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Recovery for Patients, Families and Communities

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Good Morning. It is a great honor to be with you again and to be part of this distinguished panel.

It is quite fitting that today we honor the life and contributions of Lisa Mojer-Torres. More than a decade ago, I met Lisa at the recovery summit in St. Paul, Minnesota that launched the new recovery advocacy movement in the U.S. At the time, I was still emotionally steeped in the anti-medication rhetoric of the 1960's therapeutic communities and 12-step treatment programs. Lisa challenged every pre-conceived notion I had about methadone maintenance treatment (MMT) and the broader arena of medication-assisted treatment (MAT). The transformation of my views on MAT came not from previously unknown facts that Lisa conveyed, but from the power and nobility of her life and service work. She was for me, as she was for thousands of others, the living proof of the role medication could play in long-term addiction recovery. Future generations will view what Lisa Mojer-Torres did for medication-assisted recovery from opioid addiction on par with what Rosa Parks did for the civil rights movement and Marty Mann did for the modern alcoholism movement. That recognition will be most deserving.

I have been asked this morning to share the essence of Lisa and my co-authored papers and interviews on recovery-oriented methadone maintenance (ROMM). Our major conclusions are reflected in the following sequence of propositions.

1. Key recovery-focused practices of the original model of MMT diminished during the mass replication of MMT in the United States, resulting in:
 - Subclinical methadone dosages
 - Arbitrary limits on duration of MMT

- A shift in emphasis from therapeutic engagement to behavioral control (policing), regulatory compliance (paperwork) and income generation (profit)
 - Erosion of ancillary medical/psychiatric/social/legal services
 - Decreased presence of recovery role models and recovery culture within the MMT milieu, and
 - Diminished contact between MMT leaders and indigenous recovery mutual aid groups (We should recall that Dr. Vincent Dole served on the Board of Trustees of Alcoholics Anonymous and Dr. Marie Nyswander served on the Board of Directors that guided early efforts to start Narcotics Anonymous in New York City before NA as we know it today was even founded).
2. Early political, public and professional criticisms of person-focused MMT were deflected by reframing MMT as a strategy to reduce public harm and social costs (via crime and disease prevention) rather than as a medical treatment aimed at personal addiction recovery.
 3. What Lisa and I described as recovery-oriented methadone maintenance (ROMM) attempts to renew MMT as a person-centered medical treatment aimed at long-term personal and family recovery from opioid addiction. Reduction of social harm is viewed as a beneficial by-product of person-centered MMT—not its primary purpose.
 4. Historically acrimonious and increasingly stale debates between harm reductionists and “drug-free” treatment advocates are giving way to new experiments in collaboration. All HR should include partial and full recovery as viable strategies of HR; all treatment and recovery support services should encompass the prevention and reduction of personal and social harm. These approaches constitute varied strategies of reaching different populations and reaching the same individuals at different stages of their addiction and recovery careers. To the radical abstentionists, we argued that you cannot recover if you are dead and interventions are needed to reduce the enduring burdens people bring with them into the recovery process. To the radical harm reductionists, we argued that recovery was the ultimate harm reduction strategy, that the choice of recovery needed to be available, visible and encouraged at all stages of addiction, and that all interventions need to be evaluated based on what they could add to people’s lives, not just what they could subtract.

5. ROMM frames medication-assisted recovery within the emerging consensus definitions of *recovery* as sobriety (or remission), improvements in global health and community re-integration. Continued medication maintenance or tapering and sustaining recovery without medication represent different styles of recovery, NOT the boundary of transition into recovery. Medication-assisted treatment, like any addiction treatment, does not in itself constitute recovery, but medication-assisted treatment should not by itself constitute a disqualification of recovery status.
6. The increased recovery orientation of MAT will require substantial changes in service practices within American Opioid Treatment Programs (OTPs) and office-based Treatment (OBT), including
 - a) enhanced early engagement and retention strategies,
 - b) expansion of the current service menu for patients and families,
 - c) assertive linkage to indigenous recovery community resources (recovery mutual aid groups, recovery community centers, recovery homes, recovery schools, recovery ministries), and
 - d) assertive post-treatment monitoring (recovery check-ups), support and, if needed, early re-intervention for all persons ending MMT regardless of discharge status for a minimum of five years.
7. The major obstacle to increased recovery orientation of MAT is the continued social and professional stigma attached to such treatment—including internalized stigma within MAT programs.
8. The most effective strategy for reducing such stigma is not public or professional education but increased social contact with individuals/families whose long-term recoveries have been aided by medication and with whom the public can identify. It is not enough to change how people perceive and think about medication-assisted treatment of opioid addiction; we must change how people feel about such treatment. To achieve the latter, we must move from the language of science to the “language of the heart”—from the arena of studies to the arena of stories. A thousand more brain slides of addiction hijacked brains will not end the stigma attached to MAT, but such stigma would fade as individuals (like Lisa Mojer-Torres) and families step into the light to share their stories of the role medication played in their long-term recovery from addiction.

9. Creating such contact will require identifying and mobilizing a vanguard of people in medication-assisted recovery who are called to, temperamentally suited for and whose life circumstances allow a recovery advocacy role.
10. That potential vanguard exists. (Lisa and I were unsure of its existence and size until we posted notices in Opioid Treatment Programs (OTPs) and on MAT advocacy sites asking for people in medication-assisted recovery to review our work. We were overwhelmed for months with phone calls and emails from patients, with many requests of how they could become involved in advocacy activities.) It is time for that hidden vanguard to be called to service.
11. As we welcome patients into partnership and leadership roles within treatment programs and the recovery advocacy movement, we must also welcome their family members. The voices of family members have also been historically excluded from discussions of treatment policy and treatment practices. I just completed and posted an interview with Lisa's husband, Rolando Torres, who offers a poignant family perspective on medication-assisted treatment and recovery. Since its posting, I have been inundated with responses from other family members seeking a venue to share their experience. It is time their voices were heard.
12. ROMM ultimately extends from the patient to the family to the community. OTPs are imbedded in communities who have been severely wounded by addiction and related problems. There is a need for a community-wide healing process—what might well be called *community recovery*. OTPs, their patients and families can be part of this community healing process.

Lisa and I did not expect everyone to agree with these propositions, but we hoped our writings would stir fresh discussions within addiction treatment and local recovery community organizations. They can be downloaded for free at www.facesandvoicesofrecovery.org or at www.williamwhitepapers.com.

The addictions field is rapidly shifting from traditional pathology and intervention paradigms to a recovery paradigm as its organizing center. I wish each of you and your programs Godspeed on your journey into this recovery frontier.

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