RECOVERY-ORIENTED METHADONE MAINTENANCE

William L. White, MA

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CSAT
Center for Substance Abuse Treatment
SAMHSA

Dedication

This monograph is dedicated
to those who are stepping out of the shadows
to put a face and voice
on medication-assisted recovery.

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Foreword

During its long history, Methadone Maintenance has struggled with a reputation that conjures images of seedy Methadone clinics in rundown neighborhoods, inhabited by drug users who are merely substituting one drug for another. The emphasis seemed to be on "maintenance" rather than "treatment."

Meanwhile, the substance abuse treatment field began to evolve, recognizing that substance use disorders are diseases that respond to treatment that can lead to recovery. The focus shifted to defining exactly what was needed to support recovery, and the idea of a more holistic approach began to take shape.

This recovery-oriented systems approach acknowledges the importance of a person-centered, community-involved recovery process–ideas that had not previously been associated with Methadone Maintenance. The question is why not?

Recovery-oriented Methadone Maintenance answers that question by presenting a dynamic and convincing picture of how recovery-oriented systems can be applied to Methadone Maintenance, bringing it into the recovery process. In doing so, the stigma that has surrounded Methadone Maintenance for much of its life is replaced by the recognition that Methadone has a legitimate place within the recovery-oriented system.

When brought into the recovery process, the benefits of Methadone Maintenance are enhanced through linkages with other communities, resources, and systems. Methadone becomes part of the client's recovery, rather than being perceived as a crutch. Through the integration of the recovery-oriented approach the Methadone Maintenance client becomes empowered to affect his or her recovery. The provider begins to treat the entire person, not just the addiction. The result is better and more accurate treatment management and reduced misuse and abuse.

The challenge becomes communicating this new approach to the Methadone Maintenance community. *Recovery-oriented Methadone Maintenance* meets that challenge, establishing an appropriate place for Methadone Maintenance within the recovery community. It is a volume that should be absorbed by medication-assisted treatment providers, whether or not they are currently involved in Methadone Maintenance, as well as all treatment providers. It is time to overcome the stigma associated with Methadone and focus on recovery. It is time to recognize that each person's path to recovery is different and that Methadone Maintenance can and does have a legitimate place on that path for many.

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Preface

Sit down and be prepared to feel the earth move beneath you. For nearly half a century, methadone has been used successfully—but never without controversy—as a medication in the treatment of opioid addiction. This latest recovery monograph by William L. White and Lisa Mojer-Torres reviews the history and cultural context of methadone maintenance (MM) treatment in the United States, with an emphasis on the evolution of practices that directly influence long-term recovery outcomes. These pages offer a distinct understanding of medication-assisted recovery in general, and methadone-assisted recovery in particular. On page 7, the authors write:

> *Recapturing and extending methadone maintenance as a person-centered, recovery-focused treatment of opioid addiction—what we here refer to 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).*

Too much to ask, one might say? Actually, not at all. It's just the beginning. In this new recovery-focused understanding, methadone maintenance is saved from being an end in itself and is instead portrayed as a medication that, when wrapped in an array of professional and peer-based support services, will offer many individuals their best opportunity for long-term recovery. Because it is recovery-focused and measured by more than drug stabilization, Recovery Oriented Methadone Maintenance (ROMM) becomes simultaneously an enhancement to medication maintenance alone, a defense against medication as personal pacification or social control, and a safeguard against non-rehabilitative approaches that perversely profit from the dependence of others. ROMM protects pharmacotherapy with an array of technically skilled, recovery-thinking professional and peer-based recovery supports; opportunities for family and community involvement (often absent today); and measures and accountabilities. Together, these reach into the quality and wellness of the individual's life and tie the gained recovery capital of the individual to the gained recovery capital of the community.

Most critical in this new understanding is the realization that being "in recovery" may or may not mean being on methadone. Indeed, some readers will contest or challenge this view, insisting that only by being "drug-free" and off methadone can one even begin to say, "I am in recovery." The authors chart the historical sources of that view, but herein advance that being on properly monitored methadone is really no different from being on other medications (e.g., insulin for diabetics, antidepressants for depression, disulfirum for alcoholism, etc.) that support one's recovery from other chronic illnesses. In this view, the MM patient attains recovery when he or she engages in a process of recovery that:

- leads to stabilization on his or her optimal dose,
- helps the patient abstain from the use of alcohol and other intoxicating drugs, and
- produces evidence of improved global health and social functioning.

As the authors contend, it is time that MM patients who meet this three-part definition of recovery are welcomed into American communities of recovery. It is also time that recovery from opioid dependence was recognized as more than the removal of drug use from an otherwise unchanged life.

Perhaps the most important insights are related to the entwining of the social contexts and historical influences that the authors illuminate. White, a world leader in recovery-focused historical research and advocacy, and Mojer-Torres, an eminent lawyer and advocate for people involved in MM treatment, speak for the person and family first. In speaking of the quality of methadone

services and its cultural and professional status today, the authors open new frontiers by traversing across time to present-day criticisms of MM, and delineate what ROMM in particular can do to help us transcend those concerns. In this, providers are asked to "go the distance" by adding a recovery focus, staff in recovery (with or without MM), recovery representation on their boards of directors, program recovery philosophy, and recovery-focused and -measured care. Regulators are directly challenged to ameliorate the overwhelming barriers to achieving a more humane, sensitive, and potentially effective system of opioid dependence treatment. Even the traditional role of MM dispensed only via Opioid Treatment Programs (OTPs) is challenged by the advocacy of office-based care for those well into recovery but still in need of methadone-assisted physical stabilization. The monograph concludes with a paper describing recovery in the city of Philadelphia that offers priceless added understanding of ways of recognizing, addressing, and reducing stigma in this population. This one is a classic in and of itself.

Indeed, by now, if you are still in your chair, you have felt the earth move. William White and Lisa Mojer-Torres offer a new view, one which must be considered fully and which we as publishers believe will ultimately elevate and advance the quality of methadone treatment in the United States.

Read on, dear reader, travel this monograph with its sweeping review of the history of MM, reframed and elevated today within a recovery focus and framework. You will hear much in this work from these two long-term recovery advocates, from other experts and critics, and from other voices in recovery—with and without current methadone assistance—who share their personal experience and insight. The articles, each also available as a stand-alone for separate use and publication, will stir thought and discussion, but they will also suggest that we do much more in implementation, if we are to evolve and individuals and communities are to find ROMM. Many examples are provided, and clinicians, seasoned addiction experts, and methadone practitioners are asked to take the next step—instilling and sustaining a recovery focus in treatment—that will restore purpose and invigorate the desire to treat the person and the addiction in general, rather than just treating addiction with a particular drug or defining a person by a particular medication.

In the end, we believe we are all enhanced by this work: authoritative, experiential, novel, and yet sensible—very sensible. Recovery, defined for medication-assisted treatments and methadone maintenance in particular, re-asserts a clear purpose and measurable and accountable outcomes. These pages offer hope that we can connect professionally directed biopsychosocial intervention to the process of long-term, self-maintained recovery.

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Publishers' Note: This latest monograph represents the seventh in a series of monographs by William White and co-authors, a series that explores the evolving understanding of addiction as a chronic illness best addressed through a focus on its recovery and on those seeking or in recovery. All have been published by the Great Lakes Addiction Technology Transfer Center (ATTC), the Northeast Addiction Technology Transfer Center, and the Philadelphia Department of Behavioral Health and Mental Retardation Services. The publishers wish to gratefully acknowledge the SAMHSA Center for Substance Abuse Treatment for the support that makes this work possible, and to acknowledge our respective ATTC parent organizations: the University of Illinois – Chicago (UIC) and the Institute for Resarch, Education and Training in the Addictions (IRETA). In these publications we seek, not to be clinically proscriptive, but to challenge through insight and experience, so as to build from these works an even greater world of possibility for improved care and more effective and fulfilling recovery. The monographs are available for free viewing or download at www.williamwhitepapers.com, www.ireta.org, and www.attcnetwork.org/greatlakes.

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The authors would first like to thank the many current and former methadone patients for their contributions to this monograph. The experiences you shared with us were crucial to the vision of medication-assisted recovery presented in this monograph.

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Regarding the fourth article on stigma attached to medication-assisted treatment and recovery, additional thanks are due to Dr. Herman Joseph for his landmark dissertation on methadone-related stigma and for the insights he provided in interviews with the author. A portion of the literature review presented in this fourth article was published as: White, W., Evans, A., & Lamb, R. (2009). Stigma: The addictions professional as activist. *Counselor,10*(6), 52-58.

Executive Summary

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 monograph 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.

Recovery-oriented Methadone Maintenance 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 in reviving and extending 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 is divided into four articles:

I. Historical Context

II. Recovery and Methadone

III. A Vision Statement

IV. Long-Term Strategies to Reduce the Stigma Attached to Addiction, Treatment, and Recovery within the City of Philadelphia

These four articles are also available individually, each containing both the relevant Executive Summary material and the content from the body of the monograph. The intent is to provide tools for both broad and focused examinations of this critical topic.

Introduction

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

Summary of Key Points — I: Historical Context

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 toward 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.

Summary of Key Points — II: Recovery And Methadone

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 FROM 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 between 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.

Summary of Key Points — III: A Vision Statement

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 attracts voluntary participation by 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 and 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, and 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.

Summary of Key Points — IV: Long-Term Strategies to Reduce the Stigma Attached to Addiction, Treatment, and Recovery Within the City of Philadelphia

INTRODUCTION

This article, 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 toward 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 2) "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 topically 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.

A Brief Note On Language

The terms *opiate* and *opioid* both appear in this monograph. *Opiate* refers to drugs derived from the poppy plant, whereas *opioid* is a more encompassing term that includes synthetic and semi-synthetic drugs. *Medication-assisted treatment* (MAT), as used in this monograph, refers to the use of medications to facilitate detoxification, suppress withdrawal symptoms, reverse cravings (normalize physiological functions), neutralize or create an aversion to the effects of particular drugs, or treat symptoms of a co-occurring medical/psychiatric disorder (normalize psychological functions). MAT is most frequently applied to the use of medications in the treatment of alcoholism (e.g., antabuse, naltrexone, nalmefene, acamprosate) and heroin addiction (e.g., methadone, buprenorphine, naltrexone). *Medication-assisted Recovery* (MAR) refers to the use of medications as an aid in recovery initiation and/or recovery maintenance. MAT refers to professional interventions; MAR refers to the activities and experience of patients whose recoveries have been supported by medications such as methadone, Buprenorphine/Suboxone, or naltrexone. *Methadone maintenance* (MM) is the use of the medication methadone in individualized, optimum doses, in tandem with counseling and other recovery support services, as a treatment for opioid addiction (primarily addiction to heroin and prescription opioids). While methadone may be prescribed by private physicians as an analgesic, MM as a treatment of opioid dependence is provided in the United States primarily by the 1,215 (as of March 5, 2010) accredited *Opioid Treatment Programs* (OTPs).[2] Patients who have achieved prolonged dose stabilization and psychosocial rehabilitation may also be eligible for *medical maintenance*—a program that allows them to see a physician once per month and receive four weeks of medication without the requirement of continued participation in an OTP. *Office Based Opioid Treatment* (OBOT) is medication-assisted treatment for opioid dependence provided in a setting other than an OTP—an option that is legal but currently limited in its availability.

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2. N. Reuter, personal communication, March 5, 2010.

I. Historical Context

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There are growing calls to shift the acute care model of addiction treatment to a model of sustained recovery support analogous to the treatment and management of other chronic diseases.[3] Efforts are underway at federal, state, and local levels to define and implement models of sustained recovery management and to nest these approaches within larger recovery-oriented systems of care.[4]

> *Recovery management (RM) is a philosophical framework for organizing addiction treatment services aimed at early pre-recovery identification and engagement, recovery initiation and stabilization, long-term recovery maintenance, and enhancement of quality of life for individuals and families affected by severe substance use disorders.*[5]
>
> *Recovery-oriented systems of care (ROSC) are networks of formal and informal services developed and mobilized to sustain long-term recovery for individuals and families impacted by severe substance use disorders. The "system" in ROSC is not a local, state, or federal treatment agency but a macro level organization of a community, a state, or a nation.*[6]

The theoretical and scientific foundations of RM and ROSC and their implementation processes are outlined in a series of monographs developed by the Substance Abuse and Mental Health Service Administration's Center for Substance Abuse Treatment and the Philadelphia Department of Behavioral Health and Mental Retardation Services.[7] Those seminal documents provided a vision for the future of addiction treatment and recovery support services, but they only peripherally addressed medication-assisted treatment (MAT) and, more specifically, the role of methadone maintenance (MM) in RM and ROSC.

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4. Halvorson, A., & Whitter, M. (2009). *Approaches to recovery-oriented systems of care at the state and local levels: Three case studies* (DHHS Publication No. (SMA) 09-4438). Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration. White, W. L. (2008). *Perspectives on systems transformation: How visionary leaders are shifting addiction treatment toward a recovery-oriented system of care.* (Interviews with H. Westley Clark, Thomas A. Kirk, Jr., Arthur C. Evans, Michael Boyle, Phillip Valentine and Lonnetta Albright). Chicago, IL: Great Lakes Addiction Technology Transfer Center.

5. White, W. (2008). *Recovery management and recovery-oriented systems of care: Scientific rationale and promising practices.* Pittsburgh, PA: Northeast Addiction Technology Transfer Center, Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health & Mental Retardation Services.

6. White, W. (2008). *Recovery management and recovery-oriented systems of care: Scientific rationale and promising practices.* Pittsburgh, PA: Northeast Addiction Technology Transfer Center, Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health & Mental Retardation Services.

7. Flaherty, M. (2006). *Special Report: A unified vision for the prevention and management of substance use disorders: Building resiliency, wellness and recovery—A shift from an acute care to a sustained care recovery management model.* Pittsburgh: Institute for Research, Education and Training in Addictions. White, W. (2008). *Recovery management and recovery-oriented systems of care: Scientific rationale and promising practices.* Pittsburgh, PA: Northeast Addiction Technology Transfer Center, Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health & Mental Retardation Services. White, W. (2009b). *Peer-based addiction recovery support: History, theory, practice, and scientific evaluation.* Chicago, IL: Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health and Mental Retardation Services. White, W., & Kurtz, E. (2006). *Linking addiction treatment and*

In this monograph, the authors outline a model of recovery-oriented methadone maintenance.

> *Recovery-oriented methadone maintenance (ROMM) is an approach to the treatment of opioid addiction that combines medication 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.*

ROMM provides an alternative to acute care (heroin detoxification) and palliative care (long-term medication maintenance as a form of social pacification, e.g., control of crime and disease). ROMM is a person-centered model of long-term recovery management whose primary goals are defined in terms of remission of primary and secondary substance use disorders, enhancement of personal/family health and functioning, and positive community reintegration. The ultimate aim of ROMM is an enhanced quality of life for each MM patient and his or her family, with larger social benefits viewed as flowing from this primary achievement.

This article will review the evolution of service practices within MM in the United States that have a direct relationship to long-term recovery outcomes.

MEDICATION AND CHRONIC DISEASES

Chronic diseases are distinguished by their prolonged if not lifelong course. Medications have long played a role in the stabilization and management of such disorders. Today, medications play a central role in the treatment of cancer, diabetes, thyroid disease, asthma, chronic obstructive pulmonary disease, hypertension, migraine, hemophilia, anemia, AIDS, lupus, multiple sclerosis, rheumatoid arthritis, Hepatitis C, osteoporosis, Crohn's disease, epilepsy, Alzheimer's disease, severe mental health issues, psoriasis, glaucoma, sleep disorders, and chronic pain. Medications used in the stabilization and management of chronic conditions share five defining characteristics.

1. They eliminate, reduce, or manage symptoms of the disorder but do not "cure" (permanently alter the root cause of) the disorder.
2. They "work" only as long as the medication is being consumed at optimally effective doses and frequencies.
3. Their maximum benefits are often, and to varying degrees, achieved only in tandem with changes in the patient's daily lifestyle.

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communities of recovery: A primer for addiction counselors and recovery coaches. Pittsburgh, PA: Institute for Research, Education and Training in Addictions. White, W., Kurtz, E., & Sanders, M. (2006). *Recovery management.* Chicago, IL: Great Lakes Addiction Technology Transfer Center.

4. Recurrence of symptoms can occur even with medication adherence, most often when larger aspects of the patient's bio/psycho/social/spiritual health are disrupted.
5. When combined with broader strategies of bio/psycho/social/spiritual support, these medications can transform potentially lethal and profoundly disabling diseases into conditions that can be actively managed to sustain and enhance quality of life.[8]

It was the dream of those who developed methadone maintenance that chronic opioid addiction would one day be treated with the same philosophies and service technologies used to treat other chronic medical disorders and that the methadone maintenance patient would be viewed no differently than patients requiring daily doses of insulin, anti-convulsive medication, or hypertensive medication.[9] While there is little debate about the prolonged or lifelong use of medications in the management of other common chronic health conditions, the use of methadone in the management of chronic heroin addiction has stirred considerable professional and public controversy.[10]

A strong anti-medication bias pervades the history of addiction treatment and recovery in the United States. This antipathy toward medications is rooted in efforts to treat addiction with drugs that later were revealed to have great addictive potential. This history spans the treatment of morphine addiction with cocaine (1870s and 1880s) and the treatment of alcohol dependence with opium, morphine, cocaine, amphetamines, sedatives, and tranquilizers. The practice of defining recovery or abstinence as incompatible with the use of any mood-altering medications flows from this history.[11] It is within this context that we will explore the development and evolution of methadone maintenance as a medical treatment for opioid dependence in the United States.

THE HISTORY OF METHADONE MAINTENANCE

There are excellent histories of the development and evolution of methadone maintenance.[12] The purpose of this article is not to retell the story of methadone maintenance, but to draw from existing accounts to illustrate two ideally complimentary but often contrasting visions of MM: one focused on long-term personal recovery and the other on the reduction of personal and social harm. The prominence of one or the other of these visions has exerted a profound influence on the evolving nature of MM treatment, patients' perception and experience of MM, and public and professional attitudes toward MM. We will pay particular attention to changes in key MM clinical practices that have a clear connection to recovery initiation, recovery maintenance, and quality of personal and family life in long-term recovery.

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OPIOID ADDICTION TREATMENT BEFORE METHADONE MAINTENANCE

Opioid addiction in the United States grew in tandem with a series of innovations: the isolation of the alkaloids morphine (1806) and codeine (1820) from opium, the introduction of the hypodermic syringe (1853), the sophisticated marketing of opiate-based patent medicines (late 1800s), and the introduction of heroin as an alternative to morphine (1898). Nineteenth century opium and morphine addicts seeking recovery were preyed upon via opiate-laced miracle cures promulgated by the same patent medicine industry that had long supplied them with opiate-based medicines. Medical treatments for opiate dependence in the U.S. during this early era focused on the best procedures and pacing of withdrawal and strengthening the patient's physical, emotional, and moral constitution. Such treatment was provided via prolonged institutional care in specialized inebriate asylums (e.g., the DeQuincey Home, the Brooklyn Home for Habitués), brief outpatient treatment in private addiction cure institutes (e.g., the Keeley, Neal, Gatlin, or Openheimer Institutes), or by private physicians, some of whom specialized in the treatment of opiate addiction. Treatment across all of these settings was usually followed by relapse. Intractable addicts—most with accompanying chronic medical problems—were maintained on opium or morphine by their physicians or, more commonly, were subjected to ineffective and potentially lethal withdrawal schemes.[13]

Following passage of the Harrison Tax Act[14] in 1914 and a 1919 Supreme Court decision (Webb v. United States) that interpreted such maintenance as criminal, 44 communities established morphine maintenance clinics (1919-1923). The clinics were criticized by the medical establishment and were subsequently closed under threat of criminal indictment. Private physicians were allowed to legally detox patients using diminishing doses of opiates, but those who attempted a maintenance treatment approach faced arrest and prosecution by the Bureau of Narcotics. Through the early twentieth century, cultural responsibility for the management of opioid addiction was transferred from the medical community to the criminal justice system.

When prisons became inundated with addicts who had violated the Harrison Act, Congress passed legislation (1929) that provided for the construction of two federal "narcotics hospitals" (prisons/"farms")—one in Lexington, Kentucky (1935) and one in Fort Worth, Texas (1938). Beyond the Lexington and Forth Worth facilities, few resources existed for the treatment of opioid addiction. The exceptions included a small number of state facilities (e.g., State Narcotics Hospital in Spadra, California, 1928-1941), private hospitals, and psychiatrists who catered to addicted persons of affluence.

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in the treatment of opiate dependence: A personal perspective. *Journal of Psychoactive Drugs, 23*(2), 103-107. Platt, J.J., Widman, M., Lidz, V., & Marlowe, D. (1998). Methadone maintenance treatment: Its development and effectiveness after 30 years. In J.A. Inciardi & L. Harrison (Eds.), *Heroin in the age of crack-cocaine* (pp. 160-187). Thousand Oaks, CA: Sage. Senay, E.D., Lewis, D.C., & Millar, D.G. (1997). The history and current status of drug substitution therapy for narcotic addiction in the United States. In *Medical prescription of narcotics* (pp. 189-200). Seattle: Hogrefe & Huber.

13. Kleber, H., & Riordan, C. (1982). The treatment of narcotic withdrawal: A historical review. *Journal of Clinical Psychiatry, 43*(6), 30-34. White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

14. The Harrison Tax Act in effect made physicians the cultural gatekeepers of access to narcotic drugs by levying a tax on narcotic distribution and providing licenses for such distribution only to physicians. Musto, D. (1973). *The American disease: Origins of narcotic controls*. New Haven: Yale University Press.

Noteworthy in this early history is the limited availability and access to treatment, the risk of harmful treatment (prolonged sequestration, injury from medications and medical procedures, financial exploitation), and the absence of models of sustained, community-based support for addiction recovery—no sustained professional treatment or support protocols, no opioid addiction recovery mutual aid societies, and no visible role models of recovery from opioid addiction. The pathways to recovery from narcotic addiction, if they existed in this era, were hazardous and poorly marked.

THE CONTEXT FOR METHADONE MAINTENANCE

The development of methadone maintenance in the early 1960s occurred within a unique historical context. First and foremost was the dramatic rise in heroin addiction following World War II and the Korean War, particularly among adolescents and transition-age youths. This triggered a number of responses, including church-sponsored counseling clinics, hospital detoxification units, and the first specialized adolescent addiction treatment unit in the country—a 141-bed facility opened in 1952 at Riverside Hospital.[15] Also of note were efforts to adapt the program of Alcoholics Anonymous as a framework of sustained recovery for heroin addicts, e.g., Addicts Anonymous (1947), Habit Forming Drugs (1951), Hypes and Alcoholics (early 1950s), and Narcotics Anonymous (1950, 1953), but these groups were small, geographically limited, and often short lived. NA nearly died as an organization in 1959 and did not generate a viable service structure or sizeable membership until after MM was pioneered.

Psychiatric treatment of heroin addiction in the mid-twentieth century spanned electroconvulsive therapies, psychosurgery, aversion therapy, and psychotherapies from multiple theoretical schools, but none of these revealed any sustained promise of long-term recovery from heroin addiction. Criminal penalties for drug possession and sales were dramatically increased in 1951 and 1956, further filling the nation's prisons with heroin addicts. Follow-up studies of addicts treated at the two federal "narcotics farms" revealed relapse rates exceeding 90% following community re-entry. Riverside Hospital was closed in 1961 after a report documented exceptionally high post-treatment relapse rates. Synanon was founded in 1958 as the first ex-addict-directed therapeutic community (TC), but a thriving TC movement had not yet arisen in the U.S. when work on the development of MM began. States were experimenting with different approaches, including the use of civil commitments, to find some solution to the problem of opioid addiction.

15. White, W. (2004). Riverside Hospital: The birth of adolescent treatment. *Counselor*, *5*(2), 18-20.

Therapeutic pessimism regarding the treatment of opioid addiction spurred the American Medical Association, the American Bar Association, and other groups to call for renewed experiments in the treatment of heroin addiction, including experiments in opioid maintenance. Despite calls from such prominent groups, the Federal Bureau of Narcotics aggressively opposed all maintenance-based proposals for the treatment of heroin addiction on the grounds that such drug substitution was morally wrong and would lead to increased drug use.[16] But forces were coalescing to tip the social scales toward experimentation with maintenance.

THE BIRTH AND EARLY REFINEMENT OF METHADONE MAINTENANCE AS A MODEL TREATMENT

In 1964, Dr. Vincent Dole (an internist), Dr. Marie Nyswander (a psychiatrist), and Dr. Mary Jeanne Kreek (a medical resident) led a research project at Rockefeller Institute for Medical Research (now Rockefeller University) and Rockefeller Hospital to develop a medical treatment for heroin addiction. Collectively, they were involved in every aspect of the research, but they each made special contributions, with Dole taking the lead on the funding, policy, and politics of the project, Nyswander serving as the lead clinician, and Kreek leading the scientific studies and data collection. Controversy surrounded the project from its inception, including threats of criminal indictment. They avoided prosecution due to Dr. Dole's exceptional medical prominence prior to his work on heroin addiction and because of legal briefs prepared by the Rockefeller attorneys arguing that the Bureau of Narcotics' harassment of physicians offering medical maintenance of addicts was based on a misinterpretation of the Harrison Act—an argument the Bureau did not want tested in the courts. The fruits of the Rockefeller project set the stage for the diffusion of methadone maintenance treatment throughout the world.

The original pilot studies of MM in the mid-1960s occurred at a time when there was no national treatment system. A 1968 national survey revealed only 183 drug treatment programs in the United States, with more than 75% of these having been in existence for less than 5 years. By 1984, the number of drug treatment programs in the U.S. had grown to more than 3,000.[17] Methadone maintenance as a new medical treatment for addiction had to compete with alternative medications (e.g., narcotic antagonists-naltrexone) and treatment approaches using very different theoretical frameworks and clinical approaches (psychiatric treatment, therapeutic communities, faith-based counseling clinics). The birthing and earliest clinical replications of MM were marked by:

16. Musto, D. (1973). *The American disease: Origins of narcotic controls.* New Haven: Yale University Press. White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America.* Bloomington, IL: Chestnut Health Systems. White, W. L. (2002). Trick or treat? A century of American responses to heroin addiction. In D. Musto (Ed.), *One hundred years of heroin* (pp. 131-148). Westport, CT: Auburn House.

17. Jaffe, J. (1987). Footnotes in the evolution of the American national response: Some little known aspects of the first American strategy for drug abuse and drug traffic prevention. The Inaugural Thomas Okey Memorial Lecture. *British Journal of Addiction*, *82*, 587-600.

- clinical studies concluding that short-acting opioids such as heroin and morphine were unsuitable as maintenance agents;[18]
- the discovery of methadone's unique effects on metabolic stabilization and its ability to induce cross-tolerance to other opioids ("blockade effect");[19]
- the publication of the original MM treatment protocol (a three-phase process of stabilization, counseling and rehabilitation, and maintenance) and clinical findings from the first pilots;[20]
- elaboration of a metabolic disease theory of addiction;[21]
- scientific studies of the actions and safety of methadone;[22]
- scientific confirmation that the physical, social, and occupational performance of stabilized patients was not impaired by methadone;[23]
- the extension of MM pilots to New York City hospitals/clinics/jails under the leadership of Drs. Freeman, Khuri, Lowinson, Millman, Newman, Primm, Trigg, Trussell, and New York City's Health Services Administrator Gordon Chase;[24]
- the transition from hospital-based induction into MM to ambulatory induction within outpatient clinics;[25]
- the integration of MM into multi-modality treatment systems in New York, Illinois, Connecticut, Massachusetts, Pennsylvania, and Washington, D.C. under the early leadership of Drs. Ramirez, Newman, Jaffe, Senay, Weiland, Kleber, and DuPont;[26]
- the early professionalization of MM as an addiction treatment specialty, e.g., the first National Methadone Conference (1968); and
- the increased scientific legitimacy of MM, including the first long-term outcome study of MM.[27]

Historically, MM marked the remedicalization of opioid addiction and the re-involvement of physicians and nurses in the medical treatment of opioid addiction. The innovation of MM was not the fact that it provided drug maintenance as a medical intervention for opioid dependence. As noted above, 44 clinics in the U.S. had provided morphine maintenance during the early twentieth century.[28] The core innovations were the unique properties that methadone brought to the maintenance process and the service milieus within which methadone was nested within the pilot sites. When Dr. Vincent Dole died in 2006, patients around the world were receiving methadone as a medical treatment for heroin addiction.[29]

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18. Kreek, M.J. (1993). Epilogue: A personal retrospective and prospective viewpoint. In M. W. Parrino, *State methadone treatment guidelines Treatment Improvement Protocol Series 1*. Rockville, MD: Center for Substance Abuse Treatment.

19. Kreek, M. J. (1993). Epilogue: A personal retrospective and prospective viewpoint. In M. W. Parrino, *State methadone treatment guidelines Treatment Improvement Protocol Series 1*. Rockville, MD: Center for Substance Abuse Treatment.

20. Dole, V.P., & Nyswander, M.E. (1965). A medical treatment for diacetylmorphine (heroin) addiction, *Journal of the American Medical Association*, *193*, 646-650. Dole, V.P., & Nyswander, M.E. (1966). Rehabilitation of heroin addicts after narcotic blockade with methadone. *New York State Journal of Medicine*, *66*, 2011-2017. Dole, V.P., Nyswander, M.E., & Kreek, M.J. (1966). Narcotic blockade. *Archives of Internal Medicine, 118*, 304-309.

21. Dole, V.P., Nyswander, M.E., & Kreek, M.J. (1966). Narcotic blockade. *Archives of Internal Medicine*, *118*, 304-309. Dole, V.P., & Nyswander, M.E. (1967). Heroin addiction—a metabolic disease. *Archives of Internal Medicine*, *120*, 19-24.

22. Kreek. M.J. (1973). Medical safety and side effects of methadone in tolerant individuals. *Journal of the American Medical Association*, *223*, 665-668. Kreek, M.J. (1973). Plasma and urine levels of methadone: Comparison of four medication forms used in chronic maintenance treatment. *New York State Journal of Medicine*, *73*, 2773-2777.

23. Gordon, N.B. (1973). The functional status of the methadone maintained person. In L.R.S. Simmons & M.B. Gold (Eds.), *Discrimination and the addictions* (pp. 101-123). Beverly Hills, CA: Sage Publications.

24. Joseph, H., & Woods, J. S. (2006). In the service of patients: The legacy of Dr. Dole. *Heroin Addiction and Related Clinical Problems*, *8*(4), 9-28. Newman, R.G. (2006). Expansion of opiate agonist treatment: An historical perspective. *Harm Reduction Journal, 3*(20), 1-5. M. Parrino, personal communications, February 11, 2010, and March 4, 2010.

25. Platt, J.J., Widman, M., Lidz, V., & Marlowe, D. (1998). Methadone maintenance treatment: Its development and effectiveness after 30 years. In J.A. Inciardi & L. Harrison (Eds.), *Heroin in the age of crack-cocaine* (pp. 160-187). Thousand Oaks, CA: Sage.

26. These early multimodality treatment systems were financially supported primarily by grants from the Narcotics Division of the National Institute of Mental Health, headed by Dr. Sidney Cohen.

27. Gearing, F.R. (1974). Methadone maintenance treatment five years later—where are they now? *American Journal of Public Health. 64*, 44-50.

28. White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

29. Joseph, H., & Woods, J. S. (2006). In the service of patients: The legacy of Dr. Dole. *Heroin Addiction and Related Clinical Problems*, *8*(4), 9-28.

One early change in the design of MM is very important to the theme of this monograph. Before the MM pilot began, Dr. Dole conceptualized medication maintenance as a palliative care model that focused on reduction of personal and social harm—*"a medication that would keep addicts content without causing medical harm and that would be safe and effective for use over long periods in relatively stable doses… The goal of social rehabilitation of addicts was not part of the original plan."*[30] What shifted this theoretical perspective of palliative care almost immediately was the patients' unexpectedly positive response to methadone as a stabilizing medication and the active involvement of Drs. Dole, Nyswander, Kreek, and other staff in the rapidly changing lives of their patients. Within weeks of initiating MM, patients who on other opioid medications had been obsessed only with the schedule of drug administration began to pursue other activities and talk about their futures.[31] The goal of MM then shifted from palliation to an active and highly individualized process of recovery management. The elevated expectations accompanying this shift proved quite empowering to patients who in the past had been defined more by their problems than their possibilities. A large portion of the patients during this early era of MM in the United States were older heroin addicts whose lives had been consumed by heroin in spite of multiple treatment efforts and who now saw methadone as a new life-transforming treatment.

> *It was these [methadone maintenance] patients that gave all of us in those halcyon days such hope and enthusiasm as to the possibility of eventually cutting heroin addiction down to a small problem [in the United States].*[32]

EARLY THEORETICAL FOUNDATION FOR CLINICAL PRACTICES

An analysis of the early and subsequent writings of Dole, Nyswander, Kreek, and other early MM pioneers reveals ten theoretical premises that shaped the core clinical practices within the original model of MM.

1. **Heroin addiction is a genetically-influenced, chronic brain disease** (a metabolic disorder on par with diabetes) marked by the prolonged or permanent derangement of the patient's endogenous opioid receptor system. MM pioneers viewed heroin addiction not as a problem of deviance or "badness" but as a problem of "sickness"—a "brain disease with behavioral manifestations."[33] Recovery from heroin addiction thus required sustained medical supervision and medication management. MM rested on the proposition that primary cultural ownership of the problem of heroin addiction should rest with medical institutions rather than

30. Dole, V.P. (1988). Implications of methadone maintenance for theories of addiction. The Albert Lasker Medical Awards. *Journal of the American Medical Association*, *260*, 3025-3029.

31. Dr. Mary Jeanne Kreek, personal communication, April, 2010.

32. Kleber, H. (1977). Methadone maintenance treatment—a reply. *American Journal of Drug and Alcohol Abuse*, *4*(2), 267-272.

33. Dole, V.P., & Nyswander, M.E. (1967). Heroin addiction—a metabolic disease. *Archives of Internal Medicine*, *120*, 19-24. Dole, V.P., Nyswander, M.E., & Kreek, M.J. (1966). Narcotic blockade. *Archives of Internal Medicine, 118*, 304-309. Kreek, M.J. (2000). Methadone-related opioid agonist pharmacotherapy for heroin addiction: History, recent molecular and neurochemical research and future in mainstream medicine. *Annals of New York Academy of Science, 909*, 186-216. For recent updates, see Trigo, J.M., Martin-Garcia, E., Berrendero, F. Robledo, P. & Maldonado, R. (2010). The endogenous opioid system: A common substrate in drug addiction. *Drug and Alcohol Dependence*, 108, 183-194, and Kreek, M.J. (2010). Overview and historical perspective of four papers presented on research related to the endogenous opioid system. *Drug and Alcohol Dependence*, 108, 195-199.

institutions that view addiction in terms of sin, vice (moral depravity), misbehavior, or crime.[34] MM as originally developed was a physician-directed, hospital-based model of medical care.[35]

2. **Methadone-facilitated metabolic stabilization is essential for most patients to achieve successful long-term recovery from heroin addiction; full biopsychosocial recovery is possible but is "corrective but not curative."**[36] Effective dose stabilization was posited as the foundation of biopsychosocial recovery within MM. It was assumed that efforts to treat heroin addiction that failed to account for the need for metabolic stabilization would fail for most patients.

3. **In the mid-1960s, methadone was discovered to have unique properties as a medical treatment for heroin addiction:** no increase in tolerance over time (although stress-induced neurobiological changes may require dose increases or decreases over time); no impairment from euphoria or sedation; success in relieving withdrawal distress and cravings; long duration of effect (24-36 hours); high relative safety; minimal side effects; and low cost.[37] Methadone was viewed as analogous to the use of insulin in the metabolic stabilization of diabetes. "With a relatively steady concentration [of methadone] in the blood, the narcotic receptors in critical cells remain continuously occupied and the patient becomes functionally normal."[38] In this view, the foundation of methadone-assisted recovery is the oral administration of an individualized effective dose of methadone on a daily basis.

4. **Effective metabolic stabilization and achievement of blockade effects (e.g., prevention of effects from injected heroin) is contingent upon the individual receiving his/her optimal daily dose of methadone.** This belief led to average daily doses of methadone within the MM pilot programs ranging from 80-120mgd.[39] Subsequent research confirmed the wide range of dosages required to produce the same therapeutic blood levels as a result of patient variability in methadone metabolism.[40]

5. **The dosage of methadone required for effective stabilization varies considerably from patient to patient and can vary modestly for the same patient over time.** This finding led to an early emphasis on individualized methadone dosing and adjustments in each patient's methadone dose over time as needed. There were no arbitrary floors or ceilings on methadone dosage; average methadone doses were also expected to change over time in response to changes in heroin purity and in response to new patterns of use (e.g., increased use of prescription opioid medications within the illicit drug culture).

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34. Platt, J.J., Widman, M., Lidz, V., & Marlowe, D. (1998). Methadone maintenance treatment: Its development and effectiveness after 30 years. In J.A. Inciardi & L. Harrison Eds.), *Heroin in the age of crack-cocaine* (pp. 160-187). Thousand Oaks, CA: Sage.

35. It is historically noteworthy that the metabolic theory of heroin addiction, later reformulated as receptor system dysfunction, anticipated the discovery of specific opioid receptors. Dr. Dole undertook the first study to look for opiate receptors, but this discovery would not be made until 1973 by three independent research teams, led respectively by Candace Pert and Solomon Snyder, Eric Simon, and Lars Terenius. Pert, C.B. & Snyder, S.H. (1973). Opiate receptor: demonstration in nervous tissue. *Science*, 179, 1011-1014. Simon, E.J., Hiller, J.M. & Edelman, I. (1973). Sterospecific binding of the potent narcotic analgesic (3H) Etorphine to rat-brain homogenate. *Proceedings of the National Academy of Science USA, 70, 1947-1949.* Terenius, L. (1973). Characteristics of the "receptor" for narcotic analgesics in synaptic plasma membrane fraction from rat brain. *Acta Pharmacologica et Toxicologica*, 33, 377-384. J. Woods, personal communication, March 15, 2010. See Ingolia, N.A., & Dole, V.P. (1970). Localization of d and l-methadone after intraventricular injection into rat brains. *Journal of Pharmacology and Experimental Therapeutics*, *175*, 84-87. Woods, J. (1994). The discovery of endorphins. Retrieved April 22, 2010 from http://www.methadone.org/library/woods_1994_endorphin.html.

36. Dole, V.P. (1988). Implications of methadone maintenance for theories of addiction. The Albert Lasker Medical Awards. *Journal of the American Medical Association, 260*, 3025-3029.

37. Dole, V.P. (1988). Implications of methadone maintenance for theories of addiction. The Albert Lasker Medical Awards. *Journal of the American Medical Association, 260,* 3025-3029. Dole, V.P., Nyswander, M.E., & Kreek, M.J. (1966). Narcotic blockade. *Archives of Internal Medicine*, *118*, 304-309. Kreek. M.J. (1973). Medical safety and side effects of methadone in tolerant individuals. *Journal of the American Medical Association*, 223, 665-668. E. Senay, personal communication, February 16, 2010.

38. Dole, V.P. (1988). Implications of methadone maintenance for theories of addiction. The Albert Lasker Medical Awards. *Journal of the American Medical Association, 260,* 3025-3029.

39. Kreek, M. J., & Vocci, F. (2002). History and current status of opioid maintenance treatments. *Journal of Substance Abuse Treatment, 23*(2), 93-105.

40. Eap, C., Bourquin, M., Martin, J-L, Spagnoli, J., Livoti, S., Powell, K.,… Deglon, J. (2000). Plasma concentrations of the enantiometers of methadone and therapeutic response in methadone maintenance treatment. *Drug and Alcohol Dependence, 61*, 47-54.

6. **Chronic heroin addiction produces profound, persistent, recurring, and potentially permanent metabolic changes.** Prolonged cellular cravings for heroin and the high relapse rates associated with heroin addiction are consequences of metabolic impairment rather than a function of inadequate motivation, psychopathology, or environmental stressors; individually optimal doses of methadone provide daily correction of this impairment. Some MM patients maintain their recoveries following cessation of methadone without relapsing, but most patients are at high risk of opioid relapse and development of other drug dependencies following termination of MM—particularly patients with long opioid addiction careers.[41] Early studies found that relapse after discontinuation of MM was least likely for those with longer periods of time in MM, those who had achieved substantial rehabilitation, and those who had successfully completed treatment according to plan—a small minority of all MM patients.[42] Early MM was delivered with an understanding that most patients would need prolonged if not lifelong methadone maintenance.[43] There were no arbitrary limits on duration of methadone treatment and no professional pressure for patients to taper. Patients were maintained on methadone as long as they continued to derive benefits from it. They were further encouraged to carefully weigh the risks/benefits of tapering and were provided increased support during the tapering process. Returning patients were welcomed and re-admitted without guilt or shame. Addiction recovery was defined in terms of health and functionality and not viewed as contingent upon cessation of MM.
7. **"Addict traits" are a consequence, not a cause of addiction.**[44] In the view of MM pioneers, chronic heroin addiction is a problem of neuropathology, not psychopathology. Addiction was not viewed as a manifestation of mental illness, personality flaws, emotional pain related to trauma and loss, or inadequate coping skills. They argued that the biological roots of heroin addiction should not be confused with the psychological or social sources of heroin experimentation and use.[45] The success of MM-assisted treatment/recovery was not believed to be contingent upon a specific psychiatric treatment. Counseling to maximize emotional stabilization was directed primarily at lifestyle reconstruction, e.g., housing, family/social relationships, education, work, leisure.[46] In the words of Dr. Marie Nyswander, "… drug addicts, like other patients with medical illnesses, have attending or causative emotional problems, [but] they may neither need nor want psychiatric help."[47]

41. Des Jarlais, D.C., Joseph, H., Dole, V.P., & Schmeidler, J. (1983). Predicting post-treatment narcotic use among patients terminating from methadone maintenance. *Journal of Advances in Alcoholism and Substance Abuse, 2*(1), 57-68. Dole, V.P. (1988). Implications of methadone maintenance for theories of addiction. The Albert Lasker Medical Awards. *Journal of the American Medical Association*, *260*, 3025-3029. Kreek, M.J. (2000). Methadone-related opioid agonist pharmacotherapy for heroin addiction: History, recent molecular and neurochemical research and future in mainstream medicine. *Annals of New York Academy of Science, 909*, 186-216.

42. Stimmel. B., & Rabin, J. (1974). The ability to remain abstinent upon leaving methadone maintenance: A prospective study. *American Journal of Drug and Alcohol Abuse*, *1*, 379-391.

43. Jaffe, J. (1972). The maintenance approach to the management of opioid dependence. In C. Zarafonetis (Ed.), *Drug abuse: Proceedings of the international conference* (pp. 161-170). Philadelphia: Lea and Febiger.

44. Dole, V.P., & Nyswander, M.E. (1967). Heroin addiction—a metabolic disease. *Archives of Internal Medicine*, *120*, 19-24. Dole, V.P., Nyswander, M.E., & Kreek, M.J. (1966). Narcotic blockade. *Archives of Internal Medicine, 118*, 304-309.

45. Nyswander, M. (1956). *The drug addict as a patient*. New York: Grune & Stratton.

46. Dole, V.P., & Nyswander, M.E. (1967). Heroin addiction—a metabolic disease. *Archives of Internal Medicine*, *120*, 19-24.

47. Nyswander, M. (1956). *The drug addict as a patient*. New York: Grune & Stratton.

8. **Metabolic stabilization produced by MM does not, by itself, constitute recovery from heroin addiction; methadone-mediated metabolic stabilization of heroin addiction makes broader biopsychosocial rehabilitation possible.**[48] Early MM included a broad menu of services designed to promote global health and community reintegration, including provision of or linkage to resources for treatment of co-occurring medical/psychiatric problems and secondary drug dependencies.[49] The provision of ancillary services must be individualized by need, from no such services needed to multiple and prolonged services.

9. **MM-assisted recovery initiation and maintenance is enhanced within a supportive service milieu—a vibrant recovery culture and a sustained recovery support partnership between MM staff and their patients.** The service milieu and service relationship are potent ingredients, valuable components that help maximize the potential of methadone maintenance in achieving/sustaining recovery. There was an emphasis in early MM programs on compassion and professional respect and rapport. Early units remained small (maximum of 75 patients) to ensure a close connection between staff and each patient.[50] Peer supports were provided by stabilized patients who were hired as "research assistants" who could "speak from the authority of personal experience," inspire hope in new patients, and serve as guides in the service process.[51] There was intense support for education, employment, and pursuit of personal goals. Service relationships were marked by listening, encouragement, and continuity of contact over time, with patients actively involved in clinical decision-making—including determination of personally optimal doses.[52]

10. **The structure of daily clinic participation that enhanced early biopsychosocial stabilization within MM can constitute an obstacle to full recovery once patients begin to reconstruct a prosocial life in the community.** There was growing recognition that the requirement for daily clinic contact could inhibit later-stage recovery by sustaining contact with recent and active drug users and by interfering with opportunities for education, employment, career advancement, family life, and travel. There was also an understanding that sustained recovery management of stable patients by a personal physician could improve overall medical care of patients (comparable to management of other chronic diseases), provide greater assurance of confidentiality, reduce stigma-related problems, and enhance quality of life in long-term recovery. Interest in non-clinic options for MM grew in tandem with the number of patients who had achieved complete social rehabilitation. Medical maintenance provision of monthly visits

48. Dole, V.P. (1989). Interview. In D. Courtwright & J. H. Des Jarlais, *Addicts who survived* (pp. 331-343). Knoxville, TN: The University of Tennessee Press.

49. Kreek, M.J. (1993). Epilogue: A personal retrospective and prospective viewpoint. In M. W. Parrino, *State methadone treatment guidelines, Treatment Improvement Protocol Series 1*. Rockville, MD: Center for Substance Abuse Treatment. McLellan, A. T., Arndt, I. O., Metzger, D. S., Woody, G. E., & O'Brien, C. P. (1993). The effect of psychosocial services in substance abuse treatment. *Journal of the American Medical Association, 269*, 1953-1957.

50. Hentoff, N. (1967). *A doctor among the addicts*. New York: Rand McNalley & Company.

51. Hentoff, N. (1967). *A doctor among the addicts*. New York: Rand McNalley & Company.

52. Ashton, M. (2005). Methadone maintenance: The original. *Drug and Alcohol Findings, 14*, 20-21. Joseph, H., & Woods, J. S. (2006). In the service of patients: The legacy of Dr. Dole. *Heroin Addiction and Related Clinical Problems*, *8*(4), 9-28.

for take-home methadone (in diskette or tablet form) from physicians' offices rather than the individual portions of juice provided in plastic bottles at MM clinics—was pioneered in the early 1980s as a viable alternative for highly stabilized patients, but its availability remains extremely limited.[53]

Theory was important to the development of particular clinical practices within MM, and several of these practices reflect what we will later define in this monograph as recovery-oriented clinical practices, e.g., transitioning from acute biopsychosocial stabilization to support for long-term biopsychosocial recovery, a relationship marked by personal encouragement and continuity of contact over an extended period of time, and availability of peer supports. There were two aspects to the biological emphasis in the metabolic theory of addiction and the central innovation of methadone that limited the recovery orientation in the evolution of MM. (We will explore these issues in greater depth in article three of this monograph.)

First, opioid dependence was viewed as a specialized disorder, and, as a result, MM treatment was aimed at and explicitly evaluated in terms of remission/reduction/cessation of heroin use as opposed to focusing on a larger construct of recovery from addiction. As a result, Opioid Treatment Programs (OTPs) historically have not provided for their patients a coherent rationale for abstinence from alcohol and other drugs, as has occurred in other addiction treatment modalities, nor have OTPs integrated the core technologies used in other treatment modalities to address patterns of and vulnerabilities to multiple drug use. At a systems level, this also created MM clinics that were isolated from the larger addiction treatment and recovery communities—isolation that left both MM staff and patients marginalized from these larger communities.

Second, the metabolic disease theory placed primary emphasis on the importance of pharmacological stabilization. Missing was a larger theoretical outline of how the addiction process poisoned personal character and interpersonal relationships and, as a result, how recovery involves not just a cessation of heroin use but a reconstruction of personal values, personal identity, and one's relationship to family, friends, and community. The biological rationale for MM also provided little in the way of a framework to consider spirituality (including life meaning and purpose) as a potentially important dimension of the recovery process. What that has meant throughout the history of MM is that mainstream MM patients have never been afforded the scope and intensity of educational and counseling experiences routinely provided to those in other addiction treatment modalities.

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53. Novick, D.M., & Joseph, H. (1991). Medical maintenance: The treatment of chronic opiate dependence in general medical practice. *Journal of Substance Abuse Treatment, 8*, 233-239. Novick, D.M., Joseph, H., Salsitz, E.A., Kalin, M.F., Keefe, J.B., Miller, E.L., & Richmond, B.L. (1994). Outcomes of treatment of socially rehabilitated methadone patients in physicians' offices (medical maintenance): Follow-up at three and a half to nine and a fourth years. *Journal of General Internal Medicine, 9*, 127-130. Salsitz, E.A., Joseph, H., Frank, B., Perez, J., Richmond, B.L., Salomom, N., & Novick, D.M. (2000). Methadone medical maintenance treating chronic opioid dependence in private medical practice: A summary report (1983-1998). *The Mount Sinai Journal of Medicine*, *67*, 388-397. Senay, E.D., Barthwell, A.G., Marks, R., Bokos, P., Gillman, D., & White, R. (1993). Medical maintenance: A pilot. *Journal of Addictive Diseases*, *12*(4), 59-76.

The counseling bar has been set low in MM, dominated by mechanics of medication management and regulatory compliance within counselor caseloads that would be unthinkable in other modalities. Services aimed at assertive recovery management and lifestyle reconstruction have generally been viewed within MM programs as "ancillary" or optional "wrap-around" services to the pharmacotherapy that was viewed as the primary mechanism of MM treatment.

EARLY CHALLENGES

There is a tendency to portray the mid- to late 1960s and early 1970s as the Camelot period or "Golden era" for MM,[54] but the realities are much more complex. There were many problems that plagued the earliest years of MM—and some of them endure to the present. These included challenges in:

- determining optimum therapeutic dosages of methadone, optimum duration of methadone maintenance, effective tapering procedures, and post-tapering support protocols to reduce relapse risks;
- defining the optimal multidisciplinary team to operate a MM clinic;
- competing with private physicians who claimed to be providing addiction treatment but who only prescribed methadone;[55]
- minimizing the number of deaths from methadone, e.g., deaths from high-dose induction, overdoses among neophyte users from diverted methadone, and accidental ingestion by children—problems compounded early (1969-1970) by private physicians financially profiting from prescribing liberal quantities of methadone;[56]
- determining the most clinically effective procedures for central intake units to match individual patients to particular treatment options, e.g., pharmacotherapies such as methadone detoxification, methadone maintenance, and narcotic antagonists; therapeutic communities (TCs); and other residential programs and outpatient psychosocial programs;
- managing the intense conflict and competition among programs, particularly between MM and TC advocates;[57]
- developing clinical and administrative responses to continued opioid use and other drug and alcohol use after MM induction;

54. Kleber, H. (2002). Methadone: The drug, the treatment, the controversy. In D. Musto (Ed.), *One hundred years of heroin* (pp. 149-158). Westport, CT: Auburn House. White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

55. J. Jaffe, personal communication, March 10, 2010.

56. DuPont, R.L. (2002). Heroin addiction in the nation's capital, 1966-1973. In D. Musto (Ed.), *One hundred years of heroin* (pp. 67-90). Westport, CT: Auburn House. Jaffe notes: "Some [private physicians prescribing methadone doses as high as 300 mg] used a different algorithm in which the methadone dose was related to the size of the fee paid by the patient." J. Jaffe, personal communication, March 10, 2010.

57. Kleber, H. (2002). Methadone: The drug, the treatment, the controversy. In D. Musto (Ed.), *One hundred years of heroin* (pp. 149-158). Westport, CT: Auburn House.

- formulating protocols to respond to co-occurring medical and psychiatric disorders among MM patients;
- garnering sufficient financial resources to sustain methadone clinic operations—a process that required finding a balance between cost effectiveness and clinical effectiveness in defining the billable units of MM clinic services; and
- responding to professional and community criticism of MM, including great difficulties in finding locations for MM clinics acceptable to the community—a subject we will return to shortly.

Perhaps the most challenging demand was the need to refine a new addiction treatment modality while simultaneously responding to a demand for treatment that far outstripped available capacity. The early MM programs in cities like New York City, Washington, D.C., Chicago, New Haven, and Philadelphia could respond to only a small fraction of those needing treatment, and most cities had few if any resources to respond to a heroin epidemic that was peaking across the country.

EARLY RECOVERY ORIENTATION OF MM

In 1968-1970, the emerging multimodality treatment systems spoke of rehabilitation rather than recovery and defined rehabilitation in terms of three goals: reduced drug use, reduced criminal activity, and increased employment. Although there was not a "recovery consciousness" per se in the early MM clinics, there were several key clinical practices that the present authors will later define in this monograph as essential elements of a recovery-oriented model of methadone maintenance. These elements included:

- **Rapid Service Access:** Within the early MM clinics in New York City and Washington, D.C., every effort was made to expand treatment availability, speed service initiation, and stay connected to those on waiting lists for treatment as MM availability increased. The extent of early demand is evident by the two-year waiting list for admission into New York MM clinics in 1967.[58] In 1969, the Narcotics Treatment Administration (NTA) in Washington, D.C. admitted 2,000 heroin addicts into 12 treatment programs within its first two months of operation[59]: "At that time NTA would rather treat two people half as well than one person in the best way possible. We did not want to leave anybody on a waiting list… We always had room for another heroin addict to come in off the street."[60]

58. Hentoff, N. (1967). *A doctor among the addicts*. New York: Rand McNalley & Company.

59. DuPont, R.L. (2002). Heroin addiction in the nation's capital, 1966-1973. In D. Musto (Ed.), *One hundred years of heroin* (pp. 67-90). Westport, CT: Auburn House.

60. DuPont, R.L. (2005). Conversation with Robert L. DuPont. *Addiction, 100*, 1402-1411.

- **Patient Choice:** Patients most often entered treatment through a central intake unit that considered patient preference in linking patients to a particular treatment modality/organization. The assessment process was independent from the treatment process and provided options and respect for patient choices. It was clear from the beginning that some persons addicted to heroin were achieving recovery in treatment modalities other than MM, but it was (and remains) unclear which patients can recover with these other options, which will benefit from short-term maintenance, and which will require prolonged and potentially lifelong maintenance.[61]
- **Effective/Individualized Dose Stabilization:** Methadone doses were individually set based on patient need without arbitrary ceilings on doses that could be prescribed. Most early programs maintained the average 80-120 mg per day "blockade levels" originally pioneered by Dole, Nyswander, and Kreek.
- **Therapeutic Response to Continued Drug Use:** Drug testing was integrated into the MM clinical protocol as soon as it became available. It served multiple purposes, including the inhibition of methadone diversion and a means of providing timely therapeutic responses to continued drug use (e.g., dose adjustments, intensified counseling). Testing conveyed the message that the continued use of illicit drugs was incongruent with personal recovery and a potential threat to clinic participation.
- **Chronic Care Perspective:** Heroin addiction was viewed as a chronic, relapsing disorder whose treatment required prolonged if not lifelong medical and psychosocial support. There were no limits placed on length of MM treatment, nor was there pressure from staff for patients to taper. Sustainable recovery was viewed as requiring continued or intermittent treatment of most patients over a number of years.[62]
- **Therapeutic Alliance:** There was emphasis on forging a sustained, respectful relationship between MM clinic staff and each patient. This relationship was viewed as a critical dimension of the success of MM.[63]
- **Recovery Role Models:** People in stable medication-assisted recovery from heroin addiction were integrated into the treatment milieu in multiple roles, to affirm the potential for long-term recovery from heroin addiction and to serve as recovery guides for new patients.

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61. J. Jaffe, personal communication, March 10, 2010.

62. Jaffe, J. (1969). *Possible solutions to the drug dependence and abuse problem.* Presented at the Michigan Governor's Conference on Drug Dependence and Abuse, December 18, 1969.

63. Kreek, M.J. (1993). Epilogue: A personal retrospective and prospective viewpoint. In M. W. Parrino, *State methadone treatment guidelines Treatment Improvement Protocol Series 1*. Rockville, MD: Center for Substance Abuse Treatment.

- **Focus on the Whole Person:** Methadone pharmacotherapy was wrapped in a larger menu of medical, psychiatric, and social support services (housing, employment, legal) aimed at enhancing global health and quality of life.
- **Safety Net:** MM clinics developed special programs for patient populations whose needs exceeded the services available in mainstream clinics (e.g., specialty programs for women, younger patients, patients with serious psychiatric illness, patients with co-occurring severe alcohol problems, chronically relapsing patients). Referral to other programs/modalities was used as a safety net based on the assumption that the lack of optimal response was sometimes a function of the program or bad chemistry in the program-patient relationship rather than a function of patient pathology.[64]
- **Community as Patient:** The organizations that first extended the MM model (e.g., those in New York City, Washington D.C, Chicago, New Haven) viewed themselves not as health care businesses but as public health agencies. In a very real sense, they viewed the community as their patient and sought mobilization of a community-wide response to problems of addiction.[65]

Other recovery-focused elements (e.g., recovery-focused patient and family education, collaboration with and assertive linkage to local recovery mutual aid groups, assertive follow-up of patients following successful tapering or disengagement) were weak or missing from early MM treatment models.

FUNDING, DIFFUSION, AND REGULATION OF METHADONE MAINTENANCE

The mid-twentieth-century heroin epidemic peaked (in terms of incidence of new heroin use) between 1969 and 1971.[66] On the domestic front, there was alarm about rising drug use (particularly heroin use) and its most visible manifestation: escalating crime rates. That alarm intensified in 1971 when two members of Congress returned from a visit to Vietnam and reported that "10-15% of GIs were addicted to heroin."[67] Fears of ever-escalating, drug-fueled crime and legions of addicted soldiers returning from Vietnam (which never materialized) triggered unprecedented action. On June 17, 1971, President Richard Nixon declared a "war on drugs" and announced the creation of the Special Action Office for Drug Abuse Prevention (SAODAP) to coordinate a national response to the growing drug problem. The resulting federal strategy balanced traditional drug supply-reduction efforts with expanded activities related to drug demand reduction (e.g., prevention and treatment).[68]

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64. White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

65. DuPont, R.L. (2005). Conversation with Robert L. DuPont. *Addiction, 100*, 1402-1411.

66. DuPont, R.L. (2002). Heroin addiction in the nation's capital, 1966-1973. In D. Musto (Ed.), *One hundred years of heroin* (pp. 67-90). Westport, CT: Auburn House.

67. Jaffe, J. (1987). Footnotes in the evolution of the American national response: Some little known aspects of the first American strategy for drug abuse and drug traffic prevention. The Inaugural Thomas Okey Memorial Lecture. *British Journal of Addiction*, *82*, 587-600. Jaffe. J. (2002). One bite of the apple: Establishing the Special Action Office for Drug Abuse Prevention. In D. Musto (Ed.), *One hundred years of heroin* (pp. 43-53). Westport, CT: Auburn House.

68. Jaffe, J. (1987). Footnotes in the evolution of the American national response: Some little known aspects of the first American strategy for drug abuse and drug traffic prevention. The Inaugural Thomas Okey Memorial Lecture. *British Journal of Addiction*, *82*, 587-600.

This unprecedented federal investment in addiction treatment was led by two individuals, Drs. Jerome Jaffe and Robert DuPont, each of whom had led multimodality treatment systems—Jaffe in Chicago and DuPont in Washington, D.C. Based on their collective experience, they convinced the White House that methadone maintenance was an essential element of any comprehensive strategy and that it could exert a direct, rapid effect on urban crime rates. The resulting infusion of federal dollars led to the rapid expansion of addiction treatment programs—MM clinics, therapeutic communities, outpatient counseling programs—across the country. The speed of MM diffusion was staggering—from 22 patients in 1965 and less than 400 patients in 1968 to more than 80,000 patients in 1976.[69] It should be noted that much of the expansion of MM was in New York City (36,000 by 1972), and that many American cities with significant opioid dependence problems did not provide MM, in part due to political controversies surrounding maintenance treatment. The New York City Health Department under the leadership of health czar Gordon Chase pushed the rapid expansion of MM in spite of cautions from even the most ardent MM defenders to avoid replicating MM too quickly. Chase acted on his belief that the prevalence of heroin addiction in New York City required a significant treatment response and that the most effective means of engaging those in need of treatment was through methadone maintenance.[70]

This rapid expansion of MM programs led to federal and state regulatory structures, program licensure requirements, and new funding guidelines that exerted a profound and oft-debated influence on MM clinical practices. These new regulatory guidelines contributed to the dramatically enhanced availability, quality, credibility, and acceptability of MM. They restricted who could provide MM to approved clinics and hospital pharmacies—an effort that deterred private physicians from profiteering from methadone prescriptions. They also restricted who could have access to MM—a response to allegations that physicians were prescribing methadone to non-dependent heroin users.[71] Without such requirements and guidelines, funding for MM would have been unlikely, and unacceptable practices in the worst-managed MM clinics could have triggered a backlash that would have threatened the very existence of MM. In a comparison of MM diffusion with such requirements to MM diffusion in countries that lacked such structures, it becomes clear that these requirements did serve to limit methadone diversion and methadone-related deaths.[72]

The 1980s were marked by two successive presidential administrations (Carter and Reagan) in which White House Policy advisors were first lukewarm to MM and then distinctly anti-methadone. Diminished public funding support for MM—by more than 50%[73]—changes in the core philosophy

69. White, W. L. (2002). Trick or treat? A century of American responses to heroin addiction. In D. Musto (Ed.), *One hundred years of heroin* (pp. 131-148). Westport, CT: Auburn House.

70. Dr. Robert Newman, Personal Communication, July 2, 2010.

71. Jaffe, J., & O'Keefe, C. (2003). From morphine clinics to buprenorphine: Regulating opioid agonist treatment of addiction in the United States. *Drug and Alcohol Dependence, 70,* S3-S11.

72. J. Jaffe, personal communication, March 10, 2010.

73. Jaffe, J., & O'Keefe, C. (2003). From morphine clinics to buprenorphine: Regulating opioid agonist treatment of addiction in the United States. *Drug and Alcohol Dependence, 70,* S3-S11.

of MM, and erosion of quality within many MM programs troubled early MM pioneers, as did the increasingly hostile attitudes toward MM at local and national levels.[74] Indicative of such erosion was the 1988 White House Conference for a Drug Free America, which called for the abolishment of MM and an investigation of NIDA for its support of MM. Dr. Herbert Kleber[75] describes 1988 as the "lowest point methadone reached, in terms of national policy." These years were marked by decreased public funding of MM, increased reliance on patient fees to support MM, and the dramatic growth of privately owned for-profit MM clinics.[76] But even at this low benchmark, some 200,000 patients were enrolled in MM in the United States.[77]

The most significant factor that brought MM back into policy favor was the spread of HIV/AIDS by injection drug users and growing evidence that MM significantly lowered the risk of HIV infection.[78] Public and professional alarm about rising rates of HIV infection and AIDS-related deaths pushed the primary rationale for methadone from a medical treatment for heroin addiction to a public health strategy of HIV/AIDS prevention. A more calculated harm-reduction approach to MM led to proposals for stripped-down versions of "interim MM" and "low-threshold MM." MM pioneer Vincent Dole was quite clear that such approaches to MM lacked the core technology and personal focus—what we refer to in this monograph as recovery orientation—of the original MM model.

> *… "harm reduction" is an improvement in the sterile policy of simply blaming the addict for having a chronic, relapsing disease. At present methadone is being dispensed liberally in various harm reduction programs throughout the world, with doses and schedules being guided by the wishes of the addicts. This is not entirely bad, but it is a poor way to practice medicine and is not the "methadone maintenance treatment" described in the early literature.*[79]

CHANGING CLINICAL PRACTICES IN MM IN THE 1970S AND 1980S

As MM programs spread in the 1970s and 1980s, several factors contributed to changes in core MM practices, their degree of effectiveness, and the cultural and professional perception of MM programs. First was the sheer level of demand for MM treatment. As waiting lists to enter MM lengthened, many programs responded by shortening treatment. They accomplished this by encouraging stabilized patients to taper/terminate MM and by administratively discharging patients for continued drug or alcohol use or for infraction of clinic rules.[80] Characteristics of patients entering MM evolved toward a younger, less motivated population that was more prone to view

74. Kreek, M.J. (1993). Epilogue: A personal retrospective and prospective viewpoint. In M. W. Parrino, *State methadone treatment guidelines Treatment Improvement Protocol Series 1*. Rockville, MD: Center for Substance Abuse Treatment.

75. Kleber, H. (2002). Methadone: The drug, the treatment, the controversy. In D. Musto (Ed.), *One hundred years of heroin* (pp. 149-158). Westport, CT: Auburn House.

76. Kleber, H. (2002). Methadone: The drug, the treatment, the controversy. In D. Musto (Ed.), *One hundred years of heroin* (pp. 149-158). Westport, CT: Auburn House.

77. J. Jaffe, personal communication, March 10, 2010.

78. Longshore, D., Hsieh, S., Danila, B., & Anglin, M.D. (1993). Methadone maintenance and needle/syringe sharing. *International Journal of the Addictions*, *28*, 983-996. Novick, D.M., Khan, I., & Kreek, M.J. (1986). Acquired immunodeficiency syndrome and infection with hepatitis viruses in individuals abusing drugs by injection. *Bulletin of Narcotics*, *38*(1-2), 15-25. Novick, D.M., Kreek, M.J., Des Jarlais, D.C., Spira, T.J., Khuri, E.T., Ragunath, J., Kalyanaraman, V.S., Miescher, A. (1986). Abstract of clinical research findings: Therapeutic and historical aspects. *Problems of Drug Dependence, 1984: Proceedings of the 47th Annual Scientific Meeting, The Committee on Problems of Drug Dependence, Inc* (pp. 318-320). Rockville, MD: National Institute on Drug Abuse.

79. Dole, V.P. (1997). What is "methadone maintenance treatment"? *Journal of Maintenance in the Addictions*, *1*(1), 7-8.

80. Perkins, M.D., & Bloch, H.I. (1971). A study of some failures in methadone treatment, *American Journal of Psychiatry*, *128*(1), 447-450.

methadone as just another drug, or a control device, rather than a medication that could aid addiction recovery. The quality of staff also changed with mass expansion. Second-generation staff were sometimes less capable and less enthusiastic about MM and more likely to view their work as "just a job." MM programs became increasingly characterized by inadequate staffing levels, hiring of staff philosophically opposed to maintenance, and relegating physicians (often in part-time positions) to conducting physicals and writing prescriptions rather than providing clinical leadership. Some of the newer expansion programs were also plagued with poor leadership and weak infrastructure (e.g., inadequate capitalization, facilities, and information technology) and were often perceived to be motivated more by financial gain than by community service.

Many of the new methadone programs and regulatory bodies governing MM grew without a foundational knowledge of the pharmacology and theoretical framework that had guided MM's early development. Dr. Dole later reflected on this period of mass MM diffusion.

> *With the growth of the programs, there was an adoption of methadone by people who still fundamentally believed that [heroin addiction] was a psychological problem. They were only using methadone as a means to engage somebody in treatment, with the ideas that ultimately the cure would be through psychotherapy… This type of attitude was adopted and expanded into an official view by the federal government, and it was incorporated in their regulations by 1974. The goal of [methadone maintenance] treatment was [from that period on] not rehabilitation but abstinence.*[81]

Dole was particularly incensed at the shift away from the use of methadone doses high enough to achieve a blockade effect and at arbitrary limits on length of MM treatment—trends he viewed as being based on political considerations rather than medical science or clinical judgment.[82] Dole[83] viewed each episode of tapering as "an experiment with the life of a patient" with potentially ominous outcomes that should not be undertaken without a sustained period of stability, the patient's request, and prolonged follow-up by the physician. In later interviews, Dole continued to criticize the mass diffusion of what he considered to be a watered down approach to MM:

> *There is no sense in multiplying [methadone maintenance] programs that are administered by people who do not understand the pharmacology of methadone, or who lack compassion and a grasp of what it is to be an addict.*[84]

Drs. Dole and Nyswander were critical of the loss of key ingredients of MM throughout the late 1970s

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81. Dole, V.P. (1989). Interview. In D. Courtwright & J. H. Des Jarlais, *Addicts who survived* (pp. 331-343). Knoxville, TN: The University of Tennessee Press.

82. Cushman P., & Dole, V.P. (1973). Detoxification of rehabilitated methadone-maintained patients. *Journal of the American Medical Association*, *226*, 747-752. Dole, V.P. (1973). Detoxification of methadone patients and public policy. *Journal of the American Medical Association, 226*, 780-781.

83. Dole, V.P. (1973). Detoxification of methadone patients and public policy. *Journal of the American Medical Association, 226*, 780-781.

84. Dole, V.P. (2002). Conversation with Vincent Dole. In G. Edwards (Ed.), *Addiction: Evolution of a specialist field* (pp. 3-10). Oxford: Blackwell Science Ltd. (Reprinted from Conversation with Vincent Dole, by Dole, V.P., 1994, *Addiction, 89*, 23-29).

and 1980s. They argued that "Bureaucratic control of methadone programs has given us 'slots,' a rule book, and an army of inspectors, but relatively little rehabilitation."[85] Dole's and Nyswander's criticism of the effects of federal regulation obscure the fact that some of the most restrictive of such regulations came not from the federal level but from states, counties, and cities. These criticisms also failed to acknowledge the fact that many methadone treatment providers resisted loosening MM regulations on the grounds that current regulations were essential for continued state funding of MM services.[86]

Dr. Dole later spoke of the "stagnation of treatment" that occurred throughout the 1970s and 1980s.[87] He was particularly incensed at the depersonalization of MM and the loss of partnership with patients in MM: "the contempt with which many regulators and program administrators have treated their patients seems to me scandalous."[88]

> *The strength of the early programs as designed by Marie Nyswander was in their sensitivity to individual human problems. The stupidity of thinking that just giving methadone will solve a complicated problem seems to me beyond comprehension.*[89]

Dole was not the only early MM pioneer who criticized the evolution of MM in the 1970s. In 1976, Dr. Robert Newman, who led the expansion of MM in New York City, declared:

> *Methadone maintenance treatment, with its unique, proven record of both effectiveness and safety, no longer exists. One can only hope that it is not too late to reassess that which has been cast aside, and to resurrect a form of treatment which has helped so many, and which could help many more.*[90]

Other critics, including Dr. Stephen Kandall, concurred with Newman and further argued that:

> *Political forces reduced methadone to an inexpensive, stripped down way to "control" a generation of addicts without having to provide essential rehabilitative services…* [91]

Whether one believes the mass diffusion and regulation of MM was a curse or a positive and essential stage in the maturation of modern addiction treatment, it is clear that key changes occurred in the philosophy and practice of MM in the 1970s and 1980s. Changes that have had the greatest impact on long-term medication-assisted recovery include the following, as reported in the literature and observed by the authors:

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85. Dole, V.P., & Nyswander, M.E. (1976). Methadone maintenance treatment: A ten year perspective. *Journal of the American Medical Association*, *235*, 2117-2119.

86. J. Jaffe, personal communication, March 10, 2010. Jaffe, J., & O'Keefe, C. (2003). From morphine clinics to buprenorphine: Regulating opioid agonist treatment of addiction in the United States. *Drug and Alcohol Dependence, 70,* S3-S11.

87. Dole, V.P. (1996). Interview with Dr. Vincent Dole, M.D.: Methadone: The next 30 years? *Addiction Treatment Forum*, Winter, 1-6.

88. Dole, V.P. (1996). Interview with Dr. Vincent Dole, M.D.: Methadone: The next 30 years? *Addiction Treatment Forum*, Winter, 1-6.

89. Dole, V.P. (1989). Interview. In D. Courtwright & J. H. Des Jarlais, *Addicts who survived* (pp. 331-343). Knoxville, TN: The University of Tennessee Press.

90. Newman, R.G. (1976). Methadone maintenance: It ain't what it used to be. *British Journal of Addiction, 71*, 183-186.

91. Kandall, S. (1996). *Substance and shadow: Women and addiction in the United States.* Cambridge, MA: Harvard University Press.

- **Purpose:** MM's primary focus shifted from personal rehabilitation to reduction in social harm (e.g., crime, violence, disease transmission); at policy levels, and sometimes at clinical levels, the whole person and the personal recovery process became an afterthought.[92] Protection of public safety/health and personal recovery are not incompatible, but emphasis on the former to the exclusion of the latter led to depersonalized and degrading treatment in some OTPs.[93] Increased privatization of MM (via for-profit methadone clinics) in response to cuts in public funding focused institutional missions on financial margins and led to cuts in ancillary services, as well as subsequent exposés of excessive profits in some clinics[94]—a situation that not only continues but has worsened.[95]
- **Variation in Quality:** There was widening variation in program adherence to accepted guidelines and best practices, and decreases in optimal care, as indicated by increased reports of adverse events and quality concerns raised by funding, licensing, and accreditation authorities.
- **Decreased Access:** Cuts to publicly funded methadone programs, program closings, and reduced MM treatment capacity increased MM waiting lists, prompted prolonged delays in treatment entry, created pressure for premature and involuntary tapering, and led to service fees that forced some patients into criminal activity to pay for MM[96]—all at a time when demand for MM treatment was increasing.[97]
- **Inadequate Dose Stabilization:** Arbitrary limits were imposed on methadone doses, with average MM dosages dropping from their original optimal range of 80-120mgd to 88% of MM patients receiving suboptimal doses (below 60mgd) in 1988.[98] Patient success became measured in terms of achievement of lower methadone doses and in getting patients off of methadone.[99]
- **Concerns about Patient Safety:** Some private clinics used exceptionally high doses (above 120mgd) to attract patients, in spite of the lack of research on long-term effects and effectiveness of such dosage levels.[100]
- **Shortened Treatment Duration:** Arbitrary limits were set for duration of MM, e.g., requirements for medical justification for sustaining treatment beyond two years, staff pressure for patients to progressively reduce methadone dosage and cease maintenance, extrusion of "troublesome" patients (i.e., those with the most severe and complex problems) via administrative discharge. One-year retention rates in MM in New York City dropped from an initial

92. Newman, R.G. (1987). Methadone treatment: Defining and evaluating success. *New England Journal of Medicine*, *317*, 447-450.

93. Bourgois, P. (2000). Disciplining addictions: The bio-politics of methadone and heroin in the United States. *Culture, Medicine and Psychiatry*, *24*, 165-195.

94. Britton, B.M. (1994). The privatisation of methadone maintenance: Changes in risk behavior associated with cost related detoxification. *Addiction Research, 2*(2), 171-181.

95. Jackson, T. (2006). A methadone cash cow. *Treatment Magazine: Addiction Industry News*, November, 23-25. Herbert Kleber, personal communication, March 2010.

96. Knight, K.R., Rosenbaum, M., Irwin, J. Kelley, M.S., Wenger, L., & Washburn, A. (1996). Involuntary versus voluntary detoxification from methadone maintenance treatment: The importance of choice. *Addiction Research, 3*(4), 351-362.

97. Ball, J. C. (1994). Methadone maintenance: A reply to the commentaries. *Addiction, 89,* 813.

98. D'Aunno, T., Foltz-Murphy, N., & Lin, X. (1999). Changes in methadone treatment practices: Results from a panel study: 1988-1995. *American Journal of Drug and Alcohol Abuse, 25*, 681-699. D'Aunno, T., & Pollack, H.A. (2002). Changes in methadone treatment practices: Results from a national panel study, 1988-2000. *Journal of the American Medical Association*, *288*(7), 850-856.

99. Rosenbaum, M., & Murphy, S. (1984). Always a junkie?: The arduous task of getting off methadone maintenance. *Journal of Drug Issues*, *14,* 527-552. Woody, G.E., Luborsky, L, McLellan, A.T., O'Brien, C.P., Beck, A.T., Blaine, J., Hole, A. (1983). Psychotherapy for opiate addicts: Does it help? *Archives of General Psychiatry, 40*(6), 639-645.

100. E. Senay, personal communication, February 16, 2010.

98% to 59% ten years later.[101] With growing professional, family, and community expectations that MM should be as short as possible, opioid addiction became the only chronic disease in which patients were shamed and stigmatized for long-term medication adherence. With these changes, MM patients were denied pride in the achievement of sustained recovery stabilization—in marked contrast to those celebrating the length of their recoveries in AA, NA, and treatment alumni association meetings.

- **Lowered Expectations:** The shift from a rehabilitation to a harm-reduction philosophy led to tolerance of continued drug and alcohol use in some clinics.
- **Contraction of Service Menu:** There was a reduction in the range and intensity of medical, psychiatric, psychological, counseling, and social rehabilitation services provided, as funds to operate MM tightened and private programs discovered that providing fewer services generated greater profits.[102]
- **Regulator and Funder as the Patient:** Increased preoccupation with regulatory compliance and its ever-escalating paperwork burden: "[MM] Programs quickly learned that survival depended on the condition of the records and not the patients."[103] Close observers of MM throughout the 1970s and 1980s noted a shift in the character of the MM milieu from one of care, compassion, and choice to one of power, surveillance, and control.

The very understanding of recovery within the context of MM changed during the 1970s and 1980s. Whereas recovery was initially defined in the MM context in terms of global health and functioning irrespective of one's medication status, recovery later became defined as beginning only at the point of cessation of MM. This newly imposed goal of "abstinence" from the use of methadone created a definition of recovery that precluded the use of methadone as a medication. (The subject of the relationship between methadone and recovery status and the controversies surrounding this question will be the topic of the second article in this monograph). Ironically, a study by Des Jarlais, Joseph, Dole, and Schmeidler[104] found that the likelihood of sustaining abstinence from heroin after tapering from MM was greater in patients entering treatment in 1966-1967, when methadone doses were higher and sustained for longer time periods than in 1972, when methadone doses and maintenance duration were decreasing.

Many MM clinics valiantly struggled to maintain the core clinical practices and personal recovery focus of the early MM model, but others became little more than methadone dosing stations

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101. D'Aunno, T., Foltz-Murphy, N., & Lin, X. (1999). Changes in methadone treatment practices: Results from a panel study: 1988-1995. *American Journal of Drug and Alcohol Abuse, 25*, 681-699. D'Aunno, T., & Pollack, H.A. (2002). Changes in methadone treatment practices: Results from a national panel study, 1988-2000. *Journal of the American Medical Association*, *288*(7), 850-856. Dole, V.P., & Nyswander, M.E. (1976). Methadone maintenance treatment: A ten year perspective. *Journal of the American Medical Association*, *235*, 2117-2119.

102. Kleber, H. (2002). Methadone: The drug, the treatment, the controversy. In D. Musto (Ed.), *One hundred years of heroin* (pp. 149-158). Westport, CT: Auburn House.

103. Zweben, J.E., & Payte, J.T. (1990). Methadone maintenance in the treatment of opioid dependence: A current perspective. *The Western Journal of Medicine, 152*(5), 588-599.

104. Des Jarlais, D.C., Joseph, H., Dole, V.P., & Schmeidler, J. (1983). Predicting post-treatment narcotic use among patients terminating from methadone maintenance. *Journal of Advances in Alcoholism and Substance Abuse, 2*(1), 57-68.

stripped of the rehabilitation services and recovery cultures that had once been essential parts of their character. As drug cultures flourished within and around these dosing stations (e.g., medication diversion, drug sales, prostitution), neighborhood acceptance of MM clinics, which was marginal at best, declined and was replaced by heightened opposition to MM. The worst-managed methadone clinics became the media-shaped face of methadone, and the best-managed clinics became virtually invisible. Myths and misconceptions about methadone flourished in this environment even among MM patients. Patient surveys found that while many believed methadone had positively affected their lives, they also believed that methadone could hurt their health and that its use should be terminated as soon as possible.[105]

Studies of patients clinically or administratively pushed out of MM revealed high rates of post-treatment heroin use, deaths, hospitalizations, arrests, incarcerations, and re-admission to MM. These findings led to calls for sustained retention of patients in MM.[106] Ethnographic studies of local drug cultures revealed that the early vision of MM-facilitated social rehabilitation became replaced by a lifestyle for many MM patients marked by visits to the MM clinic, supplemental alcohol and drug use (e.g., cocaine and fortified wine), panhandling and other criminal activity, and welfare dependence.[107] The erosion in quality of methadone maintenance, and its lost status as an effective, safe, and life-altering treatment for persistent heroin addiction, helped fuel the growing stigma and discrimination attached to MM. In spite of these limitations, a significant core of MM patients negotiated an increasingly oppressive system and forged their individualized recovery paths. Many of these otherwise invisible MM patients also became involved in advocacy, so that others could benefit from their experience, knowledge, wisdom, and tenacity. These patients and patient advocates are among the hidden heroes within the modern history of MM treatment.[108]

EARLY METHADONE CRITICS

One aspect of the story of MM we have not yet discussed is the heightened stigmatization of methadone as a medication, methadone maintenance treatment (particularly high-dose treatment), MM patients, and MM providers at cultural, governmental, and professional levels as well as within American communities of recovery.[109]

Media reports following the initial announcement of MM's development characterized methadone as a panacea—a "Cinderella drug" that induced miraculous changes in addicts. Methadone was portrayed in the popular press as the magic bullet that would solve the country's heroin addiction

105. Stancliff, S., Myers, J.E., Steiner, S., & Drucker, E. (2002). Beliefs about methadone in an inner-city methadone clinic. *Journal of Urban Health, 79*, 571-578.

106. Perkins, M.D., & Bloch, H.I. (1971). A study of some failures in methadone treatment. *American Journal of Psychiatry*, *128*(1), 447-450.

107. Preble, E., & Miller, T. (1977). Methadone, wine and welfare. In R.S. Weppner (Ed.), *Street ethnography.* Beverly Hills: Sage Publications.

108. Joyce Woods, personal communication, March 2010.

109. Fraser, S., & Valentine, K. (2008). *Substance and substitution: Methadone subjects in liberal societies.* New York: Macmillan. Hunt, G., & Rosenbaum, M. (1998). 'Hustling' within the clinic: Consumer perspectives on methadone maintenance treatment. In J.A. Inciardi, & L.D. Harrison (Eds.), *Heroin in the age of crack-cocaine.* Thousand Oaks, CA: Sage. Joseph, H., Stancliff, S., & Langrod, J. (2000). Methadone maintenance treatment: A review of historical and clinical issues. *Mount Sinai Journal of Medicine*, *67*, 347-364. Kleber, H. (2008). Methadone maintenance 4 decades later: Thousands of lives saved but still controversial. *Journal of the American Medical Association, 300*(9), 2303-2305. Murphy, S., & Irwin, J. (1992). "Living with the dirty secret": Problems of disclosure for methadone maintenance clients. *Journal of Psychoactive Drugs, 24*(3), 257-264. Newman, R.G. (1976). Methadone maintenance: It ain't what it used to be. *British Journal of Addiction, 71*, 183-186. Newman, R.G. (1993). Methadone maintenance and recovery. *American Journal of Drug and Alcohol Abuse, 19*(1), 135-137. Newman, R. G., & Peyser, N. (1991). Methadone treatment: Experiment and experience. *Journal of Psychoactive Drugs, 23*(2), 115-121. Rosenbaum, M. (1995). The demedicalization of methadone maintenance. *Journal of Psychoactive Drugs*, *27*, 145-149. Vigilant, L. G. (2001). "Liquid handcuffs": The phenomenology of recovering on methadone maintenance. *Boston College Dissertations and Theses.*

problem.[110] Efforts by Dr. Jerome Jaffe and others to explain that the positive outcomes of MM programs were the result of a total rehabilitative effort and not just the use of methadone went unheeded. The public and professional focus remained on the perceived power of methadone as a medical "cure" for heroin addiction.

Early critics of MM (1970s and 1980s), including competing approaches to addiction recovery (e.g., therapeutic communities, Narcotics Anonymous) and government personnel whose views about maintenance had long been influenced by Bureau of Narcotics Chief Harry Anslinger, proffered 10 key criticisms of MM.

1. MM reinforces the illusion that there are *chemical answers to complex human and social problems.* This criticism came particularly from those who viewed the cause of heroin addiction to be rooted in poverty and racism and who feared this new medication would be a "technological fix" that diverted direct action on those underlying issues.
2. Methadone merely *substitutes a legal addiction for an illegal addiction*; it is a form of "legalized euphoria" that does not eliminate craving for heroin.
3. Addicts maintained on methadone suffer from *cognitive, emotional, and behavioral impairment:* MM is a "crutch"—a pharmacological shield that prevents addicts from adjusting to reality.[111]
4. Government distribution of methadone reflects an attitude of permissiveness that *contributes to youthful drug experimentation.*
5. The *positive effects attributed to MM in published research studies are over-stated.*
6. The *source of addiction* is rooted in the addict's character/personality, not his or her cells.
7. Treating heroin addiction with another opioid like methadone is *morally unacceptable*.
8. Methadone maintenance is a *tool of genocide and racial oppression.*
9. The methadone treatment industry *financially exploits* those it has pledged to serve.[112]
10. MM is a "hostile exercise in disciplining the unruly misuses of pleasure and in *controlling economically unproductive bodies*" through enforced dependency.[113]

Widely publicized criticisms of MM became part of the growing body of myths and misunderstandings that have plagued MM since its inception.[114] Such misconceptions exerted considerable

110. Senay, E.C. (1971). Methadone: Some myths and hypotheses. *Journal of Psychedelic Drugs*, *4*(2), 182-185.

111. Jackman, J. (1973). A hypothesis concerning the difficulty of withdrawal from maintenance on methadone. In *Proceedings of the Fifth National Conference on Methadone Treatment* (pp. 471-475). New York: HAPAN.

112. See Berry, 2007 for the most current presentation of this argument and Boudaris' 1975 contention that MM patients are tethered to daily clinic visits not out of clinical necessity but financial advantage to the clinics. Berry, L.C. (2007). *In$ide the methadone clinic industry: The financial exploitation of America's opiate addicts*. Tucson, AZ: Wheatmark. Boudouris, J. (1975). The economics of methadone programs. *British Journal of Addiction*, *70*, 374-380.

113. Ausbel, D.P. (1983). Methadone maintenance treatment: The other side of the coin. *The International Journal of the Addictions*, *18*(6), 851-862. Bourgois, P. (2000). Disciplining addictions: The bio-politics of methadone and heroin in the United States. *Culture, Medicine and Psychiatry, 24*, 165-195. Brecher, E. (1972). *Licit and illicit drugs*. Boston: Little, Brown and Company. Jaffe, J., & O'Keefe, C. (2003). From morphine clinics to buprenorphine: Regulating opioid agonist treatment of addiction in the United States. *Drug and Alcohol Dependence, 70,* S3-S11. Lennard, H.L., Epstein, L.J., & Rosenthal, M.S. (1972). The methadone illusion. *Science*, *176*(4037), 881-884. E. Senay, personal communication, February 16, 2010. White, W. (2009). *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).* Philadelphia: Department of Behavioral Health and Mental Retardation Services.

114. Zweben, J.E., & Sorensen. J.L. (1988). Misunderstandings about methadone. *Journal of Psychoactive Drugs*, *20*(3), 275-280.

influence on how MM clinics and MM patients viewed themselves and how allied professionals, the public, and policymakers viewed MM treatment. At a most practical level, starting or relocating new MM clinics became increasingly difficult from the mid-1970s forward in a cultural climate filled with such views.[115] Most poignantly, MM patients faced stigma and discrimination from many quarters based on these perceptions, including within the larger addiction treatment field and local recovery mutual aid societies.[116]

TOWARD THE REVITALIZATION AND ELEVATION OF METHADONE MAINTENANCE

In 2003, Mark Parrino, President of the American Association for the Treatment of Opioid Dependence (AATOD), suggested that methadone maintenance was entering a renaissance period of renewal, revitalization, and potential transformation. This renaissance began in the late 1980s and early 1990s with the reaffirmation of the effectiveness of MM by prominent scientific, professional, and governmental bodies, including the:

- Lasker Foundation (1988),[117]
- Institute of Medicine (1990),[118]
- American Society of Addiction Medicine (1990),[119]
- Government Accounting Office Report (1990),[120]
- Office of Technology Assessment of the United States Congress (1990),[121]
- Ball and Ross systematic review of MM outcomes (1991),[122]
- American Medical Association Council on Scientific Affairs (1994),[123]
- New York State Office of Alcoholism and Substance Abuse Services (1994),[124]
- California Drug and Alcohol Treatment Assessment (1994),[125]
- National Institutes of Health Consensus Conference on Effective Treatment of Heroin Addiction (1997),[126]
- American Public Health Association (1997),
- American Medical Association House of Delegates (1997),

115. Courtwright, D. (1997). The prepared mind: Marie Nyswander, methadone maintenance, and the metabolic theory of addiction. *Addiction*, *92*(3), 257-265.

116. White, W. (2009). *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)*. Philadelphia: Department of Behavioral Health and Mental Retardation Services.

117. Accessed April 20, 2010 at http://www.laskerfoundation.org/awards/1988_c_description.htm.

118. Institute of Medicine (1990). *Treating drug problems, Vol. 1*. Washington, DC: National Academy Press. Institute of Medicine (1995). *Federal regulation of methadone treatment*. (Richard A. Rettig and Adam Yarmolinsky, Editors). Washington, D.C.: National Academy Press. Institute of Medicine (2006). *Improving the quality of health care for mental and substance-use conditions*. Washington, D.C.: The National Academies Press.

119. American Society of Addiction Medicine. (1990, Revised 2006). *Methadone treatment of addiction: Public policy statement*. Retrieved November 2, 2009 from http:/www.asam.org/MethadoneTreatmentofAddiction.html.

120. U.S. General Accounting Office (1990). *Methadone maintenance: Some treatment programs are not effective; greater federal oversight needed* (GAO Report No. GAO/HRD-90-104).

121. Office of Technology Assessment, US Congress. (1990). *The effectiveness of drug abuse treatment: Implications for controlling AIDS/HIV infection*. Washington, DC: Office of Technology Assessment.

122. Ball, J.C., & Ross, A. (1991). *The effectiveness of methadone maintenance*. New York: Springer-Verlag.

123. Yoast R., Williams, M.A., Deitchman, S.C., & Champion, H.C.. (2001). Report of the Council on Scientific Affairs: Methadone maintenance and needle-exchange programs to reduce the medical and public health consequences of drug abuse. *Journal of Addictive Diseases, 20*, 15-40.

124. Joseph, H., & Woods, J.S. (Chemical Dependency Research Working Group). (1994). *Methadone treatment works: A compendium for methadone maintenance treatment*. New York State Office of Alcoholism and Substance Abuse Services.

125. Gerstein D., Johnson R. A., Harwood H., Fountain D., Suter N., & Malloy K. (1994). *Evaluating recovery services: the California Drug and Alcohol Treatment Assessment (CALDATA)*. California Department of Alcohol and Drug Programme Resource Center, Sacramento, CA.

126. National Consensus Development Panel on Effective Medical Treatment of Opiate Addiction. (1998). Effective medical treatment of opiate addiction. *Journal of the American Medical Association, 280*(22), 1936-1943.

- Office of National Drug Control Policy (1990, 1999),[127]
- National Institute on Drug Abuse (1999),[128]
- World Health Organization (2001), and
- Cochrane Review (2003).[129]

These well respected reviews confirmed that methadone delivered at sustained optimal daily dosages and combined with ancillary psychosocial services delivered by competent practitioners:

- decreases the death rate of opioid-dependent individuals by as much as 50%;
- reduces the transmission of HIV, Hepatitis B and C, and other infections;
- eliminates or reduces illicit opioid use;
- reduces criminal activity;
- enhances productive behavior via employment and academic/vocational functioning;
- improves global health and social functioning; and
- is cost-effective.[130]

The effectiveness of MM was affirmed, and MM became the primary method used worldwide in the medical treatment of heroin addiction "despite regulatory constraints and suboptimal performance by many programs."[131]

> *Today, the safety, effectiveness, and value of properly applied MMT is no more controversial [from the standpoint of science] than is the assertion that the earth is round.*[132]

As the international body of scientific studies supporting MM grew, Dr. Dole continued to communicate what MM could and could not do as a treatment for heroin addiction.

> *The treatment therefore, is corrective but not curative for severely addicted persons. A major challenge for future research is to identify the specific defect in receptor function and to repair it. Meanwhile, methadone maintenance provides a safe and effective way to normalize the function of otherwise intractable narcotic addicts.*[133]

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127. Office of National Drug Control Policy. (March, 1999). *Policy paper—opioid agonist treatment.* Washington, DC: Executive Office of the President, Office of National Drug Control Policy.

128. National Institute on Drug Abuse. (1983). *Research on the treatment of narcotic addiction-State of the art.* US Department of Health and Human Services, Rockville, Maryland. National Institute on Drug Abuse (1999). *Principles of addiction medicine: A research-based guide* (NIH Publication No. 99-1180). Rockville, MD: National Institute on Drug Abuse.

129. Mattick R.P., Breen, C., Kimber, J., & Davoli, M. (2003). Methadone maintenance therapy versus no opioid replacement therapy for opioid dependence. *Cochrane Database of Systematic Reviews, (Issue* 2):CD002209.

130. Kreek, M. J., & Vocci, F. (2002). History and current status of opioid maintenance treatments. *Journal of Substance Abuse Treatment, 23*(2), 93-105.

131. Dole, V.P. (1992). Hazards of process regulation: The example of methadone maintenance. *Journal of the American Medical Association*, *267*, 2234-2235.

132. Bell, J., & Zador, D. (2000) A risk-benefit analysis of methadone maintenance treatment. *Drug Safety, 22*(3), 179-190. Payte, J. T. (1991). A brief history of methadone in the treatment of opiate dependence: A personal perspective. *Journal of Psychoactive Drugs, 23*(2), 103-107.

133. Dole, V.P. (1988). Implications of methadone maintenance for theories of addiction. The Albert Lasker Medical Awards. *Journal of the American Medical Association*, *260*, 3025-3029.

RECENT GROWTH OF METHADONE MAINTENANCE

The number of patients admitted to OTPs in the United States grew dramatically between 1998 and 2008—influenced by the growth in for-profit OTPs and new patterns of opioid addiction, e.g., increased addiction to pharmaceutical opioids. There are now 1,203 opioid treatment programs in 46 states (and the District of Columbia, U.S. Virgin Islands, American Samoa, and Puerto Rico), treating more than 260,000 patients on any given day.[134] A 2009 analysis provides the latest profile of OTPs in the United States:

- OTPs constitute only 8% of all U.S. addiction treatment facilities, but OTP patients constitute 23% of all patients in addiction treatment.
- 67% of OTPs serve only patients in medication-assisted treatment—reflecting the isolation of OTPs and their patients from the mainstream treatment system.
- 50% of OTPs are operated by for-profit organizations.
- Of 265,716 patients in OTP treatment in 2008, 99% were treated with methadone, and 1% were treated with buprenorphine.
- Half of all OTP patients pay out-of-pocket for their own treatment, at an average annual cost of $4,176 per year.
- 40% of OTP patients in the United States have been in methadone maintenance treatment for more than two years.[135]

THE QUALITY OF METHADONE MAINTENANCE

As the safety and effectiveness of MM was being reaffirmed, three additional findings in the 1990s triggered efforts to elevate the quality of methadone treatment.[136] The first centered on the scientific studies of Dr. John Ball and his colleagues suggesting that program factors (e.g., program policies, management capabilities, workforce stability, and staff training) play a greater role in MM clinical outcomes than do patient factors.[137] The second was the 1990 General Accounting Office (GAO) report that exposed the high frequency of heroin and other drug use by MM patients as resulting from subtherapeutic doses of methadone.[138] The third factor was growing awareness of the wide variability in quality of MM treatment programs in the United States and the lack of clear standards or guidelines for best clinical practices in MM.[139]

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134. Parrino, M. (2008). Coordinating methadone treatment providers and policymakers: Lessons learned over 30 years. *Heroin Addiction and Related Clinical Problems*, *11*(1), 43-46.

135. DASIS (2006). *The DASIS Report: Facilities operating opioid treatment programs: 2005*. Office of Applied Studies, Substance Abuse and Mental Health Services Administration. Kresina, T.F., Litwin, A., Marion, I., Lubran, R., & Clark, H.W. (2009). United States government oversight and regulation of medication assisted treatment for the treatment of opioid dependence. *Journal of Drug Policy Analysis*, *2*(1), Article 2.

136. M. Parrino, personal communications, February 11, 2010 and March 4, 2010.

137. Ball, J. C. (1994). Methadone maintenance: A reply to the commentaries. *Addiction, 89,* 813. Ball, J. C., & Corty, E. (1988). Basic issues pertaining to the effectiveness of methadone maintenance treatment. In C. G. Leukefeld & F. M. Tims (Eds.), *Compulsory treatment of drug abuse: Research and clinical practice* (NIDA Research Monograph 88, pp. 178-191). Rockville, MD: National Institute on Drug Abuse. Ball, J. C., Corty, E., Petroski, S. P., Bond, H., Tommasello, A., & Graff, H. (1986). Medical services provided to 2,394 patients at methadone programs in three states. *Journal of Substance Abuse Treatment, 3,* 203-209. Ball, J. C., & Ross, A. (1991). *The effectiveness of methadone maintenance treatment.* New York: Springer-Verlag.

138. U.S. General Accounting Office. (1990). *Methadone maintenance: Some treatment programs are not effective; greater federal oversight needed* (GAO Report No. GAO/HRD-90-104).

139. M. Parrino, personal communications, February 11, 2010 and March 4, 2010.

The revived scientific orientation and reaffirmation of the clinical effectiveness of MM, and concerns about quality of care across MM programs, led to the formation of a Commission established by the Institute of Medicine[140] to study the Federal regulation of methadone. One of the Study Panel's major recommendations led to the 2001 shift in regulatory authority over MM from the Drug Enforcement Administration (DEA) and the Food and Drug Administration (FDA) to the Center for Substance Abuse Treatment (CSAT), one of the arms of the Substance Abuse and Mental Health Services Administration (SAMHSA). One of CSAT's first acts was a conceptual shift in the identity of MM from that of the methadone clinic to that of an Opioid Treatment Program (OTP). CSAT supported the independent accreditation of OTPs, refined and disseminated OTP guidelines and best-practices protocol, and provided OTP-related training and technical assistance. The shift from a regulatory oversight model to an accreditation and technical assistance model reflected the desire for greater emphasis on quality improvement and elevated outcomes in MM.[141] Consistent with this quality emphasis, CSAT developed a series of updated Treatment Improvement Protocols (TIPs) related to MM: *State Methadone Treatment Guidelines*, 1993; *Assessment and Treatment of Cocaine-Abusing Methadone-Maintained Patients*, 1994; *Matching Treatment to Patient Needs in Opioid Substitution Therapy*, 1995; *LAAM in the Treatment of Opiate Addiction,* 1995; and *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs*, 2005.

CULTURAL AND PROFESSIONAL STATUS OF METHADONE MAINTENANCE

Other changes influenced the cultural and professional status of MM. First, there was an increase in public education efforts that portrayed addiction as a treatable brain disease. These noteworthy programs, including the PBS special, *Moyers on Addiction: Close to Home* (1998) and the HBO special, *Addiction* (2007) heightened public awareness of new neurobiological understandings of drug addiction and effective treatments. The educational programming was accompanied by efforts by the American Bar Association Standing Committee on Substance Abuse, Join Together, Legal Action Center, and other organizations to address the stigma and discrimination faced by MM patients[142] and the growing political interest in protecting the rights of MM patients (e.g., work of the Congressional Caucus on Addiction, Treatment and Recovery). Among these efforts was a combined initiative by the American Bar Association and Join Together soliciting testimony about the current state of stigma and discrimination toward those who are addicted, those who have loved ones who are addicted, those in or seeking treatment and recovery, and those who have tried to put addiction behind them only to encounter discrimination based on their history of addiction.

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140. Institute of Medicine. (1995). *Federal regulation of methadone treatment.* (Richard A. Rettig and Adam Yarmolinsky, Editors). Washington, D.C.: National Academy Press.

141. Parrino, M. (1998). The American Methadone Treatment Association, Inc. (AMTA): The tornado of change. *Journal of Maintenance in the Addictions*, *1*(3), 71-80.

142. Join Together (2003). *Ending discrimination against people with alcohol and drug problems.* Retrieved December 18, 2009 from www.jointogether.org/discrimination.

A second force was the political awakening of people in medication-assisted recovery, as evidenced by the creation of new recovery advocacy groups as well as the inclusion of people in medication-assisted recovery in leadership roles in mainstream recovery advocacy organizations, such as Faces & Voices of Recovery.[143] The medication-assisted groups included Advocates for the Integration of Recovery and Methadone (AFIRM, founded 1995), the National Alliance for Medication Assisted Recovery (formerly the National Alliance of Methadone Advocates, founded 1988), Advocates of Recovery through Medicine (ARM, founded in 1999-2000), and the Opioid Dependence Resource Center. One outcome of this awakening was the growth in patient advisory boards and patient run groups within OTPs, as well as increased representation of MM patients on various federal, state, and local policy committees.

The heightened professionalization of the MM treatment field also served to elevate the status of MM. Such professionalization spanned the evolution of the Northeast Regional Methadone Treatment Coalition (1984) into the American Methadone Treatment Association (1990), the American Association for the Treatment of Opioid Dependence (AATOD, 2001), and the more recent founding of the World Federation for the Treatment of Opioid Dependence (2007). These associations emerged in direct response to the contraction of publicly funded methadone treatment and public attacks on methadone maintenance (e.g., the 1983 "Deadly Cure" series in the *South Florida Sun-Sentinel*). The drive to both defend and elevate the quality of MM contributed to the transformation of "methadone clinics" into "Opioid Treatment Programs" (OTPs), the development of OTP accreditation standards, and the subsequent accreditation of all 1,215 OTPs in the United States.[144]

These achievements co-exist with regressive forces that continue to tarnish the image of methadone as a medication, methadone treatment patients, and America's OTPs. In spite of scientific and professional advancements, cultural stigma and professional and political hostility toward methadone maintenance continue.[145]

RECOVERY-ORIENTED METHADONE MAINTENANCE

There is growing interest in recovery-oriented OTPs in the U.S. In 2005, the National Quality Forum (NFQ), through support from the Robert Wood Johnson Foundation and the Center for Substance Abuse Treatment, created national standards for addiction treatment that called for treating persons with severe substance use disorders via a "chronic care model" focused on long-term

143. Woods, J. (1997). Advocacy and making change: The voice of the consumer. In J. H. Lowinson, P. Ruiz, R. B. Millman, & J. Langrod (Eds.), *Comprehensive textbook of substance abuse* (3rd edition, pp. 865-873). Baltimore, MD: Williams and Wilkins.

144. M. Parrino, personal communications, February 11, 2010 and March 4, 2010.

145. Clark, H.W. (2010). Pennsylvania may limit methadone treatment to one year. *Alcoholism & Drug Abuse Weekly*, 22(25), 4-6.

recovery management support. The NFQ further supported the availability of integrated pharmacotherapy and psychosocial treatment for all adults diagnosed with opioid dependence. Efforts are underway to move beyond harm reduction toward an enhanced recovery orientation[146] and to conceptually and clinically bridge medication-based strategies aimed at reduction of personal and social harm and psychosocial models of addiction treatment.[147] Proponents argue that these efforts to bring dichotomized approaches into an integrated framework are particularly promising because they provide a means of working with individuals at different stages of their addiction and recovery careers. The New York State Office of Alcoholism and Substance Abuse Services (OASAS) is working to transform its methadone clinics into comprehensive addiction recovery centers offering multiple levels and modalities of care. In New York, a peer-based recovery support services model was developed in 2006 for patients in methadone treatment via the CSAT-funded Recovery Community Services Program. The Medication Assisted Recovery Services (MARS) project in New York City is likely to be widely replicated.[148]

In 2009, Southwest Behavioral Health Management, a large behavioral health management organization in Pennsylvania, and the Institute for Research, Education and Training in the Addictions (IRETA) developed the first recovery-focused practice guidelines for methadone maintenance treatment.[149] Other evidence of the movement toward a recovery orientation in OTPs includes the number of recovery-themed plenary presentations at the 2009 AATOD annual conference and the growing number of OTPs and recovery advocacy organizations providing Methadone Anonymous meetings. The Center for Substance Abuse Treatment has also been influential in this movement through its funding of several MM recovery support initiatives, including a new CSAT monograph, Introduction to *Recovery-Oriented Systems of Care for Opiate Treatment.* Also promising are renewed efforts to reduce the cultural and professional stigma that has permeated methadone as a medication, methadone maintenance patients, and methadone maintenance treatment providers.[150]

These broad initiatives are influencing particular aspects of recovery-oriented service practice within MM. Some of the more promising of these include:

- **Recovery Representation:** OTPs are attempting to increase recovery representation at board, leadership, staff, and volunteer levels, e.g., growing interest in consumer councils and other patient-centered advisory and governance structures.[151]

146. Rabinowitz, A. (2009). Enhancing medication-assisted treatment: Success beyond harm reduction. *Journal of Social Work Practice in the Addictions*, *9*, 240-243.

147. Kellogg, S.H. (2003). On "Gradualism" and the building of the harm reduction-abstinence continuum. *Journal of Substance Abuse Treatment*, *25*, 241-247. Kellogg, S.H., & Kreek, M.J. (2005). Gradualism, identity, reinforcements, and change. *International Journal of Drug Policy*, *16*, 369-375. McLellan, A.T. (2003). What's the harm in discussing harm reduction: An introduction to a three-paper series. *Journal of Substance Abuse Treatment*, *25*, 239-240.

148. Ginter, W. (2009). *Advocacy for medication-assisted recovery.* Retrieved November 4, 2009 from http://www.facesandvoicesofrecovery.org/publications/profiles/walter_ginter.php.

149. Institute for Research, Education and Training on Addictions (IRETA). (2010). *Recovery-oriented methadone: Improving practice to enhance recovery* (Report prepared for Southwest Behavioral Health Management, Inc.). Pittsburgh, PA: IRETA.

150. White, W. (2009). *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).* Philadelphia: Department of Behavioral Health and Mental Retardation Services.

151. The Net Consumer Council, Evans, A.C., Lamb, R.C., Mendelovich, S., Schultz, C.J., & White, W.L. (2007). *The role of clients in a recovery-oriented system of addiction treatment: The birth and evolution of the NET Consumer Council.*

- **Recovery-Linked Quality Indicators**: Substantial progress is being made in meeting consensus guidelines for methadone treatment, e.g., increases in the percentage of OTPs using optimal methadone dosages, increased retention/duration of participation in OTPs, and HIV testing, counseling, and outreach.[152]
- **Patient Choice:** There is increased emphasis on the importance of patient participation in decision-making within OTPs.[153] The introduction of buprenorphine as an alternative medical treatment for opioid dependence via the 2002 approval of Subutex® and Suboxone® is also giving patients additional medication and delivery site options, although this is severely limited due to its cost.[154]
- **Service Relationship:** There is growing interest in elevating the quality of service relationships in OTPs—relationships free of contempt and grounded in a sustained partnership marked by respect, emotional authenticity, and continuity of support. MM advocates are calling for a reaffirmation of the MM patient's status to that of a "patient" whose concerns are heard rather than an addict whose every complaint represents "drug seeking behavior" and who must be controlled in a paternalistic fashion.
- **Peer-Based Recovery Support:** There are new experiments with MM-specific approaches to peer-based recovery support services, improved relationships between OTPs and existing recovery mutual aid groups, development of new medication-assisted recovery support groups, and development of assertive procedures for linking MM patients to mutual aid groups and other recovery community institutions. Patients who daily stand in the queue to receive their dose of methadone have little contact with highly stabilized and high functioning MM patients in recovery, and few patients beginning MM treatment know of former MM patients who have tapered from MM and successfully sustained long-term recovery. What they do see are the least stabilized patients as well as patients who are returning to MM following earlier post-treatment relapse; they see neither successful long-term maintenance nor sustained recovery after medication maintenance.[155] The goal of OTP-based or -linked peer-based recovery support services is to offer living proof of long-term medication-assisted recovery and the variation in styles of such recoveries.

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152. Stocker, S. (2000). Drug abuse treatment programs make gains in methadone treatment and HIV prevention. *NIDA Notes*, *15*(3), 1-2.

153. Stocker, S. (2000). Drug abuse treatment programs make gains in methadone treatment and HIV prevention. *NIDA Notes*, *15*(3), 1-2.

154. D'Aunno, T., & Pollack, H.A. (2002). Changes in methadone treatment practices: Results from a national panel study, 1988-2000. *Journal of the American Medical Association*, *288*(7), 850-856.

155. Rosenbaum, M., & Murphy, S. (1984). Always a junkie?: The arduous task of getting off methadone maintenance. *Journal of Drug Issues*, *14*, 527-552.

- **Alternative Frameworks for Recovery Maintenance Support:** Early pilots of medical maintenance—medication maintenance via a monthly visit to a physician's office—hold great promise as a support option for highly stabilized patients.[156] Medical maintenance represents a means of nesting recovery within each patient's natural environment as well as a means of more completely severing ties with the drug culture.
- **Post-treatment Monitoring, Support, and Early Re-intervention:** Regardless of the theoretical orientation underlying MM, the reality is that few MM patients are continuously enrolled in MM for life. In 2005, the average time in treatment for patients discharged from opioid replacement therapy in the United States was 245 days.[157] Models of sustained post-treatment recovery checkups and outreach-based re-intervention with disengaged MM patients are available for wide replication and adaptation, to support the ongoing treatment and recovery of these patients.[158]

We will explore recovery-oriented service practices in great detail in the third article in this monograph. There are significant but not insurmountable challenges to achieving greater recovery orientation within OTPs. The cultural and professional climates remain hostile toward MM. Patients and service providers were reminded of this when public billboards proclaiming "Methadone Kills" appeared across the country in 2008. Attacks on MM from other addiction treatment professionals continue amidst allegations of financial profiteering by MM clinics and tort lawyers who view OTPs as a new source of potential plunder. Like that of other addiction services, public funding of MM is precarious in these difficult financial times because of municipal and state budget crises. Also, third-party payors (private and public insurance) are exerting an ever greater influence on MM through their decisions regarding what MM-related services they will and will not pay for, and for how long.

Acknowledging such challenges does not imply that OTPs lack ownership of their own fate. The future of OTPs will rest primarily on their own collective ability to forge a more person-centered, recovery-focused medical treatment for opioid addiction and to confront methadone-related social stigma through assertive campaigns of education and political/professional influence. The degree of success of such campaigns will determine the safety and quality of MM as a person-centered, recovery-focused medical treatment. It will also determine the future of the "peculiar American ambivalence about the opioid addict as not quite a patient and not quite a criminal."[159]

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156. Novick, D.M., & Joseph, H. (1991). Medical maintenance: The treatment of chronic opiate dependence in general medical practice. *Journal of Substance Abuse Treatment, 8*, 233-239. Novick, D.M., Joseph, H., Salsitz, E.A., Kalin, M.F., Keefe, J.B., Miller, E.L., & Richmond, B.L. (1994). Outcomes of treatment of socially rehabilitated methadone patients in physicians' offices (medical maintenance): Follow-up at three and a half to nine and a fourth years. *Journal of General Internal Medicine*, *9,* 127-130. Senay, E.D., Barthwell, A.G., Marks, R., Bokos, P., Gillman, D., & White, R. (1993). Medical maintenance: A pilot. *Journal of Addictive Diseases*, *12*(4), 59-76.

157. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2008). *Treatment Episode Data Set (TEDS): 2005. Discharges from Substance Abuse Treatment Services* (DASIS Series: S-41, DHHS Publication No. (SMA) 08-4314). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

158. Dennis. M. L., Scott, C. K., & Funk, R. (2003). An experimental evaluation of recovery management checkups (RMC) for people with chronic substance use disorders. *Evaluation and Program Planning, 26*(3), 339-352. Zanis, D. A., McLellan, A. T., Alterman, A. I., & Cnaan, R. A. (1996). Efficacy of enhanced outreach counseling to reenroll high-risk drug users 1 year after discharge from treatment. *American Journal of Psychiatry*, *153*, 1095-1096.

159. Jaffe, J., & O'Keefe, C. (2003). From morphine clinics to buprenorphine: Regulating opioid agonist treatment of addiction in the United States. *Drug and Alcohol Dependence, 70,* S3-S11.

SUMMARY

Methadone maintenance as originally conceived and practiced constituted one of the few treatments based explicitly on an understanding of addiction as a chronic disease. The original model of MM posited that full recovery from, but not a cure of, heroin addiction was possible and that such recoveries were best nourished within a supportive and service-rich treatment milieu marked by a sustained recovery support partnership between MM staff and their patients. Throughout the 1970s and 1980s, many core beliefs and practices of MM programs changed in ways that eroded their personal recovery orientation, the scope of services offered, and their overall effectiveness (as measured by attraction, retention, and personal recovery outcomes). The work to revitalize today's OTP programs in the United States and to recapture their focus on long-term recovery should be welcomed by all addiction professionals.

The OTP system of care in the United States may itself be in need of a recovery process. This would involve acknowledging that, as a system of care, OTPs have lost their recovery orientation, and that patients are being harmed in some OTPs by sub-standard services and by service milieus that fail to visibly model and nurture long-term personal and family recovery. The gross power inequities between the patient and clinic must be acknowledged, abuses of such power admitted, and new service relationships forged on a long-term recovery partnership model. Substandard care must be exposed and confronted, amends must be made where possible, and OTPs must be transformed into recovery-oriented systems of care.

In the next two articles, we will attempt to lay a foundation for such systems-transformation processes by defining recovery within the context of methadone treatment (and the broader arena of medication-assisted treatment) and discussing strategies of sustained recovery management in the OTP context.

II. Recovery and Methadone

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

> *Essentially the question is whether the emphasis in treatment should be directed to the patient or to the medication.*
>
> *—Dr. Vincent Dole*[160]

> *I am not my disease, and I am not my medication.*
>
> *—Excerpt from methadone patient's email to the authors, 2009*

> *The only places my recovery is known of and respected is at my MMTP and among my family. To others, my recovery remains nonexistent, it's a part of my life I sometimes feel ashamed of, not because of my ignorance, but that of others. I have worked hard over the years to achieve my optimal dose stabilization & to sustain my recovery.*
>
> *—Excerpt from methadone patient's email to the authors, 2010*

The use of medications such as methadone, naltrexone, and Buprenorphine/Suboxone/Subutex in the treatment of opioid addiction, and questions related to the recovery status of patients taking these medications, continue to be debated vigorously at professional and cultural levels. Such discussions have intensified in tandem with recent efforts in the United States and the United Kingdom to define recovery from substance use disorders and with the emergence of recovery as a central organizing construct for the addictions field and the larger arena of behavioral health care.[161]

Can a methadone patient who has achieved long-term dose stabilization, uses no other non-prescribed opioids or other intoxicants (including alcohol), and has achieved significant improvements in psychosocial health and positive community integration be considered *in recovery* or *recovering*? The authors offer a clear, affirmative answer to that question as we outline 24

160. Dole, V.P. (1973). Detoxification of methadone patients, and public policy. *Journal of the American Medical Association*, *226*(7), 780.

161. Betty Ford Institute Consensus Panel. (2007). What is recovery? A working definition from the Betty Ford Institute. *Journal of Substance Abuse Treatment*, *33*, 221-228. Center for Substance Abuse Treatment (CSAT). (2007). *National Summit on Recovery: Conference Report* (DHHS Publication No. SMA 07-4276). Rockville, MD: Substance Abuse and Mental Health Services Administration. Laudet, A. B. (2007). What does recovery mean to you? Lessons from the recovery experience for research and practice. *Journal of Substance Abuse Treatment*, *33*, 221-228. United Kingdom Drug Policy Commission. (2008). A consensus definition of recovery. Accessed June 24, 2010 at http://www.ukdpc.org.uk/resources/A%20Vision%20of%20Recovery.pdf . White, W. (2005). Recovery: Its history and renaissance as an organizing construct. *Alcoholism Treatment Quarterly, 23*(1), 3-15. White, W. (2007). Addiction recovery: Its definition and conceptual boundaries. *Journal of Substance Abuse Treatment*, *33*, 229-241. White, W. (2008). Recovery: Old wine, flavor of the month or new organizing paradigm? *Substance Use and Misuse, 43*(12&13), 1987-2000.

propositions related to the role of methadone maintenance in long-term addiction recovery, propositions that we believe are supported by the available historical, scientific, and clinical evidence.

METHADONE AND RECOVERY STATUS

1. **Productive explorations of the effects of methadone or other medications on addiction recovery status hinge on a clear definition of recovery.**
2. **The recovery status of methadone maintenance (MM) patients should be evaluated using the same definition of recovery that applies to the resolution of all substance use disorders.**

Controversy and stigma continue to surround the use of methadone in the 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 is debated even within the professional field of addiction treatment and various recovery communities. Answering the controversy regarding the recovery status of methadone patients requires a clear understanding of what constitutes recovery from opioid addiction. Recovery from opioid addiction and other substance use disorders is a historically ill-defined concept that is often viewed differently by policymakers, the public, addiction and allied health professionals, and affected individuals and families.

RECOVERY AS INTENTION

3. **Public understanding of addiction *recovery* as a motivational state rather than a stable behavioral health status contributes to therapeutic pessimism and the social stigma attached to addiction and addiction treatment.**
4. **Recovery is more than "trying" to decelerate or stop opioid and other drug use. The "trying" definition sets a low bar for expectations related to global health and functioning, contributes to the stigma attached to methadone treatment, and restricts opportunities for the methadone patient to participate positively in community life.**

When Faces & Voices of Recovery commissioned a survey of how the American public understood the word "recovery," one of the findings was particularly surprising. The majority of those

surveyed thought the term recovery referred to someone who was "*trying* to stop using alcohol or drugs."[162] Bombarded by daily scenes of celebrities heading back to "rehab," the public has come to see recovery as a fragile motivational state rather than as the durable experience of the millions of individuals in the U.S. who are in stable long-term addiction recovery.[163]

The understanding of recovery as intention shapes differing views of MM based on how the public perceives methadone and motivations for its use. If methadone is viewed as an intoxicating drug (a "legal high") and patient motivation for MM is viewed as a search for intoxication, then MM patients will not be afforded recovery status due to their failure to meet the "trying to stop" criterion. If, on the other hand, methadone is viewed as a non-intoxicating, normalizing medication taken by MM patients to promote social rehabilitation and eliminate the symptoms that lead to drug-seeking, MM might well be embraced within the public's current conception of recovery. The danger even in this latter scenario is that the bar for recovery would be set so low that those achieving it would still be stigmatized and estranged from mainstream community life.

RECOVERY AS REMISSION

5. **Recovery is more than remission (defined as the sustained cessation or deceleration of drug use/problems to a point at which the person no longer meets diagnostic criteria for opioid dependence or another substance use disorder).**
6. **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 personal/family life.**

Remission is a clinical term used in psychiatry and addiction medicine to convey that the diagnostic elements for a substance-related disorder have diminished completely (key symptoms no longer present) or partially (presence of some symptoms, but not sufficient in number or severity to meet diagnostic criteria).[164] If recovery is defined as remission, then the primary measure of recovery is not abstinence from drug use but the absence of drug-related clinical pathology. This approach is reflected in opioid addiction treatment outcome studies that have defined recovery as a state in which "drug abuse and related behavior are no longer problematic in the individual's life."[165] Simpson and Marsh,[166] for example, define recovery from opioid addiction in terms of the indicators of "reduction of drug use, criminal involvement and unemployment"—a definition that does not explicitly require abstinence from heroin or other drugs.

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162. Peter D. Hart Research Associates. (2004). *Faces and Voices of Recovery Public Survey*. Washington, D.C.: Peter D. Hart Research Associates.

163. Compton, W.M., Thomas, Y.F., Stinson, F.S., & Grant, B.F. (2007). Prevalence, correlates, disability, and comorbidity of DSM-IV drug abuse and dependence in the United States. *Archives of General Psychiatry, 64*(5), 566-576. Dawson, S.A., Grant, B.F., Stinson, F.S., Chou, P.S., Huang, B., & Ruan, W.J. (2005). Recovery from DSM-IV alcohol dependence: United States, 2001-2002. *Addiction, 100*(3), 281-292. Hasin, D.S., Stinson, F.S., Ogburn, E., & Grant, B. F. (2007). Prevalence, correlates, disability and comorbidity of DSM-IV alcohol abuse and dependence in the United States: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Archives of General Psychiatry, 64*(7), 830-842. . . . .

164. American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

165. Leukefeld, C.G., & Tims, F.M. (1986). Relapse and recovery: Some directions for research and practice. In F. Tims & C. Leukefeld (Eds.), *Relapse and recovery in drug abuse* (NIDA Monograph 72, pp. 185-190). Rockville, MD: National Institute on Drug Abuse. . . . .

166. Simpson, D.D., & Marsh, K.L. (1986). Relapse and recovery among opioid addicts 12 years after treatment. In F. Tims & C. Leukefeld (Eds.), *Relapse and recovery in drug abuse* (NIDA Monograph 72, pp. 86-103). Rockville, MD: National Institute on Drug Abuse.

Some MM advocates have argued that MM treatment should be evaluated by one criterion only: its ability to bring heroin dependence into stable remission.[167] Others have argued against the recovery-as-remission definition.

> *… cultural and professional misunderstandings and stigma attached to methadone led to justifications of MM 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.*[168]

> *As long as well-intentioned people go around saying that "methadone is recovery," it is going to continue to be misunderstood. Methadone is a medication, a tool, even a pathway, but it is not recovery. Recovery is a way of living one's life. It doesn't come in a bottle.*[169]

When recovery is defined solely in terms of remission, stabilized MM patients who are no longer addicted to opioids meet the criteria for achieving the status of recovery without accounting for other drug (including alcohol) use patterns or whether or not they have achieved larger improvements in quality of life and social functioning.

The American Society of Addiction Medicine has taken a step beyond the recovery-as-remission definition by defining recovery as "overcoming both physical and psychological dependence to a psychoactive drug while making a commitment to sobriety."[170] ASAM added the criterion of intentionality via a commitment for future sobriety, perhaps to distinguish recovery from the artificially imposed periods of enforced abstinence that are often part of prolonged addiction careers. Based on this definition, the stabilized person in MM who is no longer addicted to heroin *and* who is committed to continued abstinence from heroin would meet this definition of recovery. One weakness of the ASAM definition is that it doesn't specify what other kinds of drug use would fall outside the boundaries of this definition of sobriety.

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167. Newman, R.G. (1991). What's so special about methadone maintenance? *Drug and Alcohol Review*, *10*, 225-232.

168. White, W. (2009a). *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).* Philadelphia: Department of Behavioral Health and Mental Retardation Services.

169. W.Ginter, personal communication, June 22, 2009.

170. American Society of Addiction Medicine. (2001). *Patient placement criteria for the treatment of substance use disorders* (2nd Ed.). Chevy Chase, MD: ASAM.

RECOVERY AS ABSTINENCE

7. **Recovery from opioid addiction is more than the removal of drug use from an otherwise unchanged life.**
8. **Optimum, individualized doses of methadone do not produce intoxication in stabilized MM patients; as such, methadone prescribed under these circumstances should be viewed as a medication rather than a "drug."**
9. **Methadone pharmacotherapy enhances rather than interferes with the reduction/cessation of drug use and the broader processes of psychosocial rehabilitation.**

The predominant abstinence orientation of addiction treatment in the United States is reflected in abstinence-based treatment goals and in reporting treatment follow-up studies in terms of the percentage of patients who have been continuously abstinent since discharge or abstinent at the time of follow-up—abstinence here referring to abstinence from the substance(s) to which the patient was once addicted. Recovery as abstinence is also reflected in the use of "sobriety birthdays" and "clean time" within recovery mutual aid groups. Recovery as the cessation of all "alcohol and other drug use" is similarly the centerpiece of the anti-stigma messaging campaigns of recovery advocacy organizations.[171] Historically, a broad spectrum of addiction professionals and recovery community leaders have posited concepts such as "dry drunk," "mental sobriety," "emotional sobriety," "wellbriety," and "stage II recovery"[172] to convey that addiction recovery is more than the absence of drug use. Yet the question remains, "Does the use of methadone as a medication violate the abstinence requirement that many would posit as a component of addiction recovery?" Answering that question involves two related questions.

The first of these questions is: Does the consumption of a medically supervised, optimum oral dose of methadone by the stabilized MM patient produce intoxicating effects? Or put another way, "From the standpoint of recovery status, should methadone used in these circumstances be viewed as equivalent to the use of heroin or other intoxicants?" The anti-methadone stance within NA has at its roots the experiential knowledge of many NA members who used methadone as an intoxicant during their addiction careers, who used MM for purposes other than recovery, who jockeyed for high methadone doses and combined those doses with other drugs for purposes of intoxication, and who had little if any contact with highly stabilized, high-functioning MM patients. Through the lens of that experience, it is easy to see methadone as just another drug and any methadone use as precluding status as a person in recovery. But there is another side to this story.

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171. Faces and Voices of Recovery (2006). *New messaging from Faces & Voices of Recovery: Talking about recovery.* Retrieved January 5, 2010 from http://www.facesandvoicesofrecovery.org/publications/recovery_messaging/about_recovery.php.

172. For a review, see White, W., & Kurtz, E. (2006). The varieties of recovery experience. *International Journal of Self Help and Self Care, 3*(1-2), 21-61.

Stabilized doses of methadone that are individualized, optimal, and ingested orally as a medication in MM do not usually produce euphoria in stabilized patients. For most patients, the tolerance to methadone resulting from prolonged daily administration of optimum dosages neutralizes the potentially intoxicating properties of the medication and other opioids when properly administered.[173] Three pioneers of MM in the United States—Drs. Mary Jeanne Kreek, Ed Senay, and Robert DuPont—elaborate on this point:

> *When initial methadone treatment doses are appropriately chosen and then increased at a sufficiently slow rate so that tolerance develops following each increment, no narcotic-like effects should be perceived by a patient in methadone maintenance treatment.*[174]
>
> *There are sedating and intoxicating doses of any opioid, methadone included, but in a well-run clinic one does not see sedation or intoxication because dose effects are monitored and therapy deals with the issue of intoxication [from other substances].*[175]
>
> *A patient receiving a stable, once-a-day oral dose of methadone is not intoxicated or impaired by the methadone because of virtually complete tolerance to the sedating effects of the medication. For patients taking stable daily oral dosages of methadone, the effect is the functional equivalent of a depressed patient taking a daily dose of Prozac. However, when that same dose of methadone is injected intravenously, it elicits an equivalent "brain reward" as would be experienced with injected heroin or Oxycodone. For the nontolerant person—a person who has not taken a stable oral dose of methadone for days, weeks or longer—the commonly prescribed methadone dosages are intoxicating and often fatal. MM patients who exhibit signs of intoxication or sedation while taking a therapeutic dose of methadone have either not yet achieved dose stabilization (usually during the induction period or when the dose is raised significantly), or they are exhibiting signs of other recent alcohol or other drug use. Any methadone patient showing signs of impairment needs to be promptly evaluated: intoxication and impairment are not an expected part of the therapeutic experience of methadone treatment.*[176]

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173. Dr. Vincent Dole did note the rare patient who failed to develop full tolerance to the sedating effects of methadone. Cushman, P., & Dole, V.P. (1973). Detoxification of rehabilitated methadone-maintained patients. *Journal of the American Medical Association*, *226*(7), 747-752. Newman, R.G. (1991). What's so special about methadone maintenance? *Drug and Alcohol Review*, *10*, 225-232.

174. Kreek, M.J. (1993). Epilogue: A personal retrospective and prospective viewpoint. In M.W. Parrino, *State methadone treatment guidelines Treatment Improvement Protocol Series 1*. Rockville, MD: Center for Substance Abuse Treatment.

175. Senay, E.C. (1985). Methadone maintenance treatment. *International Journal of the Addictions*, *20*(6&7), 803-821.

176. R. DuPont, personal communication, February 17, 2010.

The second question is: Does the use of methadone aid or hinder the broader processes of psychosocial rehabilitation? Early tests of MM found that patients who had achieved effective dose stabilization were "functionally normal"[177] and that methadone did not interfere with mental or physical performance.[178] Continued participation in MM in spite of problems related to such participation (e.g., medication side-effects in some patients; limitations on education, work, and travel; social stigma) reflects the positive stability that MM offers and the experience of relapse to heroin that patients often experience following cessation of MM. MM studies consistently report decreased death rates (as much as 50%); reduced transmission of HIV, Hepatitis B and C, and other infections; and improvements in global health and social functioning.[179]

In spite of this evidence, many MM patients experience sustained pressure to end methadone maintenance.

> *There is a constant theme experienced daily by MM patients—that they must be lowering their dose and proceeding toward detoxification. Only total abstinence from methadone is considered a methadone success story. The PA [physician's assistant] who runs my program said to me at my physical last year that he "thought I'd be off this stuff" by now… In his eyes, I'm not a success because I am still on methadone. If the people who literally dispense methadone don't view it in terms of recovery or even as medication, how can the patients?* [180]

The professional controversies over the question of methadone, abstinence, and recovery status are well illustrated in the debate surrounding a study by Maddux and Desmond.[181] The authors conducted a study to determine if MM prolonged addiction careers—defined as the time period from onset of drug use to achievement of sustained abstinence, with *abstinence* defined as also terminating the use of methadone as a medication. Dr. Robert Newman challenged this definition:

> *We do a disservice to methadone maintenance programs and their patients by suggesting that "completion" of treatment and subsequent abstinence are the sine qua non of therapeutic success in the treatment of opioid dependence.*[182]

Newman further argued that recovery should be understood solely in terms of "cessation of heroin use, sharply reduced morbidity and mortality, and restoration of the ability to lead a productive and self-fulfilling life."[183]

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177. Dole, V.P., & Nyswander, M.E. (1965). A medical treatment for diacetylmorphine (heroin) addiction. *Journal of the American Medical Association*, *193*, 646-650. Dole, V.P., & Nyswander, M.E. (1967). Heroin addiction—a metabolic disease. *Archives of Internal Medicine*, *120*, 19-24.

178. Gordon, N.B. (1973). The functional status of the methadone maintained person. In. L.R.S. Simmons & M.B. Gold (Eds.), *Discrimination and the addiction* (pp. 101-123). Thousand Oaks, CA: Sage.

179. Joseph, H., Stancliff, S., & Langrod, J. (2000). Methadone maintenance treatment: A review of historical and clinical issues. *Mount Sinai Journal of Medicine, 67*, 347-364. Kreek, M.J., & Vocci, F. (2002). History and current status of opioid maintenance treatments. *Journal of Substance Abuse Treatment, 23*(2), 93-105.

180. Methadone patient email to the authors, June, 2010.

181. Maddux, J.F., & Desmond, D.P. (1992). Methadone maintenance and recovery from opioid dependence. *American Journal of Drug and Alcohol Abuse*, *18*(1), 63-74. Maddux, J.F., & Desmond, D.P. (1992). Ten-year follow-up after admission to methadone maintenance. *American Journal of Drug and Alcohol Abuse*, *18*(3), 289-303.

182. Newman, R.G. (1993). Methadone maintenance and recovery. *American Journal of Drug and Alcohol Abuse, 19*(1), 135-137.

183. Newman, R.G. (1993). Methadone maintenance and recovery. *American Journal of Drug and Alcohol Abuse*, *19*(1), 135-137.

Dr. Vincent Dole, co-developer of MM, was similarly critical of definitions of recovery that focused narrowly on abstinence without regard to health and social functioning:

> *"… methadone patients are not necessarily committed to a lifelong dependence on the medication… The key to this result [sustained abstinence following termination of methadone maintenance] is the realization that the most important objective in treatment of an addict is support of good health and normal function. This may or may not require continuation of maintenance. An obsessive preoccupation with abstinence is self-defeating, leading to low-dose programs (which fail to stabilize the patient), premature discharge from treatment and low self-esteem if long-term abstinence seems unattainable… Available data suggest that the longer a patient continues in a maintenance program that provides adequate doses (e.g., five years or more), the greater his or her probability of permanent abstinence after termination of treatment… the neurochemical adaptations produced by thousands of heroin injections… are capable of gradual repair in some cases under the steady conditions of methadone maintenance.*[184]

Subsequent studies have confirmed Dole's contention that higher methadone doses are linked to greater reductions in illicit opioid use than lower doses.[185]

Cessation of methadone use as a requirement for recovery status is contradicted by research linking methadone dose stabilization to decreased drug use and increased global health, and cessation of MM to increased risk for clinical deterioration, resumption of heroin use, and death. Dole argued that there was no medical evidence that the majority of MM patients could be completely tapered from methadone without compromising recovery stability and that "the question of whether and when to discontinue methadone therapy can be answered in medical terms if the treatment is judged by the same standards as apply to other chronic diseases."[186]

There are recent efforts to explicitly define abstinence in the MM context and to abandon use of "abstinence" and "drug free" as a treatment program designation, as was recently recommended by the Clinical Training Program Caucus (NIDA's Clinical Trials Network):

> *We are writing to recommend that NIDA retire the terms "abstinence-based" and "drug free" to refer to programs that do not use or permit the use of methadone. At best, these terms are confusing, and at worst, they perpetuate the stigma against*

184. Dole, V.P. (1994). What we have learned from three decades of methadone maintenance treatment. *Drug and Alcohol Review*, *13*, 3-4.

185. Strain, E.D., Bigelow, G.E., Liebson, I.A., & Stitzer (1999). Moderate- vs. high-dose methadone in the treatment of opioid dependence. *Journal of the American Medical Association*, *28*(11), 1000-1005.

186. Dole, V.P. (1973). Detoxification of methadone patients, and public policy. *Journal of the American Medical Association*, *226*(7), 781.

methadone patients and treatment providers. "Abstinence" no longer precludes the appropriate use of prescribed medications. "Drug free" refers to patients who are no longer using illicit drugs…We do not suggest that someone on Prozac is not abstinent, so why do so with methadone? A methadone patient is abstinent if he/she is not using alcohol or illicit drugs, and is using legal ones as prescribed. This definition is accepted within the methadone treatment community, and is consistent with the stance that appropriately prescribed medication is compatible with recovery. Clinging to the obsolete terms perpetuates the stigma of methadone as something less noble than other treatments by suggesting that success is measured by the discontinuation of opioid agonist medication. Some patients and providers have internalized this stigma, to their detriment.[187]

RECOVERY AS GLOBAL HEALTH AND FUNCTIONING

10. **Recent attempts to define addiction recovery 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 reintegration).**
11. **MM patients stabilized on medically supervised, individualized, optimum doses do not experience euphoria, sedation, or other functional impairments from the methadone.**
12. **The stabilized methadone maintenance patient who does not use alcohol or illicit drugs and takes methadone and other prescribed drugs only as indicated by competent medical practitioners meets the first criterion for recovery.**
13. **Physical dependence on a medication and drug addiction are not the same: like many pain patients maintained on opioid medications, the stabilized methadone maintenance 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 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 adverse and escalating consequences).**

There is growing consensus across historical, cultural, and professional contexts that recovery from severe alcohol and other drug problems includes more than the subtraction of these sub-

187. J. Zweben, personal communication, February 5, 2010.

stances from one's life. In 2007, the Center for Substance Abuse Treatment hosted a Recovery Summit in which participants defined recovery from alcohol and drug problems as *"a process of change through which an individual achieves abstinence and improved health, wellness, and quality of life."*[188] That same year, the Betty Ford Institute published a recovery definition drawn from a consensus conference of addiction researchers, addiction treatment professionals, and people in recovery. Conference members defined recovery from substance dependence as *"a voluntarily maintained lifestyle characterized by sobriety, personal health, and citizenship."*[189] The issue raised in these definitions that is most relevant to this monograph is whether stabilized methadone maintenance patients are embraced within or excluded from the meaning of abstinence and sobriety.

Methadone recovery status is at the center of evolving and conflicting perceptions of methadone use (recovery-enhancing medication versus addictive drug). It profoundly influences the lives of potential, current, and past MM patients who see attitudes toward methadone revealed in the:

- cultural/professional equation of methadone and heroin (e.g., the claim that MM just substitutes one addicting drug for another—an equation reinforced by the characterization of MM *as replacement therapy or substitution therapy*);
- pressure experienced by MM patients from family members to stop MM treatment;
- prohibition against having an MM patient speak at a meeting, lead a service committee, or receive a sobriety chip within many local Narcotics Anonymous groups;
- refusal on the part of addiction treatment programs and recovery support institutions that do not use medications to admit MM patients in need of their services or to refer their own patients who could benefit from adjunctive, medication-assisted treatment;
- within MM clinic cultures, stigmatization of patients on higher methadone dosages;
- pressure from counselors for patients to terminate MM;
- the discrimination MM patients experience in such arenas as education, employment, housing, health care, and government benefits; and
- ultimata issued by family members and drug court judges who order the parents/defendants to taper methadone intake or leave methadone maintenance treatment as a condition of retaining child custody or visitation rights, or as a condition of probation.[190]

188. Center for Substance Abuse Treatment (CSAT). (2007). *National Summit on Recovery: Conference Report* (DHHS Publication No. SMA 07-4276). Rockville, MD: Substance Abuse and Mental Health Services Administration.

189. Betty Ford Institute Consensus Panel. (2007). What is recovery? A working definition from the Betty Ford Institute. *Journal of Substance Abuse Treatment*, *33*, 221-228.

190. White, W. (2009). *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).* Philadelphia: Department of Behavioral Health and Mental Retardation Services.

Such attitudes and overt acts of discrimination can leave even the most stable and healthiest of MMT patients hiding their "dirty little secret."[191]

The Betty Ford Institute (BFI) Consensus Panel specifically addressed the question of Opioid Treatment Program (OTP) medications and recovery status by defining recovery in terms of sobriety, global health, and citizenship, and then by clearly stating that:

> *… 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.*[192]

This declaration, coming from one of the institution most often associated with mainstream 12-Step-infused addiction treatment in the United States, stands as a historical milestone in the addiction treatment field's (and this country's) perception of methadone maintenance.

A variant of the Betty Ford Institute definition moves beyond remission and intention by defining long-term recovery as "an enduring lifestyle marked by: 1) the resolution of alcohol and other drug problems, 2) the progressive achievement of global (physical, emotional, relational) health, and 3) citizenship (life meaning and purpose, self-development, social stability, social contribution, elimination of threats to public safety)."[193] The first of these criteria is synonymous with the medical definition of remission-symptom reduction/elimination to subclinical levels that might or might not include complete abstinence. Criteria two and three create additional inclusion/exclusion measures that focus on the assertive management of collateral problems (e.g., secondary drug dependencies, co-occurring medical and psychiatric illnesses) in tandem with improvements in multiple areas of life functioning and a reconstruction of the person-to-family/community relationship. The added criteria place emphasis on quality of personal and family life and social contribution in long-term recovery.

Within this broader conceptualization of recovery, the question becomes how methadone as a medication, and the realities of the lived experience of methadone maintenance treatment, might enhance or inhibit the fulfillment of each of these three criteria. For example, methadone as a medication could provide a foundation for patients' achievement of all three of the above criteria, while the rigorous demands of MM treatment within the existing clinic system might actually interfere with criteria two and three, e.g., inhibit one's ability to pursue education, full-time employment, financial independence, family responsibilities, home ownership, community service,

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191. Joseph, H. (1995). *Medical methadone maintenance: The further concealment of a stigmatized condition* (Unpublished doctoral dissertation). City University of New York. Murphy, S., & Irwin, J. (1992). "Living with the dirty secret": Problems of disclosure for methadone maintenance clients. *Journal of Psychoactive Drugs, 24*(3), 257-264.

192. Betty Ford Institute Consensus Panel. (2007). What is recovery? A working definition from the Betty Ford Institute. *Journal of Substance Abuse Treatment*, *33*, 221-228. McLellan, A.T. (2010). What is recovery? Revisiting the Betty Ford Institute Consensus Panel definition. *Journal of Substance Abuse Treatment*, *38*, 200-201.

193. White, W. (2009c). *The recovery paradigm and the future of medication-assisted treatment.* Plenary Remarks: American Association for the Treatment of Opioid Dependence, Inc. Conference, New York City, April 28, 2009.

travel, and leisure. Definitions of recovery that address issues of quality of personal/family life will, when applied to the MM patient, need to disentangle methadone as a medication from the lifestyle constraints imposed by MM treatment.

Consistent with Newman's and Dole's views are definitions of recovery that focus on health and functionality without reference to cessation of medical use of methadone. The examples below illustrate such definitions:

> *Recovery is the process of pursuing a fulfilling and contributing life regardless of the difficulties one has faced. It involves not only the restoration but continued enhancement of a positive identity and personally meaningful connections and roles in one's community. Recovery is facilitated by relationships and environments that provide hope, empowerment, choices and opportunities that promote people reaching their full potential as individuals and community members.*[194]
>
> *Recovery is a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles.*[195]
>
> *The process of recovery from problematic substance use is characterised by voluntary sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society.*[196]

Stabilized MM patients would meet these criteria for recovery if they were demonstrating progress toward increased health and functionality. The "sustained control over substance use" in the UK recovery definition is broad enough to include multiple pathways of alcohol and other drug (AOD) problem resolution—traditionally defined abstinence, decelerated patterns of AOD use that no longer meet criteria for a substance use disorder, and medication-assisted recovery—as long as the other criteria of health and positive community participation are met. Similar in spirit to the UK definition were suggestions to the authors from some methadone patients that a broadened definition of recovery is needed.

> *The only way we will ever be able to move addiction treatment to a chronic disease model is if we take the "abstains from alcohol and other intoxicating drugs" our of the recovery definition, or at least stop making it the deciding factor*

194. Recovery Advisory Council, Philadelphia, PA 2005, Department of Behavioral Health and Mental Retardation Services.

195. Anthony, W.A., Rogers, E.S., & Farkas, M. (2003). Research on evidence-based practices: Future directions in an era of recovery. Community Mental Health Journal, *39*(2), 101-114.

196. United Kingdom Drug Policy Commision. (2008). A consensus definition of recovery. Accessed June 24, 2010 at http://www.ukdpc.org.uk/resources/A%20Vision%20of%20Recovery.pdf .

for the status of being "in recovery"… I think we need to make it one of many goals rather than the focus. This would help us achieve the focus of every other chronic disease treatment: QUALITY OF LIFE and the reduction of symptoms… We have got to stop thinking of recovery as ALL or NOTHING."

THE AMBIGUOUS IDENTITY OF THE MM PATIENT

14. **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) inhibits rather than supports the long-term recoveries of MM patients.**
15. **For stabilized MM patients, continued methadone maintenance and successful tapering from methadone maintenance represent two varieties/styles of recovery experience, not the line of demarcation between addiction and recovery initiation.**
16. **The highly 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.**
17. **It is time that MM patients who meet the three-part recovery definition were welcomed into full membership in the culture of recovery and offered opportunities to pursue full citizenship in their local communities.**

The widely varying definitions of recovery and the role of methadone as a disqualifying, qualifying, or neutral influence in determining recovery status is more than just a theoretical issue for addictionologists. MM patients live their daily lives amidst conflicting perceptions of methadone and MM patients. Stable MM patients have lost membership and status and have acquired stigma within the cultural world of drug users, where they are more likely to be disparaged for having compromised control of their opioid use by their submission to the MM clinic system. Those who should celebrate the MM patient's budding recovery—family members, friends, acquaintances, co-workers, and even other MM patients—all too often still perceive the patient as "on drugs" and continue to ask when he or she is going to "get off methadone." Seeking shelter within the worlds of addiction treatment and recovery, stabilized MM patients encounter continued indignities that demean the value of their accomplishments—denying their right to speak, denying their right to lead, denying their very recovery status. MM patients are taught by addiction treatment professionals that opioid addiction is a brain disease,

but they are treated through institutional practices as if they were feeble-minded, insane, criminal, or recalcitrant children—treated as people who need control rather than care. MM patients face a wider community environment that defines methadone as "just another drug" and MM patients in terms of their perceived addiction rather than their recovery achievements. It is little wonder that the concept of recovery has had so little value in the ambiguous, conflicted world of the MM patient.

Addiction recovery is often the product of a highly personal synergy of pain and hope. Such catalytic turning points usually involve three complementary processes: ***renunciation*** (what is permanently expelled from one's life—the *recovery from* process), ***retrieval*** (what has been lost through one's addiction career—the *recovery of* process), and ***embrace*** (what is newly drawn into the center of one's life—the *recovery to* process).[197] If recovery for the MM patient involves a renunciation of drugs and the drug culture—a physical, psychological, and cultural escape from addiction and a search for new destinations for healing and hope—in what direction is the MM patient expected to step in order to be welcomed?

> *Positing recovery as a journey of self-transformation, the methadone patient subsists in undetermined space—a hinterland beyond the clearly demarcated identity fissures of "addict" or "recovering addict." In the absence of a proactive recovery culture, the methadone maintenance patient becomes tied to an archetypal "spoiled identity"*[198] *to be managed and governed rather than retrieved, nurtured and healed.*[199]

To speak of recovery for the MM patient requires a world in which that recovery can be firmly nested and nurtured—a world where the ambiguous, fractured identity of the stable MM patient may be healed and made whole.[200] The good news is that such a world may be struggling to emerge in communities across the United States.

THE QUESTION OF FAMILY RECOVERY[201]

18. **Chronic opioid addiction severely wounds family and kinship relationships—wounds that feed the intergenerational transmission of drug-related problems.**
19. **Family recovery involves healing those wounds; reconstructing family roles, rules, and relationships; and enhancing the resistance/resilience/health of all family members.**

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197. Amplified from: Horvath, A.T. (1998). Recovery of vs. recovery from. (Reflections on statement by Monica Harris). *Smart Recovery® News & Views Newsletter*, April, p. 1.

198. Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Englewood Cliffs: Prentice-Hall.

199. S. Bamber, personal communication, March 22, 2010.

200. S. Bamber, personal communication, March 22, 2010.

201. We wish to thank Mark Parrino for suggesting the inclusion of this discussion within the paper.

Chronic disorders take an inordinate toll on family life due to their duration, the unpredictable ebb and flow of acute episodes, and their potentially profound effects on functionality. The transformation of family life through the addiction and recovery processes include changes in the family system's boundary permeability, the health and functioning of individual family members, family subsystem relationships (e.g., adult intimate relationships, parent-child relationships, sibling relationships, relationships with the extended family and kinship network), and key dimensions of family life (e.g., roles, rules, and rituals).[202] Families must develop their own defense structures to survive the effects of addiction, and the fragility of these defense structures can be threatened by the onset of a recovery process. Some research suggests that the restructuring of family processes in early recovery can be so traumatizing as to threaten the survival of the family as a system.[203]

Family recovery is thus a process of the family surviving the insults inflicted by severe AOD problems as well as the adjustments required for the restoration of individual and family health during the stages of recovery initiation and maintenance. Family recovery also involves reducing the intergenerational risks for substance use disorders. At present, most OTPs do not provide services aimed at reducing these risks, e.g., child-focused prevention or early intervention services, parenting training, or family counseling.

> *My daughter is now 15, but she was just seven when I went into treatment. I was very publicly outed (newspaper stories) as an addict, and I had no idea what to tell her about my addiction, let alone about the methadone treatment. Guidance from my counselor would have been wonderful, and I know it would have done my daughter a world of good to have someone to talk to at that time…* [204]

There are far fewer studies of family and parental functioning of MM patients than of patients in alcoholism treatment, but studies to-date confirm two key findings: 1) family/parental functioning is a significant problem for many MM patients, and 2) family-focused services enhance the health of MM patients, their families, and their children.[205] As recovery re-emerges as an organizing construct within OTPs, involving the family members of MM patients in refining the concept of family recovery and in helping design family-focused recovery support services will be important agendas.

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202. White, W., & Savage, B. (2005). All in the family: Alcohol and other drug problems, recovery, advocacy. *Alcoholism Treatment Quarterly, 23*(4), 3-38.

203. Brown, S., & Lewis, B. (1999). *The alcoholic family in recovery: A developmental model*. New York: Guilford.

204. Methadone patient email to authors, June 2010.

205. Dawe, S., & Harnett, P. (2007). Reducing potential for child abuse among methadone-maintained parents: Results from a randomized controlled trial. *Journal of Substance Abuse Treatment, 32*(4), 381-390. Dawe, S., Harnett, P. H., Rendalls, V., & Staiger, P. (2003). Improving family functioning and child outcome in methadone maintained families: The Parents Under Pressure Programme. *Drug and Alcohol Review*, *22*(3), 299-307. Grella, C.E., Needell, B., Shi, Y., & Hser, Y-I. (2009). Do drug treatment services predict reunification outcomes of mothers and their children in child welfare? *Journal of Substance Abuse Treatment*, *36*(3), 278-293.

SUMMARY

- 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) constitute different styles of recovery and should not be framed in categories of inferiority or superiority.
- Rather than a source of disqualification for recovery status, methadone, provided 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.
- 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 as a collective witness to offer living proof of the role methadone can play in long-term recovery from opioid addiction.
- There are multiple pathways and styles of long-term addiction recovery, and all should be cause for celebration.

Social and professional stigma constitutes a major obstacle, if not the obstacle, to methadone-assisted recovery. But these cultural winds are shifting. Scientific breakthroughs related to the neurobiology of addiction and addiction recovery are forcing a re-evaluation of methadone maintenance. Some local recovery mutual aid meetings are welcoming MM patients, and Methadone Anonymous and other medication-assisted recovery mutual aid groups are defining and legitimizing recovery within the MM context, as are new methadone-based peer-recovery support projects such as the CSAT-funded Medication Assisted Recovery Services (MARS) project in New York City operated in conjunction with the Division of Substance Abuse at the Albert Einstein College of Medicine.[206] The 2007 Betty Ford Consensus Panel statement that the MM patient who takes methadone as prescribed and is abstinent from alcohol and other drugs meets the definition of sobriety may well constitute a "tipping point" in the field's understanding of and attitudes toward methadone pharmacotherapy. The leading recovery advocacy organization in the United States

206. W. Ginter, personal communication, June 22, 2009.

(Faces & Voices of Recovery) celebrates diverse pathways of long-term addiction recovery (including medication-assisted recovery), and medication-assisted recovery advocates have been a part of the governing board and committees of Faces & Voices since its inception in 2001. Increased recovery orientation within American OTPs is also evidenced by activities of the American Association for the Treatment of Opioid Dependence, efforts to forge recovery-focused models of MM in Philadelphia and New York State, and the Center for Substance Abuse Treatment's *Introduction to Recovery-Oriented Systems of Care for Opiate Treatment.*

The purpose of this article was to directly address the question: Can a methadone patient who has achieved long-term dose stabilization, uses no other non-prescribed opioids or other drugs (including alcohol), and has achieved significant improvement in psychosocial health and positive community integration be considered *in recovery* or *recovering*? After reviewing multiple definitions of recovery, the authors draw the following conclusion:

> *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) are issues of style of recovery and should not be framed in categories of inferiority or superiority. Rather than a source of disqualification for recovery status, methadone, provided 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 by the addiction treatment community, communities of recovery, and the public. There are multiple pathways and styles of long-term addiction recovery, and all should be cause for celebration.*

Widespread acceptance of methadone maintenance is contingent upon elevating the quality of MM in the United States and on launching an effective and sustained campaign of professional and community education regarding methadone, methadone maintenance treatment, and methadone-assisted personal and family recovery.[207] As a beginning, it is time that current and former MM patients and their families were invited to fully participate in the design, conduct, and evaluation of such a campaign. It is time all addiction professionals stood with Faces & Voices of

207. White, W. (2009). *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).* Philadelphia: Department of Behavioral Health and Mental Retardation Services.

Recovery in acknowledging that there are many pathways to recovery and that all are cause for celebration. It is time we as a national body of addiction professionals and recovery advocates fully acknowledged the legitimacy and value of methadone-assisted recovery and welcomed stabilized methadone patients as peers in the American culture of recovery.

We are not saying that all or even most methadone patients are in recovery as defined in this monograph. (The prevalence of recovery within MM patients in the U.S. based on these new definitions of recovery has not been measured.) As a starting point, we are saying that there are methadone patients who meet this definition of recovery and that the percentage of MM patients who meet this definition could be significantly increased with a more recovery-focused approach to MM treatment. It is our further hope that this monograph will stimulate discussion about medication and recovery status and the extent to which new definitions of recovery will help or harm persons in methadone maintenance.

In the next article, we will explore why changes in policies and clinical practices within Opioid Treatment Programs in the United States are needed to enhance long-term recovery outcomes.

III: A Vision Statement

William L. White, MA

Lisa Mojer-Torres, JD

> *If opioid dependence is a career, then therapeutic interventions must be measured in career terms.*[208]

To recap the content of this monograph thus far, the first article reviewed the history of MM through three stages: 1) the personal recovery orientation of the early MM model, 2) a shift in the justification, design, and evaluation of MM toward reduction of social harm during the regulation and mass diffusion of MM across the United States, and 3) recent efforts to recapture and refine a person-centered, recovery-focused approach to MM. This third stage was seen as historically significant for its potential to revitalize and elevate the quality of MM treatment as a medical treatment for opioid addiction.[209]

The second article reviewed multiple definitions of recovery and discussed the question: Can a methadone maintenance patient who has achieved long-term dose stabilization, uses no other nonprescribed opioids or other drugs (including alcohol), and has achieved significant improvement in psychosocial health and positive community integration be considered "in recovery" or "recovering"? We noted that emerging definitions of addiction recovery focus on three essential criteria: 1) the resolution of drug-related problems (defined in terms of sustained sobriety or clinical remission—the patient no longer meets diagnostic criteria for a substance use disorder), 2) progress toward global (physical, mental, emotional, relational, and ontological) health, and 3) positive integration and contribution to the community.[210] Using these criteria, we concluded:

> *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 improved global health and social functioning should be considered to be in recovery or recovering. Rather than a source of disqualification for recovery status, methadone, provided under competent medical supervision at proper dosages with appropriate ancillary psychosocial support services, aids*

208. Senay, E.C. (1985). Methadone maintenance treatment. *International Journal of the Addictions*, *20*(6&7), 803-821.

209. White, W., & Torres, L. (2010a). Recovery-oriented methadone maintenance: I. Historical context.

210. Betty Ford Institute Consensus Panel. (2007). What is recovery? A working definition from the Betty Ford Institute. *Journal of Substance Abuse Treatment*, *33*, 221-228. White, W. (2007). Addiction recovery: Its definition and conceptual boundaries. *Journal of Substance Abuse Treatment*, *33*, 229-241.

> *long-term recovery from heroin addiction and should be so recognized by the addiction treatment community, communities of recovery, and the public.*[211]

We concluded in the first two articles that it was time we as a country and a professional field stopped debating the morality of methadone maintenance and focused our energies instead on elevating the quality of methadone maintenance treatment. In this third article, we will attempt to answer two overlapping questions: 1) How would opioid addiction be treated if we *really* believed that it was a chronic brain disease? 2) How would policies and clinical practices related to MM change if the primary goal of MM treatment were long-term personal recovery—defined as remission of the substance use disorder, improved global health, and community re-integration?

One of the most definitive summaries of best practices in opioid addiction treatment is the Center for Substance Abuse Treatment's *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs*.[212] Our intent is not to duplicate this exceptional effort, but to highlight particular clinical and support services that have a clear connection to short- and long-term recovery outcomes. Many of the key issues we address in this monograph were highlighted in CSAT's first Treatment Improvement Protocol[213] on methadone treatment. That TIP set forth a clear vision for the future of methadone maintenance:

> *Methadone maintenance providers will be under greater pressure to offer a richer mix of comprehensive services. Peer support groups will become a permanent part of the treatment system. More medical care will be offered at the clinic site as programs create better primary health care linkages to mainstream medical communities. Vocational referral and job placement will become more critical treatment components… More programs will begin to address the tragic realities of intergenerational drug abuse by implementing parenting skill workshops at or through the treatment setting.*[214]

More than fifteen years later, that vision remains unfulfilled, so it will be revisited in this article.

On a final introductory note, it is difficult to envision an article on the integration of medications within a recovery management paradigm without considering Buprenorphine/Suboxone/Subutex and other medications currently available (on and off label) and those in the pipeline of medication research on the treatment of opioid addiction. New medications for the treatment of heroin and other opioid addictions hold considerable promise, but that future potential does not alter the fact

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211. White, W., & Torres, L. (2010b). Recovery-oriented methadone maintenance: II. Recovery and methadone.

212. Center for Substance Abuse Treatment. (2005). *Medication-assisted treatment for opioid addiction in opioid treatment programs* (Treatment Improvement Protocol (TIP) Series 43, DHHS Publication No. (SMA) 05-4048). Rockville, MD: Substance Abuse and Mental Health Services Administration.

213. Center for Substance Abuse Treatment. (1993). *State methadone treatment guidelines. Treatment Improvement Protocol (TIP) Series 1.* Rockville, MD: U.S. Department of Health and Human Services.

214. Center for Substance Abuse Treatment. (1993). *State methadone treatment guidelines. Treatment Improvement Protocol (TIP) Series 1.* Rockville, MD: U.S. Department of Health and Human Services.

that most patients in opioid treatment programs (OTPs) currently are treated with methadone.[215] No other pharmacotherapeutic agent prescribed in the treatment of heroin addiction has demonstrated such consistently high efficacy, been more widely replicated and regulated, and yet been so linked to stigma and controversy.[216] Therefore, our focus in this monograph is on methadone, and on the approach to treatment we refer to as recovery-oriented methadone maintenance (ROMM).

THE MANAGEMENT OF CHRONIC DISEASE

Either addiction is a disease or it isn't.[217]

Simply put, diseases of the human body are defined by the presence of an organ defect and predictable signs and symptoms of that defect.[218] Methadone maintenance is based on the understanding that chronic heroin addiction is a metabolic brain disease whose core symptoms include drug tolerance, withdrawal, persistent craving, and continued drug-seeking in spite of adverse consequences and failed personal resolutions to cease drug use.[219] Addiction to heroin or other short-acting exogenous opioids shares many characteristics with other primary chronic illnesses. These illnesses:

- are influenced by genetic as well as personal, family, and environmental risk factors;
- are linked to behaviors that begin as voluntary choices but evolve into compulsive behaviors fueled by neurobiological changes in the brain;
- are marked by sudden or gradual onset and a variable though often prolonged course;
- are accompanied by risk of profound pathophysiology, disability, and premature death; and
- have effective treatments, self-management protocols, peer support frameworks, and remission rates similar to those of other chronic illnesses, but no known cures.[220]

Opioid addiction has been defined as a chronic, progressive illness for more than a century, but the treatment of this disorder, like the treatment of other addictions, has been conducted primarily within an acute care (AC) model of service delivery. The AC model is marked by five distinguishing characteristics. First, care is provided within self-encapsulated, crisis-oriented episodes of care, each of which is marked by screening, admission, intake assessment, a short series of treatment procedures, discharge (with, at best, short-term follow-up), and termination of the service relationship. Second, a professional expert directs and dominates the service delivery decision-making

215. Kresina, T.F., Litwin, A., Marion, I., Lubran, R., & Clark, H.W. (2009). United States government oversight and regulation of medication assisted treatment for the treatment of opioid dependence. *Journal of Drug Policy Analysis*, *2*(1), Article 2.

216. Joseph, H. (1995). *Medical methadone maintenance: The further concealment of a stigmatized condition*. Unpublished doctoral dissertation, City University of New York. Joseph, H., Stancliff, S., & Langrod, J. (2000). Methadone maintenance treatment (MMT): A review of historical and clinical issues. *Mount Sinai Journal of Medicine*, *67*, 347-364.

217. Methadone patient email to authors, 2010

218. McCauley, K. (2009). *Pleasure unwoven: A personal journey about addiction*. Salt Lake City, UT: The Institute for the Study of Addiction.

219. Dole, V. P., & Nyswander, M. E. (1967). Heroin addiction—A metabolic disease. *Archives of Internal Medicine*, *120*, 19-24.

220. White, W., & McLellan, A.T. (2008). Addiction as a chronic disease: Key messages for clients, families and referral sources. *Counselor*, *9*(3), 24-33.

process. Third, services transpire over a short (and historically ever-shorter) period of time. Fourth, the individual/family/community is given the impression at discharge ("graduation") that long-term addiction recovery is now self-sustainable without further professional assistance. Fifth, post-treatment relapse and re-admissions are viewed as the failure (non-compliance) of the patient rather than a failure of service design or execution.[221]

Considerable effort is underway in primary medicine to develop models of chronic disease management,[222] and there are growing calls to shift the acute care model of addiction treatment to a model of sustained recovery support analogous to the medical management of other chronic diseases.[223] Efforts are underway at federal, state, and local levels to define and implement models of sustained *recovery management* (RM) and to nest these approaches within larger *recovery-oriented systems of care* (ROSC).[224]

RM of chronic opioid addiction is based on the following four assumptions:

- Severe and chronic opioid addiction is a brain disease characterized by neurobiological defects that are not corrected through acute detoxification.
- Exceptionally high rates of drug seeking and re-addiction following detoxification and cessation of treatment are manifestations of these neurobiological defects.
- Acute episodes of detoxification and biopsychosocial stabilization do not constitute sustainable recovery from opioid dependence and are more likely to constitute predictable milestones within a prolonged addiction career.
- 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 (primarily heroin) addiction.

METHADONE MAINTENANCE AND RECOVERY MANAGEMENT

Recapturing and extending methadone maintenance as a person-centered, recovery-focused treatment of opioid addiction—what we here refer to 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). The primary emphasis in this article will be on defining the core clinical and

221. White, W., & McLellan, A.T. (2008). Addiction as a chronic disease: Key messages for clients, families and referral sources. *Counselor*, *9*(3), 24-33.

222. Bodenheimer, T., Wagner, E.H., & Grumbach, K. (2002). Improving primary care for patients with chronic illness. *Journal of the American Medical Association*, *288*(14), 1775-1779. Wagner, E.H. (1998). Chronic disease management: What will it take to improve care for chronic illness? *Effective Clinical Practice*, *1*, 2-4. Wagner, E.H., Austin, B.T., Davis, C., Hindmarsh, M., Schaefer, J., & Bonomi, A. (2001). Improving chronic illness care: Translating evidence to practice into action. *Health Affairs*, *20*, 64-78.

223. Dennis, M.L., & Scott, C.K. (2007). Managing addiction as a chronic condition. *Addiction Science & Clinical Practice*, *4*(1), 45-55. Institute of Medicine. (2006). *Improving the quality of health care for mental and substance-use disorders: Quality chasm series*. Washington, DC: National Academy Press. McLellan, A.T., Lewis, D.C., O'Brien, C.P., & Kleber, H.D. (2000). Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. *Journal of the American Medical Association, 284*(13), 1689-1695. White, W., Boyle, M., & Loveland, D. (2002). Alcoholism/addiction as a chronic disease: From rhetoric to clinical application. *Alcoholism Treatment Quarterly*, *20*(3/4), 107-130. White, W., & McLellan, A.T. (2008). Addiction as a chronic disease: Key messages for clients, families and referral sources. *Counselor*, *9*(3), 24-33.

224. Halvorson, A., & Whitter, M. (2009). *Approaches to recovery-oriented systems of care at the state and local levels: Three case studies* (HHS Publication No. (SMA) 09-4438). Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration. White, W. (2008a). *Perspectives on systems transformation: How visionary leaders are shifting addiction treatment toward a recovery-oriented system of care* (Interviews with H. Westley Clark, Thomas A. Kirk, Jr., Arthur C. Evans, Michael Boyle, Phillip Valentine and Lonnetta Albright). Chicago: Great Lakes Addiction Technology Transfer Center. White, W. (2008b). Recovery: Old wine, flavor of the month or new organizing paradigm? *Substance Use and Misuse, 43*(12&13), 1987-2000.

recovery support practices that would distinguish a recovery management approach to the treatment of opioid addiction: the who, what, when, where, and "how long" of MM treatment.

Eight arenas of service practice distinguish RM from AC models of addiction treatment: 1) attraction, access, and early engagement; 2) assessment and service planning; 3) service team composition; 4) the service relationship; 5) service quality and duration; 6) the locus of service delivery; 7) assertive linkage to recovery community resources; and 8) long-term post-treatment recovery check-ups, stage-appropriate recovery support, and, when needed, early re-intervention.[225] The current status of each of these areas related to methadone maintenance will be evaluated using available scientific studies and national treatment systems performance data. The authors will also explore potential changes in service design that would increase the focus of MM on long-term recovery outcomes.

As we explore changes in clinical practices in MM, it is important to remain cognizant of the growing heterogeneity of MM patients. Today's aging MM patients, a new generation of prescription opioid addicts, and the young polyaddicted heroin/cocaine addicts steeped in a street culture of ruthlessness, risk-taking, and violence[226] all present needs much different from those of the mid-twentieth-century "cool cats" and "righteous dope fiends" whose heroin use was nested within a lifestyle of carefully crafted slickness and street sophistication.[227] Also of note is the wide variability of MM provider organizations. For example, few studies are available that illuminate potential differences between public and private MM programs, in spite of the growing privatization of MM in the United States over the past two decades.[228]

ATTRACTION, ACCESS, AND EARLY ENGAGEMENT/RETENTION

Interventions at early stages in the development of chronic diseases improve long-term health outcomes. Such early intervention is crucial in addressing conditions such as heroin addiction that often become more severe, more complex, and more intractable over time. The keys to early intervention are public knowledge about the disorder; treatments that are perceived to be effective, accessible, and affordable by those affected; systems of intervention that encourage early treatment and resolve obstacles to participation; and mechanisms that enhance service engagement and reduce early service attrition. Early intervention can be framed conceptually as including three distinct processes: 1) attracting those currently in need of treatment, 2) facilitating rapid access to services, and 3) enhancing therapeutic alliance and resolving intrapersonal, program, and environmental obstacles to continued participation.

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225. White, W. (2008c). *Recovery management and recovery-oriented systems of care: Scientific rationale and promising practices*. Pittsburgh, PA: Northeast Addiction Technology Transfer Center, Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health & Mental Retardation Services.

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227. Finestone, H. (1957). Cats, kicks and color. *Social Problems*, *5*, 3-13. Preble, E., & Casey, J. (1969). Taking care of business: The heroin user's life on the street. *International Journal of the Addictions, 4*(1), 1-24. Sutter, A.G. (1966). The world of the righteous dope fiend. *Issues in Criminology*, *2*(2), 177-222.

228. Of patients in methadone treatment in the United States on March 31, 2005, 47% were enrolled in private for-profit organizations; on March 31, 2008, that percentage had risen to 49%. Britton, B.M. (1994). The privatization of methadone maintenance: Changes in risk behavior associated with cost related detoxification. *Addiction Research & Theory*, *2*(2), 171-181. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2006). *The DASIS Report: Facilities operating opioid treatment programs: 2005. Issue 36*. Retrieved January 13, 2010 from http://www.oas.samhsa.gov/2K6/OTP/OTP.cfm. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2010). *The N-SSATS Report. Overview of opioid treatment programs within the United States: 2008*.

Attraction

Methadone maintenance treatment attracts voluntarily participation by more people addicted to heroin and other short-acting opioids than any other addiction treatment modality,[229] but most people addicted to heroin and other opioids are not currently enrolled in addiction treatment. There are an estimated 750,000 to 1,000,000 opioid (primarily heroin) addicts in the United States,[230] but only 337,342 persons with a primary drug choice of heroin (246,835; 13.6% of all admissions) or other opioids (90,489; 5% of all admissions) were admitted to addiction treatment in the United States in 2007.[231] Of these admissions, only 29% received methadone or buprenorphine as a planned part of their treatment.[232] A 2008 survey identified 1,132 certified OTPs in the United States (8% of the 13,688 treatment facilities in the U.S.).[233] A March 31, 2008 survey of OTPs in the United States found that 268,071 patients were being treated with methadone and 4,280 were being treated with buprenorphine.[234]

Methadone maintenance is considered the most effective treatment for chronic heroin dependence,[235] but the percentage of heroin-dependent people seeking treatment who receive methadone pharmacotherapy declined precipitously between 1992 and 2007 (from 42% to 22%).[236] The systems in which heroin addicts are most likely to be encountered (the health care and criminal justice systems) refer only a small fraction (5.5%) of those currently enrolled in MM. Most patients entering methadone treatment get to MM by self/family referral (72.8%). Other addiction treatment providers make up only 9.6% of MM referrals, with other referral sources including health care providers (4.2%) and other community referrals (6.1%).[237] Heroin users still linked to conventional society through living with family or an intimate partner are more likely to seek treatment than those living in isolation from such connections.[238] Breaking such isolation may require special outreach services to elicit treatment seeking.

The most common pattern of treatment for injection drug users consists of multiple episodes of detoxification—the least effective of all treatments for opioid addiction.[239] A recent Massachusetts study of first treatment entry for injection drug users revealed that 66% sought detoxification, 15% outpatient counseling, 14% methadone maintenance, and 5% residential treatment.[240] The same study found that, throughout the six-year span of the study, 30% of injection drug users experienced multiple episodes of detoxification but did not participate in any additional treatment.[241] What is of most concern is the finding that those who seek heroin detoxification only and eschew further treatment have the fewest resources to support a process of long-term recovery.[242]

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231. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2009). *Highlights for 2007 Treatment Episode Data Set (TEDS), Table 2a.* Retrieved November 23, 2009 from http://www.oas.samhsa.gov/TEDS2k7highlights/TEDShigh2k7Tb2a.htm.

232. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2009). *Highlights for 2007 Treatment Episode Data Set (TEDS), Table 4.*

233. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2010). *The N-SSATS Report. Overview of opioid treatment programs within the United States: 2008.*

234. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2010). *The N-SSATS Report. Overview of opioid treatment programs within the United States: 2008.*

235. NIH. (1998). Effective medical treatment of opiate addiction: National Consensus Development Panel on Effective Medical Treatment of Opiate Addiction. *Journal of the American Medical Association, 280*(22), 1936-1943. Retrieved from http://odp.od.nih.gov/consensus/cons/108/108_statement.htm.

236. United States Department of Health and Human Services. Substance Abuse and Mental Health Services Administration. Office of Applied Studies. Treatment Episode Data Set—Admissions (TEDS-A)—Concatenated, 1992 to Present [Computer file]. ICPSR25221-v2. Ann Arbor, MI: Inter-university Consortium for Political and Social Research [distributor], 2009-09-21. doi:10.3886/ICPSR25221.

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240. Lundgren, L.M., Sullivan, L., & Amodeo, M. (2006). How do repeaters use the drug treatment system? An analysis of injection drug users in Massachusetts. *Journal of Substance Abuse Treatment, 30*, 121-128.

Popular and professional conceptions of methadone as a "legal substitute for heroin," street myths about methadone (e.g., "it rots your bones"), and the view that MM is a "last resort" inhibit timely treatment seeking by those who could benefit from MM.[243] Such views about methadone are particularly magnified within minority communities.[244]

The myths, misconceptions, and stigma surrounding heroin addiction, methadone, and methadone treatment; the public visibility of the worst methadone clinics and the least stabilized MM patients; and the virtual invisibility of the best OTP clinics and the most successful MM patients create a climate in which people enter MM mostly under conditions of extreme desperation and only in the late stages of their addiction careers. The average duration of heroin use prior to first admission to treatment ranges from 6-10 years[245] to 14.5 years,[246] and an average span of 22 years' heroin use precedes the onset of long-term recovery from heroin addiction (with recovery defined in this study as 5 years' continuous heroin abstinence).[247]

Future efforts to attract people who are heroin dependent to enter MM include national and local professional education campaigns, targeted education of injection drug users, increasing the recovery orientation of syringe exchange programs, community intervention programs aimed at early problem identification and assertive linkage to MM or alternative treatments (via physicians, hospitals, health clinics, police, etc.), community education campaigns about opioid addiction and the effectiveness of MM as a medical treatment of heroin addiction, and street outreach programs conducted by people who offer themselves as "living proof" of the reality of long-term medication-assisted recovery.

Recovery catalysts (outreach workers) trolling the natural environments of prospective patients can reach, motivate, and engage individuals who resist entering MM due to their own ambivalence about giving up heroin and the associated lifestyle.[248] Such workers challenge the myths about methadone and correct the view that MM is not accessible, effective, or affordable. They also avoid using ineffective pleas and threats such as those that warn of continued pain and the threat of death. People addicted to heroin and other opioids all too often are already drowning in pain, disregard death as a potential consequence of heroin use (e.g., by avoiding overdose protection measures), and even view the possibility of death as a seductive source of escape.[249] Outreach in ROMM is often based on the recognition that sparking the recovery initiation process is more about hope (seeing the top) than about a heightened experience of pain (hitting bottom). And sometimes it is as simple as get-

241. Lundgren, L.M., Sullivan, L., & Amodeo, M. (2006). How do repeaters use the drug treatment system? An analysis of injection drug users in Massachusetts. *Journal of Substance Abuse Treatment*, *30*, 121-128.

242. Lundgren, L.M., Schilling, R., Ferguson, F., Davis, K., & Amodeo, M. (2003). Examining drug treatment program entry of injection drug users: Human capital and institutional disaffiliation. *Evaluation and Program Planning*, *26*, 123-132.

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245. Hser, Y., Anglin, M., Grella, C., Longshore, D., & Prendergast, M. (1997). Drug treatment careers: A conceptual framework and existing research findings. *Journal of Substance Abuse Treatment, 14*(3), 1-16.

246. Lundgren, L.M., Schilling, R., Ferguson, F., Davis, K., & Amodeo, M. (2003). Examining drug treatment program entry of injection drug users: Human capital and institutional disaffiliation. *Evaluation and Program Planning*, *26*, 123-132.

247. Hser, Y. (2007). Predicting long-term stable recovery from heroin addiction: Findings from a 33-year follow-up study. *Journal of Addictive Diseases, 26*(1), 51-60.

248. Booth, R.E., Corsi, K.F., & Mikulich, S. K. (2003). Improving entry to methadone maintenance among out-of-treatment injection drug users. *Journal of Substance Abuse Treatment*, *24*, 305-311. Rosenblum, A., Magura, S., & Joseph, H. (1991). Ambivalence toward methadone treatment among intravenous drug users. *Journal of Psychoactive Drugs*, *23*(1), 21-27.

ting a clear message to those in need of services. Imagine a sign visible in every emergency room and ambulatory care center reading, "Dependence on narcotics is a medical problem that can be treated effectively. Ask our staff about taking the first step toward recovery."[250]

A study by Amodeo and colleagues[251] offers another potential clue for outreach within ROMM. Their study found that female injection drug users who had previously received mental health services were 66% more likely to enter treatment beyond detoxification than female injection drug users who had not received such services. Outreach aimed at linking and providing mental health services to injection drug users may provide a novel window of opportunity for subsequent engagement in MM and other addiction treatment modalities.

Patient attraction to methadone maintenance would also be enhanced if all opioid-addicted patients seeking treatment were afforded objective choices about their treatment options regardless of the settings in which they were screened and evaluated. For example, patients who were seeking buprenorphine treatment but discover they cannot afford this treatment should be provided treatment options that include MM as well as other treatment options that are more affordable. The clarification of patient expectations of treatment and a presentation of treatment choices through a more education-oriented consent-to-treatment process would enhance each patient's capacity for informed decision-making. The goals would be to correct false expectations, enhance the best match between patient and treatment approach/setting, and ensure that each patient has sufficient information and understanding to appreciate the benefits and risks of MM and other addiction treatment modalities. All addiction treatment programs should be required to provide regular opportunities for patients and family members to evaluate the treatments they are receiving and should make the results of these evaluations available to prospective patients/families and referral sources.

A final issue related to patient attraction to MM involves the attractiveness, accessibility, perceived safety, and overall community reputation of the OTP.

Access

Rapid access to addiction treatment is particularly critical for injection drug users due to their ambivalence about treatment and about ceasing heroin use, their low frustration tolerance, their likelihood of continued drug use, and the high risk of harm to self and others via overdose death, HIV transmission, and criminal behavior.[252] Reports from MM counselors include vivid accounts of people dying while on waiting lists to enter treatment.[253] Between 25-50% of persons on waiting

249. Miller, P. (2009). Safe using messages may not be enough to promote behavior change amongst injecting drug users who are ambivalent or indifferent toward death. *Harm Reduction Journal*, *6*:18.

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253. Berry, L.C. (2007). *In$ide the methadone clinic indu$try: The financial exploitation of America's opiate addicts*. Tucson, AZ: Wheatmark.

lists fail to enter addiction treatment,[254] with as many as 40% of persons dropping out of the waiting list within the first two weeks.[255] MM treatment access can be limited—even for the most highly motivated patient—by lack of geographical proximity, inadequate treatment capacity/waiting lists for treatment admission, restrictive admission criteria, the demand for daily attendance, limited timeframes within which individuals can receive medication or pick up take-home medication, shaming rituals (e.g., standing in line on public streets, frontally-observed urination for drug testing), lack of insurance and prohibitive service fees, homelessness, child care, and language and cultural barriers.[256]

Potential patients have also experienced lost access to MM through closure of public treatment programs or their inability to pay for public or private treatment. Studies of such patients who have lost access to MM have documented adverse personal and community consequences.[257] It is critical that each OTP have an emergency plan that anticipates how each patient will be medicated in the event of a brief, prolonged, or permanent disruption in services at the clinic—a current requirement of the OTP accreditation process.

Future efforts to increase access to MM treatment include increased public and private funding to expand MM treatment capacity, distribution of coupons for free treatment, regulatory reform to minimize obstacles to treatment access, expedited admission (e.g., interim maintenance-methadone without counseling), and moving stabilized patients to medical maintenance (methadone provided by a primary care physician).[258]

For patients willing to enter MM only on a time-limited basis,[259] MM programs could admit patients under such conditions; provide patient education about the benefits of longer periods of maintenance; and, for those patients choosing to taper quickly, provide assertive post-treatment recovery check-ups to offer support, monitor recovery stability, and provide rapid re-engagement in treatment as needed (with or without methadone pharmacotherapy). Potential patients resistant to MM could be offered other treatment options, including alternative pharmacotherapies (e.g., buprenorphine). The goal of these efforts would be to shorten addiction careers and improve recovery outcomes by intervening in the progression of addiction at earlier stages of problem severity and complexity at a time when patients still have personal/family recovery capital that can be mobilized to enhance recovery initiation and recovery maintenance.

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There is also an issue of MM patients' access to other needed addiction treatment modalities. Historically, MM patients have been refused admission to abstinence-based addiction treatment and recovery support services, e.g., refused admission to alcohol detoxification, residential treatment, and sober living facilities.[260] Efforts to involve MM patients in these services have shown positive results and should be expanded via professional education and the establishment of formal linkages between OTPs and other addiction treatment programs.[261] OTPs can improve this situation by educating other treatment providers about the benefits of concurrent treatment, advocating on behalf of their patients (e.g., for state regulations that prohibit such discriminatory exclusion), and encouraging patients who have been denied access to treatment to seek legal redress. Some state addiction treatment authorities (e.g., Maine) explicitly prohibit (as a condition of licensing or funding) programs from refusing admission of patients who are also enrolled in medication-assisted treatment.

Early Engagement and Retention

Another distinctive feature of recovery management approaches is their emphasis on enhancing early patient engagement in the treatment process. This is related to two issues we will discuss later—therapeutic alliance and duration of service involvement—and the critical role each plays in influencing long-term recovery outcomes.

Recent reviews[262] of patient retention studies lead to six critical conclusions:

- Sustained treatment retention is critical to long-term recovery outcomes: "Addiction is a chronic relapsing disorder and short-term treatment is not likely to have any lasting impact."[263]
- MM programs retain opioid-addicted patients at higher rates than all other treatment modalities, but retention remains a significant problem in MM treatment.[264]
- Though MM was originally conceptualized as a prolonged if not lifelong treatment, the majority of newly admitted MM patients drop out within the first year.
- Retention and dropout rates vary widely from program to program.
- Retention and dropout are more related to in-treatment program factors than pre-treatment patient factors.[265]

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265. Magura, S., Nwakeze, P., & Demsky, S. (1998). Pre- and in-treatment predictors of retention in methadone treatment using survival analysis. *Addiction*, *93*(1), 51-60.

- Early dropout is related to four factors: 1) program-related factors (e.g., arbitrary and unequally enforced rules, conflict with one's counselor, discharge for non-payment of fees, schedule conflicts that interfere with daily pickups), 2) dissatisfaction with methadone (e.g., fear of prolonged dependence on medication and the clinic), 3) life events/logistics (e.g., stressful events or other obstacles that interfere with treatment participation), and 4) incarceration due to past legal problems or new minor criminal charges (e.g., loitering).

As we will review shortly, the optimum effects of MM in terms of full biopsychosocial recovery require a sustained period of treatment participation. Failure to establish a strong therapeutic alliance with each patient and early disengagement from treatment are key indicators that these optimum effects will not be achieved.[266] Of those admitted to MM, 24% drop out in the first 60 days,[267] with new patients dropping out at higher rates than returning patients—31% versus 20% in the first 90 days of treatment.[268] Studies have shown that the same factors that inhibit access also contribute to premature disengagement from MM, factors that include misconceptions and negative attitudes about methadone.[269] A critical finding worth restating is that patient retention in treatment is predicted more by program characteristics, including degree of therapeutic engagement, than by the patient's demographic or clinical characteristics.[270]

Among critical program factors that influence retention are medication dose, which we will discuss shortly, and each patient's belief that he or she is being treated fairly and with dignity and that his or her preferences are being respected. The "patient-centered approach" advocated by the Institute of Medicine[271] is the ideal for OTPs. Because of the amount of time the counselor spends with the patient compared to the time spent by other staff, the counselor plays a pivotal role in this process of patient engagement. Due-process assurances and the right of redress (e.g., grievance processes) are critical to resolving early problems in this engagement process.

Promising practices related to early engagement and retention include interim MM, rapid admission, same-day dosing, expanded clinic hours, individualized methadone doses with no dose floors or ceilings, formal patient/family orientation sessions, increased numbers of patient options, patient participation in clinical decision-making, peer guides for new patients, telephone prompts following missed appointments, patient education related to safety and pharmacology (e.g., how methadone works to overcome withdrawal, suppress cravings, provide feeling of "normalcy," create a blockade effect), provision of specialized services for co-occurring mental

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268. Deren, S., Goldstein, M.F., Des Jarlais, D.C., Richman, B.L., Kang, S-J., & Flom, P.L. (2001). Drug use, HIV-related risk behaviors and dropout status of new admissions and re-admissions to methadone treatment. *Journal of Substance Abuse Treatment*, *20*(2), 185-189.

269. Zaller, N.D., Bazazi, A.R., Velazquez, L., & Rich, J.D. (2009). Attitudes toward methadone maintenance among out-of-treatment minority injection drug users: Implications for health disparities. *International Journal of Environmental Research on Public Health*, *6*(2), 787-797.

270. Lowinson, J.H. (1977). Commonly asked clinical questions about methadone maintenance. *The International Journal of the Addictions*, *12*(7), 821-835. Meier, P.S., Barrowclough, C., & Donmall, M.C. (2005). The role of the therapeutic alliance in the treatment of substance misuse: A critical review of the literature. *Addiction*, *100*, 304-316.

271. Institute of Medicine. (2006). *Improving the quality of health care for mental and substance-use disorders: Quality chasm series*. Washington, DC: National Academy Press.

illnesses, use of patient advocates to resolve conflicts with staff, and completion of patient satisfaction surveys/interviews.[272] Another possible engagement strategy would be to reach out via intense peer-based educational interventions with patients who recycle through short heroin detoxification episodes without ever achieving an optimal therapeutic dose for maintenance pharmacotherapy.

Key recovery-focused systems performance measures related to attraction, access, and early retention include community-level measures of social and professional stigma related to MM, attitudes toward MM among persons who are in need of but not currently in treatment, referral source patterns (e.g., increases in self-referrals and referrals from systems traditionally hostile to MM), length of opioid use prior to first admission, percentage of admissions without prior addiction treatment, percentage of admissions without prior MM treatment, average time lag between help seeking and treatment admission, percentage of patients admitted from waiting lists, and early treatment retention.

ASSESSMENT AND SERVICE PLANNING

Assessment processes for patients with chronic diseases differ from assessment of acute disorders due to the following principle: chronic diseases beget other acute and chronic disorders that collectively exert sustained and profound strain on the patient and family. Assessment of chronic disorders is therefore global in scope, family-inclusive, and continual.

Assessment and service planning procedures within MM programs historically have paralleled those used in acute-care models of addiction treatment. A team of professionals conducts an initial screening and assessment, verifies and diagnoses opioid addiction, admits the patient, identifies primary and collateral problems, generates a professional treatment plan that delineates how these problems will be addressed, and maintains progress notes related to service activities aimed at the identified problems. Efforts to increase the recovery orientation of these processes include:

- shifting from categorical to global assessment instruments and interview protocols;
- conceptualizing the family (as defined by the patient) as the unit of service rather than the individual patient;

272. Bao, Y-P., Liu, Z-M., Epstein, D., Du, C., Shi, J., & Lu, L. (2009). A meta-analysis of retention in methadone maintenance by dose and dosing strategy. *The American Journal of Drug and Alcohol Abuse, 35,* 28-33. Deck, D., & Carlson, M. J. (2005). Retention in publicly funded methadone maintenance treatment in two Western states. *Journal of Behavioral Health Services & Research*, *32*(1), 43-60. Maddux, J.F., Desmond, D. P., & Esquivel, M. (1995). Rapid admission and retention on methadone. *American Journal of Drug and Alcohol Abuse*, *21*(4), 533-547. Reisinger, H.S., Schwartz, R.P., Mitchell, S.G., Peterson, J.A., Kelly, S.M., O'Grady, K.E., Agar, M.H. (2009). Premature discharge from methadone treatment: Patient perspectives. *Journal of Psychoactive Drugs*, *41*(3), 285-296. Schwartz, R.P., Jaffe, J.H., O'Grady, K.E., Das, B., Highfield, D.A., & Wilson, M. E. (2009). Scaling-up interim methadone maintenance: Treatment for 1,000 heroin-addicted individuals. *Journal of Substance Abuse Treatment*, *37,* 362-367. Stancliff, S., Myers, J.E., Steiner, S., & Drucker, E. (2002). Beliefs about methadone in an inner city methadone clinic. *Journal of Urban Health*, *79*, 571-578.

- 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 versus single-point-in-time intake process (based on the understanding that service needs change across the developmental stages of recovery); and
- making the transition from professionally directed treatment plans to patient-directed recovery plans.[273]

Traditional assessment processes (and level-of-care and modality-placement decisions) in addiction treatment have relied primarily on an assessment of addiction severity (its acuity and chronicity) and complexity (co-occurring problems and obstacles to recovery). Recovery management approaches to MM balance this emphasis on pathology assessment with an assessment of recovery capital in decisions related to placement, readiness for take-home privileges, and responses to a patient's interests or preferences related to tapering. For example, a patient presenting with high problem severity, but exceptionally high recovery capital may require lower treatment intensity and shorter duration than the patient presenting with lower problem severity but little or no recovery capital.[274] Assessing recovery capital and delivering services aimed at mobilizing and increasing internal and external recovery capital are essential strategies within recovery management approaches to the treatment of opioid dependence.

Neither the assessment nor counseling processes within MM programs have historically focused on needs of the children of MM patients, parenting concerns of MM patients, or the needs of the family as a whole.[275] We envision a future in which MM programs will offer a wide menu of child-, parent-, and family-focused recovery support services (See later discussion).

COMPOSITION OF THE SERVICE TEAM

Treatment of chronic diseases, in contrast to the treatment of acute disease or trauma, involves a broader multidisciplinary team and a greater emphasis on peer support for long-term recovery management. The typical staffing pattern of MM programs in the United States is made up of medical staff (physicians, physician's assistants, nurses, and nurse practitioners), counseling staff, and ancillary professionals (pharmacists, psychologists, and social workers).[276] We anticipate significant changes in the composition and duties of staff of MM programs that pursue greater recovery orientation, including expanded:

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273. Borkman, T. (1998). Is recovery planning any different from treatment planning? *Journal of Substance Abuse Treatment, 15*(1), 37-42. White, W. (2008c). *Recovery management and recovery-oriented systems of care: Scientific rationale and promising practices.* Pittsburgh, PA: Northeast Addiction Technology Transfer Center, Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health & Mental Retardation Services.

274. White, W., & Cloud, W. (2008). Recovery capital: A primer for addiction professionals. *Counselor, 9*(5), 22-27.

275. Lundgren, L.M., Schilling, R.F., & Peloquin, S.A.D. (2005). Evidence-based drug treatment practice and the child welfare system: The example of methadone. *Social Work*, *50*(1), 53-63.

276. Calsyn, D., Saxon, A.J., Blaes, P., & Lee-Meyer, S. (1990). Staffing patterns of American methadone maintenance programs. *Journal of Substance Abuse Treatment*, *7*, 255-259.

- roles of addiction medicine specialists in patient/family/community education;
- involvement of primary care physicians in MM treatment, including co-location of MM clinics and primary health care clinics (potential conduits for opening office-based treatment sites);
- use of case managers, freeing counselors to do scheduled recovery-focused counseling;
- involvement of therapists trained in clinical work with families and children;
- use of current and former patients in medication-assisted recovery as staff and volunteers within the MM milieu, e.g., as patient educators, recovery coaches, and advocates; and
- use of indigenous healers drawn from diverse cultural communities, e.g., leaders of faith-based recovery ministries.

These staffing changes are congruent with the RM focus on recovery as a process of enhanced global health and positive community re-integration and its emphasis on the potential contributions of peer-based recovery support services (P-BRSS) in long-term recovery from opioid addiction.

Medical staff members play a central role in service delivery during a patient's involvement in MM, but physician roles in MM focus primarily on conducting physical examinations, setting dosing levels, and performing administrative activities. Similarly, nursing time in OTPs is consumed primarily in dispensing medication for a high volume of patients. Most OTP physicians and nurses are not, or are only peripherally, involved in broader aspects of care delivery, nor are they involved in the sustained monitoring and support of patients following cessation of MM.[277] Some MM patients who reviewed a summary of this monograph were quite critical of the lack of physician involvement in their care.

> *I have NEVER MET the doctor whose name is on my methadone take home bottles. Never once in 15 years. There is no medicine going on in the MMT system.*[278]

One of the principles of RM is that every patient in recovery needs a sustained relationship with a primary care physician. Ideally, these physicians are involved as partners in the addiction treatment process, play a central role in the long-term management of health and wellness, and conduct ongoing post-treatment recovery check-ups.

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277. Loth, C., Schippers, G.M., Hart, H., & van de Wijngaart, G. (2007). Enhancing the quality of nursing care in methadone substitute clinics using action research: A process evaluation. *Journal of Advanced Nursing, 57*(4), 422-431. Wechsberg, W.M., Flannery, B., Kasten, J.J., Suerken, C., Dunlap, L., Roussel, A.E., & Diesenhaus, H. (2004). Physicians practicing in methadone treatment programs: Who are they and what do they do? *Journal of Addictive Diseases, 23*(2), 15-31.

278. MM patient feedback to authors, May 2010.

We anticipate greater involvement of primary care physicians in MM treatment, experiments in co-location of MM clinics and primary health care clinics, and an increased number of experiments delivering methadone treatment through the auspices of primary care physicians. Integrating addiction medicine and primary medicine may be particularly important for older MM patients who face risks of premature death from such co-occurring conditions as nicotine dependence and diabetes.[279] The high rate of psychiatric co-morbidity of MM patients and their generally low quality of life would also suggest a potentially greater role for psychologists and social workers in MM programs.[280]

As a byproduct of the professionalization of addiction counseling, the percentage of addiction counselors with a history of personal recovery decreased from more than 70% in the late 1960s to 30% in 2009.[281] Recovery representation is even lower in the MM arena, in spite of the fact that many MM patients recommended the use of recovering counselors in surveys asking them to identify the ideal characteristics of an MM program.[282] Calsyn and colleagues'[283] study of staffing patterns in MM programs found that less than half of MM programs had any staff in recovery, and only 10% of all MM staff in the United States self-identified as being in recovery. We anticipate a number of innovative, MM-specific peer recovery support initiatives in the near future that will forever reshape the milieu of methadone maintenance in the United States.[284] We anticipate a day when current and former MM patients in stable recovery are ever-present within OTPs via their roles as service staff, members of governing boards and patient advisory councils, and through formal volunteer programs and alumni associations.

From the standpoint of long-term recovery management, peer-based recovery support services can play a critical role in outreach (pre-recovery identification and recovery priming), recovery initiation and stabilization, transition to recovery maintenance, and enhancing the quality of personal and family life in long-term recovery (with or without continued methadone pharmacotherapy). Some OTPs, such as Beth Israel Medical Center in New York City, recruited patients who had been optimally dose—stabilized for years to be trained and credentialed as addiction counselors. Other OTPs are exploring the use of non-clinical peer-based recovery support services. Of particular note is the development of a peer-based recovery support services model for patients in methadone treatment via the CSAT-funded Medication Assisted Recovery Services (MARS) project in New York City.[285]

279. Fareed, A., Casarella, J., Amar, R., Vayalapalli, S., & Drexler, K. (2009). Benefits of retention in methadone maintenance and chronic health conditions as risk factors for premature death among older heroin addicts. *Journal of Psychiatric Practice*, *15*(3), 227-234. Lofwall, M.R., Brooner, R.K., Bigelow, G.E., Kindbom, K., & Strain, E. C. (2005). Characteristics of older opioid maintenance patients. *Journal of Substance Abuse Treatment*, *28*, 265-272.

280. Carpentier, P.J., Krabbe, P.F., van Gogh, M.T., Knapen, L.J., Buitelaar, J.K., & de Jong, C.A. (2009). Psychiatric comorbidity reduces quality of life in chronic methadone maintained patients. *American Journal on Addictions*, *18*(6), 470-480.

281. White, W. (2009b). *Peer-based addiction recovery support: History, theory, practice, and scientific evaluation.* Chicago, IL: Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health and Mental Retardation Services.

282. Jones, S.S., Power, R., & Dale, A. (1994). The patients' charter: Drug users' views on the "ideal" methadone programme. *Addiction Research*, *1*(4), 323-334.

283. Calsyn, D., Saxon, A.J., Blaes, P., & Lee-Meyer, S. (1990). Staffing patterns of American methadone maintenance programs. *Journal of Substance Abuse Treatment*, *7*, 255-259.

284. White, W. (2009b). *Peer-based addiction recovery support: History, theory, practice, and scientific evaluation.* Chicago, IL: Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health and Mental Retardation Services.

285. Ginter, W. (2009). *Advocacy for medication-assisted recovery*. Retrieved November 4, 2009 from http://www.facesandvoicesofrecovery.org/publications/profiles/walter_ginter.php.

THE SERVICE RELATIONSHIP

Relationships between patients with chronic diseases and their service providers are markedly different than interactions surrounding the treatment of acute disorders. The treatment of acute disorders places the physician and care team in a position of elevated power and responsibility to "fix" the problem presented by the patient. In contrast, the patient with a chronic disease bears central responsibility for managing his or her own recovery in consultation with his or her professional care providers. Physicians and the broader care team provide ongoing adjustments in medical management (e.g., medications) and respond to acute crises, but they play equally important roles as educators, consultants, and recovery coaches. In these latter roles, they provide to each patient a rich menu of information and support services. As we shall see, the scope, depth, and duration of resources provided to patients managing other chronic diseases are far greater than those of the resources offered to current and former methadone patients.

The service relationships within chronic disease management are particularly distinctive in terms of their duration (measured in years or decades), the high degree of intimacy that develops between 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. One would think that service relationships within OTPs would reflect this type of relationship, given MM's foundational belief that opioid dependence is a chronic disease requiring sustained and active management.

The importance of the therapeutic alliance in the treatment of addiction is clearly evident in the early publications of the developers of MM. Dr. Marie Nyswander declared that the most important thing in the life of a drug addict is "to be understood." She called upon treatment providers to "convey an interest in every aspect of the patient's life."[286] Dr. Nyswander's capacity for such alliances with her patients was legendary, and Dr. Dole was fond of suggesting that it was impossible to rehabilitate any patient without getting to know the patient as a human being.[287]

> *I made a practice of spending two or three hours almost every day just sitting and talking with the addicts in a somewhat aimless way. I was just trying to get a sense of their way of thinking, their values, their experiences. They educated me about a world that was out of my reach, one that I had never been in and would never enter.*[288]

286. Nyswander, M. (1956). *The drug addict as a patient*. New York: Grune & Stratton.

287. Dole, V.P. (1989). Interview. In D. Courtwright & J. H. Des Jarlais (Eds.), *Addicts who survived* (pp. 331-343). Knoxville, TN: The University of Tennessee Press.

288. Dole, V.P. (1989). Interview. In D. Courtwright & J. H. Des Jarlais (Eds.), *Addicts who survived* (pp. 331-343). Knoxville, TN: The University of Tennessee Press.

Like teachers in a one-room school, we knew each patient personally.[289]

Dr. Mary Jeanne Kreek also extolled the importance of listening to patients as the most important quality of those working in MM treatment.

> *Less easily measured than blood levels of the pharmacotherapeutic agent, urine content of a drug of abuse, receptor or peptide ligand levels, or the myriad of social and psychological indices measured by well-validated instruments of psychology and psychiatry are those qualities that make any individual staff member an excellent and human care giver.*[290]

MM in its earliest years was grounded in a relationship free of contempt and in attitudes of personal respect and professional humility.[291] The climate of partnership between the original MM pioneers and their patients was so strong that critics suggested their outcomes were a product of the supportive milieu rather than of methadone. "There's something very special about the climate at Rockefeller" was proffered by such detractors as a criticism rather than a compliment.[292]

MM pioneers grieved the loss of such relationships as MM was widely diffused in the United States and beyond.

> *The most any chemical agent can do for an addict is to relieve his compulsive drive for illicit narcotics. To give him hope and self-respect requires human warmth; to become a productive citizen he needs the effective support of persons who can help him find a job and protect him from discrimination. It is in these human qualities that the [methadone maintenance] programs of the past five years have failed.*[293]

> *… to succeed in bringing disadvantaged addicts to a productive way of life, a treatment program must enable its patients to feel pride and hope and to accept responsibility. This is often not achieved in present-day [methadone maintenance] treatment programs. Without mutual respect, an adversary relationship develops between patients and staff, reinforced by arbitrary rules and the indifference of persons in authority. Patients held in contempt by the staff continue to act like addicts…* [294]

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289. Dole, V. P. (1971). Methadone maintenance treatment for 25,000 addicts. *Journal of the American Medical Association*, *215*, 1131-1134.

290. Kreek, M.J. (1993). Epilogue—a personal restrospective and prospective viewpoint. In M.W. Parrino, *State Methadone Guidelines: Treatment Improvement Protocol (TIP) Series 1*. Rockville, MD: Center for Substance Abuse Treatment.

291. Dole, V.P. (1994b). What we have learned from three decades of methadone maintenance treatment. *Drug and Alcohol Review*, *13*, 3-4. Newman, R. G. (2000). Addiction and methadone. *Heroin Addiction & Related Clinical Problems, 2*(2), 19-27.

292. Dole, V.P. (1989). Interview. In D. Courtwright & J. H. Des Jarlais (Eds.), *Addicts who survived* (pp. 331-343). Knoxville, TN: The University of Tennessee Press.

293. Dole, V.P., & Nyswander, M. E. (1976). Methadone maintenance treatment: A ten year perspective. *Journal of the American Medical Association*, *235*, 2117-2119.

294. Dole, V.P., & Nyswander, M. E. (1976). Methadone maintenance treatment: A ten year perspective. *Journal of the American Medical Association*, *235*, 2117-2119.

Service relationships within MM treatment have been inordinately shaped by the regulatory environment and the growing business orientation of OTPs.

> *The "Catch-22" in which the methadone patient, methadone treatment staff, and methadone clinic as an institution are trapped grew out of the conflicting interests that emerged as methadone maintenance was mainstreamed as a treatment modality. On the one hand, there were the needs of the methadone patient and the need for a long-term service relationship based on empathy, trust, and respect. On the other hand, there were concerns about public safety via the potential for methadone diversion. This tension between a milieu of engagement and empowerment versus a milieu of distrust and control left those being served caught between the status of a patient and the status of a prisoner/probationer and left the physician/nurse/counselor caught between their aspirations to serve as healers and onerous, regulatory-imposed policing functions. The result is a demedicalized system of methadone maintenance in which people entering methadone maintenance are treated more like criminals (or recalcitrant children) than patients, within a relational world more dominated by surveillance and control than compassion and choice.*[295]

> *The MM model is based on **control** and **dehumanizes** its "clients" with practices such as observed urinalysis.*[296]

> *I have been on MMT for over 11 yrs now and I can't even remember the last time I had a dirty UA. I have always been a model patient, never caused any problems, or made any formal complaints (even though there were many times I would have if I had not feared retaliation by the clinic owner and doctor).*[297]

To seek help at an OTP requires willingness to surrender central control of one's life to the OTP staff. The person entering the OTP is typically desperate and at the end of his/her rope, having burned all bridges to civility and support in the non-addict world. By entering methadone maintenance pharmacotherapy, patients surrender control over their drug use and their lives to absolute strangers. If that trust is affirmed during the induction period, the patient is likely to remain receptive to maintenance pharmacotherapy. As relationships with clinical staff deepen, the patient is likely to reveal his or her life experience and aspirations to the OTP staff. Establishment of a strong

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295. Curet, E., Langrod, J., Page, J., & Lowinson, J.H. (1985). Issues of transference in methadone maintenance treatment. *The International Journal of the Addictions, 20*(3), 435-448. Fraser, S., & Valentine, K. (2008). *Substance and substitution: Methadone subjects in liberal societies.* New York: Macmillan. Hunt, G., & Rosenbaum, M. (1998). 'Hustling' within the clinic: Consumer perspectives on methadone maintenance treatment. In J.A. Inciardi & L.D. Harrison (Eds.), *Heroin in the age of crack-cocaine* (6th edition, pp. 188-214). Thousand Oaks, CA: Sage. Rosenbaum, M. (1995). The demedicalization of methadone maintenance. *Journal of Psychoactive Drugs*, *27*, 145-149. White, W. (2009a). *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).* Philadelphia: Department of Behavioral Health and Mental Retardation Services.

296. MM patient feedback to authors, May 2010.

297. MM patient feedback to authors, June 2010.

alliance with the patient, beginning with the achievement of optimal dose stabilization in collaboration with the patient, lays the foundation for the larger and more enduring process of biopsychosocial recovery. Recovery-focused helping relationships are distinguished by a shared vision of long-term recovery, a recovery-focused partnership/consultant relationship, and an emphasis on continuity of relational support over time.

ROMM requires abandoning the view that the individual is the sole source of the problem and that the credentialed professional is the source of the solution. The gross power inequities between the patient and OTP clinic must be acknowledged, abuses of such power admitted, and new service relationships formed on a long-term recovery partnership model. Substandard and exploitive care must be exposed and confronted, amends must be made where possible, and policies and practices that punish patient honesty must be abandoned.

There are several measures within MM that can be used to gauge changes in the quality of service relationships over time. These indicators include: 1) measures of therapeutic alliance; 2) surveys of patient attitudes toward OTP staff and OTP services; 3) ethnographic studies of MM patients and the OTP milieu; 4) patient dropout rates during early treatment (first 30 days); 5) rates of dropout during dose and recovery stabilization (first 6 months); 6) discharge status, particularly the rates of administrative discharge and patient termination of services against medical advice; and 7) recovery rates of patients assigned to different counselors or service units.

Positive indicators that an OTP is moving toward 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;[298] reduced incidence of administrative discharges and changes in administrative discharge policies; elevating patient hopes and personal goals (e.g., helping patients weigh the pros and cons of SSI disability support and, where appropriate, achieve productive employment); transitioning patients from professionally developed treatment plans to patient-developed recovery plans; and emphasizing continuity of patient/family contact and support across the stages of long-term recovery.

Ensuring continuity of contact and support might be the Achilles heel of ROMM and the larger movement toward an RM model for all addiction treatment. Such continuity of support in a primary recovery support relationship cannot be ensured in a workforce undergoing constant turnover. Surveys of the addiction treatment workforce reveal high rates (25-50%) of staff turnover and high

298. White, W. (2008e). Toward a philosophy of choice: A new era of addiction treatment. *Counselor, 9*(1), 38-43.

percentages of staff members reporting their intention to leave their current positions in the next five years.[299] There are reports of counselor turnover rates in OTPs as high as 400% per year.[300]

> *Staff turnover is definitely a problem. I got used to the counselor I had when I first started methadone maintenance treatment. I told her all my history, all the dirty details and things I hadn't been able to talk about before. Without me even knowing it was going to happen, she was gone, no goodbye—nothing. Then I had to try and go through all the same stuff again with a new counselor, and for what? Four months later, that one was gone too.*[301]

Ensuring continuity of contact and support within a long-term recovery management framework will require strategies for stabilization of the professional workforce and reliance on others (e.g., volunteers, recovery mutual aid sponsors) to provide such continuity. It is our hope that revitalized, recovery-focused OTPs will make these settings a more fulfilling place to work for physicians, nurses, counselors, other staff, and volunteers.

SERVICE QUALITY/DURATION

Concerns about the quality of MM include six issues: methadone dosing philosophies, the character of addiction counseling, service scope, service duration, discharge status, and the service milieu. All are critical to treatment retention and long-term recovery outcomes.

DOSING PHILOSOPHY/PROTOCOL

Once a patient is admitted into MM treatment, the induction process involves identifying the safest, most appropriate initial dose of methadone. The induction dosing process is fraught with risk. The medication must fulfill the primary objective of alleviating a patient's withdrawal symptoms (if the dose is inadequate, the patient is likely to seek illicit sources of relief), but there is a countervailing danger of lethal toxicity if the medication dose is too high. Ideally, the physician works with each patient, informing the patient of the need to share accurate and complete information regarding past and current use of opioids in order to determine the safest, most effective dose induction schedule for the patient.

Methadone dose is a critical factor in ongoing patient retention and in long-term recovery outcomes,[302] and optimal methadone doses can vary widely from patient to patient based on multiple

299. Kaplan, L. (2003). *Substance abuse treatment workforce environmental scan.* Rockville, MD: Center for Substance Abuse Treatment. McLellan, A.T., Carise, D., & Kleber, H.D. (2003). The national addiction treatment infrastructure: Can it support the public's demand for quality of care? *Journal of Substance Abuse Treatment*, *78*, 125-129. Murphy, D.M., & Hubbard, R.L. (2009). *Understanding America's substance use disorders treatment workforce: A summary report.* National Addiction Technology Transfer Center National Office.

300. Berry, L.C. (2007). *In$ide the methadone clinic indu$try: The financial exploitation of America's opiate addicts.* Tucson, AZ: Wheatmark.

301. MM patient feedback to authors, May 2010.

302. Faggiono, F., Vigna-Tagliantiu, F., Versino, E., & Lemma, P. (2003). Methadone maintenance at different dosages for opioid dependence. *Cochrane Database of Systematic Reviews*, Issue 3, Article No.: CD002208. DOI: 10.1002/14651858.CD002208.

factors, including genotypes that influence the rate of methadone metabolism.[303] The likelihood of continued use of heroin and other drugs following enrollment in MM decreases as the daily dose of methadone increases and tolerance is either matched (to the person's prior illicit opioid dose) or built up (to a point where cross-tolerance/blockade to other opioids is established). A significant portion of heroin and other drug use in low-dose MM programs stems from therapeutic (e.g., self-medication of withdrawal symptoms) rather than hedonic motivations.[304] Methadone dose and positive attitudes toward the option of sustained MM treatment are the most critical factors influencing MM retention, which in turn influences long-term recovery outcomes.[305]

The history of MM is filled with intense debates about the superiority of high doses versus low doses of methadone. Anyone with extended tenure in the field of methadone maintenance treatment will recall concerns about "under-dosing," "sub-therapeutic dosing," and "dosing ceilings." Prevailing practice has moved through four stages: 1) high doses (80-120mgd) and long duration in the founding model of MM, 2) arbitrary- and low-dose ceilings (40-60mgd) and time limits on the duration of MM during the 1970s and 1980s, 3) emergence of private clinics known for exceptionally high-dose MM (above 120mgd), and 4) recent trends driven by scientific research and cumulative clinical experience that more closely approximate the founding model.[306] At each dose level of MM, there are patients who do well; the critical factor in this dimension of MM treatment is the need for clinically individualized doses and the recognition that doses may need to be adjusted over time based on the physical, emotional, and social stressors experienced by the patient.[307]

The key benefits of methadone as a pharmacotherapeutic agent in the management of chronic opioid addiction include: (1) cessation of withdrawal symptoms; (2) elimination of drug craving; (3) blocking the euphorigenic effects of other opiates and opiate derivatives; (4) physiological normalization (lack of impairment from intoxication or sedation); and (5) physiological stability due to slow onset, long-acting metabolites (half life of 24-36 hours), and slow elimination due to deep storage in body tissues. Methadone maintenance pharmacotherapy first seeks to eliminate opioid withdrawal symptoms and, by either building or matching tolerance, to identify the patient's optimal dose—the particular methadone dose that maximizes the benefits of methadone in managing the disease of opioid addiction in the individual. Optimal dose stabilization is achieved by maintaining the same benefits from the same optimal dose over time, without interruption. Once optimal dose stabilization is achieved, the patient is neither in a state of withdrawal nor opioid impaired; is considered opioid abstinent (in that the euphorigenic effects of other opioids are blocked); does

303. Tennant, F. (2010). Cytochrome P450 Abnormalities in *Patients Who Require High-Dose Opioids*, The American Journal on the Addiction, 19(4), p. 370.

304. Fatséas, M., Lavie, E., Denis, C., & Auriacombe, M. (2009). Self-perceived motivations for benzodiazepine use among opiate-dependent patients. *Journal of Substance Abuse Treatment*, *37*, 407-411.

305. Caplehorn, J.R. M., Lumley, T., & Irwig, L. (1998). Staff attitudes and retention of patients in methadone maintenance programs. *Drug and Alcohol Dependence*, *52*, 57-61.

306. White, W., & Torres, L. (2010a). Recovery-oriented methadone maintenance: I. Historical context.

307. Senay, E. (2010). Personal communication, February 16, 2010.

not suffer from opioid cravings; and, most important, has acquired the state of stability that is at the heart of the recovery initiation process. Again, these benefits are dependent on each patient's receipt of individualized and optimal doses of methadone.

Caplehorn and colleagues[308] found that patients in abstinence-oriented MM programs (low-dose/low duration philosophy) were more likely to leave treatment (26% more likely in first 6 months and 39% more likely between 18 and 24 months) than patients in maintenance-oriented programs (high-dose/long duration philosophy). Subsequent studies (reviewed below) have affirmed the superiority of higher methadone doses in enhancing treatment retention and outcomes.

MM is unique in the annals of medicine as the only arena in which patients have been denied medication or had their medication dosage lowered as a punishment for clinic rule infractions.[309] The use of medication as a coercive tool has no place in a recovery-oriented approach to the treatment of opioid addiction.

ADDICTION COUNSELING

Recovery outcomes vary significantly across OTPs,[310] and a portion of that variability is attributable to counselor factors.[311] OTPs historically have been staffed with medical personnel charged with the mechanics of MM induction/dosing and counseling staff whose charge has been to facilitate the psychosocial rehabilitation process. Efforts have been made to formulate the special principles and activities that distinguish addiction counseling within the MM treatment setting.[312] However, patients in most OTPs are not afforded the type of counseling that their counterparts receive in other addiction treatment modalities.

Regularly scheduled counseling sessions guided by a theoretical framework of change and overseen by regular clinical supervision, with careful attention to the counseling process and counselor-patient relationship, are uncommon in many OTPs, and most MM patients are not offered a menu of individual, group, marital, or family counseling services.[313] This is not to say that the MM counselor does not wish to provide more counseling or that the counselor has an insignificant role in MM treatment outcomes, but such effects often occur in spite of rather than because of the way the counselor's role is defined in the OTP. MM counselors function more closely to what would be called case managers in other treatment settings. The "counseling" itself is more likely to involve activities such as monitoring urine drops, monitoring patients' behavior in "the line" and at the "dosing

308. Caplehorn, J.R.M., McNeil, D.R., & Kleinbaum, D.G. (1993). Clinic policy and retention in methadone maintenance. *The International Journal of the Addictions, 28*(1), 73-89.

309. Platt, J.J., Widman, M., Lidz, V., & Marlowe, D. (1998). Methadone maintenance treatment: Its development and effectiveness after 30 years. In J.A. Inciardi & L. Harrison (Eds.), *Heroin in an age of crack-cocaine* (pp. 160-187). Thousand Oaks, CA: Sage.

310. Ball, J.C., & Ross, A. (1991). The effectiveness of methadone maintenance treatment. New York: Springer-Verlag.

311. Blaney, T. & Craig, R.J. (1999). Methadone maintenance: Does dose determine differences in outcome? *Journal of Substance Abuse Treatment*, *16*(3), 221-228. McLellan, A.T., Woody, G.E., Luborsky, L., & Goehl, L. (1988). Is the counselor an "active ingredient" in substance abuse rehabilitation? An examination of treatment success among four counselors. *The Journal of Nervous and Mental Disease*, *176*(7), 423-430.

312. Center for Substance Abuse Treatment. (2005). *Medication-assisted treatment for opioid addiction in opioid treatment programs* (Treatment Improvement Protocol (TIP) Series 43, DHHS Publication No. (SMA) 05-4048). Rockville, MD: Substance Abuse and Mental Health Services Administration. Hagman, G. (1994). Methadone maintenance counseling: Definitions, principles, components. *Journal of Substance Abuse Treatment, 11*(5), 405-413. Weiner, H., & Schut, J. (1975). The interaction between counseling and methadone in the treatment of narcotic addicts: The challenge of the counseling relationship. *International Journal of Clinical Pharmacology*, *11*, 292-298. Zweben, J.E. (1991). Counseling issues in methadone maintenance treatment. *Journal of Psychoactive Drugs*, *23*(2), 177-190.

313. Berry, L.C. (2007). *In$ide the methadone clinic indu$try: The financial exploitation of America's opiate addicts.* Tucson, AZ: Wheatmark.

window," enforcing clinic rules (e.g., ban on loitering), fielding requests for changes in medication dosage, arranging "guest doses" at other clinics for traveling patients, responding to non-payment of fees, and completing the endless paperwork required to maintain clinic regulatory compliance.

> *Most of the time, you only see your counselor to sign your treatment plan every 3 months. They copy down what they had from the last time, change a few sentences and the dates, and there you have your current treatment plan. I think there should be psychotherapy going on along with MMT, and I thought that is what the counselor was supposed to be for. Not to mention, the clinics I have gone to have all only had ONE counselor for the whole clinic!*[314]

The lack of adequate counseling services is likely to emerge as a source of legal vulnerability for OTPs, as indicated by a recent lawsuit alleging that a major provider of methadone treatment in the U.S. failed to provide the counseling services that it had promised.[315]

Studies to-date confirm an important relationship between MM staff attitudes about MM and retention in treatment.[316] Studies have also found that clinical outcomes of MM patients differ considerably depending on the counselors to whom they are assigned, with neither level of formal education nor recovery status of the counselor predicting the best treatment outcomes.[317] Quantity of counseling also matters. Simpson and colleagues[318] found that increased numbers and/or lengths of counseling sessions for MM patients led to a series of critical effects: decreased in-treatment drug use, increased retention in treatment, and enhanced long-term recovery outcomes. MM patients who communicated with the authors about this monograph often contrasted their experiences with counselors at different clinics.

> *Basically it comes down to this: if I were to relapse and pee dirty for cocaine right now, my current clinic staff* ***would CONGRATULATE themselves on a job well done****—because they caught me. At [my former clinic], my counselor would feel like* ***SHE failed me*** *somehow and she would have been* ***angry and worried FOR ME—not AT me****.*[319]

Prolonged heroin use and its associated lifestyle poisons personal character and interpersonal relationships. As a result, recovery involves not just a cessation of heroin use but also a reconstruction of personal values, personal identity, and relationship to family, friends, and community.[320]

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314. MM patient feedback to authors, June 2010.

315. Enos, G. (2010). Methadone provider with operations in 18 states sued over lack of services: Suite alleges that clinic does not offer promised therapeutic care. Addiction Professional. Online posting June2, 2010 at http://www.addictionpro.com/ME2/Segments/Publications/Print.asp?Module=Publications

316. Caplehorn, J.R. M., Lumley, T., & Irwig, L. (1998). Staff attitudes and retention of patients in methadone maintenance programs. *Drug and Alcohol Dependence*, *52*, 57-61.

317. McLellan, A.T., Woody, G.E., Luborsky, L., & Goehl, L. (1988). Is the counselor an "active ingredient" in substance abuse rehabilitation? An examination of treatment success among four counselors. *The Journal of Nervous and Mental Disease*, *176*(7), 423-430.

318. Simpson, D.D., Joe, G.W., Rowan-Szal, G.A., & Greener, J.M. (1995). Client engagement and change during drug abuse treatment. *Journal of Substance Abuse*, *7*, 117-134. Simpson, D.D., Joe, G.W., Rowan-Szal, G.A., & Greener, J.M. (1997). Drug abuse treatment process components that improve retention. *Journal of Substance Abuse Treatment*, *14*(6), 565-572.

319. MM patient feedback to authors, May 2010.

320. White, W. (1996). *Pathways from the culture of addiction to the culture of recovery*. Center City, MN: Hazelden.

The biological rationale for MM and the focus on the pharmacotherapeutic aspects of MM have minimized attention to these broader aspects of recovery. These factors have also provided little framework for patients to consider spiritual (including life meaning and purpose) dimensions of the recovery process. Kurtz,[321] in his historical studies of Alcoholics Anonymous and in his writings on spirituality,[322] describes seven experiences that are at the core of the addiction recovery process:

- release (a shedding of mistruths about oneself; surrender; experience of breaking free or being freed; a lessening or loss of burdens);
- gratitude (receptiveness, appreciation, and thanksgiving);
- humility (acceptance of imperfection, being free of comparisons, honesty, balance);
- tolerance (experience of mutual vulnerability; openness to difference; compassion);
- forgiveness (shedding the past; letting go of resentment, anger, and sadness);
- awe and wonder (being humbled before something of great power and beauty); and
- compassion (recognizing the woundedness of others; desire to share awe and joy with others; affirmation of life in the face of pain and loss).

Rarely have mainstream MM patients had such issues explored in a counseling process. They have not been afforded the scope and intensity of educational and counseling experiences routinely provided to those in other addiction treatment modalities.

There are several matters over which the methadone counselor has either exclusive or considerable control that can adversely affect the life of a methadone patient. These include how often and at what time the patient must come to the OTP for daily dosing and whether, or under which, circumstances the patient can earn "take-home" medication bottles and how many they can earn. Denying a patient take-home medication, insisting the patient attend the OTP daily, and limiting the time or hours in which the patient can receive his/her daily dose profoundly affects the patient's self-esteem and his or her capacity to take on or to fulfill family, work, school, and travel obligations. Patients can request take-home privileges for special occasions, vacations, or in the case of a hardship, through a system in which there is much counselor discretion but little patient recourse in response to denial. Patients who find the courage to challenge staff decisions or actions often do so in fear of retaliatory action. The counselor relationship carries the most weight in such decision-making.

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321. Kurtz, E. (1979). *Not-God: A history of Alcoholics Anonymous*. Center City, MN: Hazelden (revised and expanded edition, 1991). Kurtz, E. (1999). *The collected Ernie Kurtz*. Wheeling, WV: Bishop of Books.

322. Kurtz, E., & Ketcham, K. (1992). *The spirituality of imperfection*. New York: Bantam Books.

Under the current MM system, patients achieve substantial improvements related to heroin use and lifestyle stability, but many continue to experience difficulties with a variety of drugs (e.g., opioids, cocaine, benzodiazepines, alcohol) and remain economically dependent and socially unproductive—still isolated and socially estranged from the mainstream of community life.[323] The founders of methadone maintenance were quite explicit about its limitation in addressing drug problems other than heroin (or other opioid) addiction.

> *…methadone has no unique value in the treatment of non-opiate addictions—alcohol, cocaine, sedatives and tranquilizers—or smoking. The therapeutic environment of a good methadone clinic can help in dealing with these complicating problems, but credit for improvement in these areas must go mainly to persistent, supportive counseling.*[324]

MM patients have not been afforded the intensity of education and counseling to address these larger issues of global health and functioning that mark other addiction treatment modalities—in part because of the high ratios of patients to counselors that typify OTPs.

Changing the counseling relationship to a sustained partnership grounded in the need to manage a chronic disease over the patient's lifetime will require orienting patients in the fundamentals of long-term recovery from opioid addiction. Patients will need to understand such concepts as chronic disease, optimum dose stabilization, recovery management, recovery partnership, patient-centered care, and recovery planning. Rather than being passive recipients of new models of care, patients in ROMM will be required to become fully engaged in shaping these new approaches to long-term recovery management. This orientation, education, and participation process should provide new inspiration and confidence for patients who have been quieted by shame, misinformation, and fear of reprisal for speaking out about the inadequacy of current treatment services. In the same vein, it will be important to acknowledge that not all patients need continued counseling and that periodic recovery checkups might replace required counseling when the latter serves only as a meaningless ritual of regulatory compliance for patients who have reached a high degree of recovery stability. We are arguing simultaneously for more and less counseling in the OTP milieu based on the needs of the particular patient.

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323. Magura, S., & Rosenblum, A. (2001). Leaving methadone treatment: Lessons learned, lessons forgotten, lessons ignored. *Mount Sinai Journal of Medicine*, *68*, 62-74.

324. Dole, V.P. (1994b). What we have learned from three decades of methadone maintenance treatment. *Drug and Alcohol Review*, *13*, 3-4.

SCOPE OF ANCILLARY SERVICES

Ancillary services in methadone treatment include resources for identifying and treating co-occurring medical, psychiatric, and illicit substance use problems; vocational/employment services; legal services; and peer-based recovery support services. Several studies have been conducted to assess whether or not the scope of ancillary services influences post-treatment recovery outcomes.

- McLellan and colleagues[325] found that MM patients who received enhanced services (medical/psychiatric care, family counseling, and employment services) achieved better treatment outcomes than patients who received only methadone or methadone plus counseling.
- McLellan and colleagues[326] found that patients who received supplemental social services (case management, medical screening, housing assistance, parenting classes, and employment services) achieved better outcomes (less substance use, fewer medical/psychiatric problems, and better social functioning) than patients who received only core MM services.
- Friedmann and colleagues[327] found that ancillary on-site medical services enhanced post-treatment substance use outcomes.
- Berkman and Wechsberg[328] confirmed that a higher percentage of MM patients received ancillary services when these services were provided on-site at the MM clinic rather than provided through off-site referral.[329]
- Kraft and colleagues[330] conducted a study of varying intensity levels of ancillary services in MM and found that abstinence rates were highest for those receiving the highest intensity of supplemental services, but that methadone plus counseling was the most clinically effective and cost-effective threshold of service provision.
- Avants and colleagues[331] compared two 12-week formats for delivering intensified MM services and found that outpatient MM amplified with ancillary services generated the same outcomes as a more intense day treatment format, and for less than half the cost.

The need for legal and other advocacy services is rarely mentioned in the professional literature on MM, despite the many legal issues faced by patients seeking MM and the variety of discrimination issues that they face. Such services would be a welcomed addition to the OTP service menu.

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325. McLellan, A.T., Arndt, I.O., Metzger, D.S., Woody, G.E., & O'Brien, C.P. (1993). The effect of psychosocial services in substance abuse treatment. *Journal of the American Medical Association, 269*, 1953-1957.

326. McLellan, A.T., Hagan, T.A., Levine, M., Gould, F., Meyers, K., Bencivengo, M., & Durell, J. (1998). Supplemental social services improve outcomes in public addiction treatment. *Addiction*, *93*(10), 1489-1499.

327. Friedmann, P.D., Zhang, A., Hendrickson, J., Stein, M.D., & Gerstein, D.R. (2003). Effect of primary medical care on addiction and medical severity in substance abuse treatment programs. *Journal of General Internal Medicine*, *18*, 1-8.

328. Berkman, N.D., & Wechsberg, W.M. (2007). Access to treatment-related and support services in methadone treatment. *Journal of Substance Abuse Treatment, 32*, 97-104.

329. Umbricht-Schneiter, A., Ginn, D.H., Pabst, K.M., & Bigelow, G.E. (1994). Providing medical care to methadone clinic patients: Referral vs. on-site care. *American Journal of Public Health*, *84*, 207-210.

330. Kraft, M.K., Rothbard, A.B., Hadley, T.R., McLellan A.T., & Asch, D.A. (1997). Are supplementary services provided during methadone maintenance really cost-effective? *American Journal of Psychiatry, 154*(9), 1214-1219.

331. Avants, S.K., Margolin A., Sindelar J.L., Rounsaville B.J., Schottenfeld, R., & Stine S. (1999). Day treatment versus enhanced standard methadone services for opioid- dependent patients: A comparison of clinical efficacy and cost. *American Journal of Psychiatry, 156*(1), 27-33.

Some early treatment systems, such as the Illinois Drug Abuse Program, provided such legal services as an ancillary service for MM patients.[332]

Expanding the range of services provided is congruent with the ROMM understanding that recovery encompasses global health and positive community integration. Further reflecting this understanding is ROMM's family orientation. Family-focused services have not been a part of mainstream MM treatment services, with only the youngest of MM patients likely to have their family members consistently involved in the treatment process.[333] Research in the past decade confirms three critical findings in this area: 1) family relationships are profoundly influenced by addiction,[334] 2) these relationships exert a critical influence on recovery outcomes,[335] and 3) drug-free family members can be mobilized to participate in the treatment of MM patients.[336]

Pilot efforts to provide more family-focused services within OTPs have been evaluated positively. Dawe and colleagues[337] evaluated the Parents under Pressure program and found that a family-focused service intervention attached to MM enhanced parental functioning, improved parent-child relationships, reduced the risk of child abuse, reduced behavior problems of children of MM patients, and decreased parental substance use. Fals-Stewart, O'Farrell, and Birchler[338] tested the value of individual versus couples-focused MM counseling services and found that those patients receiving behavioral couples therapy experienced less substance use and enhanced quality of family relationships. Greif and Drechsler[339] have outlined how parenting training groups can address some of the parenting issues faced by MM patients, e.g., difficulty providing consistent daily structure, guilt from past acts of neglect, sabotage of parenting by one's own parents, anger from children due to addiction/recovery history, and the special challenges of raising adolescents. Grella and colleagues found that mothers treated in programs with a high level of family-focused services were twice as likely to experience successful reunification with their children as mothers treated in programs rated low in such services.[340] Given the widespread community misunderstandings about methadone maintenance treatment, educational and support services for parents, siblings, intimate partners, children, and friends of the MM patient would seem to be particularly indicated to prevent sabotage of the patient's recovery efforts and to mobilize support for recovery initiation and maintenance.

One of the issues of considerable importance in ROMM is the need to provide treatment that has the potential of breaking intergenerational cycles of alcohol and other drug problems.[341] Haggerty

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332. Senay, E. (2010). Personal communication. May 20, 2010.

333. Guarino, H.M., Marsch, L.A., Campbell, W.S., Gargano, S.P., Haller, D.L., & Solhkhan, R. (2009). Methadone maintenance treatment for youth: Experience of clients, staff and parents. *Substance Use and Misuse*, *44*(14), 1979-1989.

334. See, for example, McMahon, T.J., Winkel, J.D., & Rounsaville, B.J. (2008). Drug abuse and fathering: A comparative study of men enrolled in methadone maintenance. *Addiction*, *103*(2), 269-283.

335. Heinz, A.J., Wu, J., Witkiewitz, K, Epstein, D.H., & Preston, K.L. (2009). Marriage and relationship closeness as predictors of cocaine and heroin use. *Additive Behaviors*, *34*(3), 258-263. Knight, D.K., & Simpson, D.D. (1996). Influences of family and friends on client progress during drug abuse treatment. *Journal of Substance Abuse*, *8*(4), 417-429. Powers, K.I., & Anglin, M.D. (1996). Couples' reciprocal patterns in narcotic addiction: A recommendation on treatment strategy. *Psychology and Marketing*, *13*(8), 769-783.

336. Kidorf, M., Brooner, R.K., & Kinh, V.L. (1997). Motivating methadone patients to include drug-free significant others in treatment: A behavioral intervention. *Journal of Substance Abuse Treatment*, *14*(1), 23-28.

337. Dawe, S., & Harnett, P. (2007). Reducing potential for child abuse among methadone-maintained parents: Results from a randomized controlled trial. *Journal of Substance Abuse Treatment*, *32*(4), 381-390. Dawe, S., Harnett, P.H., Rendalls, V., & Staiger, P. (2003). Improving family functioning and child outcome in methadone maintained families: The Parents Under Pressure Programme. *Drug and Alcohol Review*, *22*(3), 299-307.

338. Fals-Stewart, W., O'Farrell, T.J., & Birchler, G.R. (2001). Behavioral couples therapy for male methadone maintenance patients: Effects on drug-using behavior and relationship adjustment. *Behavior Therapy*, *32*(2), 391-411.

339. Greif, G. L., & Drechsler, M. (1993). Common issues for parents in a methadone maintenance group. *Journal of Substance Abuse Treatment, 10,* 339-343.

340. Grella, C.E., Needell, B., Shi, Y., & Hser, Y-I. (2009). Do drug treatment services predict reunification outcomes of mothers and their children in child welfare? *Journal of Substance Abuse Treatment*, *36*(3), 278-293.

341. White, W. L., & Chaney, R.A. (2008). *Intergenerational patterns of resistance and recovery within families with histories of alcohol and other drug problems: What we need to know.* Retrieved from www.facesandvoicesofrecovery.org.

and colleagues[342] evaluated a program (Families Facing the Future) that provided parent training workshops and home-based family support services. They found that such services reduced the risk of substance use disorders among the male children of MM patients. We envision a day when a full range of family-, parent-, and child-focused services will be an integral component of mainstream methadone maintenance. Such services might include recovery-focused family education classes, family counseling, family support groups, parenting training, in-home family support services, family night social events, a children's program (counseling, prevention, and early intervention), and inclusion of family members in leadership roles in patient councils and alumni associations.

SERVICE DURATION

MM was conceptualized as a chronic disease by founders who envisioned that many if not most people treated for chronic heroin addiction would require prolonged if not lifelong methadone pharmacotherapy, analogous to the way in which many patients with diabetes or hypertension receive prolonged medication support. This conclusion was based on the finding in the earliest study of MM patient outcomes that less than 10% of patients were found to be "doing well" after cessation of methadone pharmacotherapy.[343] Through this and subsequent studies, MM was defined as corrective rather than curative.

> *It may be necessary for [MM] patients to remain in treatment for indefinite periods of time, possibly for the duration of their lives.*[344]

> *…we don't see the need of getting people off [methadone maintenance] treatment any more than you'd try to get people off treatment from insulin…*[345]

From the beginning, there were some MM patients who sustained abstinence-based recoveries following cessation of MM, but Dr. Dole cautioned that "an obsessive preoccupation with abstinence is self-defeating, leading to low-dose programs (which fail to stabilize the patient), premature discharge from treatment and low self-esteem if long-term abstinence seems unattainable."[346] He further noted that:

> *…methadone patients are not necessarily committed to a lifelong dependence on the medication… The key to this result [sustained abstinence following termination of methadone maintenance] is the realization that the most important objective in treatment of an addict is support of good health and normal function. This may*

342. Haggerty, K. P., Skinner, M., Fleming, C. B., Gainey, R. R., & Catalano, R. F. (2008). Long-term effects of the Focus on Families project on substance use disorders among children of parents in methadone treatment. *Addiction*, *103*(12), 2008-2016.

343. Joseph, H., Stancliff, S., & Langrod, J. (2000). Methadone maintenance treatment (MMT): A review of historical and clinical issues. *Mount Sinai Journal of Medicine, 67*, 347-364. Lowinson, J.H., Berle, B., & Langrod, J. (1976). Detoxification of long-term methadone patients: Problems and prospects. *The International Journal of the Addictions*, *11*(6), 1009-1018.

344. Joseph, H., Stancliff, S., & Langrod, J. (2000). Methadone maintenance treatment (MMT): A review of historical and clinical issues. *Mount Sinai Journal of Medicine, 67*, 347-364.

345. Kreek, M.J. (2001). Myths about heroin addiction. In B. Seega (Producer), *The Health Report*. Sydney, Australia: Health Report. Retrieved June 23, 2003 from http://www.abc.net.au/rn/talks/8.30/helthrpt/stories/s391783.htm.

346. Dole, V.P. (1994b). What we have learned from three decades of methadone maintenance treatment. *Drug and Alcohol Review*, *13*, 3-4.

> *or may not require continuation of maintenance pharmacotherapy… Available data suggest that the longer a patient continues in a maintenance program that provides adequate doses (e.g., five years or more), the greater his or her probability of permanent abstinence after termination of treatment… the neurochemical adaptations produced by thousands of heroin injections… are capable of gradual repair in some cases under the steady conditions of methadone maintenance.*[347]

Dole also noted that the potential for post-MM abstinence was linked to the issue of methadone dose.

> *A wrong belief exists in the general public and in the medical profession, and even, I'm sorry to say, in methadone programs around the world. This is the illusion that by giving a very low dose [of methadone], you facilitate the evolution of this treatment to complete abstinence. The opposite is really the truth.*[348]

As reflected in Dole's observations, sustained recovery after tapering requires the achievement of two time-dependent processes within MM: 1) neurophysiological healing of the brain, and 2) a larger process of healing the physical, psychological, and social impairments produced by chronic heroin addiction. When such healing has not taken place, successful tapering from MM is unlikely. Unfortunately, we currently know a great deal more about the neuropathology and psychosocial pathologies of addiction than we know about the processes of neurophysiological and psychosocial healing in long-term addiction recovery.[349] The duration of MM declined throughout the 1970s and 1980s in tandem with the growing professional, family, and community expectations that MM should be as short as possible. Opioid addiction then became the only chronic disease in which patients were shamed and stigmatized for long-term medication adherence and denied pride in the achievement of sustained recovery stabilization—in marked contrast to the experience of those celebrating the length of their recoveries in AA, NA, and treatment alumni association meetings.

There have been contentious debates for more than four decades about how long a patient should be maintained on methadone, but the reality is that most patients admitted to MM voluntarily or involuntarily leave in less than a year, frequently relapse following their discharge, and are often readmitted to MM or other treatment in what becomes a long, complex career of serial episodes of acute, treatment-facilitated stabilization. In spite of theoretical foundations supporting the efficacy of prolonged if not lifelong MM for most patients, studies beginning in the 1980s found that 80-100% of MM patients expect to taper from methadone at some time in the future and to continue their

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347. Dole, V.P. (1994b). What we have learned from three decades of methadone maintenance treatment. *Drug and Alcohol Review*, *13*, 3-4.

348. Dole, V.P. (1994a). Addiction as a public health problem. *Alcoholism: Clinical and Experimental Research*, *15*(5), 749-752.

349. Erickson, C., & White, W. (2009). Commentary: The neurobiology of addiction recovery. *Alcoholism Treatment Quarterly*, *27*(3), 338-341.

recovery without medication.[350] Great anxiety, if not outright phobia, is common as the time to initiate tapering approaches as a result of a personal goal or one imposed by one's treatment program.[351] These anxieties are related to folklore about the difficulty of tapering, prior failed efforts at tapering, and lack of contact with patients who have successfully sustained recovery after tapering.[352] Such emotional distress may account for the fact that the majority of patients who begin to taper do not complete the tapering process and either return to maintenance treatment or drop out of treatment.[353] The rates of success have improved with the advent of new pharmacological adjuncts to aid the tapering process.

The majority of patients who are discharged from MM eventually return to heroin or other illicit opioid use,[354] with first-year rates of resumed opioid use approaching or exceeding 50%, followed by a longer-term progressive decay in abstinence rates.[355] Also striking is the speed at which relapse occurs. In a follow-up study of tapered MM patients by Gossop and colleagues,[356] 42% of those who relapsed did so within one week of reaching zero dose of methadone, and 71% of this group relapsed within six weeks. Post-treatment abstinence rates from heroin range from 8% to 33% (based primarily on self-report and varying by length of follow-up period),[357] and treatment re-admission rates are high.[358]

The best single predictors of post-MM abstinence from heroin are longer periods of time in treatment, discharge status of treatment completion as planned, and employment during and after treatment.[359] The latter is of particular significance in light of data revealing that only 26% of MM patients discharged from treatment in 2005 were employed at the time of discharge (46% were identified as not in the labor force, and 27% were identified as unemployed—rates similar to those of all patients discharged from addiction treatment in the U.S.).[360]

Patients who remained continuously in MM or who completed a sustained period of MM have post-treatment recovery outcomes superior to those of patients completing only methadone-assisted detoxification and patients who cycle in and out of MM.[361] The shorter the first treatment period in MM, the greater the likelihood of treatment readmission.[362] Based on post-treatment recovery outcomes, the minimum clinically optimal amount of time in MM has been defined as one year of continuous MM treatment,[363] with some researchers concluding that two years constitutes the minimum optimal MM treatment duration.[364] Clinical outcomes deteriorate with decreased length of time in treatment, with patients who spent less than three months in MM treatment

350. Langrod, J., Des Jarlais, D.C., Alksne, L., & Lowinson, J. (1983). Locus of control and initiation of detoxification among male methadone maintenance patients. *International Journal of the Addictions*, *18*(6), 783-790. Stancliff, S., Myers, J.E., Steiner, S., & Drucker, E. (2002). Beliefs about methadone in an inner city methadone clinic. *Journal of Urban Health*, *79*, 571-578.

351. Milby, J.B. (1988). Methadone maintenance to abstinence: How many make it? *Journal of Nervous and Mental Disorders*, *176*(7), 409-422.

352. Gold et al. found that only 48% of MM patients knew someone who had successfully tapered his/her methadone dose to zero compared to 83% of MM staff. Both staff and patients were pessimistic about the odds of tapering success: 14% estimated success rate by patients and 10% estimated success rate by MM staff. Gold, M.L., Sorensen, J.L., McCanlies, N., Trier, M., & Dlugosch, G. (1988). Tapering from methadone maintenance: Attitudes of clients and staff. *Journal of Substance Abuse Treatment, 5*, 37-44.

353. Kleber, H.D. (1977a). Detoxification from methadone maintenance: The state of the art. *International Journal of the Addictions, 12,* 807-820. Magura, S., & Rosenblum, A. (2001). Leaving methadone treatment: Lessons learned, lessons forgotten, lessons ignored. *Mount Sinai Journal of Medicine*, *68*, 62-74.

354. Joseph, H., Stancliff, S., & Langrod, J. (2000). Methadone maintenance treatment (MMT): A review of historical and clinical issues. *Mount Sinai Journal of Medicine*, *67*, 347-364. Magura, S., & Rosenblum, A. (2001). Leaving methadone treatment: Lessons learned, lessons forgotten, lessons ignored. *Mount Sinai Journal of Medicine, 68*, 62-74.

355. Gold, M.L., Sorensen, J.L., McCanlies, N., Trier, M., & Dlugosch, G. (1988). Tapering from methadone maintenance: Attitudes of clients and staff. *Journal of Substance Abuse Treatment, 5*, 37-44. Milby, J. B. (1988). Methadone maintenance to abstinence: How many make it? *Journal of Nervous and Mental Disorders*, *176*(7), 409-422.

356. Gossop, M., Green, L., Phillips, G., & Bradley, B. (1989). Lapse, relapse and survival among opiate addicts after treatment. *British Journal of Psychiatry*, *154*, 348-353.

357. Ball, T.C., & Ross, A. (1991). *The effectiveness of methadone treatment.* New York: Springer-Verlag. Dole, V. P., & Joseph, H. (1978). Long-term outcome of patients treated with methadone maintenance. *Annals of the New York Academy of Science*, *311*, 173-180. Milby, J. B. (1988). Methadone maintenance to abstinence: How many make it? *Journal of Nervous and Mental Disorders*, *176*(7), 409-422.

358. Newman, R.G., Tytun, A., & Bashkow, S. (1976). Retention of patients in the New York City Methadone Maintenance Treatment Program. *International Journal of the Addictions, 11*(5), 905-931.

359. Des Jarlais, D.C., Joseph, H., Dole, V.P., & Schmeidler, J. (1983). Predicting post-treatment narcotic use among patients terminating from methadone maintenance. *Journal of Alcohol and Substance Abuse*, *2*(1), 57-68. Ward, J., Mattick, R.P., & Hall, W. (1998). How long is long enough? Answers to questions about the duration of methadone maintenance

experiencing only minimal long-term improvement.[365] Hubbard and colleagues[366] found that MM had substantially higher retention rates (68% after three months) than outpatient counseling without methadone (36%) or residential programs without methadone (45%).

In spite of the importance of treatment retention and duration, one-year retention rates in most programs are less than 50%,[367] but this can vary considerably by program. Kreek[368] has reported retention rates ranging from 60-85% in "good programs"—those providing optimum methadone doses, on-site counseling, and ancillary medical and psychiatric services. In 2005, the average length of time in treatment for patients discharged from opioid replacement therapy in the United States was 245 days.[369] The majority of MM patients who spend less than a year in their first treatment episode will return to treatment for multiple treatment episodes.[370] Problems related to the retention of stabilized patients include pressure from self and others to "get off methadone"; resentment toward program rules that are perceived as restrictive, paternalistic, and humiliating[371]; and legislative or regulatory efforts to set arbitrary limits on the length of time a patient can remain in methadone maintenance.[372]

Most MM patients cycle in and out of treatment via 5 stages: 1) enter treatment in a state of crisis, 2) extract substantial benefits from treatment, 3) leave treatment during a period of recovery stability, 4) resume opioid use and clinically deteriorate following treatment discharge, and 5) re-enter treatment in crisis but with less severity than in earlier admissions.[373] Of patients discharged from OTPs in the United States in 2005, 77% had been in treatment before and 24% had five or more prior treatment episodes.[374] Recycling in and out of treatment is a dominant pattern in MM,[375] as it is in the larger addiction treatment arena.[376]

In conclusion, discharge from MM is accompanied by significantly increased risk or resumption of illicit opioid use and death.[377] Like medication-based treatments for other chronic health conditions, methadone is effective as a medication only as long as it continues to be used as prescribed. MM policies that lower patient retention rates, even when done with the noblest of intentions (promoting abstinence from all opioids, including methadone), heighten patient risk for re-addiction, infectious disease, resumption of addiction-related criminality, arrest and incarceration, and death.[378] Tapering from MM is most conducive to long-term recovery outcomes when it is voluntary, recommended by MM staff based on rehabilitation progress, phased over an extended period of time, and accompanied by increased professional and peer support

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treatment. In J. Ward, R.P. Mattick, & W. Hall (Eds.), *Methadone maintenance treatment and other opioid replacement therapies* (pp. 305-336). Amsterdam: Harwood Academic.

360. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2008). *Treatment Episode Data Set (TEDS): 2005. Discharges from substance abuse treatment services* (DASIS Series: S-41, DHHS Publication No. (SMA) 08-4314). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

361. Kosten, T.R., Rounsaville, B.H., & Kleber, H.D. (1986). A 2.5 year follow-up of treatment retention and reentry among opioid addicts. *Journal of Substance Abuse Treatment*, *3*, 181-189.

362. Bell, J., Burrell, T., Indig, D., & Gilmour, S. (2006). Cycling in and out of treatment: Participation in methadone treatment in NSW, 1990-2002. *Drug and Alcohol Dependence*, *81*, 55-61.

363. Greenfield, L., & Fountain, D. (2000). Influence of time in treatment and follow-up duration on methadone treatment outcomes. *Journal of Psychopathology and Behavioral Assessment, 22*(4), 353-364. National Institute on Drug Abuse. (1999). *Principles of drug addiction treatment* (NIH Publication No. 00-4180). Rockville, MD: National Institute on Drug Abuse. Retrieved from http://www.nida.nih.gov/PODAT/PODATIndex.html. Simpson, D.D., Brown, B.S., & Joe, G.W. (1998). Treatment retention and follow-up outcomes in the Drug Abuse Treatment Outcome Study (DATOS). *Psychology of Addictive Behaviors, 11*(4), 294-307.

364. Kleber, H.D. (2008). Methadone maintenance 4 decades later: Thousands of lives saved but still controversial. *Journal of the American Medical Association*, *300*(9), 2303-2305. Leshner, A. (2000). *Keynote address.* Presented at the National Institute on Drug Addiction Blending Conference, Weston Hotel, Los Angeles, CA.

365. NIH. (1998). Effective medical treatment of opiate addiction: National Consensus Development Panel on Effective Medical Treatment of Opiate Addiction. *Journal of the American Medical Association, 280*(22), 1936-1943. Retrieved from http://odp.od.nih.gov/consensus/cons/108/108_statement.htm.

366. Brands, B., & Brands, J. (Eds.) (1998). Methadone maintenance: A physician's guide to treatment. Toronto: Addiction Research Foundation, Centre for Addiction and Mental Health. Hubbard, R.L., Marsden, M.E., Rachal, J.V., Harwood, H.J., Cavanaugh, E.R., & Ginzburg, H.M. (1989). *Drug abuse treatment: A national study of effectiveness.* Chapel Hill, NC: University of North Carolina Press.

367. Deck, D., & Carlson, M.J. (2005). Retention in publicly funded methadone maintenance treatment in two Western states. *Journal of Behavioral Health Services & Research*, *32*(1), 43-60.

368. Kreek, M.J. (2000). Methadone-related agonist therapy for heroin addiction: History, recent molecular and neurochemical research and future in mainstream medicine. *Annals of the New York Academy of Science*, *909*, 186-216.

services.[379] Even with such supports, post-treatment relapse rates are high.[380] A key predictor of the degree of effectiveness of MM (like that of other addiction treatment modalities) is duration of active participation in treatment, with longer periods of retention associated with better long-term recovery outcomes.[381] Promising practices to increase MM retention include higher, individualized methadone doses to ensure optimum stabilization, training and supervision to strengthen the counselor-patient relationship, expanding the service menu, and exposing patients to successful patients and former patients in stable, successful long-term recovery.[382]

A rarely discussed issue related to patient retention in MM is that of fees charged to patients. There are three types of OTPs in terms of payment for medication and other services: 1) for-profit OTPs, such as the large networks of CRC and Colonial clinics, whose fees are fully paid by a combination of the patient and his/her insurance company; 2) hybrid clinics that charge fees but on a sliding scale based on the patient's ability to pay; and 3) OTPs whose costs are fully covered by Medicaid or various state services, with no direct costs incurred by the patients. Of the 1,132 OTPs in the United States surveyed in 2008, only 34% of OTPs offered free treatment for patients who could not pay for their treatment, and only 51% offered a sliding fee scale.[383]

During times of personal and widespread financial distress, the issue of fees can undermine patient retention. Patients who are "financially noncompliant" are at high risk of voluntarily or involuntarily terminating MM—the latter christened "fee-tox" by MM patients.[384] It is most often the working poor who are shut out of methadone because of inability to pay. Strategies with the potential of addressing the fee-tox issue include: 1) establishing funds that would award patients low-interest loans to sustain their treatment while they rebuilt their financial stability, 2) lowering fees for financially distressed patients, and 3) extending the tapering period in hopes that the patient will be able to catch up on the balance due. MM patients who communicated with the authors about this monograph were particularly incensed by those clinics they perceived to be more concerned with financial outcomes than recovery outcomes.

> *The clinic I go to is a true "business" in every sense of the word. It is not anything close to "therapeutic," it's just shoveling out methadone and we keep taking it. They think money, talk money, and probably even "dream" money… Until the day all clinics are ran as "therapy" centers, things will never change.*[385]

369. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2008). *Treatment Episode Data Set (TEDS): 2005. Discharges from substance abuse treatment services* (DASIS Series: S-41, DHHS Publication No. (SMA) 08-4314). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

370. Bell, J., Burrell, T., Indig, D., & Gilmour, S. (2006). Cycling in and out of treatment: Participation in methadone treatment in NSW, 1990-2002. *Drug and Alcohol Dependence*, *81*, 55-61.

371. Lowinson, J.H., Berle, B., & Langrod, J. (1976). Detoxification of long-term methadone patients: Problems and prospects. *The International Journal of the Addictions*, *11*(6), 1009-1018.

372. Clark, H.W. (2010). Pennsylvania may limit methadone treatment to one year. *Alcoholism & Drug Abuse Weekly*, 22(25), 4-6.

373. Kosten, T.R., Rounsaville, B.H., & Kleber, H.D. (1986). A 2.5 year follow-up of treatment retention and reentry among opioid addicts. *Journal of Substance Abuse Treatment*, *3*, 181-189.

374. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2008). *Treatment Episode Data Set (TEDS): 2005. Discharges from substance abuse treatment services* (DASIS Series: S-41, DHHS Publication No. (SMA) 08-4314). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

375. Bell, J., Burrell, T., Indig, D., & Gilmour, S. (2006). Cycling in and out of treatment: Participation in methadone treatment in NSW, 1990-2002. *Drug and Alcohol Dependence*, *81*, 55-61.

376. Dennis, M.L., Scott, C.K., Funk, R., & Foss, M.A. (2005). The duration and correlates of addiction and treatment careers. *Journal of Substance Abuse Treatment*, *28*, S51-S62.

377. Magura, S., & Rosenblum, A. (2001). Leaving methadone treatment: Lessons learned, lessons forgotten, lessons ignored. *Mount Sinai Journal of Medicine, 68*, 62-74. Woody, G., Kane, V., Lewis, K., & Thompson, R. (2007). Premature deaths after discharge from methadone maintenance: A replication. *Journal of Addiction Medicine*, *1*(4), 180-185.

378. Caplehorn, J.R.M., McNeil, D.R., & Kleinbaum, D.G. (1993). Clinic policy and retention in methadone maintenance. *The International Journal of the Addictions, 28*(1), 73-89.

379. Knight, K.R., Rosenbaum, M., Irwin, J., Kelley, M.S., Winger, L., & Washburn, A. (1996). Involuntary versus voluntary detoxification from methadone maintenance treatment: The importance of choice. *Addiction Research, 3*(4), 351-362. Milby, J. B. (1988). Methadone maintenance to abstinence: How many make it? *Journal of Nervous and Mental Disorders*, *176*(7), 409-422. Platt, J. J., Widman, M., Lidz, V., & Marlowe, D. (1998). Methadone maintenance treatment: Its development and effectiveness after 30 years. In J.A. Inciardi & L.Harrison (Eds.), *Heroin in an age of crack-cocaine* (pp. 160-187). Thousand Oaks, CA: Sage.

The private clinics I have attended charge anywhere from $80-$95 a week in addition to separate charges for all other services and they do not take private insurance or Medicaid and are CASH ONLY. If you are late on fees, they will detox you within a matter of weeks. They take no excuses for getting behind and do not let you "charge" and catch up at a later date, even if you are having a financial hardship. They can go up on their prices any time they want; they can give you a decrease on your dose anytime they want. They can make you jump through all these hoops like a show dog and you just have to take it![386]

DISCHARGE STATUS AND RECOVERY OUTCOMES

A discharge status of treatment completion signals that both the MM patient and OTP staff members have collaborated on a planned process of tapering from methadone and have a plan for sustained recovery self-management following the cessation of methadone pharmacotherapy. The process involves substantial progress in psychosocial rehabilitation as well as successful tapering off methadone. Treatment completion has generally served as an intermediary measure of treatment outcome, with patients who have completed treatment having better post-treatment outcomes than those discharged for other reasons (e.g., dropping out, administrative discharge, incarceration, or transfer).[387]

The scientific and clinical literature on MM is filled with reports on the MM patient induction process, but it is striking how little focus has been paid to the process of patient disengagement from MM (beyond a focus on dosing protocols for tapering). Of MM patients discharged from outpatient opioid replacement therapy in the United States in 2005, only 11% completed treatment as planned; 45% dropped out; 17% were transferred to other programs; 13% were terminated by the program; and 15% were discharged for other reasons.[388] Opioid replacement therapy has the lowest completion rate of all addiction treatment modalities.[389] Much greater attention needs to be focused on the process through which patients disengage from participation in MM and the supports that best sustain recovery without the aid of medication or, when needed, speed the re-initiation of medication-assisted recovery.

Patients may be "administratively discharged" (also referred to as "involuntary discharge" or "therapeutic termination") from OTPs for continued drug use, violence or threats of violence, failure to pay fees, selling drugs, loitering, or repeated violation of program rules. We find the practice

380. Sorensen, J. L., Trier, M., Brummett, S., Gold, M., & Dumontet, R. (1992). Withdrawal from methadone maintenance: Impact of a tapering network support program. *Journal of Substance Abuse Treatment*, *9*, 21-26.

381. Sees, K.L., Delucchi, K.L., Masson, C., Rosen, A., Clark, H., Robillard, H., Hall, S.M. (2000). Methadone maintenance vs. 180-day psychosocially enriched detoxification for treatment of opioid dependence: A randomized controlled trial. *Journal of the American Medical Association, 283*(10), 1303-1310.

382. Simpson, D.D., Brown, B.S., & Joe, G.W. (1998). Treatment retention and follow-up outcomes in the Drug Abuse Treatment Outcome Study (DATOS). *Psychology of Addictive Behaviors, 11*(4), 294-307.

383. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2010). *The N-SSATS Report. Overview of opioid treatment programs within the United States: 2008*. January 28, National Survey of Substance Abuse Treatment Services.

384. Berry, L.C. (2007). *In$ide the methadone clinic indu$try: The financial exploitation of America's opiate addicts*. Tucson, AZ: Wheatmark.

385. MM patient feedback to authors, May 2010.

386. MM patient feedback to authors, May 2010.

387. Hubbard, R.L., Craddock, S.G., & Anderson, J. (2002). Overview of 5-year follow-up outcomes in the Drug Abuse Treatment Outcome Studies (DATOS). *Journal of Substance Abuse Treatment, 25*, 125-134. Wallace, A. E., & Weeks, W. B. (2004). Substance abuse intensive outpatient treatment: Does program graduation matter? *Journal of Substance Abuse Treatment*, *27*, 27-30.

388. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2008). *Treatment Episode Data Set (TEDS): 2005. Discharges from substance abuse treatment services* (DASIS Series: S-41, DHHS Publication No. (SMA) 08-4314). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

389. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2008). *Treatment Episode Data Set (TEDS): 2005. Discharges from substance abuse treatment services* (DASIS Series: S-41, DHHS Publication No. (SMA) 08-4314). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

of discharging patients for continued drug use particularly onerous. There is no other health care sector where one can be punished and extruded for exhibiting a symptom of the disorder being treated. In other settings, symptom continuation or a resurgence in symptoms calls for reassessment and refinement of treatment procedures, rather than the expulsion of the patient from treatment.[390] Dr. Robert Newman describes this paradox:

> *Patients also face termination [of MM] for a host of other reasons that are without parallel in the medical management of disease. For instance, renal dialysis would never be stopped because a patient smoked marijuana, or crack, or used other illicit substances. Nor would those suffering from hypertension, diabetes, arthritis, glaucoma, schizophrenia or any other illness be abandoned because they used drugs. How ironic, then, that most methadone programs, whose express mission is to treat addiction, refuse to tolerate patients who demonstrate signs and symptoms of drug use…Medical care should not be withheld except for strictly medical reasons.*[391]

The risks of administrative discharge from MM are compounded in programs that impose mandatory waiting periods before patients who were administratively discharged can be considered for readmission. In some OTP studies, the rate of administrative (involuntary) discharge exceeds 50% of all discharges.[392] Of the total discharges from OTPs in 2005, 13% were administrative discharges.[393] Disciplinary discharges appear to be more prevalent when OTPs have limited capacity, have high counselor caseloads, and experience pressure for admission of persons from their waiting lists.[394]

At least one study claimed evidence of reduced drug use and increased retention in programs that expel patients exceeding particular levels of drug use,[395] but these benefits usually accrue at the expense of "terminating" those patients most in need of sustained and intense clinical management.[396] Involuntary discharge from MM is associated with rapid clinical deterioration, e.g., re-addiction, criminal activity, disease exposure/transmission, and alienation from family and community.[397] There is no evidence of "therapeutic" effects of administrative discharge for the patient being discharged, in spite of anecdotal reports of such effects.[398] Patients who are administratively discharged from MM are at increased risk of post-treatment relapse and death;[399] patients subjected to involuntary tapering and termination have the worst post-discharge recovery outcomes.[400]

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390. White, W., Scott, C., Dennis, M., & Boyle, M. (2005). It's time to stop kicking people out of addiction treatment. *Counselor, 6*(2), 12-25.

391. Newman, R.G. (2000). Addiction and methadone. *Heroin Addiction & Related Clinical Problems, 2*(2), 19-27.

392. Zanis, D.A., McLellan, A.T., Alterman, A.I., & Cnaan, R.A. (1996). Efficacy of enhanced outreach counseling to reenroll high-risk drug users 1 year after discharge from treatment. *American Journal of Psychiatry*, *153*, 1095-1096.

393. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2008). *Treatment Episode Data Set (TEDS): 2005. Discharges from substance abuse treatment services* (DASIS Series: S-41, DHHS Publication No. (SMA) 08-4314). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

394. Deck, D., & Carlson, M.J. (2005). Retention in publicly funded methadone maintenance treatment in two Western states. *Journal of Behavioral Health Services & Research*, *32*(1), 43-60. Stewart, D., Gossop, M., & Marsden, J. (2004). Increased caseloads in methadone treatment programs: Implications for the delivery of services and retention in treatment. *Journal of Substance Abuse Treatment*, *27*(4), 301-306.

395. McCarthy, J.J., & Borders, O.T. (1985). Limit setting on drug abuse in methadone maintenance patients. *American Journal of Psychiatry*, *142*, 1419-1423.

396. Kahn, R.B. (1992). Methadone maintenance treatment: Impact of its politics on staff and patients. *Journal of Psychoactive Drugs*, *24*(3), 281-283.

397. Britton, B.M. (1994). The privatization of methadone maintenance: Changes in risk behavior associated with cost related detoxification. *Addiction Research & Theory*, *2*(2), 171-181. Knight, K.R., Rosenbaum, M., Irwin, J., Kelley, M.S., Winger, L., & Washburn, A. (1996). Involuntary versus voluntary detoxification from methadone maintenance treatment: The importance of choice. *Addiction Research, 3*(4), 351-362. Zanis, D.A., McLellan, A.T., Alterman, A.I., & Cnaan, R.A. (1996). Efficacy of enhanced outreach counseling to reenroll high-risk drug users 1 year after discharge from treatment. *American Journal of Psychiatry, 153*, 1095-1096.

398. Tozman, S., & DeJesus, E. (1981). The positive side of administrative discharge (in a drug program). *The International Journal of the Addictions*, *16*(1), 135-139.

399. Zanis, D.A., & Woody, G.E. (1998). One-year mortality rates following methadone treatment discharge. *Drug and Alcohol Dependence, 52*(3), 257-260.

400. Knight, K.R., Rosenbaum, M., Irwin, J., Kelley, M.S., Winger, L., & Washburn, A. (1996). Involuntary versus voluntary detoxification from methadone maintenance treatment: The importance of choice. *Addiction Research, 3*(4), 351-362.

Ward and colleagues[401] reviewed the issue of administrative discharge from MM programs and concluded that non-punitive approaches were more effective. Belding, McLellan, Zanis, & Incmikoski's[402] study of MM "non-responders" suggested three broad strategies to address continued opioid and other drug use: 1) increasing methadone doses to optimal levels (43% of their non-responders were below 80 mgd), 2) increasing internal motivation for cessation of drug use via counseling, and 3) creating external contingencies that rewarded positive treatment participation.

THE MM MILIEU: CULTURE OF ADDICTION OR CULTURE OF RECOVERY?

> *The current clinic structure keeps recovering addicts in contact with people who are still using—a fatal flaw because the MM program is itself immersed within the drug scene, not a step away from it. One gets off the dope line and into another line—behind the same folks.*[403]

There are several key points related to the relationship between the addiction treatment milieu and recovery outcomes.

- For persons enmeshed in illicit drug cultures, the transition from addiction to recovery is a journey between two physical and social worlds—from a culture of addiction to a culture of recovery, each with its own distinct cultural trappings, e.g., language, values, dress, symbols, rituals, roles, social pecking orders, etc.
- Patients who are deeply enmeshed in illicit drug cultures bring the trappings of these cultures with them when they enter the treatment milieu.
- The best single predictor of continued drug use during MM is the presence of drug users within the social and intimate relationships of the patient.[404]
- Effective addiction treatment involves facilitating the patient's physical and social disengagement from the culture of addiction and shedding of the trappings of that culture, as well as guiding the patient into a relationship with an alternative culture of recovery.
- The presentation of drug culture trappings in the treatment milieu reinforces continued drug use and undermines recovery initiation and maintenance; the presence of trappings of the recovery culture enhances recovery initiation and maintenance.

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401. Ward, J., Mattick, R.P., & Hall, W. (1998). How long is long enough? Answers to questions about the duration of methadone maintenance treatment. In J. Ward, R.P. Mattick, & W. Hall (Eds.), *Methadone maintenance treatment and other opioid replacement therapies* (pp. 305-336). Amsterdam: Harwood Academic.

402. Belding, M.A., McLellan, A.T., Zanis, D.A., & Incmikowski, R. (1998). Characterizing "nonresponsive" methadone patients. *Journal of Substance Abuse Treatment, 15*(6), 485-492.

403. MM patient feedback to authors, May 2010.

404. Goehl, L., Nunes, E., Quitkin, F., & Hilton, I. (1993). Social networks and methadone treatment outcome: The costs and benefits of social ties. *The American Journal of Drug and Alcohol Abuse, 19*(3), 251-262.

- There is a daily struggle for dominance between these two cultures within addiction treatment milieus.
- Relapse and recovery rates—good and bad—are as often influenced by the cultural milieu of treatment as by the intrapersonal factors of the patients.[405]

Treatment quality in MM has focused primarily on medication-related issues at the exclusion of the larger treatment milieu. As Dr. Edward Senay suggests,

> *… dispensing methadone is not synonymous with treatment. It is methadone plus an institutional or organization transference which is responsible for the success of methadone maintenance programs… The role of methadone is an important element in a whole, but it is a major error to confuse the element with the whole.*[406]

A distinctive dimension of recovery-oriented methadone maintenance (ROMM) is its emphasis on a therapeutic milieu that suppresses illicit drug cultures and provides a portal of entry into an alternative community of recovery. ROMM is distinguished by a:

- recovery-focused institutional identity, e.g., a recovery center that sees medication as an aid in the goal of recovery rather than defining itself institutionally as a methadone clinic;
- presence of recovery (hope, honesty, and mutual help) so palpable that it is socially contagious;
- physical plant that conveys respect via its safety, privacy, attractiveness, and comfort;
- distinctive recovery-focused culture reflected in language, literature, art, symbols, music, and daily rituals; and
- the visible presence of recovering people (e.g., recovering people serving as board members, staff, volunteers, and peer mentors) who offer living proof of the transformative power of long-term recovery.

THE LOCUS OF SERVICE DELIVERY

> *I haven't given a positive heroin urine in almost 20 years and I cannot go pick up a monthly prescription of my "medication." If I were psychotic and hearing voices and declared a schizophrenic, I WOULD be given a monthly prescription for powerful drugs and the freedom to pick up those drugs at a pharmacy. Yet I am not to be trusted because I am still viewed as a "junkie."*[407]

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405. White, W. (1996). *Pathways from the culture of addiction to the culture of recovery*. Center City, MN: Hazelden.

406. Senay, E.C. (1971). Methadone: Some myths and hypotheses. *Journal of Psychedelic Drugs*, *4*(2), 182-185.

407. MM patient email to authors, 2010

Treatment of acute illness most often involves placing a patient in a medical facility where he or she can be treated by a professional; the management of chronic illness focuses instead on nesting a recovery management process within each patient's natural environment. This distinction is important to the future of MM.

The focus of MM, like that of most addiction treatment modalities, has been on getting patients to the treatment facility (with methadone used in MM as the primary incentive for sustained patient-clinic contact). 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-stigmatizing community environments. A possible omen of this shift is the vision of abolishing specialized MM clinics and integrating MM into organizations that are currently providing a comprehensive menu of treatment and recovery support services. Such a vision is now guiding the reorganization of addiction treatment in the State of New York.[408] We anticipate the evolution of OTPs from silo-like businesses toward integrated, recovery-oriented systems of care. We envision the expansion of medical maintenance in the United States (methadone and related recovery support services provided through a primary care physician) and the integration of medication and other recovery support services within other health and human service institutions within the community. The expansion of pre-treatment and post-treatment recovery support services will also create new home-based and neighborhood-based models of service delivery.

ROMM also is based on the concept of the community as patient—the idea that neighborhoods and whole communities can be severely wounded by addiction and be in need of community-level intervention and sustained recovery support. Also of import is the idea that recovery flourishes in supportive communities. ROMM seeks to shape community perceptions, attitudes, and actions that welcome and offer support and inclusion for people in long-term medication-assisted recovery. Long-term recovery outcomes are as often contingent upon community factors (e.g., attitudes toward methadone, methadone treatment, and methadone patients) as they are on intrapersonal factors.[409]

ASSERTIVE LINKAGE TO RECOVERY COMMUNITY RESOURCES

Peer-support has emerged as a primary recovery management strategy in the treatment of chronic illness. In the addiction context, there are two noteworthy trends. First, is the growth of peer recovery support via the ever-growing network of addiction recovery mutual aid groups, the

408. *OASAS Commissioner announces plans for one outpatient system of addiction services* [Press release]. (2009). State of New York Office of Alcoholism and Substance Abuse Services. Retrieved from http://www.oasas.state.ny.us/pio/press/pr-4-27-09methadone.cfm.

409. White, W. (2009c). The mobilization of community resources to support long-term addiction recovery. *Journal of Substance Abuse Treatment, 36*, 146-158.

philosophical (secular, spiritual, religious) diversification of these groups, the emergence of a new addiction recovery advocacy movement, new recovery community institutions (recovery homes, schools, industries, ministries, community centers), and the emergence of new peer-based service roles, e.g., that of the recovery coach.[410] Second is the growing body of scientific evidence that participation in peer-based recovery support societies and other recovery community institutions significantly elevates the prognosis for long-term recovery.[411] Community integration strategies may be particularly important for injection drug users, who often have prolonged histories of "institutional disaffiliation" and enmeshment in subterranean drug cultures.[412]

Methadone pioneers Drs. Vincent Dole and Marie Nyswander both had an interest in addiction recovery mutual aid societies. Dr. Nyswander served on the Board of Directors of the National Advisory Commission on Narcotics—the governing body of East Coast Narcotics Anonymous in the 1950s—and Dole served as a non-alcoholic trustee of Alcoholics Anonymous. Given this interest, one would think that mutual aid involvement would have been part of the original MM model. There are two likely reasons for its exclusion: 1) the fragile organizational status of NA at the time MM was being pioneered (there were only 4 NA meetings in New York City in 1965) and 2) the general antipathy toward "mainline addicts" in AA.[413]

The potential benefits of recovery mutual aid societies for patients in addiction treatment have not been fulfilled due to ineffective (passive) linkage procedures, ill-timed linkage (following rather than during treatment), failure to offer choices related to recovery support frameworks, and failure to match each patient to a person/meeting most likely to enhance the process of mutual identification and engagement.[414] The use of recovery mutual aid groups to enhance the recovery outcomes of MM patients has been further limited by:

- weak-to-nonexistent relationships between MM programs and local recovery mutual aid groups,
- the stigma attached to methadone (equation of methadone and heroin) within Narcotics Anonymous (e.g., common prohibitions against MM patients speaking at meetings, chairing meetings, chairing a service committee), which leads to avoidance of such groups or keeping one's MM status secret,[415]
- until the founding of Methadone Anonymous (1991), the lack of a recovery mutual aid society explicitly for people in medication-assisted recovery from heroin addiction,[416] and

410. White, W. (2008d). The culture of recovery in America: Recent developments and their significance. *Counselor*, *9*(4), 44-51. White, W. (2009b). *Peer-based addiction recovery support: History, theory, practice, and scientific evaluation.* Chicago, IL: Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health and Mental Retardation Services.

411. Kelly J.F., & Yeterian, J. (2008). Mutual-help groups. In W. O'Donohue & J.R. Cunningham (Eds.), *Evidence-based adjunctive treatments* (pp. 61-106). New York: Elsevier. White, W. (2009b). *Peer-based addiction recovery support: History, theory, practice, and scientific evaluation.* Chicago, IL: Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health and Mental Retardation Services.

412. Lundgren, L.M., Schilling, R., Ferguson, F. Davis, K., & Amodeo, M. (2003). Examining drug treatment program entry of injection drug users: Human capital and institutional disaffiliation. *Evaluation and Program Planning, 26*, 123-132.

413. White, W. L. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America.* Bloomington, IL: Chestnut Health Systems.

414. White, W. (2009b). *Peer-based addiction recovery support: History, theory, practice, and scientific evaluation.* Chicago, IL: Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health and Mental Retardation Services.

415. Obuschowsky, M.A., & Zweben, J.E. (1987). Bridging the gap: The methadone client in 12-step programs. *Journal of Psychoactive Drugs*, *19*(3), 301-302. White, W. (2009a). *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).* Philadelphia: Department of Behavioral Health and Mental Retardation Services. Zweben, J.E. (1987). Can the patient on medication be send to 12-step programs? *Journal of Psychoactive Drugs*, *19*(3), 299-300.

416. Gilman, S.M., Galanter, M., & Dermatis, H. (2001). Methadone Anonymous: A 12-step program for methadone maintained heroin addicts. *Substance Abuse*, *22*(4), 247-256. McGonagle, D. (1994). Methadone Anonymous: A 12-step program. Reducing the stigma of methadone use. *Journal of Psychosocial Nursing*, *32*(10), 5-12.

- the lack of a model for peer-based recovery support services for patients in medication-assisted recovery, until the creation of the CSAT-funded Medication Assisted Recovery Services project in New York City in 2006.

ROMM has two long-term recovery support goals: 1) integrating people in medication-assisted recovery into existing communities of recovery and 2) building a recovery community and long-term recovery support services for people in medication-assisted recovery and their families.

> *I have participated in 12-Step type recovery programs and I find them a necessary part of treatment. It is a shame that NA and 12-Step groups feel about MMT patients like they do because I think if there was a way to combine the two therapies, there would be more successful recovering opiate addicts out there.*[417]

Promising practices within recovery-oriented methadone maintenance include active liaison between MM clinics and the service committees of local recovery mutual aid societies, encouraging/supporting the development of local Methadone Anonymous group meetings and other 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 how to address medication issues at recovery support meetings, hosting on-site peer recovery support meetings at MM clinics, sponsoring educational events on medication-assisted recovery for recovery community members, inclusion of indigenous healers and healing practices within MM clinics, using patient/alumni councils to visibly celebrate patient recovery milestones, and participating visibly in local recovery celebration events.[418] The key is to expose every patient entering MM to "living proof" of the reality and varieties/styles of long-term medication-assisted recovery.

POST-TREATMENT RECOVERY CHECKUPS, STAGE-APPROPRIATE RECOVERY EDUCATION AND SUPPORT, AND WHEN NEEDED, EARLY RE-INTERVENTION

Perhaps the most distinctive feature of chronic disease management is the prolonged if not lifelong duration of professional monitoring and support. In suggesting that addiction treatment should emulate this feature, Humphreys[419] referred to this as a shift in the focus in addiction treatment from one of *intensity* (high intensity acute stabilization) to one of *extensity* (low intensity but

417. Feedback from MM patient to authors, May 2010.

418. White, W., & Kurtz, E. (2006b). *Linking addiction treatment and communities of recovery: A primer for addiction counselors and recovery coaches*. Pittsburgh, PA: Institute for Research, Education and Training in Addictions.

419. Humphreys, K. (2006). Closing remarks: Swimming to the horizon—reflections on a special series. *Addiction*, *101*, 1238-1240.

prolonged recovery support). The rationale for such assertive approaches to continuing care in the OTP context is worth restating. In spite of the theoretical potential of lifelong methadone maintenance, most patients cease MM treatment, often before they have reached the optimum time in MM. The therapeutic effects of MM erode for most patients following discharge from treatment.[420] Most patients who terminate MM resume opioid use/addiction—most within the first days and weeks of methadone cessation.[421] MM patients who leave treatment against medical advice or for program rule infractions are at particularly high risk for post-treatment relapse. Studies of long-term heroin addiction "careers" do not support the contention that persons chronically addicted to heroin eventually "mature out" of addiction as a function of aging; heroin addiction has the potential of being a lifelong condition.[422] The death rate for out-of-treatment methadone patients is 8-20 times that of in-treatment methadone patients.[423]

The recovery stability point (duration of current sobriety that predicts lifetime sobriety—the point at which the risk of future lifetime relapse drops below 15%) is higher for opioid addiction than for alcohol dependence—the latter being in the range of 3 to 5 years.[424] Five years' abstinence from heroin is a good benchmark for recovery stability,[425] but 14-25% of heroin addicts who achieve five or more years' abstinence will later return to opioid use.[426] Others addicted to heroin cease heroin use for extensive periods but fail to achieve this 5-year stability benchmark.[427] As we noted earlier, most people addicted to opioids experience prolonged addiction careers marked by cycles of treatment, periods of abstinence, relapse, and treatment re-entry.[428] Such data confirm the need for intense monitoring throughout early recovery and sustained if not lifelong recovery checkups combined with early re-intervention as needed for rapid restabilization.

Patients who have dropped out of MM and subsequently relapsed can be re-engaged through assertive models of outreach,[429] and patients who relapse following discharge from treatment show marked improvements following re-admission to treatment,[430] but the longer the delay in treatment re-entry, the more likely it is that such improvements will be compromised.[431] The level of improvement following re-entry to MM approximates that achieved during earlier treatment: as currently designed, there is no evidence of cumulative, progressive improvement across multiple episodes of MM treatment.[432] There is evidence that patients experiencing multiple MM treatment episodes stay in treatment longer in later episodes of treatment, creating opportunities for greater recovery stability.[433]

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420. Greenfield, L., & Fountain, D. (2000). Influence of time in treatment and follow-up duration on methadone treatment outcomes. *Journal of Psychopathology and Behavioral Assessment*, *22*(4), 353-364.

421. Gossop, M., Green, L., Phillips, G., & Bradley, B. (1989). Lapse, relapse and survival among opiate addicts after treatment. *British Journal of Psychiatry*, *154*, 348-353.

422. Hser, Y. (2007). Predicting long-term stable recovery from heroin addiction: Findings from a 33-year follow-up study. *Journal of Addictive Diseases, 26*(1), 51-60. Hser, Y., Hoffman, V., Grella, C., & Anglin, D. (2001). A 33-year follow-up of narcotics addicts. *Archives of General Psychiatry, 58*, 503-508.

423. Fugelstad, A., Stenbacka, M., Leifman, A., Nylander, M., & Thblin, I. (2007). Methadone maintenance treatment: The balance between life-saving treatment and fatal poisonings. *Addiction*, *102*, 406-412. Hser, Y. (2002). Drug use careers: Recovery and mortality. In Substance Abuse and Mental Health Services Administration, Office of Applied Studies, *Substance use by older adults: Estimates of future impact on the treatment system* (OAS Analytic Series #A-21, DHHS Publication No. (SMA) 03-3763, pp. 39-59). Rockville, MD: Substance Abuse and Mental Health Services Administration. Perkins, M.E., & Bloch, H.I. (1971). A study of some failures in methadone treatment. *American Journal of Psychiatry*, *128*, 47-51. Zanis, D.A., & Woody, G.E. (1998). One-year mortality rates following methadone treatment discharge. *Drug and Alcohol Dependence, 52*(3), 257-260.

424. Jin, H., Rourke, S.B., Patterson, T.L., Taylor, M.J., & Grant, I. (1998). Predictors of relapse in long-term abstinent alcoholics. *Journal of Studies on Alcohol, 59,* 640-646.

425. Cushman, P., & Dole, V.P. (1973). Detoxification of rehabilitated methadone-maintained patients. *Journal of the American Medical Association, 226*(7). 747-752.

426. Dennis, M.L., Foss, M.A., & Scott, C.K. (2007). An eight-year perspective on the relationship between the duration of abstinence and other aspects of recovery. *Evaluation Review*, *31*(6), 585-612. Hser, Y., Hoffman, V., Grella, C., & Anglin, D. (2001). A 33-year follow-up of narcotics addicts. *Archives of General Psychiatry, 58*, 503-508. Simpson, D.D., Joe, G.W., Lehman, W.E.K., & Sells, S.B. (1986). Addiction careers: Etiology, treatment and 12-year follow-up outcomes. *Journal of Drug Issues*, *16*, 107-121. Simpson, D.D., & Marsh, K.L. (1986). Relapse and recovery among opioid addicts 12 years after treatment. In F.M. Tims & C.G. Leukefeld (Eds.), *Relapse and recovery in drug abuse* (NIDA Research Monograph 72, DHHS Publication No. 88-1473, pp. 86-103). Rockville, MD: National Institute on Drug Abuse.

427. Hser, Y., Hoffman, V., Grella, C., & Anglin, D. (2001). A 33-year follow-up of narcotics addicts. *Archives of General Psychiatry, 58*, 503-508.

Studies of persons in long-term recovery from heroin addiction and persons who are continuing their heroin addiction careers confirm that negative affect and lack of coping skills are major risk factors for relapse and that self efficacy, social support, and participation in pro-social activities serve as the major protective factors for sustaining recovery.[434] Recovery checkups and other assertive approaches to continuing care following addiction treatment elevate short- and long-term recovery outcomes,[435] but systematic, long-term monitoring and support of patients who have ceased MM treatment are not common practices within OTPs.

Findings such as the above on the post-discharge status of methadone patients led Dr. Edward Senay[436] to recommend 25 years ago that all MM patients should have continued professional treatment for at least a year after tapering to a zero dose of methadone. The percentage of MM patients who receive such support is not even routinely measured in OTPs, but the authors suspect that percentage would be quite low. 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, when needed, early re-intervention will be standard practices in OTPs and that such practices will reduce post-treatment mortality and enhance the long-term recovery outcomes of MM patients. We would suggest as a beginning point for design of such services that MM patients be provided periodic recovery checkups for at least five years following achievement of a zero dose and/or any disengagement from treatment, with the frequency of contact determined by time (high intensity through the first 90 days of disengagement) and a personalized schedule of contact reflecting patient-identified circumstances in the future that are likely to pose elevated risks of drug use.

RECOVERY-ORIENTED METHADONE MAINTENANCE: FURTHER REFLECTIONS ON OUTCOME MEASURES

Methadone maintenance treatment has been evaluated using two broad benchmarks: 1) changes in behaviors that generate harm and costs to society (e.g., crime, disease transmission, unemployment, abuse/neglect/abandonment of children), and (as in the evaluation of other treatment modalities) 2) the percentage of clients who maintain abstinence or no longer meet diagnostic criteria for opioid dependence following discharge from treatment.

The first benchmark reflects legitimate public health concerns, although it is noteworthy that these have been collected and emphasized at the exclusion of measures of the effects of MM on

428. Hser, Y., Anglin, M., Grella, C., Longshore, D., & Prendergast, M. (1997). Drug treatment careers: A conceptual framework and existing research findings. *Journal of Substance Abuse Treatment, 14*(3), 1-16. Lundgren, L.M., Sullivan, L., & Amodeo, M. (2006). How do repeaters use the drug treatment system? An analysis of injection drug users in Massachusetts. *Journal of Substance Abuse Treatment*, *30*, 121-128.

429. Zanis, D.A., McLellan, A.T., Alterman, A.I., & Cnaan, R.A. (1996). Efficacy of enhanced outreach counseling to reenroll high-risk drug users 1 year after discharge from treatment. *American Journal of Psychiatry*, *153*, 1095-1096.

430. Weisner, C., Ray, G.T., Mertens, J.R., Satre, D.D., & Moore, C. (2003). Short-term alcohol and drug treatment outcomes predict long-term outcome. *Drug and Alcohol Dependence*, *71*, 281-294.

431. Simpson, D.D., & Savage, L.J. (1980). Treatment re-entry and outcomes of opioid addicts during a four-year follow-up after drug abuse treatment in the United States. *Bulletin on Narcotics*, *32*(4), 1-10.

432. Powers, K.I., & Anglin, M.D. (1993). Cumulative versus stabilizing effects of methadone maintenance: A quasi-experimental study using longitudinal self-report data. *Evaluation Review*, *17*, 243-270.

433. Nosyk, B., MacNab, Y.C., Sun, H., Fischer, B., Marsh, D., Schecter, M.T., & Anis, A. (2009). Proportional hazards frailty models for recurrent methadone maintenance treatment. *American Journal of Epidemiology*, *170*(6), 783-792.

434. Hser, Y. (2007). Predicting long-term stable recovery from heroin addiction: Findings from a 33-year follow-up study. *Journal of Addictive Diseases, 26*(1), 51-60.

435. Dennis. M.L., Scott, C.K., & Funk, R. (2003). An experimental evaluation of recovery management checkups (RMC) for people with chronic substance use disorders. *Evaluation and Program Planning, 26*(3), 339-352. McKay, J. (2009). *Treating substance use disorders with adaptive continuing care*. Washington, D.C.: American Psychological Association. Scott, C.K., Dennis, M.L., & Foss, M.A. (2005). Utilizing recovery management checkups to shorten the cycle of relapse, treatment re-entry, and recovery. *Drug and Alcohol Dependence*, *78*, 325-338.

436. Senay, E.C. (1985). Methadone maintenance treatment. *International Journal of the Addictions*, *20*(6&7), 803-821.

personal/family recovery (including measures of global health and quality of life). As a professional field, we know a great deal about what methadone maintenance treatment can eliminate from the lives of patients, but we know very little from the standpoint of science about what it adds. In fact, we know very little about the stages and styles of long-term medication-assisted recovery. It is regrettable that information on long-term MM-assisted recovery has not been collected and used to shape a menu of stage-specific recovery support services.

Historically, multiple stakeholders other than MM patients have sat at the tables at which the criteria for evaluating MM have been defined. It is time MM patients and their family members are seated at these tables. There are thousands of stabilized MM patients in the United States who are invisible and silent. It is time they and their families were empowered to tell their recovery stories and help us as addiction professionals extract lessons from those stories that can elevate the quality of MM treatment and recovery support services.

The second benchmark, evaluating MM based on abstinence from all opioids following cessation of MM, is a fundamentally flawed approach. Dr. Robert Newman[437] explains:

> *… the assessment of methadone's effectiveness in the treatment of addicts continues to focus on the study of former patients who are no longer receiving treatment—a focus no more logical than gauging the effectiveness of birth-control pills by counting the number of pregnancies that occur after administration is discontinued…Methadone is dismissed by many and damned by others because it does not "cure" patients or render them immune from such societal ills as unemployment, alcoholism, marijuana smoking, and criminality. In other words, methadone maintenance has come to be evaluated by virtually every criterion except a decline in heroin use.*

Evaluating MM on in-treatment and post-treatment abstinence from alcohol and non-opioid drugs is similarly flawed if OTPs are not designed and funded to provide services beyond methadone pharmacotherapy that are capable of treating co-occurring drug dependencies.

We propose that OTPs and all other addiction treatment programs be evaluated based on the same criteria and that such criteria be drawn from the Betty Ford Institute Consensus Panel definition of recovery—a definition that through its core components of sobriety, global health, and citizenship encompasses personal, family, and community interests. Using these criteria might

437. Newman, R.G. (1987). Methadone treatment: Defining and evaluating success. *New England Journal of Medicine*, *317*, 447-450.

lead to enriching MM with a much broader array of professional and peer-based recovery support services and extend such support to patients far beyond the potential cessation of methadone pharmacotherapy. The same criteria would focus attention on intermediate outcome measures (related to sobriety, global health, and community reintegration) and process measures (attraction, access, engagement, retention, service duration, etc.) that have a strong nexus to long-term personal and family recovery outcomes. Such an approach is consistent with McLellan and colleagues'[438] call to shift the evaluation of addiction treatment from a model of evaluating discrete episodes via post-treatment follow-up to a process of *concurrent recovery monitoring* and evaluating unique combinations and sequences of service elements on long-term addiction, treatment, and recovery careers.[439]

A BRIEF NOTE ON EVIDENCE-BASED PRACTICES IN ROMM

We have tried to the extent possible to ground our recommendations in this article within the peer-reviewed scientific literature, but it is important to acknowledge that every MM program sees patients whose needs are never reflected in the randomized clinical trials that the field so worships. These are the patients who present with multiple drug choices, multiple co-occurring disorders, and multiple personal and environmental obstacles to long-term recovery. These patients are the first to be excluded from clinical trials and the first to be extruded from mainstream OTPs. We know almost nothing about the prevalence, pathways, and styles of long-term recovery for such patients or the kinds of clinical and support interventions that help facilitate such recoveries. Lacking such a scientific roadmap, we would be well served to find ways to listen to these patients and their families and forge models of care that respond to the complexity of their needs. We cannot assume that what we have learned about the treatment of MM patients in clinical trials applies to those patients with more complex needs. Of all patients entering OTPs today, these are the patients most in need of the kind of long-term recovery partnership we have described in this article.[440]

SUMMARY

This article has outlined a vision of recovery-oriented methadone maintenance (ROMM). Put simply, ROMM seeks to:

- *focus on recovery from addiction* rather than remission of a drug-specific disorder (e.g., opioid dependence);

438. McLellan, A.T., McKay, J.R., Forman, R., Cacciola, J., & Kemp, J. (2005). Reconsidering the evaluation of addiction treatment: From retrospective follow-up to concurrent recovery monitoring. *Addiction*, *100*, 447-458.

439. White, W. (2008c). *Recovery management and recovery-oriented systems of care: Scientific rationale and promising practices*. Pittsburgh, PA: Northeast Addiction Technology Transfer Center, Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health & Mental Retardation Services.

440. Senay, E. (2010). Personal communication, February 16, 2010.

- *attract* people at an earlier stage of addiction via programs of assertive community education, screening, and outreach;
- *ensure rapid service* access for individuals and families seeking help;
- *resolve obstacles* to admission, initial stabilization, and continued participation in MM treatment;
- *achieve safe, optimum dose stabilization* through individualized patient care that is responsive to patients' needs and respectful of patients' preferences and values;
- *engage and retain* individuals and families in a recovery-focused service relationship marked by mutual respect, hope, and emotional authenticity;
- *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;
- *shift the service relationship* from a professional expert model to a long-term recovery partnership/consultation model;
- *ensure minimum (at least one year of stabilization) and optimum (individualized) duration of treatment* via focused retention strategies, assertive responses to early signs of disengagement, and use of patient surveys to identify and resolve grievances that might contribute to disengagement;
- *shift the treatment focus* from that of an episode of care to the management of long-term addiction/treatment/recovery careers;
- *ensure that MM patients are afforded educational and counseling services* on a par with those offered to patients in other addiction treatment modalities.
- *expand the service menu* to include medical/psychiatric/social services, non-clinical, peer-based recovery support services, and spiritual and culturally indigenous healing activities;
- *extend the locus of service delivery* beyond the OTP clinic to non-stigmatized service sites and neighborhood-based, church-based, work-based, and home-based recovery support services;

- *assertively link patients/families* to recovery community support resources (including 12-Step groups, other recovery mutual aid societies, and grassroots recovery advocacy and support organizations), and identify and establish partnerships with non-traditional sources of patient support within the community (e.g., faith-based recovery ministries);
- *engage the community* via a positive program presence in the community, anti-stigma and community education campaigns about medication-assisted recovery, and recovery community development activities;
- *provide individualized plans for post-treatment monitoring and support, stage-appropriate education, support, and 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.

Achieving these changes in practice will be contingent on re-aligning the philosophy of MM toward a greater focus on long-term personal and family recovery (as opposed to a narrower focus on reduction of social harm), and it will require re-aligning the context of MM (policy, regulatory, funding, and community environment) to support this recovery vision. Facilitating such a transformation will in turn require enhancing the organization infrastructures of OTPs in such critical areas as capitalization, leadership/workforce development and stabilization, technological capabilities, institution-community relationships, and advocacy capabilities. As discussions proceed on the potential for OTP systems transformation, care should be taken to explore the risks of unintended consequences within such a transformation process.[441] We will need to address critical questions, including:

- Is there a risk that opioid-addicted persons not desirous of recovery as defined in this monograph will be punished, denied services or otherwise abandoned for their lack of readiness to accept this goal? Might new recovery rhetoric be used to justify punitive treatment of "recovery-resistant" patients?
- Could approaches to recovery-oriented methadone maintenance be used to foist services on patients who do not need or want or cannot afford such services?
- Might this recovery orientation add a new layer of regulatory demands on OTPs that in the long run will add administrative burdens and further depersonalize service relationships?

441. A special thanks to Dr. Robert Newman for raising this concern.

Might these new recovery-focused regulatory demands actually decrease the individualization of care within the OTP? (Our fear here is of new mandates for particular types of services for *all* patients.)

- Is there not a danger that the assertive outreach programs advocated in this monograph might quickly overwhelm national OTP capacities?
- What effects will increased patient retention have on community treatment capacity?
- Will the financial resources required to deliver a service-enriched model of methadone maintenance reduce the numbers of people served by the OTPs and inadvertently widen the gap between treatment needs and treatment capacity?
- Might the emphasis on patient-directed recovery plans and peer-based recovery support services inadvertently lead to the deprofessionalization of addiction treatment?
- Are there circumstances in which patients might be harmed within the context of peer-based recovery support services? What kinds of screening, selection, training, supervision practices and ethical guidelines will be needed to minimize this risk?
- Might the integration of medication-assisted treatment and recovery support services into health, human services, and other community organizations lead to the eventual destruction of OTPs and the broader addictions field as a specialized arena of care?
- Will the resources that will be required to provide sustained continuing care following cessation of MM reduce OTP capacity for acute stabilization and maintenance?

We feel that the best way of avoiding such risks is to ensure that one particular voice is always at the table and prominent in the coming discussions of recovery-oriented methadone maintenance. For the past 45 years, the design of methadone maintenance treatment in the United States has rested in the hands of policy-makers, scientists, and treatment professionals. The voice of the patient in shaping MM has grown from a whisper to the early stirrings of a patient advocacy movement. In preparing this monograph, we talked with many MM patients, including a particularly hidden population of MM patients: those who have achieved prolonged recovery, health, productivity, and service. What we found through these latter conversations is a population of current and former MM patients who are strong, capable, and willing and ready to participate and help lead such systems-transformation processes. They represent an unknown portion of MM patients in

the U.S., and they have achieved a high quality of life in recovery, sometimes in spite of treatment milieus in which recovery was rarely discussed.

> *I think it is WAY past time for MMT patients to speak up and stop allowing those who do not have a clue to make the rules and regs for methadone treatment. I am tired of the clinics taking advantage of patients and treating us like they do, and I will do whatever is needed to help change these things.*[442]

Many MM patients will not become excited about a heightened recovery orientation of their clinic until they are first engaged in education and discussion about recovery—what recovery means in the MM context, pathways and styles of recovery, its prevalence, and its rewards. Perhaps the greatest failure of methadone maintenance is represented in the high proportion of MM patients who understand methadone maintenance as a *treatment* for opioid addiction but lack an understanding of medication-assisted long-term recovery. OTPs will have come of age when their emphasis shifts from the personal and social injuries that MM subtracts from patients' lives to a focus on what recovery-oriented methadone maintenance can add to the quality of personal, family, and community lives.

Patients will embrace a vision of recovery only to the extent that the realities of their daily lives and their needs and aspirations are reflected in that vision. Patients thus need to be co-creators of the vision rather than just passive recipients. That vision will most easily flow from the collective experiences of current and former MM patients whose quality of personal and family life has been elevated through their recovery journeys. We believe that the visioning process needs to start with conversations between patients who have survived the demands of the clinic system and have built lives of sustained recovery, and patients who are beginning treatment, often with little understanding of, or hope for, long-term recovery. We think the recovery vision we speak of can emerge from such connections.

The seeds for a vibrant MM patient advocacy and peer support movement have been sown for decades by individual patients and early advocacy efforts.[443] The time for the full emergence of that movement has arrived, and as it comes of age, this movement will profoundly shape the future of medication-assisted treatment and recovery in the United States. One of the most significant challenges to be faced is the social and professional stigma attached to medication-assisted treatment and recovery, particularly methadone-assisted treatment and recovery. That will be the subject of the final article in this monograph.

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442. MM patient feedback to authors, May 2010.

443. Woods, J. (2001). Methadone advocacy: The voice of the patient. *The Mount Sinai Journal of Medicine*, *68*, 75-78.

IV: Long-Term Strategies to Reduce the Stigma Attached to Addiction, Treatment, and Recovery within the City of Philadelphia

William L. White, MA

> *The guiding vision of our work must be 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."*[444]

INTRODUCTION

When Dr. Arthur Evans, Jr. assumed leadership of the Philadelphia Department of Behavioral Health and Mental Retardation Services in 2004, he initiated a broad community-visioning exercise that ignited a "recovery-focused systems transformation" process. Systems transformation involves aligning concepts, contexts (policies, regulatory guidelines, funding mechanisms), and service practices to: 1) identify and engage individuals and families affected by alcohol and other drug (AOD) problems, 2) help these individuals and families initiate and sustain a process of long-term recovery, and 3) enhance the quality of personal/family life in long-term recovery. The emerging vision in Philadelphia was 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."[445]

The purpose of this article is twofold. First, it provides an overview of key findings drawn from historical and scientific research on social/professional stigma related to addiction to illicit drugs, with a particular focus on the stigma experienced by people in medication-assisted treatment and long-term medication-assisted recovery. Second, it outlines a menu of potential strategies that could be implemented by the Philadelphia Department of Behavioral Health and Mental Retardation Services and its many community partners to reduce this stigma. The document was prepared with input

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

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

from local and national addiction treatment professionals and recovery advocates and is intended as a starting point for further discussions and strategy-development meetings that will be facilitated by the Philadelphia Department of Behavioral Health and Mental Retardation Services.

STIGMA BASICS

Stigma Defined

Stigma is the experience of being "deeply discredited" due to one's "undesired differentness." To be stigmatized is to be held in contempt, shunned, or rendered socially invisible because of a socially disapproved status.[446] It involves processes of labeling, stereotyping, social rejection, exclusion, and extrusion—the essential ingredients of discrimination.[447]

There are three types of personal stigma:

- Enacted stigma (direct experience of social ostracism and discrimination)
- Perceived stigma (perception of stigmatized attitudes held by others toward oneself)
- Self-stigma (personal feelings of shame and self-loathing related to regret over misdeeds and "lost time" in one's life due to addiction).[448]

Self-stigma, or internalized stigma, results from the internalization of community attitudes by the person being discredited.

Stigma and Addiction

There is an extensive body of literature documenting the stigma attached to alcohol and other drug problems.[449] No physical or psychiatric condition is more often or more deeply associated with social disapproval and discrimination than alcohol and/or other drug dependence.[450] 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.[451]

Stigma and Recovery

Addiction-related social stigma extends to people who have achieved stable recovery from addiction.[452] In fact, people in recovery may have a greater fear of stigma and experience stigma more intensely precisely because of their recovery status and all that they now have to lose.[453] The

446. Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity.* Englewood Cliffs: Prentice-Hall.

447. Sayce, L. (1998). Stigma, discrimination and social exclusion: What's in a word? *Journal of Mental Health*, *7*, 331-343. van Olphen, J., Eliason, M.J., Freudenberg, N., & Barnes, M. (2009). Nowhere to go: How stigma limits the options of female drug users after release from jail. *Substance Abuse Treatment Prevention and Policy, 4*. Retrieved from http://www.substanceabusepolicy.com/content/pdf/1747-597X-4-10.pdf.

448. Luoma, J.B., Twohig, M.P., Waltz, T., Hayes, S.C., Roget, N., Padilla, M., et al. (2007). An investigation of stigma in individuals receiving treatment for substance abuse. *Addictive Behaviors, 32*(7), 1331-1346. Vigilant, L.G. (2004). The stigma paradox in methadone maintenance: Naïve and positive consequences of a "treatment punishment" approach to opiate addiction. *Humanity and Society, 28*(4), 403-418.

449. Dean, J.C., & Rud, F. (1984). The drug addict and the stigma of addiction. *International Journal of Addictions, 19*(8), 859-869. McLaughlin, D., & Long, A. (1996). An extended literature review of health professionals' perceptions of illicit drugs and their clients who use them. *Journal of Psychiatric and Mental Health Nursing, 3*(5), 283-288. Sobell, L.C., Sobell, M.B., & Toneatto, T. (1992). Recovery from alcohol problems without treatment. In N. Heather, W.R. Miller, & J. Greeley (Eds), *Self control and addictive behaviors* (pp. 198-242). New York: Maxwell Macmillian.

450. Corrigan, P.W., Watson, A.C., & Miller, F. E. (2006). Blame, shame and contamination: The impact of mental illness and drug dependence stigma on family members. *Journal of Family Psychology, 20*(2), 239-246.

451. Woll, P. (2005). *Healing the stigma of addiction: A guide for treatment professionals.* Chicago, IL: Great Lakes Addiction Technology Transfer Center.

452. Tootle, D.M. (1987). Social acceptance of the recovering alcoholic in the workplace: A research note. *Journal of Drug Issues*, *17*, 273-279.

453. Woods, J. (2009). Personal communication, July 27, 2009.

intensity of stigma varies by problem intensity and different styles of recovery. Stigma attached to natural recovery may be less severe, due to the perception of it as more noble (pulling oneself up by the bootstraps) and to the possibility that people might perceive the naturally recovering person as having had less severe problems. At the same time, natural recovery is often viewed by the public as less credible and durable than recovery from severe AOD problems initiated through professional treatment.[454]

Courtesy Stigma

The social stigma attached to addiction can be experienced by families, organizations (e.g., addiction treatment programs), neighborhoods, and whole communities.[455] Goffman[456] referred to this stigma-by-association as "courtesy stigma."[457]

The social stigma attached to families affected by addiction carries the implication that the family somehow failed to prevent this problem, contributed to its onset, and/or played a role in inciting or failing to prevent relapse episodes. Children may be socially shunned due to the perception that they have been contaminated by the addiction of their parents or siblings.[458]

Many family member behaviors that historically have been defined as "enabling" or "co-dependent" are better understood as attempts to protect the family from the stain of social stigma.[459] The "courtesy stigma" experienced by family members as embarrassment and shame is often displaced on the family member experiencing AOD problems in the form of anger and exclusion. Family members thus sacrifice their own family member to escape or lessen their own social condemnation.

Addiction-related courtesy stigma can also extend to particular organizations, neighborhoods, and communities. Professionals who work with stigmatized groups may also be affected by this same stigma through, for example, the stigma's effects on addiction professionals' percption of themselves in relation to other fields and disciplines, and on the ways in which they are perceived by others. A particular neighborhood can be stigmatized when AOD problems become part of its public identity through repeated portrayal of the neighborhood's challenges with no references to its strengths. Examples of ways in which whole communities can be stigmatized by addiction-related stigma include the historical portrayal of the surge in cocaine use in the late 19th and early 20th centuries, and again in the 1980s, as a distinctly African American problem[460] and the centuries-long misrepresentation ("firewater myths") of the nature of alcohol problems in Native American communities.[461]

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454. Cunningham, J.A., Sobell, L.C., & Chow, V.M. (1993). What's in a label? The effects of substance types and labels on treatment considerations and stigma. *Journal of Studies on Alcohol, 54*(6), 693-699.

455. Luoma, J.B., Twohig, M.P., Waltz, T., Hayes, S.C., Roget, N., Padilla, M., et al. (2007). An investigation of stigma in individuals receiving treatment for substance abuse. *Addictive Behaviors, 32*(7), 1331-1346.

456. Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Englewood Cliffs: Prentice-Hall.

457. Also see: Barton, J.A. (1991). Parental adaptation to adolescent drug abuse: An ethnographic study of role formulation in response to courtesy stigma. *Public Health Nursing, 8*(1), 39-45.

458. Corrigan, P.W., Watson, A.C., & Miller, F.E. (2006). Blame, shame and contamination: The impact of mental illness and drug dependence stigma on family members. *Journal of Family Psychology, 20*(2), 239-246.

459. *The stigma of substance abuse: A review of the literature.* (1999). Toronto, Canada: Centre for Addiction and Mental Health.

460. White, W., & Sanders, M. (2002). Addiction and recovery among African Americans before 1900. *Counselor, 3*(6), 64-66.

461. Coyhis, D. & White, W. (2006). Alcohol problems in Native America: The untold story of resistance and recovery—The truth about the lie. Colorado Springs, CO: White Bison, Inc.

Stigma and Choice

Addiction has been alternately defined as a problem of vulnerability (an involuntary medical/psychiatric disease) and a problem of culpability (a voluntary, self-inflicted moral lapse/character defect/vice/habit). The former model provides pathways of return to health; the latter proscribes sequestration and punishment as blame for moral/criminal liability, as a means of rehabilitation, and/or as a method of suppressing excessive substance use in the community.[462] Stigma rises for some but not all disorders in which the individual is perceived as having personally contributed to the onset of the disorder. People with substance use disorders are less likely to be offered help by other citizens than are people with mental illnesses or physical disabilities.[463] The stigma attached to drug dependence, and arguments for and against the personal or social harm or value of such stigma, hinge to a great degree on widely varying views on the degree to which those with significant alcohol and other drug problems have voluntary control over their drug use.

Stigma and Motivation for Drug Use

American attitudes toward addiction have varied based on the motivation for drug use, with relief of pain viewed as more excusable than the search for unearned pleasure.[464] Where pain-related addiction elicits compassion, addiction that results from the search for pleasure elicits condemnation and social marginalization. At the same time, cultural phobia related to opioid addiction and fear that addiction-related stigma will be attached to prescription opioid use has resulted in the underuse of opioid medication in the treatment of acute and chronic pain, from both physician hesitation to prescribe opioids and patient ambivalence about taking opioid medications.[465] Perhaps the best example of this is patients' resistance to their physicians' suggestions that they take methadone for chronic pain because of the patients' association with methadone as "that junkie drug." This is further exacerbated by public and professional confusion on the difference between *physical dependence* on an opioid medication and opioid *addiction* (See later discussion).

Stigma and "Badness"

American social policies on licit and illicit drugs have long been bifurcated by the notion of *good drugs* and *bad drugs*, with drugs in the latter category rated across degrees of badness. Good drugs have been celebrated, commercialized, and taxed as a source of government revenue with control mechanisms relying primarily on the social and legal definitions of who can use, when use can occur, where use can occur, how much can be consumed, and under what conditions use

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462. Acker, C.J. (1993). Stigma or legitimation? A historical examination of the social potentials of addiction disease models. *Journal of Psychoactive Drugs, 25*(3), 193-205. Husak, D.N. (2004). The moral relevance of addiction. *Substance Use and Misuse, 39*(3), 399-436.

463. Corrigan, P.W., Kuwabara, S.A., & O'Shaughnessy, J. (2009). The public stigma of mental illness and drug addiction: Findings from a stratified random sample. *Journal of Social Work, 9*(2), 139-147.

464. Husak, D.N. (2004). The moral relevance of addiction. *Substance Use and Misuse, 39*(3), 399-436.

465. Woods, J. (2009). Personal communication, July 27, 2009.

can and cannot occur. Bad drugs (and their users) have been demonized and prohibited, with the space between good and bad occupied by tolerated drugs (discouraged but not prohibited, e.g., tobacco) and instrumental drugs (approved for use only under special circumstances, e.g., prescription drugs). Historically, heroin and crack cocaine have been the most severely stigmatized substances and injection drug use the most severely stigmatized method of ingestion.[466] The manner in which stigma triggered by public panic can demonize users and suppress treatment seeking is well illustrated by the "moral panic" linked to crack cocaine in the 1980s and the more recent panic related to surges in methamphetamine use.[467] The attribution of "badness" (social stigma) has for most of the past century been most intense for those persons who regularly self-inject heroin.[468]

By extension, greater addiction recovery-related stigma is extended to people in opioid treatment modalities. This stigma is particularly severe for persons whose treatment and recovery is supported by methadone, in spite of the well established scientific legitimacy and effectiveness of methadone treatment.[469] In one of the most recent studies of methadone-related stigma, 98% of MAT patients surveyed reported that "stigma is an essential feature of methadone maintenance treatment."[470] For many opiate addicts, the stigma attached to medication-assisted treatment (MAT) is internalized from the culture at large and from illicit opioid street cultures long before treatment becomes a possibility or a necessity. Members of the illicit opioid street culture are also aware of methadone-related stigma and discrimination—spanning employment, child custody, access to other forms of addiction treatment, and even denial of certain privileges within the recovery community, e.g., right to speak at a recovery fellowship meeting, chair a meeting, head a service committee, or be credited with "clean time" while taking methadone.[471]

Multidimensional Stigma

The weight of addiction-related social stigma is not equally applied. Its burdens fall heaviest on those with the fewest resources to resist it, e.g., those for whom stigma is layered across multiple conditions (addiction, mental illness, HIV/AIDS, incarceration, minority status, poverty, homelessness, aging) and when these conditions are perceived as conflicting with gender-linked role responsibilities, e.g., those of addicted pregnant women/mothers.[472] Persons experiencing such layered, multidimensional stigma are less likely to seek addiction treatment than persons experiencing a single discredited condition.[473] The social stigma attached to addiction begins primarily at the point

466. Capitanio, J.P., & Herek, G.M. (1999). AIDS-related stigma and attitudes toward injecting drug users among Black and White Americans. *American Behavioral Scientist*, *42*(7), 1144-1157. Jones, E.E., Farina, A., Hastorf, A.H., Markus, H., Miller, D.T., Scott, R.A., et al. (1984). *Social stigma: The psychology of marked relationships*. New York: W.H. Freedman. Surlis, S., & Hyde, A. (2001). HIV-positive patients' experiences of stigma during hospitalization. *Journal of the Association of Nurses in AIDS Care*, *12*, 68-77.

467. Semple, S.J., Grant, L., & Patterson, T.L. (2005). Utilization of drug treatment programs by methamphetamine users: The role of social stigma. *The American Journal of Addictions*, *14*, 367-380. Humphries, D. (1999). *Crack mothers: Pregnancy, drug and the media*. Columbus: Ohio University Press.

468. Surlis, S., & Hyde, A. (2001). HIV-positive patients' experiences of stigma during hospitalization. *Journal of the Association of Nurses in AIDS Care*, *12*, 68-77.

469. Joseph, H. (1995). *Medical methadone maintenance: The further concealment of a stigmatized condition*. Unpublished doctoral dissertation, City University of New York. Murphy, S., & Irwin, J. (1992). "Living with the dirty secret": Problems of disclosure for methadone maintenance clients. *Journal of Psychoactive Drugs, 24*(3), 257-264. Woods, J. (2001). Methadone advocacy: The voice of the patient. *The Mount Sinai Journal of Medicine*, *68*, 75-78.

470. Vigilant, L.G. (2004). The stigma paradox in methadone maintenance: Naïve and positive consequences of a "treatment punishment" approach to opiate addiction. *Humanity and Society, 28*(4), 403-418.

471. Hettema, J., & Sorenson, J.L. (2009). Access to care for methadone maintenance patients in the United States. *International Journal of Mental Health and Addiction*. Online publication ahead of print. Retrieved from http://www.springerlink.com/content/c5v56125880u2p64/. Joseph, H., Stancliff, S., & Langrod, J. (2000). Methadone maintenance treatment: A review of historical and clinical issues. *Mount Sinai Journal of Medicine, 67*, 347-364.

472. Anderson, T.L., & Levy, J.A. (2003). Marginality among older injectors in today's illicit drug culture: Assessing the impact of ageing. *Addiction, 98*, 761-770. Capitanio, J.P., & Herek, G.M. (1999). AIDS-related stigma and attitudes toward injecting drug users among Black and White Americans. *American Behavioral Scientist*, *42*(7), 1144-1157. Conner, K.O., & Rosen, D. (2008). "You're nothing but a junkie": Multiple experiences of stigma in an aging methadone maintenance population. *Journal of Social Work Practice in the Addictions, 8*(2), 244-264. Minior, T., Galea, S., Stuber, J., Ahern, J., & Ompad, D. (2003). For the patient. Does discrimination affect the mental health of substance abusers? *Ethnicity and Disease, 13*(4), 549-550. Yannessa, J.F., Reece, M., & Basta, T.B. (2008). HIV provider perspectives: The impact of stigma on substance abusers living with HIV in a rural area of the United States. *AIDS Patient Care, 22*(8), 669-675.

473. Conner, K.O., & Rosen, D. (2008). "You're nothing but a junkie": Multiple experiences of stigma in an aging methadone maintenance population. *Journal of Social Work Practice in the Addictions, 8*(2), 244-264.

of admission to treatment (a social signal of problem severity) and intensifies with multiple treatment episodes (a social signal of treatment failure).[474] One MAT patient distinguished the "inner shame" experienced during active addiction from the "public shame when you're in the clinic."[475]

Stigma in the Professional Context

The majority of health care professionals hold negative, stereotyped views of illicit drug users. These views are shaped for the most part, not by their professional training, but by each professional's past experimentation with or lack of experimentation with illicit drugs.[476]

Stigma, Treatment-Seeking, and Long-Term Health

Stigma can elicit social isolation, reduce help-seeking, and compromise long-term physical and mental health status.[477] Social stigma is a major factor in preventing individuals from seeking and completing addiction treatment[478] and from utilizing harm-reduction services such as needle exchange programs.[479] Social stigma increases the service needs of persons with substance use disorders, but, by fostering social rejection and discrimination, that same stigma decreases access to such services.[480] Treatment seeking is also reduced by the perception that drug treatment program staff will "treat you like a little, nasty dope fiend."[481]

Chronic Illness, Stigma, and Methadone Maintenance

Acute illness is something you have ("I have a cold"); chronic illness is something you are ("I am a diabetic"). With acute illnesses, one experiences the onset of the illness, one is professionally treated or self-treated, and one recovers without a lasting imprint on personal or social identity. Chronic illness bears a greater stigma burden, in part because of the uncertainty with which the concept of recovery is applicable to a condition that is prolonged; is not in a technical sense "cured"; and will require sustained self-management and, in many cases, periodic professional treatment. Chronic illness can inflict social death, a loss of self, and a struggle to define a "time horizon" for recovery.[482]

Vigilant[483] attributes the stigma attached to methadone maintenance to the imperfect medicalization of chronic opioid addiction and its treatment. By "imperfect," Vigilant means that: 1) heroin addiction and its treatment have been trapped between medical and moral/criminal models of problem definition and resolution; 2) methadone maintenance has never achieved full legitimacy as a medical treatment in the eyes of the public, health care professionals, and the recovery

474. Luoma, J.B., Twohig, M.P., Waltz, T., Hayes, S.C., Roget, N., Padilla, M., et al. (2007). An investigation of stigma in individuals receiving treatment for substance abuse. *Addictive Behaviors, 32*(7), 1331-1346.

475. Vigilant, L.G. (2004). The stigma paradox in methadone maintenance: Naïve and positive consequences of a "treatment punishment" approach to opiate addiction. *Humanity and Society, 28*(4), 403-418.

476. McLaughlin, D., & Long, A. (1996). An extended literature review of health professionals' perceptions of illicit drugs and their clients who use them. *Journal of Psychiatric and Mental Health Nursing, 3*(5), 283-288.

477. Ahern, J., Stuber, J., & Galea, S. (2007). Stigma, discrimination and the health of illicit drug users. *Drug and Alcohol Dependence, 88*(2-3), 188-196. Link, B.G., Struening, E.L., Rahav, M., Phelan, J.C., & Nuttbrock, L. (1997). On stigma and its consequences: Evidence from a longitudinal study of men with dual diagnosis of mental illness and substance abuse. *Journal of Health and Social Behavior*, *38*, 177-190. Minior, T., Galea, S., Stuber, J., Ahern, J., & Ompad, D. (2003). For the patient. Does discrimination affect the mental health of substance abusers? *Ethnicity and Disease, 13*(4), 549-550.

478. Luoma, J.B., Twohig, M.P., Waltz, T., Hayes, S.C., Roget, N., Padilla, M., et al. (2007). An investigation of stigma in individuals receiving treatment for substance abuse. *Addictive Behaviors, 32*(7), 1331-1346. Thom, B. (1986). Sex differences in help-seeking for alcohol problems—I. The barriers to help-seeking. *The British Journal of Addictions*, *81*, 777-788.

479. Simmonds, L., & Coomber, R. (2009). Injecting drug users: A stigmatized and stigmatizing population. *International Journal of Drug Policy, 20*(2), 121-130.

480. van Olphen, J., Eliason, M.J., Freudenberg, N., & Barnes, M. (2009). Nowhere to go: How stigma limits the options of female drug users after release from jail. *Substance Abuse Treatment Prevention and Policy, 4*. Retrieved from http://www.substanceabusepolicy.com/content/pdf/1747-597X-4-10.pdf.

481. Beschner, G.M. & Walters, J.M. (1985). Just another habit? The heroin users' perspective on treatment. In B. Hanson, G. Beschner, J. M. Walters, & E. Bovelle (Eds.), *Life with heroin: Voices from the inner city.* Lexington, MA: Lexington Books.

482. Vigilant, L.G. (2001). "Liquid handcuffs": The phenomenology of recovering on methadone maintenance. *Boston College Dissertations and Theses.* Vigilant, L. G. (2008). "I am still suffering:" The dilemma of multiple recoveries in the lives of methadone patients. *Sociological Spectrum, 28*, 278-298. Vigilant, L.G. (2005). "I don't have another run left with it": Ontological security in illness narratives of recovery on methadone maintenance. *Deviant Behavior, 26*(5), 399-416.

483. Vigilant, L.G. (2001). "Liquid handcuffs": The phenomenology of recovering on methadone maintenance. *Boston College Dissertations and Theses.*

community, in spite of the scientific studies supporting it; 3) the person enrolled in methadone maintenance has never received full status as a "patient"; and 4) the methadone clinic has yet to be viewed as a place of healing on a par with hospitals or outpatient medical clinics.

Vigilant further argues that heroin addicts entering methadone treatment are christened "patients," but the treatment protocol—required daily clinic visits, forced sequestration of addicts together in a closed group regardless of recovery motivation and status, restrictive and inflexible medication pickup schedules, public exposure while standing in line for medication, observed urination for drug testing, mandatory counseling, sanctions for violations of treatment rules—is more akin to the status of "inmates" of "total institutions" than protocol befitting a medical patient.[484] Methadone clinics have not achieved the social status of medical clinics because they have not been allowed to operate like medical clinics. Methadone patients have not achieved their full status as "patients" because they have not been treated as patients.

The "Catch-22" in which the methadone patient, methadone treatment staff, and methadone clinic as an institution are trapped grew out of the conflicting interests that emerged as methadone maintenance was mainstreamed as a treatment modality. On the one hand, there were the needs of the methadone patient and the need for a long-term service relationship based on empathy, trust, and respect. On the other hand, there were concerns about public safety via the potential for methadone diversion. This tension between a milieu of engagement and empowerment and a milieu of distrust and control left those being served caught between the status of a patient and the status of a prisoner/probationer, and left physicians/nurses/counselors caught between their aspirations to serve as healers and onerous, regulatory-imposed policing functions.[485] The result is a demedicalized system in which people entering methadone maintenance are treated more like criminals (or recalcitrant children) than patients, within a relational world more dominated by surveillance and control than compassion and choice.[486]

> *… clients often felt that the relationship between themselves and their counselors was less focused on therapy than power; less about psychological growth, getting help, and a sense of well-being than about social control, conforming to rules and regulations, and punishment.*[487]

Such focus on control rather than care may be even more greatly exaggerated for female patients,

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484. Vigilant, L.G. (2001). "Liquid handcuffs": The phenomenology of recovering on methadone maintenance. *Boston College Dissertations and Theses*.

485. Best, D. (2009). Personal communication.

486. Fraser, S., & Valentine, K. (2008). *Substance and substitution: Methadone subjects in liberal societies.* New York: Macmillan. Rosenbaum, M. (1995). The demedicalization of methadone maintenance. *Journal of Psychoactive Drugs*, *27*, 145-149.

487. Hunt, G., & Rosenbaum, M. (1998). 'Hustling' within the clinic: Consumer perspectives on methadone maintenance treatment. In J. A. Inciardi, & L. D. Harrison (Eds.), *Heroin in the age of crack-cocaine*. Thousand Oaks, CA: Sage.

leaving unattended many obstacles to participation and recovery, e.g., child care, transportation, caretaking responsibilities, sabotage from addicted partners, threats of partner violence, and difficulty paying for treatment.[488]

The professional status of methadone treatment has suffered from the absence of theoretical models of addiction treatment and recovery that integrate the prevailing preoccupation with the mechanics of the medicine (e.g., concern with dosages, pick-up schedules, drug testing, take-home privileges, tapering procedures) and control of the milieu (e.g., concern with loitering) with a focus on the broader physical, cognitive, emotional, relational, occupational, and spiritual aspects of long-term recovery.[489] The lack of such theoretical models and the performance expectations emanating from such models breeds clinics in which patients' contact with their counselors is rare, brief, and superficial, and in which ancillary services are minimal. As a result, methadone patients are all too often rendered and perceived as "passive figures onto which a treatment modality [methadone] is applied."[490] Missing is the image of the methadone patient as his or her own engineer of an enduring process of global (whole life) recovery.

Types of Stigma Attached to Methadone Maintenance

Vigilant's[491] study of the phenomenology of methadone-assisted recovery revealed five types of stigma unique to methadone treatment:

1. **Methadone treatment stigma:** the stigma attached to treatment for opiate addiction; methadone treatment as a social signal of problem severity; stigma attached to methadone as a treatment modality by the culture at large and by major segments of the professional and recovery communities. (Methadone-related stigma is far greater for women than men, due to the perceived connection between heroin addiction and prostitution).
2. **Dose stigma:** the stigma attached within the clinic culture to those on high doses of methadone—a status often interpreted by other patients as indicating a lack of interest in recovery.
3. **Stigma of personal regret:** shame of looking back on the devastation to self, family, and community caused by heroin addiction.
4. **Stigma-related loss of associational ties:** shrinking of the social network to the recovery/clinic community, in order to avoid the social stigma attached to addiction and methadone treatment.

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488. Fraser, J. (1997). Methadone clinic culture: The everyday realities of female methadone clients. *Qualitative Health Research*, *7*(1), 121-139.

489. Hagman, G. (1995). A psychoanalyst in methadonia. *Journal of Substance Abuse Treatment, 12*(3), 167-179.

490. Hunt, G., & Rosenbaum, M. (1998). 'Hustling' within the clinic: Consumer perspectives on methadone maintenance treatment. In J.A. Inciardi, & L.D. Harrison (Eds.), *Heroin in the age of crack-cocaine*. Thousand Oaks, CA: Sage.

491. Vigilant, L.G. (2001). "Liquid handcuffs": The phenomenology of recovering on methadone maintenance. *Boston College Dissertations and Theses*.

5. **Loss-of-control stigma:** shame related to the excessive demands of the clinic, its domination of one's life and forced participation in shaming rituals (e.g., observed urination to confirm that urine for drug testing is "fresh" and not being surreptitiously substituted).

Dr. Robert Newman[492] places Viglant's work within an important historical perspective. Newman argues that the original model of methadone maintenance was corrupted as it was mainstreamed.[493] Methadone treatment during this transition phase shifted to lower methadone doses, shorter lengths of methadone treatment participation, and decreased emphasis on services for collateral problems (e.g., counseling, employment, housing) that are critical to recovery stabilization and maintenance. These changes violated the original theoretical framework of methadone maintenance to the extent that Newman drew the following provocative conclusion:

> *Methadone maintenance treatment, with its unique, proven record of both effectiveness and safety, no longer exists. One can only hope that it is not too late to reassess that which has been cast aside, and to resurrect a form of treatment which has helped so many, and which could help many more.*[494]

Payte[495] suggests that the history of methadone maintenance treatment stands as an argument for professional activism:

> *It is no longer sufficient to take care of patients. Treatment providers must also become teachers, public relations workers, politicians, and advocates for all patients who want and need treatment.*[496]

Personal Responses to Stigma

There is a high degree of variability in the ways in which persons in methadone maintenance respond to stigma. Patients with more positive self-concepts and more social resources are better able to counter stigma and assert the positive benefits of MAT. Those with lower self-esteem and fewer social resources are less capable of resisting stigma and tend to self-define methadone treatment as another addiction (internalized stigma).[497] Personal strategies to deal with stigma include:

- Secrecy/concealment (e.g., concealing one's methadone treatment status at AA and NA meetings)
- Social withdrawal (e.g., avoiding new friendships, avoiding recovery support meetings)

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492. Newman, RG. (1976). Methadone maintenance: It ain't what it used to be. *British Journal of Addiction, 71*, 183-186. See also: Des Jarlais, D.C., Paone, D., Friedman, S.R., Peyset, N. & Newman, R.G. (1995). Regulating controversial programs for unpopular people: Methadone maintenance and syringe exchange programs. American Journal of Public Health, 85(11), 1577-84.

493. See Payte, J.T. (1991). A brief history of methadone in the treatment of opiate dependence: A personal perspective. *Journal of Psychoactive Drugs, 23*(2), 103-107.

494. Newman, RG. (1976). Methadone maintenance: It ain't what it used to be. *British Journal of Addiction, 71*, 183-186.

495. Payte, J.T. (1991). A brief history of methadone in the treatment of opiate dependence: A personal perspective. *Journal of Psychoactive Drugs, 23*(2), 103-107.

496. Payte, J.T. (1991). A brief history of methadone in the treatment of opiate dependence: A personal perspective. *Journal of Psychoactive Drugs, 23*(2), 103-107. See also Newman,, R.G., & Peyser, N. (1991). Methadone treatment: Experiment and experience. *Journal of Psychoactive Drugs, 23*(2), 115-121.

497. Gourlay, J., Ricciardelli, L., & Ridge, D. (2005). Users' experiences of heroin and methadone treatment. *Substance Use and Misuse, 40*(12), 1875-1882.

- Preventive disclosure (selective disclosure to test acceptability)
- Compensation (using personal strengths in another area to counter the imposed stigma)
- Strategic interpretation (comparing oneself to others within the stigmatized group rather than to those in the larger community)
- Political activism.[498]

People with diminished internal assets and diminished social capital experience difficulty resisting a stigmatizing label and challenging the personal/organizational entities that are applying the label.[499]

Stigma and Cultures of Addiction

Social stigma contributes to the propensity of persons with drug dependencies to become enmeshed in illicit drug subcultures.[500] Individuals who share the "spoiled identity" of addiction have historically organized their own countercultures marked by distinct language, values, roles, rules (behavioral codes), relationships, and rituals.[501] These subcultures provide shelter from stigma; access to drug supplies; social support for sustained drug use; meaningful roles, activities, and relationships; and mutual protection.

Within these cultures, drug users protect their own identities by stigmatizing other drug users viewed as having less control of their drug use.[502] Such attitudes can be played out within the social pecking order of drug treatment milieus. "Street cultures" are also embedded with myths designed to inhibit treatment-seeking, contribute to ambivalence about treatment, and increase the likelihood of treatment disengagement, including a number of myths about methadone (e.g., "it rots your teeth and bones").[503]

Many individuals enmeshed in such cultures progressively diminish their contact with the mainstream culture and become as dependent on the culture of addiction as they have been on the drugs in their lives. As drug-related personal impairment escalates, individuals may experience rejection and isolation from both the mainstream society and the illicit drug cultures that have sheltered them.[504] If recovery and community reintegration are to be achieved and sustained, addiction treatment, recovery mutual aid societies, and other helping structures must facilitate a journey from the culture of addiction, or from this marginalized isolation, to a culture of recovery. Stigma is a major obstacle to successfully traversing the physical, psychological, and social space between these two worlds.[505] Methadone advocate Walter Ginter recently reflected on this journey:

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498. Herman, N. (1993). Return to sender: Reintegrative stigma-management strategies for ex-psychiatric patients. *Journal of Contemporary Ethnography*, *22*(3), 302-321. Link, B.G., Struening, E.L., Rahav, M., Phelan, J.C., & Nuttbrock, L. (1997). On stigma and its consequences: Evidence from a longitudinal study of men with dual diagnosis of mental illness and substance abuse. *Journal of Health and Social Behavior*, *38*, 177-190. Shih, M. (2004). Positive stigma: Examining resilience and empowerment in overcoming stigma. *Annals of the American Academy of Political and Social Science*, *591*, 175-185. Vigilant, L.G. (2004). The stigma paradox in methadone maintenance: Naïve and positive consequences of a "treatment punishment" approach to opiate addiction. *Humanity and Society, 28*(4), 403-418.

499. Schur, E.M. (1971). *Labeling deviant behavior: Its sociological implications*. New York: Harper & Row Publications.

500. Anderson, T.L. (1993). Types of identity transformation in drug using and recovery careers. *Sociological Focus*, *26*(2), 133-145. White, W. (1996). *Pathways from the culture of addiction to the culture of recovery*. Center City: Hazelden. Anderson, T.L., & Ripullo, F. (1996). Social setting, stigma management, and recovering drug addicts. *Humanity and Society, 20*, 25-43.

501. Agar, M. (1977). *Ripping and running: A formal ethnography of urban heroin addicts*. New York: Seminar Press, Inc. Biernacki, P. (1979). Junkiework, hustles, and social status among heroin addicts. *Journal of Drug Issues*, *9*, 535-551. Finestone, H. (1969). Cats, kicks and color. In H. Becker (Ed.), *The other side* (pp. 281-297). New York: Free Press. Waldorf, D. (1973). *Careers in dope.* Englewood Cliffs, NJ: Prentice-Hall, Inc. White, W. (1996). *Pathways from the culture of addiction to the culture of recovery*. Center City: Hazelden.

502. Boeri, M.W. (2004). "Hell, I'm an addict but I ain't no junkie": An ethnographic analysis of aging heroin users. *Human Organization*, *63*, 236-245. Simmonds, L., & Coomber, R. (2009). Injecting drug users: A stigmatized and stigmatizing population. *International Journal of Drug Policy, 20*(2), 121-130. Sutter, A.G. (1966). The world of the righteous dope fiend. *Issues in criminology*, *2*, 177-222. Zinberg, N.E. (1984). *Drug, set, and setting: The basis for controlled intoxicant use*. New Haven: Yale University.

503. Rosenblum, A., Magura, S., & Joseph, H. (1991). Ambivalence toward methadone treatment among intravenous drug users. *Journal of Psychoactive Drugs*, *23*(1), 21-27.

504. Anderson, T.L., & Levy, J.A. (2003). Marginality among older injectors in today's illicit drug culture: Assessing the impact of ageing. *Addiction*, *98,* 761-770.

505. White, W. (1996). *Pathways from the culture of addiction to the culture of recovery*. Center City: Hazelden.

> *Methadone patients are caught between these two cultures. Even if recovery is their goal, they must stand in line at the clinic each day with people who are as interested in the best crack spot as they are about recovery. Under such a handicap, it is amazing that many patients find their way to medication-assisted recovery. When they do, it is more likely to be in spite of the treatment system than because of it. We have to find a way to separate the culture of addiction from the culture of recovery in our OTP's [opioid treatment programs]. It is unreasonable to expect patients to find recovery until we do.*[506]

Ginter's observation elicits the image of "life in the queue"—the social influences that pervade interactions in the dosing line of the methadone clinic. The long-term addiction/recovery scales may well be tipped as much by the milieu as by methadone as a medication in the treatment of addiction.[507]

Strategies to Address Social Stigma

Three broad social strategies have been used to address stigma related to behavioral health disorders: 1) protest, 2) education, and 3) contact.[508] One major strategy, seeking to inculcate the belief that alcohol and drug addiction is a disease, may help alleviate personal shame[509] but has not been consistently shown to produce sympathetic attitudes toward those with severe alcohol and other drug problems.[510] Public surveys reveal that those who agree that alcohol and drug addiction is a disease are more likely to see these problems as severe and intractable and to doubt reports of successful recovery.[511]

One of the most effective strategies to reduce social stigma is to increase interpersonal contact between mainstream citizens and members of the stigmatized group.[512] Contact between stigmatized and non-stigmatized groups as a vehicle of stigma reduction is most effective when the contact is between people of equal status (mutual identification); is personal, voluntary, and cooperative; and is mutually judged to be a positive experience.[513] Encounters marked by such characteristics break down in-group/out-group boundaries of "us" and "them."

Social stigma is influenced by social proximity and distance. For example, community attitudes toward Oxford Houses are most positive among neighbors who live closest to these houses.[514] Reducing social distance and increasing interpersonal contact are important goals of any anti-stigma campaign. Individuals can express negative feelings toward a particular group

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506. Ginter, W. (2009). Personal Communication (Interview), June 22, 2009.

507. Fraser, S., & Valentine, K. (2008). Substance and substitution: Methadone subjects in liberal societies. New York: Macmillan.

508. Corrigan, P.W., & Penn, D.L. (1999). Lessons from social psychology on discrediting psychiatric stigma. *American Psychologist*, *54*, 765-776.

509. White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

510. Crawford, J.R., Thomson, N.A., Gullion, F.E., & Garthwaute, P. (1989). Does endorsement of the disease concept of alcoholism predict humanitarian attitudes to alcoholics? *The International Journal of the Addictions*, *24*, 71-77. Cunningham, J.A., Sobell, L.C., & Chow, V.M. (1993). What's in a label? The effects of substance types and labels on treatment considerations and stigma. *Journal of Studies on Alcohol, 54*(6), 693-699.

511. Cunningham, J.A., Sobell, L.C., & Sobell, M.B. (1996). Are disease and other conceptions of alcohol abuse related to beliefs about outcome and recovery? *Journal of Applied Social Psychology, 26*(9), 773-780.

512. Corrigan, P.W. (2002). Testing social cognitive models of mental illness stigma: The prairie state stigma studies. *Psychiatric Rehabilitation Skills*, *6*, 232-254. Corrigan, P.W., River, L.P., Lundin, R.K., Penn, D.L., Uphoff-Wasowski, K., Campion, J., et al. (2001). Three strategies for changing attributions about severe mental illness. *Schizophrenia Bulletin*, *27*, 187-195. Corrigan, P.W., & Wassel, A. (2008). Understanding and influencing the stigma of mental illness. *Journal of Psychosocial Nursing and Mental Health Services*, *27*, 187-195. Couture, S.M., & Penn, D.L. (2003). Interpersonal contact and the stigma of mental illness: A review of the literature. *Journal of Mental Health*, *12*, 291-305.

513. Couture, S.M., & Penn, D.L. (2003). Interpersonal contact and the stigma of mental illness: A review of the literature. *Journal of Mental Health*, *12*, 291-305.

514. Jason, L.A., Roberts, K., & Olson, B.D. (2005). Attitudes toward recovery homes and residents: Does proximity make a difference? *Journal of Community Psychology, 33*(5), 529-535.

while simultaneously having positive regard for individuals of that group. As such relationships increase, the sentiment toward the group weakens and dissipates. Strategies that focus on increasing public awareness of multiple pathways of long-term recovery and exposing people to others who have resolved these problems may be more effective in countering social stigma than promoting a particular conceptualization of the nature of addiction.[515]

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, religion, social class, gender roles, and intergenerational conflict. The social reform campaigns that have demonized certain drugs and classes of drug users shared common conceptual themes:

- The drug is associated with a hated subgroup of the society or a foreign enemy.
- The drug is identified as solely responsible for many problems in the culture, e.g., crime, violence, insanity.
- The survival of the culture is pictured as being dependent on the prohibition of the drug.
- The concept of "controlled" use is destroyed and replaced by a "domino theory" of chemical progression.
- The drug is associated with the corruption of young children, particularly their sexual corruption.
- Both the user and the supplier of the drug are defined as fiends, always in search of new victims; use of the drug is considered "contagious."
- Policy options are presented only in terms of total prohibition or total access.
- Anyone questioning any of the above assumptions is bitterly attacked and characterized as part of the problem that needs to be eliminated.[516]

These themes shape what Lindesmith[517] referred to as "dope fiend mythology"—a "body of superstition, half-truths and misinformation" that claims that narcotic drug use causes moral degeneracy and violent crime (rape and murder) and that drug "pushers" and drug users have a voracious appetite for infecting non-users.[518] Modern studies of the historical origins of these myths have placed their beginnings within the Federal Bureau of Narcotics' early and mid-twentieth-century

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515. Corrigan, P.W. (2002). Testing social cognitive models of mental illness stigma: The prairie state stigma studies. *Psychiatric Rehabilitation Skills, 6*, 232-254. Cunningham, J. A., Sobell, L. C., & Sobell, M.B. (1996). Are disease and other conceptions of alcohol abuse related to beliefs about outcome and recovery? *Journal of Applied Social Psychology, 26*(9), 773-780.

516. White, W. (1979). Themes in chemical prohibition. In *Drugs in perspective*. Rockville, MD: National Drug Abuse Center/National Institute on Drug Abuse.

517. Lindesmith, A.R. (1940). Dope fiend mythology. *Journal of Criminal Law, Criminology and Police Science*, *31*, 199-208.

518. It was Lindesmith's position that moral degeneracy was a consequence of drug policy rather than drug pharmacology: "If our addicts appear to be moral degenerates and thieves it is we who have made them that by the methods we have chosen to apply to their problems." Lindesmith, A. R. (1940). Dope fiend mythology. *Journal of Criminal Law, Criminology and Police Science*, *31*, 199-208.

anti-drug campaigns,[519] but similar myths were also promulgated by the leaders of nineteenth-century anti-alcohol, anti-tobacco, anti-opium, and anti-cocaine campaigns.[520] These myths about the nature of various drugs and the nature of the drug user constitute the conceptual foundation of addiction-related stigma.

The social stigma attached to methadone is rooted in a larger anti-medication bias within the history of addiction treatment.

That bias is rooted in the fact that many new drugs announced as breakthroughs in the treatment of alcohol and other addiction were later found to create problems in their own right. Alcohol, opium, morphine, cocaine, cannabis, barbiturate and non-barbiturate sedatives, amphetamines and other psychostimulants, LSD, and the so-called "minor" tranquilizers have all been claimed to have curative properties in the treatment of addiction.[521] The history of such iatrogenic insults bodes caution and close scientific scrutiny of any new drug claimed as a treatment for drug addiction.[522] But that same history also suggests that newly developed drugs of unsurpassed effectiveness might be socially and professionally rejected because of this traditional anti-medication bias.

Social stigma toward alcohol and other drug (AOD) addiction may be defined as an obstacle to problem resolution or as a strategy of problem resolution.

The stigmatization and criminalization of alcohol and other drug problems in the United States has grown over more than two centuries, as an outcome of a series of "drug panics" and resulting social reform campaigns.[523] These campaigns have generated policies of isolation, control, and punishment of drug users.[524] Stigmatization is not an accidental by-product of these campaigns. It is a reflection of policies that "unashamedly aim to make the predicament of the addict as dreadful as possible in order to discourage others from engaging in drug experimentation."[525] An outcome of this complex social history is that many addiction professionals and recovery advocates see the stigma produced by "zero tolerance" policies as a problem to be alleviated, whereas preventionists see the stigma produced by such policies as a valuable community asset.[526] A key question thus remains, "How do addiction treatment professionals, recovery advocates, and preventionists avoid working at cross-purposes in their educational efforts in local communities?" Efforts to reduce addiction-related stigma must engage multiple community groups in ways that alter community perception of the sources and solutions to alcohol and other drug problems.

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519. Reasons, C.E. (1972). *Dope, fiends and myths*. Paper presented at American Sociological Association's Annual Meeting (New Orleans, LA, August). Reasons, C.E. (1976). Images of crime and the criminal: The dope fiend mythology. *Journal of Research in Crime and Delinquency, 13*(2), 133-144.

520. White, W. (1979). Themes in chemical prohibition. In *Drugs in perspective*. Rockville, MD: National Drug Abuse Center/National Institute on Drug Abuse.

521. White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

522. White, W.L. & Kleber, H.D. (2008). Preventing harm in the name of help: A guide for addiction professionals, *Counselor*, *9*(6), 10-17.

523. Jonnes, J. (1996). *Hep-cats, narcs, and pipe dreams*. New York: Scribner. Musto, D. (1973). *The American disease: Origins of narcotic controls*, New Haven: Yale University Press.

524. White, W. (1979). Themes in chemical prohibition. In *Drugs in perspective*. Rockville, MD: National Drug Abuse Center/National Institute on Drug Abuse.

525. Husak, D.N. (2004). The moral relevance of addiction. *Substance Use and Misuse, 39*(3), 399-436.

526. There are those who take an extreme position on this, arguing that addiction is a moral problem, addicts are "bad people," stigma attached to addiction is good and should be increased, the internalized stigma attached to addiction directs most addict violence within the drug culture, and that any lowering of that stigma might create a re-direction of that violence outward toward normal citizens. Dalrymple, T. (2007). *Junk Medicine: Doctors, lies and the addiction bureaucracy*. Great Britain: Harriman House, Ltd.

Efforts to increase or reduce stigma attached to illicit drug use may have intended or unintended side-effects.[527]

Two examples illustrate this point. First, efforts to decrease illicit drug use by portraying the drug user as physically diseased, morally depraved, and criminally dangerous may inadvertently decrease help-seeking behavior by creating caricatured images of addiction with which few people experiencing AOD problems identify. Such efforts may also promote patterns of social exclusion and discrimination within local communities that block the ability of drug-dependent individuals to reenter mainstream community life. Second, community education efforts aimed at reducing stigma might increase drug use.[528] This might occur if these campaigns inadvertently normalized illicit drug use, increased non-user curiosity about drug effects, conveyed the impressions that addiction treatment is an assured safety net (available and affordable) or that recovery is easily attainable, or glamorized the recovering addict as a heroic figure within cultural contexts in which few heroic models are available.

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?"[529]

Efforts by one group to define another group as deviant can serve psychological, political, and economic interests. Simply put, stigmatizing others often serves to increase the self-esteem of the stigmatizer.[530] It elevates oneself as more worthy than the demeaned "other" and defines oneself as an upholder of community health and morality. Social scapegoating of others increases during periods in which personal esteem, security, safety, and social value are threatened. Participation in, or support of, a campaign that defines a particular group as "outsiders" serves to confirm one's own status as an "insider." Addiction professionals seeking to reduce social stigma attached to addiction/treatment/recovery must address such issues of esteem, security, safety, and social value.

Stigma has political utility. Anti-drug campaigns often mask and reflect deeper conflicts of gender, race, social class, and generational conflict. Such issues have long been manipulated for political gain. Stigma is often the delayed fruit of anti-drug campaigns waged for the benefit of those seeking to build or retain political power. Anti-stigma campaigns must address the question of how the community and its political leaders can benefit from changes in attitudes toward addiction/treatment/recovery.

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527. Room, R. (2005). Stigma, social inequality and alcohol and drug use. *Drug and Alcohol Review, 24*(2), 143-155.

528. Gerber, J. (1973). Role of the ex-addict in drug abuse intervention. *Drug Forum*, *2*(2), 105-106.

529. Weinstein, 2009, personal communication.

530. Tajfel, H., & Turner, J.C. (1979). An integrative theory of intergroup conflict. In W.G. Austin, & S. Worchel (Eds.), *The social psychology of intergroup relations* (pp. 33-48). Monterey, CA: Brooks/Cole.

Social stigma can be fed by individuals and institutions whose economic interests are served by such attitudes. Changes in attitudes can trigger shifts in cultural ownership of alcohol and other drug problems and, in that process, shift millions of dollars in ways that affect the destinies of individuals, organizations, and whole communities. For example, changes in community attitudes have in the past shifted millions of dollars between community-based addiction treatment and the criminal justice system. Such shifts influence the fate of professional careers, organizations, and in some cases, entire community economies. Similarly, what may be viewed as a problem of "not in my back yard" (NIMBY) prejudice by citizens of a particular neighborhood may actually reflect a manipulation of public opinion by hidden financial interests, e.g., developers who would profit from gentrification of a neighborhood targeted for a new addiction treatment facility.[531]

Formal studies of public resistance to locating behavioral health (addiction or mental health) treatment clinics and recovery homes in a particular neighborhood have drawn several key conclusions. Facilities that notify neighbors before their entrance into the community experience greater initial resistance than those who do not, but achieve better long-term relationships with the local community—particularly when the facility has an active strategy of neighborhood relations, e.g., open houses and community service.[532] Many facilities are well accepted in their communities, and acceptance is associated with public concepts of "social responsibility and collective care."[533] Acceptance is highest among community residents who are younger, are more economically and educationally advantaged, personally know someone in recovery, rely on education/experience rather than the media as the most important source of information, see facility residents as similar to other people, and believe local residents encountering behavioral health problems should have access to local, community-based services.[534] By enhancing positive recovery outcomes, larger facilities (eight or more residents) generate fewer neighborhood complaints related to criminal or aggressive behavior.[535]

Local opposition to the opening of a new methadone clinic has been linked to fear of increased drug use and crime, fear of potential effects on property values, objections to the profits made by private methadone clinics, and philosophical opposition to methadone as a treatment and as a perceived method of social control of communities of color.[536] This opposition can be reduced by involvement of neighborhood leaders in site planning, placement of clinics in low-traffic areas, minimization of patient visibility (e.g., providing space for socializing to minimize loitering outside

531. Joseph, H. (2009). Personal Communication (Interview), June 5, 2009.

532. Zippay AL. (2007). Psychiatric Residences: Notification, NIMBY, and Neighborhood Relations. *Psychiatric Services* 58, 109–113. http://www.psychservices.psychiatryonline.org/

533. Zippay, A. & Lee, S.K. (2008). Neighbors' perceptions of community-based psychiatric housing. *Social Service Review* 82(3), 395-417.

534. Iutcovich, M., Iutcovich, J., & Strikland, W .J. (1996). Group homes for the mentally ill? NIMBY! *Social Insight*, 11-15. Repper, J., & Brooker, C. (1996). Public attitudes toward mental health facilities in the community. *Health and Social Care in the Community*, *4*(5), 290-299.

535. Jason, L.A., Groh, D.R., Durocher, M., Alvarez, J., Aase, D.M., & Ferrari, J.R. (2008). Counteracting "Not in My Backyard": The positive effects of greater occupancy within mutual-help recovery homes. *Journal of Community Psychology, 36,* 947-958.

536. Genevie, L., Struening, E.L., KAllos, J.E., Gelier, I., Muhlin, G.L. & Kaplan, S. (1988). Urban community reaction to health facilities in residential areas: Lessons from the placement of methadone facilities in New York City. *The International Journal of the Addictions*, *23*(6), 603-616.

the clinic, encouraging early morning pickups), and demonstration that methadone clinic patients can make a positive contribution to the community (e.g., community service programs).[537]

There has been considerable rethinking of the NIMBY issue. First, NIMBY may represent, not local prejudice, but a local manifestation of a belief system that is deeply ingrained within the national culture—suggesting the need for national as well as local anti-stigma strategies.[538]

> *It is essential that attempts are made to improve tolerance not only within local populations but also within the total population. This might be achieved through a broad based educational and awareness raising strategy which is properly funded by purchasers of health and social care.*[539]

Second, as a local issue, NIMBY is being viewed as more than a manifestation of misinformation and prejudice.

> *Siting conflicts should not be seen as resulting from the unreasonable and selfish attitudes of the local population, but as a real reflection of concerns about health, safety, quality of life, political interests, rights and moral issues… There is a need to break out of adversarial approaches toward cooperation.*[540]

Siting conflicts may be minimized if preceded by efforts to promote community consensus on such key propositions as the following:

- Each family/neighborhood has a responsibility to take care of its own.
- Each neighborhood/community is responsible for developing a level of prevention, early intervention, treatment, and recovery support services commensurate with the vulnerability to AOD problems in that neighborhood.
- Neighborhoods/communities may band together to create a full continuum of prevention, early intervention, treatment, and recovery support services available to all of their members, with all neighborhoods/communities having a voice (through their elected representatives) regarding the location of such resources.
- Neighborhoods/communities have a right to be involved in planning decisions related to the siting of new addiction treatment and recovery support resources.

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537. Genevie, L., Struening, E.L., KAllos, J.E., Gelier, I., Muhlin, G.L. & Kaplan, S. (1988). Urban community reaction to health facilities in residential areas: Lessons from the placement of methadone facilities in New York City. *The International Journal of the Addictions, 23*(6), 603-616.

538. Tempalski, B., Friedman, R., Keem, M., Coopoer, H. & Friedman, S.R. (2007). NIMBY localism and national inequitable exclusion alliances: The case of syringe exchange programs in the United States, Geoforum, 38(6), 1250-1263.

539. Repper, J., & Brooker, C. (1996). Public attitudes toward mental health facilities in the community. *Health and Social Care in the Community*, *4*(5), 290-299.

540. Repper, J., & Brooker, C. (1996). Public attitudes toward mental health facilities in the community. *Health and Social Care in the Community*, *4*(5), 290-299.

- Neighborhoods/communities have a right to know the extent to which individuals served by a treatment or recovery support facility come from within or outside the neighborhood/community.
- Neighborhoods/communities have a right to know about potential problems that may arise within treatment and recovery support facilities and how such problems will be managed.
- Organizations seeking to open new treatment or recovery support facilities have a right to a fair hearing in which they can present ways in which that facility meets current legal/regulatory requirements and ways in which the facility will benefit the community via services, jobs, and economic resources.[541]

The stigma attached to methadone treatment for opioid addiction is rooted in the unique history of this drug and its close association with heroin addiction.

Methadone maintenance as a treatment for heroin addiction has grown from a handful of patients in the mid-1960s to more than 260,000 patients in 2008 (plus an additional 140,000 opioid-dependent patients being treated with buprenorphine).[542] Early attacks on methadone in the late 1960s and 1970s focused on what was perceived as "drug substitution" and concerns about methadone diversion and methadone-related deaths.[543] Since that time, attitudes toward methadone are due in great part to the fact that the least stabilized medication-assisted treatment (MAT) patients and the worst MAT programs (e.g., poorest clinical, administrative, and fiscal practices) garner nearly all of the attention the media gives to the subject of methadone treatment.

Widely disseminated myths and misconceptions about the drug methadone and methadone maintenance as an addiction treatment have flourished since its introduction and continue to affect discussions about methadone at personal, professional, public, and policy levels. In spite of the established scientific legitimacy and effectiveness of methadone maintenance treatment (see later citations), methadone patients are forced to hide their "dirty little secret" for fear of social rejection and discrimination.[544]

Attitudes toward methadone as a mechanism of recovery support are unique in the broad arena of addiction treatment. For other areas of recovery support (e.g., participation in professional continuing care groups, peer-based recovery support meetings, daily recovery support rituals not involving medication), there is consistent praise for continuing or increasing these activities over

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541. White, W. (2009). Personal Communication to Dr. Arthur Evans

542. Kleber, H. (2008). Methadone maintenance 4 decades later: Thousands of lives saved but still controversial. *Journal of the American Medical Association*, *300*(9), 2303-2305.

543. Kleber, H. (2008). Methadone maintenance 4 decades later: Thousands of lives saved but still controversial. *Journal of the American Medical Association*, *300*(9), 2303-2305.

544. Gryczynski, J. (2005). *Patient views on methadone treatment as conveyed in an online support group.* Presented at the annual meeting of the American Sociological Association, Philadelphia, PA. Murphy, S., & Irwin, J. (1992). "Living with the dirty secret": Problems of disclosure for methadone maintenance clients. *Journal of Psychoactive Drugs, 24*(3), 257-264.

time. But for the person whose recovery is supported by methadone, there is encouragement to taper off methadone and congratulations when such tapering is complete, in spite of research finding high relapse rates following such tapering and the lack of expectation among patients or staff that tapering will be successful.[545] Professional congratulations to the person who similarly reduced and ended his or her recovery support meeting participation would be unthinkable in most current recovery cultures.[546]

The stigma attached to methadone is also shaped by the expectations of methadone treatment as a system of care. Methadone advocate Walter Ginter comments on such expectations:

> *Patients, former patients, staff, policy makers, and the public expect the methadone treatment program to treat* ***addiction****. While that is a reasonable expectation, it is not what Opioid Treatment Programs (OTPs) do. OTPs treat opiate* ***dependence****, and they do it very well. Most patients on an adequate dose of methadone do not continue to use opiates. However, opiate addiction is more than dependence on opiates; it is dependence combined with a series of behaviors. OTPs (with a few exceptions) do not treat the behavioral aspects of addiction. The behavioral aspects are not treated by a medication but rather by counseling, therapy, peer recovery supports, and 12-step groups. As long as well-intentioned people go around saying that* ***"methadone is recovery,"*** *it is going to continue to be misunderstood. Methadone is a medication, a tool, even a pathway, but it is not recovery. Recovery is a way of living one's life. It doesn't come in a bottle.*[547]

Modern OTPs, under the influence of the American Association for the Treatment of Opioid Dependence, are making significant strides in moving from this narrow focus on metabolic stabilization to the broader processes involved in addiction treatment and long-term addiction recovery.[548]

Patients entering methadone treatment are as likely to be seeking respite as they are to be seeking recovery.[549] Entrance into addiction treatment can be a milestone in one's addiction career as well as a potential milestone of recovery.[550] It is the milieu of the clinic, the service relationships, and the broader menu of services in which methadone is nested that can tip the scales from the former to the latter. The social and professional perception of methadone treatment as consisting almost exclusively of the medication itself has contributed to the stigma attached to methadone and methadone maintenance treatment.

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545. Gold, M. L., Sorenson, J.L., McCanlies, N., Trier, M., & Dlugosch, G. (1988). Tapering from methadone maintenance: Attitudes of clients and staff. *Journal of Substance Abuse Treatment*, *5*, 37-44.

546. Woods, J. (2009). Personal communication, July 27, 2009.

547. Ginter, W. (2009). Personal Communication (Interview), June 22, 2009.

548. Kaltenbach, K. (2009). Personal Communication, October 12, 2009.

549. Faulpel. C. (1999). *Shooting dope*. Gainesville, FL: University of Florida Press. Johnson, P. D., & Friedman, J. (1993). Social versus physiological motives in the drug careers of methadone clinic clients. *Deviant Behavior: An Interdisciplinary Journal, 14*, 23-42.

550. White, W. (1996). *Pathways from the culture of addiction to the culture of recovery*. Center City: Hazelden.

CONCEPTUAL UNDERPINNINGS OF MAT-LINKED STIGMA

Social and professional stigma, particularly stigma associated with methadone treatment, is buttressed by a set of core assumptions or beliefs. Table 1 (beginning on the following page) outlines some of these key assumptions and beliefs and their current scientific status.

Table 1: Stigma-Linked Beliefs and Their Scientific Status

STIGMA-LINKED BELIEFS	THE SCIENCE
1. Compulsive drug use is a choice, and such voluntary choices and their consequences should not be masked within a disease rhetoric that fails to hold people accountable for their decisions and actions.	1. Volitional control over whether to use or not use a drug, and how much and for how long to use once use begins, progressively diminishes in vulnerable populations as the brain is "hijacked" via the dysregulation of normal brain functioning produced by sustained drug exposure.[551]
2. Methadone is a "crutch": it provides symptomatic treatment but fails to treat the deeper emotional and relational disturbances that led to the initiation and maintenance of heroin addiction.[552]	2. Opioid addiction is at its core more a physiological than psychological disorder,[553] but recovery rates in MAT can be compromised by high rates of co-occurring medical and psychiatric disorders.[554] MAT outcomes are enhanced when methadone is wrapped in a broader menu of medical, psychiatric, and social services.[555] The primary rationale for MAT is the following: the physiological core of opioid dependence requires a core treatment of physiological stabilization; abstinence-based treatment of opioid dependence is limited in terms of attraction, retention, and post-treatment outcomes because it lacks this core physiological treatment.

551. Dackis, C., & O'Brien, C. (2005). Neurobiology of addiction: Treatment and public policy ramifications. *Nature Neuroscience*, *8*(11), 1431-1436. Shaham, Y., & Hope, B. T. (2005). The role of neuroadaptations in relapse to drug seeking. *Nature Neuroscience*, *8*(11), 1437-1439.

552. Beschner, G.M., & Walters, J.M. (1985). Just another habit? The heroin users' perspective on treatment. In B. Hanson, G. Beschner, J.M. Walters, & E. Bovelle (Eds.), *Life with heroin: Voices from the inner city.* Lexington, MA: Lexington Books.

553. Kreek, M.J., & Reisinger, M. (1997). In J. Lowinson, P. Ruiz, R.B. Millman, & J.G. Langrod (Eds.), *Substance abuse: A comprehensive text* (pp. 822-853). Baltimore, MD: Williams and Wilkins.

554. Cacciola, J.S., Alterman, A.I., Rutherford, M.J., McKay, J.R., & Milvaney, F.D. (2001). *Drug and Alcohol Dependence*, *61*, 271-280.

555. Abbot, P.J., Moore, B., Delaney, H., & Weller, S. (1999). Retrospective analyses of additional services for methadone maintenance patients. *Journal of Substance Abuse Treatment*, *17*(1-2), 129-137. Hesse, M., & Pedersen, M.U. (2008). Easy-access services in low-threshold opiate agonist maintenance. *International Journal of Mental Health and Addiction*, *6*(3), 316-324. McLellan, A. T., Arndt, I.O., Metzger, D.S., Woody, G.E., & O'Brien, C.P. (1993). The effects of psychosocial services in substance abuse treatment. *Journal of the American Medical Association*, *269*, 1953-1959.

STIGMA-LINKED BELIEFS	THE SCIENCE
3. Methadone simply replaces one drug/addiction for another: "methadone is like the alcoholic replacing Bourbon with Scotch."[556]	3. Injected heroin produces intense euphoria, whereas oral consumption of appropriate doses of methadone in an opioid-tolerant patient produces a normalizing rather than a euphoric effect.[557] Because of this, most patients on methadone view methadone as a "medication" rather than a "drug."[558] Methadone and buprenorphine are best thought of as addiction-ameliorating medications rather than addiction-inducing drugs.[559] Methadone, like other legal medications, is subjected to quality controls (assurance of proper and consistent dosage and purity) not available with illicit opioids. Self-reports of MMT patients switching from being a "slave to heroin" to a "slave to methadone"[560] have more to do with the rigorous demands of the MMT clinic structure than with the pharmacological equivalency of heroin and methadone.
4. Methadone maintenance diminishes one's capacity to eventually achieve long-term abstinence from opiates.	4. The effect of methadone on the duration of addiction careers is unclear. Maddux and Desmond[561] found rates of long-term abstinence (defined in this study as abstinence from all opiates including methadone) of persons following MMT (9-21%) similar to those for persons treated in drug-free treatment (10-19%). The data "do not suggest that methadone impedes eventual recovery."[562] In a study published the same year, Maddux and Desmond conducted a 10-year follow-up comparison of patients with less than one year and more than one year on methadone maintenance and concluded: "methadone maintenance for 1 year or longer impedes eventual recovery from opioid dependence." They went on to say that "For many patients, however, the benefits of prolonged methadone maintenance could outweigh the possible cost of diminished likelihood of eventual recovery."[563] A definitive answer to the effects of methadone maintenance on long-term addiction and recovery careers remains unclear. Future studies must include those in stable medication-assisted treatment without secondary drug use, with indicators of progress toward global health and community integration within the definition of recovery.[564]

556. Marion, I.J. (2009). Personal communication with author, June 24, 2009.

557. Zweben, J. (1991). Counseling issues in methadone treatment. *Journal of Psychoactive Drugs*, *23*(2), 177-190.

558. McGonagle, D. (1994). Methadone Anonymous: A 12-Step program. *Journal of Psychosocial Nursing*, *32*(10), 5-12.

559. Maremmani, I., & Pacini, M. (2006). Combating the stigma: Discarding the label "substitution treatment" in favour of "behavior-normalization treatment." *Heroin Addiction and Related Clinical Problems*, *8*(4), 5-8.

560. Baldino, R.G. (2000). *Welcome to Methadonia: A social worker's candid account of life in a methadone clinic*. Harrisburg, PA: White Hat Communications.

561. Maddux, J.F., & Desmond, D. P. (1992). Methadone maintenance and recovery from opioid dependence. *American Journal of Drug and Alcohol Abuse*, *18*(1), 63-74.

562. Maddux, J.F., & Desmond, D. P. (1992). Methadone maintenance and recovery from opioid dependence. *American Journal of Drug and Alcohol Abuse*, *18*(1), 63-74.

563. Maddux, J.F. & Desmond, D.P. (1992). Ten-year follow-up after admission to methadone maintenance. *American Journal of Drug and Alcohol Abuse*, *18*(3), 289-303.

564. Betty Ford Institute Consensus Panel. (2007). What is recovery? A working definition from the Betty Ford Institute. *Journal of Substance Abuse Treatment*, *33*, 221-228. White, W. (2007). Addiction recovery: Its definition and conceptual boundaries. *Journal of Substance Abuse Treatment*, *33*, 229-241.

STIGMA-LINKED BELIEFS	THE SCIENCE
5. Low doses and short periods of methadone maintenance result in better rates of long-term recovery.	5. There is a significant relationship between methadone dosage and the odds of continued heroin use during MAT.[565] Two-thirds of methadone treatment patients receive inadequate daily dosages of methadone-dosages below 80 mg/day[566]—in spite of growing evidence that higher dosages are linked to greater reductions in the use of other opiates, greater reductions in secondary drug use (e.g. cocaine, benzodiazepines),and enhancements in global recovery outcomes.[567] The effective duration of methadone maintenance associated with the best long-term recovery outcomes is at least one year of participation.[568] In 2002, the average length of time from admission to discharge in outpatient methadone maintenance was 175 days.[569]
6. MAT patients should be encouraged to end MAT as soon as possible.	6. The majority of opioid-dependent persons leaving MAT, like their opioid-dependent counterparts leaving drug-free treatment, quickly relapse, and up to two-thirds later return to treatment—often for repeated episodes of treatment.[570] The choice to end MAT is a decision to be made by the patient in consultation with his or her physician, but it is best attempted after a substantial period of stability in MAT and with increased support during and following the tapering and cessation periods. The inability of some people to successfully taper from methadone may result more from physiological differences than from inadequate levels of personal motivation or family/social support.

SEMANTIC AND VISUAL IMAGES UNDERPINNING MAT-RELATED STIGMA

Social and professional stigma attached to opiate addiction and medication-assisted treatment (MAT) is buttressed by language. It is manifested in language that demedicalizes the status of addiction and depersonalizes and demonizes those with the disorder. Words and phrases such as *drug habit, drug abuse, dope fiend, junkie, smackhead, addict, dirty* (versus clean), *user, client* (rather than *patient*), and *substitution* all reflect such demedicalized and objectifying language.[571]

565. Caplehorn, J.R.M., Bell, J., Kleinbaum, D.G., & Gebski, V.J. (1993). Methadone dose and heroin use during maintenance treatment. *Addiction*, *88*, 119-124. Gossop, M., Marsden, J., Stewart, D., & Treacy, S. (2001). Outcomes after methadone maintenance and methadone reduction treatments: Two-year follow-up results from the National Treatment Outcome Research Study. *Drug and Alcohol Dependence, 62*(3), 255-264.

566. D'Aunno, T. (2006). The role of organization and management in substance abuse treatment: Review and roadmap. *Journal of Substance Abuse Treatment*, *31*, 221-233.

567. Gerra, G., Ferri, M., Polidori, E., Santoro, G., Zaimovic, A., & Sternieri, E. (2003). Long-term methadone maintenance effectiveness: Psychosocial and pharmacological variables. *Journal of Substance Abuse Treatment*, *25*, 1-8.

568. Simpson, D.D., & Joe, G.W. (2004). A longitudinal evaluation of treatment engagement and recovery stages. *Journal of Substance Abuse Treatment*, *27*, 99-121.

569. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2005). *Treatment Episode Data Set (TEDS): 2002. Discharges from Substance Abuse Treatment Services* (DASIS Series: S-25, DHHS Publication No. (SMA) 04-3967). Rockville, MD. Retrieved from http://wwwdasis.samhsa.gov/teds02/2002_teds_rpt_d.pdf.

570. Ball, J.C., & Ross, A. (1991). *The effectiveness of methadone maintenance treatment: Patients, programs, services and outcomes*. New York: Springer Verlag. Bell, J., Burrell, T., Indig, D., & Gilmour, S. (2006). Cycling in and out of treatment; participation in methadone treatment in NSW, 1990-2002. *Drug and Alcohol Dependence*, *81*, 55-61.

571. White, W. (2001). *The rhetoric of recovery advocacy.* Retrieved from www.facesandvoicesofrecovery.org. NAMA (1994). Client vs. patient. National Alliance of Methadone Advocates, inc, Policy Statement # 4, May, 1994. Retrieved July 28, 2009 from http://www.methadone.org/nama-documents/ps04client_v_patient.html.

> *… these terms [substitution therapy, replacement therapy] do not confer legitimacy or status on treatment… indeed the opposite is the case. All are associated with a culture of inauthenticity, and as a result, their value is permanently in question. It might be that, endemic as this language of substitution has become, new terms should be found.*[572]

The stigma attached to heroin addiction has been extended to methadone treatment and intensified through such language as *methodonia, methodonian*, and *deathadone*. Books with titles like *Methadone: A Technological Fix*[573] are popular, and the titles of professional articles proclaim "Stoned on Methadone," "Hooked: The Madness in Methadone Treatment," "Methadone: The Forlorn Hope," and "The Methdonians." Film "documentaries" are promoted through such titles as "Methadonia," and "Methadone: An American Way of Dealing,"[574] and methadone treatment is commonly portrayed as ineffective through such popular films as "Sid and Nancy," "Trainspotting," and "Permanent Midnight."[575] The language of methadone maintenance (e.g., its designation as a "substitution therapy" or "replacement therapy") has contributed to the stigma attached to MAT by reinforcing the proposition that MAT is nothing more than the replacement of an illegal high with a legal high.[576]

As noted earlier, the social stigma attached to narcotic addiction has been internalized within American drug cultures. The pecking orders within these cultures are reinforced by one's status as a *righteous dope fiend, hope-to-die dope fiend,* or *gutter hype*. Such pecking orders can be acted out within the addiction treatment milieu as well as within local drug cultures.

STREET MYTHS AND STIGMA

Stigma attached to methadone has also been infused within the illicit drug culture of the United States.[577] Beginning on the following page, Table 2 illustrates some of the methadone-related myths that pervade the American drug culture and that serve to inhibit treatment-seeking behavior and contribute to early treatment termination.

572. Fraser, S., & Valentine, K. (2008). *Substance and substitution: Methadone subjects in liberal societies.* New York: Macmillan.

573. *Nelkin*, D. (*1973*). Methadone *maintenance: A technological fix.* New York: George Braziller.

574. Joseph, H. (1995). *Medical methadone maintenance: The further concealment of a stigmatized condition.* Unpublished doctoral dissertation, City University of New York.

575. Cape, G.S. (2003). Addiction, stigma, and movies. *Acta Psychiatrica Scandinavica, 107*(3), 163-169.

576. Maremmani, I., & Pacini, M. (2006). Combating the stigma: Discarding the label "substitution treatment" in favour of "behavior-normalization treatment." *Heroin Addiction and Related Clinical Problems, 8*(4), 5-8.

577. Beschner, G.M., & Walters, J.M. (1985). Just another habit? The heroin users' perspective on treatment. In B. Hanson, G. Beschner, J.M. Walters, & E. Bovelle (Eds.), *Life with heroin: Voices from the inner city.* Lexington, MA: Lexington Books.

Table 2: Myths and Facts

THE MYTH	THE FACTS
1. The name Dolophine (a pharmaceutical brand of methadone marketed by Eli Lilly) was named for Adolf Hitler.	1. The "dolo" in Dolophine comes from the Latin dolor, meaning "pain," and the "phine" likely comes from morphine or is derived from "fin," meaning "end"; the name reflects the search for an alternative for morphine in the treatment of pain.[578]
2. Methadone is addicting.	2. Prolonged use of methadone, like that of any opioid, induces physical dependence, but there is no evidence that it induces addiction. The definitional determinants of addiction have historically included three components: 1) tolerance, 2) withdrawal, and 3) compulsive use in spite of adverse consequences. Methadone meets the first two criteria, but not the third. Since its widespread introduction, there has not been a significant population of people who compulsively pursue methadone as a primary drug choice, although the potential for emergence of such a population continues to be monitored.[579] People maintained on methadone for prolonged periods may be physically dependent upon methadone, but their addiction is to heroin or other short-acting narcotics, not methadone.
3. Methadone is harder to "kick" than heroin.	3. Acute withdrawal from methadone takes longer than acute withdrawal from heroin.
4. Methadone is nothing more than a cheap, legal high for people who cannot obtain heroin.	4. Methadone at optimal doses does not produce intoxication; it produces physiological stabilization without heroin's brief cycles of withdrawal distress and impairment related to acute intoxication.
5. Once on methadone, you can never get off of it.	5. Relapse rates are high following cessation of both heroin and methadone. Some individuals do initiate and maintain recovery with the aid of methadone and later stop using methadone as a recovery adjunct while maintaining successful long-term recovery.

578. Payte, J.T. (1991). A brief history of methadone in the treatment of opiate dependence: A personal perspective. *Journal of Psychoactive Drugs*, *23*(2), 103-107.

579. A few commentators suggested that this has recently begun to change and that trends in this area should be closely monitored.

THE MYTH	THE FACTS
6. Methadone maintenance extends the total length of addiction careers.	6. There is no scientific evidence that MAT lengthens addiction careers; addiction careers are instead influenced by factors such as age of onset of use, degree of problem severity/complexity, and the level of personal recovery capital (internal and external resources that can be mobilized to initiate and sustain recovery).
7. Methadone hurts your health, e.g., rots your bones and teeth.[580]	7. The safety of methadone, including its safety for pregnant women and the infants they deliver, has been established in innumerable scientific studies.[581] Most side-effects reported by patients are not a function of methadone per se, but are due to "inadequate dosages which precipitate withdrawal symptoms, excessive amounts of methadone, undiagnosed medical problems, or the interaction of methadone with other drugs and/or alcohol."[582] Long-term health problems, specifically dental disease, result from years of avoiding medical/dental care and are often first identified when the person enters MAT.
8. Methadone makes you fat.	8. Weight gain is common among MAT patients and is a product of increased food intake and improvement in overall health. Weight stabilizes with improved nutrition and exercise.[583]
9. MAT patients are at increased risk of developing alcohol problems.	9. Problems of secondary drug dependence are a risk factor for all persons in recovery from opioid addiction, but this risk is similar across modalities of treatment. These problems are elevated in MAT programs that use sub-optimal doses of methadone and do not clinically address the problem of co-occurring psychiatric illness and secondary drug use—particularly the "pill culture" (e.g., benzodiazepines) that permeates many methadone clinics. The lack of meaningful activities may also contribute to such secondary drug use among MAT patients.[584]

580. Beschner, G.M., & Walters, J.M. (1985). Just another habit? The heroin users' perspective on treatment. In B. Hanson, G. Beschner, J.M. Walters, & E. Bovelle (Eds.), *Life with heroin: Voices from the inner city.* Lexington, MA: Lexington Books.

581. Kreek, M.J. (1983). Health consequences associated with the use of methadone. In J. R. Cooper, F. Altman, B.S. Brown, & D. Czechowicz (Eds.), *Research on the treatment of narcotic addiction: State of the art* (NIDA Research Monograph Series; DHHS Publication No. (ADM) 83-1281; pp. 456-482). Rockville, MD: National Institute on Drug Abuse. Kreek, M. J., & Vocci, F. (2002). History and current status of opioid maintenance treatments. *Journal of Substance Abuse Treatment, 23*(2), 93-105. Center for Substance Abuse Treatment (2005). *Medication-assisted treatment for opioid addiction in opioid treatment programs* (Treatment Improvement Protocol (TIP) Series 43. DHHS Publication No. (SMA) 05-4048). Rockville, MD: Substance Abuse and Mental Health Services Administration.

582. Goldsmith, D.S., Hunt, D.E., Litpon, D.S., & Strug, D.L. (1984). Methadone folklore: Beliefs about side effects and their impact on treatment. *Human Organization*, *43*(4), 330-340.

583. Marion, I.J. (2009). Methadone: Myths and Facts (Presentation slides).

584. Best, D. (2009). Personal communication.

THE MYTH	THE FACTS
10. Methadone blunts the emotions, e.g., references to "methadone mummies."	10. MAT patients actually report increased capacity to acknowledge and express emotion.[585] The blunting of emotion might result from excessive methadone doses or secondary use of other drugs, e.g., benzodiazepines.
11. Methadone maintenance is for "losers." It is for people who can no longer "take care of business" on the streets.[586]	11. "This image of the methadone client as a 'loser,' without 'heart,' and unable to 'make it on the streets anymore,' is reinforced by the low visibility of methadone clients who are working regularly and/or have what both clients and users not in treatment describe as a 'steady hustle,' that is, regular, income-generating employment, either legal or illegal."[587]
12. Methadone is a tool of political pacification of poor communities of color.	12. Methadone makes a positive contribution to poor communities of color via reduced heroin-related deaths, reduced transmission of HIV and other diseases, reduced crime, and the social and economic assets that stable MAT patients add to their communities. Anti-methadone attitudes within the African American community must be viewed within the context of a long history of victimization of this community by scientific and medical enterprises, e.g., withholding medical treatment from 399 African American sharecroppers in the Tuskegee Syphilis Study.[588]

Sources: Hunt, D.E., Litpon, D.S., Goldsmith, D.S., Strug, D.L., & Spunt, B. (1985). "It takes your heart": The image of methadone maintenance in the addict world and the effect on recruitment into treatment. *International Journal of the Addictions, 20(*11-12), 1751-1171; Velton, E. (1992). Myths about methadone. National Alliance of Methadone Advocates, *Education Series Number 3*; Joseph, H., Stancliff, S. & Langrod, J. (2000). Methadone maintenance treatment: A review of historical and clinical issues. *Mount Sinai Journal of Medicine,* 67, 347-364.

Again, these myths inhibit help-seeking, contribute to ambivalence about treatment, and increase the likelihood of treatment disengagement of MAT patients.[589]

585. Flynn, P.M., Joe, G.W., Broome, K.M. Simpson, D.D., & Brown, B.S. (2003). Recovery from opioid addiction in DATOS. *Journal of Substance Abuse Treatment*, *25*(3), 177-186.

586. Preble, E., & Casey, J. (1969). Taking care of business—The heroin user's life on the street. *The International Journal of the Addictions*, *6*(1), 1-24. Preble, E., & Miller. T. (1977). Methadone, wine and welfare. In R.S. Weppner (Ed.), *Street ethnography* (pp. 229-248). Beverly Hills: Sage Publications.

587. Hunt, D.E., Litpon, D.S., Goldsmith, D.S., Strug, D.L., & Spunt, B. (1985). "It takes your heart": The image of methadone maintenance in the addict world and the effect on recruitment into treatment. *International Journal of the Addictions*, *20*(11-12), 1751-1171.

588. White, W., & Sanders, M. (2008). Recovery management and people of color: Redesigning addiction treatment for historically disempowered communities. *Alcoholism Treatment Quarterly*, *26*(3), 365-395.

589. Hunt, D.E., Litpon, D.S., Goldsmith, D.S., Strug, D.L., & Spunt, B. (1985). "It takes your heart": The image of methadone maintenance in the addict world and the effect on recruitment into treatment. *International Journal of the Addictions*, *20*(11-12), 1751-1171. Rosenblum, A., Magura, S., & Joseph, H. (1991). Ambivalence toward methadone treatment among intravenous drug users. *Journal of Psychoactive Drugs*, *23*(1), 21-27.

EXAMPLES OF ADDICTION/TREATMENT/RECOVERY-RELATED STIGMA/ DISCRIMINATION

Addiction-related stigma is manifested in a broad range of attitudes, behaviors, and policies. These general effects include:

- Social shunning/distancing
- Expression of disregard and contempt
- Denial of needed medication for pain (interpreting expressions of pain as drug-seeking behavior)
- Disrespect from primary health care providers and social service personnel
- Denial of basic medical services
- Denial of liver transplantation
- Discrimination via denial of governmental benefits for people with drug-related felonies, e.g., student loans, public housing, small business loans
- Denial of training/employment opportunities
- Denial of housing and homelessness services

Other effects of such stigma are reserved specifically for those persons whose treatment and recovery is supported by methadone. These more specific effects include:

- Denial of methadone support or medically-supervised withdrawal during incarceration
- Denial of access to other addiction treatment modalities and recovery support services, e.g., denial of access to many residential treatment facilities and recovery homes in spite of evidence that persons on methadone can benefit on par with non-medicated patients from such services[590]
- Denial of medication for pain on the false assumption that pain is relieved by the existing methadone dose
- Exposure to punitive, as opposed to supportive, styles of counseling

590. De Leon, G., Stains, G.L., Perlis, T.E., Sacks, S., McKendrick, K., Hilton, R., & Brady, R. (1995). Therapeutic community methods in methadone maintenance (Passages): An open clinical trial. *Drug and Alcohol Dependence, 37*, 45-57. Sorensen, J. L., Andrews, S., Delucchi, K. L., Greenberg, B., Guydish, J., Masson, C.L., et al. (2008). Methadone patients in the therapeutic community: A test of equivalency. *Drug and Alcohol Dependence*, *100*(1), 100-109.

- Denial of the right to speak and assume leadership roles in local AA/NA meetings
- Denial of detoxification services for other addictive substances in acute medical facilities (e.g., medical management of alcohol withdrawal) while being maintained on one's prescribed and stabilized dose of methadone[591]
- Loss of child custody due to participation in MAT.

The stigma attached to addiction, and to the use of methadone as a medication in particular, has influenced key clinical practices within methadone treatment since its inception in the mid-1960s. Such practices, often "legislated" by oversight bodies, further contributed to the stigma associated with methadone treatment.[592] These practices, some of which have declined due to changes in regulatory guidelines, include:

- Resistance to hiring methadone patients as counselors (e.g., requirement that they first be tapered)
- Being required to stand in line in a publicly visible area (e.g., public sidewalk) to receive methadone
- Separate bathrooms for staff and patients (required by regulation in most states)
- Refusing to admit people on the grounds of insufficient motivation
- Informal use of pejorative labels to designate readmitted patients (e.g., *frequent flyers, re-treads*)
- Lowered "horizons of possibilities" (expectations) communicated to patients
- Suboptimal methadone doses
- Lowering methadone dose or disciplinary discharge as a punishment for clinic rule violations
- Discharging patients for drug use[593]
- "Blind dosing" without patients' involvement and consent
- Stigma attached to having a high dose of methadone within the MAT subculture
- Staff pressure on patients to taper (medically withdraw) from methadone in settings with an abstinence orientation toward MAT

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591. Hettema, J., & Sorenson, J.L. (2009). Access to care for methadone maintenance patients in the United States. *International Journal of Mental Health and Addiction*. Online publication ahead of print. Retrieved from http://www.springerlink.com/content/c5v56125880u2p64/. Joe, G.W., Simpson, D.D, & Rowan-Szal, G.A. (2009). Interaction of counseling rapport and topics discussed in sessions with methadone treatment clients. *Substance Use and Misuse*, *44*, 3-17. Joseph, H., Stancliff, S., & Langrod, J. (2000). Methadone maintenance treatment: A review of historical and clinical issues. *Mount Sinai Journal of Medicine*, *67*, 347-364.

592. Anstice, S., Strike, C.J., & Brands, B. (2009). Supervised methadone consumption: Client issues and stigma. *Substance Use and Misuse, 44*(6), 794-808. O'Brien, C.P. (2008). A 50 year old woman addicted to heron: Review of treatment for heroin addiction. *Journal of the American Medical Association*, *300*, 414-321.

593. NAMA (1994). Discharge from treatment for drug use. Policy statement # 3. Retrieved May 25, 2009 from http://www.methadone.org/namadocuments/ps03discharge_from.html.

- Staff discouragement of tapering for all patients out of fear "they won't make it" in settings with a harm-reduction orientation toward MAT
- Onerous pickup schedules and restricted dispensing hours that interfere with pro-social roles, e.g., education, employment, parenting
- Supervised consumption of methadone and frontally observed urine drops (required by regulation)
- Arbitrary limits on the duration of methadone maintenance
- Discouragement/prohibition of fraternization among MAT patients
- Inadequate funding/reimbursement for ancillary health and social services, inadequate education and training of staff, and inadequate clinical supervision
- Elaborate and medically unprecedented regulatory requirements governing the use of methadone as a medication in addiction treatment.[594]

In the MAT context, these practices are often experienced by patients as a demonstration of the power held over them by professional staff. There are evidence-based training strategies and techniques that can lower stigma and its behavioral manifestations displayed by frontline addiction treatment service providers.[595]

Methadone-specific stigma can also affect methadone treatment organizations and their staff. Organizational effects can include community resistance to the opening of a new methadone treatment site, resistance to the relocation of an existing program, or political pressure to close an existing MAT site.

CONCEPTUAL UNDERPINNINGS OF A CAMPAIGN TO ELIMINATE STIGMA RELATED TO METHADONE

Anti-stigma campaigns in the addictions arena have historically focused on a core set of ideas.[596] These simply stated propositions serve as the skeletal foundation of professional and public education efforts and policy advocacy efforts. For example, the "modern alcoholism movement" launched in the 1940s laid the foundation for the rise of modern addiction treatment. This movement was built on the five "kinetic" ideas:

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594. Järvinen, M., & Andersen, D. (2009). The making of the chronic addict. *Substance Use and Misuse*, *44*, 865-885. Rosenbaum, M. (1995). The demedicalization of methadone maintenance. *Journal of Psychoactive Drugs*, *27*, 145-149.

595. Andrews, S.B., Sorenson, J.L., & Delucchi, K. (2004). *Methadone stigma and the potential effect of sensitivity training for drug treatment staff*. Presented at the annual meeting of the American Public Health Association, November 6-10, Washington, DC. Hayes, S.C., Bissett, R., Roget, N., Padilla, M., Kohlenberg, B.S., Fisher, G., et al. (2004). The impact of acceptance and commitment training and multicultural training on the stigmatizing attitudes and professional burnout of substance abuse counselors. *Behavior Therapy, 35*(4), 821-835.

596. Johnson, B. (1973). *The alcoholism movement in America: A study in cultural innovation.* Unpublished doctoral dissertation, University of Illinois, Urbana, Illinois.

Modern Alcoholism Movement: Kinetic Ideas

1. Alcoholism is a disease.
2. The alcoholic, therefore, is a sick person.
3. The alcoholic can be helped.
4. The alcoholic is worth helping.
5. Alcoholism is our No. 4 public health problem, and our public responsibility.[597]

New Recovery Advocacy Movement: Core Ideas

The "new addiction recovery advocacy movement" is also based on a set of core ideas:

1. Addiction recovery is a reality in the lives of hundreds of thousands of individuals and families throughout the United States.
2. There are many paths to recovery, and all are cause for celebration.
3. Recovering and recovered people are part of the solution to alcohol and other drug problems.
4. Recovery flourishes in supportive communities.
5. Recovery is voluntary.
6. Recovery gives back what addiction has taken from individuals, families, neighborhoods, and communities.[598]

Any movement to destigmatize methadone treatment and the broader arena of medication-assisted recovery will need its own set of core ideas. The propositions listed below constitute a menu of propositions from which such a set of ideas might be formulated and condensed to form operational slogans.

THE NATURE OF ADDICTIVE DISORDERS

- The initial decision to consume or not consume alcohol, tobacco, and other drugs is, in most but not all circumstances, a voluntary choice.[599]

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597. Anderson, D. (1942). Alcohol and public opinion. *Quarterly Journal of Studies on Alcohol*, *3*(3), 376-392. Mann, M. (1944). Formation of a National Committee for Education on Alcoholism. *Quarterly Journal of Studies on Alcohol, 5*(2), 354-358.

598. White, W. (2006). *Let's go make some history: Chronicles of the new addiction recovery advocacy movement.* Washington, D.C.: Johnson Institute and Faces and Voices of Recovery.

599. Dr. Karol Kaltenbach and others point out that multiple factors compromise the volitional intent involved in initial drug consumption: early age of onset, introduction of drug use by an older authority figure, coerced use as a dimension of sexual victimization, and drug-saturated peer environments can all compromise the voluntary quality of such choices.

- This initial choice may be consciously influenced by moral or religious values,[600] but more often reflects behavior directed at normal needs and experiences, e.g., pleasure seeking, social inclusion, personal identity, relief from physical/emotional discomfort or family distress.
- The long-term consequences flowing from continued drug exposure have more to do with factors of personal and environmental vulnerability than with personal morality or strength of character.
- Addiction is a brain disease that manifests itself in the loss of volitional control over drug-seeking, drug use, and its consequences.
- This loss of volitional control is related to neurobiological changes in the brain that place the need for the drug above other physical needs and social responsibilities.
- Addiction is not a problem easily resolved through "willpower"; addiction is, by definition, a failure of such power.
- Nearly two-thirds of American families have direct experience with alcohol or drug addiction.[601]

NATURE OF ADDICTION RECOVERY

- Recovery from alcohol and drug addiction requires personal persistence and sustained family and social support; recovery flourishes in supportive communities.
- Recovery-supportive communities are good for everyone; all citizens reap dividends from successful long-term recovery.
- Long-term addiction recovery is a living reality for hundreds of thousands of individuals and families.
- Recovery from alcohol and drug addiction requires personal persistence and sustained family and social support; recovery flourishes in supportive communities.
- There are multiple pathways of long-term recovery, and all are cause for celebration.
- Providing addiction treatment and sustained recovery support services is more effective and a more prudent use of community resources than the strategy of mass incarceration.

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600. Husak, D.N. (2004). The moral relevance of addiction. *Substance Use and Misuse, 39*(3), 399-436.

601. Peter D. Hart Research Associates/Coldwater Corporation (2004). *2004 Peter D. Hart Research Associates/Coldwater Corporation, Faces and Voices of Recovery public survey.* Washington, DC: Faces and Voices of Recovery.

MEDICATION AND RECOVERY

- Some opioid-dependent individuals with sustained abstinence from short-acting opioids and social support may achieve long-term recovery (brain recovery and psychosocial recovery) without the aid of medications, while other drug-dependent individuals will require prolonged, if not lifelong, use of medications that reduce drug craving and facilitate full biopsychosocial/spiritual functioning.
- Stabilizing medications are available for the treatment of severe opioid addiction, and even more effective medications may become available in the future.
- Opiate addiction is a "brain-related medical disorder" that is treatable with effective medications; other professionally directed medical, psychological, and social services; and peer-based recovery support services.[602]
- Appropriate daily dosages of methadone suppress cellular craving for narcotics, prevent withdrawal symptoms (the opioid abstinence syndrome); block the effects of heroin use; and provide a platform or metabolic stability upon which full physical, emotional, and cognitive recovery can be achieved.[603]
- The dosages required to achieve these effects vary from individual to individual.[604]
- Appropriate oral doses of methadone do not produce an experience of sedation or euphoria in individuals who are opiate-tolerant;[605] stabilized patients not using other substances are capable of experiencing the full range of emotional and physical pain.[606]
- Methadone maintenance combined with needed ancillary medical, psychological, and social services is the most effective method of treating chronic heroin addiction.[607]
- The effectiveness of methadone maintenance treatment has been reviewed and affirmed by major health research and policy bodies, including the National Institute on Drug Abuse, the American Medical Association, the American Society of Addiction Medicine, the Institute of Medicine, the National Academy of Sciences, the National Institute on Health Consensus Panel, and the Office of National Drug Control Policy,[608] as well as the World Health Organization and other governmental health policy groups around the world.

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602. Joseph, H., Stancliff, S., & Langrod, J. (2000). Methadone maintenance treatment: A review of historical and clinical issues. *Mount Sinai Journal of Medicine*, *67*, 347-364. White, W. (2009). The mobilization of community resources to support long-term addiction recovery. *Journal of Substance Abuse Treatment, 36*, 146-158.

603. Joseph, H., Stancliff, S., & Langrod, J. (2000). Methadone maintenance treatment: A review of historical and clinical issues. *Mount Sinai Journal of Medicine*, *67*, 347-364.

604. Joseph, H., Stancliff, S., & Langrod, J. (2000). Methadone maintenance treatment: A review of historical and clinical issues. *Mount Sinai Journal of Medicine*, *67*, 347-364.

605. Marion, I.J. (2009). Methadone: Myths and Facts (Presentation slides); Murray, J.B. (1998). Effectiveness of methadone maintenance for heroin addiction. *Psychological Reports*, *83*, 295-302. Zweben, J. (1991). Counseling issues in methadone treatment. *Journal of Psychoactive Drugs*, *23*(2), 177-190.

606. Joseph, H., Stancliff, S., & Langrod, J. (2000). Methadone maintenance treatment: A review of historical and clinical issues. *Mount Sinai Journal of Medicine*, *67*, 347-364.

607. Rettig, R.A., & Yarmolinsky, A. (1995). *Federal regulation of methadone treatment*. Washington, D.C.: National Academy Press. National Consensus Development Panel on Effective Medical Treatment of Opiate Addiction. (1998). Effective medical treatment of opiate addiction. *Journal of the American Medical Association, 280*(22), 1936-1943.

608. White, W., & Coon, B. (2003). Methadone and the anti-medication bias in addiction treatment. *Counselor*, *4*(5), 58-63.

- These collective reviews conclude that orally administered methadone can be provided for a prolonged period at stable dosages with a high degree of safety and without significant effects on psychomotor or cognitive functioning.[609]
- Methadone is the safest medication available to treat heroin addiction in pregnant women.[610]
- These reviews also confirm that MAT delivered at optimal dosages by competent practitioners: 1) decreases the death rate of opiate-dependent individuals by as much as 50%; 2) reduces the transmission of HIV (four-to-six-fold reductions), hepatitis B and C, and other infections; 3) eliminates or reduces illicit opiate use (by minimizing narcotic craving and blocking the euphoric effects of other narcotics); 4) reduces criminal activity; 5) enhances productive behavior via employment and academic/vocational functioning; 6) improves global health and social functioning; and 7) is cost-effective.[611]
- Methadone-related deaths are related primarily to the diversion of methadone prescriptions for pain rather than from methadone used as a treatment for addiction or illegally diverted from methadone clinics/patients.[612]
- Methadone as a pharmacological adjunct in the treatment of opioid addiction, like insulin in the treatment of diabetes, is a corrective therapy, not a curative therapy. It is effective only when it is consumed on a sustained daily basis. Relapse rates are high following cessation of methadone maintenance, and mortality rates rise following medical withdrawal.[613] People should not be precipitously encouraged to end such treatment.[614] Patients choosing to taper (end methadone maintenance) should receive increased program support, including educational guidance on the tapering decision, relapse prevention, and recovery strengthening techniques; support for changes in diet and exercise; continued professional and peer-based support; close post-tapering monitoring; and, if and when needed, early re-intervention and re-initiation of methadone maintenance.[615]
- After more than 40 years' experience with methadone maintenance, primary addiction to methadone within the illicit drug culture occurs but still constitutes a rare phenomenon. Methadone has value in the illicit drug culture primarily for the self-medication of opiate-dependent individuals who cannot procure heroin or other short-acting opioids, or who cannot gain access to methadone maintenance programs.[616]

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609. Kreek, M.J., & Vocci, F. (2002). History and current status of opioid maintenance treatments. *Journal of Substance Abuse Treatment, 23*(2), 93-105. National Consensus Development Panel on Effective Medical Treatment of Opiate Addiction. (1998). Effective medical treatment of opiate addiction. *Journal of the American Medical Association, 280*(22), 1936-1943.

610. Joseph, H., Stancliff, S., & Langrod, J. (2000). Methadone maintenance treatment: A review of historical and clinical issues. *Mount Sinai Journal of Medicine*, *67*, 347-364. Kreek, M.J., & Vocci, F. (2002). History and current status of opioid maintenance treatments. *Journal of Substance Abuse Treatment, 23*(2), 93-105.

611. Clausen, T., Ancherson, K., & Waal, H. (2008). Mortality prior to, during and after opioid maintenance treatment (OMT): A national prospective study. *Drug and Alcohol Dependence*, *94*, 151-157. Corsi, K.F., Lehman, W.K. & Booth, R.E. (2009). The effect of methadone maintenance on positive outcomes for opiate injection drug users. *Journal of Substance Abuse Treatment*, *37*, 120-126. Kreek, M.J., & Vocci, F. (2002). History and current status of opioid maintenance treatments. *Journal of Substance Abuse Treatment, 23*(2), 93-105. National Consensus Development Panel on Effective Medical Treatment of Opiate Addiction. (1998). Effective medical treatment of opiate addiction. *Journal of the American Medical Association, 280*(22), 1936-1943.

612. Paulozzi, L.J., Budnitz, D.S., & Xi, Y. (2006). Increasing deaths from opioid analgesics in the United States. *Pharmacoepidemiology and Drug Safety*, *15*(9), 618-27. Sims, S.A., Snow, L.A., & Porucznik, C.A. (2006). Surveillance of methadone-related adverse drug events using multiple public health data sources. *Journal of Biomedical Information, 40*(4), 382-389. Webster, L.R. (2005). Methadone-related deaths. *Journal of Opioid Management*, *1*, 211-217.

613. Davoli, M., Bargagli. A.M., Perucci C.A., Schifano, P., Belleudi, V., Hickman, M., et al. (2007). Risk of fatal overdose during and after specialist drug treatment: The VEdeTTE study: A national multi-site prospective cohort study. *Addiction*, *102*, 1954-1959. Joseph, H., Stancliff, S., & Langrod, J. (2000). Methadone maintenance treatment: A review of historical and clinical issues. *Mount Sinai Journal of Medicine*, *67*, 347-364.

614. Cooper, J.R. (1992). Ineffective use of psychoactive drugs: Methadone is no exception. *Journal of the American Medical Association*, *267*(2), 281-282.

615. Gold, M.L., Sorenson, J.L., McCanlies, N., Trier, M., & Dlugosch, G. (1988). Tapering from methadone maintenance: Attitudes of clients and staff. *Journal of Substance Abuse Treatment*, *5*, 37-44. Joseph, H., Stancliff, S., & Langrod, J. (2000). Methadone maintenance treatment: A review of historical and clinical issues. *Mount Sinai Journal of Medicine*, *67*, 347-364.

616. Hunt, D.E., Litpon, D.S., Goldsmith, D.S., Strug, D.L., & Spunt, B. (1985). "It takes your heart": the image of methadone maintenance in the addict world and the effect on recruitment into treatment. *International Journal of the Addictions*, *20*(11-12), 1751-1171. Joseph, H., Stancliff, S., & Langrod, J. (2000). Methadone maintenance treatment: A review of historical and clinical issues. *Mount Sinai Journal of Medicine*, *67*, 347-364.

STIGMA AS A BARRIER TO RECOVERY

- The stigma attached to addiction, treatment, and recovery injures those—the patient and family—directly affected by these experiences, as well as the larger community.[617]
- The stigma attached to addiction perpetuates the very problem it is intended to discourage.
- There is substantial shame embedded in the experience of addiction; people in need of addiction treatment should not be shamed for seeking the very resources that may be critical to their long-term recovery. Yet entry into methadone maintenance, because of the attached stigma, is often experienced as failure as a person—and even failure as an addict.[618]

AN ADDICTION/TREATMENT/RECOVERY CAMPAIGN

The stigma attached specifically to methadone maintenance is embedded at the community level within a larger body of negative attitudes toward illicit drug use, drug addiction, addiction treatment, and addiction recovery. The best stigma-reduction campaign would aim at general attitudes toward addiction, treatment, and recovery, with a sub-campaign that specifically addresses stigma related to methadone and other medications.

Guiding Vision: 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."[619]

Campaign Goals: To:

- Change public and professional views on methadone maintenance treatment from a practice that just "substitutes one drug/addiction for another" to a scientifically validated medical practice capable of saving and transforming lives and enhancing the quality of community life.[620]
- Change the view of methadone maintenance within the heroin using community from that of a passive process of "giving up" to an assertive lifestyle of active recovery.[621]
- Put a face and voice on medication-assisted recovery by conveying the stories of individuals and families in long-term addiction recovery and explaining the role MAT programs are playing in enhancing the health and safety of particular neighborhoods.

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617. Lavack, A. (2007). Using social marketing to de-stigmatize addictions: A review. *Addiction Research and Theory, 15*(5), 479-492.

618. Hunt, D.E., Litpon, D.S., Goldsmith, D.S., Strug, D.L., & Spunt, B. (1985). "It takes your heart": the image of methadone maintenance in the addict world and the effect on recruitment into treatment. *International Journal of the Addictions*, *20*(11-12), 1751-1171.

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

620. Joseph, H. (1995). *Medical methadone maintenance: The further concealment of a stigmatized condition*. Unpublished doctoral dissertation, City University of New York.

621. Hunt, D.E., Litpon, D.S., Goldsmith, D.S., Strug, D.L., & Spunt, B. (1985). "It takes your heart": the image of methadone maintenance in the addict world and the effect on recruitment into treatment. *International Journal of the Addictions*, *20*(11-12), 1751-1171.

- Portray the contributions of people in medication-assisted recovery to their communities through their family support, educational, occupational, and community service activities.
- Encourage participation of MAT providers in local community activities to improve the public image of the methadone clinic/patient.

A Menu of Potential Strategies: Listed below is a menu of potential strategies that might be refined and implemented to achieve the goals outlined above. These potential strategies, developed by the Philadelphia Department of Behavioral Health and Mental Retardation Services, are offered as a starting point for local discussion.

RECOVERY REPRESENTATION AND COMMUNITY MOBILIZATION

1. Ensure broad representation of people in medication-assisted recovery and professional representation from medication-assisted treatment providers within policy advisory groups and technical work groups.
2. Create an organizational structure to lead a campaign to define and promote methadone-assisted recovery initiation and recovery maintenance (sobriety, global health, and citizenship) as a morally honorable pathway of long-term recovery. Try to elevate the legitimacy and visibility of the campaign via local political sponsorship, e.g., a mayoral commission.
3. Encourage the inclusion of people in medication-assisted recovery in existing recovery support fellowships and develop/support recovery fellowships specifically for people in medication-assisted recovery, e.g., Methadone Anonymous.[622] (The encouragement and use of recovery support groups has significantly increased in MAT clinics in the United States, and the M.A.R.S. Project in New York City is receiving many requests for information about such support groups).[623]
4. Encourage the development of venues through which people in recovery (particularly current or former MAT patients) can perform acts of service to those seeking recovery, as well as broader acts of community service.
5. Create a Mayor's Task Force to assist in the planned relocation of existing treatment programs or site locations for new programs—proactive management of "Not in my backyard" (NIMBY) resistance by establishing principles for locating addiction treatment and recovery support resources. (This may be best addressed within a Task Force that explores siting issues for all

622. Gilman, S.M., Galanter, M., & Dermatis, H. (2001). Methadone Anonymous: A 12-step program for methadone maintained heroin addicts. *Substance Abuse*, *22*(4), 247-256. Glickman, L. Galanter, M., Dermatis, H., & Dingle, S. (2006). Recovery and spiritual transformation among peer leaders of a modified Methadone Anonymous group. *Journal of Psychoactive Drugs*, *38*(4), 531-533. Obuchowsky, M., & Zweben, J.E. (1987). Bridging the gap: The methadone client in 12-Step programs. *Journal of Psychoactive Drugs*, *19*(3), 301-302.

623. Ginter, W. (2009). Personal Communication (Interview), June 22, 2009.

health and social service programs.) Those principles identified earlier in this article might serve as beginning points for discussion.

6. Explore ways to use patient writing, art, drama, music, dance, and videography as vehicles of education on medication-assisted treatment and recovery.

COMMUNITY EDUCATION

1. Design, implement, and evaluate a public education campaign (similar to the drunk driving media campaigns of the 1980s and California's Methadone Saves Lives campaign) through a Mayor's task force that would include representatives from all major local media outlets.
   - Put mainstream faces and voices on addiction, treatment, and recovery.
   - Include the faces of family members whose lives have been influenced by addiction treatment and recovery.
   - Embed information on opioid addiction and medication-assisted recovery in mainstream healthcare outlets, e.g., medical clinics, pharmacies, health fairs, etc.
   - Target those zip codes experiencing the most severe opioid dependence problems.
2. Establish interdisciplinary work groups who, as part of the Mayor's task force, will be charged with: developing/disseminating articles, pamphlets, and training materials on medication-assisted recovery aimed at reaching local lay and professional audiences; placing articles in media outlets; and immediately responding to inaccurate portrayals of medication-assisted treatment/recovery by the media.[624]
3. Develop *and support* a corps of people who, through interviews and speeches, can put a positive face and voice on medication-assisted recovery; recruit people in medication-assisted recovery for participation in Storytelling Training;[625] organize speaking teams of professionals and recovery advocates who can speak to local groups; and develop information packets to support the work of these teams.
4. Develop brief information packets and oral presentations that can be used by outreach workers to challenge "street mythologies" on methadone and other medications used in the treatment of addiction.

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624. Jones, D.J. (2002). Methadone patient advocacy—letters to the media helps change attitudes. *Methadone Today, 6*(9), 4. Joseph, H. (1995). *Medical methadone maintenance: The further concealment of a stigmatized condition*. Unpublished doctoral dissertation, City University of New York.

625. Storytelling Training is a skills-based training for persons in recovery to assist them in developing their recovery stories and gaining confidence in refining and presenting those stories in public and professional forums.

PROFESSIONAL EDUCATION

1. Create opportunities for people throughout the treatment system to be exposed to the faces and voices of people in long-term medication-assisted recovery.
2. Ensure that all staff and volunteers working within addiction treatment are educated about the effectiveness of medication-assisted treatment, myths versus scientific findings on methadone maintenance, the importance of proper dosing in medication-assisted treatment, comparative outcomes of medication-assisted and drug-free treatment, and post-treatment outcomes for both medication-assisted and drug-free treatment.[626] On a monthly basis, provide a centralized orientation for all new staff entering the Philadelphia treatment system, with the above information included.[627]
3. Provide structured opportunities for staff exchanges between medication-assisted and drug-free treatment programs, exchanges that include opportunities for formal and informal interactions with staff and patients. Ensure admission policies/practices that allow people in medication-assisted treatment to receive collateral treatment and recovery support services from other addiction treatment and recovery support organizations, e.g. the integrated treatment of methadone patients for co-occurring alcohol dependence within alcoholism treatment programs.[628]
4. Ensure that scientifically grounded information on medication-assisted recovery is included in local addiction studies programs and within the in-service training programs of all funded addiction treatment programs.
5. Integrate information on medication-assisted addiction treatment into the curricula of local medical schools, and host an annual training for local physicians and psychiatrists on the use of medications in the treatment of addiction and best practices for pain management in patients being treated for addiction with methadone or buprenorphine. Provide information and resources on persons in medication-assisted recovery for use in psychology, social work, and allied health professional training programs.
6. Ensure that all managed care behavioral health organizations (MCBHOs) include an adequate number of panel providers with experience or training in the area of medication-assisted opioid treatment and pain management.

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626. Kang, S-Y, Magura, S., Nwakese, P., & Demsky, S. (1997). Counselor attitudes in methadone maintenance. *Journal of Maintenance in the Addictions*, *1*(2), 41-58.

627. Recent studies—Abraham, A.J., Ducharme, L. & Roman, P. (2009). Counselor attitudes toward pharmacotherapies for alcohol dependence, *Journal of Studies of Alcohol and Drugs*, *70*, 628-635—suggest that counselors are quite receptive to pharmacological adjuncts in the treatment of alcohol dependence when given proper training on the use of such adjuncts. The extent to which these findings would extend to receptiveness to methadone with similar training is unclear.

628. Kipnis, S.S., Herron, A., Perez, J., & Joseph, H. (2001). Integrating the methadone patient in the traditional addiction inpatient rehabilitation program—problems and solutions. *The Mount Sinai Journal of Medicine*, *68*(1), 28-32.

7. Host a training on medication-assisted treatment for key criminal justice personnel to police (via police academy), jail staff, attorneys, and judges—particularly criminal court, drug court, and family court judges. This is of paramount importance to the well being pregnant and parenting women.[629]
8. Provide orientation to treatment and medication-assisted treatment to key city officials—both political leaders and department heads and supervisors.

NON-STIGMATIZING, RECOVERY-FOCUSED LANGUAGE

1. Conduct an audit of the core concepts and language of addiction treatment and recovery, purging language that perpetuates myths, misunderstandings, and stigma and replacing that language with words and phrases that convey respect and hope for multiple pathways of long-term recovery.
2. Purge language that grew out of moral models of addiction, e.g., *dirty/clean*. Clarify the meaning of *drug free, abstinence, sobriety,* and *recovery*. Promote the Betty Ford Institute's (BFI) three-component consensus definition of recovery: sobriety, global health, and citizenship, in which "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."[630]
3. Use the BFI recovery definition in order to achieve conceptual clarity and expose the abstinence-versus-methadone debate as a false dichotomy. The issue is not one of method but of mission: full recovery and a meaningful life in the community—by any means necessary. By the BFI definition of recovery, there are individuals who are abstinent from all psychoactive drugs who do not meet the criteria for recovery and individuals maintained on methadone who do meet those criteria. Recovery is more than the elimination of alcohol and drugs from an otherwise unchanged life, and recovery is more than medication-facilitated metabolic stabilization. The BFI definition of recovery may help address stigma and discrimination at both professional and public levels.
4. Encourage members of Methadone Anonymous to advocate for a change in the name of the fellowship to something that does not equate methadone with heroin (e.g., Medication-Assisted Recovery Anonymous). Many other anonymous fellowships include in their names the drug or activity to be given up, e.g., Narcotics Anonymous, Cocaine Anonymous, Crystal

629. Dr. Karol Kaltenbach (2009). Personal communication.

630. Betty Ford Institute Consensus Panel. (2007). What is recovery? A working definition from the Betty Ford Institute. *Journal of Substance Abuse Treatment, 33*, 221-228.

Meth Anonymous, Gamblers Anonymous. This is not the explicit intent of Methadone Anonymous, but that is what is currently being conveyed via its name.[631]

5. Develop a policy statement on language and stigma for dissemination to all DBH/MRS-funded treatment programs.

6. Cease describing methadone maintenance in terms that suggest the equivalency of heroin and methadone, such as *substitution therapy* or *replacement therapy*, and the use of the term *detoxification* to describe tapering (methadone is a medication, not a toxic substance). Replace such language with words and phrases that convey the link between methadone and long-term recovery, e.g., *medication-assisted treatment* and *medication-assisted recovery*.[632]

> *Dole and Nyswander would never prescribe a "substitute" for heroin. When Dole used the term "replacement therapy," he meant it in a physiological sense—that there were impairments in the central nervous system caused by the continuous use of opiates and that methadone could correct but not cure these impairments. He did not mean that methadone replaces heroin as a legal intoxicant. Methadone is a corrective medication, not a substitute for heroin.*[633]

TREATMENT PRACTICES

1. Change institutional identities of medication-assisted treatment providers from "methadone clinics" to "addiction recovery centers"—as is currently being attempted in the State of New York. This would signal the institutional mission of recovery and identify medication as one of many tools that can help people achieve that goal. Encourage patients to participate in a broad menu of professionally directed and peer-based recovery support activities at the clinic or at a closely located recovery support center. Build strong cultures of recovery—a recovery haven, refuge, sanctuary—within or in proximity to existing clinics. Expose the least stabilized patients to role models who have achieved successful stabilization and long-term recovery.[634]

2. Explore regulatory and funding policy changes that would allow addiction treatment and recovery support services to be provided in less stigmatized sites, e.g., mainstream health care delivery institutions, schools, churches, neighborhood centers, and other community service organizations.[635] Expand medical methadone maintenance-methadone provided to the most stabilized patients via a monthly visit to a private health practitioner.[636]

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631. NAMA (1995). On the name of Methadone Anonymous. National Alliance of Methadone Advocates, inc, Policy Statement # 6, May, 1994. Retrieved July 28, 2009 from http://www.methadone.org/namadocuments/ps06ma_name.html.

632. Maremmani, I., & Pacini, M. (2006). Combating the stigma: Discarding the label "substitution treatment" in favour of "behavior-normalization treatment." *Heroin Addiction and Related Clinical Problems*, *8*(4), 5-8. Joseph, H. (2009). Personal Communication (Interview), June 5, 2009. Ginter, W. (2009). Personal Communication (Interview), June 22, 2009.

633. Joseph, H. (2009). Personal Communication (Interview), June 5, 2009.

634. Until opioid treatment programs as a whole develop such vibrant cultures of recovery, they will be vulnerable to collective charge that they have done little more than transition their patients from an active life of hustling and getting high to a life of "methadone, wine and welfare". Prebble, E., & Miller. T. (1977). Methadone, wine and welfare. In R. S. Weppner (Ed.), *Street ethnography* (pp. 229-248). Beverly Hills: Sage Publications.

635. Radcliffe, P., & Stevens, A. (2008). Are drug treatment services only for 'thieving junkie scumbags'? Drug users and the management of stigmatized identities. *Social Science and Medicine, 67*(7), 1065-1073.

636. King, V.L., Burke, C., Stoller, K.B., Neufeld, K.J., Peirce, J., Kolodner, K., et al. (2008). Implementing methadone medical maintenance in community-based clinics: Disseminating evidence-based treatment. *Journal of Substance Abuse Treatment*, *35*, 312-321. Marion, I.J. (2009). Personal communication with author, June 24, 2009.

3. Prohibit the exclusion of persons on methadone or buprenorphine by any organization receiving funding. This would add authority to existing regulations prohibiting organizations receiving city/state/federal dollars to discriminate against MAT recipients. Any communication from public authorities regarding such prohibition should also include the reminder that MAT recipients are protected under the American Disabilities Act.
4. Improve the public image of methadone clinics by upgrading the exterior and maintenance of the physical plant; improve the quality of the clinic visit experience by upgrading the quality and maintenance of the interior physical plant of methadone clinics. Increase the use of "warm welcome" procedures, including casual dress by security personnel.
5. Facilitate greater integration between harm reduction (HR) projects (needle-exchange programs), medication-assisted treatment, and medication-focused recovery advocacy, e.g., pilot programs that infuse clearer recovery options into HR, such as recovery-focused outreach workers available at needle exchange sites.

LOCAL, STATE, AND FEDERAL POLICY ADVOCACY

1. Encourage the development of medication-assisted recovery advocacy groups, e.g., local chapters of the National Alliance for Medication-Assisted Recovery (NAMA Recovery), and/or the inclusion of people in medication-assisted recovery within existing or emerging recovery advocacy organizations.
2. Encourage medication-assisted treatment providers to continue their advocacy activities through state Associations for the Treatment of Opioid Dependence and the American Association for the Treatment of Opioid Attendance (AATOD) related to federal, state, and local policy/regulatory/funding/research issues.
3. Seek alignment of policies, funding guidelines, and mechanism and regulatory guidelines to support recovery-focused treatment of chronic opioid dependence.
4. Encourage individuals and organizations to seek full legal redress in response to acts of discrimination related to medication-assisted treatment and recovery.

EVALUATION

1. Establish a baseline of community attitudes and practices—among citizens, addiction treatment providers, allied health and human service providers, criminal justice personnel, child protection personnel, and members of recovery support fellowships—for use in evaluating this overall plan over time.

The implementation of some of these strategies will require a vanguard of people in methadone-assisted recovery to involve themselves in a larger recovery advocacy movement. Efforts must be made to encourage and support that vanguard.

SUMMARY

The social stigma attached to addiction, addiction treatment, and addiction recovery exists at cultural, institutional, interpersonal, and intrapersonal levels.[637] This stigma is particularly intense for those with histories of heroin self-injection and who are in medication-assisted treatment. Efforts to lower stigma and discrimination for those in addiction treatment and recovery, particularly those in MAT, will need to operate at all these levels. Commitment at the highest levels is essential to the mobilization of citizens to support policies and programs that support long-term personal and family recovery from alcohol and other drug problems, and to provide services to youth aimed at breaking intergenerational cycles of alcohol and other drug problem transmission in individuals, families, and neighborhoods. It is essential to engage multiple stakeholders in formulating strategies to reduce social stigma related to addiction treatment and recovery and to take special action to reduce the stigma related to medication-assisted treatment and recovery. Through this process, we will use one guiding principle: *There are multiple pathways of long-term addiction recovery, and all are cause for celebration.*

637. Woll, P. (2005*). Healing the stigma of addiction: A guide for treatment professionals.* Chicago, IL: Great Lakes Addiction Technology Transfer Center.

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