Recovery Centered Research Requires Accepted Definitions of Recovery -
An Interview with Justin Bell, the Frontiers of Recovery Research Interview Series

What is this series of interviews? In April of 2024, I had the distinct honor of being asked by author and thought leader of the new recovery advocacy movement, William White, to present his words publicly. It was the keynote to open up the first annual NIDA Consortium on Addiction Recovery Science (CoARS) conference. The paper was titled Frontiers of Recovery Research. It is one of his most important writings. It should serve as a blueprint for the future of recovery research in America. One of the challenges we have suffered for at least the last six decades is a deficit focus in respect to addiction instead of a recovery orientation. His paper properly orients future research efforts on long term recovery and resiliency. To that end, I have decided to do interviews with key thought leaders on the future direction of recovery research across the 12 domains that Bill White delineated in his paper.

The 12 domains Bill White addressed in his Frontiers of Recovery Research paper include, the Definition & Measurement of Recovery, the Neurobiology of Long-Term Recovery, Incidents and Prevalence of Recovery, Resolution and Recovery Across the Severity Spectrum, Pathways and Styles of Recovery Across Diverse Geographical / Cultural / Religious Contexts and Clinical Subpopulations, Recovery Across the Lifecycle, Stages of Recovery, Social Transmission of Recovery, Family Recovery, Recovery Management & Recovery Oriented Systems of Care, New Recovery Support Institutions, Service Roles and Recovery Cultural Production and Flourishing / Thriving in Recovery.

This interview is with Justin Bell, PhD, a rising star in the realm of recovery research who works at Chestnut Health Systems. This is the place where William White and others fostered a lot of recovery-oriented processes over the last generation. When I first approached Dr Bell for this interview, it was my thought we may focus on areas including resolution across the severity spectrum, social transmission of recovery / new recovery support institutions, service roles and recovery cultural production. AS Dr Bell reflected and prepared for the interview, it was his conclusion that to further those dimensions, we need to make progress with our capacity to establish widely accepted definitions of recovery. This is foundational to the other domains, so that became the focus of this interview. This is the seventh interview in this series. The six prior interviews include Mark Sanders, Dr David Best, Jason Schwartz, Dr Michael Flaherty, William White and Caroline Beidler.

An Introduction to Justin Bell, PhD

Dr Justin Bell currently serves as an Assistant Research Scientist at the Lighthouse Institute, where he specializes in exploring recovery science, positive psychology, and peer support. His work primarily examines the peer recovery support workforce, including their working conditions, formal integration into treatment settings, and overall effectiveness. He has led studies on "low-barrier recovery housing" (LBRH) in Chicago and investigates workforce outcomes such as burnout and role clarity among peer specialists. Dr. Bell is a person in open recovery, which informs his commitment to studying lived-experience-based workforces and advocating for non-traditional recovery professionals. He earned his Ph.D. in Community Psychology from DePaul University and has authored numerous peer-reviewed articles and frequently speaks on the professionalization of the peer support workforce. He is also a contributor to Recovery Review, a blog on addiction recovery on which I also contribute. I value his perspective. It is my sense he is an important voice for next generation's iterations of recovery efforts in the USA and beyond.

- **In the topic area the Definition & Measurement of Recovery, what progress have we made in the last twenty years? What in your estimation has driven the progress or hindered forward momentum?**

When I started preparing for this interview, I thought I'd focus on the peer workforce. But as I consider the frontier we find ourselves on, I thought about an issue that seems to hinder progress in every dimension: the lack of definitional clarity around words like "addiction" and "recovery".

As an example, I recently read the book [Evaluating the Brain Disease Model of Addiction](). Many of our best thinkers on the topic were included. But even they couldn't agree what *addiction* is. The first seven or so chapters argue that it's a brain disease. Another 16 or so argue against it. Some chapters literally take the stance of "unsure." It left me wondering how we can make any significant progress describing recovery if we can't come to consensus about the pathology involved.

This isn't so much the case with other (stigmatized) conditions. Consider HIV/AIDS, for instance. Funding for HIV/AIDS associated research and services now eclipses that of many other conditions. This was achieved through incredible feats of solidarity and activism. Something has seemed to bind people together and fuel over 40 years of sustained advocacy. We don't see the same thing in the recovery advocacy movement, which has had shorter bursts of activity; phasic movements that seem to quickly rise but then fall just as fast. Why is that?

Sociologist Nikolas Rose has this term *biological citizenship,* which helps describe the rather recent phenomenon of people making claims to their rights based on biology (e.g., "We have this biological condition, so we deserve rights/treatment access/resources from our government."). Rose identified the HIV/AIDS movement as an exemplar of this. According to Rose, new medical definitions and HIV testing really helped form a shared identity for the HIV/AIDS community - people who were once living in isolation. Before these definitions and testing technologies, they could only be identified by perceived behavior (i.e., exemplified in early labels like "gay cancer" or "homosexual syndrome"). But a *biological* or *clinical definition* allowed for solidarity and the organization of communities to amplify voices.

Am I arguing that we lean completely into medicalizing definitions of "addiction" and "recovery"? No. But I do think it's worth considering the utility of existing definitions. We have lots of great definitions of recovery that get at the spirit of recovery: the Betty Ford consensus statement; CCAR defining it as when people say they are; the Chicago Recovery Alliance (CRA) considering recovery it as "any positive change". We don't seem to have as equally great definitions that would be useful for scientific purposes (e.g., what is "remission"?) or, even, established biomarkers that might evoke a more *biological citizenship* approach to recovery identity. Until we have a way to describe recovery from a scientific perspective, I think we are going to struggle with maintaining progress.

I recently read the paper you coauthored with Dr John Kelly, Utility or futility? Toward an operational definition of addiction recovery. I appreciated how the paper suggests both community definitions of recovery and objective clinical definitions that can support measurement and define change. It is a good step forward. But it's going to be an interesting road ahead because the relationship between "addiction", "recovery", and biological approaches to understanding these terms is really, well, *weird.* According to a recent study, many people in addiction treatment find genetic frameworks of addiction to be unhelpful for their recovery, even if they believe them. This isn't exactly what we find in say, schizophrenia, where people report feeling empowered by genetic causal explanations.

There's something happening here that feels like a paradox – and a paradox probably requires a hybrid approach. Neither this nor that, but this *and* that. Recovery is neither entirely biological nor entirely spiritual/subjective/non-biological. Sure, we can separate these definitions, but can we also combine them?

- **Why is this an important area of focus?**

As I mentioned, I see this phasic history of recovery advocacy, and I hope for a future where progress is sustained. I also hope for a recovery science that is taken more seriously. One of the things that a very imperfect document like the Diagnostic Service Manual (DSM) did is make people take mental health seriously because you could define it. You used have a Tower of Babel scenario with mental health – get a psychoanalyst, a doctor, a patient, and a researcher together and you might have four different definitions of depression. The DSM then became like a Rosetta Stone, everyone could use the same language. We could easily quantify symptoms, classify people, and predict things. Now, you have 'Use Disorders in the DSM, but the remission definitions are controversial, and not as well studied. And you almost never hear these referred to in recovery communities. So there's a lot of potential to help link community knowledge (experiential knowledge) and scientific knowledge so we can move away from our own 'Towel of Babel' scenario.

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

William White has contributed so very much to our shared insight on addiction, recovery and all of the related facets. A lot of what he has written has resonated broadly across our communities. I think it could be argued that William White

has been the person that fostered that solidarity through his writings. That strategy of creating space for people to find common ground is vital. We should expand on our efforts to include people in authentic dialogue that respects are differences, sets up steering concepts to foster mutual respect where they occur and to find the points that we can all drive forward together.

These areas of focus involve great complexities. Peer services which are rooted in lived experience, but there are just as many questions around that term. What is lived experience? How much of it (or what type) does one need to be effective as a peer support worker? Does efficacy of peer work increase the longer a person is in recovery, or does it not matter? What happens if a person has a resumption of use? Do our systems recognize the same employment standards with peer workers that they do with other people protected under the American with Disability Act? Not just in respect to resumption of use and employment protections but also in respect to disclosing recovery status as a condition of employment? How we navigate these questions is vitally important to our future efforts.

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

There are already so many fantastic methods for co-production of research, and I only hope that we see them used more. Community-based participatory research (CBPR) and using community boards are two great examples of how recovery communities can directly inform the scientific process. However, we need more training on these participatory research methods to ensure that these communities are protected in the research process.

But I'd really like to see lived experience and recovery embedded at higher levels of the research process. NIDA, for example, has their National Advisory Council on Drug Abuse, which helps select grants for funding following peer review. It has an important role in suggesting to NIDA how to disseminate research findings and better align research efforts with consumers. While the Council contains "six knowledgeable members of the general public", I'd like to see an official role for a scientist with recovery experience. Scientists in recovery have both a deep comprehension of scientific material *and* a deep understanding of the real-world implications of science on the recovery community. They can serve as connective tissue between the scientific community and the many recovery communities that are meant to be consumers of some of NIDA's work. They understand how to disseminate knowledge in a way that reaches the people on the ground. I want to see the inclusion of recovery voices beyond the immediate research process – beyond its value added, a position on Council for a scientist in recovery would be of great symbolic significance to people in recovery, those seeking recovery, and the people who support them.

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

As you noted in the forward, most of my research efforts have focused on the peer workforce and the centering of efforts on the peer discipline now and into the future. Perhaps my experience and insight on that facet of our space is informative to larger truths. For us to move forward in the broadest sense, we must have common ground and find ways to have varied interest groups work together on what they can actually agree on. One can look at the peer workforce at this juncture and see both its potential and challenges. Peer services rose up out of the failures of our system to address care beyond acute models and the tendency for persons to "drop out" of care at every transition point. It also occurred in part because of the lack of recovery culture in our treatment system workforce.

A paper I recently authored with other researchers found significant challenges in respect to addiction peer services that impact worker well-being and ability to achieve career longevity. This included role drift and compensation as the roles have been by our funding systems as "counseling lite." That feeds into the conflict model and pulls our eye off the prize of effective interdisciplinary care that sustains more people into long term stable recovery. We have high turnover rates as there are no career ladders for peers even as we know that well-seasoned workers take time to and resource to nurture and develop. We have come a long way but if we are to realize the full potential of peer services. We must fully invest in them and to do so in ways that center the evolution of the discipline in the recovery community and to not allow it to become an adjunct to acute care treatment strategies.

The answers to these challenges involve building connective tissue across our divides and seeking solutions that address broad needs while respecting how and what various groups have to contribute. My hope for our future is we take a long and deliberative look at the lessons of the last few decades and apply them to what we are doing now so we do not simply repeat errors but learn from them, which is the keystone of the scientific method. We can only achieve that if we

can foster broad community support for these objectives. I do believe there is cause for hope that we will do so. I would consider myself as evidence of that. I have invested an education and a career focus on doing just that, and there are many others who have done so as well. We are putting our feet in the process, just like so many who have come before us. This is why I am ultimately an optimist about our future.

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3/27/26 Interview link – HERE