

2020 Virtual Summit: Assessing Progress and Setting Priorities in Recovery Research

Summary Report
Global Recovery Initiatives Foundation
June 2021

TABLE OF CONTENTS

SUMMARY REPORT.....	3
Background.....	3
Key Findings.....	4
Theme One.....	4
Theme Two.....	6
Theme Three.....	9
Theme Four.....	10
Theme Five.....	11
Emerging Topics.....	12
APPENDIX.....	13
A. Summit Agenda.....	13
B. Summit Planning Panel.....	16
C. Speaker Bios.....	17

This meeting summary was prepared by Fors Marsh Group, LLC (FMG) for the Global Recovery Initiatives Foundation (GRI). The views expressed in this document reflect both individual and collective opinions of the meeting participants and not necessarily those of FMG/GRI.

SUMMARY REPORT

Background

Significant gaps exist in support for individuals in early recovery from substance use disorder (SUD). The organizational infrastructure and workforce of recovery support services are inadequate even in states and communities with the most robust capacity and are woefully lacking or entirely unavailable in other states and communities. Additionally, although scientific knowledge of the pathology of addiction and the relative effectiveness of various treatment approaches continues to grow, research on the recovery process and the relative effectiveness of various recovery support service approaches and our comprehension of them remains inadequate.

To address these challenges and identify opportunities to inform SUD research priorities among federal agencies, foundations, and private sector organizations, Global Recovery Initiatives Foundation (GRI), in partnership with Fors Marsh Group (FMG), convened the **Virtual Summit: Assessing Progress and Setting Priorities in Recovery Research on Substance Use Disorder** (Summit) on July 27, 2020. This first-of-its-kind summit included leaders representing federal, state, and local government and philanthropy and recovery advocacy organizations.

The Summit was co-chaired by Andrea Barthwell, MD (former president of the American Society of Addiction Medicine), John Kelly, PhD (Massachusetts General Hospital and Harvard Medical School), and Andrew Finch, PhD (Peabody College of Education and Human Development and Vanderbilt University). The Summit was attended by key government leaders, including James Carroll, the former Director of the Office of National Drug Control Policy (ONDCP), who opened the proceeding, former U.S. Surgeon General Jerome M. Adams, MD, MPH, who offered remarks, and former Center for Substance Abuse Treatment Director H. Westley Clark, MD, JD, MPH (Santa Clara University), who closed the Summit.

Six breakout sessions provided forums for 213 Summit participants to discuss what is known and what needs to be determined about the recovery process, current approaches to peer recovery support services, and how to best support those in various stages of recovery. The sessions were structured to build on the important work summarized in findings from the [2018 Substance Abuse and Mental Health Services Administration's \(SAMHSA\) Recovery Research and Evaluation Technical Expert Panel Summary Report](#), which provides an essential assessment of the state of recovery support services and outlines the needs for more research, funding, clarity, and consistency of terms and agreed upon metrics.

Importantly, the COVID-19 pandemic has had an especially negative impact on those in or seeking recovery.¹ Because of this, the themes outlined throughout this report highlight the relevant impact of the pandemic as well as what has been learned through the recovery community's response to it, especially in relation to the use of online platforms to maintain supportive social networks, to provide peer recovery support services, and to initiate the recovery process. Although the key issues that arose during the Summit were not caused by the COVID-19 pandemic, the pandemic has intensified many of them. It also has engendered innovation and unplanned learning as communities rise to meet the challenges the pandemic poses. Although the pandemic and our response to it are ongoing, this report in no way represents the final word on its impact on individuals in or seeking recovery. However, the next-to-last section of this report summarizes current thoughts and recommendations on recovery research related to or occasioned by the COVID-19 pandemic.

KEY FINDINGS

The following section outlines five themes that emerged from the Summit. For each theme, we summarize key topics discussed and outline potential activities for addressing gaps.

Theme #1:



We need a multifaceted, measurable, person-centered definition of recovery that encompasses the stages of the recovery process, their potential duration and recurrence, the many recovery pathways, and how factors, such as policy and the social determinants of health, may interact with these different variables.

Recovery from SUD is defined in a variety of ways in the SUD treatment and recovery fields and among recovery and other advocacy communities, reflecting a wide range of paradigms and personal experiences.¹ In addition, members of the public define recovery in different ways. For instance, Faces & Voices of Recovery commissioned Hart Research Associates to conduct surveys and focus groups on this topic between 2001 and 2005. At that time, members of the public most frequently thought of recovery from SUD as “struggling to overcome an addiction” and assumed those recovering from SUD still use alcohol or other drugs.²

Among treatment and recovery stakeholders, there appears to be broad consensus that abstinence and recovery are not synonymous terms and that abstinence can be present without recovery, as reflected in the Alcoholics Anonymous concept of the “dry drunk.”³ However, there is no uniformity in how these stakeholders conceptualize the relationship between abstinence and recovery. For some, abstaining from the use of psychoactive substances other than as prescribed is considered an essential condition of recovery. Others feel that abstinence is best understood as one of many tools for achieving recovery, noting that recovery is characterized by improvements in health, wellness, social functioning, quality of life, and other factors.⁴ Moreover, certain individuals can experience remission from SUD without entirely ceasing use.⁵ In such cases, their patterns of use and the consequences of that use do not meet diagnostic criteria for SUD. This type of remission can occur because of efforts to change on the part of the individual or as part of an apparently natural de-escalation of substance use in relation to changing environmental factors and/or individual maturation.

SAMHSA has attempted to address the complexity of factors that influence mental health and substance use recovery by convening diverse mental health and SUD recovery advocates to develop a *working definition* of recovery from mental health issues and SUDs. This definition, which is intended to bridge and

¹ White, W., & Kurtz, E. (2005). The varieties of recovery experience: A primer for addiction treatment professionals and recovery advocates. *International Journal of Self Help and Self Care*, 3(1–2), 21–61. <https://doi.org/10.2190/911r-mtg5-vj1h-75cu>.

² Robert Wood Johnson Foundation. (2012, December 13). *The faces & voices of recovery campaign raises awareness about recovery from addiction*. Program Results: Grant ID: 38514, 47155, 51965, 59193, 69585. https://www.rwjf.org/content/dam/farm/reports/program_results_reports/2012/rwif70324.

³ Watkins, M. (2020, February 3). *What is a dry drunk?* American Addiction Centers. <https://americanaddictioncenters.org/alcoholism-treatment/dry-drunk>.

⁴ *Key Findings: Recovery: The Many Paths to Wellness | Surgeon General's Report on Alcohol, Drugs, and Health*. (2019). Surgeongeneral.Gov. <https://addiction.surgeongeneral.gov/key-findings/recovery>.

⁵ National Institute on Drug Abuse (2020). Treatment and Recovery. <https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/treatment-recovery>.

supplant earlier separate definitions of mental health and SUD recovery, identifies four major dimensions that support a life in recovery and 10 guiding principles for recovery.⁶

One of 10 principles in particular, “recovery occurs via many pathways,” has proven a challenge to operationalize for those in recovery research, as recovery pathways can include many different components. Examples of these components include specialty SUD treatment; pharmacotherapy in the context of specialty SUD treatment or apart from it with so-called “natural recovery,” which takes place without apparent SUD services or supports; peer recovery support services; or mutual aid groups (e.g., Alcoholics Anonymous, Narcotics Anonymous, SMART Recovery, Women for Sobriety).⁷ In addition, recovery pathways often include either a spiritual or a faith-based component, and some pathways are predominantly or almost exclusively faith based and may be affiliated with specific religious traditions or congregations. However, these elements speak to the recovery process and not to recovery outcomes. What may be most of interest to researchers is how these pathways relate to outcomes, for whom the various pathways appear effective, and any distinguishing characteristics of individuals who are attracted to or likely to be successful in following specific pathways.

Recovery is a developmental process that unfolds over an extended period—typically many years or a lifetime.⁸ It can be understood as a non-linear staged process in which challenges, needs, and growth opportunities evolve over time; a process in which it may be necessary to revisit certain learning experiences to fully integrate and deploy the skills and resources needed to engage the next stage of recovery.⁹

The research community needs a definition of recovery that is flexible but includes specific, measurable components that can be scientifically validated. However, a definition that has validity among diverse recovery stakeholders and rings true to their experience is also needed. The recovery community dictum, “nothing about us without us,” must be honored in the development of such a definition. One way of accomplishing this may be to build upon existing research to identify key components or outcomes of recovery that can be measured through existing, updated, and new instruments. Such an approach could provide an array of validated instruments in domains, such as quality of life, recovery capital, social engagement, self-efficacy, and self-stigma, that could be deployed while updated or while new measures are developed and validated. Additionally, such an approach could help avoid the exclusion or discounting of certain recovery pathways in as much as recovery would be defined by such measures and not by factors such as abstinence rates, mutual aid group attendance, or treatment attendance and compliance. These measures would not need to be ignored; rather, their strength of association with direct recovery outcomes such as those listed above could be studied, and to the extent necessary and appropriate, they might be used as proxies for the direct recovery outcome measures, provided they are presented as such and provided any caveats regarding their validity across populations or recovery pathways are highlighted. Any definition or consensus package of measures must balance the potentially competing needs for

⁶ SAMHSA’s Working Definition of Recovery. (n.d.). In *www.samhsa.gov* (pp. 1–8). Substance Abuse and Mental Health Services Administration. <https://store.samhsa.gov/sites/default/files/d7/priv/pep12-recdef.pdf>.

⁷ For more information on available mutual aid groups, see Faces & Voices of Recovery’s Mutual Aid Guide: <https://facesandvoicesofrecovery.org/resources/mutual-aid-resources/>.

⁸ *Key Findings: Recovery: The Many Paths to Wellness | Surgeon General’s Report on Alcohol, Drugs, and Health*. (2019). Surgeongeneral.Gov. <https://addiction.surgeongeneral.gov/key-findings/recovery>.

⁹ Ibid.

inclusiveness and for simplicity, clarity, and consistency. Potential next steps for addressing these gaps are proposed here:

- ❖ Conduct a meta-analysis of the scientific and gray literature to identify recovery definitions and measures, both proposed and validated.
- ❖ Convene researchers, representatives of diverse recovery communities, and other recovery experts to develop a consensus definition of recovery¹⁰ for the purpose of conducting research and to identify measurable components and outcomes of the recovery process.¹¹
- ❖ Vet the formal construct and potential measures through broader stakeholder communities, adjusting them as warranted, and build consensus around the definition through strategic partnerships.
- ❖ Adopt, modify, or develop and validate specific measures as needed.
- ❖ Publish and disseminate the final definition or construct in a document that explains the reason it has been established, describes the process through which it was developed, and offers recommendations regarding both its adoption as a standard and its measurement.
- ❖ Concurrently disseminate and promote adoption of the definition and measurement recommendations to key stakeholders, such as political leaders, the recovery community and recovery support services and treatment providers, health professionals, and potential private sector research funders through other communications channels (e.g., conferences, newsletters, blog posts, other gray literature, social media).

Theme #2:



We need research that addresses persistent barriers to recovery, particularly addiction-related stigma and discrimination, as well as racial, gender, socioeconomic, and geographic inequalities.

There are persistent barriers to substance use recovery that must be overcome. The most significant barriers are addiction-related stigma; racial, gender, socioeconomic, and geographic inequalities; and associated discrimination, which can be embodied in laws, regulations, policies, practices, and employers.^{12,13,14,15,16} Stigma is perpetuated at many levels and is a major barrier to those with SUD getting

¹⁰ This definition would need to be sufficiently comprehensive and clear to provide a recovery construct that would lend itself to consistent measurement using validated instruments.

¹¹ Here, the recovery process includes both psychosocial and neurobiological processes and milestones.

¹² Kelly, J. F., Saitz, R., & Wakeman, S. (2016). Language, substance use disorders, and policy: The need to reach consensus on an “addiction-ary.” *Alcoholism Treatment Quarterly*, 34(1), 116–123. [doi:10.1080/07347324.2016.1113103](https://doi.org/10.1080/07347324.2016.1113103).

¹³ National Academies of Sciences Engineering and Medicine. (2016). Ending discrimination against people with mental and substance use disorders: The Evidence for Stigma Change. Washington, DC: National Academies Press.

¹⁴ Ahern, J., Stuber, J., & Galea, S. (2007). Stigma, discrimination and the health of illicit drug users. *Drug Alcohol Depend*, 88(2–3), 188–196. [doi:10.1016/j.drugalcdep.2006.10.014](https://doi.org/10.1016/j.drugalcdep.2006.10.014).

¹⁵ Avery, J. D., & Avery, J.J. (2019). *The Stigma of Addiction: An Essential Guide* (J. D. Avery, Avery, J.J Ed.). Cham, Switzerland.

¹⁶White, W. L., Evans, A.C., & Lamb, R. (2009). Reducing addiction-related social stigma. *Counselor*, 10(6), 6.

the support that they need.¹⁷ For instance, research shows that individuals with SUD take 4 to 5 years from the onset of their SUD to disclose it to a health professional.^{18,19} Achieving 1 year of sustained abstinence, on average, takes three to four treatment episodes over 8 to 9 years.^{20,21} Negative attitudes toward patients with SUD are common among health professionals. These attitudes result in reduced empathy, routinized care, and poorer outcomes for these patients.²² Moreover, persons with SUD have reported avoiding seeking care or not disclosing a substance use problem to a health professional due to a history of poor treatment in the health care system.²³ Thus, attitudes among health care professionals contribute to avoidance of health services by people with SUD and to reluctance to disclose substance use problems to health professionals.

Inequalities in recovery outcomes and access to care are particularly prevalent in communities of color, lower-income communities, rural communities, and communities at the intersection of these demographics. These inequalities are in part the result of existing socioeconomic and health disparities.²⁴ They exist on top of stigma, shame, and misunderstanding about SUD; are moderated by them; and vary by community.²⁵ The quality of available health care to these communities and conscious or subconscious biases among health care professionals that lead to discriminatory behavior and care may also contribute to inequalities.²⁶

Gender and perceived socioeconomic status also moderate stigma. For example, women with SUDs are more likely than men with SUDs to face barriers affecting access and entry to substance abuse treatment and to be judged negatively for having an SUD.²⁷ In addition, research has found that narratives depicting a pregnant woman with opioid use disorder (OUD) as being of high socioeconomic status (SES) elicited

¹⁷ van Boekel, L. C., Brouwers, E. P., van Weeghel, J., & Garretsen, H. F. (2015). Comparing stigmatising attitudes towards people with substance use disorders between the general public, GPs, mental health and addiction specialists and clients. *Int J Soc Psychiatry*, 61(6), 539-549. <https://doi.org/10.1177/0020764014562051>.

¹⁸ Martinez-Hume, A. C., Baker, A. M., Bell, H. S., Montemayor, I., Elwell, K., & Hunt, L. M. (2017). "They treat you a different way": Public insurance, stigma, and the challenge to quality health care. *Cult Med Psychiatry*, 41(1), 161–180. <https://doi.org/10.1007/s11013-016-9513-8>.

¹⁹ Paquette, C. E., Syvertsen, J. L., & Pollini, R. A. (2018). Stigma at every turn: Health services experiences among people who inject drugs. *International Journal of Drug Policy*, 57, 104–110. <https://doi.org/10.1016/j.drugpo.2018.04.004>.

²⁰ Dennis, M. L., Scott, C. K., Foss, M., & Funk, R. (2005). The duration and correlates of addiction and treatment careers. *Journal of Substance Abuse Treatment*, 28 (Suppl. 1): S51–S62. <https://www.sciencedirect.com/science/article/abs/pii/S0740547204001382>.

²¹ Dennis, M. L., Foss, M. A., & Scott, C. K. (2007). An eight-year perspective on the relationship between the duration of abstinence and other aspects of recovery. *Eval Rev*, 31(6), 585–612. <https://doi.org/10.1177/0193841x07307771>.

²² van Boekel, L. C., Brouwers, E. P. M., van Weeghel, J., & Garretsen, H. F. L. (2013). Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: Systematic review. *Drug and Alcohol Dependence*, 131(1–2), 23–35. <https://doi.org/10.1016/j.drugalcdep.2013.02.01>.

²³ Biancarelli, D. L., Biello, K. B., Childs, E., Drainoni, M., Salhaney, P., Edeza, A., Mimiaga, M. J., Saitz, R., & Bazzi, A. R. (2019). Strategies used by people who inject drugs to avoid stigma in healthcare settings. *Drug and Alcohol Dependence*, 198, 80–86. <https://doi.org/10.1016/j.drugalcdep.2019.01.037>

²⁴ Ku, L., & Brantley, E. (2020). Widening social and health inequalities during the COVID-19 pandemic. *JAMA Health Forum*, 1(6), e200721–e200721. <https://doi.org/10.1001/jamahealthforum.2020.0721>.

²⁵ Crapanzano, K. A., Hammarlund, R., Ahmad, B., Hunsinger, N., & Kullar, R. (2018). The association between perceived stigma and substance use disorder treatment outcomes: A review. *Substance Abuse and Rehabilitation*, 10, 1–12. <https://doi.org/10.2147/SAR.S183252>

²⁶ Ashford, R. D., Brown, A. M., & Curtis, B. (2018). [The language of substance use and recovery: Novel use of the go/no-go association task to measure implicit bias](https://doi.org/10.1177/1099801018791111). *Health Communication*, 1–7.

²⁷ Kelly, J. F., Greene, M. C., & Abry, A. A US national randomized study to guide how best to reduce stigma when describing drug-related impairment in practice and policy. *Addiction*, n/a(n/a). <https://doi.org/10.1111/add.15333>.

lowered perceptions of individual blame for having OUD and reduced support for punitive policies than did narratives depicting the woman as being of lower SES. Additionally, depicting the barriers to treatment faced by a low-SES woman reduced the endorsement of punitive policies and increased support for expanded SUD insurance coverage treatment.²⁸ The interplay of SES, gender, and other factors is complex and needs to be considered in research about substance use and SUD.

Given the critical importance of public support for policies that will effectively address SUD and help people achieve and sustain recovery, research on the impact of narratives and messaging strategies is essential. The terms adopted for describing SUD or people with it are, therefore, crucial.²⁹ Additionally, the interaction of factors such as race, ethnicity, gender, sexual orientation, and SES need to be considered when framing recovery research and when developing policies and initiatives to support recovery.

Stigma and inequalities also occur at other levels beyond health care, such as policy and employment. To address these issues, the [2020 National Drug Control Strategy](#) calls on government agencies to support the ongoing development of recovery community organizations, to increase the number of recovery support workers, and to increase employment of those in recovery.³⁰ To accomplish these goals, the ONDCP is working to expand peer recovery support service workforces and to address long-standing barriers to employing persons in recovery, including employers' perceptions of workers in recovery.³¹

There are still many unanswered questions about the inequalities of accessing recovery support and SUD treatment services. Potential next steps for addressing these gaps are proposed here:

- ❖ Identify consensus measures of recovery or a subset of measures that are predictive of recovery outcomes, whether positive or negative.
- ❖ Track inequities in access to recovery care, including in relation to social determinants of health, such as SES, racial/ethnic identity, and rural/urban environment.
- ❖ Conduct research into the growing social openness about addiction and recovery and how it impacts not only individual recovery but public perception, support for treatment, recovery support, etc.
- ❖ Expand research on social and structural factors that may facilitate or impede recovery, such as discriminatory or punitive laws and policies, stigma, culture, resource scarcity, financial stress, and living environment.
- ❖ Conduct research on the role of family and social networks in supporting or impeding recovery.

²⁸ Kennedy-Hendricks, A., McGinty, E. E., & Barry, C. L. (2016). Effects of competing narratives on public perceptions of opioid pain reliever addiction during pregnancy. *Journal of Health Politics, Policy and Law*, 41(5), 873–916. <https://doi.org/10.1215/03616878-363223>.

²⁹ Kelly, J. F., & Westerhoff, C. M. (2010). Does it matter how we refer to individuals with substance-related conditions? A randomized study of two commonly used terms. *International Journal of Drug Policy*, 21(3), 202–207. <https://doi.org/10.1016/j.drugpo.2009.10.010>.

³⁰ Office of National Drug Control Policy. (2020). *National Drug Control Strategy* (pp. 1–44). Executive Office of the President of the United States. <https://www.whitehouse.gov/wp-content/uploads/2020/02/2020-NDCS.pdf>

³¹ Office of National Drug Control Policy. (2020, February). *National Drug Control Strategy*. A Report of the Office of National Drug Control Policy. <https://www.whitehouse.gov/wp-content/uploads/2020/02/2020-NDCS.pdf>

Theme #3:



We need a better understanding of SUD recovery and remission among adolescents.

Although SUD typically emerges in adolescence, adolescent treatment and recovery support services are insufficient, and research on adolescent recovery and adolescent peer recovery support models is extremely limited.^{32,33} The needs of adolescents with SUD differ significantly from those of their adult counterparts, and the milestones of the recovery process for adolescents may differ from those found among adults.³⁴

Recovery high schools, alternative peer groups, and other after-school or community-based models, such as clubhouses or cafes, are the most common models for providing adolescents with recovery support. Often, these approaches combine clinical and peer recovery support services and may include mentoring from older adolescents or young adults in recovery. Research involving adolescents is challenging in that the consent of parents or other legal guardians is required, and extensive measures exist to ensure the safety of this vulnerable population. Further, recruitment and retention of adolescents with SUD are often complicated by factors such as school transitions, executive function issues, and concerns that identification as a person in recovery could diminish social status and threaten the youth's emerging sense of identity.³⁵ Stigma and isolation are barriers to recovery support for all age groups, but particularly for adolescents.³⁶ Potential next steps for addressing these gaps are proposed here:

- ❖ Explore the interaction of emotional and social development with substance use and how best to encourage seeking help and support for recovery among youth with SUD.
- ❖ Study the interaction of neurobiological development and SUD, including developmental vulnerabilities and the impact of SUD on neurological development.
- ❖ Investigate the relative effectiveness and scalability of various adolescent recovery support models, including recovery high schools, alternative peer groups, and other models.
- ❖ Conduct research at the intersection of prevention and recovery support and how to develop integrated, complementary models that are mutually reinforcing.
- ❖ Investigate the relative effectiveness of various strategies for engaging youth in services, support programs and research.

³² Tobler, N. S., Roona, M. R., Ochshom, P., Marshall, D. G., Streke, A. V., & Stackpole, K.M. (2000) School-based adolescent drug prevention programs: 1998 meta-analysis. *Journal of Primary Prevention*, 20(4): 275–336.

³³ Brannigan, R., Schackman, B. R., Falco, M., & Millman, R. B. (2004) The quality of highly regarded adolescent substance abuse treatment programs: Results of an in-depth national survey. *Archives of Pediatrics & Adolescent Medicine*, 158(9): 904–909. <https://jamanetwork.com/journals/jamapediatrics/fullarticle/485811>

³⁴ Kaminer, Y. (2001). Adolescent substance abuse treatment: Where do we go from here? *Psychiatric Services*, 52(2), 147–149. <https://doi.org/10.1176/appi.ps.52.2.147>

³⁵ Committee on the Science of Changing Behavioral Health Social Norms; Board on Behavioral, Cognitive, and Sensory Sciences; Division of Behavioral and Social Sciences and Education; National Academies of Sciences, Engineering, and Medicine. (2016). *Ending discrimination against people with mental and substance use disorders: The evidence for stigma change*. The National Academies Press. https://www.ncbi.nlm.nih.gov/books/NBK384915/pdf/Bookshelf_NBK384915.pdf

³⁶ Ibid.

Theme #4:



We need to understand the impact of COVID-19 on recovery and to identify innovative approaches for continuing service delivery, mutual aid, and other needed social support through electronic platforms.

The COVID-19 pandemic has impacted every aspect of our lives, and it presents unique challenges and opportunities in the realms of recovery research and support. Not only is the nation dealing with a virus pandemic, but it is also occurring during an SUD and overdose epidemic.³⁷ As one Summit participant noted, “We have to understand that there is a crisis on top of a crisis: a pandemic on top of an epidemic.” The standard best practices for building resiliency against SUDs and sustaining recovery are now in direct conflict with public health recommendations for avoiding the spread of COVID-19. Most notably, engagement with a supportive network of peers and accountability to them are linchpins of recovery. The need to practice social distancing and, in some cases, to quarantine directly undermines this essential support for recovery.

Fatal overdoses have been increasing during the pandemic.³⁸ In addition to potentially driving more substance use, the pandemic has likely resulted in more use of substances in isolation, reducing the likelihood of overdose reversal or calls to emergency services by peers or passersby.³⁹ The pandemic has also exacerbated preexisting medical, health, and social inequalities.⁴⁰ Additionally, although virtual service and support options have greatly expanded, the platforms that support these types of support are not easily accessible to everyone.⁴¹ For example, those who are unemployed or otherwise of limited means may not be able to afford broadband or wireless cellular networks. Those who reside in rural or frontier communities may simply not have access to reliable cell phone connectivity or to broadband.

Although the COVID-19 pandemic has had a detrimental effect on mental health, employment, and access to recovery support, it might be a once-in-a-lifetime opportunity to rethink and reimagine society, and it will likely result in the expanded use of telehealth and other virtual platforms after the pandemic. In addition, the rapid expansion of telehealth services may provide opportunities to conduct natural experiments regarding the comparative effectiveness of online and in person interventions.

Recovery support service providers and mutual aid groups (e.g., Alcoholics Anonymous, Narcotics Anonymous, SMART Recovery) have made a rapid transition to virtual services and meetings by expanding access to these vital services and support and by building recovery networks that are sometimes national and even international.⁴² In response to the COVID-19 pandemic, the federal government has moved

³⁷ Volkow, N. D. (2020). Collision of the COVID-19 and addiction epidemics. *Annals of Internal Medicine*. <https://doi.org/10.7326/M20-1212>.

³⁸ Alter, A., Yeager, C., & Analyst, O. (2020). *COVID-19 impact on US national overdose crisis*. <http://www.odmap.org/Content/docs/news/2020/ODMAP-Report-June-2020.pdf>

³⁹ Alexander, G. C., Stoller, K. B., Haffajee, R. L., & Saloner, B. (2020). An epidemic in the midst of a pandemic: Opioid use disorder and COVID-19. *Annals of Internal Medicine*. [doi:10.7326/M20-1141](https://doi.org/10.7326/M20-1141).

⁴⁰ Ku, L., & Brantley, E. (2020). Widening social and health inequalities during the COVID-19 pandemic. *JAMA Health Forum*, 1(6), e200721–e200721. <https://doi.org/10.1001/jamahealthforum.2020.0721>.

⁴¹ Hulse, J., Mellis, A., & Kelly, B. (2020). Survey: COVID-19 affecting access to addiction treatment and key services. *Addiction Policy Forum* (pp. 1–22). <https://www.addictionpolicy.org/covid19-report>.

⁴² <https://aa-intergroup.org/oiaa/meetings/>

quickly to reduce barriers to the use of telehealth platforms to ensure continued access for those in or seeking care for SUD, including allowing greater use of telehealth platforms for prescribing medications for opioid use disorder (MOUD). Indeed, telehealth visits for all health conditions have expanded exponentially during the pandemic.⁴³ This work is far from over, and there are still many unique opportunities for future research that stem from the disruption caused by the COVID-19 pandemic.

The COVID-19 pandemic also provides a unique opportunity to promote and invest in research on virtual services and on more flexible rules regarding the prescribing or administration of MOUD. Potential next steps for addressing these gaps are proposed here:

- ❖ Compare the efficacy of virtual and in-person peer recovery support services and mutual aid group participation.
- ❖ Expand understanding of the challenges and opportunities that individuals in or seeking recovery have encountered during this time of social distancing.

Theme #5:



We need to establish recovery research as a research domain, develop diverse funding streams for conducting recovery research, and establish effective strategies for targeted and timely dissemination of recovery research findings.

Recovery research needs to be clearly understood as a research *domain*, with a range of focus areas to which a variety of quantitative and qualitative research models can be applied. The importance of research on recovery and its distinction from research on treatment or other clinical services needs to be widely understood.

Recovery research findings also need to be better disseminated. Because the research has been fragmented, it has been difficult to develop reliable channels for disseminating findings to the relevant audiences. This is further complicated because recovery researchers may not look like the people they study. This incongruence may create barriers to knowledge acquisition, trust, and distribution of resources. Also, academic papers—where most research is published—are not the most effective means to educate the public about research on recovery.

Nevertheless, significant progress has been made through the establishment of recovery research institutes or centers affiliated with major teaching institutions (e.g., Harvard, Yale), some of which focus extensively on the dissemination of findings to the public and the recovery community. Overall, recovery researchers need to make better use of websites, electronic newsletters (e.g., the Recovery Research Institute’s bulletin), social media, radio, television, and streamed media, conferences, town halls, and other public-facing communication avenues. Additionally, it would be useful for recovery researchers to

⁴³ Verma, S. (2020, July 15). Early impact of CMS expansion of Medicare telehealth during COVID-19. *Health Affairs Blog*. <https://www.healthaffairs.org/doi/10.1377/hblog20200715.454789/full/>.

identify key stakeholders who are capable of funding or otherwise supporting the dissemination of their findings outside of academic journals. Potential next steps for addressing these gaps are proposed here:

- ❖ Create an inventory of current recovery research funding so that a gap analysis can be completed to help inform the development and prioritization of future funding.
- ❖ Survey the current recovery research dissemination landscape to identify gaps and funding opportunities and recommend steps for addressing significant gaps in recovery research funding and communications.
- ❖ Host a second annual summit to continue building on the work accomplished through this Summit.

EMERGING TOPICS

The convergence of the opioid epidemic and the COVID-19 pandemic has laid bare the significant lack of equity in access to recovery services for specific populations. The social isolation required by the pandemic has had an exponentially larger impact on those in early recovery who require community to sustain their recovery. In particular, the lack of technology and internet capacity in rural and urban poor communities has contributed to the fact that online services have not been available to those in recovery in many cases.

Although investment in recovery services has increased, the resulting interest in expanding recovery research and funding has been limited. This limitation has resulted in the reduced number of researchers who are engaged in the field of recovery and working to help it grow.

THE ROAD AHEAD

The Summit has helped increase interest in the field of recovery research and expansion of recovery services. The Biden Administration has proposed expanded funding for both recovery services and research and, for the first time, designated specific funding to engage states in expanding access to recovery coaching.

This report is the first step in developing a comprehensive approach to recovery research and services that will engage the entire field of federal, nonprofit, philanthropy, and recovery leaders and experts.

CONCLUSION

The Summit brought together a diverse group of experts, advocates, and funders in the recovery space. A second summit is being planned that will include additional federal agencies and leaders, including those who are responsible for funding recovery services. The goal of the second summit will be to develop a comprehensive research strategy to address the specific gaps and challenges noted within this report. A key focus of the second summit will be to address inequities in access to services, including the needs of specific populations that have been underserved, and gain a greater understanding of how to best address recovery stigma so that all individuals living in recovery have the opportunity to access the services that they need.

APPENDIX

SUMMIT AGENDA

RECOVERY RESEARCH VIRTUAL SUMMIT

Monday, July 27, 2020

12:00 p.m.–5:00 p.m. EST

Working Agenda

- Noon** Opening
- 12:05** Welcome – *Jan Brown, Executive Director, Global Recovery Initiatives Foundation (GRI)* and *Matt Escoubas, Director, Fors Marsh Group*
- 12:10** James Carroll Introduction – *Pam Cytron, Chair GRI Board*
- 12:15** Remarks – *James Carroll, Director of the White House Office of National Drug Control Policy*
- 12:30** Dr. John Kelly Introduction – *Ben Garthwaite, CEO, Fors Marsh Group*
- 12:35** Addiction Recovery: Theory and Science – *Dr. John Kelly*
- 1:20** Panel discussion: Challenges and Opportunities—*Jan Brown, Moderator*
Dr. Andy Finch
Dr. John Kelly
Dr. Corrie Vilsaint
Dr. Luis Torres
- 1:50** Break
- 2:00** Instructions for breakout sessions – *Ronne Ostby, VP, Fors Marsh Group*
- 2:10** Breakouts Round 1
- 2:50** Breakouts Round 2
- 3:30** Breakouts Round 3
- 4:30** Closing panel discussion: Reflections and Next Steps – *Dr. Andrea Barthwell, Moderator*
Dr. Westley Clark
Dr. Carlos Blanco

BREAKOUT GROUPS

Setting the Recovery Research Agenda: Moving Recovery Research into Best (Emerging or Promising) Practices.

Recovery Support Services and Mutual Aid

- ❖ Peer recovery support services (PRSS) approaches, models, competencies, standards, and roles
- ❖ PRSS and organizational standards and competencies
- ❖ Definition of peer/shared experience and boundaries of effective “peerness” (shared experience)
- ❖ What works for whom? When does it work best?
- ❖ Emerging peer roles (e.g., outreach, engagement, harm reduction)

- ❖ Respective roles of peer recovery support services and mutual aid
- ❖ Models for integrating PRSS with broader systems
- ❖ Delivery mechanisms/structures (e.g., recovery community organizations, peer workers employed by clinical or social service organizations, recovery community centers, recovery residences, recovery high schools, collegiate recovery programs, community-based supports for youth and young adults [e.g., alternative peer groups, clubs, recovery cafes])
- ❖ Cost-effectiveness
- ❖ Social and cultural facilitators and barriers to effective PRSS
- ❖ Role of PRSS and recovery organizations in the broader community and the impact of PRSS and recovery organizations on the community and vice-versa (e.g., stigma, help-seeking behaviors, support for/toleration of treatment providers/peer organizations, ordinances, policies)
- ❖ PRSS and context (urban, rural, suburban, gender, race, ethnicity, culture, etc.)

Recovery Metrics and Outcomes

- ❖ Definitions and measures (e.g., quality of life, self-efficacy, social functioning, recovery capital, employment, housing)
- ❖ Development and dissemination of consistent validated measures and definitions for research
- ❖ Problems of measurement, including distortions due to a priori assumptions about recovery/remission process by researchers
- ❖ Neurobiological, including co-occurring conditions (cognition, perception, judgment, cravings, stress management, cortical blood flow/functioning, liver and cardiac function, weight, health, including status of chronic health conditions, psychiatric comorbidities)
- ❖ Data collection

Recovery Process (Neurobiological)

- ❖ Neurobiology of recovery and the relationship to psychosocial recovery
- ❖ Stress
- ❖ Craving
- ❖ Markers (cognitive, executive function, perception, judgment, neural functioning/blood flow, etc.)

Recovery Process (Psychosocial/Cultural)

- ❖ Individual (and family?)
 - ❖ Substance use
 - ❖ Self-perception, self-efficacy, goal/future orientation, individual and social identity, and self-stigma
 - ❖ Identity and its evolution through recovery and remission
 - ❖ Navigation/healing of trauma
 - ❖ Stress management, craving, self-care, and emotional functioning

- ❖ Social functioning and social cognition
- ❖ Instrumental capital (e.g., driver's license, transportation access, propinquity of work, treatment, mutual aid, family and social supports, voting rights, expungement or certificate of rehabilitation)
- ❖ Social capital (external recovery capital), including family and broader supportive social networks, mutual aid groups, clinical or peer services
- ❖ Prevalence and pathways of recovery and remission and characteristics of individuals following various pathways
- ❖ Opportunities for intervention

Recovery Equity

- ❖ External Facilitators and Barriers (mediators)
 - ❖ Social determinants of health, including economic opportunity, educational attainment and access, employment, housing, economic security at the individual and community levels, etc. (*One could argue that the entire list below consists of social determinants of health.*)
 - ❖ Socio-cultural barriers (e.g., social norms and social construction of addiction and stigma)
 - ❖ Policy barriers (e.g., collateral consequences of conviction in relation to housing, employment, educational opportunity, right to operate a motor vehicle, access to food assistance or financial support, the right to vote)
 - ❖ System involvement (e.g., criminal justice, child welfare)
 - ❖ Context (urban, rural, suburban, gender, race, ethnicity, culture, etc.)
 - ❖ Socio-cultural factors, including social norms and socio-cultural construction of addiction and recovery stigma and relationship to family individual or systemic racism or sexism

Diffusion of Supporting Policy, Practice, Systems, Services, and Community Change

- ❖ Strategies for research diffusion and advancement
- ❖ Study/evaluation of technology transfer and systems and services change models/strategies and the contexts in which they are most likely to be effective
- ❖ Role of media and messaging in addressing fear, stigma, and misunderstanding and supporting positive change
- ❖ Approaches for fostering the adoption of research-informed policy
- ❖ Organizational and social change models and recovery
- ❖ Factors associated with adoption of or resistance to recovery related policies

SUMMIT PLANNING PANEL

Name	Affiliation
Dr. John Kelly	Recovery Research Institute
Dr. Andy Finch	Department of Human and Organizational Development, Vanderbilt University
Dr. Andrea Barthwell	Global Recovery Initiatives Foundation
Peter Gaumont	Office of National Drug Control Policy (ONDCP)
Emily Einstein	National Institute on Drug Abuse (NIDA)
Matt McClune	Substance Abuse and Mental Health Services Administration (SAMHSA)
Aaron M. Whites, Ph.D.	National Institute on Alcohol Abuse and Alcoholism (NIAAA)
Dr. Keith McInnes	Department of Veterans Affairs
Capt. Christopher Jones	Centers for Disease Control and Prevention
Aaron Beswick	Health Resources and Services Administration
Matt Escoubas	Fors Marsh Group
Catherine Hartnett	Global Recovery Initiatives Foundation
Jan Brown	Faces & Voices of Recovery
Giri Mohan	Office of National Drug Control Policy (ONDCP)
Dr. Martha Barbone	Member of ONDCP Intergovernmental Group
Molly McKaughan	Global Recovery Initiatives Foundation
Dr. Keith Humphreys	Stanford University
Dr. Luis Torres	University of Texas Rio Grande Valley
Dr. Larry Davidson	Yale School of Medicine

SUMMIT SPEAKER BIOS

Andrea Grubb Barthwell, MD, DFASAM, is the founder of Encounter Medical Group, PC; manages and consults through the global health care policy firm EMGlobal; is a director at Two Dreams, a comprehensive alcoholism and addiction treatment system; and was voted in as a distinguished fellow of the American Society of Addiction Medicine (ASAM), where she served as president. Dr. Barthwell has a long-term commitment to individuals with opioid use disorder (OUD). She has many notable contributions and appointments, including being named the founding chair of the board of the Foundation for Opioid Response Effort (FORE) and nominated by President George W. Bush to serve as the deputy director for Demand Reduction in the Office of National Drug Control Policy (ONDCP).

Andy Finch, PhD, is a Professor of the Practice in the Department of Human and Organizational Development at Vanderbilt University's Peabody College. Dr. Finch co-founded the Association of Recovery Schools and has led research on two national studies of recovery high schools, both funded by the National Institute on Drug Abuse (NIDA). Among his numerous published works are *Starting a Recovery School* and *Approaches to Substance Abuse and Addiction in Educational Communities: A Guide to Practices that Support Recovery in Adolescents and Young Adults*. Dr. Finch helped design Community High School in Nashville, TN, for teens recovering from addiction and helped found Vanderbilt University's collegiate recovery program, where he serves on the advisory committee. His most recent project includes a recovery high school history, which will be published by Oxford University Press.

John F. Kelly, PhD, ABPP, is the Elizabeth R. Spallin Associate Professor of Psychiatry in Addiction Medicine at Harvard Medical School—the first-ever endowed professor in addiction medicine at Harvard. He is the founder and director of the [Recovery Research Institute](#) at the Massachusetts General Hospital and is the associate director of the Center for Addiction Medicine. Dr. Kelly is a former president and current fellow of the American Psychological Association's Society of Addiction Psychology. Dr. Kelly sits on numerous scientific advisory boards and serves as a consultant to U.S. federal agencies and foreign governments. With clinical and research expertise in addiction treatment and recovery, Dr. Kelly's work has highlighted the mechanisms of behavior change and the effects of stigma and discrimination on individuals suffering from substance use disorder.

Carlos Blanco, MD, PhD, MS, is the director of the Division of Epidemiology, Services, and Prevention Research at the National Institute on Drug Abuse (NIDA). Dr. Blanco is a nationally known expert in the epidemiology and treatment of addictive disorders. Before joining NIDA, Dr. Blanco was Professor of Psychiatry at Columbia University Irving Medical Center. Dr. Blanco has authored over 300 peer-reviewed publications.

H. Westley Clark, MD, JD, MPH, is the Dean's Executive Professor of Public Health at Santa Clara University. Dr. Clark is the former director of the Center for Substance Abuse Treatment at the Substance Abuse and Mental Health Services Administration (SAMHSA). He contributed to the 2016 *Surgeon General's Report on Alcohol, Drugs, and Health* as a section editor for treatment. Dr. Clark is a distinguished fellow of the American Society of Addiction Medicine and is a member of the National Advisory Council of the National Institute on Drug Abuse (NIDA). He is certified in Addiction Medicine by

the American Board of Addiction Medicine (ABAM); is licensed to practice medicine in California, Maryland, Massachusetts, and Michigan; and is also a member of the Washington, DC, bar.