Examining Opioid Use Disorder Through the Lens of Recovery Research

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OUTLINE

- Prevalence of OUD, Tx, recovery
- Findings from RRI OUD research
- Ways to promote successful Tx / recovery
- Summary of Discussion
OUD-Related Prevalence Estimates

- Past year opioid misuse: 9.5 million Americans age 12+
- Past year OUD: 2.7 million Americans age 12+
- Tx receipt among past-year DUD
  - 13% received any Tx for illicit drug use
- Tx receipt among past-year OUD
  - 11% received MOUD Tx
• ~207 opioid overdose deaths per day (75,673 deaths per year)
• Economic burden of Rx opioid misuse in US
  • $78.5 billion a year
  • costs of healthcare, lost productivity, SUD treatment, criminal justice involvement

OPIOID USE DISORDER THROUGH THE LENSE OF...
OPIOID USE DISORDER THROUGH THE LENSE OF...
SUD Recovery

Full Remission from SUD

5% - 15% of U.S. population = ~25 to ~40 million adults (White, 2012).

~50% of those with lifetime SUD achieve remission

NSDUH: Perceived recovery

72.5% of adults with a lifetime substance use problem report being in recovery/recovered (i.e. 21 million people)
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
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.
What is the prevalence of alcohol or other drug problem resolution?
9.1% or 22.35 million Americans have resolved an alcohol or other drug problem
Primary Substance

- Alcohol: 59%
- Cannabis: 13%
- Cocaine: 11%
- Methamphetamine: 8%
- Opioids: 6%
- Other: 3%

Legend:
- Alcohol
- Cannabis
- Cocaine
- Methamphetamine
- Opioids
- Other
• What is the prevalence of OPI problem resolution?

• Pathways (Service Use)

• Psychological Well-being
~1.18 million US adults

~11.43 million US adults

Primary Substance

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

Other substances combined 3%
OPI VS. ALC

2 Recovery Durations

“Early Recovery” 0-1 years
“Mid Recovery” 1-5 years
Figure 1: Lifetime Use of Treatment & Recovery Services

% BY GROUP & YEAR

0-1 YRS. RECOVERY

1-5 YRS. RECOVERY

MAT Recovery Support Services Mutual Help Org. Formal Tx MAT Recovery Support Services Mutual Help Org. Formal Tx

Opioid Alcohol

*
<table>
<thead>
<tr>
<th>Current Service Use (Within Drug Group and Recovery Cohort)</th>
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<tbody>
<tr>
<td><strong>0–1 yrs</strong></td>
</tr>
<tr>
<td><strong>% (SE)</strong></td>
</tr>
<tr>
<td><strong>OPI</strong></td>
</tr>
<tr>
<td>Any mutual-help service (current)</td>
</tr>
<tr>
<td>Any non-12-step service</td>
</tr>
<tr>
<td>Any 12-step service</td>
</tr>
<tr>
<td>Alcoholics Anonymous (AA)</td>
</tr>
<tr>
<td>Narcotics Anonymous (NA)</td>
</tr>
<tr>
<td>Other 12-Step services (MA, CA, or CMA)</td>
</tr>
<tr>
<td>Any pharmacotherapy (current)</td>
</tr>
<tr>
<td>Methadone</td>
</tr>
<tr>
<td>Levomethadyl acetate (Orlaam)</td>
</tr>
<tr>
<td>Buprenorphine-naloxone (Suboxone)</td>
</tr>
<tr>
<td>Buprenorphine (Subutex)</td>
</tr>
<tr>
<td>Oral Naltrexone (Revia)</td>
</tr>
<tr>
<td>Long-acting injectable naltrexone (Vivitrol)</td>
</tr>
<tr>
<td>Acamprosate (Campral)</td>
</tr>
<tr>
<td>Nalmefene (Selincro)</td>
</tr>
<tr>
<td>Topiramate (Topamax)</td>
</tr>
<tr>
<td>Disulfiram (Antabuse)</td>
</tr>
<tr>
<td>Baclofen (Lioresal)</td>
</tr>
<tr>
<td>Other Pharmacotherapy</td>
</tr>
</tbody>
</table>

Values depict the distribution of individuals reporting mutual help service use in the past 90 days and current ongoing pharmacotherapy.

—. Significance testing not applicable (see text for more detail); ALC, individuals who resolved a primary alcohol problem; CA, Cocaine Anonymous; CMA, Crystal Methamphetamine Anonymous; MA, Marijuana Anonymous; NS, not significant; OPI, individuals who resolved a primary opioid problem.

Significant difference between OPI and ALC, within recovery cohort:

*P ≤ 0.01.

†P ≤ 0.05.
Figure 2. Current Self-Esteem

Psychological Well-Being
Table 3. Well-Being (Within Drug Group & Recovery Cohort)

<table>
<thead>
<tr>
<th></th>
<th>0-1 Years</th>
<th></th>
<th>1-5 Years</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>OPI</td>
<td>ALC</td>
<td>p</td>
<td>OPI</td>
</tr>
<tr>
<td>Non-SUD psychiatric Diagnosis (lifetime), % yes (SE)</td>
<td>51.83 (19.69)</td>
<td>43.40 (6.40)</td>
<td>NS</td>
<td>43.89 (14.33)</td>
</tr>
<tr>
<td>Psychological Distress (past 30 days), M(SE)</td>
<td>9.31 (1.96)</td>
<td>7.62 (0.73)</td>
<td>NS</td>
<td>6.56 (1.00)</td>
</tr>
<tr>
<td>Happiness (current), M(SE)</td>
<td>3.08 (0.32)</td>
<td>3.25 (0.11)</td>
<td>NS</td>
<td>3.54 (0.21)</td>
</tr>
<tr>
<td>Employed (current), % yes (SE)</td>
<td>77.58 (10.97)</td>
<td>62.69 (6.16)</td>
<td>NS</td>
<td>59.32 (12.30)</td>
</tr>
</tbody>
</table>
How Many Recovery Attempts Does it Take to Successfully Resolve an Alcohol or Drug Problem? Estimates and Correlates From a National Study of Recovering U.S. Adults

John F. Kelly, Martha Claire Greene, Brandon G. Bergman, William L. White, and Bettina B. Hoppner

Background: Alcohol and other drug (AOD) problems are commonly depicted as chronically relapsing, implying multiple recovery attempts are needed prior to remission. Yet, although a robust literature exists on quit attempts in the tobacco field, little is known regarding patterns of cessation attempts related to alcohol, opioid, stimulant, or cannabis problems. Greater knowledge of such estimates and the factors associated with needing fewer or greater attempts may have utility for health policy and clinical communication efforts and approaches.

Methods: Cross-sectional, nationally representative survey of U.S. adults (N = 39,889) who reported resolving a significant AOD problem (n = 2,002) and assessed on number of prior serious recovery attempts, demographic variables, primary substance, clinical histories, and indices of psychological distress and well-being.

Results: The statistical distribution of serious recovery attempts was highly skewed with a mean of 5.35 (SD = 13.41) and median of 2 (interquartile range [IQR] = 1 to 4). Black race, prior use of treatment and mutual-help groups, and history of psychiatric comorbidity were associated with higher number of attempts, and more attempts were associated independently with greater current distress. Number of recovery attempts did not differ by primary substance (e.g., opioids vs. alcohol).

Conclusions: Estimates of recovery attempts differed substantially depending on whether the mean (5.35 recovery attempts) or median (2 recovery attempts) was used as the estimator. Implications of this are that the average may be substantially lower than anticipated because cultural expectations are often based on AOD problems being “chronically relapsing” disorders implicating seemingly endless tries. Depending on which one of these estimates is reported in policy documents or communicated in public health announcements or clinical settings, each may elicit varying degrees of help-seeking, hope, motivation, and the use of more assertive clinical approaches. The more fitting, median estimate of attempts should be used in clinical and policy communications given the distribution.

Key Words: Recovery, Opioid Use Disorder, Quit Attempts, Alcohol Use Disorder, Remission.
Median = 2 attempts for all substances combined

Fig. 4. Number of recovery attempts 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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Substance use disorder

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 it 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 desirability 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 ...
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 (AUD) 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 AUD problem (n = 1,095). Weighted analyses estimated prevalence and tested correlates of label adoption. Qualitative analyses summarized reasons for prior recovery identity adoption/ nondiscovery. 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 AUD or other psychiatric disorders. Qualitative analyses regarding reasons for not/prior recovery identity found themes related to low AUD problem severity, viewing the problem as resolved, or having little difficulty of stopping. Despite increasing use of the recovery label and concept, many resolving AUD 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 AUD-related global burden of disease, AUD 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”

45%

- 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)
Recovery Identity

Table 2
Comparison of Individuals Self-Labeling as “Being in Recovery” Versus “Used to be” Versus “Never” in Recovery

<table>
<thead>
<tr>
<th>Variable</th>
<th>Currently in recovery (n = 936; 45.1%)</th>
<th>Used to be in recovery (n = 306; 15.4%)</th>
<th>Never in recovery (n = 753; 39.5%)</th>
<th>p</th>
<th>r²</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>SE</td>
<td>%</td>
<td>SE</td>
<td>%</td>
</tr>
<tr>
<td>Alcohol</td>
<td>53.72</td>
<td>2.39</td>
<td>54.05</td>
<td>4.09</td>
<td>47.20</td>
</tr>
<tr>
<td>Cannabis</td>
<td>9.23</td>
<td>1.69</td>
<td>9.03</td>
<td>2.08</td>
<td>13.68</td>
</tr>
<tr>
<td>Cocaine</td>
<td>9.27</td>
<td>1.21</td>
<td>10.67</td>
<td>2.41</td>
<td>10.64</td>
</tr>
<tr>
<td>Methamphetamine</td>
<td>7.73</td>
<td>1.39</td>
<td>8.70</td>
<td>2.52</td>
<td>6.22</td>
</tr>
<tr>
<td>Opioids</td>
<td><strong>7.06</strong></td>
<td>1.32</td>
<td><strong>5.16</strong></td>
<td>1.97</td>
<td>3.39</td>
</tr>
<tr>
<td>Other</td>
<td>4.02</td>
<td>.97</td>
<td>2.12</td>
<td>1.11</td>
<td>1.27</td>
</tr>
</tbody>
</table>

Legend:
- **Blue**: Never in recovery
- **Orange**: Used to be in recovery
- **Golden**: Currently in recovery
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. Claro 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 39,609; final weighted sample n = 2,000). 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 testing moderators (sex, race, primary substance of abuse). 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, 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 a opioid or other drug (e.g., stimulants) had substantially lower recovery capital in the early years; major depressive 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, Resumption, Alcohol Use Disorder, Quality of Life, National, Epidemiology.
15yrs

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

OPI & Other Drug: Equivalent recovery capital not achieved until around 3yrs

![Graph showing recovery capital by years since AOD problem resolved with a red line indicating 3 years.](image)

**Fig. 5.** Locally Weighted Scatterplot Smoothing (LOWESS) analysis of recovery indices by years since problem resolution stratified by primary substance.
1.2 million Americans resolved a significant opioid use problem

Additional, more intensive, ongoing service use to achieve longer-term recovery

Enhanced support to address deficits in self-esteem

Happiness, psychological distress, employment, psychiatric DXs similar to alcohol prob resolution
High variability in # of serious quit attempts, emphasizing heterogeneity

Less comfort disclosing status as someone who has resolved AOD problem

Most but not all identify as being in recovery now or in the past

Deficient QOL & recovery capital
How can we facilitate recovery from OUD?
Comprehensive Treatment Approaches

Source: NIDA

“The best treatment programs provide a combination of therapies and other services to meet the needs of the individual patient.”
Treatment Gains: Number of Individuals Receiving Pharmacotherapy for Opioid Use Disorder (NSDUH; 2019)
MOUD Treatment

• Unmet need for MOUD Tx
  • ~11% w/ OUD receive MOUD Tx
• WHY? → Barriers to MOUD receipt
  • Institutional, provider, policy, financial
  • Individual-level
    • Attitudes toward MOUD

PATIENT SELECTION OF TX TYPE (MARCUS ET AL., 2018)

MOUD Tx RETENTION (KAYMAN ET AL., 2006)

Likely to impact MOUD provision & use
MOUD Attitudes Among Recovering Individuals

• Clinical commentaries, qualitative studies, anecdotal
  • Touch on predominantly negative attitudes, especially for agonists
  • Positive Attitudes:

20%
RECOVERY FROM AOD PROBLEMS
(BERGMAN ET AL., 2020)

31%
OUT-OF-TREATMENT OUD
(SCHWARTZ ET AL., 2008)

32-51%
OXFORD HOUSE RESIDENTS
(MAJER ET AL., 2008)

30-40%
BLACK & LATINO/A, IV USE
(ZALLER ET AL., 2009)
MOUD ATTITUDES & RCCs

• RCCs: a promising venue for fostering MOUD support?
  • Especially inclusive
    • Do not follow a particular recovery model (e.g., 12-step)
    • “Many pathways [to recovery], all should be celebrated”
    • Member OUD prevalence
Primary Substance among RCC Attendees

- Opioids: 41%
- Alcohol: 38%
- Cocaine: 9%
- Cannabis: 5%
- Other or none: 7%

Primary Substance

Primary Substance RCCs

- **Opioids**: 41%
- **Alcohol**: 38%
- **Cocaine**: 9%
- **Cannabis**: 5%
- **Other or none**: 7%

Primary Substance NRS

- **Opioids**: 23%
- **Alcohol**: 51%
- **Cocaine**: 11%
- **Cannabis**: 10%
- **Other or not reported**: 5%

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Do RCCs offer an environment that is supportive and accepting of individuals using medications for OUD Tx?
Medication Treatment for Opioid Use Disorder: Medication Attitudes at RCCs
Methods

• Cross-sectional survey
  • Data collection: 2016-2017

• Participants: 336 recovering, adult RCC attendees

• RCCs: 31 across New England region
Methods

**Agonist MOUD**
“It is a good idea for someone with an OPIOID problem to take a substitute opioid medication like Suboxone or methadone to help them stop using”

**Antagonist MOUD**
“It is a good idea for someone with an OPIOID problem to take an opioid blocking medication like naltrexone/Vivitrol to help them stop using”

**AUD**
“It is a good idea for someone with an ALCOHOL problem to take a medication to help them stop drinking”

**Mood Disorders**
“It is a good idea for someone with an EMOTIONAL problem to take a medication to help”
Negative Attitude

• Likert scale (1 – 6)

Positive Attitude
MOUD Attitudes: NRS Unpublished Data
MOUD Attitudes: Direct Comparison

Attitudes Toward MOUD: NRS

% of individuals w/ positive vs. negative attitudes

Attitudes Toward MOUD: RCCs

% of RCC attendees

Agonist MOUD (N=318)

Antagonist MOUD (N=315)
One-Stop Shopping for Recovery: An Investigation of Participant Characteristics and Benefits Derived From U.S. Recovery Community Centers

John F. Kelly, Robert L. Stout, Leonard A. Jason, Néider Fallah-Sohy, Lauren A. Hoffman, and Bettna B. Hoepner

Background: Recovery community centers (RCCs) are the “new kid on the block” in providing addiction recovery services, adding a third tier to the 2 existing tiers of formal treatment and mutual-help organizations (MHOs). RCCs are intended to be recovery hubs facilitating “one-stop shopping” in the delivery of recovery capital (e.g., recovery coaching, employment-education linkages). Despite their growth, little is known about who uses RCCs, what they use, and how use relates to improvements in functioning and quality of life. Greater knowledge would inform the field about RCC’s potential clinical and public health utility.

Methods: Online survey conducted with participants (N = 336) attending RCCs (8-31) in the northeastern United States. Substance use history, services used, and derived benefits (e.g., quality of life) were assessed. Systematic regression modeling tested prior theorized relationships among variables.

Results: RCC members (N = 336) were on average 41.1 ± 12.4 years of age, 50% female, predominantly White (76.6%), with high school or lower education (68.8%), and limited income (45.2% < $30,000 post-year household income). Most had either a primary opioid (32.7%) or alcohol (26.5%) problem. Just under half (48.3%) reported a lifetime psychiatric diagnosis. Participants had been attending RCCs for 2.6 ± 1.4 years, with many attending <1 year (33.4%). Most commonly used aspects were the socially oriented mutual-help peer groups and volunteering, but technological assistance and employment assistance were also common. Conceptual model testing found RCCs associated with increased recovery capital, but not social support; both of these theorized proximal outcomes, however, were related to improvements in psychological distress, self-esteem, and quality of life.

Conclusions: RCCs are utilized by an array of individuals with few resources and primary opioid or alcohol histories. Whereas strong social supportive elements were common and highly rated, RCCs appear to play a more unique role not provided either by formal treatment or by MHOs in facilitating the acquisition of recovery capital and thereby enhancing functioning and quality of life.

Keywords: Recovery Community Centers, Recovery, Addiction, Support Services, Recovery Coaching, Addiction, Substance Use Disorder.
BENEFITS OF RCC ATTENDANCE

RCC attendance

Enhanced recovery capital
(i.e. resources for recovery)

Lower psychological distress
Higher self-esteem
Higher quality of life
Peer recovery coaches in general medical settings: Changes in utilization, treatment engagement, and opioid use

Jessica F. Magidson, Susan Regan, Elizabeth Powell, Helen E. Jack, Grace E. Herman, Christopher Zaro, Martha T. Kane, Sarah E. Wakenen

ABSTRACT

Recovery coaches, trained peers with a history of substance use disorders (SUD) who are locally embedded in the health care team, may be a cost-effective approach to support outpatient management of SUD treatment. Although recovery coach programs are scaling nationwide, limited data exist to support their impact on clinical outcomes. This study aimed to evaluate the integration of peer recovery coaches in general medical settings. Staff hired and trained to serve recovery coaches as a part of a health system-wide effort to reduce SUD cases. We examined reflexions in acute care utilization and increases in opioid treatment utilization among patients connected to a recovery coach. Additionally, we examined buprenorphine treatment engagement and opioid utilization among a subset of patients who initiated buprenorphine prior to us within 30 days of their first recovery coach contact. We hypothesized recovery coach contact would strengthen outpatient SUD treatment and be associated with reductions in ED visits and preventable acute care utilization. We included patients with an initial recovery coach contact between January 2015 and September 2017 in the main analyses (n = 1173). We measured utilization outcomes via medical records over one year, comparing the six months before and after first recovery coach contact. We used cluster-robust to account for clustering due to buprenorphine treatment engagement for the subset of patients initiated buprenorphine (n = 119). In the six months following recovery coach contact, there was a 48% decrease in patient hospitalization and a 19% decrease in patients with an ED visit. There was a 36% increase in opioid utilization among primary care, community health center visits, mental health, and laboratory visits. Among patients who initiated buprenorphine, current recovery coach contact was associated with significantly increased odds of buprenorphine treatment engagement (OR = 1.80; 95% CI: 1.49-2.19, p < 0.001) and opioid utilization (OR = 1.32; 95% CI: 1.60-2.37, p < 0.001). Recovery coaches may be an important and potentially cost-effective addition to an SUD care team, but future research is needed that uses a matched comparison design.
• Recovery Coaches
  • Motivation
  • Overcome barriers to care & behavior change
  • Help w/ navigating systems
  • Offer harm reduction
  • Provide social support

44% in hospitalizations
9% in ED visits

66% in outpatient service use
89% greater odds of BUP Tx engagement
32% greater odds of opioid abstinence
Mutual Help Organizations

Weiss et al., 2019
Odds Ratios: Likelihood of Being Abstinent Compared Between Treatment Types to Individuals Not in Treatment

Abstinence Rates (Odds Ratios)

- 18 Months: 5.38x
- 30 Months: 4.63x
- 42 Months: 2.34x

Time in Treatment

- Opioid Agonist Treatment
- Mutual-Help Participation
- Outpatient Counseling

MHO attendees & abstinence
### Table 2: Self-help attendance and abstinence (%) from opiates, stimulants and alcohol at 1, 2 and 4–5 years follow-up.

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<thead>
<tr>
<th></th>
<th>1 year</th>
<th>2 years</th>
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<tbody>
<tr>
<td></td>
<td>No self-help</td>
<td>Self-help</td>
</tr>
<tr>
<td>Opiates</td>
<td>(n = 107)</td>
<td>(n = 35)</td>
</tr>
<tr>
<td>Stimulants</td>
<td>60</td>
<td>86</td>
</tr>
<tr>
<td>Alcohol</td>
<td>34</td>
<td>63</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>No self-help</td>
<td>Self-help</td>
</tr>
<tr>
<td>Opiates</td>
<td>(n = 114)</td>
<td>(n = 28)</td>
</tr>
<tr>
<td>Stimulants</td>
<td>58</td>
<td>75</td>
</tr>
</tbody>
</table>

Gossop et al., 2007
Other mechanisms for promoting recovery

Post overdose outreach teams in the ED (peer recovery coaches, licensed paramedics) for Tx engagement, retention, overdose prevention (Langabeer et al., 2020)

Peer outreach workers in recovery to help connect individuals to MOUD Tx (Scott et al., 2020)

Individual therapy or contingency management during MOUD to promote abstinence & prevent overdose (Harvey et al., 2020; Fairley et al., 2021)
Summary

- 1.18 Million Americans resolved sig. OPI prob
- OPI may require additional or more intensive services to achieve longer-term recovery
- OPI > 1 Yr. recovery may need enhanced support to address deficient self-esteem
- Number of recovery attempts may be somewhat greater or more variable for OPI (additional study needed)
- OPI have the lowest levels of comfort disclosing their recovery status
- OPI have deficient recovery capital in the first 3 years of problem resolution
- About 60% of OPI currently identify as “in recovery” – ¼ never identified as “in recovery”
Facilitate recovery w/ combination of clinical Tx, non-clinical RSS, continuing care, recovery monitoring

Evidence-based Tx: MOUD; reduce barriers, enhance access, promote retention

RCCs may be a particularly accepting environment for MOUD patients – positive MOUD attitudes

RCC attendance might address deficient recovery capital to promote increased self-esteem / well-being

Recovery coaches at practices: ↑ appt. attendance, MOUD retention, abstinence; ↓ hospitalizations, ED visits

MHOs benefit short & long-term abstinence (independent, additive benefits compliment MOUD)

Much to be learned from recovery research to guide Tx & recovery efforts
Questions or Comments?