

Definitions and Measurement of Recovery, Where We Have Come from and Where We Need to Go - Jason Schwartz

Frontiers of Recovery Research Interview Series Interview – William Stauffer

In April of 2024, William White asked me to present his keynote to the first annual Consortium on Addiction Recovery Science conference. It was titled [Frontiers of Recovery Research](#) and it articulates critical factors of investigation in respect to expanding recovery into the future across 12 domains within recovery grounded methods. Those 12 domains are Definitions and Measurement of Recovery, Neurobiology of Long-Term Recovery, Incidence and Prevalence of Recovery, Resolution and Recovery across the severity spectrum, Pathways and Styles of Recovery Across Diverse facets, Recovery Across the Lifecycle Stages of Recovery, Social Transmission of Recovery, Family Recovery, Recovery Management and Recovery Oriented Systems of Care, New Recovery Support Institutions, Service Roles and Recovery Culture Production and Flourishing / Thriving in Recovery. I have decided to embark on a project to interview key thought leaders across these domains of knowledge to understand where we are and where we need to go. My first of many planned interviews is with recovery thought leader Jason Schwartz.

A 2020 article in [Treatment Magazine](#) Jason Schwartz was described as “the ringleader of the treatment industry’s go-to blog ([Recovery Review](#)) covering forward ideas in everything addiction—from hardcore science, medicine and advocacy to policy and more.” His bio on Recovery Review notes that he has been an addiction professional and social worker since 1994. He started blogging in 2005 as the Clinical Director at Dawn Farm, and his writings were my first introduction to his work. He is currently the Director of Social Work and Spiritual Care at Michigan Medicine and lecturer at Eastern Michigan University. In 2018 or 2019 I was introduced to Jason by a mutual colleague and soon after, Jason invited me to join the group of writers contributing to Recovery Review. Over the years he has become a trusted colleague whose perspective means a great deal to me. It was an easy decision to have Jason be the first interview on the first domain to consider strategies moving forward. Below are the questions we explored in this interview.



1. In the topic area, what progress have we made in the last twenty years? What in your estimation has driven the progress or hindered forward momentum?

Jason: This is one of the most difficult and complicated issues we face. I think some historical context is important. Around 25 years ago, Bill White started promoting Recovery Management and Recovery-Oriented Systems of Care. He was also a major booster of the New Recovery Advocacy Movement. His work advocated for recovery as the organizing paradigm for services. Part of that process was to recognize the cooptation of recovery by professional and institutional interests that talked a lot about recovery but often delivered services in a pathology and treatment-oriented manner. The best example of this was treatment programs marketing themselves with “recovery rates” that were often based on something like 30-day abstinence rates for people who completed treatment. That’s a helpful metric for some purposes, but it’s not recovery. Deploying recovery in this way had the effect of propping up the acute care treatment model rather than representing long-term recovery.

This new recovery-orientation was intended to disrupt norms and raise the bar on treatment providers, systems of care, and policymakers. In a way, this movement’s pressure to raise the bar, focus on the facilitation of long-term recovery, and challenge the dominant acute care model. There were efforts to define the boundaries of recovery, but much of that came in the form of saying what is not recovery, making it an exclusive concept.

As this movement was taking hold, one of the first major efforts to define recovery came from the [Betty Ford Consensus Panel definition of recovery](#). Its emphasis on sobriety, personal health, and citizenship that is voluntary and maintained over time captured this desire to raise the bar.

It's important to note that, while Bill wanted to raise the bar for treatment and research by distinguishing recovery-oriented care from acute care models, there was no desire to deploy recovery in an exclusive way at the individual or community level. Any exclusionary pressure was intended to target providers, systems, and models of care, **not** people with alcohol and other drug problems. He was inclusive of less recognized pathways, which at the time were primarily methadone, faith-based, and secular pathways. Recovery Management and ROSC were intended to broaden the focus from 12-step mutual aid and affirm the value of these other pathways.

The effort to promote an exclusive concept is probably best represented in his efforts to distinguish recovery from remission and his efforts to distinguish recovery from treatment.

The difference between recovery and remission is best articulated in his monograph on [recovery-oriented methadone maintenance](#):

- Recovery from opioid addiction is also more than remission, with remission defined as the sustained cessation or deceleration of opioid and other drug use/problems to a subclinical level—no longer meeting diagnostic criteria for opioid dependence or another substance use disorder. Remission is about the subtraction of pathology; recovery is ultimately about the achievement of global (physical, emotional, relational, spiritual) health, social functioning, and quality of life in the community.

In the worlds of research and treatment outcomes, the measuring of “success” was subtractive. It focused on not being arrested, not being homeless, not using ERs, not contracting injection-related infections, and not using drugs. Strangely, our vision for success was very pathology-oriented. Focusing on recovery was intentionally a shift to emphasize global wellness and capture the reality that, when people recover, they often get well and then get “better than well.”

The best example of challenging the conflation of treatment and recovery came from a [2009 interview with Walter Ginter](#), a methadone recovery advocate. Ginter said, “Methadone is not recovery. Recovery is recovery. Methadone is a pathway, a road, a tool. Recovery is a life and a particular way of living your life. Saying that methadone is recovery let's people think that, ‘Hey, you go up to the counter there, and you drink a cup of medication, and that's it. You're in recovery.’ And of course, that's nonsense.” This conflation of treatment and recovery were not unique to methadone, the same kinds of things were said by advocates for other forms of treatment.

So... the effort to distinguish recovery from remission, treatment, and subtractive outcomes was intended to improve services and improve the lives of people with addiction. Any exclusionary pressure was intended to target providers, systems, and models of care, not people with alcohol and other drug problems. However, along the way, several overlapping factors converged to make the exclusive nature of recovery a problem.

First, the emphasis on multiple pathways. If we think about a pathway involving at least 3 elements -- a starting point, a pathway, and a destination. Multiple pathways has evolved from an emphasis on increasing the number of pathways from addiction (the most severe AOD problems) to recovery (sobriety/abstinence plus) to an emphasis on changing all 3 elements.

- Expanding the prerequisite problem from addiction to any AOD problem
- Expanding pathways to include nonmedical instrumental use of other substances (licit and illicit), harm reduction, and other behaviors previously considered incompatible with recovery
- Expanding recovery to be something that is entirely framed as a process that is self-defined, leaving us with innumerable meanings.

The original intent was to promote menus of options that include medications and non-12-step pathways to wellness and becoming “better than well” devolved into framing any change as recovery – the notion that recovery is what anyone says it is.

This represents a shift towards recovery being something subjective that is defined by individuals rather than communities of recovery and treatment programs. Two developments played important roles in this shift.

- CCAR, a leader in peer support training, adopted the position "you're in recovery if you say you are." This stance emerged for a few reasons - to emphasize engagement and remove a potential barrier to engagement; to challenge peers with rigid and narrow ideas about recovery; and to challenge clients to explain what recovery means to them.
- Recovery advocacy messaging shifted from "I'm in long-term recovery, which means I have not used alcohol or other drugs..." to "I'm in long-term recovery and, for me, that means..."
 - This represents a challenge when applied to an illness that often involves denial and a course that often involves episodic false hope for self-management and control.
 - Given that problem resolution can look so different, depending on the nature of the problem, this leaves us unable to identify recovery by looking at it
 - Modification of substance use patterns may represent problem resolution for low-severity or acute problems, but calling this recovery may represent a dangerous manifestation of denial in other cases.

Around this time, recovery advocates sought to build a big tent and capture public attention with large numbers. They reported huge numbers of people in recovery, 23 million. However, they arrived at that number with the survey question, "did you once have a problem with drugs or alcohol but no longer do?" That large number can grab attention and feel empowering, but this represented an important mechanism for the expansion of the prerequisite problem and it's important consider the following:

- This applied "recovery" to people who don't identify as in recovery.
- Self-identification of once having a problem is subjective and casts an extremely wide net. Problem resolution for various kinds of AOD problems can look very different.
- This has influenced policy advocacy, research, and public thinking about addiction.
- This represents a departure from previous public education that sought to frame addiction as categorically distinct from other AOD problems due to impaired control.

The notion that recovery is what anyone says it is can feel empowering in some contexts, but it is not something that can be measured or defined.

The NRAM's emphasis on stigma converged with social justice and libertarian cultural currents to frame people with drug problems as victims of social problems, engaging in legitimate adaptive responses to those social problems or lifestyle choices that should be protected from government interference and puritanical cultural reactions. The result is a "hands off" approach to drug use and a belief that efforts to interfere with drug use are inherently oppressive.

Finally, DSM 5's introduction of substance use disorders represented a shift from a categorical model to a spectrum model has also had significant impact on how we conceptualize substance use conditions and recovery. The spectrum model has specifiers of mild, moderate, and severe, but, in practice, SUD is discussed and researched as a single entity. A person with a relatively mild problem that will never progress into addiction and someone with a severe and chronic addiction both have SUD, despite the fact that their problems are radically different in their origins, trajectories, the treatments they require, and what their endpoints may look like with respect to alcohol and other drug use. This creates considerable challenges divisions as people can be thinking of very different things while using the same term.

2. Why is this an important area of focus?

Jason: How we define the problem, and its resolution play a role assigning cultural ownership. It influences how the general public understands AOD problems and recovery. This determines how things are funded, our program design, policy across our field, and what's believed to be possible in respect to people with addiction.

We do need to develop methods to define and measure change in order to develop more effective strategies. There are quality of life considerations to embrace here. Is your life better? Are you healthier? While most of our focus has been on measuring change over the short term, if we focus on understanding how recovery changes people for the positive over the long term we are likely to learn a great deal about this topic. We also know that addiction impacts cognition so we should consider what families see as well. We do know that some people with less severe substance use conditions can moderate their use in ways that people with more severe forms that include loss of control over their use are simply not able to do. We need to consider what happens behind closed doors. We see people who are able to maintain

employment while their use is destroying their health and harming their families and so self-reported wellness should not be our sole way to measure this.

One other consideration is that one of the things that advocates like White were concerned about was having addiction recovery being co-opted by other groups. Every time in history that substance use strategies have merged with mental health strategies the substance use strategies have suffered. We have never been equal partners. History also shows us that when that was the road our systems went down in the past, we needed to redevelop substance use treatment and support at the grassroots level.

Having said that, I wonder if we will ever be able to measure recovery as a single term that captures all the communities and institutions across our space. Perhaps what we need is not a singular definition but terms and concepts that work for different settings and different systems in consideration of the type, severity and stage that a person is experiencing.

3. What do you have to add to what Bill has written? Did he miss anything? Are there applications you would expand upon?

Jason: One way to think about the big picture is as a bell curve. Addiction care had historically been focused on the tail... the most severe cases... and had often not done a very good job due to acute care models, treatment-oriented treatment models (rather than a recovery-orientation), and stifling orthodoxies. The push toward ROSC has coincided with a shift in attention toward the middle of the curve, because of the DSM, the shape of advocacy, the opioid crisis, the growing role of public health, and correcting for past neglect of lower severity problems.

Bill wanted to destabilize several norms. Some of these norms related to practices and approaches that were lost -- often connections to community, use of lived experience, and respect for experiential knowledge. He wanted to challenge some of the forces and philosophies that replaced the lost practices -- the commercialization and professionalization of our field, shortening care to acute stays, measuring success by things like completion of treatment, and program-focused care (rather than patient-focused goals). From my perspective, the challenge is that once you start destabilizing things, it's hard to control what falls and what stays.

Similarly, Bill warned of the dangers of service integration. At the time, it was addiction systems being integrated into mental health systems. The fear was that we'd be absorbed into those systems, lose our categorically distinct identity, and have to be re-birthed to meet the needs of people of addiction. The push for integration into mental health passed, but ROSC ended up providing a framework for integration with medicine, public health, academic research, and social justice advocacy. The factors above - exclusionary vs inclusionary definitions, the evolution of multiple pathways, the DSM 5, the emphasis on recovery as a process rather than an outcome, etc. - contributed to the destabilization of recovery in some spaces (while many recovering communities continue to do their thing, completely unaware of all of this).

I am not saying that Bill missed these things. His writings do a good job of outlining these risks and warning the New Recovery Advocacy Movement to be mindful of them, but they are what each succeeding generation is left to grapple with.

4. What are some avenues for coproduction of recovery-focused research? How do we ensure that the community itself gains value from these efforts?

Jason: There are a lot of opportunities to learn from people in recovery and to understand what long-term recovery looks like. This is largely unexplored territory, even a quarter-century into this movement. What does recovery look like over the lifespan? How do life events support, risk, or change recovery? How does recovery affect life events? College, marriage, having children, job loss, divorce, losing family members, etc.? It might also be interesting to look at people who are thriving through various pathways -- methadone, buprenorphine, 12-step, secular, faith-based, etc. Doing so might help us identify what we can reverse engineer to help others. We know so little about any of this in a systematic and longitudinal manner.

A couple of bright spots come to mind with respect to recovery research. First, research on the mechanisms of change in mutual aid offered the potential to do some of the reverse engineering I just mentioned. Second, John Kelly's work on

quality of life during the early years of recovery provides a good start on better understanding the trajectories of recovery.

People in recovery should be involved in designing, facilitating, and interpreting recovery research, but looking at recovery as one undifferentiated mass creates competition for influence and representation. We might avoid some of that if we did a better job of differentiating the kinds of problems and pathways, allowing us to better understand the kind of substance problem the person has, determine the options for endpoints, and match the right kind of pathway to the kind of problem and desired endpoint.

5. Looking forward to twenty years from now, where would you hope we are at in respect to our knowledge in this domain? How do we get there?

Jason: To reflect back twenty-five years in order to answer this question, we have dramatically expanded what is out there for people. We have Smart Recovery, Dharma Recovery, Celebrate Recovery, we have medication pathways, we have Narcotics Anonymous, there are Jewish based recovery groups, internationally we have groups like Congress 60 in Iran. We have lowered the threshold to access help for persons with less severe forms. The opioid overdose crisis lowered thresholds for death prevention interventions -- we're scaling measures we never imagined being widely implemented. We have recovery community organizations, recovery high schools, and collegiate recovery programs. We live in a changed world in respect to options and opportunities for people to regain their lives and thrive.

Having said that, we need to be able to describe different levels of severity and typology of substance use problems in a way that allows us to differentiate people who can moderate or abstain with no help, minimal help, or short-term help from people who require deliberate long-term recovery maintenance. Having recommended pathways shouldn't be associated with coercion. I often think of cancer. We don't treat all cancers the same and we don't tell cancer patients to just pick the treatment that works for them. Treatment is tailored to the patient's type of cancer, its stage, the patient's health, and the patient's goals to recommend a treatment plan. The patient can accept the treatment plan, request modifications based on their preferences and priorities, or decline treatment. Better understanding the long term trajectories and outcomes for different types of problems and pathways could help us develop a body of knowledge that allows us to identify and implement what works for individuals over the long term.

While we have seen significant gains, there have also been setbacks. Options have grown for low-threshold and assertive peer care. This is good for people whose problems can be resolved with that type of care and it can provide protection from death. However, it's hard for me to see improvements in access to care that meet the needs of people with the most severe and chronic AOD problems. For a person with more severe forms of addiction, there's less clarity about the necessary steps and care they need to flourish. The conceptual changes have directed research and advocacy away from a focus on the most severe cases as the individualistic model of recovery seems to have diminished interest in research on mutual aid and the mechanisms of change in them.

6. Any last thoughts?

Jason: I mentioned earlier that I thought Bill wanted to deploy recovery in an exclusionary manner with treatment programs and systems but didn't have any exclusionary intent with individuals or groups. However, the effort to define recovery in ways that raises the bar for treatment programs ran into resistance as the following factors converged to challenge any exclusionary conceptual boundaries – recovery advocacy, social justice movements, the DSM 5's introduction of SUDs as a spectrum, and rhetoric emphasizing individual definitions and pathways.

This resistance to exclusionary definitions is a response to very legitimate concerns. Bill White once noted that: *"Imposed or self-embraced words that convey one's history, character, or status have immense power to wound or heal, oppress or liberate. At a personal level, a definition of recovery will attract or repel people seeking to resolve AOD problems, provide a benchmark for when this state of recovery is achieved, and convey directly or indirectly what actions are required to sustain this status. A particular definition of recovery, by defining who is and is not in recovery, may also dictate who is seen as socially redeemed and who remains stigmatized, who is hired and who is fired, who remains free and who goes to jail, who remains in a marriage and who is divorced, who retains and who loses custody of their children, and who receives and who is denied government benefits."*

I believe the expectation to come up with a definition of recovery that works for treatment, public health, advocacy, medicine, behavioral health systems, policy, communities of recovery, and individuals has been a barrier to progress and has the potential to end up with the worst of all worlds. We can do harm by stigmatizing some groups or by lowering expectations for others in ways that impose a ceiling on quality of life.

The access to information provided by the internet makes it hard to have a definition that works for advocacy, and another for public health, and so on, without one definition bleeding into other domains. However, domain-specific definitions could represent a significant step forward. We might be able to deploy exclusive definitions in some areas and more inclusive definitions in others.

Sources

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