MASSACHUSETTS GENERAL HOSPITAL
PSYCHIATRY ACADEMY

What is New in Addiction? New Findings on The Course of Recovery from Alcohol and Drug Problems in the U.S.

MGH Psychopharmacology Conference
OCTOBER 2020

John F. Kelly, PhD, ABPP

RECOVERY RESEARCH INSTITUTE

MASSACHUSETTS GENERAL HOSPITAL

HARVARD MEDICAL SCHOOL TEACHING HOSPITAL

Disclosures

Neither I nor my spouse/partner has a relevant financial relationship with a commercial interest to disclose.

Outline

- Why long-term remission/recovery important?
- National Recovery Study
- What is the prevalence of alcohol or other drug problem resolution?
- What proportion self-identify as being “in recovery”?
- What are the pathways followed?
- How many serious attempts does it take to resolve AOD problems?
- What is quality of life and functioning like in recovery?

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1970

During the past 50 yrs since “War on Drugs” declared, we have moved from “Public Enemy No. 1” to “Public Health Problem No. 1”

PUBLIC ENEMY NUMBER ONE
in the
United States
IS DRUG ABUSE

NIXON

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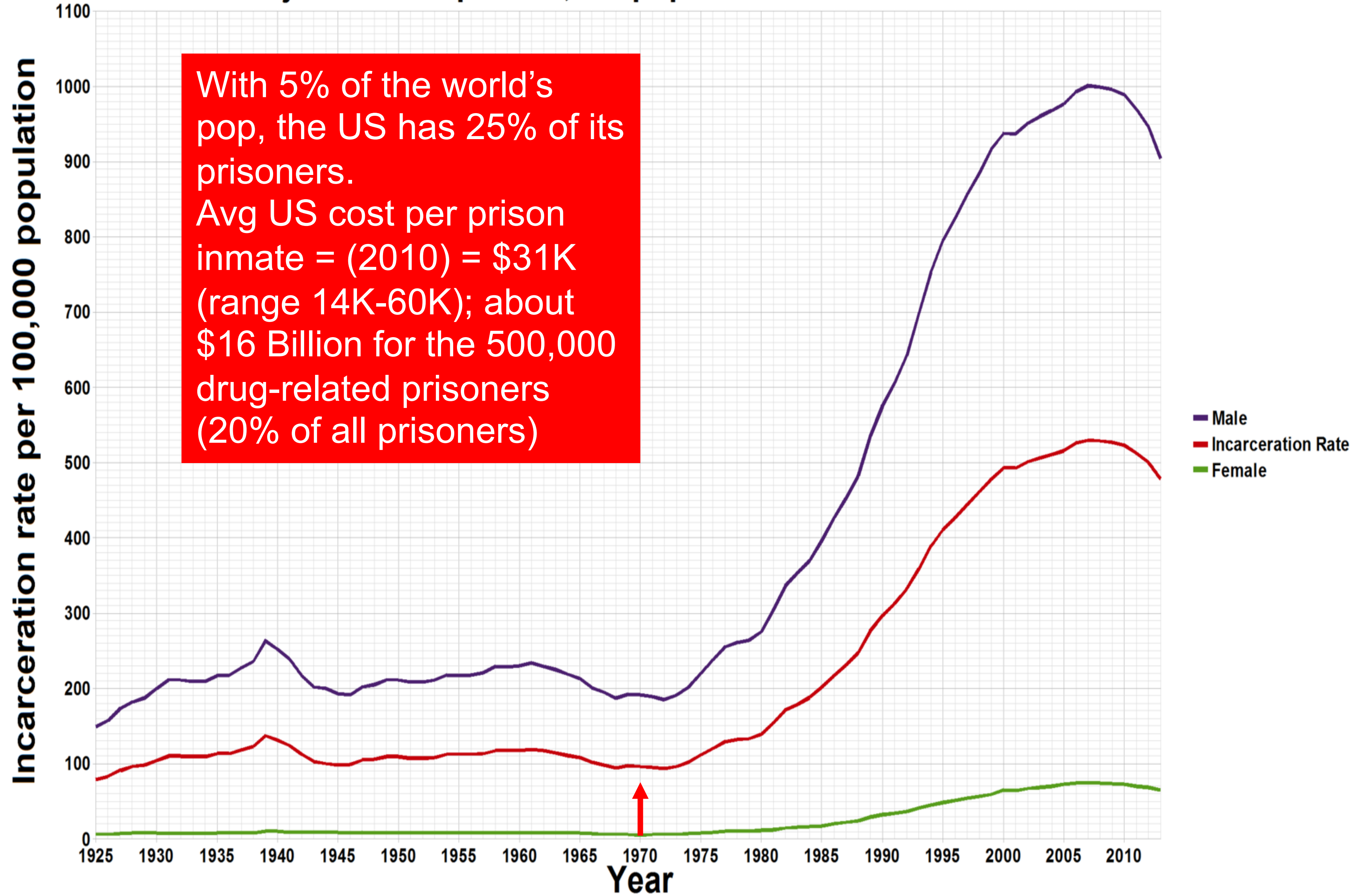
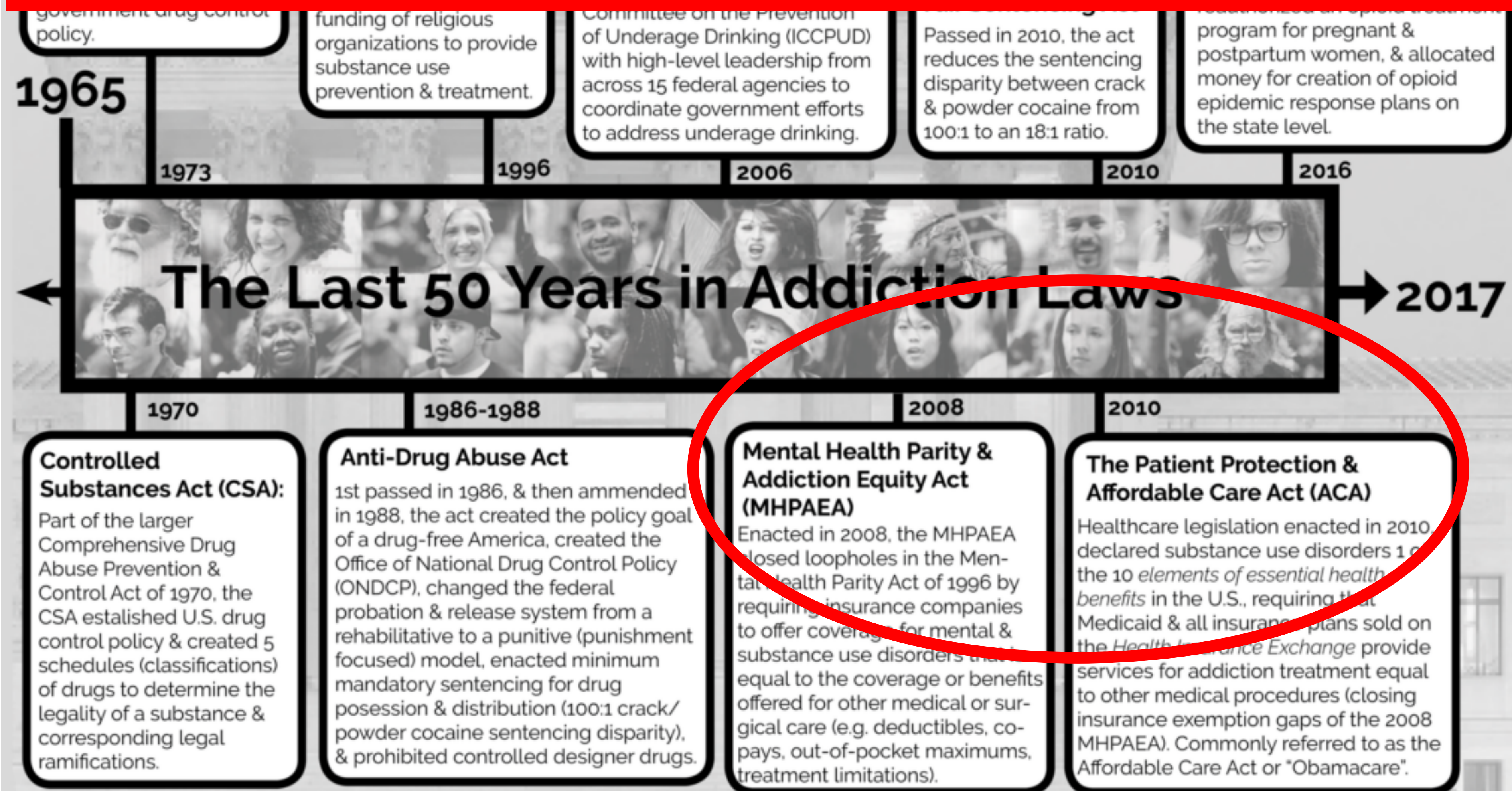
RECOVERYANSWERS.ORG
The Last 50 Years in Addiction Laws
1965
2017
1973
Reorganizational Plan No. 2
Creation of the Drug Enforcement Agency (DEA), consolidating a number of different entities to form a single federal agency to enforce government drug control policy.
1996
Charitable Choice
Charitable choice allows direct U.S. government funding of religious organizations to provide substance use prevention & treatment.
2006
Sober Truth on Preventing Underage Drinking Act (STOP Act)
Passed in 2006, the STOP act created a grant program to target underage drinking within communities & established the federal Interagency Coordinating Committee on the Prevention of Underage Drinking (ICCPUD) with high-level leadership from across 15 federal agencies to coordinate government efforts to address underage drinking.
2010
Fair Sentencing Act
Passed in 2010, the act reduces the sentencing disparity between crack & powder cocaine from 100:1 to an 18:1 ratio.
2016
Comprehensive Addiction & Recovery Act (CARA)
Passed in 2016, CARA increased access to overdose treatment, naloxone (overdose reversal medication), & medication assisted treatments (MAT), reauthorized an opioid treatment program for pregnant & postpartum women, & allocated money for creation of opioid epidemic response plans on the state level.
1970
Controlled Substances Act (CSA):
Part of the larger Comprehensive Drug Abuse Prevention & Control Act of 1970, the CSA estalished U.S. drug control policy & created 5 schedules (classifications) of drugs to determine the legality of a substance & corresponding legal ramifications.
1986-1988
Anti-Drug Abuse Act
1st passed in 1986, & then ammended in 1988, the act created the policy goal of a drug-free America, created the Office of National Drug Control Policy (ONDCP), changed the federal probation & release system from a rehabilitative to a punitive (punishment focused) model, enacted minimum mandatory sentencing for drug posession & distribution (100:1 crack/ powder cocaine sentencing disparity), & prohibited controlled designer drugs.
2008
Mental Health Parity & Addiction Equity Act (MHPAEA)
Enacted in 2008, the MHPAEA closed loopholes in the Mental Health Parity Act of 1996 by requiring insurance companies to offer coverage for mental & substance use disorders that is equal to the coverage or benefits offered for other medical or surgical care (e.g. deductibles, co-pays, out-of-pocket maximums, treatment limitations).
2010
The Patient Protection & Affordable Care Act (ACA)
Healthcare legislation enacted in 2010, declared substance use disorders 1 of the 10 elements of essential health benefits in the U.S., requiring that Medicaid & all insurance plans sold on the Health Insurance Exchange provide services for addiction treatment equal to other medical procedures (closing insurance exemption gaps of the 2008 MHPAEA). Commonly referred to as the Affordable Care Act or "Obamacare".


Incarceration rate of inmates incarcerated under state and federal jurisdiction per 100,000 population 1925-2013
With 5% of the world's pop, the US has 25% of its prisoners.
Avg US cost per prison inmate = (2010) = $31K (range 14K-60K); about $16 Billion for the 500,000 drug-related prisoners (20% of all prisoners)
Incarceration rate per 100,000 population
1100
1000
900
800
700
600
500
400
300
200
100
0
1925
1930
1935
1940
1945
1950
1955
1960
1965
1970
1975
1980
1985
1990
1995
2000
2005
2010
Year
Male
Incarceration Rate
Female

Prisons overcrowding: 20% (500,000) of US prisoners are in prison due to drug offences

- Photo: California Department of Corrections

Laws passed in the past 50 yrs have moved from more punitive ones to public health oriented ones.... increasing availability, accessibility and affordability of treatment..



ONDCP Hosts First-Ever Drug Policy Reform Conference

DECEMBER 11, 2013 AT 10:57 AM ET BY CAMERON HARDESTY

On Monday, Director Kerlikowske and Deputy Directo
discussion at the White House on the future of drug p
approximately 140 people attended to engage in a co
hundreds more watched online. Limited video on dem

2013 ONDCP Director Kerlikowske declares move away from "war on drugs" toward broader public health approach

PAST 50 YRS GONE FROM…

Also, a great deal carried out on the demand reduction side…

The “war on drugs” was part of a national concerted effort to reduce “supply” but also “demand” that created treatment and public health oriented federal agencies..

NIAAA

National Institute on Alcohol Abuse and Alcoholism

CSAT

Center for Substance Abuse Treatment

SAMHSA

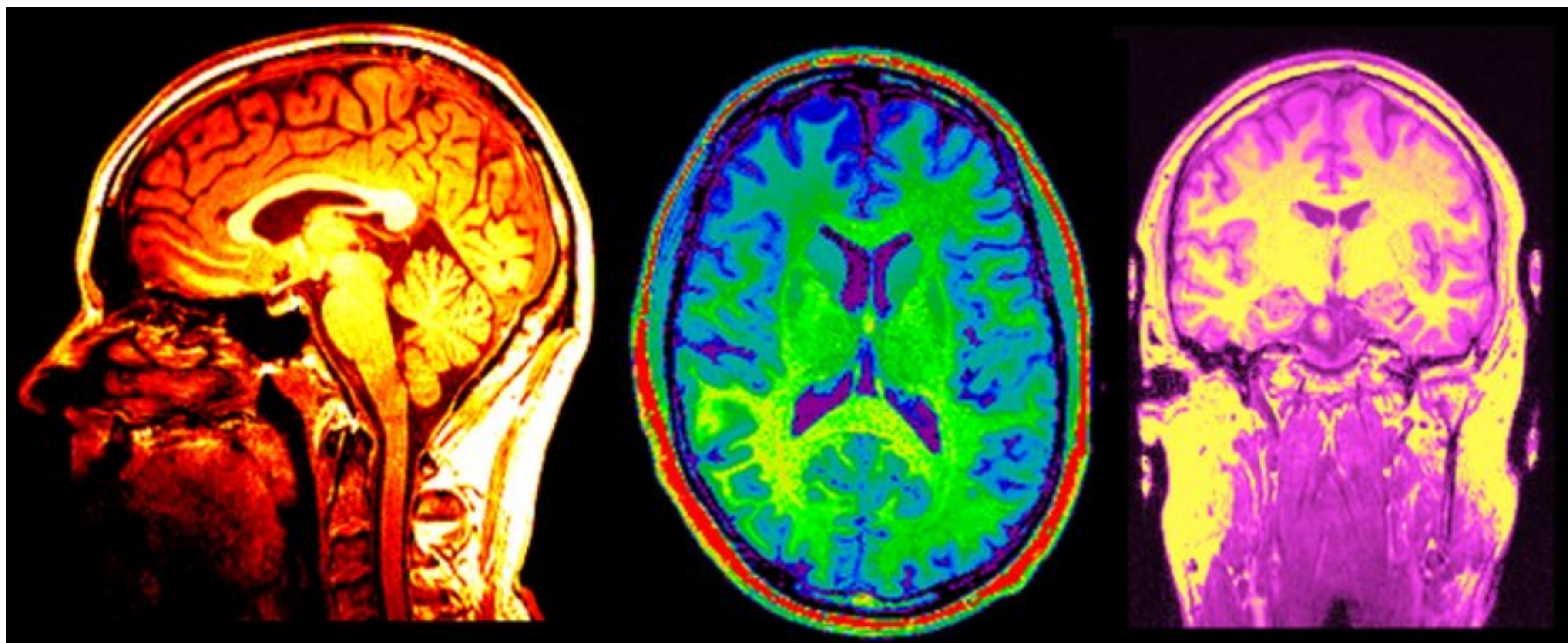
NIDA

NATIONAL INSTITUTE ON DRUG ABUSE

Paradigm Shifts

Genetics, Genomics, Pharmacogenetics

Neuroscience: Neural plasticity



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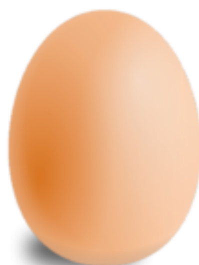
RECOVERYANSWERS.ORG

STAGES OF CHANGE

RELATED TREATMENT & RECOVERY SUPPORT SERVICES

PRECONTEMPLATIVE

In this stage, individuals are not even thinking about changing their behavior. They do not see their addiction as a problem: they often think others who point out the problem are exaggerating.



CONTEMPLATIVE

In this stage people are more aware of the personal consequences of their addiction & spend time thinking about their problem. Although they are able to consider the possibility of changing, they tend to be ambivalent about it.

PREPARATION

In this stage, people have made a commitment to make a change. This stage involves information gathering about what they will need to change their behavior.

ACTION

In this stage, individuals believe they have the ability to change their behavior & actively take steps to change their behavior.

MAINTENANCE

In this stage, individuals maintain their sobriety, successfully avoiding temptations & relapse.

HARM REDUCTION
* Emergency Services (i.e. Narcan)
* Needle Exhanges
* Supervised Injection Sites

SCREENING & FEEDBACK
* Brief Advice
* Motivational Interventions

SREENING, BRIEF INTERVENTION, & REFFERAL TO TREATMENT (SBIRT)

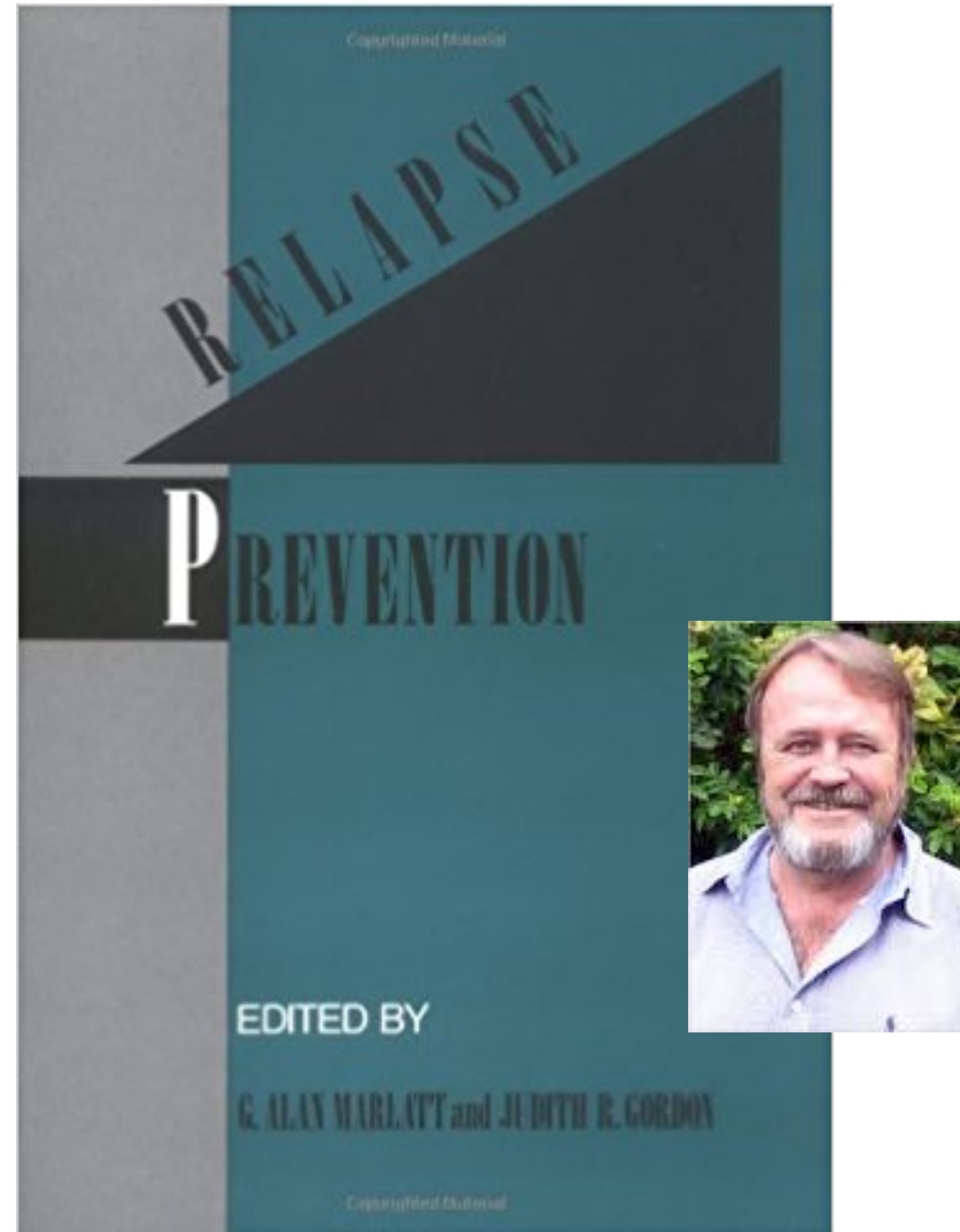
CLINCAL INTERVENTION
* Phases/Levels (e.g., inpatient, residential, outpatient)
* Intervention Types
  - Psychosocial (e.g. Cognitive Behavioral Therapy)
  - Medications: Agonists (e.g. Buprenorphine, Methadone) & Antagonists (Naltrexone)

NON-CLINICAL INTERVENTION
* Self-Management/Natural Recovery (e.g. self-help books, online resources)
* Mutal Help Organizations (e.g. Alcoholics Anonymous, SMART Recovery, Lifering Secular Recovery)
* Community Support Services (e.g. Recovery Community Centers, Recovery Ministries, Recovery Employment Assistance)

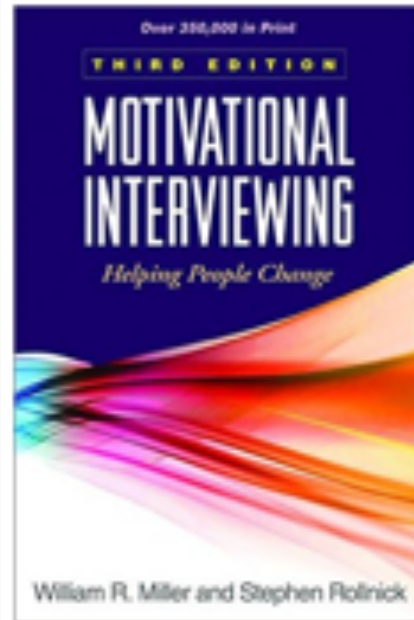
CONTINUING CARE (3m- 1 year)
Recovery Management Checkups, Telephone Counseling, Mobile Applications, Text Message Interventions

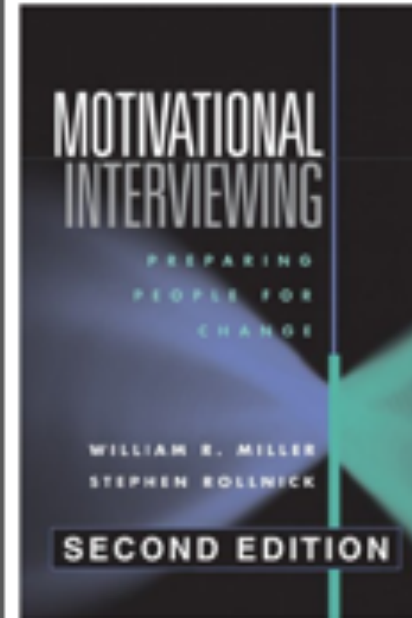
RECOVERY MONITORING (1-5+ yrs)
Continued Recovery Management Checkups, therapy visits, Primary Care Provider Visits

"Quitting smoking is easy, I've done it dozens of times" –Mark Twain

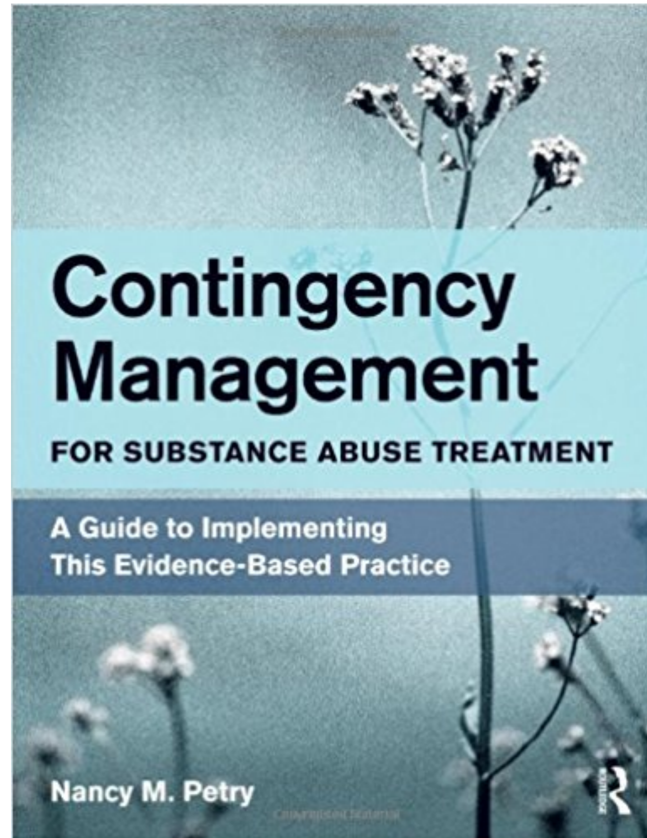


What people really need is a good listening to…

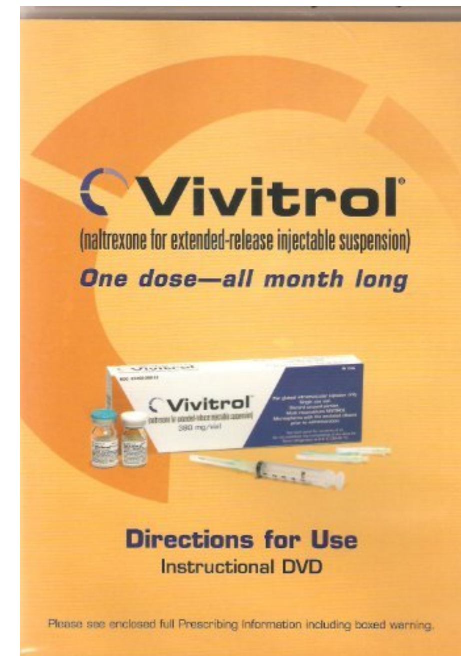


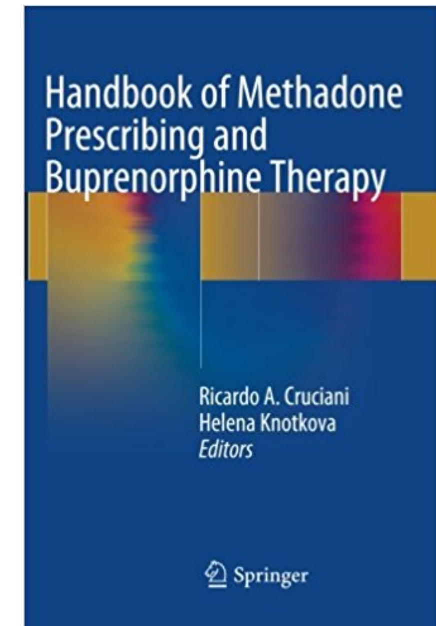


Swift, certain, modest, consequences shape behavioral choices…



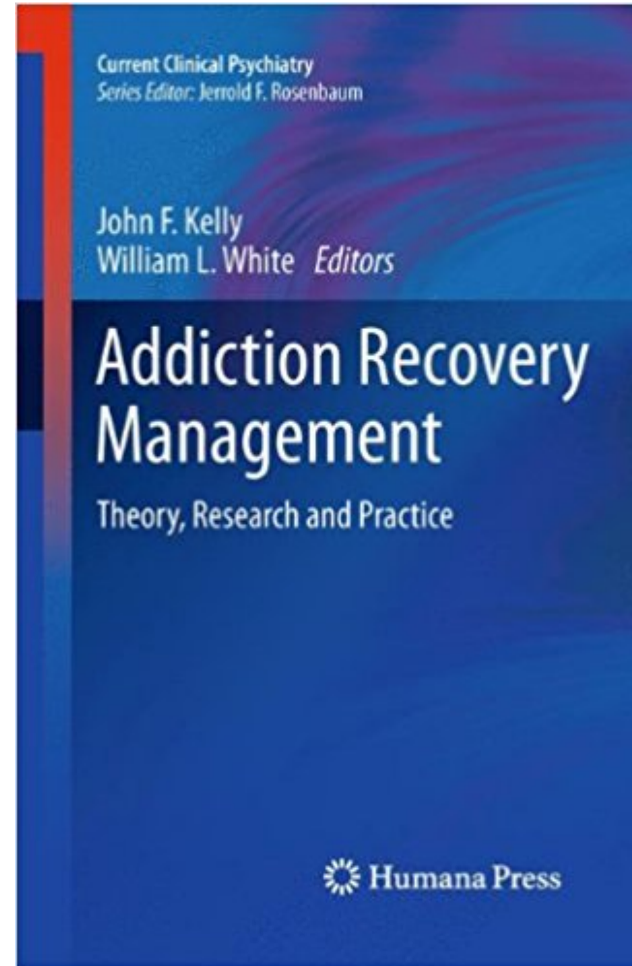
Effective Medications





Harm Reduction Strategies

- Anti-craving/anti-relapse medications (“MAT”)
- Overdose reversal medications (Narcan)
- Needle exchange programs
- Heroin prescribing
- Safe Injection Facilities/Safe Consumption sites/Overdose prevention facilities


Current Clinical Psychiatry
Series Editor: Jerrold F. Rosenbaum
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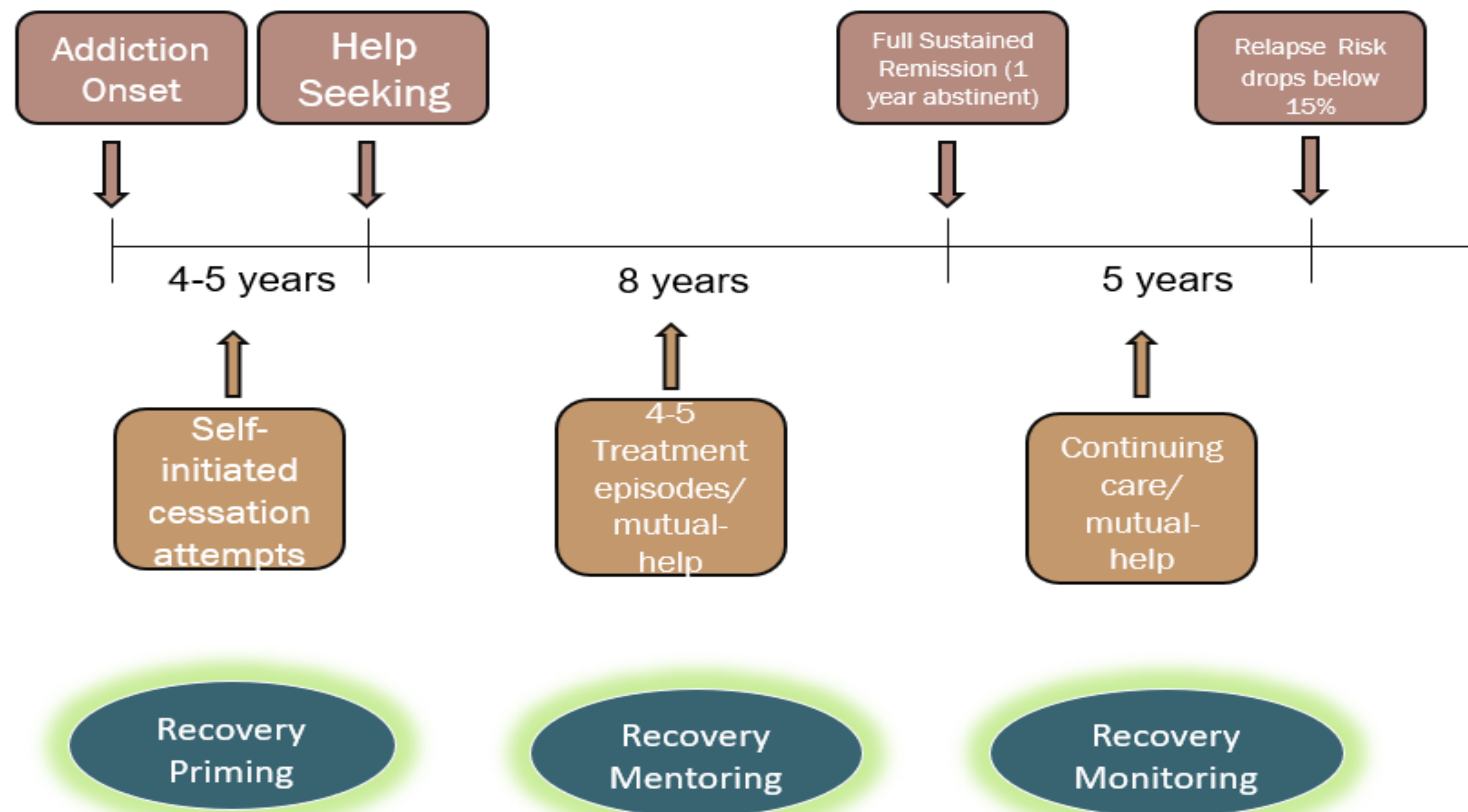
William L. White Editors
Addiction Recovery Management
Theory, Research and Practice
Humana Press

The clinical course of addiction and achievement of stable recovery can take a long time …



FACING ADDICTION IN AMERICA

The Surgeon General's Report on Alcohol, Drugs, and Health

1st Surgeon General's Report on Alcohol, Drugs, and Health 2016

Focus on Recovery

- Bill White for decades has talked about understanding more about recovery from the tens of millions already in recovery-untapped resource.
- Whole libraries/volumes written about etiology, epidemiology, and treatment, but little about recovery…
- A lot might be learned from the millions of people already successfully in long-term recovery; how they did it; what helped, made the difference.

Outline

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- How many serious attempts does it take to resolve AOD problems?
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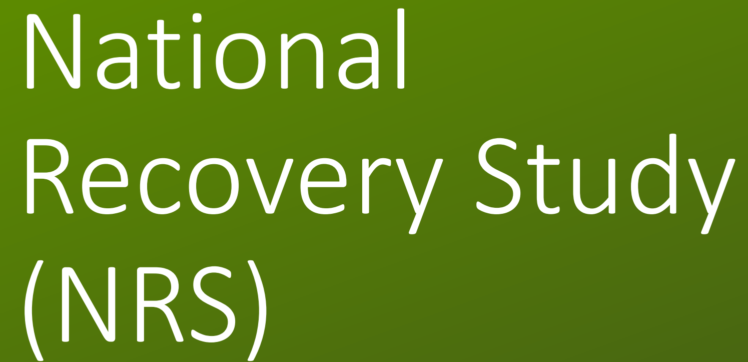


National Recovery Study (NRS)

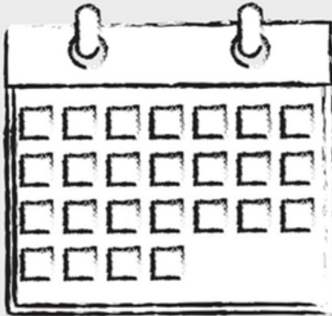
- Designed to:
  - Estimate national “recovery” prevalence using nationally-representative, probability-based, sample of individuals who self-report once having a problem with AODs but no longer do…
  - Uncover and discover more about chosen recovery pathways and their correlates
  - Estimate number of serious quit attempts prior to problem resolution
  - Investigate relationships between duration of recovery and changes in other health behaviors (e.g. smoking cessation) indices of functioning and quality of life

METHODS

NRS

Using the National Recovery Survey (NRS), a cross sectional, random, nationally representative sampling frame of 39,809 was identified. Out of the 25,229 that then responded, 2,002 individuals self-identified as resolving a significant alcohol or other drug problem.

63% survey response rate, similar to other national epidemiological surveys

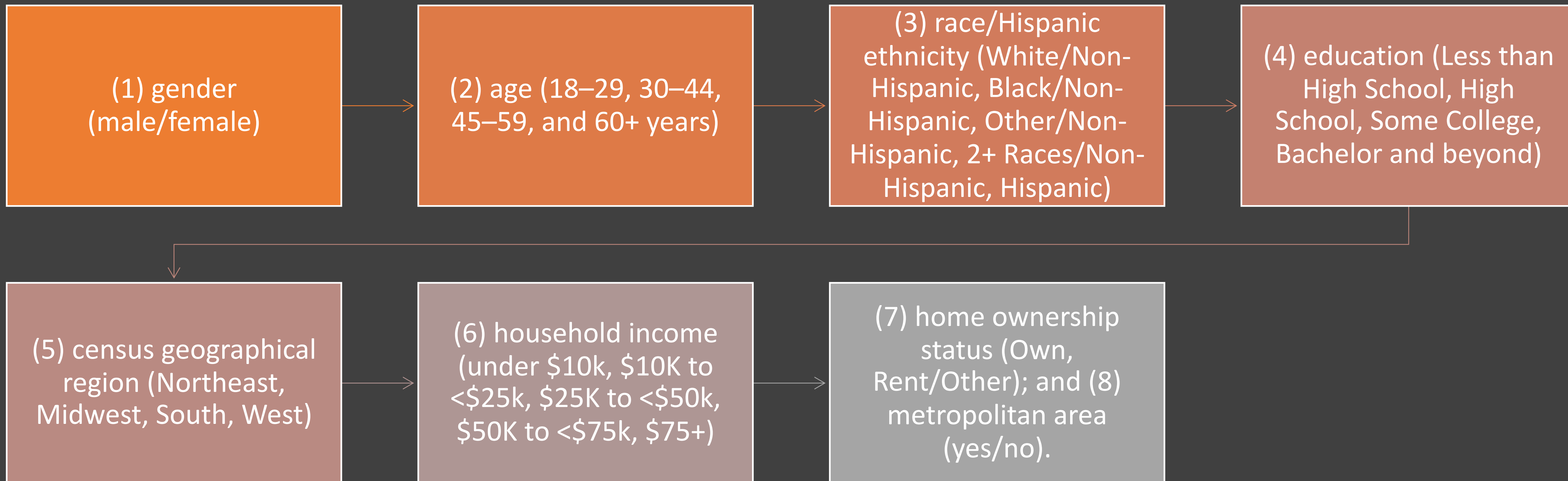


Data was collected in July & August of 2016

The data was weighted to accurately reflect the US population using iterative proportional fitting (raking), which produced weights based on eight geo-demographic benchmarks identified by the U.S. Census Bureau (CPS) in the 2015 Current Population Survey.

Sample Weighting

Weights were computed via comparisons to benchmarks from the March 2015 Current Population Survey (CPS; United States Census Bureau, 2015) along eight dimensions..



Response rate similar to other national epidemiological surveys

- This response rate is comparable to most other current nationally representative surveys
- NESARC-III; 60.1% (Grant et al., 2015)
- 2015 National Survey on Drug Use and Health (NSDUH; 58.3%; Center for Behavioral Health Statistics and Quality, 2016)
- 2013-2014 National Health and Nutrition Examination Survey (NHANES; 68.5%; Centers for Disease Control and Prevention [CDC], 2013).
- Data were weighted to accurately represent the civilian population using the method of iterative proportional fitting, which is commonly referred to as "raking" (Battaglia, Hoaglin, & Frankel, 2013).

MEASURES

- Demographic characteristics
- Substance Use History
- Medical History
- Criminal Justice History
- Treatment and Other Recovery Support Services
- Problem Resolution/Recovery History
- Recovery Capital
- Psychological Distress
- Quality of Life
- Happiness
- Self-Esteem

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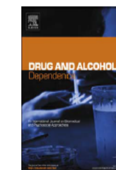


Full length article

Prevalence and pathways of recovery from drug and alcohol problems in the United States population: Implications for practice, research, and policy

John F. Kelly[a,*], Brandon Bergman[a], Bettina B. Hoeppner[a], Corrie Vilsaint[a], William L. White[b]

[a] Recovery Research Institute, Massachusetts General Hospital, 151 Merrimac Street, and Harvard Medical School, Boston, MA, 02114, United States
[b] Chestnut Health Systems, W Chestnut St, Bloomington, IL, 61701, United States

ARTICLE INFO

Keywords:
Recovery
Problem resolution
Treatment
Assisted
Unassisted
Mutual-help
Prevalence
Adults
Population

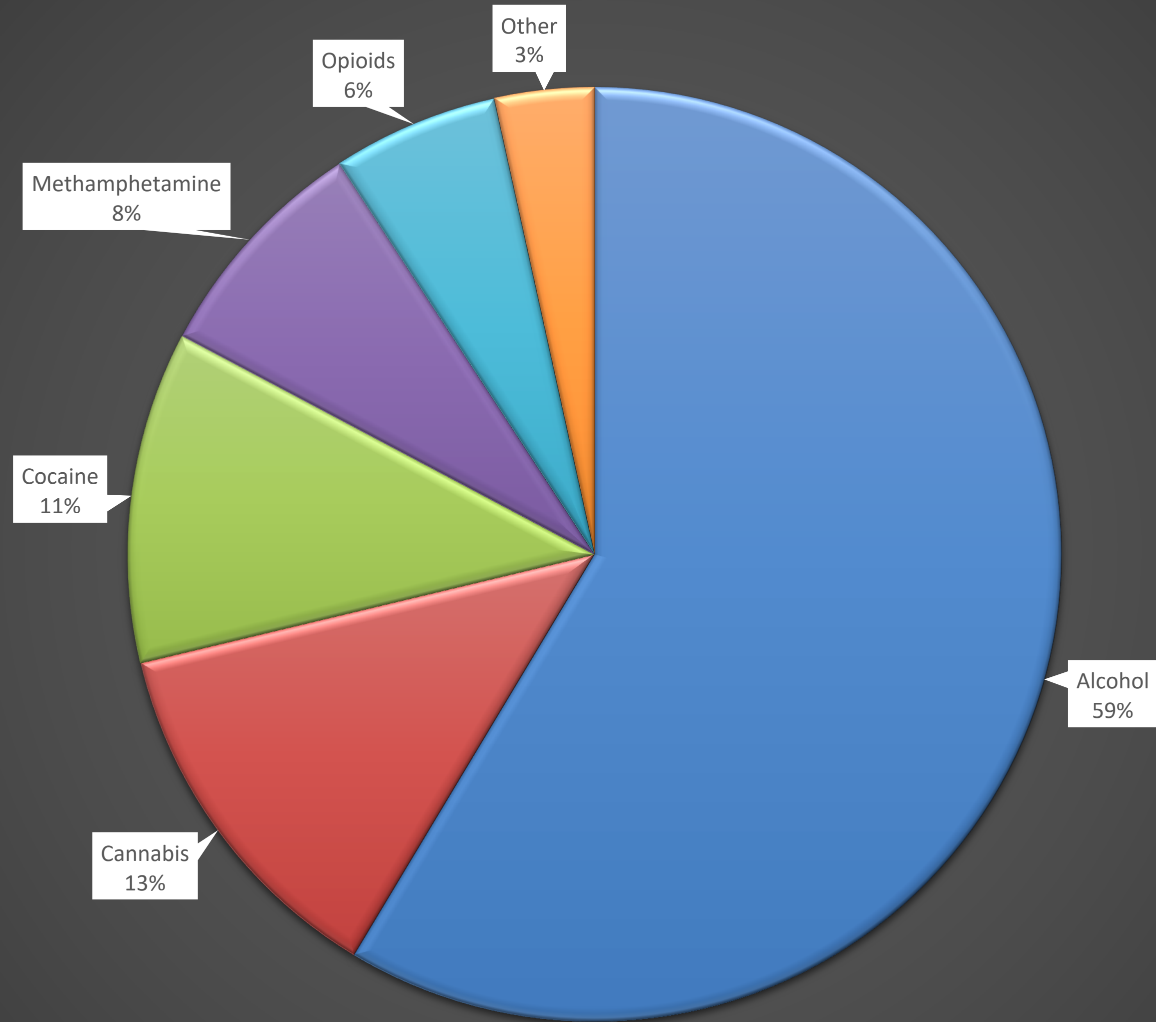
ABSTRACT

Background: Alcohol and other drug (AOD) problems confer a global, prodigious burden of disease, disability, and premature mortality. Even so, little is known regarding how, and by what means, individuals successfully resolve AOD problems. Greater knowledge would inform policy and guide service provision.
Method: Probability-based survey of US adult population estimating: 1) AOD problem resolution prevalence; 2) lifetime use of "assisted" (i.e., treatment/medication, recovery services/mutual help) vs. "unassisted" resolution pathways; 3) correlates of assisted pathway use. Participants (response = 63.4% of 39,809) responding "yes" to, "Did you use to have a problem with alcohol or drugs but no longer do?" assessed on substance use, clinical histories, problem resolution.
Results: Weighted prevalence of problem resolution was 9.1%, with 46% self-identifying as "in recovery"; 53.9% reported "assisted" pathway use. Most utilized support was mutual-help (45.1%,SE = 1.6), followed by treatment (27.6%,SE = 1.4), and emerging recovery support services (21.8%,SE = 1.4), including recovery community centers (6.2%,SE = 0.9). Strongest correlates of "assisted" pathway use were lifetime AOD diagnosis (AOR = 10.8[7.42–15.74], model R^2 = 0.13), drug court involvement (AOR = 8.1[5.2-12.6], model R^2 = 0.10), and, inversely, absence of lifetime psychiatric diagnosis (AOR = 0.3[0.2–0.3], model R^2 = 0.10). Compared to those with primary alcohol problems, those with primary cannabis problems were less likely (AOR = 0.7[0.5–0.9]) and those with opioid problems were more likely (AOR = 2.2[1.4-3.4]) to use assisted pathways. Indices related to severity were related to assisted pathways (R^2 < 0.03).
Conclusions: Tens of millions of Americans have successfully resolved an AOD problem using a variety of traditional and non-traditional means. Findings suggest a need for a broadening of the menu of self-change and community-based options that can facilitate and support long-term AOD problem resolution.

RESULTS

NRS

9.1% or
22.35 million
Americans have resolved an alcohol or other drug problem


Primary Substance
Other
3%
Opioids
6%
Methamphetamine
8%
Cocaine
11%
Cannabis
13%
Alcohol
59%
Alcohol
Cannabis
Cocaine
Methamphetamine
Opioids
Other

Outline

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Psychology of Addictive Behaviors

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2018, Vol. 32, No. 6, 595–604
http://dx.doi.org/10.1037/adb0000386

On Being "In Recovery": A National Study of Prevalence and Correlates of Adopting or Not Adopting a Recovery Identity Among Individuals Resolving Drug and Alcohol Problems

John F. Kelly, Alexandra W. Abry, Connor M. Milligan, Brandon G. Bergman, and Bettina B. Hoeppner
Massachusetts General Hospital, Boston, Massachusetts

The concept of recovery has become an organizing paradigm in the addiction field globally. Although a convenient label to describe the broad phenomena of change when individuals resolve significant alcohol or other drug (AOD) problems, little is known regarding the prevalence and correlates of adopting such an identity. Greater knowledge would inform clinical, public health, and policy communication efforts. We conducted a cross-sectional nationally representative survey (N = 39,809) of individuals resolving a significant AOD problem (n = 1,995). Weighted analyses estimated prevalence and tested correlates of label adoption. Qualitative analyses summarized reasons for prior recovery identity adoption/nonadoption. The proportion of individuals currently identifying as being in recovery was 45.1%, never in recovery 39.5%, and no longer in recovery 15.4%. Predictors of identifying as being in recovery included formal treatment and mutual-help participation, and history of being diagnosed with AOD or other psychiatric disorders. Qualitative analyses regarding reasons for no/prior recovery identity found themes related to low AOD problem severity, viewing the problem as resolved, or having little difficulty of stopping. Despite increasing use of the recovery label and concept, many resolving AOD problems do not identify in this manner. These appear to be individuals who have not engaged with the formal or informal treatment systems. To attract, engage, and accommodate this large number of individuals who add considerably to the AOD-related global burden of disease, AOD public health communication efforts may need to consider additional concepts and terminology beyond recovery (e.g., "problem resolution") to meet a broader range of preferences, perspectives and experiences.

Keywords: recovery, addiction, identity, social, remission

Proportion self-identify as being “in recovery”

46%

- Odds of self-identifying in this manner associated with greater indices of greater severity (earlier age of onset, psychiatric comorbidities, greater treatment and recovery support services use)

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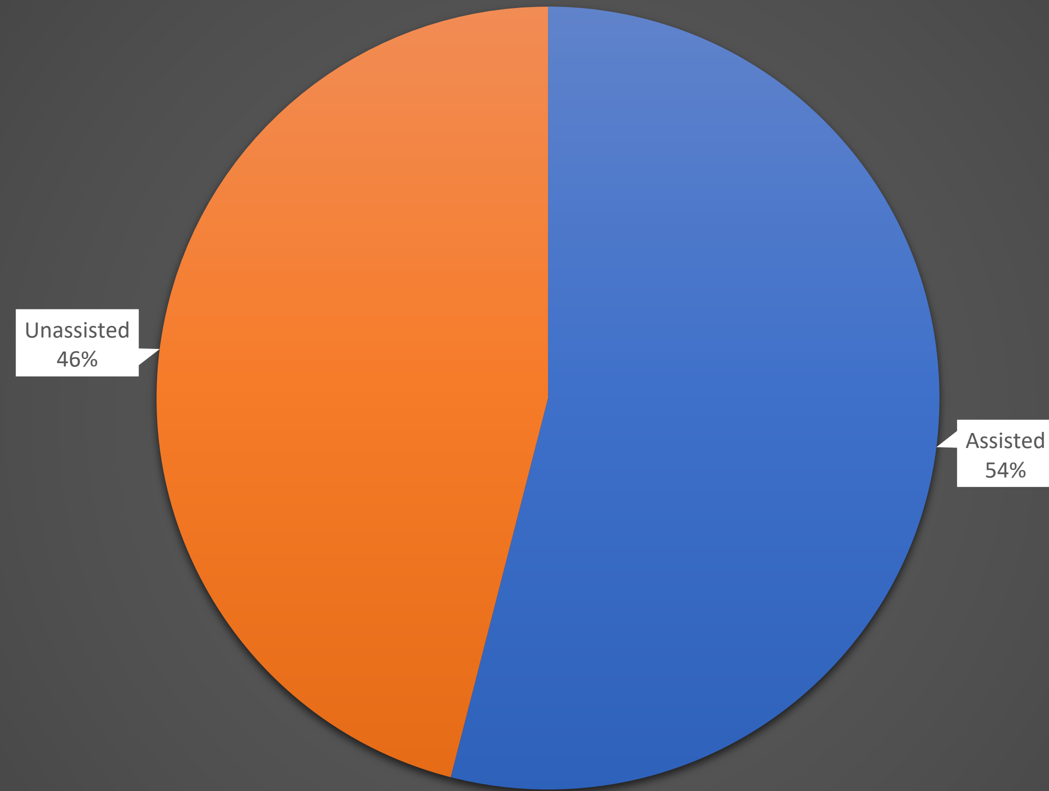
MULTIPLE PATHWAYS TO RECOVERY

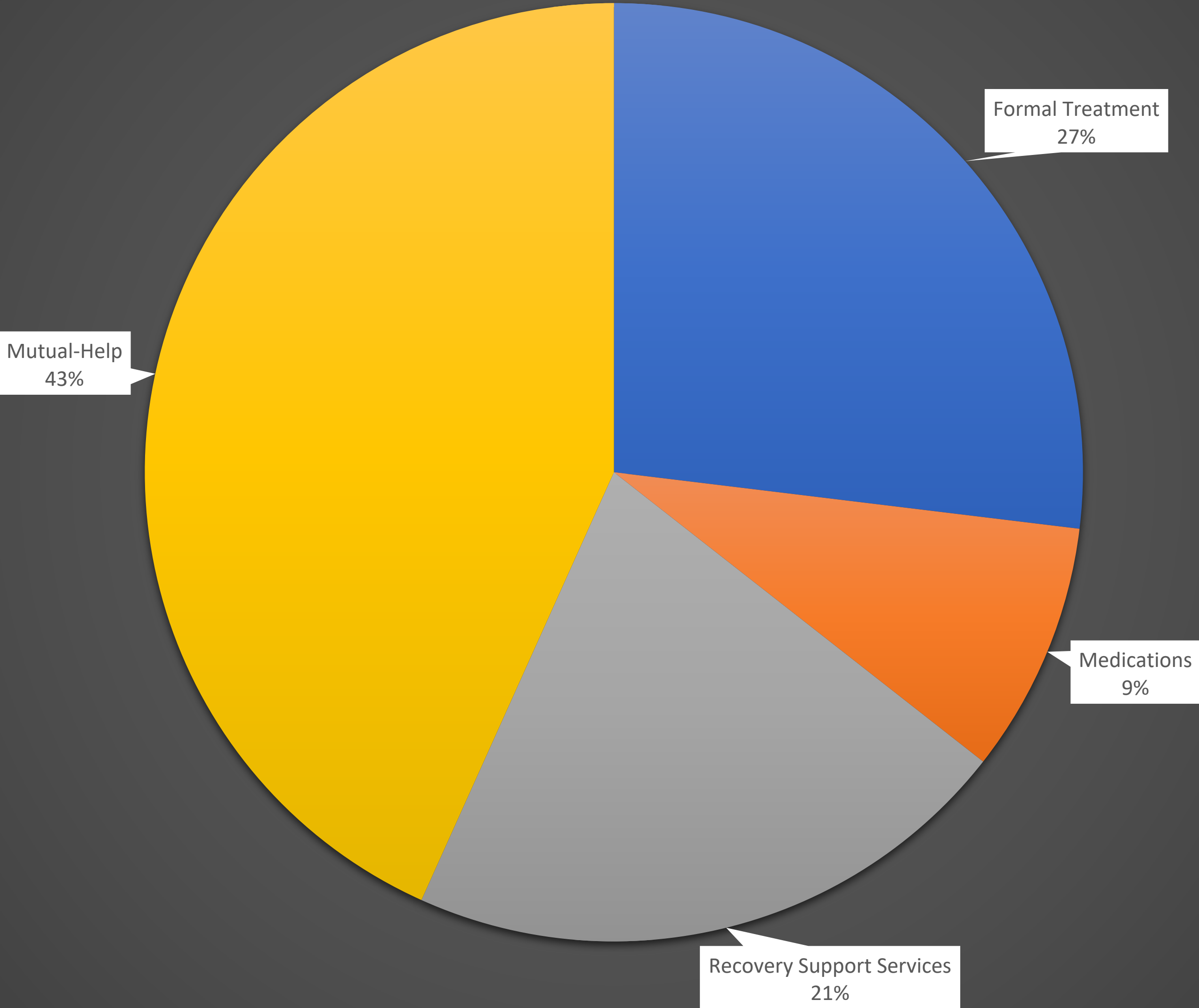
Acknowledges myriad ways in which individuals can recover:

Clinical pathways (provided by a clinician or other medical professional – both medication and psychosocial interventions)

Non-clinical pathways (services not involving clinicians like AA)

Self-management pathways (recovery change processes that involve no formal services, sometimes referred to as "natural recovery").


Recovery Pathways: Assisted vs Unassisted
Unassisted
46%
Assisted
54%
Assisted
Unassisted


Assisted Pathway: Services Used
Formal Treatment
27%
Medications
9%
Recovery Support Services
21%
Mutual-Help
43%
Formal Treatment
Medications
Recovery Support Services
Mutual-Help

Cochrane Database of Systematic Reviews

Alcoholics Anonymous and other 12-step programs for alcohol use disorder (Protocol)

Kelly JF, Humphreys K, Ferri M

Kelly JF, Humphreys K, Ferri M.
Alcoholics Anonymous and other 12-step programs for alcohol use disorder.
Cochrane Database of Systematic Reviews 2017, Issue 11. Art. No.: CD012880.
DOI: 10.1002/14651858.CD012880.

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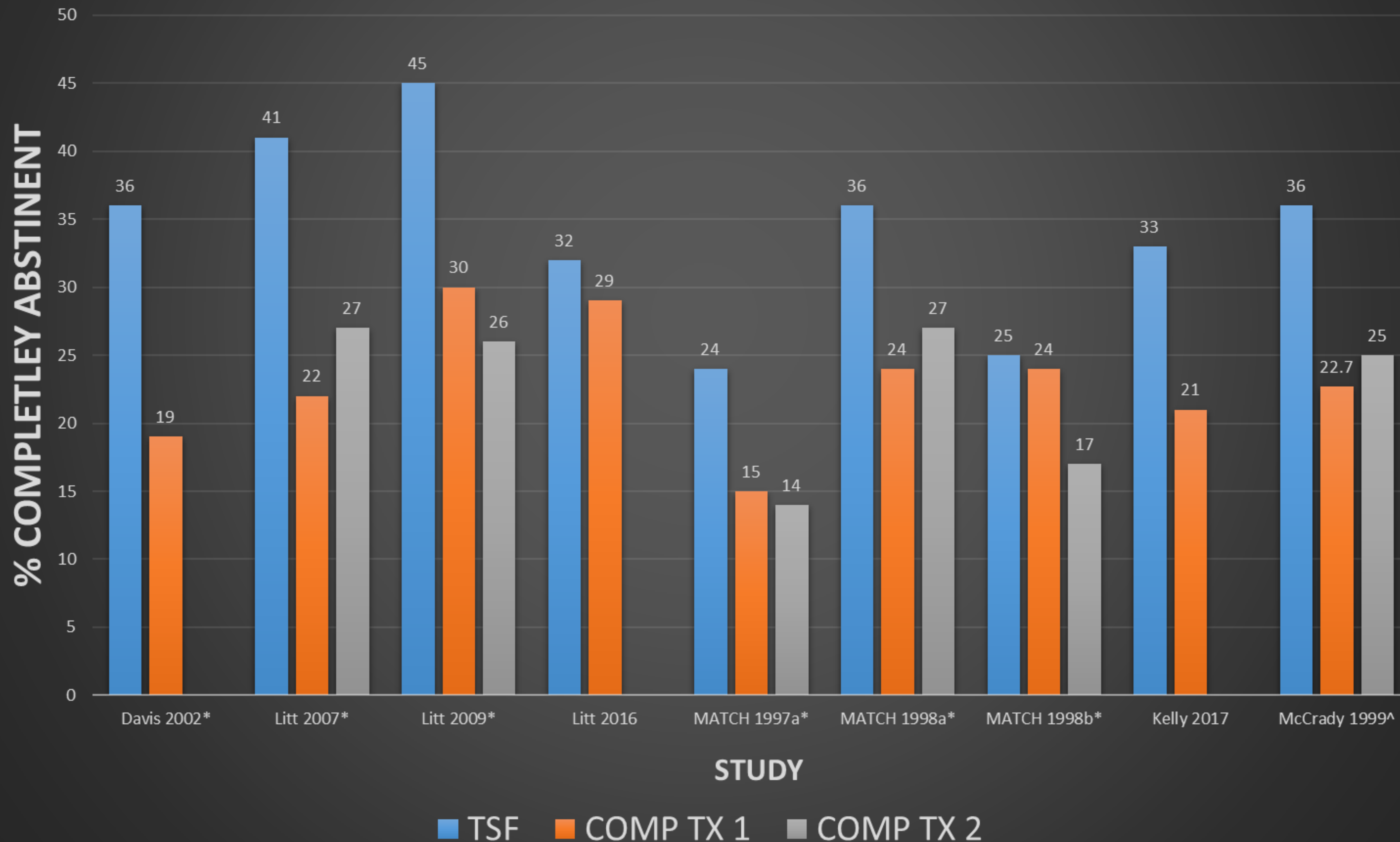
TSF Compared to Different Theoretical Orientation Treatments
(RCTs all Manualized)
% COMPLETLEY ABSTINENT
50
45
40
35
30
25
20
15
10
5
0
36
19
41
22
27
45
30
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32
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14
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17
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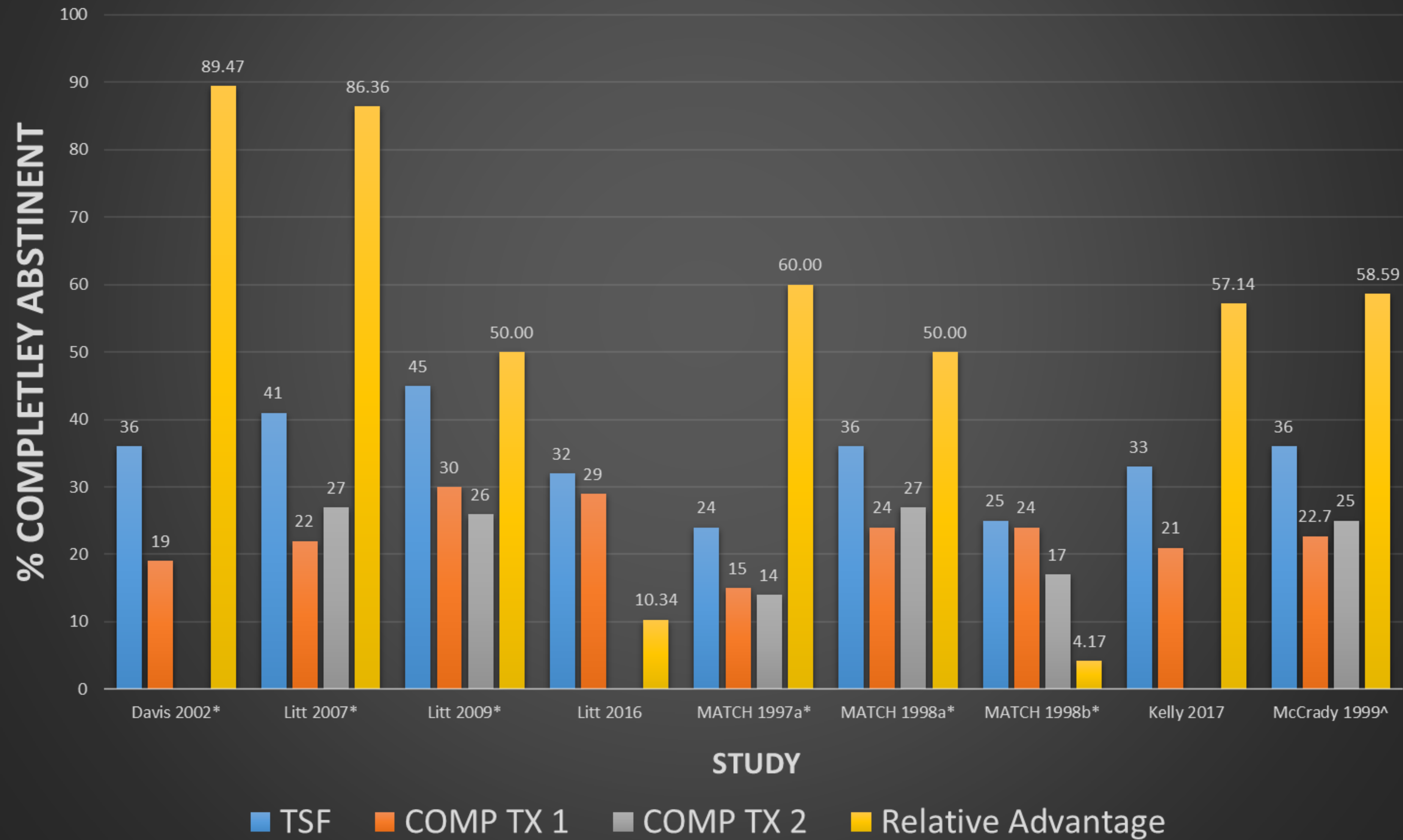
36
22.7
25
Davis 2002*
Litt 2007*
Litt 2009*
Litt 2016
MATCH 1997a*
MATCH 1998a*
MATCH 1998b*
Kelly 2017
McCrady 1999^
STUDY
TSF
COMP TX 1
COMP TX 2


TSF Compared to Different Theoretical Orientation Treatments (RCTs all Manualized)
% COMPLETLEY ABSTINENT
100
90
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19
89.47
41
22
27
86.36
45
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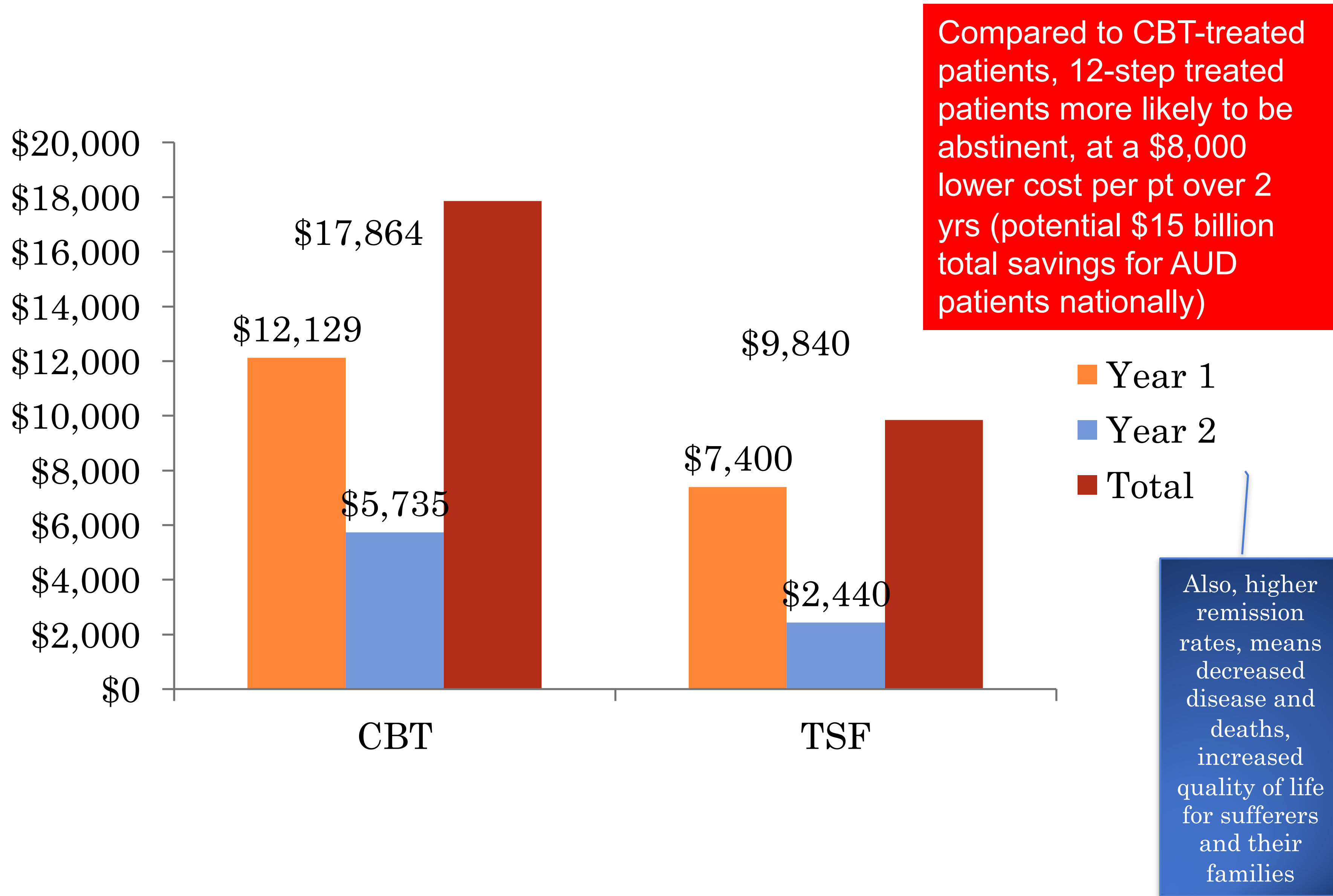
33
21
57.14
36
22.7
25
58.59
Davis 2002*
Litt 2007*
Litt 2009*
Litt 2016
MATCH 1997a*
MATCH 1998a*
MATCH 1998b*
Kelly 2017
McCrady 1999^
STUDY
TSF
COMP TX 1
COMP TX 2
Relative Advantage

HEALTH CARE COST OFFSET
CBT VS 12-STEP RESIDENTIAL TREATMENT

Compared to CBT-treated patients, 12-step treated patients more likely to be abstinent, at a $8,000 lower cost per pt over 2 yrs (potential $15 billion total savings for AUD patients nationally)



Also, higher remission rates, means decreased disease and deaths, increased quality of life for sufferers and their families

Addiction
RESEARCH REPORT doi:10.1111/j.1360-0443.2008.02467.x

Facilitating involvement in Alcoholics Anonymous during out-patient treatment: a randomized clinical trial

Kimberly S. Walitzer, Kurt H. Dermen & Christopher Barrick
Buffalo, NY, USA

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RESEARCH REPORT

Network support for drinking, Alcoholics Anonymous and long-term matching effects

RICHARD LONGABAUGH[1], PHILIP W. WIRTZ[2], ALLEN ZWEBEN[3] & ROBERT L. STOUT[4]

[1]Brown University, Center for Alcohol & Addiction Studies, Providence, RI, [2]George Washington University, Washington, DC, [3]University of Wisconsin-Milwaukee, Center for Addiction & Behavioral Health Research, Milwaukee, WI, [4]Brown University and Butler Hospital, Center for Alcohol & Addiction Studies, Providence, RI, USA

Abstract
Aims. *(1) To examine the matching hypothesis that Twelve Step Facilitation Therapy (TSF) is more effective than Motivational Enhancement Therapy (MET) for alcohol-dependent clients with networks highly supportive of drinking 3 years following treatment; (2) to test a causal chain providing the rationale for this effect.* **Design.** *Outpatients were re-interviewed 3 years following treatment. ANCOVAs tested the matching hypothesis.* **Setting.** *Outpatients from five clinical research units distributed across the United States.* **Participants:** *Eight hundred and six alcohol-dependent clients.* **Intervention.** *Clients were randomly assigned to one of three 12-week, manually-guided, individual treatments: TSF, MET or Cognitive Behavioral Coping Skills Therapy (CBT).* **Measurements.** *Network support for drinking prior to treatment, Alcoholics Anonymous (AA) involvement during and following treatment, percentage of days abstinent and drinks per drinking day during months 37–39.* **Findings.** *(1) The a priori matching hypothesis that TSF is more effective than MET for clients with networks supportive of drinking was supported at the 3 year follow-up; (2) AA involvement was a partial mediator of this effect; clients with networks supportive of drinking assigned to TSF were more likely to be involved in AA; AA involvement was associated with better 3-year drinking outcomes for such clients.* **Conclusions.** *(1) In the long-term TSF may be the treatment of choice for alcohol-dependent clients with networks supportive of drinking; (2) involvement in AA should be given special consideration for clients with networks supportive of drinking, irrespective of the therapy they will receive.*

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…y at Buffalo, The State University of New York, 1021 Main Street,
Buffalo, NY 14203, USA. E-mail: walitzer@ria.buffalo.edu

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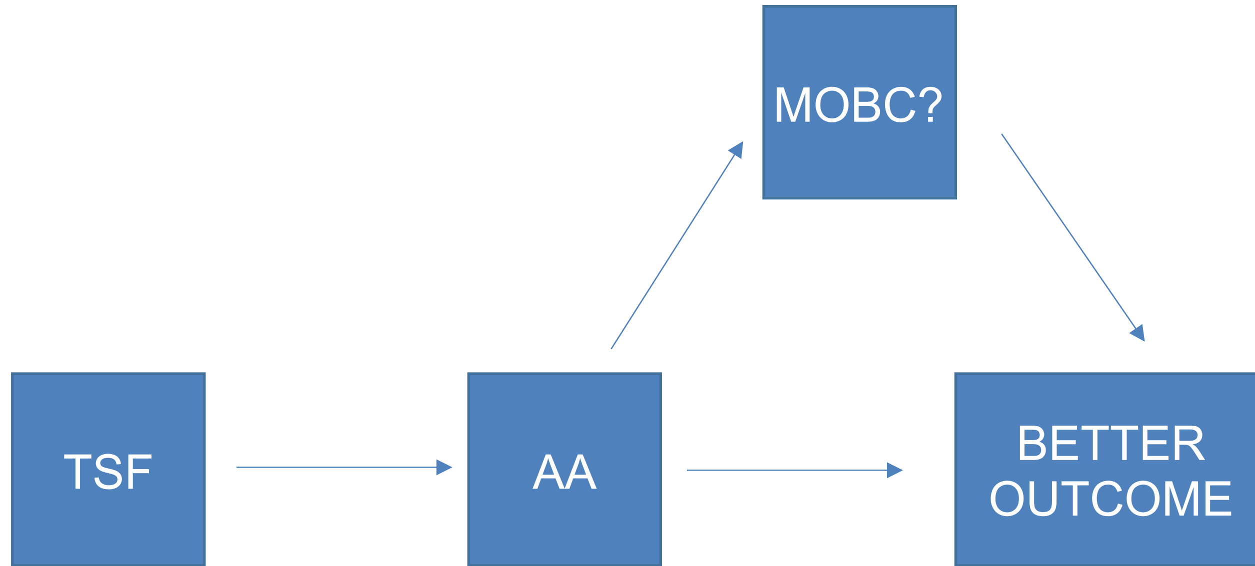
TSF often produces significantly better outcomes relative to active comparison conditions (e.g., CBT)

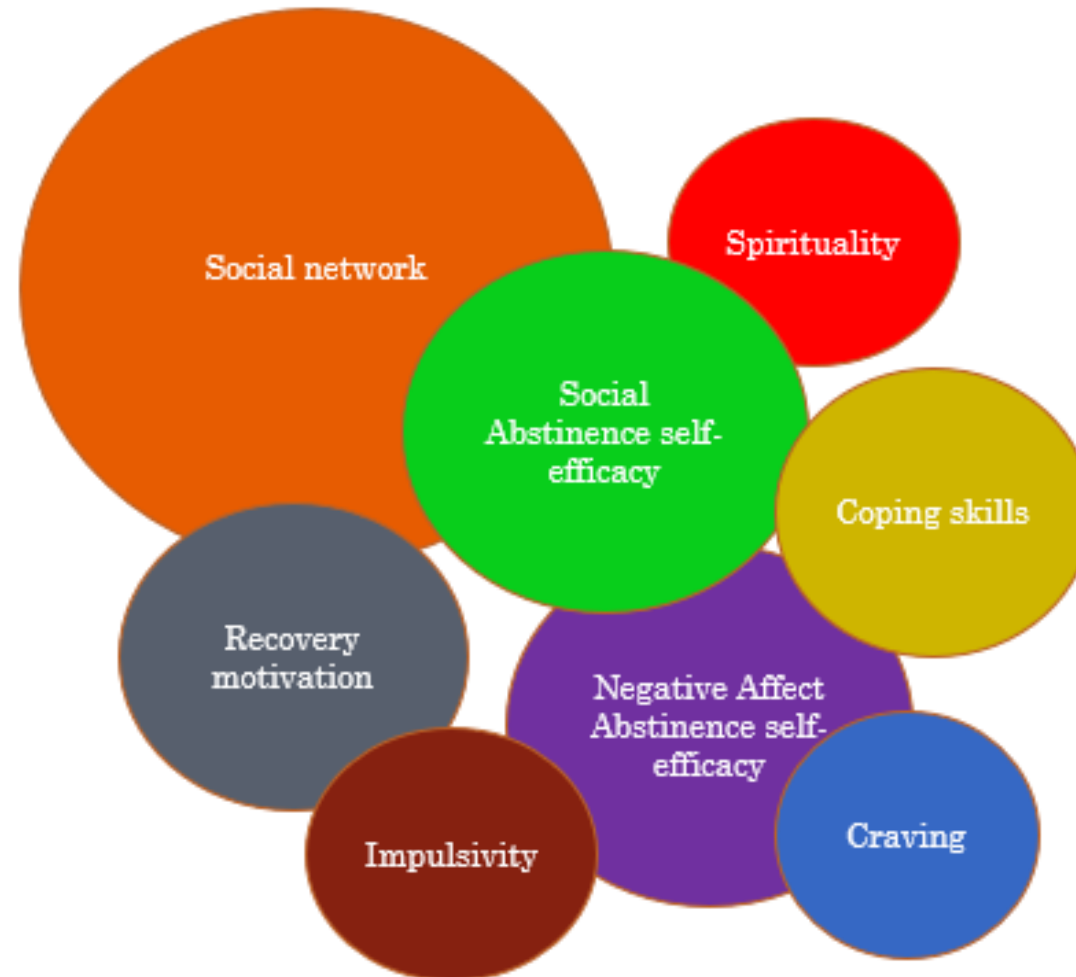
Although TSF is not "AA", it's beneficial effect is explained by AA involvement post-treatment.

TSF-AA-OUTCOME Causal chain supported…

What about support for causal chain of purported mobc of AA on outcomes?



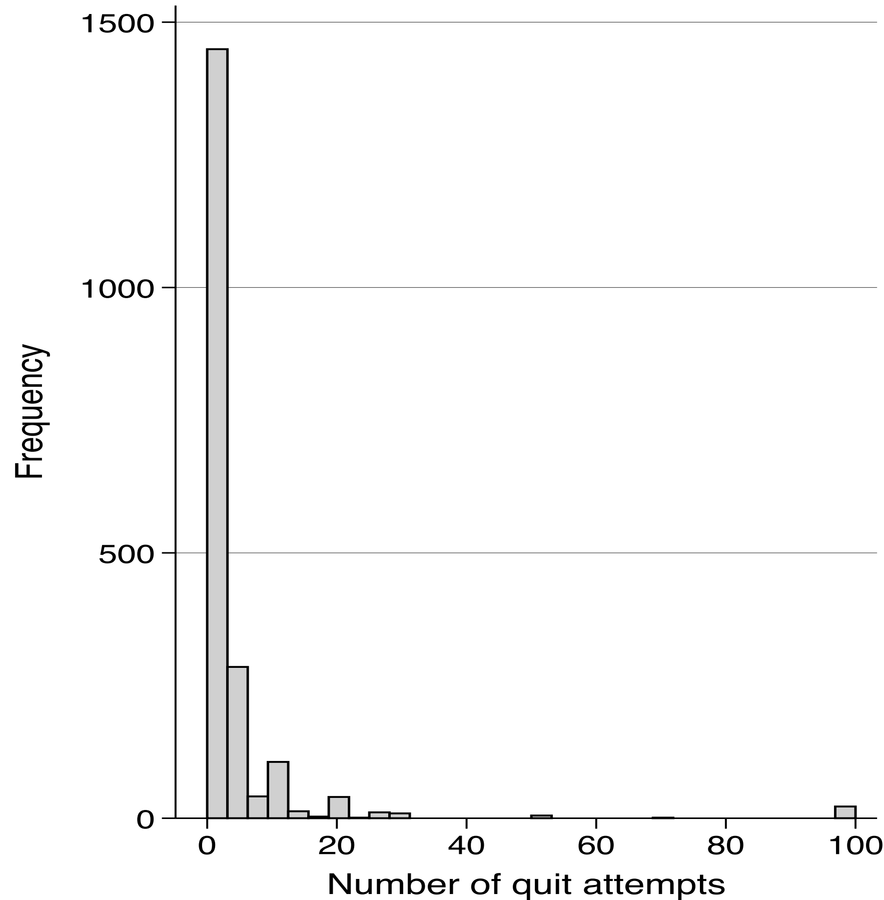
Empirically-supported MOBCs through which AA confers benefit

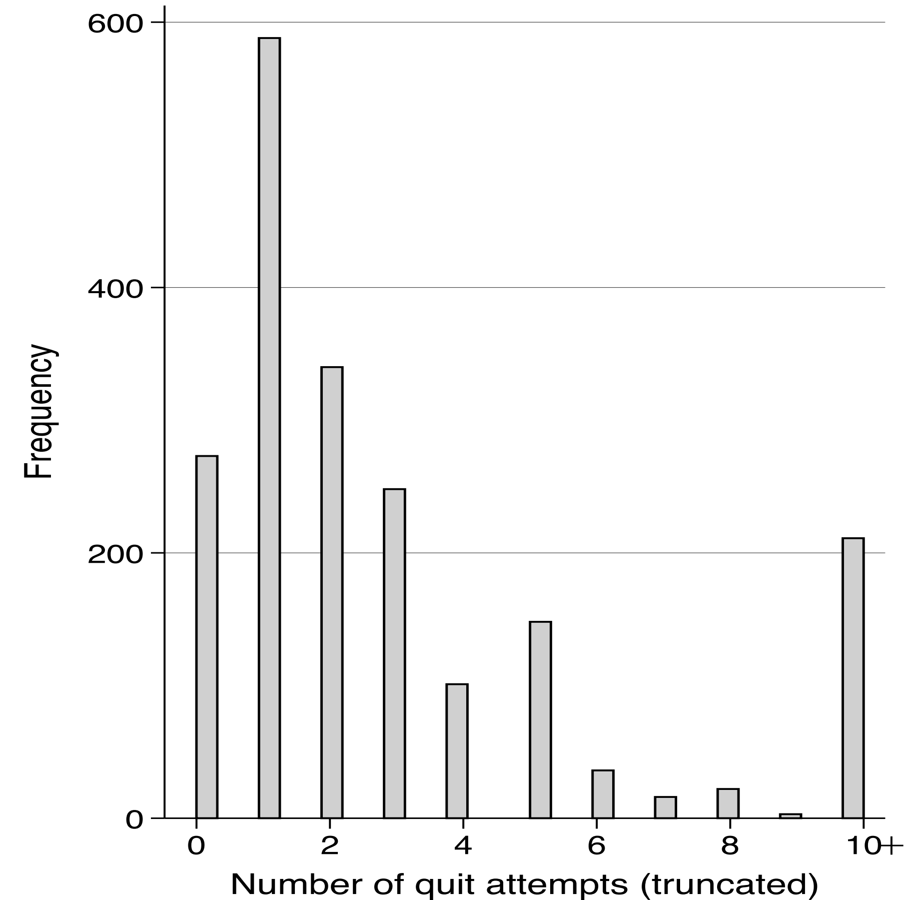


Outline

- Why long-term remission/recovery important?
- National Recovery Study
- What is the prevalence of alcohol or other drug problem resolution?
- What proportion self-identify as being “in recovery”?
- What are the pathways followed?
- How many serious attempts does it take to resolve AOD problems?
- What is quality of life and functioning like in recovery?

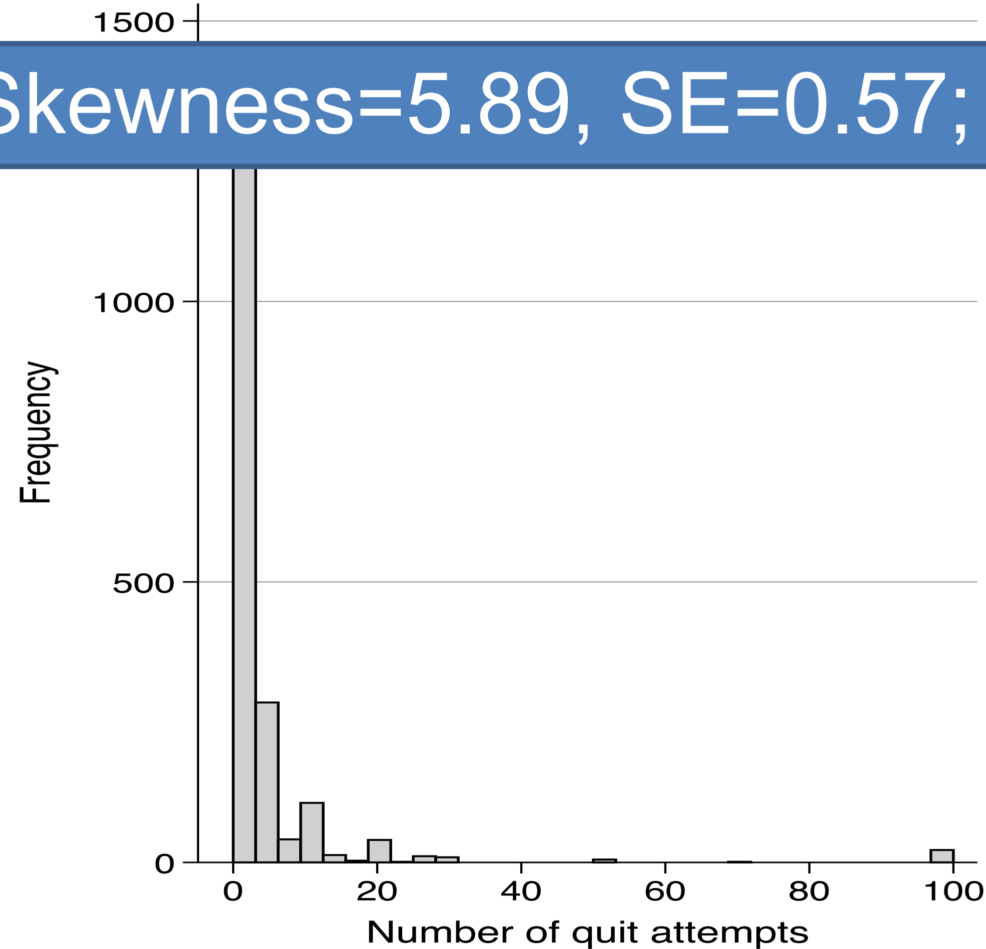
Frequency Distribution of Serious Recovery Attempts Prior to Successful Resolution
(LEFT: Full sample   RIGHT PANEL: Outliers removed)

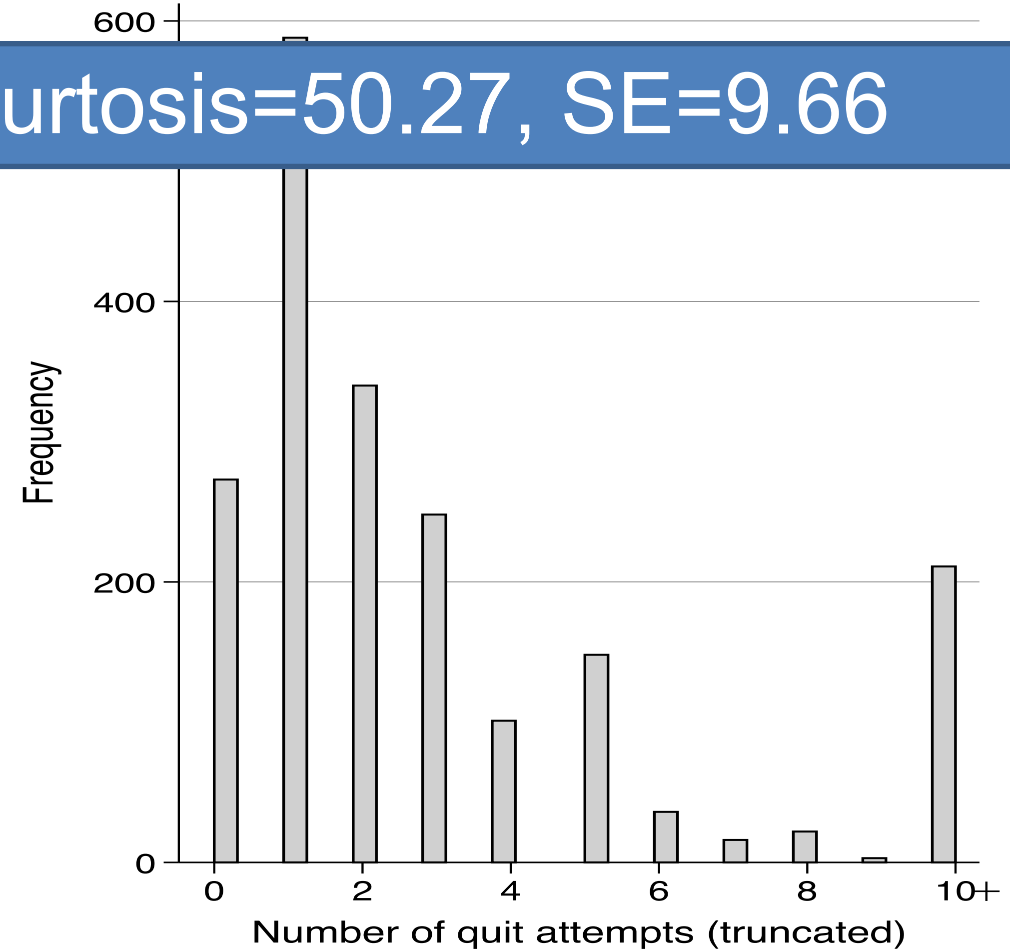




Frequency Distribution of Serious Recovery Attempts Prior to Successful Resolution
(LEFT: Full sample   RIGHT PANEL: Outliers removed)

Skewness=5.89, SE=0.57; Kurtosis=50.27, SE=9.66





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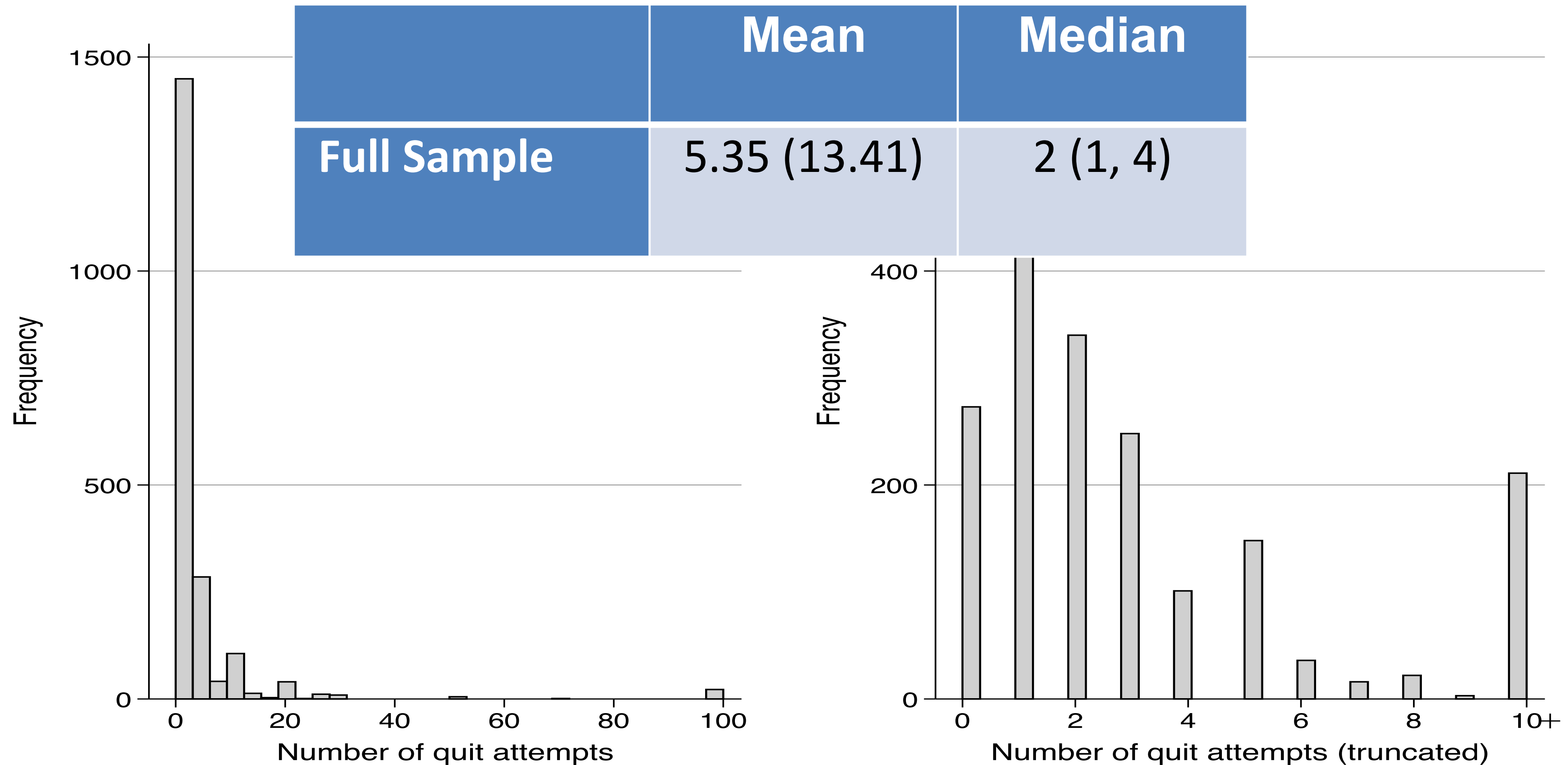
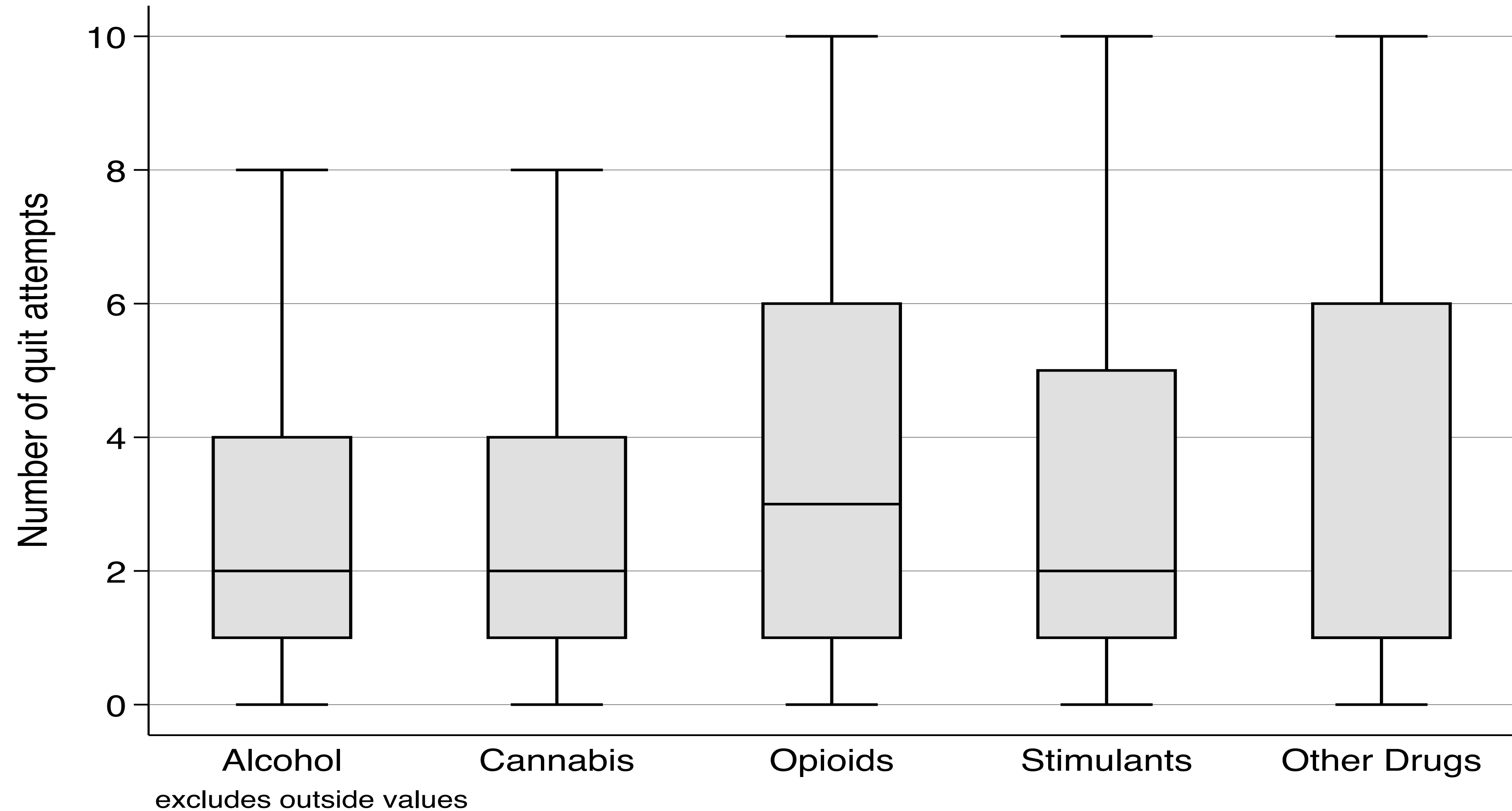
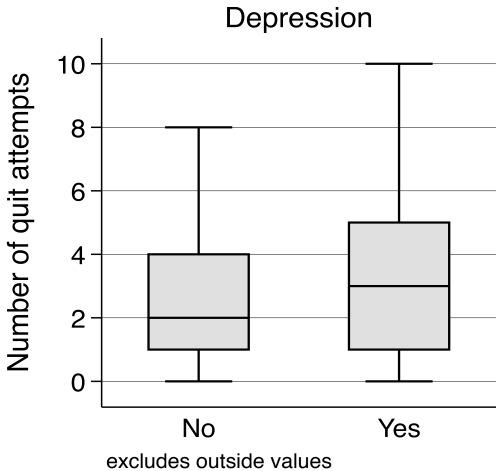


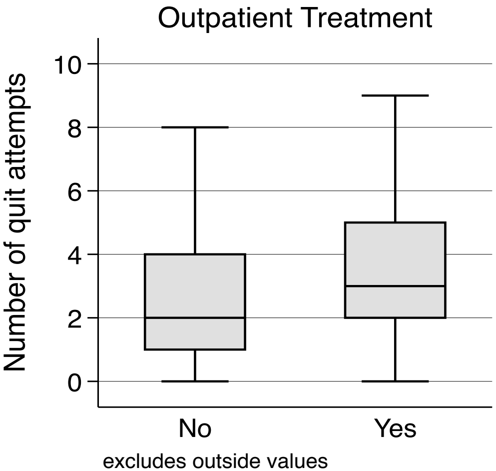
	Mean	Median
Full Sample	5.35 (13.41)	2 (1, 4)

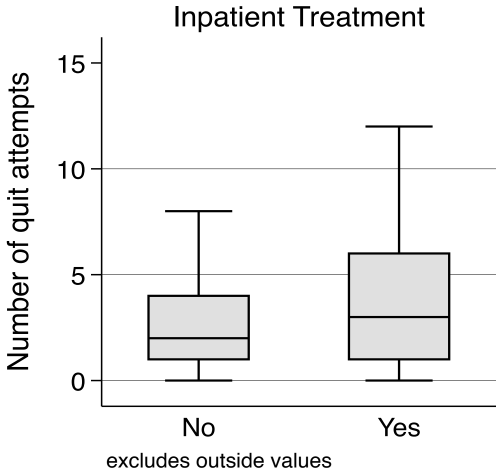
Median Recovery Attempts by Primary Drug

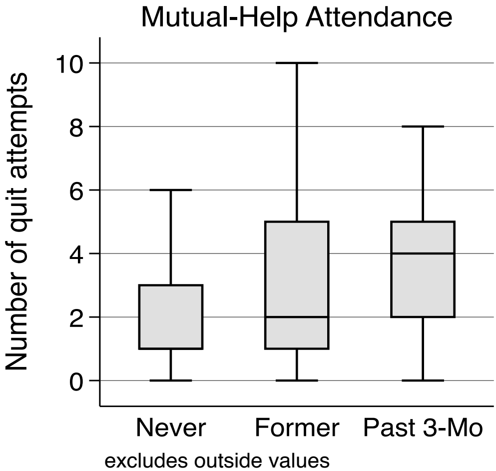


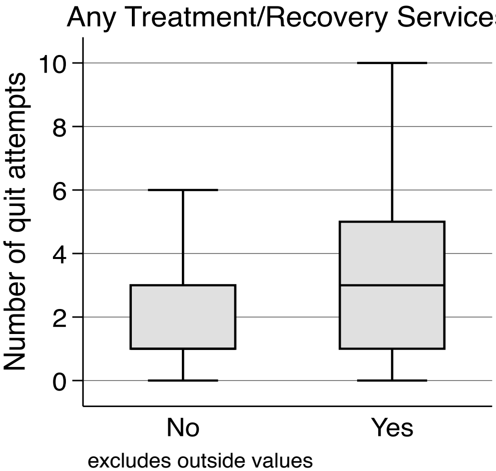
Number of Recovery Attempts by Clinical and Recovery Support Services Use











Outline

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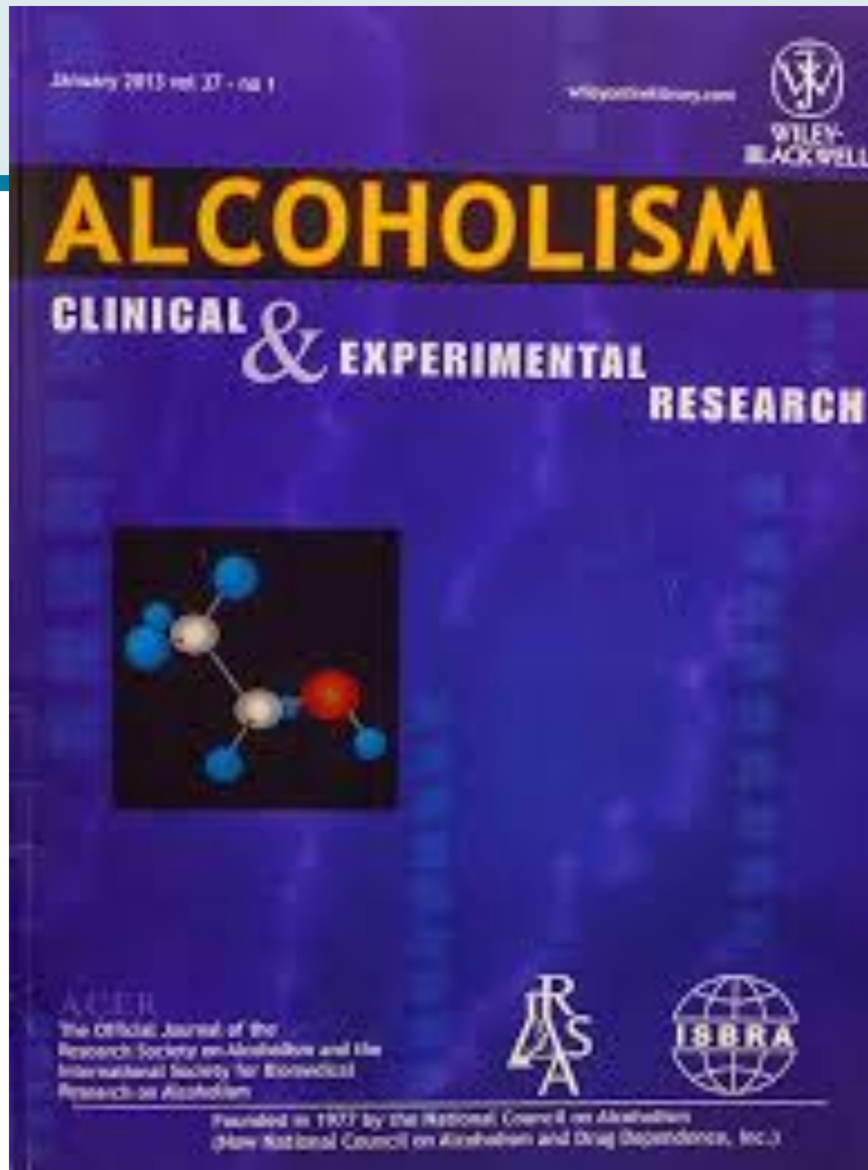


Beyond Abstinence: Changes in Indices of Quality of Life with Time in Recovery in a Nationally Representative Sample of U.S. Adults

John F. Kelly, M. Claire Greene, and Brandon G. Bergman

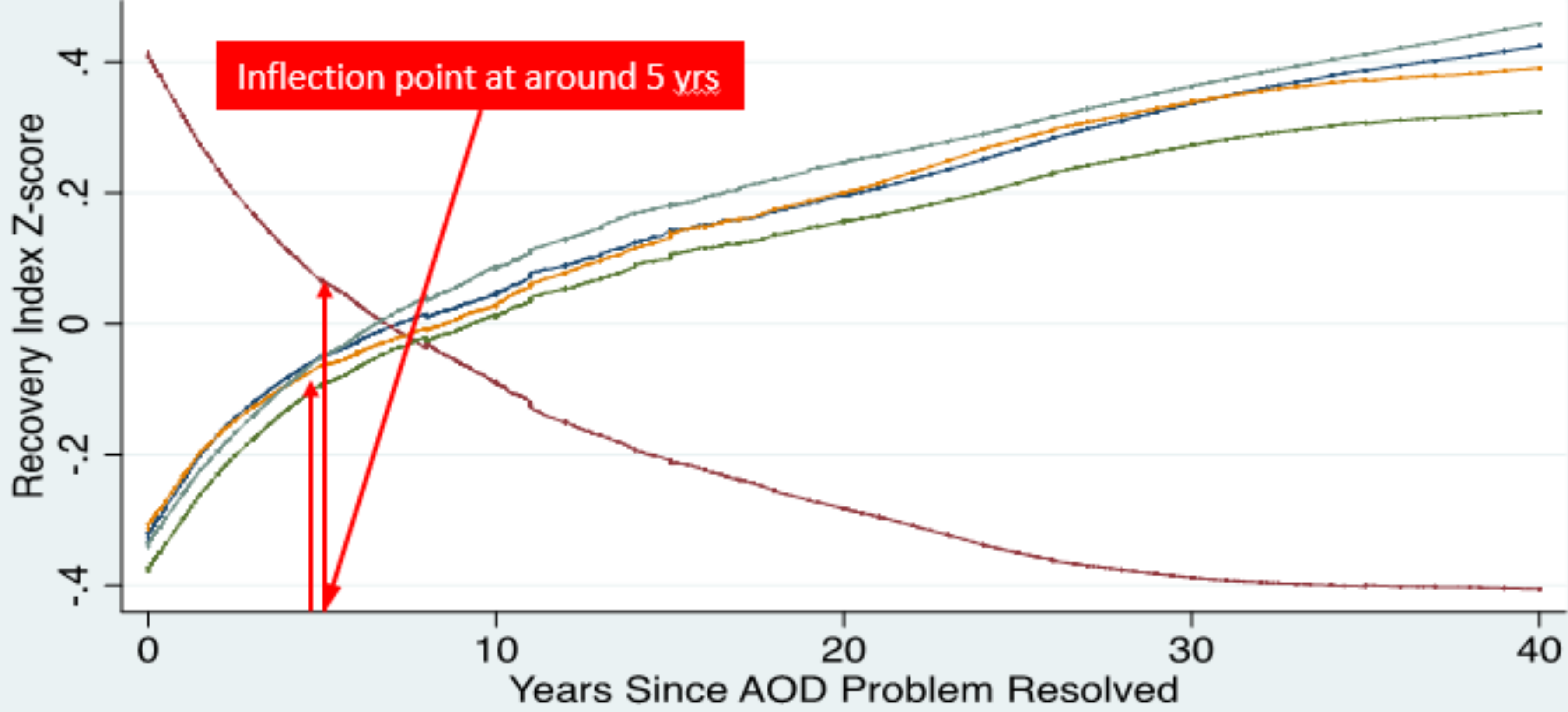
Background: Alcohol and other drug (AOD) treatment and recovery research typically have focused narrowly on changes in alcohol/drug use (e.g., "percent days abstinent") with little attention on changes in functioning or well-being. Furthermore, little is known about whether and when such changes may occur, and for whom, as people progress in recovery. Greater knowledge would improve understanding of recovery milestones and points of vulnerability and growth.

Methods: National, probability-based, cross-sectional sample of U.S. adults who screened positive to the question, "Did you used to have a problem with alcohol or drugs but no longer do?" (Response = 63.4% from 39,809; final weighted sample n = 2,002). Linear, spline, and quadratic regressions tested relationships between time in recovery and 5 measures of well-being: quality of life, happiness, self-esteem, recovery capital, and psychological distress, over 2 temporal horizons: the first 40 years and the first 5 years, after resolving an AOD problem and tested moderators (sex, race, primary substance) of effects. Locally Weighted Scatterplot Smoothing regression was used to explore turning points.

Results: In general, in the 40-year horizon there were initially steep increases in indices of well-being (and steep drops in distress), during the first 6 years, followed by shallower increases. In the 5-year horizon, significant drops in self-esteem and happiness were observed initially during the first year followed by increases. Moderator analyses examining primary substance found that compared to alcohol and cannabis, those with opioid or other drugs (e.g., stimulants) had substantially lower recovery capital in the early years; mixed race/native Americans tended to exhibit poorer well-being compared to White people; and women consistently reported lower indices of well-being over time than men.

Conclusions: Recovery from AOD problems is associated with dynamic monotonic improvements in indices of well-being with the exception of the first year where self-esteem and happiness initially decrease, before improving. In early recovery, women, certain racial/ethnic groups, and those suffering from opioid and stimulant-related problems appear to face ongoing challenges that suggest a need for greater assistance.

Key Words: Recovery, Remission, Alcohol Use Disorder, Quality of Life, National, Epidemiology.


Recovery Indices by Years Since Problem Resolution
Inflection point at around 5 yrs
Recovery Index Z-score
.4
.2
0
-.2
-.4
0
10
20
30
40
Years Since AOD Problem Resolved
Quality of Life
Psychological Distress
Happiness
Self Esteem
Recovery Capital

Recovery Indices by Years Since Problem Resolution

15yrs

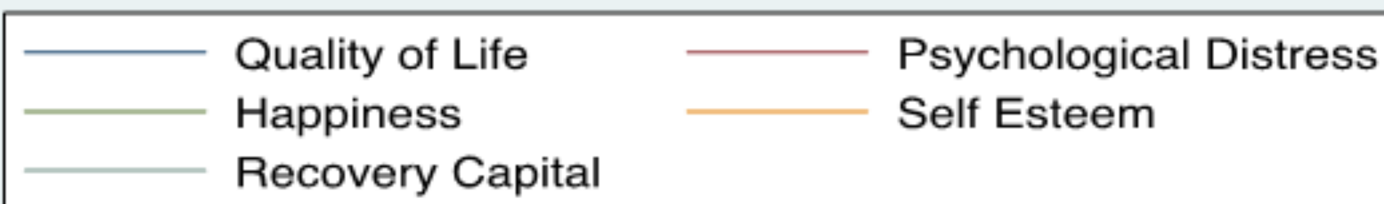
Same QOL as gen. pop. not achieved until around 15yrs

Recovery Index Z-score

.4
.2
0
-.2
-.4

0
10
20
30
40

Years Since AOD Problem Resolved



Traditional addiction treatment approach: Burning building analogy

- **Putting out the fire** -good job
- **Preventing it from re-igniting** (RP) - less emphasis
- **Architectural planning** (recovery plan) –neglected
- **Re-building materials (recovery capital) –**neglected
- **Granting “rebuilding permits”** - (removing barriers)

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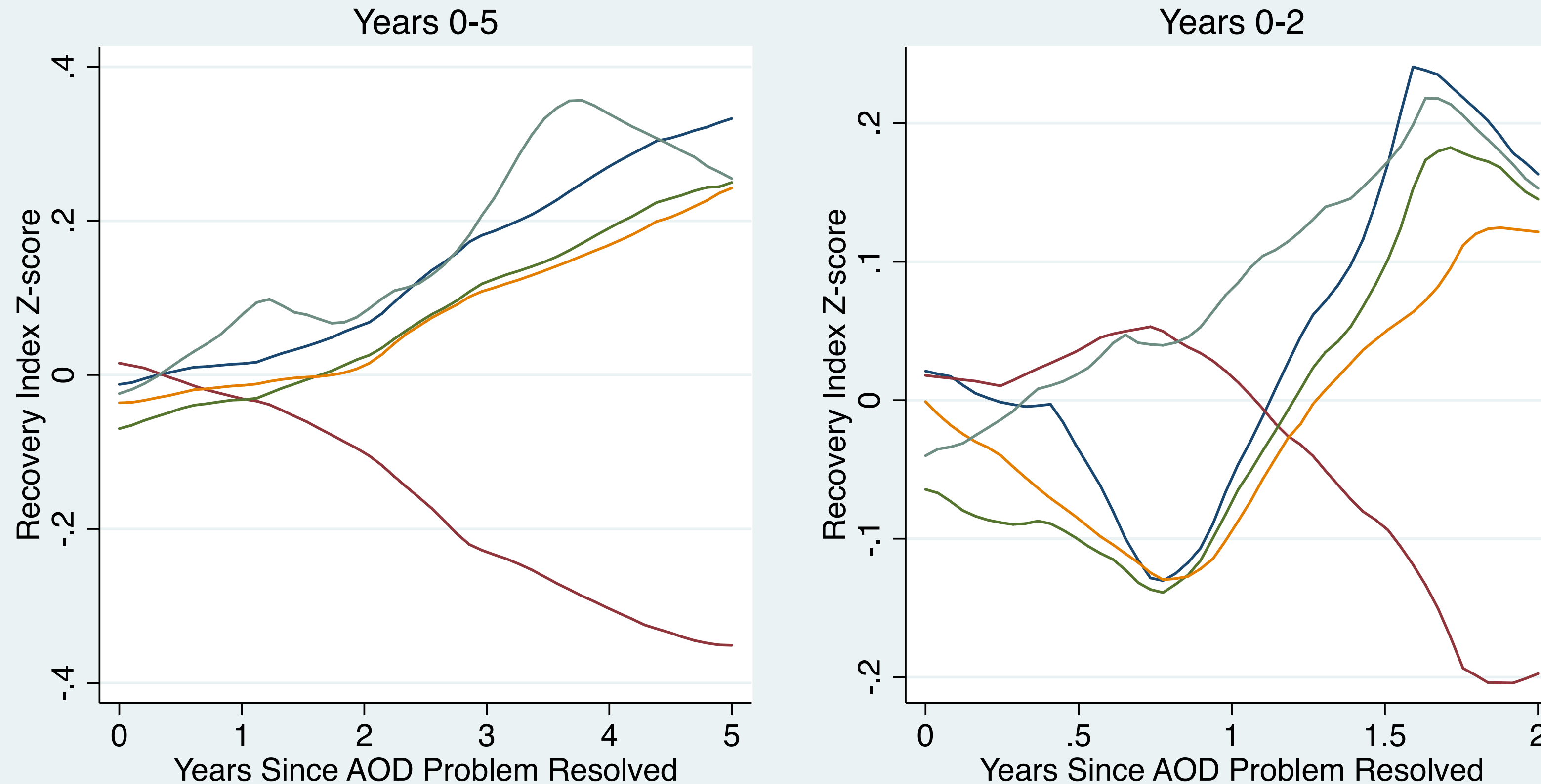
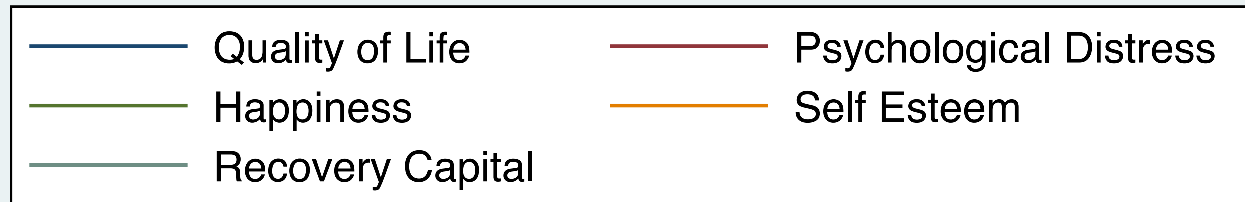
Recovery Indices by Years Since Problem Resolution





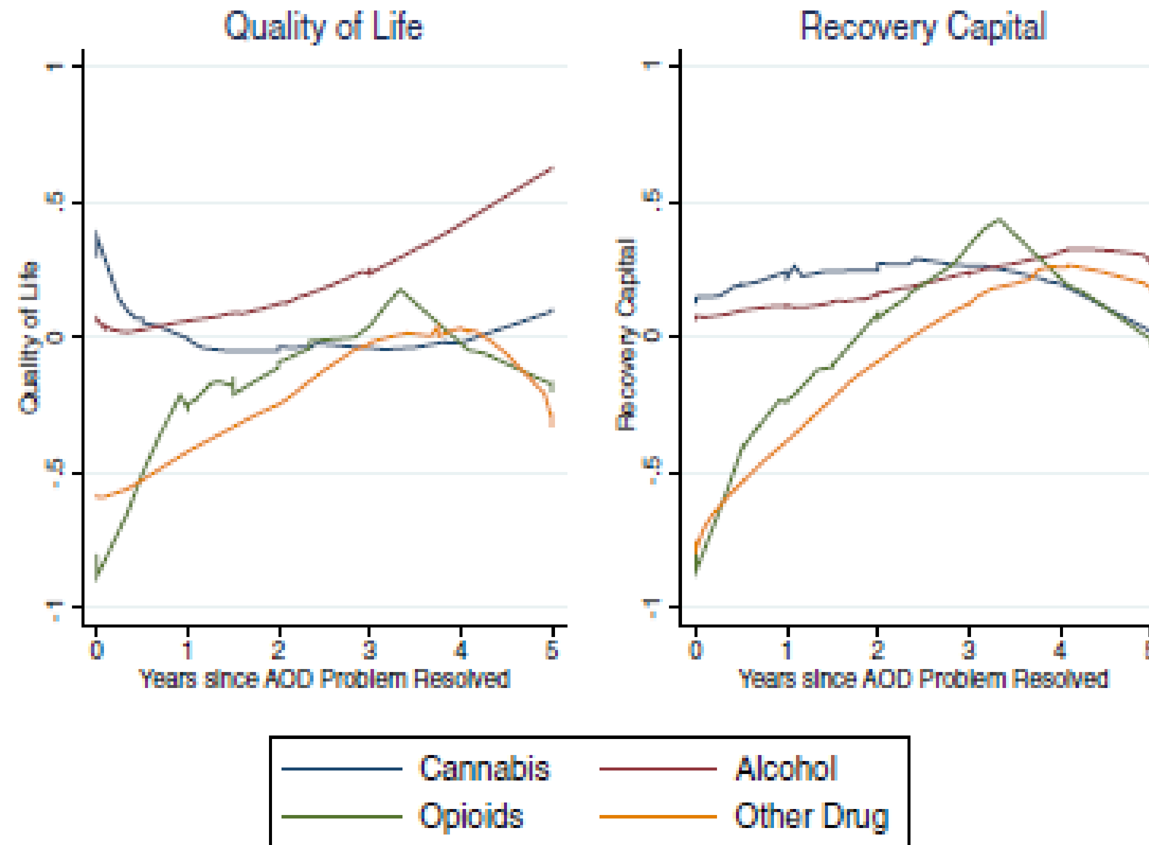


Fig. 5. Locally Weighted Scatterplot Smoothing (LOWESS) analysis of recovery indices by years since problem resolution stratified by primary substance.

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Whether, when, and to whom?: An investigation of comfort with disclosing alcohol and other drug histories in a nationally representative sample of recovering persons

Valerie A. Earnshaw[a,*], Brandon G. Bergman[b], John F. Kelly[b]

[a] University of Delaware, 111 Alison Hall West, Newark, DE 19716, United States of America

[b] Recovery Research Institute, Massachusetts General Hospital and Harvard Medical School, 151 Merrimac St, 6th Floor, Boston, MA 02114, United States of America

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ABSTRACT

Background: Due to shame and fear of discrimination, individuals in, or seeking, recovery from alcohol and other drug (AOD) problems often struggle with whether, when, and to whom to disclose information regarding their AOD histories and recovery status. This can serve as a barrier to obtaining needed recovery support. Consequently, disclosure may have important implications for recovery trajectories, yet is poorly understood.

Design and sample: Cross-sectional, U.S. nationally-representative survey conducted in 2016 among individuals with resolved AOD problems (N = 1987) investigated disclosure comfort and whether disclosure comfort differed by time since problem resolution, disclosure recipient (i.e., with interpersonal intimacy), or primary substance (i.e., alcohol [51%], cannabis [11%], opioids [5%], or "other" [33%]). Predictors of disclosure comfort were also examined. Data were analyzed using LOWESS analyses, analyses of variance, and regression.

Results: Overall, longer time since problem resolution was associated with greater disclosure comfort. In general, participants reported greater comfort with disclosure to family and friends, and less comfort with disclosure to co-workers, to first-time acquaintances, in public settings, and in the media, but these effects varied by primary drug with participants who had problems with alcohol and "other" drugs having significantly more disclosure comfort than those who had problems with opioids.

Conclusion: Dimensions of time since AOD problem resolution, interpersonal intimacy, and primary drug are significantly associated with disclosure comfort. Individuals seeking recovery may benefit from more formal coaching around disclosure, particularly those with primary opioid problems, but further research is needed to determine the desire for and effects of such coaching among those seeking recovery.

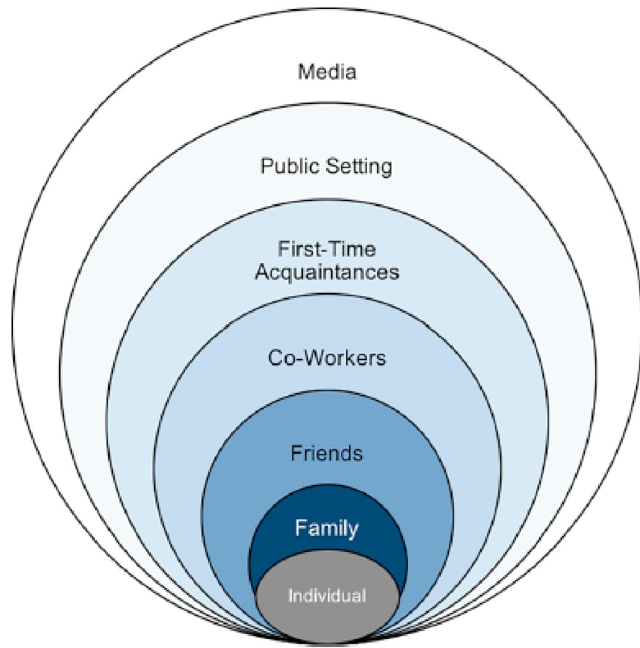
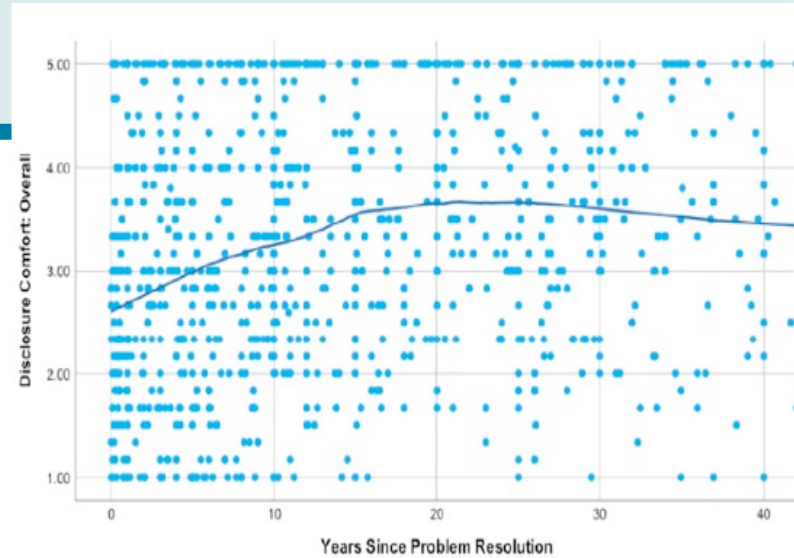


Fig. 1. Hypothesized disclosure comfort by level of interpersonal intimacy. *Note*: Darker colors indicate more hypothesized disclosure comfort. (For interpretation of the references to color in this figure legend, the reader is referred to the web version of this article.)



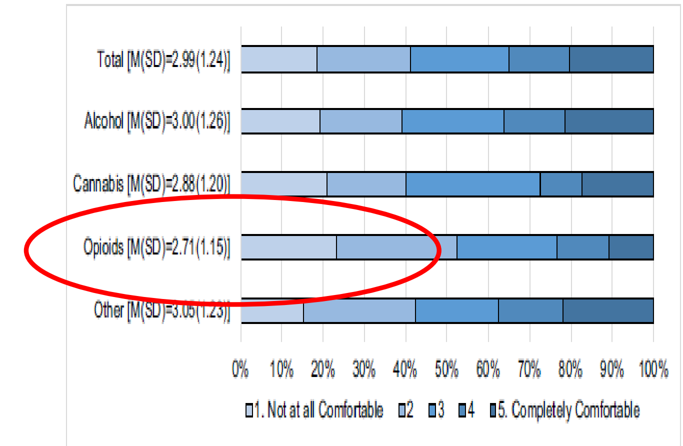


Fig. 4. Stacked bar graph indicating percentages of participants with varying levels of disclosure comfort by primary substance.

Comfort disclosing recovery status:
Compared to other primary substances, opioid group had the most difficult time disclosing…

Results Summary

9.1% or 22.35 Million Americans resolved sig. AOD prob.

Only about half self-identify as “in recovery” –those with less severe histories; similar crises but greater ability to stop sans help

Approximately half resolve these problems without any external assistance- related to less severity/complexity

Mean problem resolution attempts is around 5.5 but this number heavily skewed; Mdn number = 2; with high variability around estimates

QOL indices monotonic improvements over time, with steeper increases first 5 years, then ongoing, shallower, improvement; post “pink cloud” drop early; opioid/stimulant tougher time early on

Implications

- **RESEARCH AND POLITICAL ADVOCACY:** Estimates here similar to prior national/regional, non probability-based estimates suggesting approximately 9.1% (20-25M) of adult Americans "in recovery". Could learn more from this large, diverse, group; mobilize for change?
- **PUBLIC HEALTH & POLICY COMMUNICTION:** Although term "recovery" used in past estimates, only about half identify as "in recovery". Label adoption may serve adaptive funx; qualitative analyses suggest many resolving AOD may not relate and/or oppose this term; thus to engage more people public health and policy communication efforts might include "problem resolution" in addition to "recovery".
- **HOW TO REACH MANY NOT SEEKING SERVICES, LESSEN IMPACT:** In keeping with other studies, half resolved problem without help – those with lower severity and higher recovery capital. This large group still cause harm; how to reach/lessen impact.
- **RECOVERY NEEDS DYNAMIC, VARY BY SUBGROUP:** QOL changes suggest "pink cloud" phase end may create early challenge; 1-yr things looking rosier; continue to improve; marginalized opioid/meth groups need recovery capital/support early on
- **REASONS FOR OPTIMISM:** Prior estimates of quit/recovery attempts, may be "mean" averages, thus biased upwards (with skew); while reflective of high variability, medians should be used. These were low in non-clinical (Mdn=1) and higher in clinical (Mdn=3) samples (overall = 2 serious attempts prior to resolution; Mean=5.6; SD=13.41). Hopeful.

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