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

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

1970
- Controlled Substances Act (CSA): Part of the larger Comprehensive Drug Abuse Prevention & Control Act of 1970, the CSA established U.S. drug control policy & created 5 schedules (classifications) of drugs to determine the legality of a substance & corresponding legal ramifications.

1973
- Anti-Drug Abuse Act: 1st passed in 1986, & then amended 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-focussed) model, enacted minimum mandatory sentencing for drug possession & distribution (100:1 crack/powder cocaine sentencing disparity), & prohibited controlled designer drugs.

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.

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, copays, out-of-pocket maximums, treatment limitations).

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.

2017
- 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."
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)
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..
2013 ONDCP Director Kerlikowske declares move away from “war on drugs” toward broader public health approach
War on drugs

War on the war on drugs

BUT… not just about interdiction, supply reduction, incarceration….

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.
Paradigm Shifts
Genetics, Genomics, Pharmacogenetics
Neuroscience: Neural plasticity
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 (e.g. Narcan)
- Needle Exchanges
- Supervised Injection Sites

SCREENING & FEEDBACK
- Brief Advice
- Motivational Interventions

Screening, Brief Intervention, & Referral To Treatment (SBIRT)

CLINICAL 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
- Mutual 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
The clinical course of addiction and achievement of stable recovery can take a long time...
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

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?
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

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.

- (1) gender (male/female)
- (2) age (18–29, 30–44, 45–59, and 60+ years)
- (3) race/Hispanic ethnicity (White/Non-Hispanic, Black/Non-Hispanic, Other/Non-Hispanic, 2+ Races/Non-Hispanic, Hispanic)
- (4) education (Less than High School, High School, Some College, Bachelor and beyond)
- (5) census geographical region (Northeast, Midwest, South, West)
- (6) household income (under $10k, $10K to <$25k, $25K to <$50k, $50K to <$75k, $75+)
- (7) home ownership status (Own, Rent/Other); and (8) metropolitan area (yes/no).
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
Outline

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What is quality of life and functioning like in recovery?
Prevalence and pathways of recovery from drug and alcohol problems in the
United States population: Implications for practice, research, and policy

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drug dependence

ARTICLE INFO

Keywords: Recovery, Problem resolution, Treatment, Anonymity, Unmet needs, Prevalence, Adult, 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.

Methods: Probability-based survey of US adult population estimating: 1) AOD problem resolution prevalence; 2) Heroin use of “assisted” (i.e., treatment, medication, recovery services/trial help) vs. “unassisted” resolution pathways; 3) correlates of assisted pathway use. Participants (response = 63.4% of 38,809) responding “yes” to, “Did you use to have a problem with alcohol or drugs but no longer do?” assessed on substance use, clinical history, problem resolution.

Results: Weighted prevalence of problem resolution was 9.1%, with 49% self-identifying as “in recovery”); 53.9% reported “assisted” pathway use. Most utilized support was mutual-help (45.1%, RR = 5.6), followed by treatment (27.0%, RR = 1.4), and emerging recovery support services (21.9%, RR = 1.4), including recovery community centers (6.7%, RR = 0.9). Strongest correlates of “assisted” pathway use were lifetime AOD diagnosis (AOR = 10.6, 95% CI 8.5-13.5), model R2 = 0.31, drug court involvement (AOR = 8.1, 95% CI 2.2-61.6), model R2 = 0.10, and, inversely, absence of lifetime psychiatric diagnosis (AOR = 0.3, 95% CI 0.2-0.4), model R2 = 0.01. Compared to those with primary alcohol problems, those with primary cannabis problems were less likely (AOR = 0.7, 95% CI 0.5-0.9) and those with opioid problems were more likely (AOR = 2.1, 95% CI 1.1-2.6) to use assisted pathways. Indicators related to severity were related to assisted pathways (RR ≤ 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.
9.1% or 22.35 million Americans have resolved an alcohol or other drug problem.
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?
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

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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 = 39,839) of individuals resolving a significant AOD problem (t = 1,095). 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 not 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)
Why long-term remission/recovery important?

National Recovery Study

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What is quality of life and functioning like in recovery?
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

Assisted: 54%
Unassisted: 46%
Formal Treatment: 27%
Medications: 9%
Recovery Support Services: 21%
Mutual-Help: 43%
Alcoholics Anonymous and other 12-step programs for alcohol use disorder (Protocol)

Kelly JF, Humphreys K, Ferri M.


www.cochranelibrary.com
TSF Compared to Different Theoretical Orientation Treatments (RCTs all Manualized)
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.
Facilitating involvement in Alcoholics Anonymous during out-patient treatment: a randomized clinical trial

Kimberly S. Wallstrom, Kurt H. Dormon & Christiane Barrick

Buffalo, NY, USA

RESEARCH REPORT

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

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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 casual chain providing the rationale for this effect. Design. Outpatients were re-interviewed 3 years following treatment. ANCOVA 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; (3) clients with networks supportive of drinking assigned to TSF were more likely to be involved in AA; (4) AA involvement was associated with better 3-year drinking outcomes for each client. Conclusions. (1) In the long-term TSF may be superior to MET 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.

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

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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
Frequency Distribution of Serious Recovery Attempts Prior to Successful Resolution

(LEFT: Full sample       RIGHT PANEL: Outliers removed)

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Full Sample</strong></td>
<td>5.35 (13.41)</td>
<td>2 (1, 4)</td>
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![Graph showing frequency distribution of serious recovery attempts](image-url)
Median Recovery Attempts by Primary Drug

Number of quit attempts

- Alcohol
- Cannabis
- Opioids
- Stimulants
- Other Drugs

excludes outside values
Number of Recovery Attempts by Clinical and Recovery Support Services Use

- Depression
- Anxiety
- Outpatient Treatment
- Inpatient Treatment
- Mutual-Help Attendance
- Any Treatment/Recovery Services

The diagrams show the number of quit attempts for different conditions or services, with categories and values indicated.
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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 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 use to have a problem with alcohol or drugs but no longer do?" (Response = 63.4% from 39,019; final weighted sample n = 2,992). Linear, cubic, 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 effect. 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 5 years, followed by shallower increases. In the 5-year horizon, sign of Read 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 African 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 when 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, Relapse, Alcohol Use Disorder, Quality of Life, National, Epidemiology.
Recovery Indices by Years Since Problem Resolution

Inflection point at around 5 yrs

Years Since AOD ProblemResolved

Recovery Index Z-score

Quality of Life  Psychological Distress
Happiness       Self Esteem
Recovery Capital
Recovery Indices by Years Since Problem Resolution

- Quality of Life
- Psychological Distress
- Happiness
- Self Esteem
- Recovery Capital

Same QOL as gen. pop. not achieved until around 15yrs
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)
Recovery Indices by Years Since Problem Resolution

Years 0-5

Years 0-2

- Quality of Life
- Psychological Distress
- Happiness
- Self Esteem
- Recovery Capital

Years Since AOD Problem Resolved

Recovery Index Z-score
Fig. 5. Locally Weighted Scatterplot Smoothing (LOWESS) analysis of recovery indices by years since problem resolution stratified by primary substance.
Whether, when, and to whom?: An investigation of comfort with disclosing alcohol and other drug histories in a nationally representative sample of recovering persons

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ARTICLE INFO

ABSTRACT

Background: Due to shame and fear of discrimination, individuals in or seeking recovery from alcohol and other drug (AOD) problems when 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 (1977-1987) 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 [9%], or “other” [30%]). 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: Extensions 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.
Comfort disclosing recovery status:
Compared to other primary substances, opioid group had the most difficult time disclosing...
Full length article

Smoking cessation in the context of recovery from drug and alcohol problems: Prevalence, predictors, and cohort effects in a national U.S. sample

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National
Epidemiology

ABSTRACT

Background: Tobacco and alcohol and other drug (AUD) use remain prominent risk factors for morbidity, mortality, and health care utilization. Moreover, these often cluster together within persons, exacerbating health risks. Little is known regarding if and when people resolving AUD problems stop smoking, who stops, and whether recent general population trends toward smoking cessation are evident also among persons more recently entering recovery.

Design and participants: National cross-sectional sample resolving AUD problems (final sample n = 2002).


Results: Approximately 30% of U.S. adults in AUD recovery with a smoking history stopped smoking before entering recovery, 7% quit smoking and AUD use concurrently, 26% stopped after entering recovery, 37% still smoked. Among those quitting after entering recovery, the prevalence of smoking cessation 5- and 10-years later was 27.2% and 55.1% respectively for the 2006–2015 cohort and 14.9% and 34.5% in the 1986–1995 cohort; time to smoking cessation also was 66% shorter (5yrs vs. 8yrs). Time to smoking cessation was associated with education and income, but not 12-step participation or AUD treatment.

Conclusions: Smoking rates among those in AUD recovery are more than double that of the general population but those entering recovery in recent years are stopping and stopping sooner. It is plausible that public health-oriented tobacco policy measures and easier access to smoking cessation aids may be contributing to this salutary trend.
Little is known about if and when people resolving AOD problems quit smoking, and if the salutary trends in smoking cessation observed in the gen. pop. are also observable among those recovering from AOD problems…
Findings consistent with other studies reporting high rates of tobacco use histories among individuals who use alcohol and other drugs.
Among those in recovery with smoking history, 30% quit smoking prior to entering recovery, 7% quit smoking at time of entering recovery, 26% quit after entering recovery; 27% still smoking.

Median number of years to smoking cessation among FS who quit after AOD problem resolution was 15 years.
People who resolved their AOD problem more recently took less time to quit smoking relative to those who resolved their AOD problem less recently

Kelly JF, Greene MC, Bergman BG, Hoeppner BB. Smoking cessation in the context of recovery from drug and alcohol problems: Prevalence, predictors, and cohort effects in a national U.S. sample
Kelly JF, Greene MC, Bergman BG, Hoeppner BB. Smoking cessation in the context of recovery from drug and alcohol problems: Prevalence

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 COMMUNICATION:** 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.
Thank you for your attention!