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Medication-assisted Recovery from Opioid Addiction: Historical and Contemporary Perspectives

Abstract

Recovery is being used as a conceptual fulcrum for the redesign of addiction treatment and related support services in the United States. Efforts by policy, research, and clinical leaders to define recovery and calls for assertive models of long-term recovery management raise critical questions about how recovery-focused systems transformation efforts will affect the pharmacotherapeutic treatment of opioid addiction and the status of patients participating in such treatment. This paper highlights recent work advocating a recovery-oriented approach to medication-assisted treatment.

Keywords: addiction, medication, methadone, buprenorphine, recovery management, recovery-oriented systems of care, recovery-oriented methadone maintenance, stigma

Recovery as an Organizing Paradigm

In the past decade, *recovery* has emerged as a new organizing paradigm within the alcohol and drug problems arena.[1,2] Setting the stage for this shift were concerns voiced by long-tenured addiction professionals in the 1990s that addiction treatment, through its over-commodification/commercialization, had become detached from the larger and more enduring processes of personal and family recovery.[3,4] Growing disillusionment with acute and palliative care models of addiction treatment led to the reconceptualization of addiction as a chronic disorder,[5] calls for assertive approaches to long-term recovery management (RM),[6,7] and calls to nest these models of RM within larger recovery-oriented systems of care (ROSC).[8] Early pioneering efforts at recovery-focused system transformation at federal (e.g., the Center for Substance Abuse Treatment, [CSAT]), state (e.g., Connecticut), and city (e.g., Philadelphia) levels subsequently garnered considerable national and international attention.[2]

These activities were influenced by and unfolded within larger transformations within the culture of recovery in the United States. Such changes included the growth and diversification of recovery mutual aid societies, the rise and increased vibrancy of a new recovery advocacy movement, the growth of grassroots recovery community organizations, new recovery support institutions (e.g., recovery community centers, recovery homes, recovery schools, recovery industries, recovery ministries, recovery cafes), and a more fully developed culture of recovery with its own history, heroes, values, language, literature, and folkways that transcended those of particular recovery mutual aid societies.[9] It is within this context that the addictions field has witnessed increased interest in the varieties of recovery experience,[10] expansion of peer-based

recovery support services,[11] pioneering models of post-treatment monitoring and support,[12-15] and calls for a recovery research agenda.[16] Also of note are efforts to apply the recovery concept in different clinical and cultural contexts.[17]

It was in response to these changes that Lisa Mojer-Torres and the author were asked by two of CSAT's Addiction Technology Transfer Centers and the Philadelphia Department of Behavioral Health and Intellectual Disability Services to explore the implications of the concepts of recovery, RM, and ROSC to the pharmacotherapeutic treatment of opioid addiction. The resulting series of papers was published in the monograph, *Recovery-oriented Methadone Maintenance* (152 pages, 637 citations)[18] shortly before Lisa Mojer-Torres died of ovarian cancer on April 4, 2011. This article summarizes the key conclusions of the papers contained in the monograph.

Medication and Recovery in Historical Context

Cultural and professional resistance to the use of medications in the treatment of addictions is rooted in a long tradition of harm in the name of help within the history of addiction treatment, e.g., iatrogenic effects of past medications used to treat addiction.[19] Contemporary patterns of concurrent or sequential use of multiple drugs, including increased prescription opioid dependence, heighten concerns about the potential for such iatrogenic effects. Given this history, all medications used in the treatment of addiction require rigorous and continual evaluation of their efficacy, effectiveness, and safety.

Current discussions of the recovery status of patients in medication-assisted treatment (MAT) in the United States are taking place amidst broader historical influences related to MAT and medication-assisted recovery in the United States (See Table 1).

Table 1: Contextual Influences that Set the Stage for Current Discussions of MAT and Recovery Status

Recent MAT-related Historical Milestones
• Reaffirmation through the 1990s of the efficacy and effectiveness of methadone maintenance in the treatment of opioid addiction by prominent scientific, professional, and governmental bodies. • Expansion of pharmacotherapy choices in the treatment of opioid addiction, e.g., buprenorphine. • Increased portrayal of addiction as a brain disease that can be successfully managed via pharmacotherapy and psychosocial support. • Renewed national efforts to elevate the quality of Opioid Treatment Programs (OTPs) via training, technical assistance, and program accreditation. • Organized advocacy efforts of current and former MAT patients, e.g., Advocates for the Integration of Recovery and Methadone (AFIRM), National Alliance for Medication Assisted Recovery (NAMA).[20] • Recognition of the legitimacy of multiple pathways of long-term recovery by leading recovery advocacy organizations. • Inclusion of patients in medication-assisted recovery within leadership roles in national, state, and local recovery advocacy organizations (e.g., the Board of Faces and Voices of Recovery).

- Successful pilot projects integrating methadone maintenance patients and other MAT patients within traditional "drug free" treatment programs and recovery homes.
- Advent of recovery mutual aid and peer recovery support services specifically for people in recovery (e.g., Methadone Anonymous, Medication Assisted Recovery Support).[21-23]
- Increased availability of MA and NA meetings within U.S. OTPs.
- The development of recovery-oriented practice guidelines for medication-assisted treatment.[24]
- Increased recovery-focused presentations and discussions within the annual meeting of the American Association for the Treatment of Opioid Dependence (AATOD).
- Efforts by SAMHSA/CSAT and state, county, and city treatment authorities to infuse the concept of recovery into medication-assisted treatment programs.[25]
- Health care reforms that will likely expand the delivery of addiction pharmacotherapy and recovery support services within primary health care.

The long-term cultural and professional legitimacy of medication-assisted treatment, and its legitimacy across diverse communities of recovery, rests on a legitimized concept of *medication-assisted recovery* even though the promulgation of such a concept risks creating a special recovery status for MAT patients.

Medication and the Question of Recovery Status

Productive discussions of the recovery status of patients in MAT and the development of recovery-oriented MAT hinge on a clear definition of *recovery*. Consensus panels of policy, clinical, research, and recovery advocacy leaders (e.g., Betty Ford Institute Consensus Conference, SAMHSA/CSAT Recovery Summit, United Kingdom Drug Policy Commission) generally include three essential elements of recovery: a) the resolution of drug-related problems (with resolution variably defined as sobriety/abstinence or diagnostic remission), b) improvement in global health, and c) citizenship (positive community re-integration).[26-30]

Groups associated with mainstream, abstinence-based treatment, such as the Betty Ford Institute Consensus Panel, have in recent years taken the position that the remitted, 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 of these defining elements of recovery.[26] For MAT patients who achieve recovery via these three dimensions, continued participation in medication maintenance or eventual tapering and recovery without medication support represent varieties of recovery experience and matters of personal choice, not the boundary of passage from the status of addiction to the status of recovery.

Defining recovery within the context of MAT requires cultural and professional understanding of the distinction between *addiction* and *physical dependence* and, for the MAT patient/family, an understanding of the distinction between use of a *medication* as an aid to recovery and use of a *drug* as a threat to recovery. Debate will continue into the foreseeable future over whether the terms *recovery* and *remission* should be synonymous

or whether recovery involves more than remission (and whether *recovery* applies only to abstinence-based remissions). These are important distinctions. Remission involves the subtraction of pathology from a patient's life; recovery conveys ingredients added to a patient's life, e.g., remission plus the achievement of global (physical, emotional, relational, spiritual) health, social functioning, and enhanced quality of personal/family life in the community. The emerging three-component definition of recovery has profound implications for the future design, conduct, and evaluation of addiction treatment and related recovery support services.

Recovery in the Context of Methadone Maintenance

Key aspects of methadone maintenance (MM) critical to recovery outcomes were weakened during the period of increased regulatory control and mass dissemination of MM. These changes included a shift in focus from personal recovery of the patient to reduction of social harm; decreased emphasis on the therapeutic alliance between MM staff and MM patients; a move toward standardized versus individualized dosing protocols (e.g., minimal variation in prescribed dosages); the reduction of average methadone doses to suboptimal levels; arbitrary limits on the length of MM; pressure on patients to taper and end MM; and the progressive erosion of medical, psychiatric, and social services within MM clinics.

The call for recovery-oriented methadone maintenance (ROMM) is an effort to retrieve and amplify a patient-centered approach to the treatment of opioid addiction. MAT has suffered from the absence of theoretical models and clinical guidelines that go beyond medication preoccupations (e.g., dose protocols, pick-up schedules, drug testing procedures, take-home privileges, tapering policies) to address broader physical, cognitive, emotional, relational, occupational, and spiritual aspects of long-term addiction recovery.

ROMM is a framework for the treatment of opioid addiction that combines 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—during medication maintenance and, for those who choose to taper, throughout and following the tapering process.

ROMM is not, as some will stereotypically assume from its name, a call to: 1) raise the bar of admission to MAT, 2) set arbitrary limits on medication dosages or the duration of MAT, 3) impose pressure for MAT patients to end their medication, 4) deny MAT patients access to harm reduction information or services, 5) force counseling or peer support services on patients who do not need or want such services, 6) extrude patients who do not adopt the goal of full recovery, 7) deny patients access to other drug treatment modalities or recovery support services (based on the rationale that these services are now provided by MAT programs), 8) deny stabilized patients access to interim or office-based treatment, or 9) impose remission/recovery criteria on MAT patients different than the remission/recovery criteria applied to all persons with substance use disorders.

ROMM does focus on issues of service attraction, accessibility, affordability, comprehensiveness, effectiveness and safety—goals that when aggressively pursued will involve changes in some prevailing MAT service practices (See Table 2).

Table 2: ROMM Service Practices

Recovery-oriented MAT 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 (Excerpted from White & Mojer-Torres, 2010, with permission).[18]

Changes in service practices within ROMM are best thought of not as innovations but as a retrieval and extension of the best practices within the history of addiction treatment in general and MAT in particular. The conceptual and practice silos of medication-assisted treatment and "drug free" treatment will progressively dissipate within the addiction treatment field.[30,31] All people seeking help will have access to a

comprehensive menu of professional and peer-based recovery services. Formerly siloed MAT patients will have access to a full menu of psychosocial support services, and formerly siloed "drug free" treatment settings will provide pharmacotherapeutic support for those who can benefit from it. Such integration will parallel methods that are now standard practice in the treatment of other chronic health disorders such as asthma, diabetes, hypertension, and cancer.

ROMM and harm reduction (HR) strategies are best viewed as complementary rather than contradictory. All addiction treatment, including MAT, should facilitate and celebrate the reduction of personal and social harm; all HR strategies should encompass the option of and support for recovery. HR and recovery support strategies are interventions that can reach different populations and be of benefit to the same individuals at different stages in their respective use/addiction/recovery careers.

Stigma, Recovery, and Patient Advocacy

Addiction- and MAT-related social stigma contributes to social isolation, reduces help-seeking, and undermines long-term recovery, particularly among those with multiple discrediting identifiers, e.g., addiction, MM treatment, psychiatric illness, HIV/AIDS, minority status, poverty, homelessness. Persons in MAT, particularly those enrolled in MM, have never received full status as a "patient," and the OTP has yet to be viewed as a place of healing on par with hospitals or outpatient medical clinics. The historical stigma attached to methadone and the broader arena of medication-assisted treatment has denied MAT patients the status of recovery and left them isolated from mainstream community life and existing in limbo between cultures of addiction and cultures of recovery.

The cultural and professional stigma linked to MM and other forms of MAT has been fueled by street myths, exploitive media caricatures, and inflammatory rhetoric from those with vested interests in competing treatment modalities. It has been further fueled by the cultural and professional isolation of OTPs and by the entire addiction treatment field's inability to provide sustained education to patients and their families, addiction and allied professionals, policy makers, and the public on the clinical and scientific foundations and effectiveness of MAT. At the very core of this stigma is the deeply imbedded idea that *recovery* from opioid addiction does not begin until the day the use of medications like methadone and buprenorphine ends. Recovery from no other chronic health condition rests on such a proposition.

Three broad social strategies have been used to address stigma related to addiction and related disorders and their treatment: 1) personal or mass protest (advocacy), 2) public and professional education, and 3) strategies that increase interpersonal contact between stigmatized and non-stigmatized individuals and groups.[32] It is unlikely that the recovery status of the MAT patient will be fully embraced by policy makers, the public, addiction professionals, and recovery communities until a vanguard of present and former MAT patients and their families stand together publicly to declare, "We are the evidence"—the living proof of the role methadone and other medications can play in long-term recovery from opioid addiction. Stigma-related research would suggest that changes in attitudes toward MAT are most likely to occur not from acceptance of addiction as a brain disease, but through identification with an admired public figure or

persons in recovery from one's family, social, or occupational network who have benefited from MAT.[33-37]

Summary

Medication-assisted treatment and long-term addiction recovery have long existed as self-contained arenas. Current efforts to bridge this chasm may produce profound changes on how both are perceived and practiced.

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