



Selected Papers of William L. White

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Bamber-White Dialogue I: Recovery-Oriented Methadone Maintenance

Introduction

In September last year William White and Lisa Mojer-Torres published their landmark monograph *Recovery-Oriented Methadone Maintenance*. In the months leading up to the publication of the monograph, William and I exchanged a series of emails exploring the nature of recovery, recovery-oriented methadone maintenance and medication assisted recovery in general. We both enjoyed these exchanges and subsequently planned to produce an informal series of dialogues to further consider some of the issues covered in *Recovery-Oriented Methadone Maintenance*, publish them in a more concise “question-and-answer” format and make them available on our respective websites.

The cluster of questions surrounding medication assisted recovery have a tendency to evoke strong reactions which can obstruct the advancement of knowledge and understanding in this acutely important area. Similarly, the stigma that surrounds methadone and methadone maintenance treatment can act as a barrier to recovery itself: an untenable state of affairs for anyone committed to recovery advocacy in its broadest sense.

Recovery-Oriented Methadone Maintenance is a vitally significant work

because for the first time amongst recovery literature a coherent, comprehensive and systematic rationale is provided for the recognition of methadone maintenance as an authentic recovery pathway. Perhaps most notably it helps us identify how we can implement recovery-oriented methadone maintenance across treatment systems in the UK and the US.

The sad passing of Lisa Mojer-Torres on the 5th April this year prompted us to bring a close to this first Dialogue and dedicate it to her memory. It is our hope that this modest piece will inspire people to both read *Recovery-Oriented Methadone Maintenance* and discover more about the life and work of this inspirational human being.

Stephen Bamber

Dialogue I: Recovery-oriented Methadone Maintenance

Stephen Bamber: I thought we could start by talking a little about your recently released monograph *Recovery-Oriented Methadone Maintenance*, co-authored with Lisa Mojer-Torres. I wanted to ask you a few questions about the birthing of this monograph. First, what is Recovery-Oriented Methadone Maintenance?

William White: Recovery-Oriented Methadone Maintenance (ROMM henceforth) is a name Lisa Mojer-Torres and I coined to depict an approach to the treatment of opioid addiction that nests science-guided methadone pharmacotherapy within a broader and sustained menu of professional and peer-based support services toward the goal of long-term personal and family recovery. We define personal recovery in the methadone maintenance context in terms of optimum dose stabilization, remission of all substance use disorders and movement towards global health and community reintegration.

Stephen Bamber: Can you communicate the core message of ROMM?

William White: There are four core messages contained in the new monograph, each represented by the four papers that are included:

1. First, the recovery orientation of methadone maintenance (MM)—those service practices now confirmed to be linked to long-term recovery outcomes—diminished during its widespread dissemination and needs to be restored and further developed. MM came to serve many purposes other than personal recovery, and it is our contention that this focus needs to be restored.

2. Second, for MM patients who have achieved recovery as defined above, continued medication maintenance or completion of tapering and sustained recovery without medication support represent varieties or styles of recovery experience and matters of personal choice, not the boundary of passage from the status of addiction to the status of recovery.

3. Third, to achieve this enhanced recovery orientation in methadone maintenance will require substantial changes in prevailing service practices in such arenas as: service attraction, service access, and early engagement; assessment and service planning; service team composition; service relationships; service scope, quality and duration; locus of service delivery; assertive linkage to recovery

community resources; as well as long-term recovery check-ups, stage-appropriate recovery education and support, and when needed, early re-intervention.

4. Finally, a major barrier to medication-assisted recovery is the professional and public stigma attached to methadone that will change only through a sustained campaign of professional and public education. That campaign must be led by a vanguard of recovering people whose personal stories offer living proof of the role medication can play in long-term recovery from opioid addiction.

Stephen Bamber: I'm interested in the inspiration behind the work. Was recovery-orientated methadone maintenance a subject you've specifically wanted to address for some time, or did it emerge as an important contribution to methadone and recovery literature that you identified as expedient at this transitional period in the history of drug and alcohol treatment? The field as a whole (to varying degrees) is embracing new modalities and seems more willing to question the orthodoxies and orthopraxis of our extant configurations. It strikes me there is something 'of its time' about ROMM.

William White: The ROMM monograph is the sixth monograph I have authored or co-authored on recovery management and recovery-oriented systems of care (all the monographs can be downloaded at no cost at www.williamwhitepapers.com). When the early monographs came out, people from opioid treatment programs, therapeutic communities, adolescent treatment, drug courts and other treatment venues began asking how to implement this approach in their respective settings. I chose to address methadone maintenance first because it posed the greatest challenges and controversies. I enlisted the help of Lisa Torres, a civil rights attorney and long-time medication-assisted recovery advocate, to assist me, and we in turn engaged the assistance of many professional pioneers of methadone treatment and many current and former methadone patients in successful

long-term recovery. Support for this work came from two of the Center for Substance Abuse Treatment's Addiction Technology Transfer Centers and from the Philadelphia Department of Behavioral Health. The ROMM monograph project was also part of an extended meditation on the multiple pathways and styles of long-term addiction recovery.

Stephen Bamber: ROMM strikes me as being a particularly bold piece of work. I just wondered how that resonates with your experience of writing it? For example, did this piece bring about any particularly unique challenges as a writer, and if so, what were they? I'm particularly mindful of the (small 'p') political dimension to methadone maintenance – something I hope we can discuss in more detail later.

It is a challenge for any writer to explore an issue marked by polarized debate, inflammatory rhetoric and great personal acrimony. The first challenge was to try to rise above the emotions of this debate and to write as a statesperson rather than from any fixed ideological position. We did that by first committing our loyalty to the one party rarely if ever heard in these debates, and that was to people addicted to opioids, particularly those seeking recovery, and to those maintaining their recovery with the aid of methadone. From there it was a challenge of blending the voices of people seeking and in recovery with a sweeping review of the history and science of methadone maintenance. The work required throwing out pre-conceived notions, synthesizing all that we were absorbing and then trying to convey fresh conclusions as clearly and concisely as possible. Time will tell whether we were able to achieve that and whether our effort will have helped create the professional, political and cultural space in which methadone maintenance could be freshly re-examined by both advocates and critics.

Stephen Bamber: I'm curious as to how (if at all) your own thoughts and feelings toward methadone maintenance have been

changed during the course of writing this monograph. Are you able to discern any significant shifts in your own thinking that have transpired during this process?

William White: My personal views on methadone maintenance (MM) have undergone profound changes over the course of four decades and through my work on this project. In my early career, I exhibited great animosity toward methadone as a result of my enculturation in drug-free therapeutic communities and Minnesota Model alcoholism programs of the 1960s and 1970s. My early opinions were acquired first by osmosis and then from direct contact with people who had used illicit methadone as an intoxicant or who had used methadone to support their addiction careers—use for respite rather than recovery—and from contact with the least stabilized methadone patients and the worst MM clinics—clinics more nested in the culture of addiction than the culture of recovery. Those experiences all reflect part of the story of methadone and MM treatment, but I had interpreted these experiences as the whole truth.

My attitudes toward methadone began to change when I went back to school and was forced to review the scientific evaluations of MM, but even that stage could be depicted as a begrudging intellectual acceptance of the value of MM for some people. In my gut, I still had deep reservations about MM. I simply had not seen living proof of the connection between methadone and long-term recovery. Then I began to meet a small number of people in methadone-assisted recovery who I admired a great deal and who exemplified what I judged to be an exceptional quality of life and service in recovery—on par with people I admired in recovery without the aid of medication. But I now realize that I still saw these few methadone success stories as morally enlightened exceptions. When the ROMM project started, I believed in the potential of MM as a recovery aid intellectually, but I really did not know if there existed a large pool of people who had achieved full, long-term recovery within the framework of MM. I knew that if they existed

in large numbers, they were well-hidden. It turned out they did exist and that they were exceptionally well-hidden.

The personal turning point in the ROMM project for me was when Lisa and I decided that we needed to hear from patients in long-term methadone-assisted recovery on the issues about which we were writing. We posted notices on methadone advocacy web sites and at methadone clinics that described our project and expressed interest in talking with such people about their experience. Lisa and I did not know what to expect because we really didn't know whether such a significant population existed or its size. What followed was a regular flow of emails and phone calls from long-stabilized patients who shared their recovery stories with us. For me, it was a side of the methadone story that I had never heard or seen in my 40 years working in the addiction treatment field. Nothing has more profoundly changed my views on methadone maintenance than the voices of stabilized methadone patients. Their stories left me convinced of the potential role of methadone in long-term recovery, but appalled by the ways so many of these patients were forced to forge their recoveries not with the help of, but in spite of, the attitudes they encounter from professionals, from local communities of recovery, their own families and their local communities. These patients helped me understand MM in a new way, but even more importantly they changed how I felt about methadone in my belly.

The deeper I got into this project the more my focus shifting from concern about the medication to concern that patients in methadone maintenance were being offered medication and almost none of the other supports that we know are linked to recovery stability, global health and quality of life. In that sense, I think the allegations that methadone has served as a form of social control are apt. We have promoted MM as a strategy to reduce the social costs of addiction in the absence of personal recovery; I would like to return MM to its roots as an aid in the process of personal recovery with reduced social harm being not

the primary goal of MM but one of the many positive side-effects of this personal recovery orientation.

The biggest surprise I had in researching the history of MM is that its scientific effectiveness has been established in spite of the absence of important recovery support ingredients as MM was mainstreamed in the U.S. and internationally. It made me wonder what MM outcomes would look like if MM was nested in a vibrant recovery culture and a rich menu of person-centered, professional and peer-based recovery support resources.

Stephen Bamber: Are ROMM and the provision of methadone maintenance as a strategy of harm reduction (HR) philosophically incompatible?

William White: They are not incompatible, but they are perceived as such by many people, particularly those who reap benefit from the increasingly stale and polarized abstinence vs. HR debate. My vision is a simple one: all treatment should seek to reduce harm; all HR strategies should encompass the option, encouragement and support for full, long-term recovery. HR has traditionally been framed in the MM context as the subtraction of negatives—the risks and injuries to self and others that can be eliminated from someone's life; ROMM emphasizes what can be added to someone's life. I think the future rests in seeing HR and recovery as strategies to be uniquely combined and sequenced across the stages/styles of drug use / drug addiction and the stages of recovery rather than as warring ideologies.

Stephen Bamber: To what do you attribute the sometimes extreme resistance to methadone among those who sustain their recoveries without the aid of medication?

William White: There is a tendency for all of us to extend our own experiential truth to the status of universal truth and to then define differences between our own and others' experience in categories of inferiority and superiority. There are many people currently

in recovery who once used methadone as a drug rather than a medication and view their contact with methadone treatment as an extension of their connection to the drug culture—more a part of their addiction career than their recovery career. The animosity they express towards methadone is a means of psychologically distancing themselves from that pattern and from that culture. I think that is understandable, and yet there may be darker forces at work here.

Members of historically disempowered and stigmatized groups are prone to internalize culturally-dominant beliefs about themselves and act them out in their intragroup relationships. The development of status hierarchies and elaborate pecking orders and displacement of aggression within such groups is common. Such hierarchies have long existed in the American drug culture, from the “righteous dope fiend” to the “gutter hype.” People in addiction recovery without medical support looking down on people recovering from addiction with medication support is the psychological equivalent of light-skinned African Americans expressing superiority over dark-skinned African Americans, the house slave looking down on the field slave, and the continued pervasiveness of Black-on-Black crime.

I think these mechanisms of introjection and displacement of shame and aggression are at work in the gulf that exists between those recovering with and without the support of medication. I also think these patterns will progressively dissipate as people in recovery and their families mobilize culturally and politically. I think science is also going to help speed this process. We are quite likely to discover that the ability to recovery with or without medication is not a function of strength of character or motivation but differences in genetically-mediated neurophysiology, problem severity and recovery capital. I do think a day is coming when we will see recovery with or without medication as differences in styles of recovery and that recovery by any means necessary under any circumstances will be cause for universal

celebration and a prevailing mantra across communities of recovery.

Stephen Bamber: The monograph challenges the gulf between methadone maintenance and traditional drug free treatment. What is your vision for the future of such treatment?

William White: I envision a day when the categories of medication-assisted treatment and “drugfree” treatment will no longer exist—that treatment will no longer be provided in such conceptual and practice silos but will be provided in a setting in which all people seeking help will have a comprehensive menu of services to support them across the stages of recovery. That means that today’s methadone maintenance patients would have access to the full range of services now available in traditional drug free treatment settings. That means that today’s patients in drug free treatment settings would have a service menu that would include pharmacotherapy support for those who could benefit from it. It would also mean that all people entering treatment would have a larger menu of recovery support services, including peer-based recovery support services, provided over a much more extended period of time analogous to how we now effectively manage other chronic disorders, such as asthma, diabetes, hypertension and cancer. The key to managing those disorders has been to treat them earlier, treat them more holistically and to manage them over the life cycle. That’s what we need to do with addiction.

Medication or no medication, I know that recovery involves a reconstruction of personal identity, interpersonal relationships and daily lifestyle. The fact that some people need medication to achieve and sustain stable recovery does not change these broader recovery needs. Adding medication to a treatment milieu does not mean that other critical ingredients of recovery support can or should be deleted. It is my contention that combining the best of “drug free” treatment, medication-assisted treatment and peer-based recovery support services

will create long-term recovery outcomes greater than any of these elements could achieve in isolation. When that day comes, our past sectarian arguments over which approach is best will look petty, if not ridiculous.

Stephen Bamber: I share that belief, Bill. I have always found the most engaging and exciting theoretical accounts of recovery surround the concept of self-transformation. Isn't there a problem with the methadone identity, though? There's a sense of ambivalence about it: it lies rooted in both the culture of addiction and the culture of recovery. Perhaps that's inevitable, to a certain extent. What do you think about that, and what do you think some of the characteristics of a methadone identity rooted solely in a culture of recovery would be? Is it possible?

William White: The social and professional stigma attached to methadone is a burden every methadone patient carries like an indelible stain on the self. There are three aspects to this stigma: our professional understanding of methadone itself, the milieu of MM treatment and the historical baggage attached to social perceptions of methadone and MM. I think the first of these will change in the emerging distinctions between addiction and physical dependence and the growing distinction people in recovery will make between a drug and a medication as an aid to their own recovery management and health care decisions. Stigma tied to the milieu of methadone treatment will not abate without a recovery focused transformation of that milieu; the identity of the methadone patient cannot change without a change in the milieu of methadone treatment. That identity will change when the meaning of recovery is as fully understood and is as contagious within the MM milieu as it is in the most vibrant of recovery communities.

It remains to be seen whether such a transformation is possible, but I am encouraged by the interest in ROMM by American Opioid Treatment Programs. The social stigma attached to methadone is

based on decades of substandard treatment that left many MM patients as socially marginalized as they were in their active heroin addictions. I'm not sure changing that social perception is even possible in the short run and, if so, it will only be by a recovery movement led by stabilized MM patients. I think the best hope would be a combination of such a movement and the development of a new drug that offers methadone's unique advantages but that will have none of its historical baggage. Worldwide, conditions are right for the emergence of a medication-assisted recovery advocacy movement.

Stephen Bamber: The field has recently, and tragically lost Lisa-Mojer Torres, with whom you coauthored Recovery Oriented Methadone Maintenance. It must have been particularly sad news for you, having recently worked with her on this volume. In what ways has Lisa influenced your thinking, and what do you think her legacy is, both to the recovery movement and the wider drug and alcohol treatment field?

William White: Lisa's death from a long-fought battle with ovarian cancer was a great blow to all of us in the U.S. recovery advocacy movement and to me personally. I would not have had the courage or the credibility to take on the issue of methadone-assisted treatment and recovery without her as a collaborator. The list of what Lisa did for the recovery movement is a very long one, but what she did that no one else before her had done was step forward professionally and publicly and put a face and voice on methadone—a beautiful face and a powerful voice. When she stood as a woman, a mother and a civil rights attorney and told her recovery story and the positive role methadone played in her recovery, her very presence challenged every stereotype that has ever existed about methadone and the methadone patient. I had done a lot homework that had shifted how I THOUGHT about methadone, but Lisa was the person who changed how I FELT about methadone in my gut. Here was a woman that had so many qualities all of us in recovery aspire to:

sobriety, integrity, honesty, humility, tolerance, service to others. Her story was lucid and emotionally riveting, and she was on METHADONE! No one could walk away from her and think about methadone the same. And what was most important was her acknowledgement that she was just the tip of the iceberg of those who remained hidden because of the stigma attached to this medication. She was a force to be reckoned with. We need Lisas in every community.

Stephen Bamber: I often get the impression that here in the UK we are re-tracing some of the steps the recovery movement in the US has already taken. What advice would you give those in the UK who are trying to establish a truly inclusive culture of recovery? In its journey of formation, are there any mistakes the US recovery movement has made with respect to methadone maintenance that could be avoided by UK recovery advocates as they negotiate the boundaries of their interest?

William White: In our own recoveries, each of us found truths—some personally unique and others shared with many—that we attribute today as the source of our recovery experience, but it is danger when we elevate our personal truth to the status of THE truth. We are a people prone to excess and that excess needs to be tempered with humility and tolerance and a true sense of celebration for all recoveries—no matter how markedly they differ from our own. What we

have tried to do, not always successfully, is cultivate these key recovery values (humility, tolerance, gratitude and celebration) into the larger recovery advocacy movement. I think the lesson we learned is that we all have to become students of recovery. There are no teachers in this movement, only students.

The tendency of any stigmatized group is for its members to socially isolate themselves. I think one of the mistakes that can be made is that we spend too much time talking with each other about changing attitudes of those outside our circle and fighting with each other about how best to do that while spending far too little time communicating with people outside that circle. The first challenge in confronting community stigma, for example, is confronting and escaping that propensity for isolation and our propensity to pick fights inside the circle so that we don't have to face the more formidable challenges outside. The bottom line is that we can't change attitudes of communities if we don't fully enter the life of those communities. And the first challenge to entering those communities is confronting internalized stigma inside our own selves, our organizations and within our movement - purging the shame that tells us we are not worthy of leaving our closed circles. We can hardly expect communities to accept us when we have not yet accepted ourselves and each other. I think that acceptance for self and for each other comes through the grace of sharing our stories - first with each other and then with the world.