

Recovery-oriented Methadone Maintenance

By William L. White, M.A. and Lisa Mojer-Torres, J.D.

Executive Summary

Great Lakes Addiction Technology Transfer Center

Philadelphia Department of Behavioral Health and Mental Retardation Services

Northeast Addiction Technology Transfer Center

DRAFT

Published by the Great Lakes Addiction Technology Transfer Center, the Philadelphia Department of Behavioral Health and Mental Retardation Services, and the Northeast Addiction Technology Transfer Center

Great Lakes Addiction Technology Transfer Center
Jane Addams College of Social Work
University of Illinois at Chicago
1640 West Roosevelt Road, Suite 511 (M/C 779)
Chicago, Illinois 60608-1316

2010

This publication was written by William L. White and Lisa Mojer-Torres and jointly published by the Great Lakes Addiction Technology Transfer Center, the Philadelphia Department of Behavioral Health and Mental Retardation Services, and the Northeast Addiction Technology Transfer Center, in part under a cooperative agreement with the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT). All material appearing in this publication except any taken directly from copyrighted sources is in the public domain and may be reproduced or copied without permission from SAMHSA/CSAT or the authors. Citation of the source is appreciated. Do not reproduce or distribute this publication for a fee without specific, written authorization from the Great Lakes Addiction Technology Transfer Center. For more information on obtaining copies of this publication, call (312) 996-0966.

At the time of publication, Pamela S. Hyde, JD served as the Administrator, Substance Abuse and Mental Health Services Administration, United States Department of Health and Human Services; H. Westley Clark, MD, JD, MPH, served as CSAT Director; Catherine D. Nugent, M.S., M.S., LCPC, CP/PAT, served as Chief, Quality Improvement and Workforce Development Branch, Division of Services Improvement, SAMHSA/CSAT; and Donna M. Doolin, LSCSW, served as the ATTC Project Officer/Public Health Advisor, Quality Improvement and Workforce Development Branch, Division of Services Improvement.

The opinions expressed herein are the views of the authors and do not necessarily reflect the official position of these sponsoring agencies. No official support of or endorsement by any of the agencies for these opinions or for particular resources described in this document is intended or should be inferred. The guidelines in this document should not be considered substitutes for individualized client care and treatment decisions.

Produced under a grant funded by the Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services
Center for Substance Abuse Treatment, 5600 Fishers Lane
Rockwall II, Suite 618, Rockville, Maryland 20857, 301.443.5052
Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the agency.



Grant No. 5 UD1 T1013593-08

Recovery-oriented Methadone Maintenance

By William L. White, MA and Lisa Mojer-Torres, JD

Executive Summary

Introduction

There are growing calls to shift the acute-care model of addiction treatment to a model of sustained recovery support analogous to the long-term management of other chronic diseases. The purpose of this series of papers is to explore what this shift means to the design and delivery of methadone maintenance (MM) treatment and the status of MM treatment and MM patients in the United States.

This series has two primary audiences. For addiction treatment professionals and recovery support specialists who have not worked in methadone maintenance treatment, our goals are to:

- provide a primer on the historical evolution and scientific status of MM treatment,
- explore the controversies surrounding recovery status and methadone maintenance, and
- enlist readers' support for a model of recovery-oriented methadone maintenance (ROMM).

For addiction treatment professionals, recovery support specialists, and patients and their families directly involved with MM treatment, our goals are to:

- document the dissipation of recovery orientation within the evolution of MM treatment,
- engage readers' support to revive and extend such a recovery orientation,
- discuss MM in the context of recent efforts to define and measure addiction recovery,
- describe core clinical practices within MM that would change in the shift toward a model of ROMM, and
- outline strategies to address the professional and social stigma attached to methadone, MM treatment, and MM patients.

Recovery-oriented Methadone Maintenance:

I. Historical Context

Summary of Key Points

Recovery-oriented Methadone Maintenance

Recovery-oriented methadone maintenance (ROMM) is an approach to the treatment of opioid addiction that combines methadone pharmacotherapy and a sustained menu of professional and peer-based recovery support services to assist patients and families in initiating and maintaining long-term addiction recovery—recovery defined here as remission of primary and secondary substance use disorders, enhancement of personal/family health and functioning, and positive community reintegration.

Distinctiveness of ROMM

ROMM provides an alternative to acute care (heroin detoxification or short-term maintenance) and palliative care (medication maintenance as a strategy of personal pacification and social control). ROMM is a person-centered model of long-term recovery management.

Opioid Addiction as a Chronic Disease

It was the dream of those who developed methadone maintenance that chronic opioid addiction would one day be addressed with the same treatment philosophies and strategies used to manage other chronic medical disorders. Within this framework, the methadone maintenance patient is viewed on par with patients requiring normalizing doses of insulin, anti-convulsive medication, or hypertensive medication and psychosocial support services. Fulfillment of that vision has been thwarted by the strong anti-medication bias that pervades the history of addiction treatment and recovery in the United States.

Early Treatment History

The treatment of opioid addiction in the United States spans nineteenth-century institutional treatment (inebriate homes, inebriate asylums, and private addiction cure institutes); detoxification by private physicians; exotic and sometimes lethal medical withdrawal procedures; fraudulent proprietary home cures; early twentieth-century morphine maintenance clinics; mid-twentieth-century prison-based treatment (“narcotics farms”); and experiments with aversive conditioning, electroconvulsive treatments, psychosurgery, and psychoanalysis. All were characterized by high rates of resumed opioid addiction following treatment cessation.

The Context for Methadone Treatment

Methadone maintenance was pioneered in the mid-1960s in the wake of a dramatic rise in heroin addiction following the Second World War. Therapeutic pessimism regarding traditional approaches to treatment prompted calls by major policy bodies for new experiments in the maintenance of persons chronically addicted to heroin. Methadone maintenance developed amidst competing approaches to this problem: mass incarceration, Narcotics Anonymous, ex-addict-directed therapeutic communities, hospital-based detoxification, alternative pharmacotherapies, experiments with civil commitment, and faith-based outpatient counseling clinics.

The Origin of Methadone Maintenance

Methadone maintenance (MM) was pioneered in 1964 by Dr. Vincent Dole, Dr. Marie Nyswander, and Dr. Mary Jeanne Kreek at Rockefeller Institute for Medical Research (now Rockefeller University) and Rockefeller Hospital. Following early studies on its safety and effectiveness, MM was integrated into multi-modality treatment systems in New York, Illinois, Connecticut, Massachusetts, Pennsylvania, and Washington D.C. and then more widely disseminated in the 1970s within a growing national network of addiction treatment programs in the United States.

Early Theoretical Foundations

MM was based on a metabolic theory of addiction that viewed heroin addiction as a genetically influenced, chronic brain disease requiring sustained medical management—a problem of sickness rather than sinfulness. Metabolic stabilization and maintenance (via individualized, optimal daily oral doses of methadone) were viewed as essential for most patients to achieve successful long-term recovery. MM was defined as “corrective but not curative.” It was believed that many, if not most, MM patients would require prolonged if not lifelong pharmacotherapy to sustain their recoveries. In the early-stage theory of MM treatment, biological stabilization was expected to be followed by psychosocial rehabilitation and community reintegration—processes requiring a broad menu of ancillary services and supports.

Early Recovery Orientation

Recovery-oriented practices (those now known to be linked to elevated long-term recovery outcomes) within the early MM model included: 1) rapid access to treatment in early sites (e.g., New York City, Washington D.C.); 2) patient involvement in clinical decision-making; 3) methadone doses (usually 80-120 mgd with no dose ceilings) capable of suppressing withdrawal distress, reducing craving, and inducing a “blockade effect” to other opioids; 4) therapeutic responses to any continued drug use; 5) a chronic care perspective that placed no arbitrary limits on duration of MM participation; 6) emphasis on creating a strong therapeutic alliance with each patient; 7) use of recovering staff as role models; 8) development of programs for populations with special needs; and 9) the broader mobilization of community resources to respond to addiction, including long-term recovery support needs.

Diffusion of MM

Public and political alarm about heroin-related crime and about heroin use by U.S. soldiers in Vietnam spurred federal investment in addiction treatment and the subsequent diffusion of methadone maintenance in the United States. The number of methadone patients in the U.S. grew from fewer than 400 patients in 1968 to more than 80,000 patients in 1976, with much of that expansion occurring in New York City.

Decreased Recovery Orientation

The regulation and mass diffusion of MM in the 1970s and 1980s was accompanied by changes in treatment philosophy and clinical protocols. The most significant of these changes in terms of recovery orientation included a shift in emphasis from personal recovery to reduction of social harm; increased preoccupation with regulatory compliance; widening variation in the quality of MM programs; the reduction of average methadone doses to subtherapeutic levels;

arbitrary limits on the length of MM treatment; pressure on patients to taper and end MM treatment; the erosion of ancillary medical, psychiatric, and social services; and a decreased emphasis on therapeutic alliance between MM staff and MM patients. The definition of *recovery* during this period shifted from a focus on global health and functioning to an almost exclusive preoccupation with abstinence—then defined as including cessation of methadone pharmacotherapy. The public face of MM became defined by the worst MM clinics and the least stabilized MM patients. Professional, political, and public support for MM as a medical treatment for opioid addiction declined through the late 1970s and early 1980s until the value of MM was revived in the late 1980s as a public health strategy to address the spread of HIV/AIDS. In spite of these challenges, many MM treatment staff continued to promote a vision of recovery, and many MM patients achieved but were forced to hide their achievement of that vision to avoid the social and professional stigma attached to MM.

Methadone Critics

The inevitable backlash to early media reports of methadone as a miracle cure for heroin addiction spawned numerous critics of methadone maintenance treatment. Critics of medication-assisted treatment, many of whom were competing for cultural and economic ownership of the problem of heroin addiction, alleged that MM: 1) substitutes one drug/addiction for another; 2) conveys a societal attitude of permissiveness towards drug use; 3) fails to address the characterological or social roots of heroin addiction; 4) cognitively, emotionally, and behaviorally impairs MM patients; 5) is a tool of racial oppression and genocide; 6) is financially exploitive; and 7) as a result of these factors, is morally unacceptable.

The Revitalization of MM

Since the early 1990s, there has been a revitalization of MM in the United States. This process has included: 1) the scientific reaffirmation of the effectiveness of MM by prominent scientific, professional, and governmental bodies; 2) increased advocacy efforts by MM patients; 3) an expansion of national MM treatment capacity—most notably within the private sector; 4) national efforts to professionalize and elevate the quality of newly rechristened and accredited Opioid Treatment Programs (OTPs); and 5) an expansion of pharmacotherapy choices in the treatment of opioid addiction, e.g., buprenorphine/Suboxone/Subutex. These developments occurred amidst renewed efforts to publicly and professionally portray opioid addiction as a brain disease that can be medically managed with the aid of methadone and other pharmacotherapies. In spite of such advancements, resistance and hostility toward methadone continue from many quarters.

Recovery-oriented Methadone Maintenance

Two trends are reshaping the future of MM in the United States: 1) a clearer articulation of addiction as a chronic disorder that is best treated through methods used to manage other chronic disorders, and 2) the emergence of recovery as an organizing paradigm for the addictions field. If sustained, these trends will profoundly change the nature of all addiction treatment, including MM treatment.

The Future of MM

The future of MM in the United States rests on the collective ability of OTPs to forge a more person-centered, recovery-focused medical treatment for opioid addiction and to confront

methadone-related social stigma through assertive campaigns of public education and political/professional influence. It also rests on the mobilization of a grassroots advocacy movement of MM patients and their families. An important next step in the developmental history of MM is to define *recovery* within the context of methadone maintenance and within the broader pharmacotherapeutic treatment of substance use disorders.

Recovery-oriented Methadone Maintenance: II. Recovery and Methadone

Summary of Key Points

Defining Recovery within the Context of MM

Controversy and stigma continue to surround the use of methadone maintenance as a medical treatment of opioid addiction, in spite of more than four decades' worth of scientific evidence of its effectiveness. Methadone patients continue to be socially marginalized, and their recovery status continues to be debated—even within the professional field of addiction treatment and within communities of recovery. The question of the recovery status of methadone patients cannot be answered without a clear understanding of what constitutes *recovery* from opioid addiction. The definition of recovery applied to the patient in medication-assisted recovery from opioid addiction should be the same as that applied to recovery from any other substance use disorder.

Recovery as More than Intent

Recovery from opioid addiction is more than exhibiting motivation to stop or decelerate drug use. Defining recovery in terms of “he/she is trying” sets a low bar for expectations related to the methadone maintenance patient’s health, functioning, and quality of life. Defining recovery only as a motivational state also contributes to the professional and social stigma attached to methadone, MM treatment, and the MM patient and inhibits MM patients’ positive reintegration into the community.

Recovery as More than Remission

Recovery from opioid addiction is also more than remission, with remission defined as the sustained cessation or deceleration of opioid and other drug use/problems to a subclinical level—no longer meeting diagnostic criteria for opioid dependence or another substance use disorder. Remission is about the subtraction of pathology; recovery is ultimately about the achievement of global (physical, emotional, relational, spiritual) health, social functioning, and quality of life in the community.

Core Elements of Recovery

Recent attempts to define addiction recovery (e.g., Betty Ford Institute Consensus Conference, CSAT Recovery Summit, United Kingdom Drug Policy Commission) have focused on three essential elements: a) the resolution of drug-related problems (most often measured in terms of sobriety/abstinence or diagnostic remission), b) improvement in global health, and c) citizenship (positive community re-integration).

Methadone and Recovery

There is growing professional consensus that the stabilized methadone maintenance patient who does not use alcohol or illicit drugs, and who takes methadone and other prescribed drugs only as indicated by competent medical practitioners, meets the first criterion for recovery. MM patients stabilized on medically supervised, individualized, optimum doses do not experience euphoria, sedation, or other functional impairments from the use of methadone as a medication. For the stabilized MM patient, methadone is NOT a substitute for heroin: the motivations for, effects of, and cultural symbolism of using methadone as a medication are vastly different from those associated with heroin use.

Distinguishing Physical Dependence and Addiction

Physical dependence and addiction are not the same: the stabilized methadone maintenance patient—here defined as the patient who does not use alcohol or illicit drugs and takes methadone and other prescribed drugs only as indicated by competent medical practitioners—does not, like many pain patients maintained on opioid medications, meet key definitional criteria for addiction (e.g., obsession with using, loss of volitional control over use, self-accelerating patterns of use, compulsive use in spite of escalating consequences).

Recovery Status of the MM Patient

Denying “abstinence” or “drug free” status to stabilized MM patients (who do not use alcohol or illicit drugs and who take methadone and other prescribed drugs only as indicated by competent medical practitioners) based solely on their status as methadone patients inhibits rather than supports their long-term recoveries.

Varieties of Medication-Assisted Recovery

For stabilized MM patients, continued methadone maintenance or completed tapering and sustained recovery without medication support represent varieties/styles of recovery experience and matters of personal choice, not the boundary and point of passage from the status of addiction to the status of recovery.

MM Patient and Communities of Recovery

The stabilized MM patient is caught in an ambiguous world—separated from cultures of active drug use, denied full membership in cultures of recovery, and socially stigmatized in the larger community. It is time for recovering MM patients to be welcomed into full membership in the culture of recovery and afforded opportunities to pursue full citizenship in their local communities.

Family Recovery in the MM Context

Rarely has the concept of recovery been applied to the families of MM patients. Opioid addiction severely wounds family and kinship relationships—wounds that feed the intergenerational transmission of drug-related problems. Family recovery involves healing those wounds; reconstructing family roles, rules, and relationships; and enhancing the resistance/resilience/health of all family members. The ultimate aim of family recovery is breaking the intergenerational transmission of drug-related problems.

Seeking a Vanguard of MM Patients

It is unlikely that the recovery status of the MM patient will be fully embraced by policy makers, the public, addiction professionals, and recovery communities until a vanguard of present and former MM patients and their families stand together to offer living proof of the role methadone can play in long-term recovery from opioid addiction. The faces and voices of healthy, fully functioning MM patients will be the most powerful antidotes to the stigma attached to opioid addiction and methadone maintenance treatment.

Multiple Pathways of Recovery

There are multiple pathways and styles of long-term addiction recovery, and all should be cause for celebration. The MM patient who is stabilized on his/her optimal dose of methadone, abstains from the use of alcohol and other intoxicating drugs, and shows evidence of improving global health and social functioning is in recovery or recovering. Long-term recoveries from opioid addiction with or without the use of methadone (or naltrexone or buprenorphine/Suboxone/Subutex) represent personal styles of recovery and should not be framed in categories of superiority or inferiority, right or wrong, or recovery inclusion or recovery exclusion. Rather than a source of disqualification from recovery status, methadone, provided as a medication under competent medical supervision at proper dosages with appropriate ancillary psychosocial support services, aids long-term recovery from opioid addiction and should be so recognized.

Recovery Definition and the Design of Opioid Treatment Programs

Achieving this vision of recovery as remission, global health, and citizenship for the mass of MM patients will require expanding and elevating the range and quality of clinical and peer-based recovery support services available to MM patients and their families. It will also require creating the physical, psychological, and cultural space in local communities within which medication-assisted recovery can flourish.

Recovery-oriented Methadone Maintenance: III. A Vision Statement

Summary of Key Points

The Management of Chronic Disease

Addiction to heroin or other short-acting exogenous opioids shares many of the characteristics of other chronic illnesses. Principles and practices that characterize the effective management of other chronic primary diseases can be adapted to effectively manage and improve long-term recovery outcomes in the treatment of chronic opioid addiction.

Methadone Maintenance and Recovery Management

Recapturing and extending methadone maintenance as a person-centered, recovery-focused treatment of opioid addiction—referred to here as recovery-oriented methadone maintenance (ROMM)—will require a realignment of addiction- and recovery-related concepts, a realignment of core clinical and recovery support practices, and a realignment of the context in which treatment occurs (e.g., policies, regulatory guidelines, funding mechanisms, community recovery support resources). Eight arenas of service practice will be profoundly transformed in the move toward ROMM: 1) attraction, access, and early engagement; 2) assessment and service

planning; 3) service team composition; 4) service relationships; 5) service quality and duration; 6) locus of service delivery; 7) assertive linkage to recovery community resources; and 8) long-term recovery check-ups, stage-appropriate recovery support, and when needed, early re-intervention.

Attraction, Access, and Early Engagement/Retention

Methadone maintenance treatment voluntarily attracts more people addicted to heroin and other short-acting opioids than any other addiction treatment modality, but most people in need of treatment for opioid addiction are not currently in treatment, will seek treatment only at late stages of their addictions, will drop out of treatment before optimum therapeutic effects are achieved, and will experience prolonged addiction/treatment careers before recovery stability is achieved. A key strategy of ROMM is to attract, engage, and retain patients at the earliest stages of problem development, toward the twin goals of shortening addiction careers and extending recovery careers. Promising practices in enhancing treatment attraction include educational campaigns to reach injection drug users, designed to dispel myths and misconceptions about MM treatment, and assertive community outreach teams that provide visible role models of medication-assisted recovery, engage active users in a “recovery priming” process, mobilize family and kinship support, and resolve obstacles to treatment participation. Access to MM could be increased via expanded public and private funding of MM treatment, distribution of coupons for free treatment, reduction of regulatory obstacles that inhibit rapid access, expedited admission (e.g., interim maintenance—methadone without counseling), and moving stabilized patients to medical maintenance (methadone provided by trained primary care physicians). Promising practices related to engagement and retention in MM include individualized and higher methadone doses (above 60 mgd), increased patient choices, telephone and email prompts following missed appointments, patient education related to the safety and benefits of MM, provision of sustained peer-based recovery coaching, and provision of mental health services for co-occurring mental illness.

Assessment and Service Planning

Practices aimed at increasing the recovery orientation of the assessment and service planning process within MM treatment include shifting from categorical to global assessment instruments and interview protocols; defining the family (as defined by the patient) rather than the individual as the unit of service; using a strengths-based assessment process to identify personal, family, and community/cultural assets that can be mobilized to support recovery initiation and maintenance; viewing assessment as a continual rather than a single-point-in-time intake process (based on the understanding that service needs change across the developmental stages of recovery); and transitioning from professionally directed treatment plans to patient-directed recovery plans.

Composition of the Service Team

Treatment of chronic diseases, in contrast with the treatment of acute disease or trauma, involves a broader multidisciplinary team and a greater emphasis on peer-support for long-term recovery management. Implementing models of ROMM will involve key staffing changes within OTP programs, including a greater role of addiction medicine specialists in patient/family/community education, increased involvement of primary care physicians, co-location of OTPs and primary health care clinics, greater inclusion of family/child therapists,

increased use of current and former patients in medication-assisted recovery as staff and volunteers, and the use of indigenous healers drawn from diverse cultural communities, e.g., leaders of recovery-focused religious and cultural revitalization movements.

The Service Relationship

Service relationships within chronic disease management are distinctive in their duration (measured in years or decades), the degree of intimacy that develops between the service providers and the patient and family, and the broader focus of the relationship—the global health and functioning of the patient and family rather than treatment of a particular health defect. Positive indicators of recovery-oriented service relationships include increased levels of recovery representation at OTP governance, leadership, and service delivery levels; respect for patient opinions and preferences via a choice philosophy; changes in administrative discharge policies; reduced incidence of administrative discharges and other premature disengagements from service; elevating patients' hopes and possibilities; transitioning patients from professionally directed treatment plans to patient-directed recovery plans; and an emphasis on sustained continuity of contact and support across the stages of long-term recovery.

Service Quality/Duration

ROMM involves ensuring six critical areas of service practice: 1) dosing policies that ensure safe induction (optimum, individualized, and effective dose stabilization); 2) addiction counseling that is focused on building and sustaining a recovery process/partnership rather than the mechanics of dosing or service contact documentation; 3) expanding ancillary resources to address co-occurring medical, psychiatric, and other substance-related problems; vocational/employment/education needs; need for peer-based recovery support; and the needs of patients' families/children; 4) ensuring an adequate period of dose stabilization and psychosocial rehabilitation before any efforts to taper from MM (at least 1-2 years to achieve the best long-term recovery outcomes) and offering increased supports during and following the cessation of methadone maintenance; 5) increasing the percentage of MM patients who successfully complete treatment; and 6) building a strong culture of recovery within the MM service milieu.

The Locus of Service Delivery

ROMM anticipates a greater focus on delivery of recovery support services outside the clinic and the greater integration of medication and other recovery support services within non-stigmatized community environments. Promising practices in this area include shifting from siloed OTPs toward the integration of MM within comprehensive addiction treatment and recovery support centers, the expansion of office-based treatment and medical maintenance, and greater use of neighborhood- and home-based recovery support services. The focus of ROMM is on firmly nesting recovery within the natural environment of each patient or in helping develop an alternative environment in which long-term recovery can be nurtured.

Assertive Linkage to Recovery Community Resources

Peer-based recovery support resources are growing rapidly in the United States via the expanding network of addiction recovery mutual aid groups, the philosophical diversification of these groups, the emergence of a new addiction recovery advocacy movement, new recovery community institutions, and the emergence of new peer-based service roles (e.g., the recovery

coach). Promising practices for ROMM in this area include active liaison between OTPs and the service committees of local recovery mutual aid societies, encouraging/supporting the development of groups specifically for persons in medication-assisted recovery, assertive linkage of patients to the resources of local communities of recovery (including medication-friendly recovery support meetings), using volunteer or paid peer recovery coaches to facilitate patient connections to recovery community resources, coaching patients on ways of addressing medication issues at recovery support meetings, hosting onsite peer recovery support meetings at or near OTPs, sponsoring educational events on medication-assisted recovery for recovery community members, inclusion of indigenous healers and healing practices within OTPs, using patient/alumni councils to visibly celebrate patient recovery milestones, and visibly participating (OTP staff and MM patients/families) in local recovery celebration events.

Long-term Recovery Check-Ups; Stage-Appropriate Recovery Education and Support; and, When Needed, Early Re-Intervention

Most people addicted to opioids experience prolonged addiction careers marked by cycles of treatment, periods of abstinence, resumption of opioid addiction, and treatment re-entry. Assertive approaches to in-treatment and post-treatment monitoring significantly enhance long-term recovery outcomes. We envision a future in which a system of recovery check-ups, peer-based recovery support, stage-appropriate recovery education, assertive linkage to communities of recovery, and early re-intervention will reduce post-treatment mortality and enhance the long-term recovery outcomes of MM patients.

Summary

Put simply, ROMM seeks to:

- attract people at an earlier stage of problem development via programs of assertive community education, screening, and outreach;
- ensure rapid service access for individuals and families seeking help;
- resolve obstacles to initial and continued treatment participation;
- achieve safe, individualized, optimum dose stabilization;
- engage and retain individuals and families in a sustained recovery-focused service and support process;
- assess patient/family needs using assessment protocols that are global, family-centered, strengths-based, and continual;
- transition each patient from a professionally directed treatment plan to a patient-directed recovery plan;
- expand the service team to include primary care physicians, psychologists, social workers, peer recovery support specialists, and indigenous healers;
- shift the service relationship from a professional/expert model to a long-term recovery partnership/consultation model marked by mutual respect, hope, and emotional authenticity;
- ensure minimum (at least one year) and optimum (individualized) duration of treatment via focused retention strategies and assertive responses to early signs of disengagement;
- shift the treatment focus from an episode of care to the management of long-term addiction/treatment/recovery careers;

- expand the service menu to include ancillary medical/psychiatric/social services and non-clinical, peer-based recovery support services;
- extend the locus of service delivery beyond the OTP to non-stigmatized service sites and neighborhood-based, church-based, work-based, home-based, and technology-based (phone/Internet) recovery support services;
- assertively link patients/families to recovery community support resources;
- engage the community through anti-stigma campaigns and recovery community development activities;
- provide post-treatment monitoring and support and stage-appropriate education, support, and (if and when needed), early re-intervention for all patients regardless of discharge status; and
- evaluate MM treatment using proximal and distal indicators of long-term personal and family recovery.

Care will need to be taken to avoid potential unintended consequences of this heightened recovery orientation, e.g., the abandonment of patients who do not share this vision of a recovery-transformed life.

Recovery-oriented Methadone Maintenance:

IV. Long-Term Strategies to Reduce the Stigma Attached to Addiction, Treatment, and Recovery within the City of Philadelphia (With Particular Reference to Medication-Assisted Treatment/Recovery)

Summary of Key Points

Introduction

This paper, developed for the Philadelphia Department of Behavioral Health and Mental Retardation Services (DBHMRS): 1) reviews the historical and scientific research on the social/professional stigma related to addiction, with a particular focus on the stigma experienced by people in medication-assisted recovery; and 2) outlines strategies that could be used by DBHMRS and its many community partners to reduce addiction/recovery-related stigma.

Stigma Basics

Research on the social stigma related to addiction can be summarized briefly as follows.

- Stigma involves processes of labeling, stereotyping, social rejection, exclusion, and extrusion, as well as the internalization of community attitudes in the form of shame by the person/family being discredited.
- The social stigma attached to addiction constitutes a major obstacle to personal and family recovery, contributes to the marginalization of addiction professionals and their organizations, and limits the type and magnitude of cultural resources allocated to alcohol- and other drug-related problems.
- Social stigma attached to addiction is influenced by perceptions of the role of choice versus compulsion in addiction, the motivation for initial drug use (a search for pleasure versus escape from pain), and whether addiction is related to a socially defined “good” or “bad” drug.

- The social stigma attached to addiction is greatest for those experiencing multiple discrediting conditions, e.g., combinations of addiction, psychiatric illness, HIV/AIDS, minority status, poverty, homelessness, and the perception that a woman has failed to meet her gender-role expectations due to addiction.
- Addiction-related social stigma elicits social isolation, reduces help-seeking, and compromises long-term physical and mental health outcomes of those with severe alcohol and other drug problems.
- Heroin addiction and its treatment have been trapped between medical and moral/criminal models of problem definition and resolution for nearly a century.
- Methadone maintenance has never achieved full legitimacy as a medical treatment by the public, health care professionals, and the recovery community, in spite of the overwhelming body of scientific evidence supporting its effectiveness.
- The person enrolled in methadone maintenance has never received full status as a “patient,” and the methadone clinic has yet to be viewed as a place of healing on a par with hospitals or outpatient medical clinics.
- The professional status of methadone treatment has suffered from the absence of theoretical models of treatment and recovery that transcend a focus on the medication to address the larger movement towards global health and community integration.
- Personal strategies to deal with stigma include secrecy/concealment, social withdrawal, selective disclosure, over-compensation in other areas, and political activism.
- Three broad social strategies have been used to address stigma related to behavioral health disorders: 1) personal or mass protest (advocacy), 2) public and professional education, and 3) strategies that increase interpersonal contact between stigmatized and non-stigmatized groups.

Historical/Sociological Perspectives

The social stigma attached to certain patterns of psychoactive drug use has a long history in the United States and is inseparable from cultural strain related to such issues as race/ethnicity, religion, social class, gender roles, and intergenerational conflict. The social stigma attached to methadone is rooted in a larger anti-medication bias within the history of addiction treatment. Social stigma toward alcohol and other drug (AOD) addiction may be defined as a negative social force (an obstacle to problem resolution) or as a positive social force (discouragement of drug use; social pressure for help-seeking). A key question for local communities is: how do addiction treatment professionals, recovery advocates, and preventionists avoid working at cross-purposes in their educational efforts in local communities? Any campaign to counter addiction/treatment/recovery-related stigma must ask two related questions: 1) “What is the source of stigma?” and “Who profits from stigma?”

Conceptual Underpinnings of the Social Stigma Attached to Medication-Assisted Treatment (MAT)

Social and professional stigma, particularly stigma associated with methadone treatment, is buttressed by a set of core assumptions or beliefs. These assumptions and beliefs include the following: 1) excessive drug use is a choice, 2) methadone is a “crutch,” 3) methadone simply replaces one drug/addiction for another, 4) methadone prolongs rather than shortens addiction careers, 5) low doses and short periods of methadone maintenance result in better rates of long-term recovery, and 6) methadone maintenance patients should be encouraged to end methadone

treatment as soon as possible. These propositions have been and are being challenged by a growing body of scientific research on methadone and medication-assisted treatment and recovery.

Semantic and Visual Images Underpinning MAT-Related Stigma

The stigma attached to heroin addiction has been extended to methadone treatment and intensified through language and images within the professional and popular media that represent the least stabilized methadone patients and the lowest quality methadone clinics as the norm. The stigma attached to heroin addiction is internalized and results in an elaborate pecking order within the illicit heroin culture. Such pecking orders can be acted out with negative consequences within the milieu of methadone maintenance treatment. Any campaign to address the social stigma attached to medication-assisted treatment and recovery must transform the ideas, words, and images attached to this approach to treatment and this pathway of recovery.

Street Myths and Stigma

Stigma attached to methadone maintenance treatment has been embedded within the illicit drug culture of the United States in ways that inhibit treatment seeking and contribute to early treatment termination. These myths typically span the origin of methadone, methadone's pharmacological properties and long-term effects, and the source of the proliferation of methadone maintenance clinics in poor communities of color. Any effective anti-stigma campaign aimed at establishing the legitimacy and effectiveness of medication-assisted treatment and recovery must include the wide and sustained dissemination of myth-challenging information within local cultures of addiction and local communities.

Examples of Addiction-Related Stigma/Discrimination Addiction/treatment/recovery-related stigma manifests itself in a broad range of attitudes, behaviors, and policies that range from social shunning to discrimination, e.g., loss of access to medical/dental care, governmental benefits, training/employment opportunities, and housing and homelessness services. Stigma/discrimination related to participation in methadone maintenance includes: denial of access to methadone maintenance or medically supervised withdrawal in jail, denial of admission to other addiction treatment modalities and recovery support services, denial of pain medication, denial of the right to speak and assume leadership roles in local recovery mutual aid meetings, and loss of child custody due to participation in MMT. Stigma-influenced methadone maintenance treatment practices include arbitrary dose restrictions, restrictions on the duration of MM, lowering methadone dose as a punishment for rule infractions, disciplinary discharge for drug use, and shaming rituals (public queues to receive methadone, supervised consumption, separate bathrooms for staff and patients, observed urine drops for drug testing, discouragement of peer fraternization).

Conceptual Underpinnings of a Campaign to Eliminate Stigma Related to Methadone

A campaign to lower stigma related to medication-assisted treatment/recovery must involve a set of messages related to the nature of addictive disorders, the nature of addiction recovery, the potential benefit of medication to the recovery process, and a statement of the harmful effects of stigma on treatment/recovery outcomes and on the family and larger community. These core ideas must be science-based, clear, capable of translation into

educational slogans, and effective in altering perceptions, attitudes, and actions (as measured by pilot testing).

An Addiction/Treatment/Recovery Campaign

The guiding vision of the proposed campaign is to create a city and a world in which “people with a history of alcohol or drug problems, people in recovery, and people at risk for these problems are valued and treated with dignity, and where stigma, accompanying attitudes, discrimination, and other barriers to recovery are eliminated.”¹ The campaign goals are to: 1) enhance public and professional perceptions of the value of medication-assisted treatment, 2) enhance the perceived value of medication-assisted treatment within the heroin-using community, 3) put a face and voice on medication-assisted recovery and portray the contributions of people in medication-assisted recovery to their communities, and 4) increase the participation of medication-assisted treatment providers within local community activities. The strategies proposed for the campaign span the following areas: 1) recovery representation and community mobilization; 2) community education; 3) professional education; 4) non-stigmatizing, recovery-focused language; 5) treatment practices; 6) local, state, and national policy advocacy; and 7) campaign evaluation. The implementation of these strategies will require that people in methadone-assisted recovery take their places at the vanguard of the larger recovery advocacy movement. Efforts must be made to encourage and support that vanguard.

About the Authors: William L. White (bwhite@chestnut.org) is a Senior Research Consultant at Chestnut Health Systems. Lisa Torres (Lisa.Mojer-Torres@dhs.state.nj.us) is a civil rights attorney (admitted to the bars in NY and NJ) providing legal consultation and currently working as the first Consumer & Recovery Advocate for the Division of Addiction Services, Department of Human Services, State of New Jersey. William White and Lisa Torres have served as volunteers for Faces and Voices of Recovery since its inception in 2001.

Acknowledgments: The authors would like to thank the many current and former methadone patients for their contributions to this series. The experiences you shared with us were crucial to the vision of medication-assisted recovery presented in this paper. We are also indebted to the following individuals for providing critical information, comments and suggestions, or technical assistance in the preparation of the manuscript: Lonnetta Albright, Sadé Ali, Stephen Bamber, David Best, Dr. Bob DuPont, Mike Flaherty, Walter Ginter, Dr. Jerome Jaffe, Herman Joseph, Scott Kellogg, Dr. Herbert Kleber, Dr. Mary Jeanne Kreek, Alexandre Laudet, Roland Lamb, Ira Marion, Stephanie Merkle, Mark Parrino, Dr. Tom Payte, Constance Pechura, Terence McSherry, Dr. Ed Senay, Jason Schwartz, Bob Stringer, Pat Taylor, Stephen Weinstein, Pamela Woll, Joycelyn Woods and Joan Zweben. Special thanks to the Philadelphia Medication-assisted Treatment Providers for their many helpful suggestions, and to Dr. J. Bryce McLaulin and Dr. Charles Morgan for early discussions that inspired this series of papers.

¹ Substance Abuse and Mental Health Services Administration (SAMHSA). (2002). *National Recovery Month helps reduce stigma*. Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved June 17, 2009 from <http://www.hazelden.org/web/public/ade20909.page>.