Recovery-Oriented Methadone Maintenance

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"I am not my disease, and I am not my medication." --Methadone Patient, 2009

Dedication: Dr. Ed Senay & Lisa Mojer-Torres, J.D.

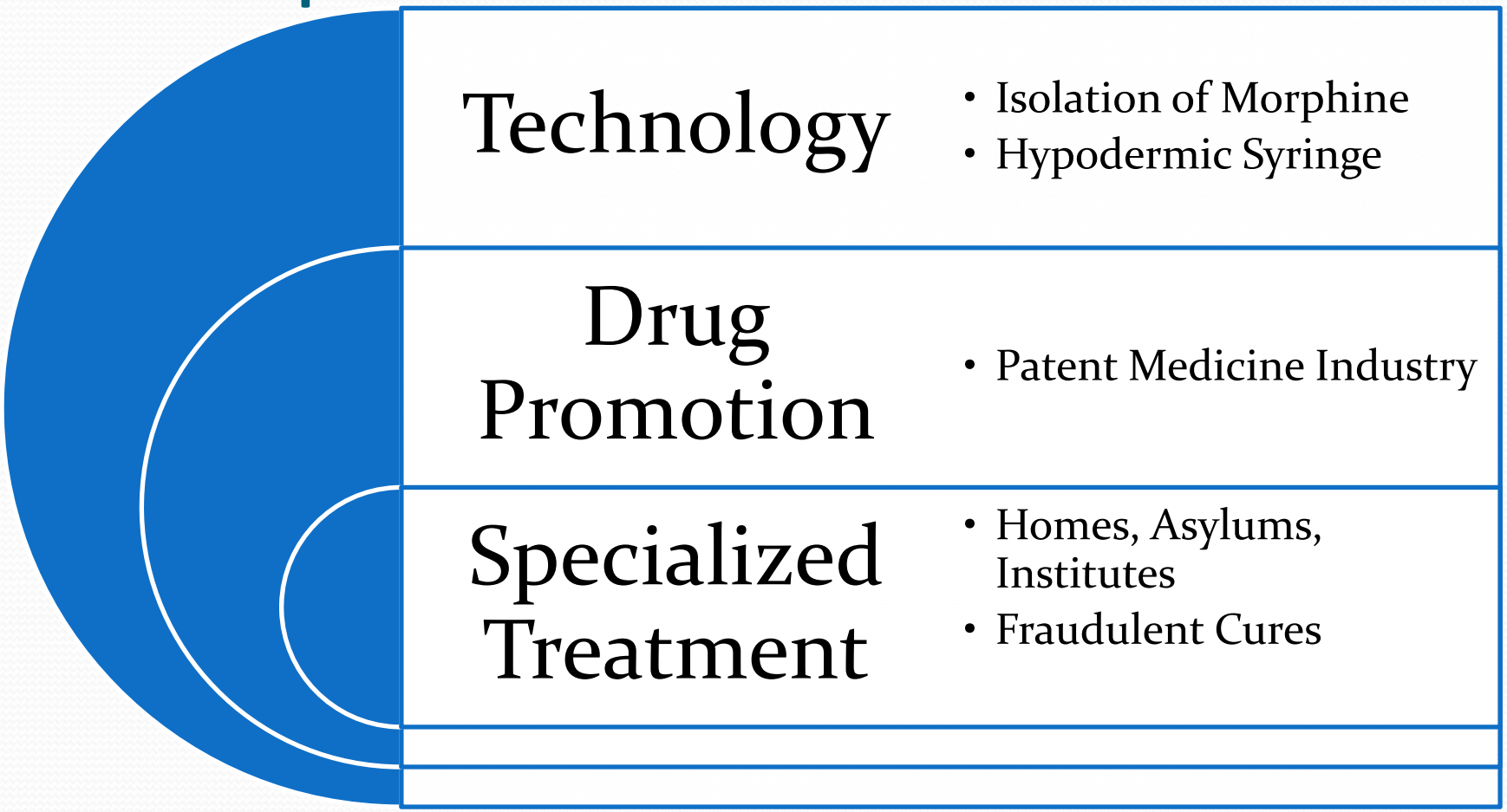
Presentation Goals

- Describe changes in recovery-oriented practices within the evolution of methadone maintenance treatment (MMT)
- Identify at least 3 concerns that led to call for increased recovery orientation of MMT
- Define Recovery-oriented MMT (and what it is NOT)
- List at least 5 service ingredients that distinguish ROMM
- Discuss strategies to reduce social and professional stigma attached to MMT and broader arena of medication-assisted treatment and recovery

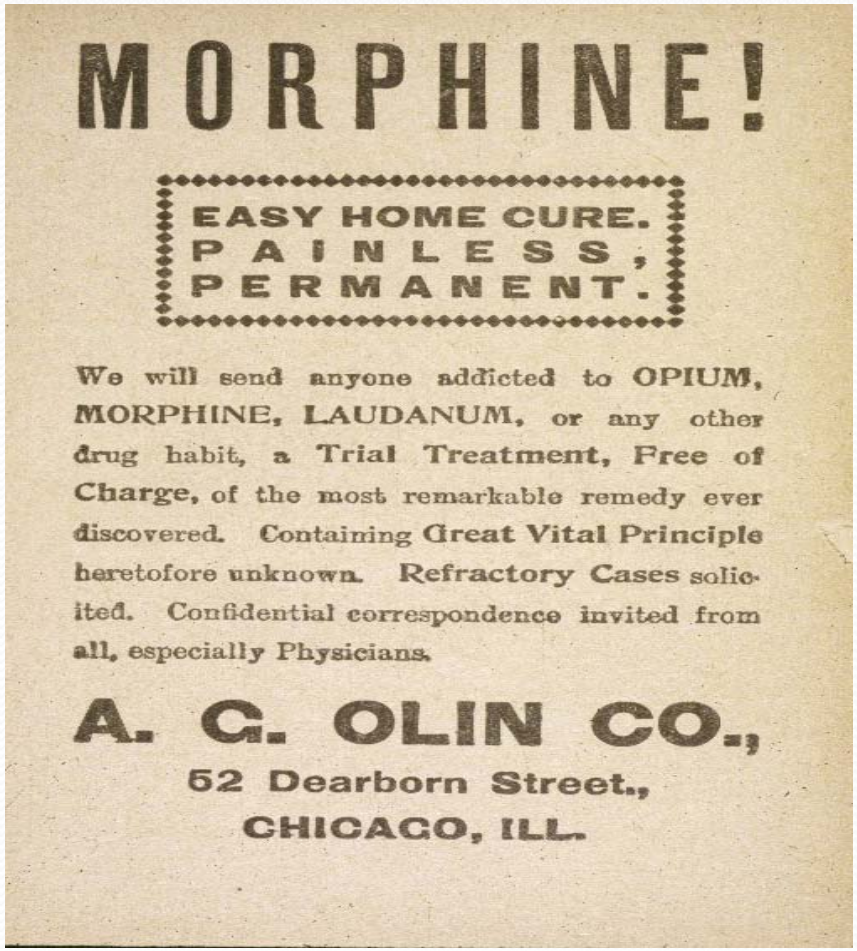
A Note on Note-taking & Resources

- The information reviewed in this webinar is detailed with full citations in the 2010 White & Mojer-Torres monograph, *Recovery-oriented Methadone Maintenance*, and the other publications noted on the last slides. All are available for free download at www.williamwhitepapers.com
- The slide of this presentation will be posted for download.

The Historical Context for the Development of MMT



Iatrogenesis:
Harm in the Name of Help



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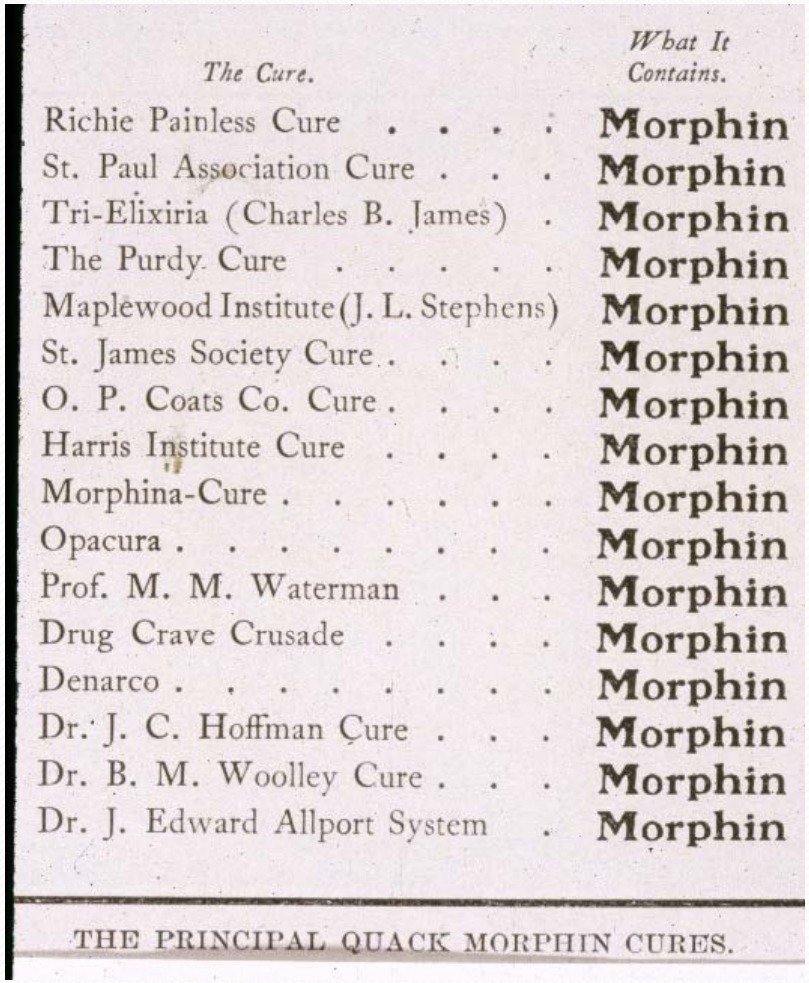
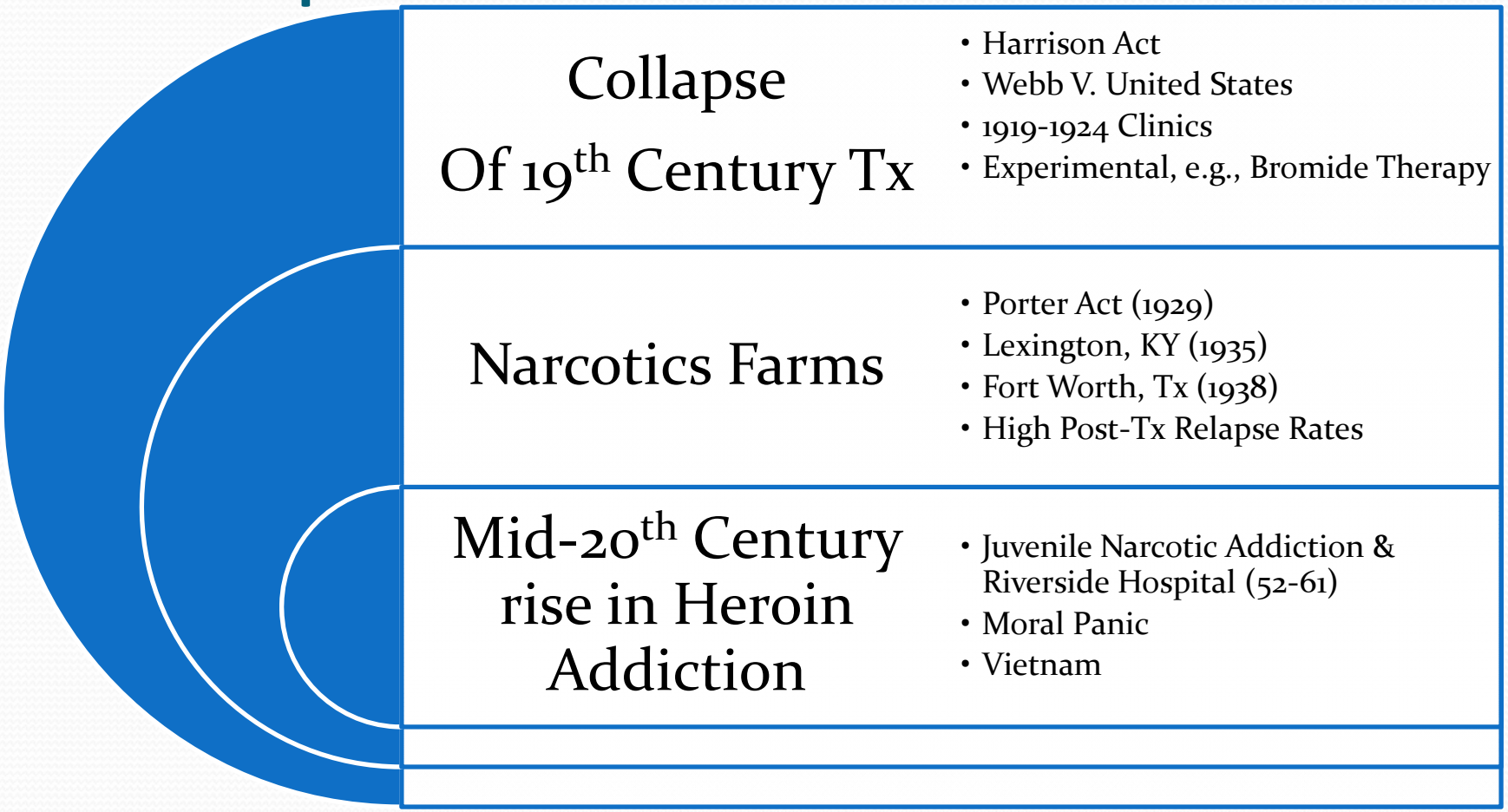


The Cure.	*What It Contains.*
Richie Painless Cure	Morphin
St. Paul Association Cure	Morphin
Tri-Elixiria (Charles B. James)	Morphin
The Purdy Cure	Morphin
Maplewood Institute (J. L. Stephens)	Morphin
St. James Society Cure	Morphin
O. P. Coats Co. Cure	Morphin
Harris Institute Cure	Morphin
Morphina-Cure	Morphin
Opacura	Morphin
Prof. M. M. Waterman	Morphin
Drug Crave Crusade	Morphin
Denarco	Morphin
Dr. J. C. Hoffman Cure	Morphin
Dr. B. M. Woolley Cure	Morphin
Dr. J. Edward Allport System	Morphin

THE PRINCIPAL QUACK MORPHIN CURES.

The Historical Context for the Development of MMT



Therapeutic Pessimism Sparks Search for New Tx Approaches

- Psychoanalysis and Psychotherapy
- Serum Therapy, ECT, Psychosurgery, LSD, ECT, Aversion Therapy,
- Grassroots community counseling clinics (1950s)
- Mutual Aid via Addicts Anonymous (1947) & Narcotics Anonymous (1953; near death in 1959; limited growth)
- Therapeutic Communities (Synanon, 1958)
- Civil Commitment
- Narcotic Antagonists (e.g., naloxone, naltrexone)
- Methadone Maintenance

MMT Pioneers

- Dr. Vince Dole
- Dr. Marie Nyswander
- Dr. Mary Jeanne Kreek
- MMT as a Patient-centered medical treatment
- Role of Psychosocial Support
- Dole/Nyswander AA/NA involvement

Recovery Orientation of Early MMT

- Rapid Access to Tx
- Emphasis on Therapeutic Alliance
- Blockade Doses (80-120 mgd)
- No limits on duration of MMT
- Programs for special populations
- Recovering staff as role models

Regulation & Mass Expansion

Federal and widely varying state and local regulation of MMT

Rapid Growth under Nixon Administration

- 22 patients in 1965
- 400 patients in 1968
- 36,000 patients in NYC in 1972
- 80,00 patients in US in 1976

Present

- 260,000 MMT patients in 2008 (in 1,132 certified OTPs)
- Estimates of persons addicted to opiates in US range between 750,000-1,000,000

Regulation & Mass Expansion

Decreased recovery orientation via

- Shift in focus from personal recovery to reduction of social costs, e.g., crime and infectious disease
- Widely varying quality of MMT clinics
- Reduction of average methadone doses to sub-therapeutic levels
- Decreased duration of MMT with increased pressure to end medication maintenance
- Erosion of ancillary services, particularly in 1980s
- Preoccupation with mechanics of dosing rather than larger process of recovery

Early Methadone Critics Alleged:

- Substitutes one addictive drug for another
- Conveys permissiveness towards drug use
- Fails to address characterological or social roots of heroin addiction
- Impairs patients cognitively, emotionally, behaviorally
- Is a tool of racial oppression
- Is financially exploitive
- Public/professional stigma left MMT & patients in a cultural limbo

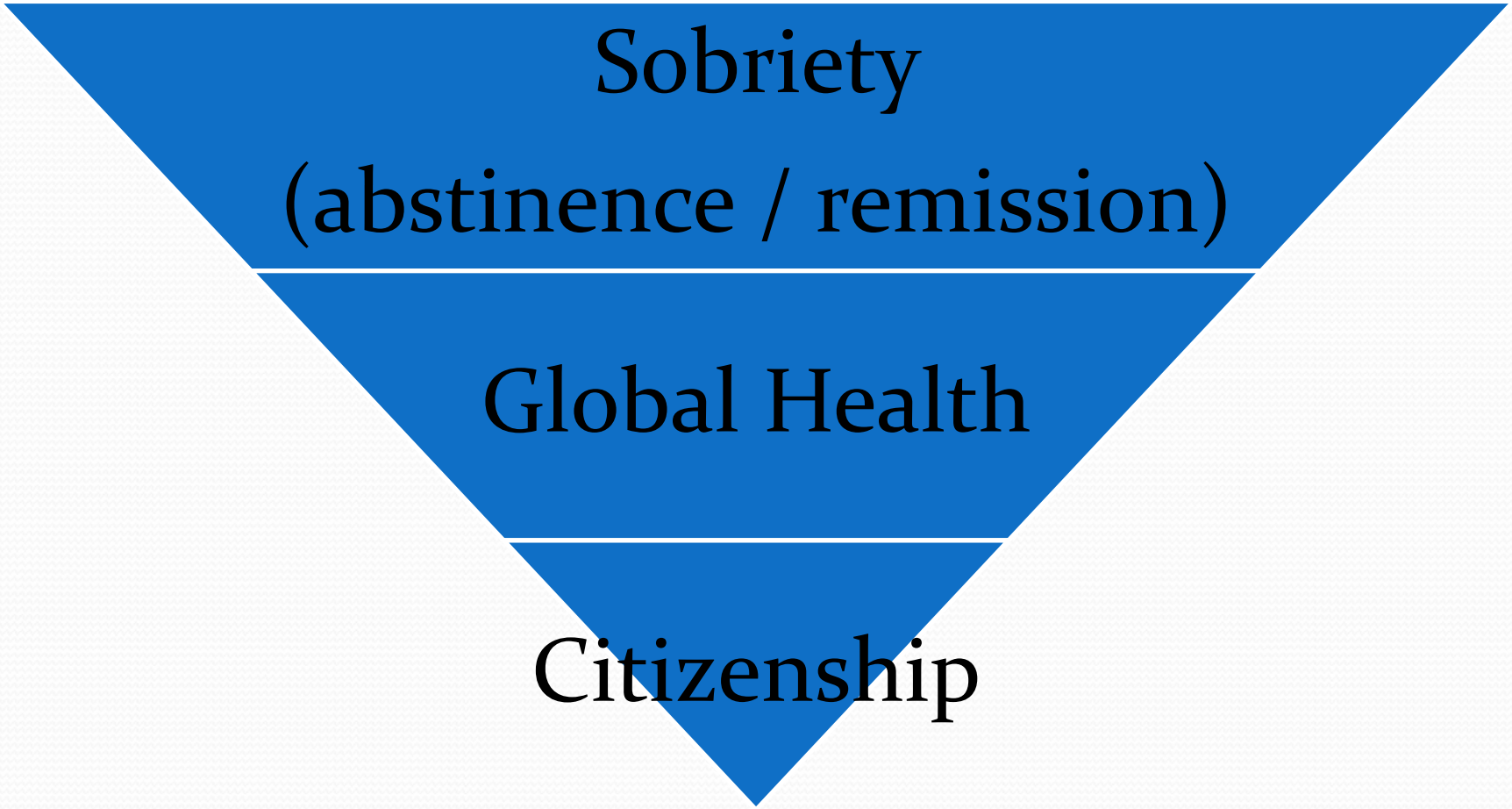
Revitalization of MMT (1990-present)

- Reaffirmation of MMT effectiveness by leading scientific, professional and governmental bodies
- Advocacy efforts of MMT patients (e.g., AFIRM, NAMA-R)
- Expansion of pharmacotherapy choice, e.g., buprenorphine
- Expansion of MMT in private sector following erosion of public funding
- Focus on elevating quality of MMT
- Accreditation of Opioid Treatment Programs

Setting the Stage for ROMM

- Understanding Opioid Addiction as a Chronic Disorder
- Emergence of Recovery as New Organizing Paradigm in Addictions Field
- Efforts to Extend Acute & Palliative Models of Care to Models of Assertive Recovery Management (RM) & Recovery-Oriented Systems of Care (ROSC)
- Questions of Implications of RM & ROSC to Medication-Assisted Treatment (MAT)

Emerging Recovery Definition



Limbo Status of the MM Patient

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" to be managed and governed rather than retrieved, nurtured and healed (Bamber, 2010).

Recovery & Medication Status
BFI Consensus Statement

"…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" (Journal of Substance Abuse Treatment, 2007)

Growing Professional Consensus

For MAT patients who achieve recovery via these three dimensions, continued participation in medication maintenance or eventual tapering and recovery without medication support represent varieties of recovery experience and matters of personal choice, not the boundary of passage from the status of addiction to the status of recovery. (White, 2012, Journal of Addictive Diseases)

This perspective requires:

Distinguishing

- Physical Dependence
- Tolerance, Withdrawal

- Addiction
- Craving, obsession, compulsion

Distinguishing

- Drugs that compromise recovery status

- Medications that may enhance recovery stability

This Perspective Requires Challenging Methadone Myths, such as

1.
   - Methadone is "addicting."
   - Stabilized MM patients do not meet criteria for DSM-IV opioid dependence
2.
   - Methadone is intoxicating and impairing
   - Stabilized patients do not experience intoxication from optimal doses of methadone nor are they impaired by the medication
3.
   - Those on lower doses of methadone and shorter duration of methadone have better long-term recovery prospects
   - Studies suggest the exact opposite

ROMM Defined

ROMM is an approach to 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 recovery.

Problems of MMT addressed by ROMM include:

- Low rate of attraction (6-15 years before 1st admission; 22 years prior to achieving recovery stability)
- Problems of access (25-50% of persons on waiting list drop out before admission)
- Subclinical dosing and dose manipulations or administrative discharge for rule infractions
- Continued drug use while in MMT related to withdrawal distress (often linked to subtherapeutic doses of methadone), dysphoric emotional states, pleasure-seeking, and impulsive responses to social opportunities to use (Best et al., 1999).

Problems of MMT addressed by ROMM include:

- Low rate of sustained engagement (24% drop-out in first 60 days; 60.2% drop-out by one year)
- High rate of drop-out/discharge without planned tapering (11% as planned; 45% drop out; 17% transferred; 13% AD; 15% other)
- High rate of post-discharge relapse (50%+ in first year after discharge; most in first 30 days) and high mortality risk (8-20 times greater than patients in treatment)
- Low linkage to indigenous recovery communities or alternative recovery support institutions
- Role of self-stigma and professional/social stigma attached to MMT as obstacle to community reintegration

ROMM does NOT:

- Raise the bar of admission to MMT
- Set arbitrary limits on dosage or duration of MMT
- Impose pressure for patients to end MMT
- Force counseling or peer support services on patients who do not want or would not benefit from them
- Extrude patients who do not adopt the goal of full recovery
- Impose remission/recovery criteria on MMT patients different that those applied to other patients with SUDs.

ROMM Does Seek To:

- Attract people at earlier stages of problem development

  -Assertive community education & outreach
- Ensure rapid access to MMT / Resolve obstacles to Tx

  -Streamlined intake and assertive waiting-list management
- Assure safe, individualized, optimum dose stabilization

  -Close medical monitoring during induction; individualized dosing philosophy, signs of clinical deterioration prompt rapid dose re-evaluation & need for ancillary services
- Engage and retain individuals/families in a sustained recovery support process

ROMM Does Seek To:

- Utilize assessment processes that are global, family-centered, strengths-based and continual

  -Examples, ASI, GAIN
- Transition each patient from a professionally-directed treatment plan to a patient-directed recovery plan

  -Former aimed at remission (-); latter aimed at recovery (+)
- Expand the service team

  -e.g., primary care physicians, family therapists, peer specialists
- Shift the service relationship from a directive expert model to a recovery partnership/consultation model

ROMM Does Seek To:

- Assure minimum/optimum duration of MMT

  -Minimum 1-2 years (Patients who taper after 1-2 years have better long-term post-Tx outcomes than those ending treatment before 1 year)

  -Option of prolonged, if not lifelong, maintenance

  -Focus is on recovery not duration of medication support
- Expand the service menu & imbed services in vibrant culture of recovery

  -Expanded menu of ancillary services

  -C of A to C of R; RC infused treatment milieu

  -*Recovery is contagious*
- Extend delivery of recovery support services into the community

  -e.g., Co-location; delivery of recovery support services outside the clinic

ROMM Does Seek To:

- Link patients/families to recovery community support resources

  -Assertive versus passive linkage procedures
- Provide post-treatment monitoring, support and, if and when needed, early re-intervention.

  -Recovery checkups & re-engagement
- Evaluate MMT using proximal and distal indicators of long-term personal and family recovery

  -Moving beyond short-term HR outcomes (mortality, crime, disease) to long-term measures of global health, quality of life and community contribution
- Conduct anti-stigma campaigns aimed at patients, families, staff, allied professionals and the community.

Strategies to Address Professional/Social Stigma

1. Protest
2. Education
3. Contact

Missing Voices in MMT Discussions

- Patients and Families
- Need for vanguard of individuals/families to put faces and voices on medication-assisted recovery
- There are signs that this vanguard is emerging
- That vanguard needs to be engaged in RM/ROSC/ROMM design and evaluation efforts

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