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Recovery Orientation in Methadone Maintenance: A Definitional Statement

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In 2010, Lisa Mojer-Torres and I co-authored a monograph entitled *Recovery-oriented Methadone Maintenance*. Since its publication, the application of the concept of recovery to the methadone maintenance treatment (MMT) context has been both warmly embraced and at times hotly debated. Interestingly, proposals for recovery-oriented methadone maintenance (ROMM) have been criticized from both poles in the often vitriolic debates about MMT. Criticisms stem from differences in definitions of recovery and the resulting criteria for recovery status and fears that the ROMM concept will result in unanticipated harm to opioid treatment programs (OTPs), harm reduction programs, recovery mutual aid groups, and to those served by these organizations. Could a newly proposed concept produce such harm? Of course. There is a long tradition of harm in the name of help within the history of addiction treatment, and any concept, no matter how well-intended, may be hijacked and corrupted to support purposes for which it was not intended. Those possibilities underscore the importance of conceptual clarity and the rigorous testing of new ideas and service approaches.

Although the ROMM philosophy and related changes in service practices were detailed in the 2010 monograph with extensive scientific citations, there appears to be the need for a short simple declaration of what ROMM is and is not. Such a declaration would ideally help ground continued discussion. This brief paper offers such a statement. The ROMM concept will continue to evolve through continued dialogue and evolving scientific findings on its central elements, but the statement below will provide a starting point for discussion reflecting the views of the authors who first proposed it.

ROMM Defined

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 (White & Torres, 2010). Recovery supports within the ROMM framework span the stages of pre-recovery identification and engagement, recovery initiation and stabilization, the transition to recovery maintenance (during medication maintenance and, for those who choose to taper, throughout and following the tapering process), and the enhancement of quality of personal/family life in long-term recovery (White, 2009, 2012).

ROMM is not....

Any time a revived or new conceptual framework is introduced that challenges existing service practices, there are innumerable efforts to reject or colonize the concept to minimize its threat and to protect prevailing personal, professional, and institutional interests. There are also quite legitimate attempts to challenge new or revised frameworks that may be ineffective or even harmful. It is hoped that ROMM will be critically evaluated both conceptually and at a service practice level. Achieving that will require maintaining the clarity of precisely what is being proposed via the ROMM concept. All kinds of fears have been expressed to the author about the overt and hidden agendas within the ROMM proposal. So, to begin with,

ROMM is NOT an effort to:

- 1) Raise the motivational bar of admission to MMT.
- 2) Limit methadone dosages or the duration of MMT.
- 3) Define methadone cessation as a criterion for recovery status.
- 4) Pressure MMT patients to end medication maintenance.
- 5) Deny or discourage MMT patient access to other treatment modalities or harm reduction information or services.
- 6) Mandate counseling or peer support services for stabilized patients who do not need or want such services.
- 7) Extrude patients who do not adopt the goal of full recovery.
- 8) Deny stabilized patients access to interim or office-based treatment.
- 9) Impose remission/recovery criteria on MMT patients different than the remission/recovery criteria applied to all persons with substance use disorders (White, 2012).

Put simply, the goal of ROMM is not to eliminate long-term MMT or other historically defined harm reduction programs. The focus is instead on elevating the quality of such services by ensuring that full recovery (with or without medication support) is a visible and supported option at all stages of service engagement.

ROMM Philosophy Does...

The proposal for ROMM was an attempt by the authors to 1) personally and professionally assert the scientific, clinical, and cultural legitimacy of MMT as a treatment for opioid addiction, 2) retrieve, celebrate, and extend the best recovery-linked practices within the history of MMT, 3) reframe MMT within emerging models of sustained recovery management and within larger recovery-oriented systems of care, and 4) outline service practices that could elevate support for long-term recovery of MMT patients and their families.

ROMM asserts that MMT patients who achieve remission from all substance use disorders and who demonstrate improvement in global health and community re-integration meet the criteria of recovery status regardless of whether they decide to sustain long-term methadone maintenance or taper and sustain their recoveries without medication support. (In short, recovery is defined by functional status rather than medication status.) ROMM further argues that, to fulfill this recovery vision, recovery-oriented service practices must be retrieved that were lost

during the regulation and mass dissemination of MMT, and that new recovery-oriented service practices must be added to existing and future opioid treatment programs (OTPs).

ROMM Service Practices Do...

In preparing the ROMM monograph, the authors reviewed countless scientific studies on opioid addiction treatment and recovery and talked with innumerable MMT patients and their family members, MMT patient advocates, and leading experts on the treatment of opioid addiction. What emerged was a sharpened vision of the kinds of service practices that could be implemented, evaluated, and refined to enhance long-term recovery outcomes from opioid addiction.

ROMM as a Model of Sustained Recovery Management Advocates:

Recovery Representation: Inclusion of current and former recovering patients and their family members within all governance and advisory bodies and within paid and volunteer treatment and recovery support teams; infusion of people in recovery within the treatment milieu—hope via living proof of potential for long-term recovery.

Attraction Strategies: Community education, assertive “street” and institutional outreach, guided service linkage, elimination of personal/environmental obstacles to service initiation/retention—all aimed at shortening addiction careers and extending recovery careers.

Accelerated Access: Streamlined intake; assertive management of waiting lists for service entry; access to interim medication maintenance.

Optimum Dose Stabilization: Individualized optimal dosing with rapid response to needed dose adjustments over time; no restrictions on duration of medication maintenance; no use of medication dose as reward or punishment for compliance or non-compliance; clinical re-evaluation in response to continued drug use; rapid identification of sub-therapeutic dosing; access to office-based dosing for highly stabilized patients in long-term recovery.

Global Assessment Protocol: Phased, multi-dimensional clinical assessment processes that are comprehensive, strengths-based, continual; assessment of family, social network, and community recovery capital; strong emphasis on patient/family self-assessment.

Recovery Planning: Phased transition from professionally directed treatment plans to patient-directed recovery plans; mobilization of community resources to assist implementation of personal recovery plans.

Retention Strategies: Emphasis on therapeutic alliance with each patient/family; assertive responses to continued drug use; prompts following missed appointments; assertive follow-up to re-engage all patients who drop out of treatment.

Recovery-focused Partnership with Patients: Shift from expert to partnership/recovery consultant relational model; focus on relationships based on mutual respect; focus on care and support rather than control.

Multidisciplinary Recovery Support Team: Expansion of service team to include greater involvement of primary care physicians, mental health professionals, and peer recovery coaches; greater use of ASAM-certified physicians in patient/family education; greater use of current former patients in volunteer recovery support roles.

Culture of Recovery: Develop a strong recovery culture within the OTP milieu, e.g., Patient Council; visible recovery role models; recovery-focused activities/rituals, language, symbols, values, art, music.

Recovery-focused Patient/Family Education: Structured patient/family education as a visible component of treatment induction process.

Expanded Professional Service Menu: Broadened array of ancillary services with personal focus on how particular services can be uniquely combined and sequenced with medication to enhance stabilization and long-term recovery outcomes.

Primary/Psychiatric Health Care Integration: Delivery of primary health care and psychiatric services via co-location of services or partnership agreements.

Peer-based Recovery Support Services: Peer recovery support services made available to all patients, e.g., recovery coaching/mentoring, stage-appropriate recovery education, introduction to advocacy and community service opportunities, recovery-supportive social activities, support for lifestyle reconstruction.

Linkage to Communities of Recovery: On-site recovery support meetings; orientation and assertive linkage to mediation-friendly recovery mutual aid meetings and other recovery support institutions, e.g., recovery homes, recovery schools, recovery ministries, recovery community centers, recovery cafes, recovery-focused art/music/theatre/sports projects.

Enhanced Supports for Patients Choosing to Taper: Education on risks/benefits of tapering; Self-assessment exercises on readiness and timing of tapering; increased access to counseling and peer-recovery support resources; safety-net plan for post-tapering adjustment period; option of advanced directives with family.

Post-treatment Recovery Check-ups: Post-treatment recovery check-ups defined as part of MMT and included in informed consent process at admission; face-to-face, telephone, or internet follow-up of all discharged patients—regardless of discharge status; saturated contact in first 90 days following treatment; at least annual recovery check-ups for five years following discharge from treatment; responsibility for contact resides with staff not the patient.

Patient Opportunities for Recovery Advocacy/Support and Community Service: Invitation to patients to participate in recovery advocacy and community service events; training

opportunities in recovery storytelling, recovery coaching, peer leadership; creating volunteer service corps for involvement in community service projects; ensuring inclusion of patients in medication-assisted treatment within local recovery community organization activities.

Recovery-focused Evaluation Measures: Treatment effectiveness measures that include recovery-focused system benchmarks and personal recovery outcomes—including measures of remission (and their social cost influences, e.g., crime, health care utilization), changes in global health, social functioning, and quality of life; regular (at least annual) public disclosure of key recovery benchmark measures.

Recovery-focused Professional & Public Education: Sponsorship or participation in educational events that challenge the stigma attached to MMT by accurately portraying the role medications can play in recovery initiation and long-term recovery maintenance and providing MMT patient/family advocates opportunities to offer “living proof” of medication-assisted recovery via their own stories.

Those wishing further details on these proposals are referred to the references below for more in-depth presentations.

References

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All of the above references are posted for free download at www.williamwhitepapers.com.