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The Recovery Paradigm and the Future of Medication-assisted Treatment

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It is an honor to have been asked to stand before you this morning. I have worked in the addictions field as a clinician, researcher and educator for the past 40 years, but I am speaking to you today primarily as a recovery advocate and a treatment and recovery historian.

My presence here to day could not have been predicted in my early career. As someone deeply entrenched in the philosophies of the therapeutic community and Minnesota Model alcoholism programs of the late 1960s and early 1970s, I regularly expressed the great hostility towards methadone and other medications that was then typical of those settings. I experienced a turning point in those attitudes when I returned to school in 1976 under the mentorship of Dr. Ed Senay, one of the early clinical pioneers in modern addiction medicine. In one of our early meetings, I launched into one of my anti-methadone rants. After quietly listening to me, Dr. Senay said, "Young man, your passion on this subject is in inverse proportion to your knowledge" and began my prolonged re-education about medication-assisted treatment. That education has been deeply influenced by relationships with people whose long-term recoveries have been aided by medication and by dedicated professionals working on the front lines of medication-assisted treatment. My words today are part of a long series of amends for the harm that may have been caused by my early professional ignorance and arrogance.

In the next few minutes, I would like to share three key points for your consideration.

The first and most important of these points is that there is a transformation underway in the conceptual center of the addictions

field. The emerging shift in focus from pathology and intervention to the pathways, processes, styles and stages of long-term recovery will profoundly influence the future of medication-assisted treatment and recovery in the United States.

This shift has been influenced by the growth, philosophical diversification, and the growing cultural and political consciousness of American communities of recovery. We are witnessing historically important growth of recovery mutual aid fellowships and broader recovery community institution building. We are seeing dramatic growth in recovery homes and colonies, recovery schools, recovery industries, faith-based recovery ministries, recovery media and entertainment, recovery community centers and cafes, and online recovery communities. In the past decade we have also witnessed the birth and rapid maturation of a new grassroots recovery advocacy movement. The cultural and political mobilization of people in recovery, their families and allies is evident in new and renewed recovery advocacy organizations, multiple recovery summits, and increasingly well-organized anti-stigma, advocacy campaigns and recovery celebration events. Let's put this movement in historical context. In 1976, 52 prominent Americans stepped forward to publicly declare their recovery from alcoholism as part of the National Council on Alcoholism's Operation Understanding. That event was a historical milestone in the history of recovery in the Unites States. Last September, more than 40,000 recovering people and their families and friends marched in recovery celebration events across the country. American communities of recovery are awakening as a cultural and political force.

Evidence of a resulting shift in our organizing center is evident in many quarters. ***Recovery*** is emerging as an organizing paradigm for behavioral healthcare systems transformation. We are witnessing **c**alls to shift the design of addiction treatment from models of acute or palliative care to a model of sustained "Recovery Management" and to reconstruct addiction treatment as a "Recovery-oriented System of Care." We are seeing intensified calls for a "recovery-focused research agenda" to guide this systems transformation process. And we are seeing an increased recovery orientation within the historical methadone advocacy community—as indicated by the National Alliance of Methadone Advocates rechristening itself the National Alliance for Medication-assisted Recovery.

Three recent milestones illustrate the import of these trends to the future of medication-assisted recovery.

The first milestone was the founding of Faces and Voices of Recovery in 2001 as the organizational center of the recovery advocacy movement. At the core of the historical recovery summit in St Paul, Minnesota that created Faces and Voices of Recovery was the idea that there are multiple pathways and styles of long-term recovery-- including medication-assisted recovery—and that all are cause for celebration. By involving people in medication-assisted recovery within Faces and Voices of Recovery at the highest levels, a historical link was forged between the work of early methadone advocates and the larger recovery advocacy movement. Members of innumerable twelve-step fellowships, secular recovery fellowships, religious recovery fellowships and medication-assisted recovery fellowships are marching side-by-side sharing the identity of "people in recovery." This is historically unprecedented and would not have been possible without the work of skilled advocates like Lisa Mojer-Torres, Walter Ginter and Joyce Woods. Today, I bring you warm greetings from and an invitation for continued participation in Faces and Voices of Recovery and other American recovery advocacy organizations.

A second important milestone is the recent work at federal, state and local levels to create recovery-oriented systems of care and to define and advance the role of medication-assisted treatment and recovery within such systems of care. The leadership of Dr. H. Westley Clark at CSAT, Dr. Tom Kirk in Connecticut, Dr. Arthur Evans in Philadelphia, and Karen Carpenter-Palumbo in New York are particularly noteworthy. CSAT's funding of the Medication Assisted Recovery Services Project (MARS) in New York City in 2006 under the innovative Recovery Community Services Program (RCSP) may prove a particularly important milestone. MARS is piloting a model peer-based recovery support services project operated for and by methadone patients that could be widely replicated and adapted. These federal, state and local initiatives are now set to transform behavioral health care in the United States.

In a third milestones, several states, CSAT and a key private organization have involved diverse stakeholders in efforts to define recovery. At the September 2006, Betty Ford Institute recovery definition consensus conference, discussions touched on some of the most

controversial issues within the addictions field. The resulting consensus definition was subsequently published in *Journal of Substance Abuse Treatment Betty Ford Institute Consensus Panel*, 2007). It defines recovery in terms of three core components: sobriety, personal health and citizenship. The paper goes on to explicitly state:

> "formerly opioid-dependent individuals who take naltrexone, buprenorphine, or methadone as prescribed and are abstinent from alcohol and all other nonprescribed drugs would meet this definition of sobriety."

Such a definition coming from an institution so linked to mainstream treatment in the United States would have been unthinkable only a few years ago.

These three milestones illustrate that something quite fundamental is shifting within the worlds of addiction treatment and recovery in America.

My second point is to urge you to become students of and contributors to this emerging recovery paradigm. The shift in thinking and practice is far more than superficial rhetoric. It involves substantial changes in service philosophies, service practices, service relationships, regulatory policies, and financing strategies. To illustrate this point, let me outline a few changes that are underway.

- We are seeing increased recovery representation with treatment organizations through such mechanisms as governing board representation, recovery advisory boards, consumer councils, a renewal of alumni associations and volunteer programs, and increased recruitment of recovering people into service roles.
- There is a significant increase in assertive community education and outreach to reduce stigma, shorten addiction careers and lengthen recovery careers. Rather than waiting for people to "hit bottom" (pain-based interventions), we are showing people an achievable vision of the top (hope-based interventions).
- Streamlined approaches to service access/intake are increasing.
- We are seeing new strategies to mobilize family/community resources within the treatment and extended recovery support process.

- We are seeing new approaches to integrating addiction medicine, addiction psychiatry, primary health care and peer-based recovery support services.
- We are seeing the service relationship shift from a professional expert model to a partnership/consultation model emphasizing client choice (e.g., rapid transition from professionally-directed treatment planning to client-directed recovery planning).
- We are seeing new approaches for assertively linking clients to indigenous communities of recovery and growing support for the development of new medication-based recovery support communities
- We are seeing increases interest in post-treatment monitoring and support, stage-appropriate recovery coaching, and, when needed, early re-intervention (to include recovery check-ups for 5 years following discharge from treatment).

We must collaborate with the individuals and families we serve to define what this long-term recovery orientation means in the context of medication-assisted treatment. Proponents (recipients and providers) of medication-assisted treatment must become active participants and leaders in this movement or risk being further marginalized by this movement.

There is growing consensus that recovery is far more than the removal of addictive substances from an otherwise unchanged life. The early cultural and professional misunderstandings and stigma attached to methadone led to justifications that focused on what methadone could subtract from an addicted individual's life in terms of crime and broader threats to public safety and health. It is time we told the story of what the use of methadone and other medications combined with comprehensive and sustained clinical and recovery support services can add to the quality of life of individuals, families and communities. To achieve that, we will need to extend our vision beyond programs of medication management toward the broader vision of sustained and person/family-centered recovery management.

My third and final point is that this shift towards a recovery paradigm constitutes a historical window of opportunity to destigmatize medication-assisted treatment and recovery.

This window of opportunity can be maximized by redirecting public attention from those patients who have yet to achieve stability and who receive the most media attention, and shining a light on those methadone maintenance patients who have achieved optimal dose stabilization and quality of life. By casting light on current and former methadone maintenance patients in sustained recovery, and celebrating their successes, we have an opportunity to change how our field and our culture perceive medication-assisted recovery. Such stories will help us transcend the dichotomized and increasingly stagnant "harm reduction versus abstinence" debates.

I don't think this will happen through our efforts alone. In fact, I believe that the future of this opportunity rests to a great degree with the individuals and families we now serve and have served in the past. It is time a vanguard of people in long-term medication assisted recovery, who are personally called, whose life circumstances allow, and who are prepared and supported for this role, to stand collectively and tell their recovery stories to this country. Our job is to help create a cultural climate in which those stories can be safely told and to help with that preparation and support process. It is time to end the iconic image of medication-assisted recovery from as a shadowed face sipping methadone. It is time that image became one of the faces and voices of real people expressing the role medication-assisted treatment played, or continues to play, in their recovery from addiction.

That day will not come without the support of those of you in this room. The time for such a movement is now. It is time we connect the field's pharmacological treatments to the larger and more enduring process of addiction recovery. That vision must and will be fulfilled.

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