#RecoveryMovement

Innovation and Creation in Recovery: The Growing Field of Recovery Science

August 14, 2019

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University of the Sciences

Substance Use Disorders Institute
EDUCATION • POLICY • RESEARCH

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Session Agenda

Innovation and Creation in Recovery: The Growing Field of Recovery Science

- Introductions
- What is recovery?
- Recovery Science
- Recovery Informed Theory
- Emerging Recovery Research & Innovation
  - Recovery Oriented Systems of Care
  - Recovery Ready Communities
  - Recovery Community Organizations
    - Models
    - Hybrid RCO case study
  - Recovery Community Center Office Based Opioid Treatment programs
  - Language, Bias, Stigma, & Discrimination

A little about me...

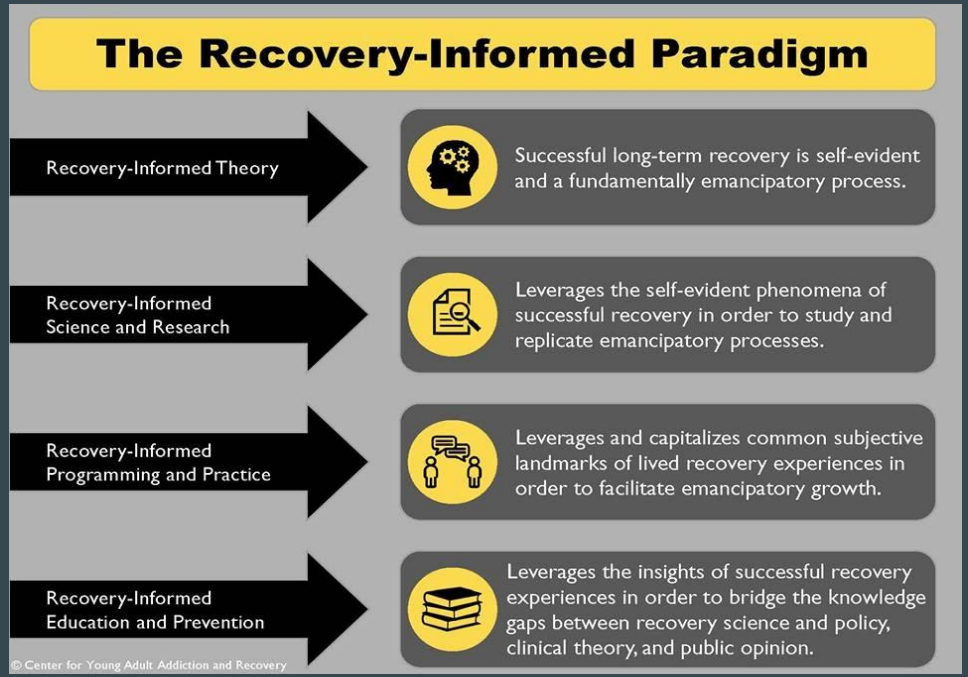
- Macro social worker and recovery scientist
- PhD student (USciences)
    - Researcher (Substance Use Disorders Institute, USciences)
    - Research Assistant (Treatment Research Center, UPenn)
- Managing Editor, Journal of Recovery Science
- Director, Unity Recovery RCO in Philadelphia
- Person in long-term recovery....AND

A NEW DAD! (Penelope)

My Background and Priorities

Research Focus

- Recovery support institutions
- Recovery Oriented Systems of Care
- Linguistics, stigma, and discrimination
- Pharmacotherapies for SUDs
- Machine learning and predictive analytics
- Harm reduction services
- Collegiate recovery programs / recovery high schools
- Health communication and health literacy
- Digital recovery supports and social networking



What is recovery?

A Brief Primer on Recovery

SOURCE	YEAR	DEFINITION
CENTER FOR SUBSTANCE ABUSE TREATMENT (CSAT)	2005	Recovery from alcohol and drug problems is a process of change through which an individual achieves abstinence and improved health, wellness and quality of life.
AMERICAN SOCIETY OF ADDICTION MEDICINE (ASAM)	2005	A patient is in a "state of recovery" when he or she has reached a state of physical and psychological health such that his/her abstinence from dependency-producing drugs is complete and comfortable.
BETTY FORD INSTITUTE	2006	A voluntarily maintained lifestyle characterized by sobriety, personal health, and citizenship.
WILLIAM L. WHITE	2007	Recovery is the experience (a process and a sustained status) through which individuals, families, and communities impacted by severe alcohol and other drug (AOD) problems utilize internal and external resources to voluntarily resolve these problems, heal the wounds inflicted by AOD- related problems, actively manage their continued vulnerability to such problems, and develop a healthy, productive, and meaningful life.
UK DRUG POLICY COMMISSION	2008	The process of recovery from problematic substance use is characterised by voluntarilysustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society.
SCOTTISH GOVERNMENT	2008	A process through which an individual is enabled to move on from their problem drug use, towards a drug-free life as an active and contributing member of society.
SAMSHA	2011	Recovery from mental disorders and substance use disorders is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.
AMERICAN SOCIETY OF ADDICTION MEDICINE (ASAM)	2013	A process of sustained action that addresses the biological, psychological, social and spiritual disturbances inherent in addiction.
KELLY AND HOEPPNER	2014	Recovery is a dynamic process characterized by increasingly stable remission resulting in and supported by increased recovery capital and enhanced quality of life.
RECOVERY RESEARCH INSTITUTE ADDICTION-ARY	2017	The process of improved physical, psychological, and social well-being and health after having suffered from a substance-related condition.

- The fields of SUD and MH recovery have seen several attempts at defining the word and concept of “recovery.”
- National organizations such as the Substance Abuse and Mental Health Association (SAMHSA), the American Society for Addiction Medicine (ASAM), the Hazelden Betty Ford Foundation (HBFF), and others have developed working definitions of recovery (SAMHSA, 2011; ASAM, 2013; The Betty Ford Institute Consensus Panel, 2007).
- Each of these has its merits, and weaknesses, and we have yet to reach true consensus among the scientific and professional communities, or the lay public.

* This figure documents the most popular definitions of recovery (Kelly & Hoeppner, 2015; *Courtesy of the Recovery Research Institute, 2017*).

A Brief Primer on Recovery

Recovery Science Research Collaborative Consensus Definition of Recovery

> "Recovery is an individualized, intentional, dynamic, and relational process involving sustained efforts to improve wellness."

Ashford, R. D., Brown A., Brown, T., Callis, J., Cleveland, H. H., Eisenhart, E., ... Whitney, J. (2018). Defining and Operationalizing the Phenomena of Recovery: A Working Definition from the Recovery Science Research Collaborative. Addiction Research and Theory.

- The RSRC recently defined recovery in this way (2018)
- The definition is intended to help operationalize future recovery research
- Includes both MH and SUD
- Helps preclude discrimination resulting from individuals using different pathways and programs of recovery

Recovery Defined for Our Work

Recovery Science Research Collaborative Consensus Definition of Recovery

"Recovery is an individualized, intentional, dynamic, and relational process involving sustained efforts to improve wellness."

Ashford, R. D., Brown A., Brown, T., Callis, J., Cleveland, H. H., Eisenhart, E., ... Whitney, J. (2018). Defining and Operationalizing the Phenomena of Recovery: A Working Definition from the Recovery Science Research Collaborative. Addiction Research and Theory.

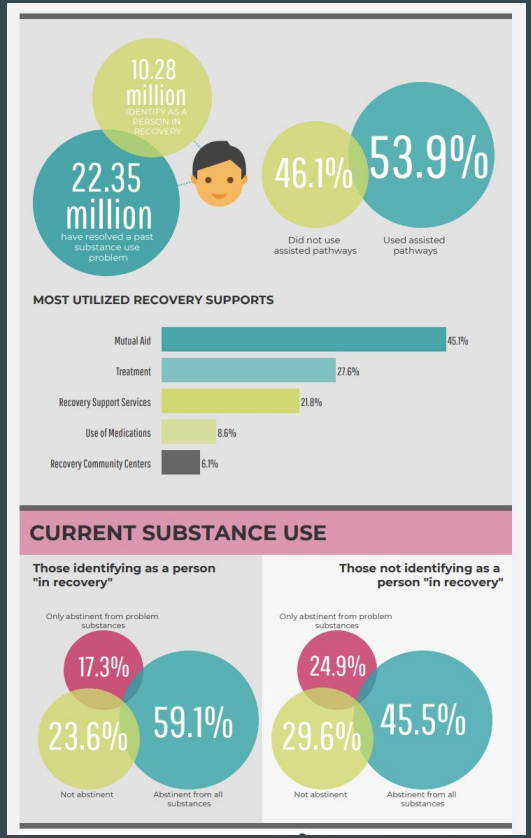
Even without true consensus, central tenants of recovery should be used for research, policy & public health purposes

These are:

1. Recovery is an individualized and self-directed process, though certain characteristics related to outcomes can likely be applied to general populations
2. Recovery does not follow a linear progression nor is it time-limited
3. Recovery begins through various access points, and can progress through the use of various pathways and programs, which often change over time
4. No matter where and how the recovery process is initiated, it is most likely to flourish and be maintained within a community (identity, geographic, social, etc.)

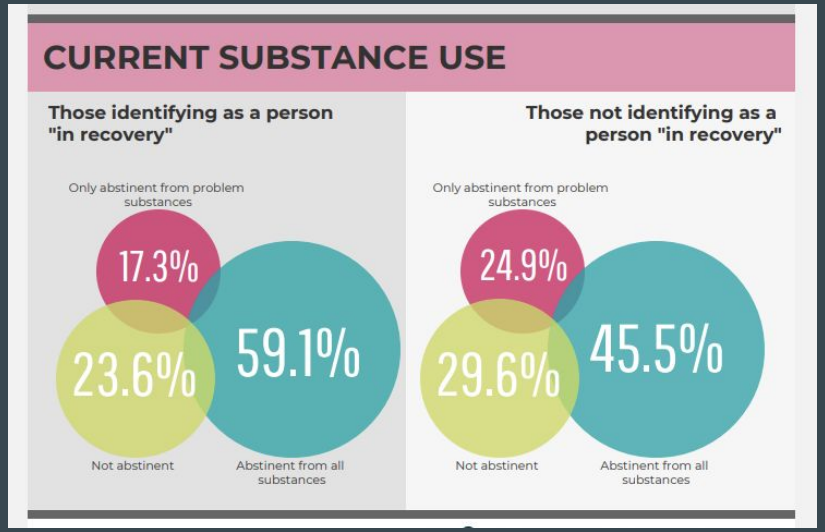
Recovery Prevalence and Outcomes

- The 2017 National Recovery Study estimates that 9.1% of the US population (18+ years, non-institutionalized) has resolved an AOD problem. (Kelly et al., 2017)
- About half of these individuals self-identified as a “person in recovery”
- Over half (53.9%) reported resolution via an “assisted pathway” (i.e. lifetime use of a formal support mechanism)
- A few previous studies have also estimated a national recovery prevalence rate between 9-10%



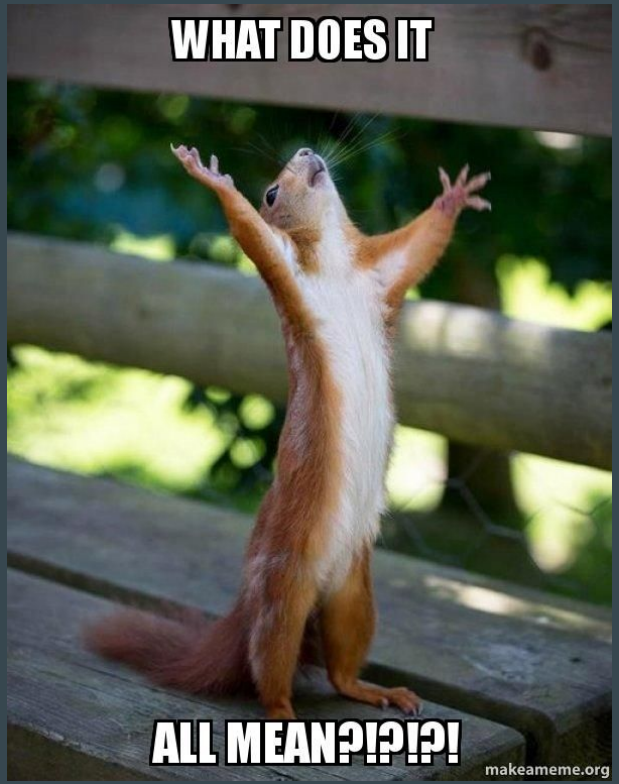
Recovery Prevalence and Outcomes

- Not all who resolve SUDs are completely abstinent (Kelly et al., 2017, 2018)
  - Among those identifying as “in recovery”
    - 59.1% completely abstinent
    - 17.3% only abstinent from most problematic substance
    - 23.6% not abstinent at all
  - Among those not identifying as “in recovery”
    - 45.5% completely abstinent
    - 24.9% only abstinent from most problematic substance
    - 29.6% not abstinent at all



So what does it all mean?

- National epidemiological studies have shown time and time again...
    - Recovery is a nuanced and individualized process that is likely to occur across a variety of pathways and initiation points
    - Recovery defined by abstinence only is an incomplete picture and discounts the lived experiences, identities, and characteristics of millions of Americans
    - Many Americans “naturally” recover, without the use of formal recovery and/or treatment supports



Recovery Science

Recovery as an Organizing Paradigm

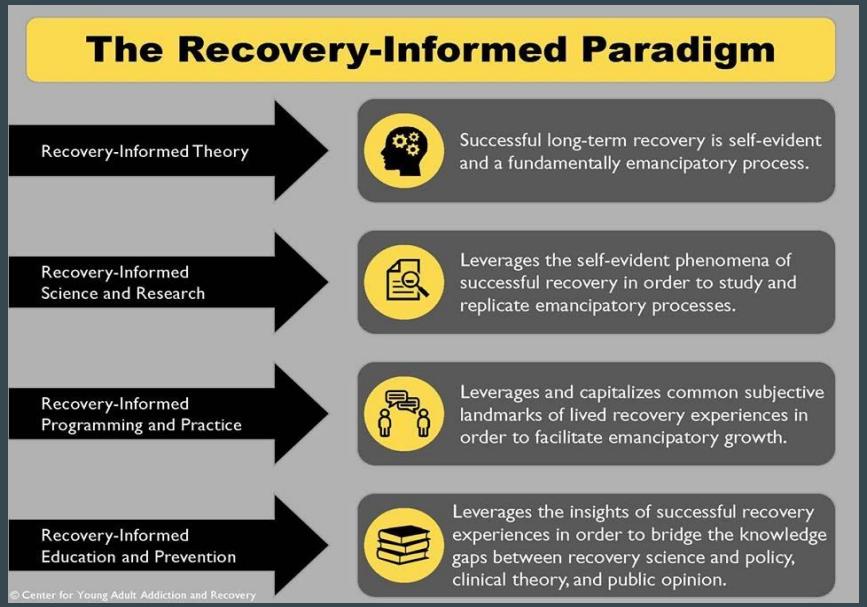
- Not only for systems of care, but also for how we organize our research agenda
- Addiction, as a primary and secondary pathology, is well studied (though we still have a lot to explore)
- Recovery - as a topic of scientific inquiry - is still in relative infancy stages and the opportunities are exciting!

Justification for Recovery Science

- How people get well differs from how they became pathological.
- The absence of specific symptoms (including abstinence) is not in and of itself an indicator of health or growth
- The engine of recovery is growth across multiple SUD-related and non-SUD related life spheres
- Recovery is inherently interdisciplinary. Attempts to reduce it to one field detract from the scientific understanding of recovery
- Recovery is more than an outcome, as per those who have recovered

Recovery Informed Theory

Recovery Informed Theory



Recovery Informed Theory (Brown & Ashford, 2018) posits that "successful long-term recovery is self-evident and is a fundamentally emancipatory process.

Key points:

1. Places the subjective experience of recovery trajectories as the chief laboratory of recovery science *in-situ*.
2. Relieves intellectual obligation to "prove recovery"
3. Allows recovery to be what it is - a phenomena that is not well understood but that does occur
4. Places the individuals in recovery at the center of the science (co-creation in participatory ways rather than a praxis of authority and power)
5. Situates emancipatory states of human freedom as the directionality of research

Recovery Measurement Methods

- Multi-time point data collection (years, not months)
- Diverse array of interpersonal and intrapersonal outcome measures
  - Recovery Capital
  - Human Flourishing
  - Self-esteem & Self-efficacy
  - Personal Growth
  - Stigma
  - Hope
  - Prosocial Battery [non-12 step recovery]
  - Service to others (12-step recovery paths)
- Community-based participatory research
- Mixed-methods when possible (phases or single mixed studies)

Recovery Oriented Systems of Care

A Brief Introduction to ROSC

1. The successful recovery of individuals with SUDs is positively impacted by the use of medical, community, and social supports, especially within the first 5-years of the recovery process (Granfield & Cloud, 2001; Hibbert & Best, 2011; Jason, Olson, Ferrari, & Lo Sasso, 2006; McKay, 2017; Sheedy & Whitter, 2009; White et al., 2013).
2. Most individuals will engage within processes of recovery within the community they live (HHS, 2003), which suggests that long-term supports will be most beneficial when they exist within an individual's local community.
3. The ROSC model brings together existing resources and stakeholders at the micro and mezzo level, with the primary goal of providing continuity of services and care, provide all stakeholders a voice, and to continue to build upon existing resources to further support individuals in recovery (Sheedy & Whitter, 2013)

A Brief Introduction to ROSC

(SAMHSA, 2010)

A Brief Introduction to ROSC

- As a foundational framework, the ROSC centers the recovery experience (the individual, the family, and the community) as the focal point and continuously self-improves

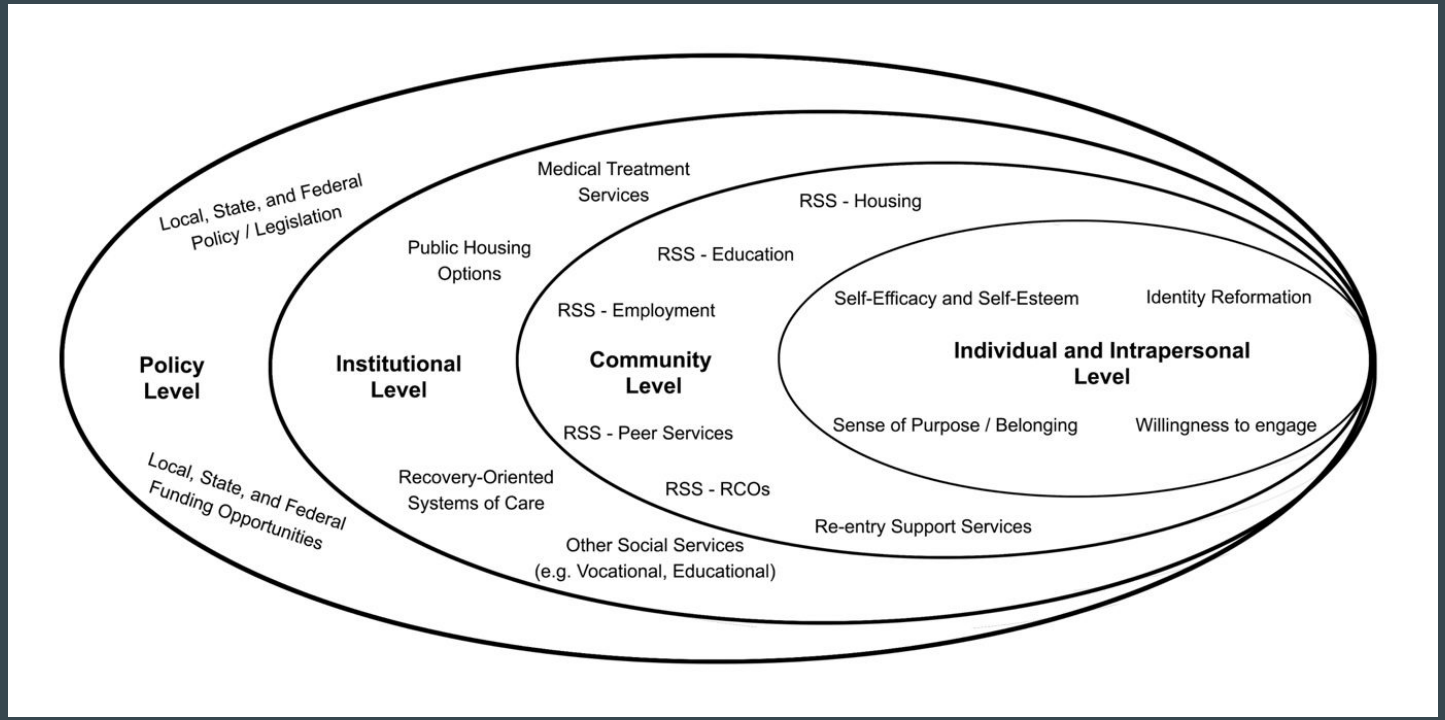
- However, the model can also be used as a starting point for community assessment and recovery support efficacy evaluation

Recovery Ready Communities

Creating Recovery Ready Ecosystems

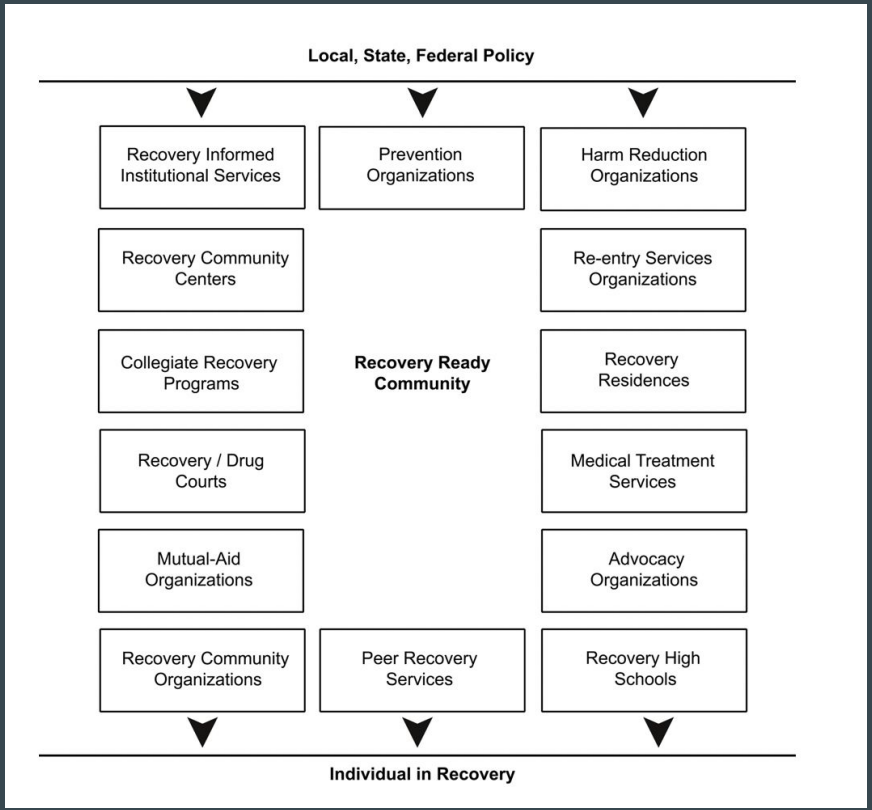
- Realizing goals of systems transformation that centers those with lived experience requires a focus on continuing to build recovery-informed infrastructure
- This must include all types of supports and resources in every community - because the community itself is dynamic as are people
- What types of supports are these?
- Why are these supports needed?

A Brief Introduction to ROSC



Ashford, R. D., Brown, A. M., Ryding, R., & Curtis, B. (2019). Building recovery ready communities: The recovery ready ecosystem model and community framework. Addiction Research & Theory, 1–11. https://doi.org/10.1080/16066359.2019.1571191

A Brief Introduction to ROSC



(Ashford et al., 2018)

Community Recovery Capital / Recovery Readiness

1. What is recovery capital?
    a. The resources connected to the individual human traits with which persons are born, the individual qualities that they have acquired over time, and the environmental and social structural spaces which they occupy in the world (Cloud & Granfield, 2008)
2. What is community recovery capital?
3. How does that apply to recovery readiness?
4. What can a community do with a quantitative score of readiness?
    a. Help inform policy, funding mechanisms and levels of support, and target future development

Community Recovery Capital / Recovery Readiness

Let X = recovery support service or resource from the RREM; Max $X = 14$

Let Y_1, $Y_2 \ldots Y_{14}$ = the presence of multiple of each X within the community (e.g. 2 recovery community centers, $Y_z = 1$; 1 recovery community center $Y_z = 0$; max $Y = 2$)

Let RR = community level of recovery readiness

$RR = (Y_{1\ldots} + Y_{14}) + X$

Scoring:

Scoring Range: 0-28

RR $<=$ 7, low level of recovery readiness

7 $<$ RR $<=$ 21, mid-level of recovery readiness

RR $>$ 21, high-level of recovery readiness

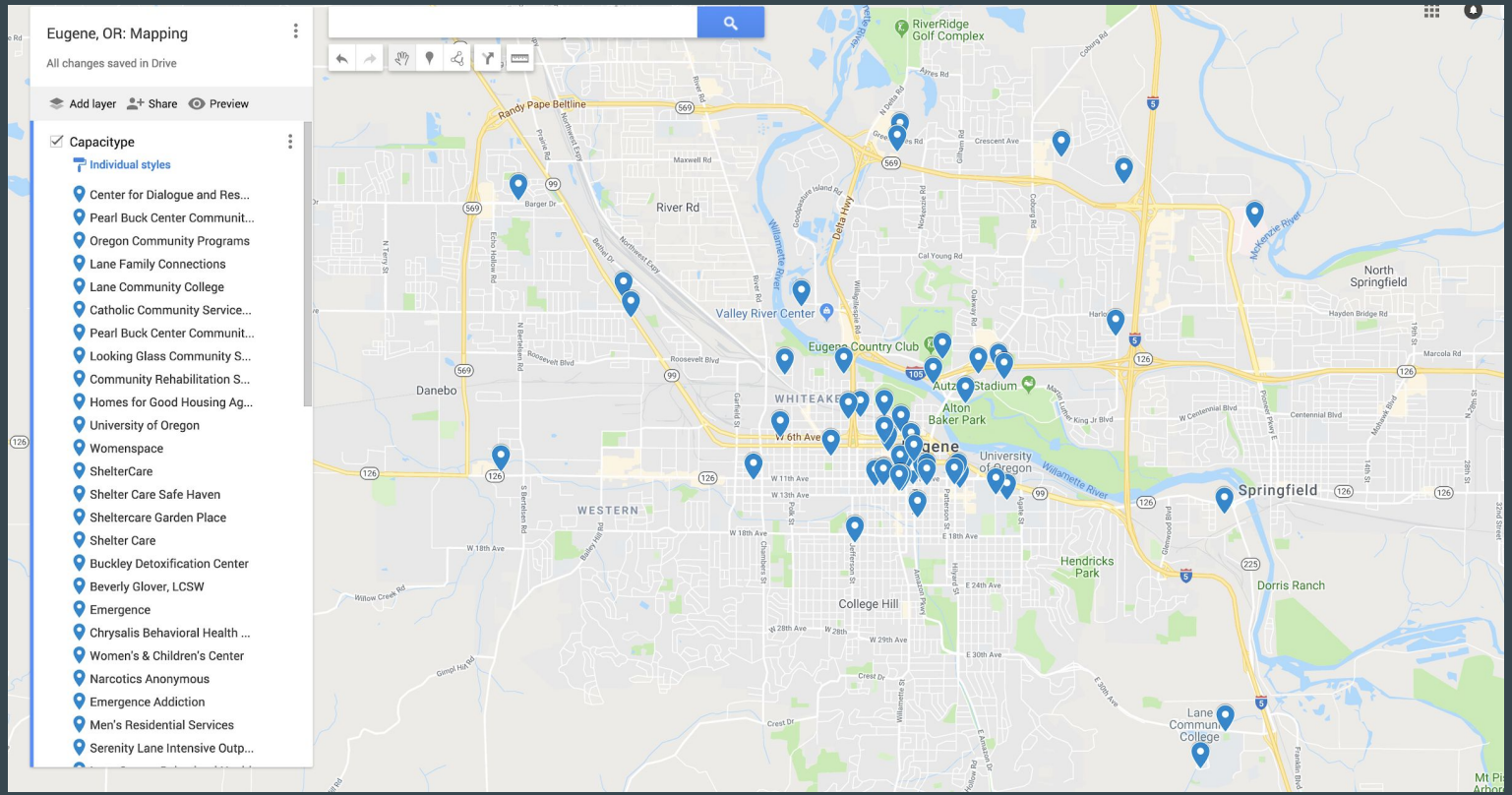
(Ashford et al., 2018)

Eugene, OR: Case Study

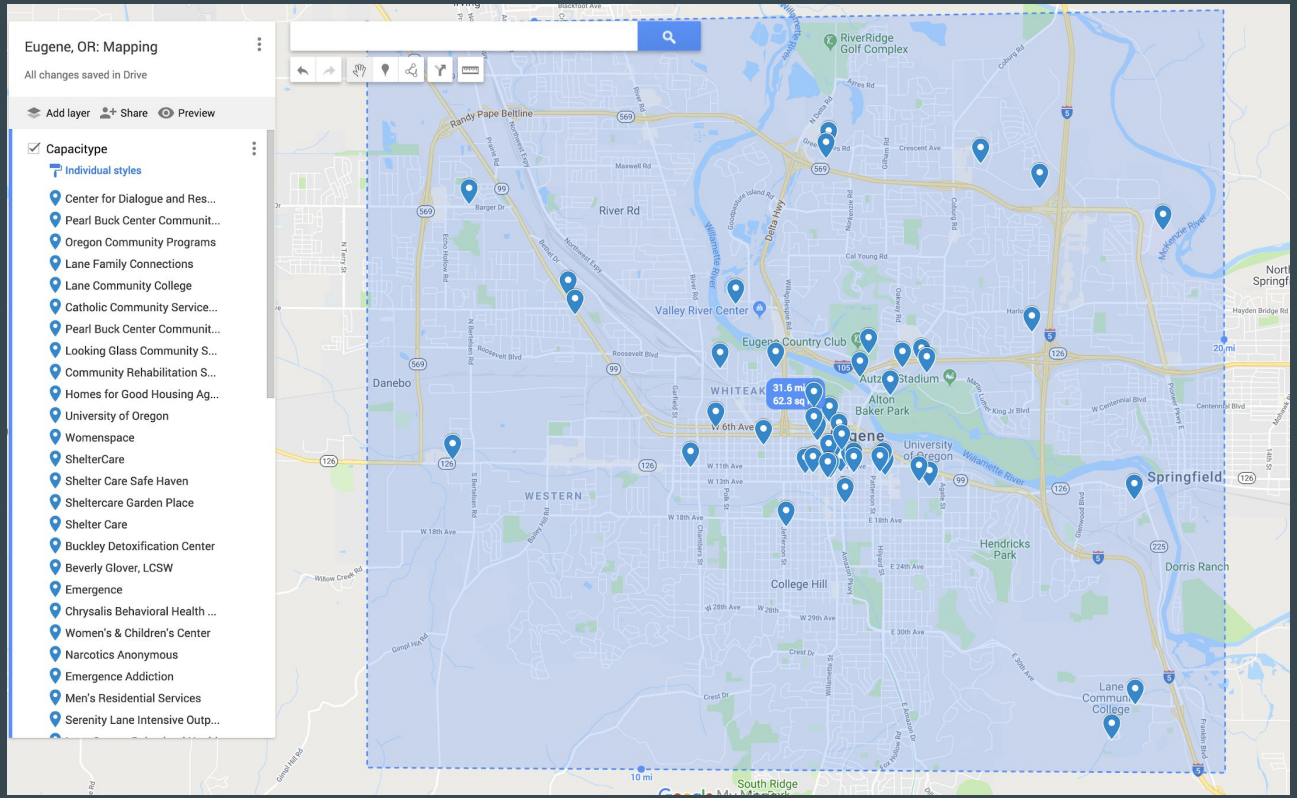
Disclaimer:

- This is an abstract representation of a single community
- There is in all likelihood resources and services missing from the case study

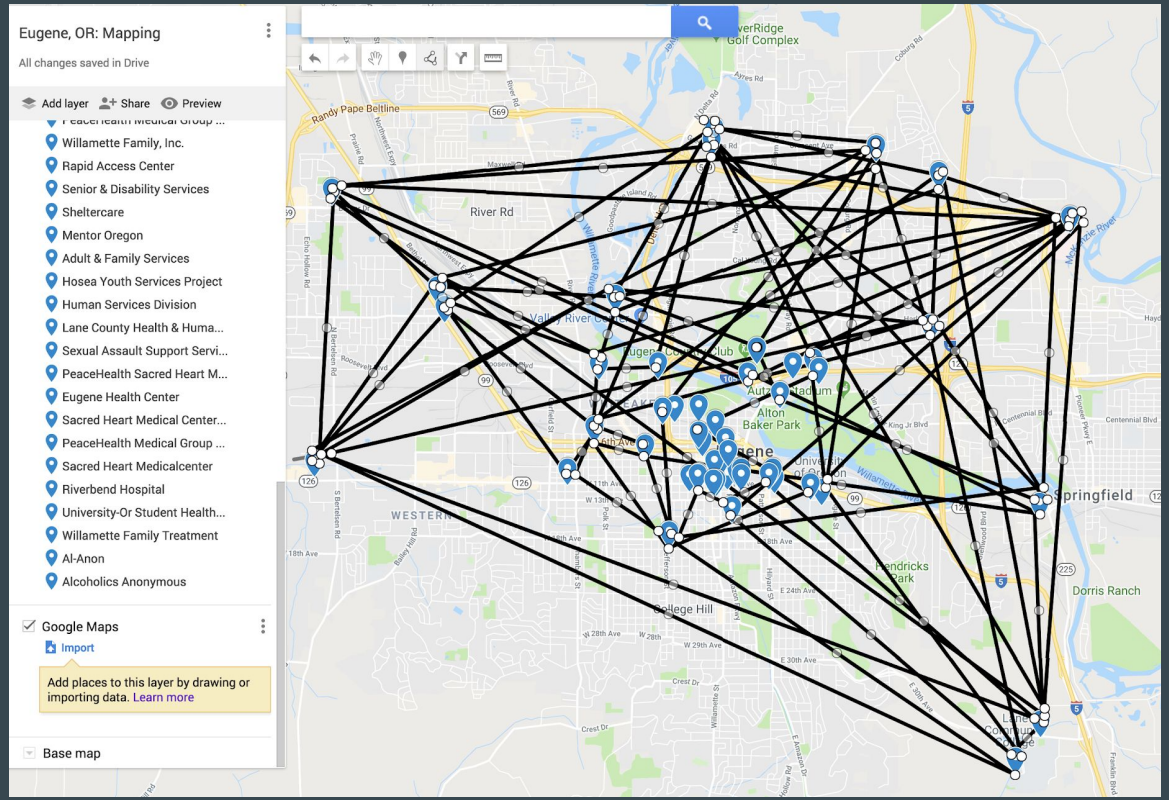
Eugene, OR: Resources and Services



Eugene, OR: Geographic - 63.2 square miles



Eugene, OR: Recovery Oriented System of Care



Connections Between Resources

1. 5 random resources found in the mapping called to inquire about information about another random resource in the list for a potential referral
2. Out of the 5 inquires, none could provide information about the requested resources or how to access it

Discussion

1. Using ROSC theory to evaluate, assess, and improve communities
2. The importance of bilateral connections
3. The importance of filling resource and service gaps, informed by the community
4. The importance of perception of utility from the recovering individual perspective

What next?

- Local community stakeholders **MUST** be included in this process
- The SUD and recovery field and respective stakeholder groups **MUST** embrace concepts such as pharmacotherapy and harm reduction as viable options (not mandates) - ROSCs will not work without this happening - and it cannot just be platitudes
- Decisions should be informed by the data - not just anecdotal stories (unless rigorously studied) or personal beliefs - not without empirical evidence

Recovery Community Organizations

History and Background

- Recovery Community Organizations are a byproduct of mutual aid recovery support services
  - Wellbriety / American Indian talking circles
  - Oxford Group -> 12-step mutual aid programs
  - 12-step clubhouses
- The confluence of the modern day recovery advocacy movement gave way to community-based supports that embraced holistic approaches to recovery (i.e., multiple pathways)
  - Agnostic to pathway or entry point, designed to be a place of peer-based and community recovery support across a range of pathways and modalities

History and Background

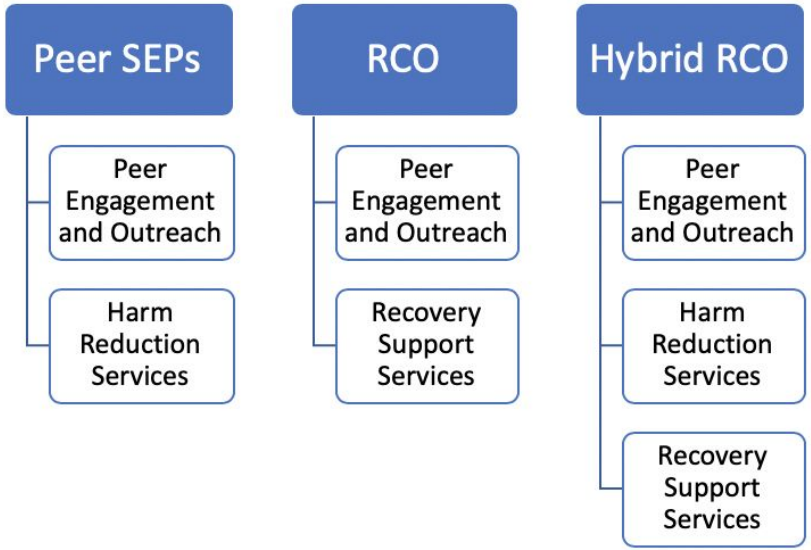
- The peer movement predates the SUD recovery space, and has much to owe to the peer movements of the HIV/AIDS and mental health fields
- The combination of the peer movement + SUD mutual aid communities + SUD advocacy = recovery community organizations
    - First established RCOs as we know them today circa 2000
    - Community-based, peer created, peer lead - not clinical nor created by governmental or clinical entities

Current Models and Capacity

- Several models of RCO exist today across the United States
  - Traditional RCO: created by the community and focused on providing a range of in-house peer-based recovery supports (e.g., recovery coaching) + resource brokering (i.e., warm handoffs)
  - Hybrid RCO: created by the community and peer-based, a combination of harm reduction peer services + traditional RCO services
  - Quasi-RCO: created by institutions or treatment programs, may or may not be community-based, may or may not employ peers used to their full capacity or actual suggested scope of work

Current RCO Models

Figure 1 – Peer SEP, RCO, and Hybrid RCO Comparison Models

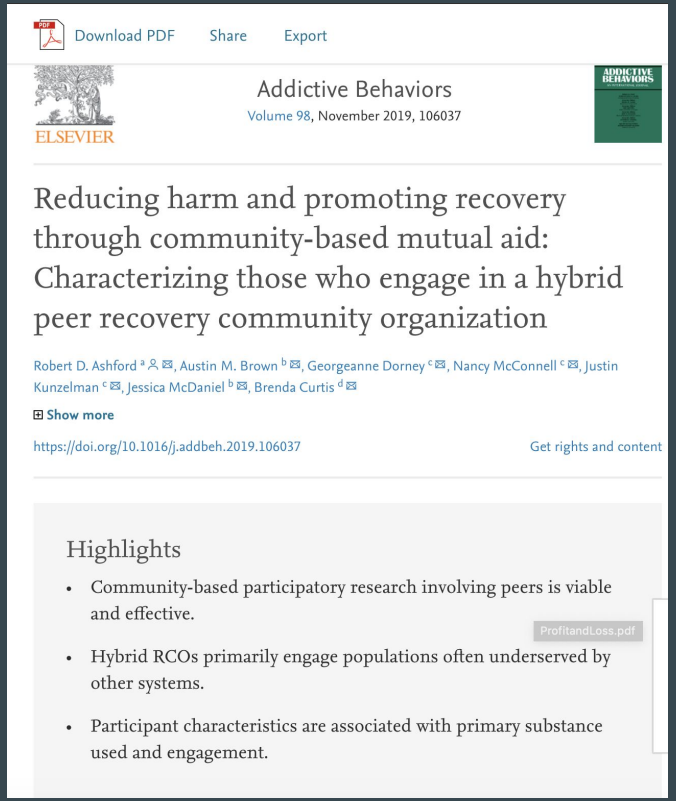


*SEP = Syringe Exchange Program; RCO = Recovery Community Organization

Ashford, R. D., Curtis, B., & Brown, A. M. (2018). Peer-delivered harm reduction and recovery support services: Initial evaluation from a hybrid recovery community drop-in center and syringe exchange program. Harm Reduction Journal, 15(1). https://doi.org/10.1186/s12954-018-0258-2

Hybrid RCO Example: Rebel Recovery

- Rebel Recovery FL is the second hybrid RCO documented in the peer-reviewed academic research
- Provides a strong empirical basis for increased engagement and service opportunity for some of the most underserved populations in our community



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Addictive Behaviors

Volume 98, November 2019, 106037

Reducing harm and promoting recovery through community-based mutual aid: Characterizing those who engage in a hybrid peer recovery community organization

Robert D. Ashford [a], Austin M. Brown [b], Georgeanne Dorney [c], Nancy McConnell [c], Justin Kunzelman [c], Jessica McDaniel [b], Brenda Curtis [d]

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Highlights

- Community-based participatory research involving peers is viable and effective.
- Hybrid RCOs primarily engage populations often underserved by other systems.
- Participant characteristics are associated with primary substance used and engagement.

RCO Recovery Support Service Delivery

- Non-clinical, non-clinical, non-clinical...and non-clinical
- Services delivered by certified peers (CPRS, CRS, PRSS, CPS, etc.), who **SHOULD** be paid, but are often volunteers
- Paraprofessional role that:
  - Leverages lived experience to meet people where they are at and provide options based on the individual's goals in key recovery capital domains
  - Assists in navigating social service systems and the world through the auspices of lived experience
  - Power dynamic = 50/50
  - Recovery and wellness planning is the primary mechanism of delivering support either in vivo or digitally

RCO Recovery Support Peer Supervision

- Supervision delivered most frequently in two ways
  - Through a peer supervisor (group + individual supervision) only
  - Through a peer supervisor, and a behavioral health professional (typically in fee-for-service or reimbursed RCOs)
- Supervision best practices:
  - Depending on the type of funding, supervision can take either form mentioned above
  - Supervision should be individual (weekly) + group (monthly) at a minimum
  - New practice guidelines suggest a daily debrief with a peer supervisor in addition to the above, especially for RCOs that provide peer services in speciality settings

RCO: Key Characteristics

- Community-based, peer-driven (all staff)
- Paid staff, not volunteers
- Individualized Recovery and Wellness Emphasis
- Partners with all organizational types, not beholden to any (only to community)
- Flexible and responsive to community voice
- Drop-in centers + mobile services

Recovery Community Center - Office Based Opioid Treatment Models of Care

RCC-OBOT

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Addictive Behaviors
Volume 98, November 2019, 106031

Responding to the opioid and overdose crisis with innovative services: The recovery community center office-based opioid treatment (RCC-OBOT) model

Robert D. Ashford [a], Austin M. Brown [b], Jessica McDaniel [b], Jenna Neasbitt [c], Chad Sobora [d], Robert Riley [d], Lesley Weinstein [d], Aaron Laxton [d], Justin Kunzelman [e], Kyle Kampman [f], Brenda Curtis [g]

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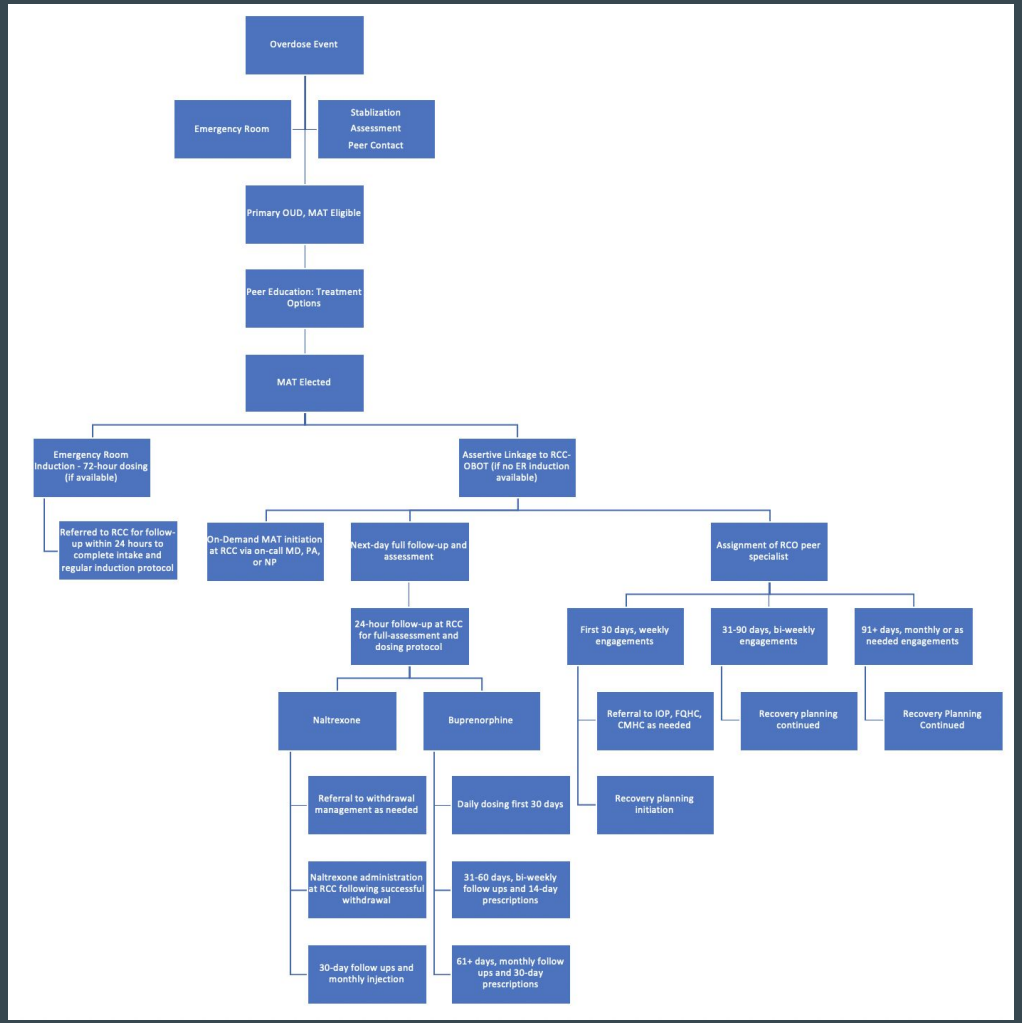
Highlights

- RCC-OBOT model developed in partnership with medical, clinical, & community-based partners.
- The model combines novel innovations that show efficacy in responding to the opioid crisis.
- Engaging higher-risk individuals in the community may improve retention and outcomes.

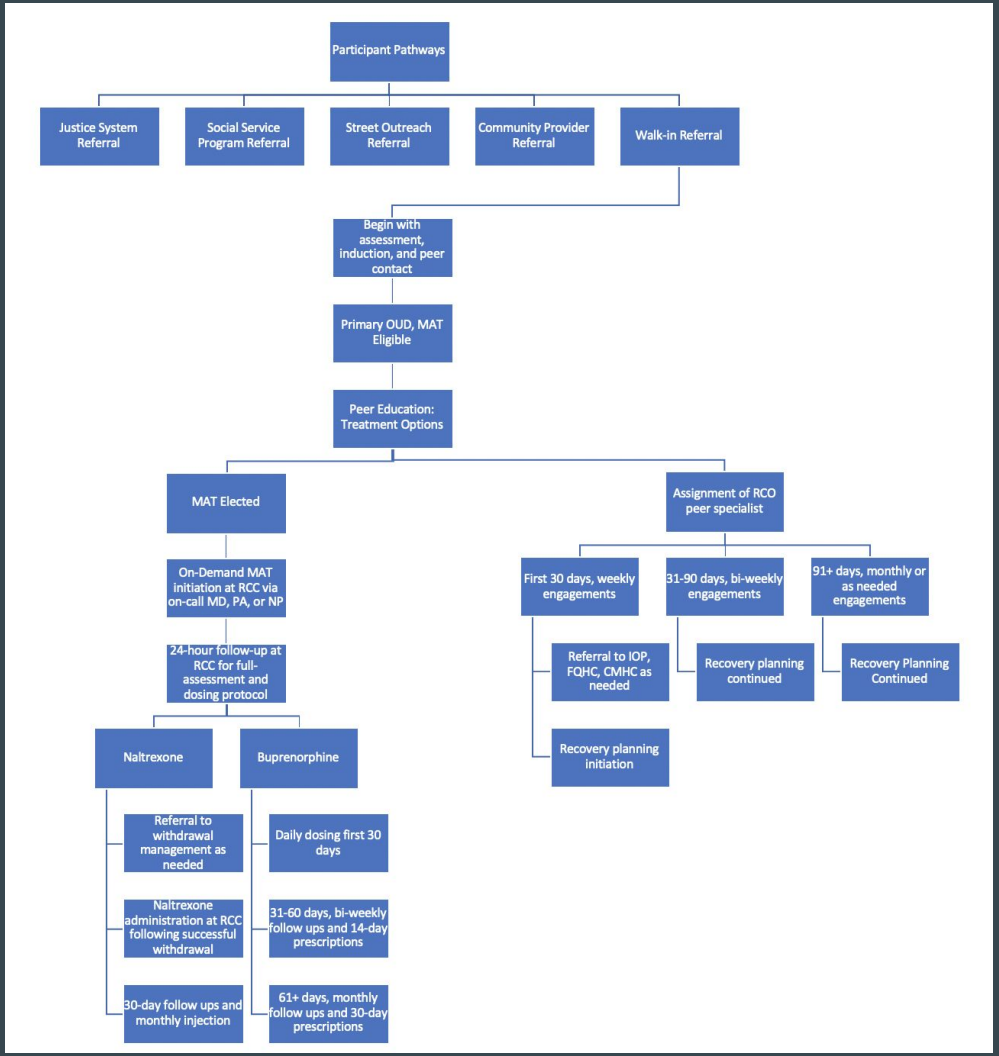
RCC-OBOT combines several recent recovery-informed and OUD treatment models to respond to:

1. Overdose and non-overdose events
2. Maintains the peer-relationship dynamic that is important and integrates recovery supports with intention in the community
3. Facilitates partnerships that do not co-opt the recovery community organizations and peer workers

Overdose Event



Non-overdose Event



Language, stigma, and discrimination

What are stigma and discrimination?

Stigma

Stigma is a multidimensional construct that can manifest in a variety of ways.

Link and Phelan (2001) define stigma as:

- A label AND a stereotype
- The label (e.g. addict) links the person to a set of undesirable characteristics (i.e. criminal, dirty, untrustworthy) that work to form the stereotype (i.e. beliefs held about a group of people with a substance use disorder).

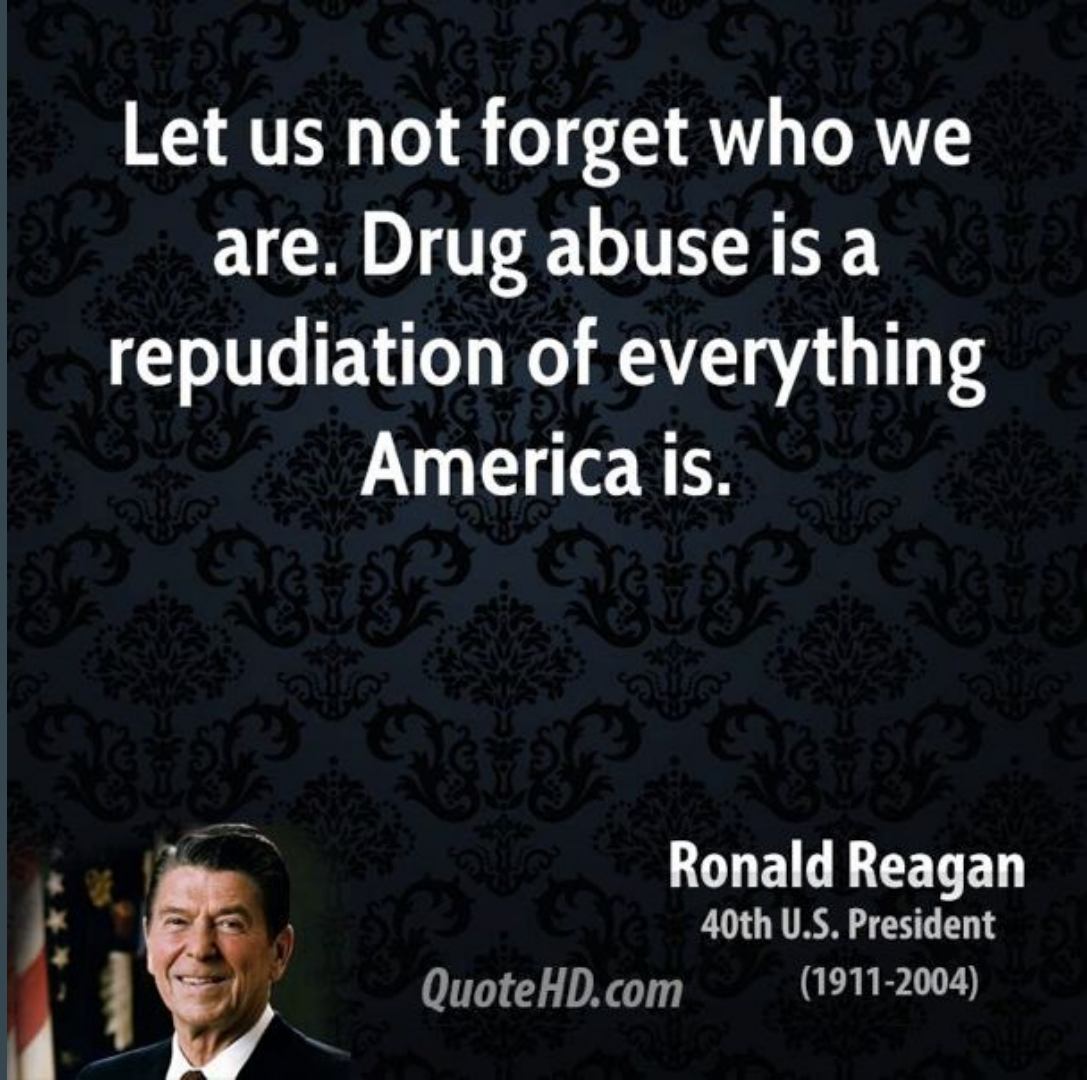
Discrimination

Discrimination is the actual manifestation of actions that people take when they believe a stereotype and then associate the label with others.

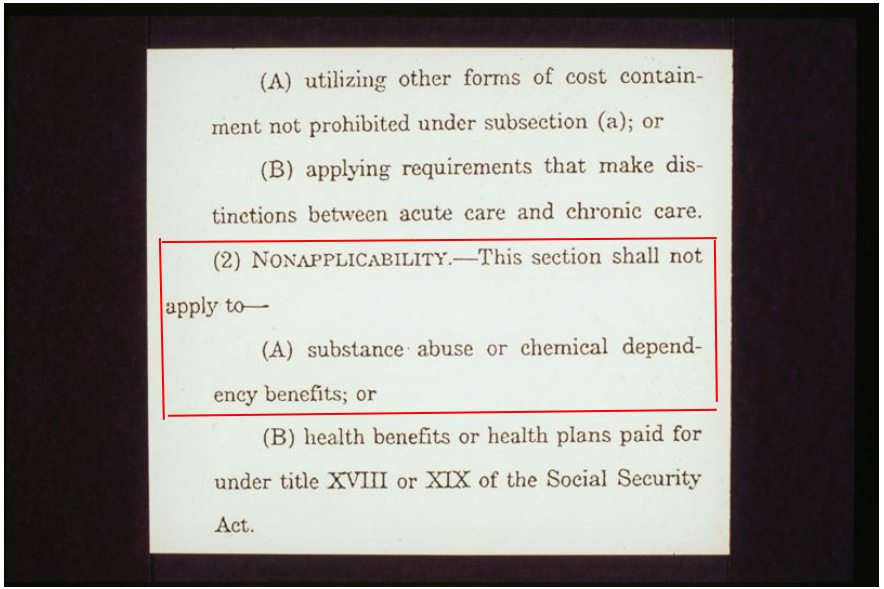
Examples of Discrimination:

- Denial of housing and employment
- Bullying and/or harassment
- A condition, rule, or policy disproportionately impacts only certain individuals

Stigma


Let us not forget who we are. Drug abuse is a repudiation of everything America is.
Ronald Reagan
40th U.S. President
(1911-2004)
QuoteHD.com

Discrimination



(A) utilizing other forms of cost containment not prohibited under subsection (a); or

(B) applying requirements that make distinctions between acute care and chronic care.

(2) NONAPPLICABILITY.—This section shall not apply to—

(A) substance abuse or chemical dependency benefits; or

(B) health benefits or health plans paid for under title XVIII or XIX of the Social Security Act.

Contributors to stigma

If labels and stereotypes makeup stigma, then what labels exist within the substance use and recovery landscape?

- “Addict”
- “Alcoholic”
- “Junkie”
- “Dope Fiend”
- “Substance Abuse”
- “Clean/Dirty”
- “Relapse”
- “Addiction”

And, what types of stereotypes are tied to these labels?

- Years of campaigns - from the temperance movement of the 1800’s to the war on drugs of the 1980s
- “Addicts” are criminals, homeless, sinners, unworthy and lack self control
- “They choose this”
- “You can’t trust a junkie”
- What stereotypes have you placed on others, or had placed on you?

What does the research say?

Substance Abuse	• Abuse versus SUD invoked greater negative explicit bias in treatment professionals • (Kelly & Westerhoff, 2010; Ashford, Brown & Curtis, 2018)
Opioid Addict	• Opioid Addict versus OUD invoked greater negative explicit bias in the general population • (Goodyear et al., 2018; Ashford, Brown, & Curtis, 2018)
Alcoholic	• Alcoholic versus AUD invoked greater negative implicit bias in the general public • (Ashford, Brown, & Curtis, 2018)
Relapse	• Recurrence of Use versus Relapse invoked greater positive implicit bias in the general public • (Ashford, Brown & Curtis, 2018)

What does the research say?

Untreated	• Untreated versus Treated behavioral health disorders invoked great negative explicit bias in the general public • (McGinty et al., 2015)
Medication-Assisted Treatment (MAT)	• Pharmacotherapy versus MAT invoked greater positive implicit bias in the general public • (Ashford, Brown, & Curtis, 2018)
Medication-Assisted Recovery (MAR)	• Both MAR and Long-term recovery invoked greater positive implicit bias in the general public • (Ashford, Brown, & Curtis, 2018)
Addict	• Addict versus SUD invoked greater negative implicit bias in the general public • (Ashford, Brown & Curtis, 2018)

Emerging Research: Delphi Study To Expand Language

Digital delphi group study of individuals in recovery, family members and loved ones, and treatment professionals.

Most stigmatizing and most non-stigmatizing (positive) words for each group over 3 rounds of testing and scoring.

Table 3. Delphi Round 3. Rank scored phrases for all groups.

People in Recovery (N=15):

Negative Word/Phrase | (M) (SD)	Positive Word/Phrase | (M) (SD)
1. Crackhead | (1.833) (.408)	1. Person in long-term recovery | (1.333) (.516)
2. Junkie | (2.333) (1.366)	2. Person in recovery | (1.500) (.837)
3. Abuser | (2.833) (1.602)	3. Recovered / Recovering Person | (1.833) (1.169)
4. Addicts | (3.333) (1.366)	4. Person / People | (2.000) (2.000)
5. Felon | (3.117) (2.137)	5. Person with a substance use disorder | (3.167) (2.401)
6. Criminals | (3.333) (2.338)	6. Person with an alcohol use disorder | (3.333) (2.733)
7. Alcoholics | (4.500) (2.810)	7. Recurrence of Use | (3.500) (3.017)
8. Drunk | (4.50) (2.074)	8. Former Drug User | (4.333) (2.066)
9. Boozer | (4.500) (2.881)	9. Sober | (4.500) (3.271)
10. Sinners | (4.833) (4.070)	10. Drug User | Substance User | (6.667) (2.733)

Family Members (N=15):

Negative Word/Phrase | (M) (SD)	Positive Word/Phrase | (M) (SD)
1. Junkie | (1.000) (0.00)	1. Long Term Recovery | (2.286) (3.402)
2. Dope Fiend | (2.143) (1.676)	2. Substance Free | (3.571) (1.902)
3. Drug Abusers | (2.571) (1.718)	3. Person with a Substance Use Disorder | (3.714) (3.729)
4. Dirty / Clean | (3.143) (2.116)	4. Positive / Negative Urinalysis | (3.857) (2.035)
5. Addict | (3.286) (1.496)	5. Impacted Loved One | (3.857) (3.079)
6. Alcoholic | (4.000) (1.915)	6. Honest | (4.714) (3.817)
7. Drunk | (4.286) (2.812)	7. Period of abstinence | (5.000) (3.464)
8. Rock Bottom | (5.571) (3.867)	8. Drug Free Person | (5.429) (2.637)
9. Codependent / Enabler | (6.000) (3.742)	9. Sober | (6.571) (2.299)
10. Relapse | (7.000) (2.769)	10. Law Abiding Citizen | (8.714) (2.628)

Professionals (N=15):

Negative Word/Phrase | (M) (SD)	Positive Word/Phrase | (M) (SD)
1. Junkie | (1.083) (.269)	1. Person / Human Being | (2.417) (3.118)
2. Dope Fiend | (1.583) (.669)	2. Person in Recovery | (2.750) (3.194)
3. Addict | (3.916) (2.503)	3. Multiple Pathways of Recovery | (3.667) (2.902)
4. Criminal | (4.083) (2.109)	4. Free from addiction | (3.750) (2.633)
5. Pothead | Stoner | (4.583) (2.151)	5. Person with a Substance Use Disorder | (3.833) (1.946)
6. Drug Injector | (4.667) (2.640)	6. Recurrence of Symptoms | (4.333) (2.934)
7. Alcoholic | (5.083) (2.065)	7. Abstinence | (4.833) (2.406)
8. Substance Abuser | (5.167) (2.330)	8. Survivors | (5.083) (3.147)
9. Relapse | (6.667) (2.570)	9. Returning Citizen | (5.250) (2.006)
10. Recovering Addict / Alcoholic | (8.667) (1.970)	10. Person who uses drugs | (5.750) (2.701)

Negative Group: 1 = most stigmatizing, 10 = least | Positive Group: 1 = most positive (least stigmatizing), 10 = least

Emerging Research: Effects of Recovery Status and Profession

Secondary analysis of our full linguistics study ("addict" and "substance abuse" data only.

Subset to individuals in recovery and health professionals

Main effects of language remained across all experiments, with a main effect for health professionals ("substance abuse" only), as well as an interaction effect for those in recovery ("addict" + bad only)

Table 2. d-prime positive and negative association scores by label and group

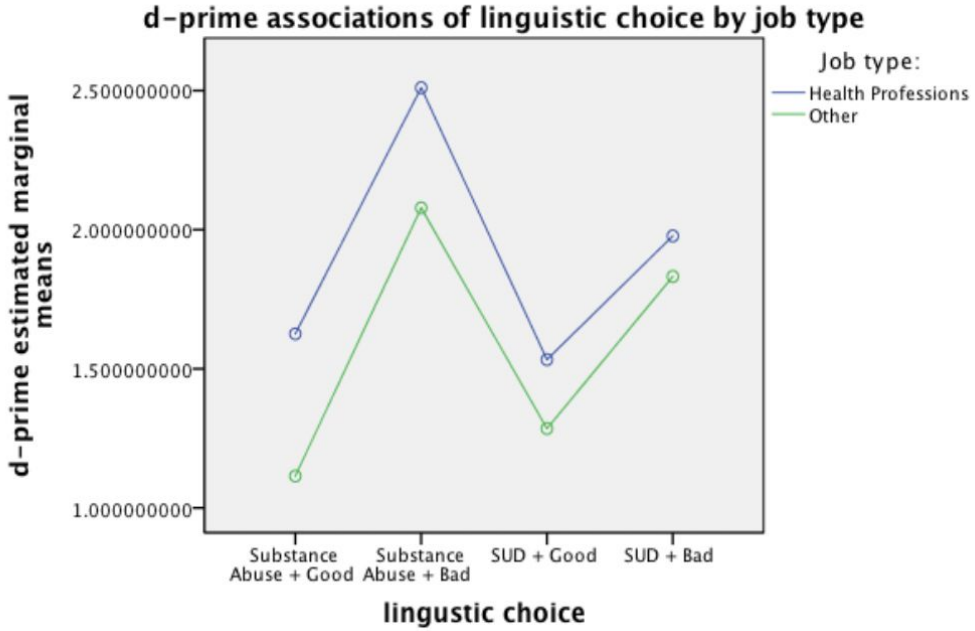
Group	Label	Positive Association MS (SD)	Negative Association MS (SD)
In Recovery			
Trial 1 (n = 51)	Substance Use Disorder	1.26 (0.95)	1.79 (1.19)
Trial 1	Substance Abuser	1.20 (0.92)	2.03 (1.13)
Trial 2 (n = 36)	Addict	1.34 (.85)	2.58 (1.45)
Trial 2	Substance Use Disorder	1.52 (1.01)	1.96 (0.66)
Not in Recovery			
Trial 1 (n = 102)	Substance Use Disorder	1.37 (1.00)	1.90 (1.03)
Trial 1	Substance Abuser	1.23 (0.94)	2.24 (1.21)
Trial 2 (n = 110)	Addict	1.66 (0.98)	2.33 (1.16)
Trial 2	Substance Use Disorder	1.61 (0.83)	2.10 (0.79)
Health Professional			
Trial 1 (n = 32)	Substance Use Disorder	1.53 (0.98)	1.98 (0.88)
Trial 1	Substance Abuser	1.63 (0.99)	2.51 (1.43)
Trial 2 (n = 31)	Addict	1.58 (0.73)	2.75 (1.46)
Trial 2	Substance Use Disorder	1.63 (0.74)	2.07 (0.65)
Other Professional			
Trial 1 (n = 121)	Substance Use Disorder	1.29 (0.98)	1.83 (1.13)
Trial 1	Substance Abuser	1.11 (0.89)	2.08 (1.09)
Trial 2 (n = 115)	Addict	1.56 (1.01)	2.30 (1.16)
Trial 2	Substance Use Disorder	1.57 (0.91)	2.06 (0.80)

MS = d-prime Mean Score, SD = d-prime Standard Deviation

Emerging Research: Effects of Recovery Status and Profession

Main effect for health professionals (“substance abuse” only)

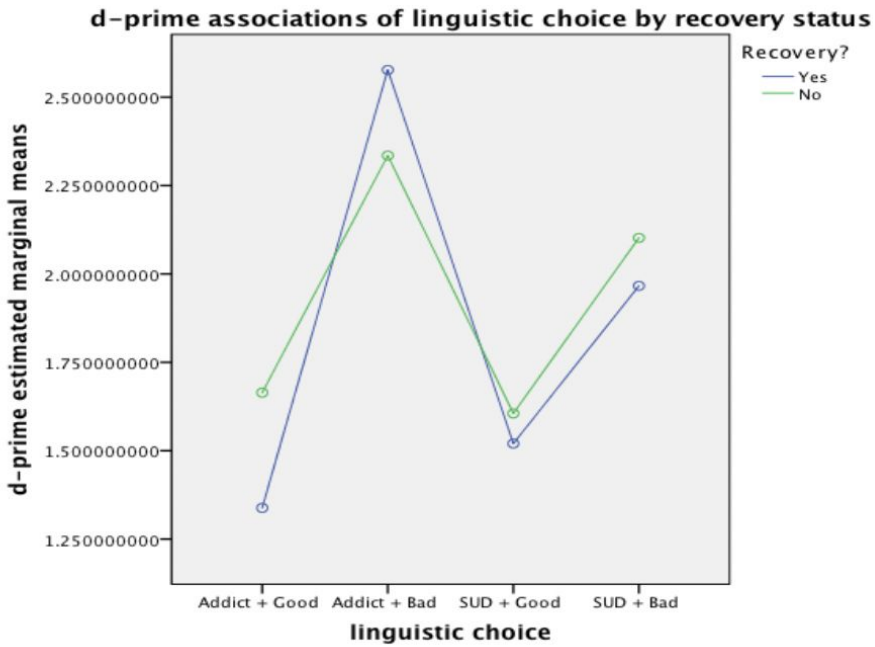
Figure 2. Effects of Employment Type and Linguistic Choice on Automatic Attitudes



Emerging Research: Effects of Recovery Status and Profession

Interaction effect for those in recovery (“addict” + bad only)

Figure 1. Effects of Recovery Status and Linguistic Choice on Automatic Associations



However, it is never so simple

- In many recovery pathways, the use of negative labels serves a purpose
- The identity of being an “addict” and “alcoholic” can serve as a mechanism for change and empowerment
- It reminds people who they once were compared to who they are now...and for many, that is believed to be a necessity to remain vigilant in the recovery process

The right to self-label and identify

Yes...it exists and should be supported

- Preliminary research has found that people in recovery also have greater levels of implicit negative bias towards labels that are re-affirming in some recovery pathways
- However - within these settings, the potential harm from the continued use of stigmatizing labels is minimized
- BUT - that doesn't mean using this type of language publicly, or in non-recovery settings, is helpful
- In fact, we know it is harmful for a variety of reasons

New Research: Catharsis and Recovery Identity

We still don't know a great deal about how self-labeling affects those in recovery

- Small sample pilot attempting to tease out when and where people using certain self-labels.
- High degree of discernment amongst the sample with participants often using both stigmatizing and non-stigmatizing labels dependent on context (i.e., dynamic label discernment"

Table 5. Settings Where Labels are Used by Participants

	Addict[a] (n = 36)		SUD[a] (n = 21)		Addict Only (n = 19)		SUD Only (n = 4)		Both (n = 17)			
									Addict		SUD	
	N / (%)		N / (%)		N / (%)		N / (%)		N / (%)		N / (%)	
MA Meetings (12-step)	33	(94.3)	4	(19.0)	17	(94.4)	1	(25.0)	16	(94.1)	3	(17.6)
MA Meetings (Non12-step)	7	(20.0)	1	(4.8)	3	(16.7)	-	-	4	(23.5)	1	(5.9)
With Family	22	(62.9)	8	(38.1)	13	(72.2)	4	(100)	9	(52.9)	4	(23.5)
With Friends	27	(77.1)	9	(42.9)	14	(77.8)	3	(75.0)	13	(76.5)	6	(35.3)
With Co-workers	17	(48.6)	9	(42.9)	10	(55.6)	3	(75.0)	7	(41.2)	6	(35.3)
Speaking in Public	20	(57.1)	13	(61.9)	12	(66.7)	4	(100)	8	(47.1)	9	(52.9)
On Social Media	17	(48.6)	9	(42.9)	9	(50.0)	4	(100)	8	(47.1)	5	(29.4)

Note: percentage totals greater than 100% due to multiple selection options

[a] non-mutually exclusive

New Research: Dynamic Labeling Discernment

Qualitative analysis of the same pilot sample

- Parsed out this “recovery dialects” phenomenon
- Stigma mitigation/protection process

Methods: The present study analysed qualitative responses to open-ended questions presented to individuals in recovery concerning how, why, and when they self-identified using the terms “alcoholic/addict” or “person with a SUD”. Responses (N = 42) were initially coded, and via latent content analysis and grounded theory methodology, evaluative structure and generative theories were developed.

Results: After secondary analysis of thematic content, four primary constructs were evident: a) the importance of context in self-identification, b) flexibility or rigidity in self-identification, c) the tendency to leverage identity based on context to counteract stigma, and d) these components being indicators of identity integration or disintegration.

Conclusion: Although certain identifiers (i.e., “addict” and “alcoholic”) have been associated with stigma and bias, individuals in recovery from SUD indicate specific contexts in which these terms are particularly useful. The illustrated complexity and nuance suggests an integrated sense of identity among many in recovery from SUD.

The labels we use result in external and internal bias...

- Stigma is a direct barrier to accessing SUD treatment among individuals who have a substance use concern
- Stigma also results in a lack of general public support for legislation that provides meaningful reform and fiscal support to prevention, treatment, and recovery
- It impacts the quality of healthcare delivery given by medical professionals
- And, most recently, in the midst of the opioid crisis, can result in death

Recovery Dialects

The words we use matter.

Positive	Negative
Person who uses substances	Substance Abuser
Recurrence of Use	Relapse
Pharmacotherapy	Medication-Assisted Treatment
Accidental Drug Poisoning	Overdose
Person with a Substance Use Disorder	Addict
	Alcoholic
	Opioid Addict

While some negative language is okay to use in mutual aid meetings, its use should be avoided in public, when advocating and in journalism.

SOURCE: Ashford, R. D., Brown, A. M., & Curtis, B. (2018). Substance use, recovery, and linguistics: The impact of word choice on explicit and implicit bias. Drug and Alcohol Dependence, 189, 131–138.

Recovery Dialects

	Mutual Aid Meetings	In Public	With Clients	Medical Settings	Journalists
Addict	✓	STOP	STOP	STOP	STOP
Alcoholic	✓	STOP	STOP	STOP	STOP
Substance Abuser	STOP	STOP	STOP	STOP	STOP
Opioid Addict	✓	STOP	STOP	STOP	STOP
Relapse	✓	STOP	STOP	STOP	STOP
Medication Assisted Treatment	STOP	STOP	STOP	STOP	STOP
Medication Assisted Recovery	✓	✓	✓	✓	✓
Person w/ a Substance Use Disorder	✓	✓	✓	✓	✓
Person w/ an Alcohol Use Disorder	✓	✓	✓	✓	✓
Person w/ an Opioid Use Disorder	✓	✓	✓	✓	✓
Long-term Recovery	✓	✓	✓	✓	✓
Pharmacotherapy	✓	✓	✓	✓	✓

Language matters but can change depending on the setting we are in. Choosing when and where to use certain language and labels can help reduce stigma and discrimination towards substance use and recovery.

SOURCE: Ashford, R. D., Brown, A. M., & Curtis, B. (2018). Substance use, recovery, and linguistics: The impact of word choice on explicit and implicit bias. Drug and Alcohol Dependence, 189, 131–138.

So much more...

We'd need a full day!

- Digital recovery support services
- Community base mutual aid recovery supports
- Medications and recovery
- Harm Reduction Services
- Life Course theory and recovery

Recovery should **never** be the exception.

Recovery should be the expectation.

Thank You!

Robert D. Ashford, MSW

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