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Recovery for Patients, Families and Communities

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Good Morning. It is a great honor to be with you again and to be part of this distinguished panel.

It is quite fitting that today we honor the life and contributions of Lisa Mojer-Torres. More than a decade ago, I met Lisa at the recovery summit in St. Paul, Minnesota that launched the new recovery advocacy movement in the U.S. At the time, I was still emotionally steeped in the anti-medication rhetoric of the 1960's therapeutic communities and 12-step treatment programs. Lisa challenged every pre-conceived notion I had about methadone maintenance treatment (MMT) and the broader arena of medication-assisted treatment (MAT). The transformation of my views on MAT came not from previously unknown facts that Lisa conveyed, but from the power and nobility of her life and service work. She was a force of nature and for me the living proof of the critical role medication can play in long-term addiction recovery.

I have been asked this morning to share the essence of Lisa and my co-authored publications on recovery-oriented methadone maintenance (ROMM). Our major conclusions are reflected in the following sequence of propositions.

1. Key recovery-focused practices within first and second generation MMT programs diminished during the mass replication of MMT, resulting in:
   - Subclinical methadone dosages
   - Arbitrary limits on duration of MMT
   - A shift in emphasis from therapeutic engagement to behavioral control (policing), regulatory compliance (paperwork) and income generation (profit)
   - Erosion of ancillary medical/psychiatric/social/legal services
   - Decreased presence of recovery role models and recovery culture within the MMT milieu, and
   - Diminished contact between MMT leaders and indigenous recovery mutual aid groups (Recall that Dr. Vincent Dole served on the Board of Trustees of Alcoholics Anonymous and Dr. Marie Nyswander served on the Board

of Directors that guided early efforts to start Narcotics Anonymous in New York City).

2. Early political, public and professional criticisms of person-focused MMT were deflected by reframing MMT as a strategy to reduce public harm and social costs (via crime and disease prevention) rather than as a medical treatment aimed at personal addiction recovery.

3. ROMM attempts to renew MMT as a person-centered medical treatment aimed at long-term personal and family recovery from opioid addiction. Reduction of social harm is viewed as a beneficial by-product of person-centered MMT—not its primary purpose.

4. Historically acrimonious and increasingly stale debates between harm reductionists and "drug-free" treatment advocates are giving way to new experiments in collaboration. All HR should include partial and full recovery as viable strategies of HR; all treatment and recovery support services should encompass the prevention and reduction of personal and social harm. These approaches constitute varied strategies of reaching different populations and reaching the same individuals at different stages of their addiction and recovery careers.

5. ROMM frames medication-assisted recovery within the emerging consensus definitions of *recovery* as sobriety (or remission), improvements in global health and community re-integration; continued medication maintenance or tapering and sustaining recovery without medication represent different styles of recovery, NOT the boundary of transition into recovery.

6. The increased recovery orientation of MAT will require substantial changes in service practices within American Opioid Treatment Programs (OTPs) and office-based Treatment (OBT), including
   a) enhanced early engagement and retention strategies,
   b) expansion of the current service menu for patients and families,
   c) assertive linkage to indigenous recovery community resources (recovery mutual aid groups, recovery community centers, recovery homes, recovery schools, recovery ministries), and
   d) assertive post-treatment monitoring (recovery check-ups), support and, if needed, early re-intervention for all persons ending MMT regardless of discharge status for a minimum of five years.

7. The major obstacle to increased recovery orientation of MAT is the continued social and professional stigma attached to such treatment—including internalized stigma within MAT programs.

8. The most effective strategy for reducing such stigma is not public or professional education but increased contact with individuals/families whose long-term recoveries have been aided by medication.

9. Creating such contact will require identifying and mobilizing a vanguard of people in medication-assisted recovery who are called to, temperamentally suited for and whose life circumstances allow a recovery advocacy role.

10. That potential vanguard exists. (Lisa and I were unsure of its existence and size until we posted notices in OTPs and on MAT advocacy sites asking for people in medication-assisted

recovery to review our work. We were overwhelmed for months with phone calls and emails following this initial request.) It is time for that hidden vanguard to be called to service.

11. As we welcome patients into partnership and leadership roles within treatment programs and the recovery advocacy movement, we must also welcome their family members. The voices of family members have also been historically excluded from discussions of treatment policy and treatment practices.

12. ROMM ultimately extends from the patient to the family to the community. OTPs are imbedded in communities who have been severely wounded by addiction and related problems. There is a need for a community-wide healing process—what might well be called *community recovery*. OTPs, their patients and families can be part of this community healing process.

I don't expect everyone to agree with these propositions, but I do hope they will stir you to read the monographs Lisa and I have written and to discuss them within your programs and your local communities. They can be downloaded for free at www.williamwhitepapers.com.

The addictions field is rapidly shifting from traditional pathology and intervention paradigms to a recovery paradigm as its organizing center. I wish each of you and your programs Godspeed on your journey into this recovery frontier.