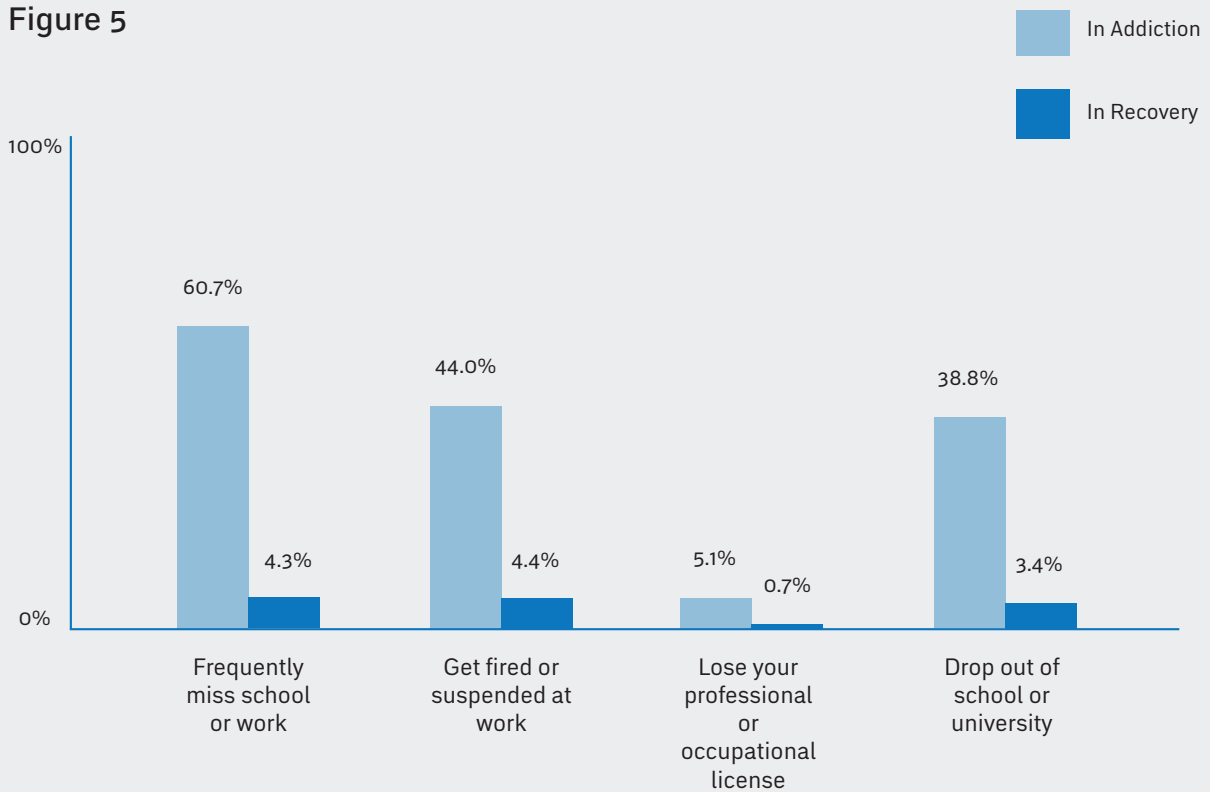| Category	In Addiction	In Recovery
Damage property, your own or someone else's	57.8%	3.5%
Get arrested	42.3%	2.3%
Have criminal charges laid against you	34.6%	2.0%
Complete a term of probation	21.5%	4.8%
Complete a term of conditional release, such as parole	11.2%	2.7%
Serve jail or prison time	13.9%	1.4%

Building Social Responsibility

Compared with life during active addiction, individuals in recovery were more likely to report access to stable housing, steady employment, and paying their bills and taxes on time. Individuals in recovery also reported lower rates of absenteeism from work or school, were less likely to experience disciplinary action(s) in the workplace, and were less likely to drop out of school or university (Figure 5).

Figure 5

In Addiction

In Recovery

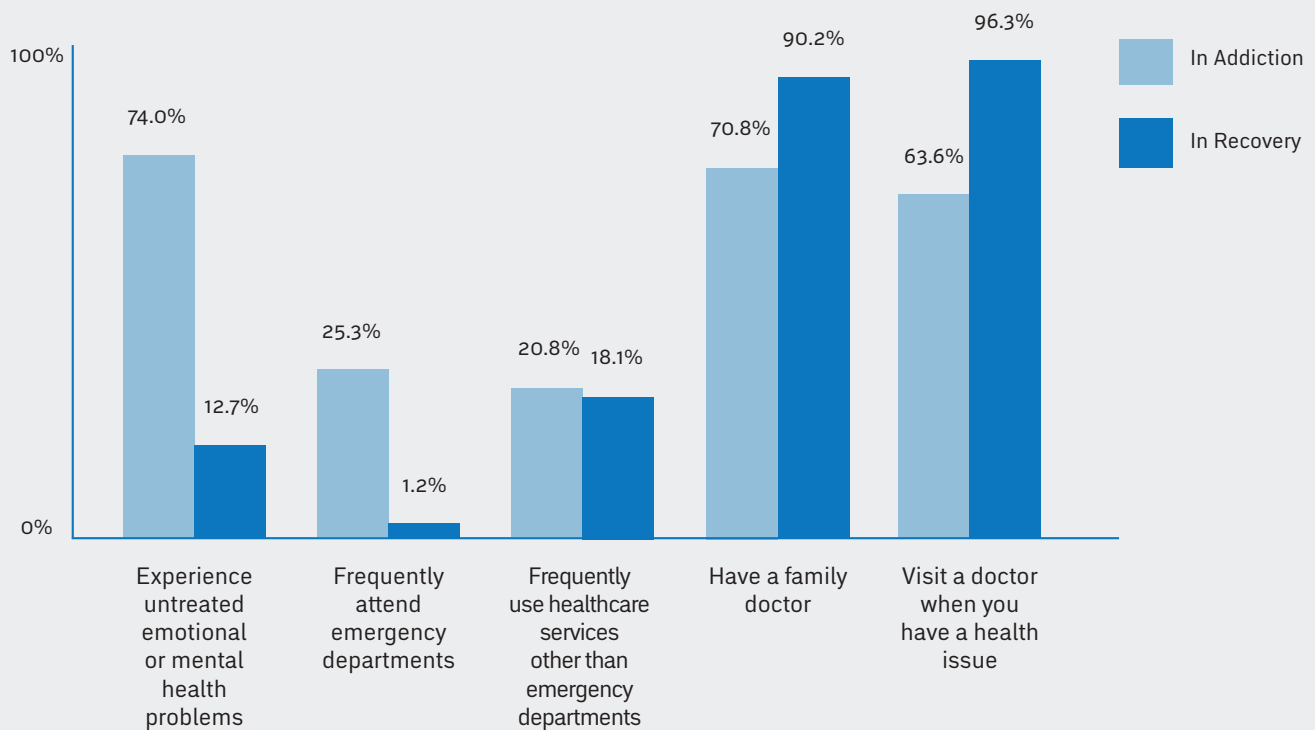|	Frequently miss school or work	Get fired or suspended at work	Lose your professional or occupational license	Drop out of school or university
In Addiction	60.7%	44.0%	5.1%	38.8%
In Recovery	4.3%	4.4%	0.7%	3.4%

Optimizing Health and Wellness

Individuals in recovery reported higher rates of healthy lifestyle practices compared to periods of active addiction, including regular exercise, regular dental and medical check-ups, and healthy eating habits. Individuals also experienced fewer untreated mental health issues during recovery and reported less frequent use of emergency departments (Figure 6).

Figure 6

	In Addiction	In Recovery
Experience untreated emotional or mental health problems	74.0%	12.7%
Frequently attend emergency departments	25.3%	1.2%
Frequently use healthcare services other than emergency departments	20.8%	18.1%
Have a family doctor	70.8%	90.2%
Visit a doctor when you have a health issue	63.6%	96.3%

Overall, the results of the *Life in Recovery in Canada* survey were consistent with similar *Life in Recovery* surveys that have been conducted in the United States,[3] Australia,[4] and the United Kingdom,[5] all of which also reported similarly positive social impacts of recovery on physical and emotional health, quality of life, and social connectedness and responsibility.

Of note, the Canadian study was the only *Life in Recovery* survey that examined barriers to initiating and sustaining recovery. The leading barriers individuals reported facing were not believing that they had a problem or not believing that their problem was serious enough, dealing with stigma and misconceptions about addiction and recovery, as well as system-level barriers, such as delays in accessing services, costs, and poor availability of high-quality recovery services within their communities. The lack of gender-specific, age-appropriate, and culturally-safe services for women, LGBT2Q+ individuals, youth and Indigenous peoples, who face unique challenges in recovery, was also identified as a barrier to initiating and sustaining recovery among many survey respondents.

The Canadian study was the only survey that examined barriers to initiating and sustaining recovery

The Research Evidence

While there are a diversity of recovery-oriented programs available in B.C., this evidence review will focus on those programs that were identified as "very important" to achieving and sustaining recovery by the majority of participants in the Canadian *Life in Recovery* survey: residential treatment programs (83%), recovery residences (82%), 12-step mutual support groups (80%), and therapeutic communities (70%).

Residential Treatment

A recent systematic review concluded that based on the available evidence, residential treatment programs for substance use disorders appear to be effective, with studies finding either an improvement or no difference in a range of outcome measures – abstinence, substance use, employment, medical conditions, psychiatric symptoms, quality of life, and social support – for residential treatment compared to other treatments.[6] The review authors concluded that while more rigorous research is needed, "Residential treatment for substance use disorders shows value, and merits ongoing consideration by policy makers as a covered benefit in public and commercially funded plans."

Several reviews of therapeutic communities (TC), a specific type of residential treatment, have found that compared to other treatment approaches, the TC model results in similar or superior abstinence and substance use outcomes, with some studies reporting greater improvements in legal issues, employment status and psychological functioning.[7-9] The TC model has also been successfully implemented in correctional settings in North America and Europe, and research has consistently demonstrated that corrections-based TCs are effective in reducing post-release criminal activity and re-incarceration rates.[10-12] One such example in B.C. is the Guthrie House program at Nanaimo Correctional Centre, which has reported a 33% reduction in re-offence rates among TC participants compared to similarly matched individuals not enrolled in the program.[13]

Research suggests that the structured and immersive residential treatment approach may be particularly beneficial for some individuals, in-

cluding those with more severe addictions who have been unsuccessful in past treatment attempts;[14-16] individuals with polysubstance use, concurrent psychiatric or medical conditions;[17,18] and individuals with minimal social supports, in an unstable environment (e.g., at-risk youth, homeless individuals) or in a social environment that does not support recovery.[7,19]

Relapse rates following residential treatment do vary widely in the research literature (from 20% to 90%),[7,20] but the strongest predictors of sustained abstinence are generally consistent across studies: completion of the program, longer duration of treatment and integration of evidence-based medical therapies where appropriate, and if continuing care is provided or available post-residential treatment (e.g., "aftercare" programs, counselling, mutual support groups, recovery residences).[7,21-25] This underscores the need to establish a robust continuum of care options in B.C. to best support individuals in achieving long-term recovery.

Recovery residences

A recent systematic review reported that based on the available research evidence, recovery residences appear to be effective in supporting long-term recovery.[26] Overall, study results showed that compared to treatment-only, the addition of recovery housing (i.e., stabilization and transitional living residences and assisted living residences) to the individual's experience was associated with improved substance use outcomes, psychiatric symptoms and social functioning; for example, those who entered recovery housing after inpatient or residential addiction treatment tended to have higher employment rates and lower rates of criminal activity than those who did not.[26] The review authors concluded that recovery residences are an important component of the continuum of care, but noted that they are often undervalued or overlooked within health and social service systems. More specifically, the authors recommended that public and private health care systems should consider secure funding mechanisms for recovery residences, in order to improve access, program safety and quality, which in turn, would better support individuals pursuing a life in recovery in the community.

Other studies have shown that recovery residences reduce relapse after treatment by providing abstinence-oriented supportive environments

where individuals in recovery can build healthy social networks and access non-judgmental support.[27] Recovery residences can also ease the burden on residential treatment centres by providing continuity of care or an alternative lower-intensity service, especially for individuals who are more autonomous and able to assume personal responsibility for their recovery.[28]

Mutual support groups

Several clinical trials have found that 12-step facilitation therapy,[29] where trained health care professionals provide structured counselling on the core 12-step principles and encourage regular attendance at community meetings, is as effective or superior to other psychosocial treatments in supporting abstinence or reducing substance use.[29-31] Other studies have found that engagement with community-based 12-step groups early in recovery,[32,33] attending meetings voluntarily[34] and on a regular basis,[35] and active involvement in the program (e.g., participation, service, sponsorship),[36] tend to predict better substance use outcomes.

For those who benefit, the following characteristics of 12-step groups have been identified as key recovery supports: the group dynamic (e.g., feeling connected to and a sense of belonging with others),[37] improved self-awareness and responsibility,[38-40] experiencing acceptance and empathy from and for others,[41] and developing or strengthening a connection with spirituality.[42,43] From a health systems perspective, advantages of 12-step and other peer-led support groups are their broad accessibility, and potential to reduce burden on and costs to the health care system (by providing an alternate, low-barrier, and no-cost source of recovery support).[44,45]

Non-12-step mutual support groups. It is important to note that there are a growing number of non-12-step mutual support groups available in B.C., such as SMART Recovery©, LifeRing, and Women for Sobriety, among others. While very little evidence has been published to date on the effectiveness of these mutual support groups in supporting recovery, in general, peer support has been consistently identified as an important component of recovery in the research literature[46,47] and by those with lived experience.[2-5]

Conclusion

The *Life in Recovery* survey and past reviews and research findings support that implementing and strengthening recovery services in B.C. can significantly reduce population harms, yield financial savings and, most importantly, improve the lives of individuals, families and communities affected by addiction.

Individuals in recovery can & do lead meaningful lives

"Connecting people to their community provides them with a sense of purpose and pride. Let's breakdown the stigma of recovery with compassion, perseverance, and inspiration. We can overcome addiction in unity."

—

Guiseppe Ganci

What Is Recovery?

Over the years, different definitions of recovery have emerged to address a general lack of understanding about recovery and to broaden its scope beyond an exclusive or linear pursuit of abstinence from alcohol or other drug use. For example, in 2006, the Betty Ford Institute defined recovery from substance use disorders as "a voluntarily maintained lifestyle characterized by sobriety, personal health, and citizenship."[48] More recently, in 2011, the Substance Abuse and Mental Health Services Administration (SAMHSA) defined recovery as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."[49]

In Canada, the American Society of Addiction Medicine's (ASAM's) definition of recovery was adopted at the National Commitment to Recovery in Canada summit in Ottawa in 2016, which states that:

> *"Recovery is a process of sustained action that addresses the biological, psychological, social and spiritual disturbances inherent in addiction. Recovery aims to improve the quality of life by seeking balance and healing in all aspects of health and wellness, while addressing an individual's consistent pursuit of abstinence, impairment in behavioral control, dealing with cravings, recognizing problems in one's behaviors and interpersonal relationships, and dealing more effectively with emotional responses."*

An individual's recovery actions lead to reversal of negative, self-defeating internal processes and behaviors, allowing healing of relationships with self and others. Since some prescribed and non-prescribed medications can interfere with recovery, it would be prudent to consult with an Addiction Specialist Physician in selected cases.[1]

It is important that provincial agencies and other stakeholders who are working with the recovery community to achieve common goals use a definition that resonates with and is meaningful to their colleagues in recovery. Working from this shared understanding will enrich collaborative efforts to strengthen recovery from addiction in British Columbia.

Recovery Capital

Recovery capital refers to the net sum of the internal and external resources and barriers that affect people with substance use disorders' initiation and maintenance of recovery.[50] While traditionally, addiction research has focused on resolution of problems related to substance use, the more recently introduced concept of recovery capital represents a novel approach to asset-based inquiry that aligns with our evolving understanding of sustained recovery. Rather than focusing on the reduction or management of substance-related harms, recovery capital shifts the emphasis to an individual's positive assets and strengths, and prioritizes therapeutic interventions that emphasize and support meaningful gains and recovery goals. Recovery capital posits that the solutions to problems are currently established in the lived experience of individuals, families and communities, and further learning could illuminate various factors and resources to enhance recovery initiation and maintenance. Re-evaluation of recovery capital as a routine part of treatment and recovery service provision provides valuable feedback, reinforcement, and direction for ongoing recovery management planning.

Treatment Then Recovery Management

Addiction treatment services are often delivered by accredited health professionals but are only the start of what can be a much longer process of recovery. For individuals who are in circumstances without sufficient recovery capital to initiate recovery on their own (e.g., homelessness), specialized professional services may include harm reduction, assessment, medical stabilization or detoxification and a range of pharmacologic and psychosocial addiction treatment modalities, delivered in outpatient and inpatient care settings. Although effective treatment can result in the initiation of healthier behaviours, it alone is often insufficient to bring about sustained remission and long-term recovery.[51] One of the most important objectives of addiction treatment is to support the initiation of recovery in people with substance use disorders and other addictions by increasing their levels of recovery capital.

As with other complex chronic medical conditions, such as heart disease and diabetes, continuing self-care for people with substance use

disorders is critical, as relapse to active addiction after an episode of standalone acute treatment can occur. A preferable outcome for those with substance use disorder following initial treatment is longer-term recovery management in the community.[52] Community-based recovery management services include mutual support from other people in recovery, volunteer service providers, peer helpers and a variety of community-based health and social services. Community-based recovery activities, especially participation in mutual support group recovery programs, are not considered addiction treatment.

Recovery-Oriented Systems of Care

Recovery-oriented systems of care are coordinated networks of community-based services and supports that build on the strengths and resiliencies of individuals, families and communities to achieve recovery and improved health, wellness, and quality of life for those with or impacted by substance use disorders. The central focus is to create an infrastructure or "system of care" to effectively support recovery within a community, encompassing a full range of individualized, person-centred, and strength-based recovery management services. Recovery-oriented systems of care engage and train volunteers and professionals, many of whom have lived experience with addiction and recovery, to provide support and recovery coaching to others who are pursuing recovery from substance use disorders and other addictions.

Comprehensive recovery-oriented systems of care[53] may include recovery community centres, recovery high schools, collegiate recovery programs, recovery workplaces and recovery supportive housing, among other services.[54] Recovery community centres in particular can serve an important role in a recovery-oriented system of care by serving as a low-barrier, central location in the community where individuals can access peer-led recovery support services, participate in education and training programs, and attend a variety of recovery-oriented mutual support group meetings.

"I am honoured to be part of a team that envisions a continuum of quality care and full spectrum recovery services for individuals and families impacted by addiction in British Columbia."

—

Brenda Plant

Ways to Strengthen Recovery in BC

A collaborative approach that involves multiple stakeholders and works from the strengths of people in recovery and existing local recovery services and programs can help to strengthen recovery and improve the lives of people facing addictions in B.C. Listed below are some immediate and long-term strategies that can have meaningful impact on the lives of British Columbians facing alcohol and/or other drug addictions.

In order to identify and define priorities, the British Columbia Centre on Substance Use (BCCSU) has engaged in a comprehensive evidence review and worked with a variety of knowledge holders and gathered their input on current challenges and proposed solutions to improve the addiction system of care in B.C. The BCCSU facilitated communication within and among groups and organizations that have not historically worked together closely: people with lived experience of substance use disorders and other addictions, peer organizations, family support groups, recovery-oriented care and treatment advocates, public and private recovery programs and treatment facilities. These groups have worked together toward achieving consensus on the top priorities and a shared vision for a functioning addiction system of care. The results of this series of knowledge holder consultations are a series of action items that are summarized below.

Based on the feedback we received, the BCCSU will create four working groups to be comprised of health leaders and members of the recovery community of B.C., who will, in collaboration with the BCCSU and other stakeholders in the province, work together to advance the action items. These working groups will build upon existing health systems planning activities underway in the province by collaborating closely with the Ministry of Health and the Ministry for Mental Health and Addiction, B.C.'s Overdose Emergency Response Centre, including the Treatment Task Group as well as with provincial and regional health authorities and associated contracted service agencies.

The working groups will have a mandate to provide recommendations to policy makers to support strategies to strengthen recovery in B.C.

Recovery working groups: areas of focus

1 *Health Systems, Education and Clinical Tools*

- Examine how to establish active and timely referral pathways between existing recovery and other addiction-related services – particularly withdrawal management (i.e., "detox") programs – that include standardized assessment and screening tools.[55-58]
- Investigate and recommend system transformations aimed at ensuring equitable access to care for inpatient and outpatient addiction treatment services.
- Plan research of and best practice policy development for recovery-focused facilities and services.
- Develop an evidence-based recovery capital checklist[59-61] to help guide Health Authorities in implementing appropriate recovery and recovery referral systems in all acute care settings.
- Support the BCCSU to educate family physicians, nurse practitioners and registered nurses, other health professionals, and service providers about recovery when addressing substance use disorders and other addictions.[62]
- Support implementation of telemedicine programs for smaller and community-based recovery programs such as recovery residences.[63-66]
- Examine how to establish, implement and support trauma-informed care education for practitioners.[67,68]
- Establish and publish best practice guidelines for recovery-oriented medicine and recovery-oriented systems of care.[54,69,70]
- Work with recovery service providers to establish standardized outcome benchmarking tools.[71-73]
- Promote recovery management checkups.[74-76]
- Work with professional credentialing organizations and regulatory colleges to establish ethical standards against working in illegal, unlicensed or unregistered facilities.

2 Underserved and Vulnerable Populations

- Examine per diem rates for treatment and recovery services and mechanisms of funding to support improved outcomes in underserved and vulnerable populations.
- Examine best practices and implement treatment and recovery strategies for workplace health and employee programs.[77]
- Develop and support strategies for increased recovery services for women (including mother and child)[78] in primary, secondary and tertiary care across the spectrum of modalities.
- Develop and support strategies for funding and increased services for youth-specific treatment and recovery support.[66,79]
- Investigate safe care models for youth with severe addictions.[80]
- Support strategies for increasing availability of recovery programs within B.C. Correctional Centres, as well as recovery services for probationers.[12,66]
- Support strategies to increase prevalence of recovery-based living units and recovery programs within B.C. Correctional Centres.[7,12,13]
- Support strategies for increasing funding and service levels for Indigenous recovery programs.[65,81-83]
- Examine the feasibility of establishing recovery high schools in B.C. (recovery centres that also provide formal education).[84,85]
- Examine and recommend models of care for families and partners of people with substance use disorders (family systems model), including workplace supports.[86,87]

3 *Awareness and Celebration*

- Support the promotion of Recovery Week[88] celebrations throughout the province.
- Increase social awareness and acceptance of people in recovery and recovery residences in the broader community.[89]
- Create and deliver anti-stigma campaigns about addiction and recovery using public education and media.[89-92]
- Create and implement education for the media to include recovery in their coverage of substance use and addiction.
- Host forums and conferences for health professionals and service providers to send a clear and consistent message that recovery is an attainable goal, as well as emphasizing the importance of a non-discriminatory and holistic approach to recovery.[93]
- Establish workplace campaigns to assist employers in recognizing substance use disorders and better supporting employees in recovery.[77]
- Establish recovery awareness campaigns focusing on Indigenous communities, LGBT2Q+ communities, women and youth.

4 Policy, Regulation, Licensing and Enforcement

- Shift from a provincial health system approach that has historically focused on harm reduction and acute treatment to a approach that better supports the full continuum of care, from harm reduction through to long-term recovery-oriented, abstinence-based interventions, supports and environments.
- Support policy development to ensure that people with substance use disorders are made aware of all care pathways available to them when they access health care services.
- Examine strategies to ensure that all licensing and enforcement officers are educated and trained in the subject matter that is the focus their work.
- Examine zoning bylaws and business licensing practices to ensure that recovery residences are well regulated and to prevent the proliferation of unsafe illegal rooming homes.[94]
- Establish a template for municipalities for the zoning and licensing of recovery homes and treatment centres.[94]
- Support strategies to ultimately increase provincial enforcement powers to close unlicensed or illegal treatment centres.[94]
- Explore the development and implementation of a mandatory certificate program for recovery residence operators to ensure a high standard of service across the province.
- Support the establishment of recovery community centres[95-99] in suburban areas throughout B.C.
- Support the establishment of collegiate recovery programs[100,101] on university and college campuses.
- Examine how to establish and pilot B.C.'s first recovery coaching[46,47,102] centre.
- Support the establishment of policy to ensure that clients receiving services in licensed or registered facilities are not referred, transferred or transitioned to illegal, unlicensed or unregistered facilities.

"I envision a day where equitable pathways to recovery are afforded to all British Columbians, facilitated by informed evidence based decisions that appreciate the variety of factors contributing to the initiation and preservation of long-term recovery."

—

Carson McPherson

Summary

The recently released review of illicit drug overdoses from the B.C. Coroner's Service Death Review Panel highlighted the urgent need to strengthen and improve recovery services in B.C.[94] Here, we can look to other international jurisdictions that have augmented recovery-oriented services and seen deaths and other harms from substance use decline dramatically as a result.

For instance, Portugal has established a robust recovery-oriented system of care where all individuals with substance use disorders are able to access, at no cost, a range of service and treatment modalities matched to their biopsychosocial needs and recovery goals, including a network of publicly funded therapeutic communities.[103] In the past decade, Portugal has seen a steady decline in illicit drug use and high-risk drug and alcohol use in the general population, and the most recently available data indicate that the overdose mortality rate is approximately 3.5-fold lower than the European average (5.8 vs. 20.3 deaths per million people).[103]

By addressing the recommendations derived from the consultations undertaken to prepare this report, and through the efforts of proposed working groups following its release, we can begin to create the system-wide changes needed to achieve the benefits that have been observed in other jurisdictions where recovery-oriented services are fully integrated within the continuum of care.

Expanding and improving recovery services is a key element of creating a coordinated and effective continuum of addiction care. While it is critically important to provide life-saving public health services, and to establish a range of effective acute treatment services (e.g., withdrawal management programs), it is also necessary to develop and strengthen long-term recovery-oriented services to support people struggling with addiction. This includes empowering people in recovery and individuals and their families to support one another in their pursuit of improved health and wellbeing. Improving access to effective, evidence-based recovery support services is an essential component of British Columbia's overdose response, but also addresses the province's longer term goal of establishing a robust, responsive system of addiction care, where patients and families only need to ask for help once, and are able to get support right away as there do with other illness.

In British Columbia, we have the knowledge, expertise and will among the recovery community to build a recovery-oriented system of care that can strengthen recovery services in the province. If we provide the same level of attention, compassion and investment to recovery as any other critical public health issue, we can make long-term recovery from substance use disorders and other addictions an attainable and sustainable reality for many British Columbians.

In British Columbia we have the knowledge, expertise, and will ... to build a recovery-oriented system of care

Glossary of Terms

Mutual support groups[32]
Mutual support groups are nonprofessional groups comprising members who share the same substance-related problem or addiction and voluntarily support one another in their pursuit of sustained recovery. Although mutual support groups are not considered to be an addiction treatment service, they are one part of a recovery-oriented system of care approach to recovery. By providing social, emotional, and informational support for persons throughout their recovery process, mutual support groups can help individuals take responsibility of their sustained health, wellness, and recovery.

12-step mutual support groups[104]
An international fellowship of peer support groups comprised of individuals in recovery, which offer emotional support and a structured, "12-step" approach to achieving abstinence from substance use disorders and addiction. The most well known examples are Alcoholics Anonymous and Narcotics Anonymous, although support groups for other addictions exist, as do 12-step groups tailored for specific populations (e.g., women, youth, LGBT2Q+). Central concepts of 12-step programs are that addiction is a spiritual and medical disease, and that recovery is a journey involving belief in a higher power, taking an honest inventory, personal exploration, and acceptance.

Non-12-step mutual support groups
Mutual support groups that do not employ the traditional 12-step model but maintain an emphasis on peer support and guidance to support individuals in pursuing and achieving their recovery goals. Some non-12-step mutual support groups have adopted a secular approach as an alternative for those individuals who may find the spiritual elements of the 12-step model to be incompatible with their personal belief systems. Some examples include SMART© Recovery, LifeRing, the Secular Organization for Sobriety/Save Our Selves (SOS), and Women For Sobriety.

Recovery-oriented system of care (ROSC)[54]
A coordinated network of community-based services and supports that is person-centred and builds on the strengths and resiliencies of individuals, families and communities to achieve recovery and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems. The central focus is to create an infrastructure or "system of care" with the resources to effectively address substance use problems within a community, encompassing a full range of individualized, person-centred, and strength-based services. By design, a ROSC provides individuals and families with more options with which to make informed decisions regarding their care.

Recovery capital[59,105]
Defined as the sum total of an individual's personal and social resources that can be brought to bear to address their addiction and bolster their capacity and opportunities for recovery. Key elements of recovery capital include physical and mental health; family, social supports, and leisure activities; safe housing and healthy environments; peer-based support; employment and resolution of legal issues; vocational skills and educational development; community integration and cultural support; and discovering (or rediscovering) meaning and purpose in life.

Recovery check-ups[76]
Modeled after approaches used in medical management of other chronic diseases (e.g., diabetes, heart disease), recovery management check-ups involve continued monitoring after treatment to provide informal support and encouragement, identify any barriers to abstinence, find ways to address these barriers, identify early relapse, and provide direct and immediate linkage to treatment services before relapse progresses to a more advanced state.

Recovery coaching[46]
A recovery coach is an individual in recovery who, through a formalized relationship or partnership, provides guidance and support to others through their transition from recovery initiation to recovery maintenance. In this role, recovery coaches draw on the strengths of their own lived experience of recovery to help others in their individual recovery journeys.

Recovery collegiate programs[106]
Recovery collegiate programs consist of recovery support services provided on university or college campuses that aim to create a supportive community within the campus culture to support educational opportunities and goals of students in recovery. Services may include recovery housing, "recovery-friendly" meeting or communal spaces, mutual-support meetings (e.g., 12-step), and access to counselling services.

Recovery community centre[99]
A central physical location in the community where a range of recovery-oriented services are provided by a largely peer-based and volunteer force. Clients actively participate in recovery-oriented programming and help support others with their recovery, so the recovery community centre is considered more than a "drop-in centre". Recovery community centres do not typically provide clinical services.

Recovery high schools[84]
Alternative high schools specifically established to support students in recovery from substance use disorders. Programs are designed to meet both academic and therapeutic needs of adolescents who have received addiction treatment, with recognition of the significant role that peer and environmental influences play among youth in recovery.

Recovery housing[26]
A direct service with multiple components that provides supervised, short-term housing to individuals with substance use disorders or co-occurring mental and substance use disorders. Typically offered following completion of a residential treatment program, recovery housing aims to increase an individual's stability, improve their social functioning, and support the individual in their transition to a productive, independent life of recovery in the community.

Residential treatment[6]
A direct service with multiple components that is delivered in a licensed facility (i.e., non-hospital or free-standing residential treatment facility) used to evaluate, diagnose, and treat the symptoms or disabilities associated with an individual's substance use disorder. A variety of therapeutic interventions may be implemented across different residential treatment settings; however, a common defining characteristic of residential treatment is that it provides a structured housing program to individuals receiving rehabilitation services.

Therapeutic community[7,22]
A specific type of residential treatment (see above) where the treatment is structured to focus on psychosocial rehabilitation (i.e., "re-socialization") of an individual and uses the program's entire community – including other residents, staff, and the broader social context – as active components of treatment. Therapeutic communities typically involve a peer-based hierarchical model, with treatment stages that reflect increased levels of personal and social responsibility. Peer influence and support, mediated through a variety of group-based dynamic processes, is viewed as a critical element for the assimilation of new social norms and developing more effective social skills.

References

1. American Society of Addiction Medicine (ASAM). Terminology Related to Addiction, Treatment, and Recovery. 2013. Available at: http://www.asam.org/docs/default-source/public-policy-statements/1-terminology-atr-7-135f81099472bc604ca5b7ff000030b21a.pdf?sfvrsn=0. Accessed Mar 6 2018.

2. McQuaid R, Aqsa M, Moussouni K, Baydack N, Stargardter M, & Morrisey M. Life in Recovery from Addiction in Canada: Technical Report. Canadian Centre on Substance Use and Addiction. 2017. Available at: http://www.ccsa.ca/Resource Library/CCSA-Life-in-Recovery-from-Addiction-Report-2017-en.pdf. Accessed Mar 6 2018.

3. Laudet AB. Life in Recovery: Report on the Survey Findings. 2013. Washington, DC: Faces & Voices of Recovery. Available at: https://facesandvoicesofrecovery.org/file_download/inline/77447c81-eb9a-467c-b988-523db82f806f. Accessed Mar 6 2018.

4. Turning Point, Easternhealth, and South Pacific Private. The Australian Life in Recovery Survey. 2015. Available at: http://www.turningpoint.org.au/site/DefaultSite/filesystem/documents/Life In Recovery Survey.pdf. Accessed Mar 6 2018.

5. Best DW, Albertson K, Irving J, Lightowlers C, Mama-Rudd A, Chaggar A. UK Life in Recovery Survey 2015: The first national UK survey of addiction recovery experiences. Helena Kennedy Centre for International Justice, Sheffield Hallam University and Action on Addiction. 2015. Available at: http://www.drugsandalcohol.ie/24542/1/UK Life in Recovery FINAL - 22915.pdf. Accessed Mar 6 2018.

6. Reif S, George P, Braude L, et al. Residential Treatment for Individuals With Substance Use Disorders: Assessing the Evidence. Psychiatric Services. 2014;65(3):301-312.

7. Smith LA, Gates S, Foxcroft D. Therapeutic communities for substance related disorder. Cochrane Database of Systematic Reviews. 2006(1).

8. Vanderplasschen W, Colpaert K, Autrique M, et al. Therapeutic Communities for Addictions: A Review of Their Effectiveness from a Recovery-Oriented Perspective. Scientific World Journal. 2013.

9. Pearson FS, Prendergast ML, Podus D, Vazan P, Greenwell L, Hamilton Z. Meta-analyses of seven of the National Institute on Drug Abuse's principles of drug addiction treatment. Journal of Substance Abuse Treatment. 2012;43(1):1-11.

10. Sacks S, Sacks JY, McKendrick K, Banks S, Stommel J. Modified TC for MICA offenders: Crime outcomes. Behavioral Sciences & the Law. 2004;22(4):477-501.

11. Wexler HK, De Leon G, Thomas G, Kressel D, Peters J. The Amity prison TC evaluation - Reincarceration outcomes. Criminal Justice and Behavior. 1999;26(2):147-167.

12. Mitchell O, Wilson DB, MacKenzie DL. The Effectiveness of Incarceration-Based Drug Treatment on Criminal Behavior: A Systematic Review. Campbell Systematic Reviews 2012:18. Available at: https://www.campbellcollaboration.org/library/effectiveness-of-incarceration-based-drug-treatment.html. Accessed March 26 2018.

13. British Columbia Ministry of Public Safety and Solicitor General. B.C. Corrections Performance, Research and Evaluation Unit. "Nanaimo Correctional Centre Therapeutic Community: Preliminary Impact Analysis Research Report." Prepared by CLZ Gress & S Arabsky. Released September 8, 2010. Available at: https://www2.gov.bc.ca/assets/gov/law-crime-and-justice/criminal-justice/corrections/research-evaluation/ncc-tc-pia.pdf. Accessed March 26 2018.

14. Harrison PA, Asche SE. Comparison of substance abuse treatment outcomes for inpatients and outpatients. Journal of Substance Abuse Treatment. 1999;17(3):207-220.

15. De Leon G, Melnick G, Cleland CM. Client matching: a severity-treatment intensity paradigm. J Addict Dis. 2008;27(3):99-113.

16. Tiet QQ, Ilgen MA, Byrnes HF, Harris AH, Finney JW. Treatment setting and baseline substance use severity interact to predict patients' outcomes. Addiction. 2007;102(3):432-440.

17. Rychtarik RG, Connors GJ, Whitney RB, McGillicuddy NB, Fitterling JM, Wirtz PW. Treatment settings for persons with alcoholism: Evidence for matching clients to inpatient versus outpatient care. J Consult Clin Psych. 2000;68(2):277-289.

18. Brunette MF, Mueser KT, Drake RE. A review of research on residential programs for people with severe mental illness and co-occurring substance use disorders. Drug Alcohol Rev. 2004;23(4):471-481.

19. Finney JW, Moos RH, Wilbourne PL: Effects of treatment setting, duration, and amount on patient outcomes; in Principles of Addiction Medicine, 4th ed. Edited by Ries RK, Fiellin DA, Miller SC, et al. Philadelphia, Wolters Kluwer/Lippincott Williams & Wilkins. 2009.

20. De Leon G, Schwartz S. Therapeutic communities: what are the retention rates? Am J Drug Alcohol Abuse. 1984;10(2):267-284.

21. Volkow ND, Koob GF, McLellan AT. Neurobiologic advances from the brain disease model of addiction. N Engl J Med. 2016;374(4):363-371.

22. Malivert M, Fatseas M, Denis C, Langlois E, Auriacombe M. Effectiveness of Therapeutic Communities: A Systematic Review. European Addiction Research. 2012;18(1):1-11.

23. National Health Service, National Treatment Agency for Substance Misuse. Medications in Recovery: Re-orientating Drug Dependence. 2012. Available at: http://www.nta.nhs.uk/uploads/medications-in-recovery-main-report3.pdf. Accessed 25 April 2018.

24. Ford JH, Abraham AJ, Lupulescu-Mann N, et al. Promoting Adoption of Medication for Opioid and Alcohol Use Disorders Through System Change. Journal of Studies on Alcohol and Drugs. 2017;78(5):735-744.

25. Schmidt LA, Rieckmann T, Abraham A, et al. Advancing Recovery: Implementing Evidence-Based Treatment for Substance Use Disorders at the Systems Level. Journal of Studies on Alcohol and Drugs. 2012;73(3):413-422.

26. Reif S, George P, Braude L, et al. Recovery Housing: Assessing the Evidence. Psychiatric Services. 2014;65(3):295-300.

27. Jason LA, Davis MI, Ferrari JR. The need for substance abuse after-care: Longitudinal analysis of Oxford House. Addictive Behaviors. 2007;32(4):803-818.

28. Polcin DL, Korcha RA, Bond J, Galloway G. Sober living houses for alcohol and drug dependence: 18-Month outcomes. Journal of Substance Abuse Treatment. 2010;38(4):356-365.

29. Project MATCH (Matching Alcoholism Treatment to Client Heterogeneity): rationale and methods for a multisite clinical trial matching patients to alcoholism treatment. Alcohol Clin Exp Res. 1993;17(6):1130-1145.

30. Donovan DM, Daley DC, Brigham GS, et al. Stimulant abuser groups to engage in 12-Step: A multisite trial in the National Institute on Drug Abuse Clinical Trials Network. Journal of Substance Abuse Treatment. 2013;44(1):103-114.

31. Matching Alcoholism Treatments to Client Heterogeneity: Project MATCH posttreatment drinking outcomes. J Stud Alcohol. 1997;58(1):7-29.

32. Donovan DM, Ingalsbe MH, Benbow J, Daley DC. 12-Step Interventions and Mutual Support Programs for Substance Use Disorders: An Overview. Social Work in Public Health. 2013;28(3-4):313-332.

33. Caldwell PE, Cutter HSG. Alcoholics Anonymous affiliation during early recovery. Journal of Substance Abuse Treatment. 1998;15(3):221-228.

34. Kownacki RJ, Shadish WR. Does Alcoholics Anonymous work? The results from a meta-analysis of controlled experiments. Subst Use Misuse. 1999;34(13):1897-1916.

35. Kaskutas LA. Alcoholics Anonymous Effectiveness: Faith Meets Science. Journal of Addictive Diseases. 2009;28(2):145-157.

36. Subbaraman MS, Kaskutas LA, Zemore S. Sponsorship and service as mediators of the effects of Making Alcoholics Anonymous Easier (MAAEZ), a 12-step facilitation intervention. Drug and Alcohol Dependence. 2011;116(1-3):117-124.

37. Rice SL, Tonigan JS. Impressions of Alcoholics Anonymous (AA) Group Cohesion: A Case for a Nonspecific Factor Predicting Later AA Attendance. Alcohol Treat Q. 2012;30(1):40-51.

38. Kelly JF, Hoeppner B, Stout RL, Pagano M. Determining the relative importance of the mechanisms of behavior change within Alcoholics Anonymous: a multiple mediator analysis. Addiction. 2012;107(2):289-299.

39. Moos RH. Active ingredients of substance use-focused self-help groups. Addiction. 2008;103(3):387-396.

40. Laudet A. The Road to Recovery: Where Are We Going and How Do We Get There? Empirically Driven Conclusions and Future Directions for Service Development and Research. Substance Use & Misuse. 2008;43(12-13):2001-2020.

41. Nace EP. Chapter 69: Twelve-Step Programs in Addiction Recovery. In: Ries RK, Fiellin DA, Miller SC, Saitz R. The ASAM Principles of Addiction Medicine, 5th Edition, pp. 1033-1042. 2014. Philadelphia: Wolters Kluwer Health.

42. Ranes B, Johnson R, Nelson L, Slaymaker V. The Role of Spirituality in Treatment Outcomes Following a Residential 12-Step Program. Alcoholism Treatment Quarterly. 2017;35(1):16-33.

43. Dermatis H, Galanter M. The Role of Twelve-Step-Related Spirituality in Addiction Recovery. Journal of Religion & Health. 2016;55(2):510-521.

44. Humphreys K, Moos R. Can encouraging substance abuse patients to participate in self-help groups reduce demand for health care? A quasi-experimental study. Alcoholism-Clinical and Experimental Research. 2001;25(5):711-716.

45. Holder HD, Cisler RA, Longabaugh R, Stout RL, Treno AJ, Zweben A. Alcoholism treatment and medical care costs from Project MATCH. Addiction. 2000;95(7):999-1013.

46. Reif S, Braude L, Lyman DR, et al. Peer Recovery Support for Individuals With Substance Use Disorders: Assessing the Evidence. Psychiatric Services. 2014;65(7):853-861.

47. Bassuk EL, Hanson J, Greene RN, Richard M, Laudet A. Peer-Delivered Recovery Support Services for Addictions in the United States: A Systematic Review. Journal of Substance Abuse Treatment. 2016;63:1-9.

48. Schwarzlose J, Belleau C, DuPont RL, et al. What is recovery? A working definition from the Betty Ford Institute. Journal of Substance Abuse Treatment. 2007;33(3):221-228.

49. Substance Abuse and Mental Health Services Administration (SAMHSA). Working Definition of Recovery. 2012. Available at: https://store.samhsa.gov/shin/content/PEP12-RECDEF/PEP12-RECDEF.pdf. Accessed Mar 8 2018.

50. Granfield R, Cloud W. Coming clean: Overcoming addiction without treatment. New York: New York University Press; 1999.

51. Hser Y-I, Anglin MD. 2010. Addiction Treatment and Recovery Careers. In: Kelly J, White W. (eds). Addiction Recovery Management: Theory, Research and Practice. Current Clinical Psychiatry. Humana Press, Totowa, NJ.

52. White WL, Kelly JF. 2010. Recovery Management: What If We Really Believed That Addiction Was a Chronic Disorder?. In: Kelly J, White W (eds). Addiction Recovery Management: Theory, Research and Practice. Current Clinical Psychiatry. Humana Press, Totowa, NJ.

53. White W. 2008. Recovery Management and Recovery Oriented Systems of Care: Scientific Rationale and Promising Practices. Jointly published by the Northeast Addiction Technology Transfer Center, the Great Lakes Addiction Technology Transfer Center, and the Philadelphia Department of Behavioral Health/Mental Retardation Services. Available at: http://www.naadac.org/assets/1959/whitewl2008_recovery_management_and_recovery-oriented_systems_of_care.pdf. Accessed 08 May 2018.

54. Substance Abuse and Mental Health Services Administration (SAMHSA). Recovery-Oriented Systems of Care (ROSC) Resource Guide. 2010. Available at: https://www.samhsa.gov/sites/default/files/rosc_resource_guide_book.pdf. Accessed 18 Apr 2018.

55. Timko C, Schultz NR, Britt J, Cucciare MA. Transitioning From Detoxification to Substance Use Disorder Treatment: Facilitators and Barriers. Journal of Substance Abuse Treatment. 2016;70:64-72.

56. Acevedo A, Garnick D, Ritter G, Lundgren L, Horgan C. Admissions to detoxification after treatment: Does engagement make a difference? Substance Abuse. 2016;37(2):364-371.

57. Spear SE. Reducing readmissions to detoxification: an interorganizational network perspective. Drug Alcohol Depend. 2014;137:76-82.

58. Lee MT, Horgan CM, Garnick DW, et al. A performance measure for continuity of care after detoxification: Relationship with outcomes. Journal of Substance Abuse Treatment. 2014;47(2):130-139.

59. Cloud W, Granfield R. Conceptualizing Recovery Capital: Expansion of a Theoretical Construct. Substance Use & Misuse. 2008;43(12-13):1971-1986.

60. Groshkova T, Best D, White W. The Assessment of Recovery Capital: Properties and psychometrics of a measure of addiction recovery strengths. Drug and Alcohol Review. 2013;32(2):187-194.

61. Vilsaint CL, Kelly JF, Bergman BG, Groshkova T, Best D, White W. Development and validation of a Brief Assessment of Recovery Capital (BARC-10) for alcohol and drug use disorder. Drug and Alcohol Dependence. 2017;177:71-76.

62. The BC Centre on Substance Use. Addiction Medicine Clinical and Research Fellowship Overview. 2018. Available at: http://www.bccsu.ca/addiction-medicine-clinical-research-fellowship-overview/. Accessed 20 April 2018.

63. Young LB. Telemedicine interventions for substance-use disorder: a literature review. Journal of Telemedicine and Telecare. 2012;18(1):47-53.

64. Kinley A, Zibrik L, Cordeiro J, Lauscher HN, Ho K, UBC Faculty of Medicine eHealth Strategy Office. TeleHealth for Mental Health and Substance Use: Literature Review. 2012. Prepared for: BC Ministry of Health, Mental Health and Substance Use Branch. Available at: http://med-fom-ehealth-office.sites.olt.ubc.ca/files/2013/04/TeleMental-Health-Literature-Review-FINAL.pdf. Accessed 18 April 2018.

65. First Nations Health Authority, the British Columbia Ministry of Health and Health Canada. A Path Forward: BC First Nations and Aboriginal People's Mental Wellness and Substance Use - 10 Year Plan. A Provincial Approach to Facilitate Regional and Local Planning and Action. 2013. Available at: http://www.fnha.ca/documents/fnha_mwsu.pdf. Accessed 18 April 2018.

66. British Columbia Ministry of Health Services and Ministry of Children and Family Development. Healthy Minds, Healthy People: A Ten-Year Plan to Address Mental Health and Substance Use in British Columbia. Released November 2010. Available at: http://www.health.gov.bc.ca/library/publications/year/2010/healthy_minds_healthy_people.pdf.

67. BC Centre of Excellence in Women's Health. Trauma-Informed Practice Guide. May 2013. Available from: http://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf.

68. Trauma-Informed Care in Behavioral Health Services. Center for Substance Abuse Treatment (US). Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2014. PMID:24901203.

69. Canadian Centre on Substance Use and Addiction. Moving Toward a Recovery-Oriented System of Care: A Resource for Service Providers and Decision Makers. 2017. Ottawa, Ont. Available at: http://www.ccsa.ca/Resource Library/CCSA-Recovery-Oriented-System-of-Care-Resource-2017-en.pdf. Accessed 18 April 2018.

70. Sheedy CK, Whitter M. Guiding Principles and Elements of Recovery-Oriented Systems of Care: What Do We Know From the Research? 2009. HHS Publication No. (SMA) 09-4439. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration (SAMSHA). Available at: https://www.samhsa.gov/sites/default/files/partnersforrecovery/docs/Guiding_Principles_Whitepaper.pdf. Accessed 18 April 2018.

71. Neale J, Finch E, Marsden J, et al. How should we measure addiction recovery? Analysis of service provider perspectives using online Delphi groups. Drugs-Education Prevention and Policy. 2014;21(4):310-323.

72. Neale J, Tompkins C, Wheeler C, et al. "You're all going to hate the word 'recovery' by the end of this": Service users' views of measuring addiction recovery. Drugs-Education Prevention and Policy. 2015;22(1):26-34.

73. Neale J, Panebianco D, Finch E, et al. Emerging consensus on measuring addiction recovery: Findings from a multi-stakeholder consultation exercise. Drugs-Education Prevention and Policy. 2016;23(1):31-40.

74. Dennis ML, Scott CK. Four-year outcomes from the Early Re-Intervention (ERI) experiment using Recovery Management Checkups (RMCs). Drug and Alcohol Dependence. 2012;121(1-2):10-17.

75. McCollister KE, French MT, Freitas DM, Dennis ML, Scott CK, Funk RR. Cost-effectiveness analysis of Recovery Management Checkups (RMC) for adults with chronic substance use disorders: evidence from a 4-year randomized trial. Addiction. 2013;108(12):2166-2174.

76. Scott CK, Dennis ML, Foss MA. Utilizing Recovery Management Checkups to shorten the cycle of relapse, treatment reentry, and recovery. Drug and Alcohol Dependence. 2005;78(3):325-338.

77. Meister SR. A Review of Workplace Substance Use Policies in Canada: Strengths, Gaps and Key Considerations. 2018. Ottawa, Ont.: Canadian Centre on Substance Use and Addiction. Available at: http://www.ccsa.ca/Resource Library/CCSA-Workplace-Substance-Use-Policies-Canada-Report-2018-en.pdf. Accessed 20 April 2018.

78. Center for Substance Abuse Treatment. Substance Abuse Treatment: Addressing the Specific Needs of Women. Treatment Improvement Protocol (TIP) Series, No. 51. HHS Publication No. (SMA) 15-4426. Revised 2015. Rockville, MD: Center for Substance Abuse Treatment. Available at: https://store.samhsa.gov/shin/content//SMA15-4426/SMA15-4426.pdf. Accessed 18 April 2018.

79. Barton J, Henderson J. Peer Support and Youth Recovery: A Brief Review of the Theoretical Underpinnings and Evidence. Canadian Journal of Family and Youth. 2016;8(1):1-17.

80. De Swart JJW, Van den Broek H, Stams G, et al. The effectiveness of institutional youth care over the past three decades: A meta-analysis. Children and Youth Services Review. 2012;34(9):1818-1824.

81. Rowan M, Poole N, Shea B, et al. Cultural interventions to treat addictions in Indigenous populations: findings from a scoping study. Substance Abuse Treatment Prevention and Policy. 2014;9:26.

82. Rowan M, Poole N, Shea B, et al. A scoping study of cultural interventions to treat addictions in Indigenous populations: methods, strategies and insights from a Two-Eyed Seeing approach. Substance Abuse Treatment Prevention and Policy. 2015;10.

83. Marsh TN, Cote-Meek S, Young NL, Najavits LM, Toulouse P. Indigenous Healing and Seeking Safety: A Blended Implementation Project for Intergenerational Trauma and Substance Use Disorders. International Indigenous Policy Journal. 2016;7(2).

84. Finch AJ, Moberg DP, Krupp AL. Continuing Care in High Schools: A Descriptive Study of Recovery High School Programs. Journal of Child & Adolescent Substance Abuse. 2014;23(2):116-129.

85. Finch AJ, Tanner-Smith E, Hennessy E, Moberg DP. Recovery high schools: Effect of schools supporting recovery from substance use disorders. American Journal of Drug and Alcohol Abuse. 2018;44(2):175-184.

86. Ventura AS, Bagley SM. To Improve Substance Use Disorder Prevention, Treatment and Recovery: Engage the Family. Journal of Addiction Medicine. 2017;11(5):339-341.

87. Family Mental Health and Substance Use Task Force. Families at the Centre: Reducing the Impact of Mental Health and Substance Use Problems on Families - A Planning Framework for Public Systems in BC. 2015. Available at: https://www2.gov.bc.ca/assets/gov/health/managing-your-health/mental-health-substance-use/child-teen-mental-health/families_at_the_centre_full_version.pdf. Accessed 20 April 2018.

88. Recovery Day BC. 2018. Available at: http://recoverydaybc.ca/ . Accessed 18 April 2018.

89. National Treatment Strategy Working Group. A Systems Approach to Substance Use in Canada: Recommendations for a National Treatment Strategy. 2008. Ottawa: National Framework for Action to Reduce the Harms Associated with Alcohol and Other Drugs and Substances in Canada. Available at: http://www.ccsa.ca/Resource Library/nts-systems-approach-substance-abuse-canada-2008-en.pdf. Accessed 20 April 2018.

90. National Academies of Sciences, Engineering, and Medicine. Ending Discrimination Against People with Mental and Substance Use Disorders: The Evidence for Stigma Change. 2016. Washington, DC: The National Academies Press. Available at: https://www.ncbi.nlm.nih.gov/books/NBK384915/pdf/Bookshelf_NBK384915.pdf . Accessed 20 April 2018.

91. Landry M, the Danya Institute, and the Central East Addiction Technology Transfer Center (ATTC). The Anti-Stigma Toolkit - A Guide to Reducing Addiction-Related Stigma. 2012 Edition. Available at: http://attcnetwork.org/regcenters/productDocs/2/Anti-Stigma Toolkit.pdf. Accessed 20 April 2018.

92. The Global Commission on Drug Policy. The World Drug Perception Problem: Countering prejudices about people who use drugs. 2017. Available at: http://www.globalcommissionondrugs.org/wp-content/uploads/2018/01/GCDP-Report-2017_Perceptions-ENGLISH.pdf. Accessed 20 April 2018.

93. Recovery Capital Conference of Canada. Available at: http://recoverycapitalconference.com/. Accessed 20 April 2018.

94. BC Coroner's Service Death Review Panel. A Review of Illicit Drug Overdoses: A Report to the Chief Coroner of British Columbia. 2018. Available at: https://www2.gov.bc.ca/assets/gov/public-safety-and-emergency-services/death-investigation/death-review-panel/bccs_illicit_drug_overdose_drp_report.pdf. Accessed 18 April 2018.

95. Veysey BM, Grasmere J, Andersen R. Supporting Peer Recovery in Rural New England: The RECOVER Project, Franklin County, MA. Alcoholism Treatment Quarterly. 2010;28(3):306-325.

96. Andreas D, Ja DY, Wilson S. Peers Reach Out Supporting Peers to Embrace Recovery (PROSPER): A Center for Substance Abuse Treatment Recovery Community Services Program. Alcoholism Treatment Quarterly. 2010;28(3):326-338.

97. Armitage EV, Lyons H, Moore TL. Recovery Association Project (RAP), Portland, Oregon. Alcoholism Treatment Quarterly. 2010;28(3):339-357.

98. Mericle AA, Cacciola J, Carise D, Miles J. Supporting Recovery In The Community: Six-Month Outcomes of Clients Participating in the Phoenix House Bronx Community Recovery Center (BCRC). Journal of Community Psychology. 2014;42(5):509-518.

99. Kaplan L, Nugent C, Baker M, Clark HW, Veysey BM. Introduction: The Recovery Community Services Program. Alcoholism Treatment Quarterly. 2010;28(3):244-255.

100. Beeson ET, Whitney JM, Peterson HM. The Development of a Collegiate Recovery Program: Applying Social Cognitive Theory within a Social Ecological Framework. American Journal of Health Education. 2017;48(4):226-239.

101. Depue MK, Hagedorn WB. Facilitating College Students' Recovery Through the Use of Collegiate Recovery Programs. Journal of College Counseling. 2015;18(1):66-81.

102. Kaplan, L. The Role of Recovery Support Services in Recovery-Oriented Systems of Care. DHHS Publication No. (SMA) 08-4315. 2008. Rockville, MD: Center for Substance Abuse Services, Substance Abuse and Mental Health Services Administration.

103. European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), General-Directorate for Intervention on Addictive Behaviours and Dependencies (SICAD). Portugal - Country Drug Report 2017. 2017. Available at: http://www.emcdda.europa.eu/system/files/publications/4508/TD0116918ENN.pdf. Accessed 25 April 2018.

104. Ferri M, Amato L, Davoli M. Alcoholics Anonymous and other 12-step programmes for alcohol dependence. Cochrane Database Syst Rev. 2006(3).

105. United Nations Office on Drugs and Crime, International Network of Drug Dependence Treatment and Rehabilitation Resource Centres (Treatnet). Drug Dependence Treatment: Sustained Recovery Management. Good Practice Document. 2008. Available at: http://www.unodc.org/docs/treatment/111SUSTAINED_RECOVERY_MANAGEMENT.pdf. Accessed 24 April 2018.

106. Laudet AB, Harris K, Kimball T, Winters KC, Moberg DP. Characteristics of Students Participating in Collegiate Recovery Programs: A National Survey. Journal of Substance Abuse Treatment. 2015;51:38-46.