CLINICAL & MEDICATIONS

Medications, Clinical Practice and Addiction Medicine

William L. White — Selected Papers, Volume VI

35 Papers

White's clinical and policy writings on medications for addiction, physician health programs, opioid treatment, and the integration of medication with psychosocial recovery support.

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Clinical Management of a Multisite Field Trial of Five Outpatient Treatments for Adolescent Substance Abusers

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Abstract

Bridging the gap between clinical research and clinical practice in the treatment of adolescent substance abuse requires empirically validated therapies and technology transfer strategies that reflect an awareness of the realities and resource constraints of local treatment service providers. This article describes the management of cross-site and cross-intervention clinical issues in the Cannabis Youth Treatment (CYT) study, a multisite, randomized, clinical trial of five outpatient therapies. The methods used in the management of such clinical trials could play an important role in elevating the quality of adolescent substance abuse treatment as practiced in the field. This technology involves 1) defining and delineating clinically relevant subpopulations of clients, 2) developing research-supported manuals that define the theory, active ingredients, and procedures of treatment, 3) monitoring therapist adherence to manual-based therapy, 4) monitoring client responses to the procedures as they are implemented, 5) individualizing and refining the delivery of these manual-based therapies within the context of clinical supervision, and 6) conducting rigorous and sustained followup to determine the enduring effects of the interventions.

Carroll and her colleagues (1994) detailed the strategies used to implement and to protect the integrity of three manual-based therapies evaluated within Project MATCH, a multisite study of adult alcoholism treatment (Project MATCH Research Group, 1993). This paper takes a similar approach in describing cross-site clinical coordination procedures within the Cannabis Youth Treatment study, the largest multisite, randomized field experiment ever conducted of adolescent substance abuse treatment. More specifically, the paper details the common clinical infrastructure within which these therapies were implemented across the treatment sites.

It is our collective experience that therapies can fail in the transition from efficacy (outcomes under ideal circumstances) to effectiveness (outcomes in the real world of adolescent treatment), not because of flaws in the interventions themselves, but because of the absence of a sound foundation of clinical management upon which empirically validated interventions are replicated. The construction of stable clinical infrastructures within local treatment programs is as important to the future of adolescent treatment as the availability of research-validated therapies.

The Cannabis Youth Treatment Study

After declining in the 1980s, both licit and illicit drug use among adolescents rose in the 1990s. In 1996, cannabis use by adolescents (8th, 10th, and 12th graders) reached its highest peak in 12 years for reported lifetime use, past year use, and past month use (ISR, 1997). As cannabis abuse/dependence emerged as the leading cause for admission to substance abuse treatment (OAS, 1997), demands increased for research-validated treatments for cannabis-involved adolescents. In response to this need, the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Center for Substance Abuse Treatment (CSAT) of the U.S. Department of Health and Human Services (DHHS) funded the CYT study.

The CYT study is a multisite, randomized field experiment designed to test the efficacy of five promising outpatient treatment interventions for cannabis-abusing and cannabis-dependent adolescents. Its long-range goal is to provide validated and cost-effective models of intervention that can be widely replicated in local treatment agencies across the country. The study sites include Chestnut Health Systems in Madison County, Illinois (CHS–MC); the University of Connecticut Health Center (UCHC) in Farmington, Connecticut; Operation PAR (PAR) in St. Petersburg, Florida; and the Children's Hospital of Philadelphia (CHOP) in Pennsylvania. The sites represent both academic, research-oriented clinics (UCHC and CHOP) and community-based adolescent treatment programs (CHS–MC and PAR) (Dennis, Babor, Diamond, Donaldson, Goldley, Tims, et al., 1998; Herrell, Babor, Brantley, Dennis, et. al., 1999). The CYT study provides a test in geographically diverse environments of treatments that differ in theoretical orientation, delivery format and focus, and dose.

Between June 1998 and February 1999, 600 adolescents (approximately 150 per site) meeting the criteria presented in the *Diagnostic and Statistical Manual of Mental Disorders* 4th Edition-Revised (DSM–IV) (American Psychiatric Association, 1994) for cannabis abuse or cannabis dependence were randomly assigned to one of three conditions, with a total of five conditions used across the four sites. The five conditions include:

- Motivational Enhancement Therapy/Cognitive Behavioral Therapy—5 individual/group sessions (MET/CBT5) (Sampl & Kadden, 2001)

- Motivational Enhancement Therapy/Cognitive Behavioral Therapy—7 individual/group sessions (MET/CBT5 + CBT7) (Webb, Scudder, Kaminer, & Kadden, 2002)

- Family Support Network (FSN) (Hamilton, Brantley, Tims, Angelovich, & McDougall, 2001) (FSN includes MET/CBT5 + CBT7 plus enhanced family supports: home visits, parent education classes, parent support groups)

- Adolescent Community Reinforcement Approach (ACRA) (Godley, Meyers, Smith, Karvinen, Titus, Godley, Dent, Passetti, & Kelberg, 2001)

- Multidimensional Family Therapy (MDFT) (Liddle, in press).

At UCHC and PAR, adolescents were assigned to a five-session brief intervention (MET/CBT5) or to one of two other interventions that combine more extensive individual and group sessions (MET/CBT5 + CBT7 or FSN). At CHS–MC and CHOP, adolescents were assigned to the five-session brief intervention (MET/CBT5) or to one of two individual/family approaches (ACRA or MDFT). All study participants were assessed at intake and at 3 months, 6 months, 9 months, and 12 months. Treatment completion rates were in the 70-percent range, and followup rates through 9 months after treatment exceeded 95 percent (Titus et al., 1999; Godley, Diamond, & Liddle, 1999).

Methodological Challenges

There were three important challenges in conducting this multisite field experiment. The first was to ensure the integrity of each of the interventions being tested (Moncher & Prinz, 1991). Following what has been referred to as the "technology model" (Carroll et al., 1994; Carroll & Nuro, 1996; Carroll, 1997), workgroups led by a technical expert in interventions and a therapist coordinator (TC) responsible for cross-site supervision of that intervention took the following six steps to enhance its integrity:

- Defined and manualized the active ingredients of each therapy, including the frequency, intensity, duration, and sequencing, and indicated responses to the most common problems that occur during delivery of the intervention

- Conducted 15 to 25 hours of centralized, competency-based training for the therapists delivering the interventions and followed this by local certification of staff in each intervention

- Developed a therapist's skillfulness scale to serve as a cross-site measure of general therapeutic competence

- Developed a service contact log to measure therapists' adherence to each of the five interventions and to document the dosage and types of services provided to each client

- Taped and rated sessions for model fidelity (all tapes were rated as part of the cross-site supervision by an expert in the intervention until each therapist was certified, after which two tapes per therapist, per month, were reviewed and rated)

- Conducted weekly (1-hour onsite or telephone) individual supervision and weekly or bimonthly (60 to 90 minute) cross-site group supervision for each intervention.

These procedures helped enhance treatment differentiability (the delineation of the ingredients and procedures that distinguished each treatment from the other treatments) and treatment adherence (the assurance that the interventions [as delivered] maintained fidelity to the original manual-defined procedures) (Hoffart, 1994).

A second challenge involved controlling extraneous factors that could compromise interpretation of the treatment outcomes. To accomplish this, every effort was made to ensure that all general clinical procedures, other than those involved in the specific therapies, would be handled similarly across sites and interventions. This was done to minimize the ability of these contextual issues to unduly influence the evaluation of the experimental interventions and was achieved in two ways. First, staff of the CYT coordinating center conducted two site visits at each of the four service delivery sites to ensure that each site met baseline standards related to arenas such as research protocol compliance, accessibility and appropriateness of clinical space, clinical supervision structure, recruitment strategies, intake and service procedures, confidentiality procedures, crisis and safety net procedures, clinical documentation, data security and storage, and followup procedures. Second, the TCs for each intervention coordinated similar responses to issues that were not part of the specific interventions in monthly conference calls facilitated by the CYT coordinating center. Details of this latter process will be described shortly.

The third challenge was to enhance the external validity of the interventions (the generalizability of study findings) by ensuring that the interventions could be implemented as designed within the resource constraints of settings that currently provide the bulk of services to drug-involved adolescents. It was the goal of the CYT TCs to do everything possible in the CYT study to bridge the traditional gap between efficacy research conducted under experimental (ideal) conditions and effectiveness research conducted in field (real) settings. We wanted to document the kind of clinical infrastructures and the management of day-to-day clinical issues that might need to accompany these unique interventions if they were to achieve comparable results in the field.

The monthly conference calls among the TCs for each of the five interventions and the staff from the CYT coordinating center were particularly helpful in facing the latter two of these challenges. The purpose of these meetings was to define how sites would manage common clinical issues that were not a unique part of the experimental interventions but which, if not identified and controlled, might corrupt the evaluation of these interventions. We were concerned, for example, that if therapists in one intervention expelled adolescents from treatment (and the study) for arriving at a session high, while another site either allowed such adolescents to participate or rescheduled their sessions, differences in completion rates between these sites would reflect not the power or weakness of the interventions but contextual policies unrelated to the active ingredients of each intervention.

What follows is a synopsis of how common clinical issues were managed across the four treatment sites and across the five interventions being

tested. It is hoped that this discussion will provide researchers and treatment practitioners alike with insights into the importance of managing such contextual influences. The discussion also represents a snapshot of baseline clinical practices in adolescent substance abuse treatment in 1998 and 1999.

Issues in Clinical Management and Clinical Care

A. Clinical Infrastructure. A rather complex clinical infrastructure was required to effectively manage clinical activities across the four treatment organizations and the five treatments in the CYT study. The care taken in constructing this infrastructure was based on the assumption that there is a close relationship between the quality of clinical supervision and treatment efficacy (Holloway & Neufeldt, 1995).

There were three levels of clinical coordination and supervision in the CYT study. First, local clinical supervisors at each service site coordinated cross-intervention clinical issues and day-to-day clinical problem solving. Second, a therapist coordinator for each of the five interventions used in the CYT study provided onsite and cross-site clinical supervision of staff working in their particular intervention. This supervision occurred weekly during the period in which therapists were being certified and bimonthly following staff certification. Third, a TC at the CYT coordinating center facilitated cross-site and cross-intervention coordination and problem solving. The centerpiece of this cross-site clinical coordination was a monthly meeting at which the respective TCs met with the cross-site TC and research coordinator via a conference call to discuss cross-site clinical and research issues. Particular problems or procedural questions emerging from these discussions were sometimes also referred to the CYT executive committee (all of the principal investigators, the CSAT project officer, and other CSAT staff) for consultation or decision making. The CYT coordinating center validated that the cross-site clinical procedures developed through these processes were in place by conducting two monitoring visits to each of the CYT research sites during the course of the study (*CYT cooperative agreement,* 1999).

Many problems and issues (administrative, fiscal, research, clinical, ethical, legal) were addressed in this multitiered supervisory structure, but the major goals were to meet the methodological challenges noted earlier: ensuring the integrity of the interventions, controlling factors that could confound outcomes, and enhancing the generalizability of findings. Several steps were taken to achieve these goals.

All sites used the same research and service intake and clinical assessment/ screening procedures, the same inclusion and exclusion criteria, and the same approach to randomization and waiting list management. To maximize transferability of findings to the field, exclusion criteria were limited to adolescents 1) who needed a higher level of care than outpatient treatment, 2) who presented for treatment with confirmed histories of drug dealing or violence (particularly predatory behavior patterns reflecting a high frequency, high intensity, and long duration), 3) whose psychiatric comorbidity was so severe as to render them inappropriate for the CYT interventions, and

4) whose primary drug of choice was not cannabis. Although the study focused on adolescents with a primary drug choice of cannabis, most adolescents entering the CYT study reported using other drugs in addition to cannabis. Although abstinence from all alcohol and drug use was a goal of the treatments in the CYT study, at admission, adolescents were asked to agree to evaluate their drug use and its effects on themselves and their families. Therapists across sites and interventions agreed that many adolescents' commitment to abstinence was something that should emerge out of the treatment process, not something that should be a precondition for entry into treatment.

Mechanisms to enhance clinical fidelity to the interventions used in the study included centralized training and booster training of clinical staff delivering the interventions, the videotaping or audiotaping of all sessions followed by the use of self- and supervisory-scored adherence measures to monitor skillful execution of the intervention, formal procedures to certify each therapist in the intervention, continued postcertification tape reviews to minimize therapist "drift," and regular cross-site group supervision led by an expert in the intervention.

A considerable portion of the monthly meeting of the CYT TCs was aimed at ensuring baseline clinical processes and data collection procedures were being handled consistently across the four sites. There were discussions of just about everything—from drug testing procedures to appropriate responses to clinical deterioration of a study participant. The monthly agenda included a site-by-site review of particular issues, such as the status of therapists' certifications and the quality of communication between sister sites (those delivering the same interventions), and an opportunity to discuss the general problems and issues encountered. Below are some of the cross-site clinical issues that were of major concern throughout the course of the study.

B. Staff Recruitment, Training, and Retention. Most of the therapists working on the CYT project were trained at the master's degree level or higher, and most had prior training and experience in addiction treatment. The research sites, like the practice field, varied in their use of full-time and part-time staff. Most sites felt there were advantages to having full-time therapists working on the project because that increased their availability to clients, provided greater flexibility in scheduling, and created a greater degree of personal investment in the project. In general, sites looked for individuals with good clinical skills whose overall clinical orientations were congruent with the intervention they were going to deliver. A particular effort was made to find staff who had a good working knowledge of child and adolescent development—a qualification not often found in those working with adolescent substance abusers (Kaminer, 1994). Staff were paid salaries that were at or slightly above the geographical norm for addiction therapists. None of the sites experienced any significant problems recruiting qualified staff.

In the course of the project, there were a total of 26 full-time and part-time clinical positions at the 4 CYT sites. Nine staff left the CYT project during

this period—two due to changes in the communities selected as service sites and the majority of the others due to a return to school, family relocation, or promotion. The highest turnover rate was among the case managers. Several things worked to enhance staff morale and retention on the CYT project: a conscious effort to build team cohesion, a knowledge of the potential importance of the research being conducted, the training and supervision opportunities, the opportunity for cross-site contact with peers working on the same intervention, and the flexibility of the individual sites regarding scheduling of part-time employees on the project.

Although considerable effort is made to ensure that conditions in clinical trials are equivalent to natural conditions in the field, there are several characteristics of clinical trials staff that make them somewhat different from those in mainstream practice. Staff who seek clinical positions in clinical trials are not scared away by the limited timeframe of employment on such a project, are often attracted by the intense nature of training and supervision such projects afford, and are not put off by the rigorous record-keeping generally required in such projects.

Strategies used for managing clinical continuity in the face of staff attrition included replicating the training that was provided to all therapists at the beginning of the CYT project, having a built-in transition/training period for entering staff, and using videotaped sessions of the current therapists to train new therapists.

The safety of staff working in the field was enhanced by hiring staff from the local community, providing inservice training on safety management and access to beepers and cellular phones, and the option of working in teams to visit areas that posed higher safety threats. Office-based safety issues were addressed by ensuring that other staff were present while sessions were being conducted and by providing walkie-talkies or silent alarms to signal other staff if assistance was needed. There were no major safety-related incidents experienced by the CYT project.

C. Client/Family Recruitment, Engagement, and Retention. The major barriers in recruiting, engaging, and retaining adolescents and their families were fairly consistent across the CYT project sites:

- Low adolescent/parent motivation for treatment involvement
- The perception that other problems in the family were more important than the drug experimentation of one child
- Parental substance abuse
- The parental view that smoking marijuana is not that big a deal
- Failure to attend due to lack of transportation or child care
- A marital or relationship breakup during the period of treatment involvement

- Inconsistent messages from the parents to the adolescent about the importance of involvement in counseling
- Relocation of the child during the course of treatment
- Parents having given up on efforts to change their child
- A general and pervasive sense of hopelessness about life (felt by both the parents and the adolescent).

Study participants were recruited by direct appeals to youth and parents through newspaper and radio public service announcements and strategically placed bulletin board posters. Staff also oriented local youth service professionals regarding how referrals could be made to the program and the nature of the various treatments that youth would be receiving. These visits and mailings included CYT information packets, business cards, and Rolodex inserts. There was some resistance to referring clients to the project when referral sources discovered that they could not control which intervention their clients would receive. Some were concerned that the five-session intervention would not provide an adequate level of service. After some education about the benefits of brief therapy in general, however, and the need to test such therapies in the substance abuse arena, most were willing to make referrals.

Of 690 adolescents referred to the CYT sites between May 1, 1998, and May 31, 1999, 38.6 percent were referred by criminal justice-affiliated agencies, 24.8 percent by families (7.6 percent of which came from a media promotion of the CYT project), and 15.2 percent by educational community health and human service agencies (Webb & Babor, 1999). An analysis of adolescents admitted to treatment in the CYT study (Tims, Hamilton, Dennis, & Brantley, 1999) revealed that 84.7 percent were age 15 or older, 38.1 percent were nonwhite, and 11.9 percent were female. The low rate of female admissions is attributable to at least two factors. The first involves the use of referral sources such as juvenile probation departments that serve predominantly male clients. The second factor is that, of those females referred to the CYT study, more than one-third presented with comorbid psychiatric disorders severe enough to exclude their participation in the study.

Client engagement was enhanced through five broad strategies. The first was to make the transition between the research staff (the equivalent of the intake staff in most agencies) and the clinical staff as personal as possible. When a therapist was not available to be introduced to the client/family by the research staff, the assigned therapist called the parents or the adolescent before the first appointment to introduce himself or herself, begin alliance building, and clarify any questions about treatment participation. All of the CYT interventions begin with an emphasis on empathy and skillful rapport building to build a strong therapeutic alliance and work through resistance related to the coercive influences that may have brought the adolescent to treatment.

The second strategy was for the therapist to speak for 5 to 10 minutes with any adolescent who had to wait more than 2 weeks to begin service (a delay sometimes caused by randomization and the cycles of starting new groups) to sustain his or her motivation for service involvement.

The third strategy was to remove as many environmental obstacles to treatment participation as possible by using geographically accessible service sites, providing assistance with transportation (that is, cab vouchers, bus tokens, picking adolescents up in the agency van), and providing or arranging child care. Case management, whether provided by therapists, case managers (in the FSN intervention), or even during the screening activities of the research staff, was an essential medium of engagement for those families whose lives were most chaotic at the point of initial contact with the CYT project. Every effort was made to link what could be learned in treatment with what could help the immediate crisis presented by the family. The CYT interventions shared the message, "We have something that could help with some of these problems and improve the quality of life for you and your child."

The fourth and most important strategy was to actively engage the adolescents and families by creating strong therapeutic alliances, expressing interest in their participation (e.g., by weekly phone prompts for participation), finding a goal that the adolescent and family were interested in working on, expressing optimism in their capacity to change, and persisting in family contacts during the earliest signs of disengagement. FSN intervention staff felt that home visits were very important in initiating and sustaining the involvement of the most treatment-resistant families.

The fifth strategy was to provide a warm, collaborative, adolescent- and parent-friendly environment (with informal but respectful hosting, providing pizza and sodas as part of the dinner-hour adolescent and parent meetings) and to provide specific incentives for involvement in treatment (help with very specific problems, fully subsidized treatment, and token prizes for homework completion).

D. Safety Net Procedures. Safety net procedures involve strategies for recognizing and responding to adolescents who before or after entering outpatient care were thought to be in need of a higher level of care or allied services. We anticipated and experienced four scenarios that required such safety net procedures. The first involved emergency situations that might arise related to an adolescent's drug use during the course of the study. All parents were provided a laminated card listing signs of acute intoxication and oriented to procedures that could be used to respond to an emergency. The second scenario occurred when adolescents underreported the frequency and intensity of their drug use at intake but disclosed it after they were randomized and admitted to one of the therapies. The third scenario involved the frequency and intensity of use escalating after the adolescent had been admitted to outpatient treatment. The fourth scenario occurred when an adolescent's mental health status deteriorated following admission, particularly where such deterioration posed the threat of harm to himself or herself or others. Safety net procedures were established at

all four sites that 1) ensured the periodic reassessment of the status of use and the appropriateness of the level of care to which clients were assigned, 2) ensured the availability and use of supervisory supports to formally reevaluate changes in clients' status and care needs, and 3) facilitated, when needed, moving an adolescent to a more structured and intense level of care or the addition of collateral services. Where alternative or additional services were thought to compromise evaluation of the effect of the CYT intervention, the adolescent and family were provided the additional services but the adolescent was no longer included in the study.

E. Concurrent Services. The exclusion of adolescents with severe psychiatric illness from the CYT study does not mean that all adolescents with psychiatric comorbidity were excluded from the CYT study. The majority of adolescents and families admitted to the CYT study presented with multiple problems, and the rate of psychiatric comorbidity of the adolescents admitted to the study was quite high. Forty-two percent met the criteria for attention deficit/hyperactivity disorder, 55 percent met the criteria for conduct disorder, and 29 percent presented with multiple symptoms of traumatic stress (Tims, Hamilton, Dennis, & Brantley, 1999). Those adolescents who were referred for more intense services prior to randomization and who were not included in the CYT study were most likely to be excluded because they presented a high risk of harm to themselves or others. (These risks were identified through the participant screening form completed at intake and through the assessment instrument [GAIN] [Dennis, Webber, White, et al., 1996] and the interviews that were part of the intake process at all of the CYT service sites.)

The multiple problems presented by the CYT adolescents and their families raised an important clinical and research issue: How to respond to the clinical needs they presented without contaminating (through concurrent service involvement) the evaluation of the particular interventions in the CYT study. This problem was complicated further by the referral patterns of the agencies that linked adolescents with the CYT project. Acutely aware of the number and complexity of the problems many of these adolescents presented, many of these referral sources used a shotgun approach—simultaneously referring the adolescent and family to multiple treatments, hoping that the cumulative dose of services would have some positive effect on the child and family. These problems diminished through education of and negotiation with referral sources. It was a policy of the CYT study that adolescents would not be allowed to remain in the study if they were receiving concurrent treatment whose primary focus was the problem of substance abuse or if they were receiving services whose impact was judged by the local staff to inordinately confound the impact of the CYT intervention being provided. However, no adolescent had to be excluded from the study for such concurrent service involvement. Several adolescents who were treated simultaneously for collateral problems (e.g., being medicated for hyperactivity or depression) were allowed to enter and remain in the CYT study because the focus of the concurrent services was not on substance abuse or dependency.

F. Session Management. Efforts were made to ensure that issues related to the management of sessions that were not unique to the particular interventions would be handled in reasonably consistent ways across the sites. Where procedures were not the same, they were reviewed to ensure the differences would not confound outcomes. These discussions included how to respond to lateness, missed sessions, the criteria for dropping cases, intoxication, contraband, disruptive behavior, preexisting relationships between members, and a group session at which only one member is present.

Lateness was handled by degree, by ensuring either that the client got the minimal dose for that session or that the session was rescheduled. Missed sessions were rescheduled or, in the case of group interventions, provided as an abbreviated makeup session prior to the next scheduled session. (All services across the five modalities were expected to be completed within 14 weeks of the time of the first therapy session, with local TCs reviewing and approving any exceptions to this rule.)

All programs made intoxication and possession of contraband grounds for exclusion from that particular session and a flag for reassessment of the appropriateness of the current level of care. (While rare episodes of an intoxicated youth arriving for services did occur, these episodes were clinically managed without excluding the adolescent from continued service.) Only one adolescent per family was included in the CYT study, and preexisting relationships between participants in the group modalities were reviewed to determine whether the prior history would undermine or enhance treatment. A group with only one member present was conducted in a 30- to 45-minute individual format covering the material that was scheduled for presentation. If an adolescent failed to appear for a family session, the session was conducted without the adolescent.

The TCs collectively sought and implemented general strategies that could enhance the effectiveness of sessions for all of the CYT therapies. Strategies that served to minimize problems and enhance session effectiveness included formalizing, posting, and consistently enforcing group/family norms on such issues as dress (banning drug/gang symbols on clothing) and language (profanity, drug argot). In the group interventions, the closed group structure made it particularly important to guard against negative influences within the peer cultures that evolved. A final issue was the appropriate level of contact between therapists and adolescents outside the intervention. The TCs decided that such contact should be minimized so as not to contaminate model fidelity by altering dose. More specifically, it was agreed that all extra-session contact should be responded to within the therapeutic framework of the particular intervention, channeled into upcoming sessions, documented, and brought to supervisors for review.

G. Gender and Cultural Adaptations. While there is significant momentum toward the development of standardized, empirically supported, and manual-based treatments (Wilson, 1998; Carroll, 1997), there is a simultaneous call for the refinement of standardized treatment that includes gender and cultural relevance and effectiveness (Orlandi, 1995). All of the CYT therapists noted making changes in their delivery of the

manual-based treatments that were based on gender, cultural, and socioeconomic status (SES) appropriateness. Therapists in group interventions explicitly noted diversity issues in the group and incorporated respect for diversity into the ground rules established at the beginning of each group. The most frequently mentioned adaptations included:

- Changing the language of the session to reflect cultural or geographical norms
- Adding items to some worksheets to make them more applicable to urban youth
- Providing special writing and reading assistance to address illiteracy
- Slowing the pace and adding repetitions of key ideas to accommodate learning impairments
- Developing examples and illustrations of key points that had greater gender, cultural, and SES relevance.

Therapists emphasized it was not the content of interventions that had changed; there were subtle changes in the way that content was framed or delivered.

H. Case Mix Issues. Therapists involved in the group interventions (MET/CBT5, MET/CBT5 + CBT7, FSN) also decided to monitor closely client mix issues according to gender, ethnicity, and other important dimensions. There was an effort to identify any potential iatrogenic effects of randomization (e.g., harassment, scapegoating, or other predatory targeting of a vulnerable group member by other group members) and to actively manage potential negative effects of group support for antisocial behavior (Dision, McCord, & Poulin, 1999). This was managed primarily by establishing and enforcing norms for group sessions.

I. Mutual Aid and Peer Support Groups. In contrast to Project MATCH, a 12-step facilitation therapy was not included in the CYT study, and there was some variation in the philosophies of the 5 interventions related to the desirability of mutual aid involvement by cannabis-involved adolescents. The ACRA, MDFT, and MET/CBT interventions do not directly encourage affiliation with addiction recovery support groups, but they do frame such involvement positively if the adolescent is already involved in such a group or self-initiates involvement during the course of treatment. FSN, while strongly encouraging parents to participate in Al-Anon, does not directly encourage adolescent clients to affiliate with Narcotics Anonymous (NA) or Alcoholics Anonymous (AA). Information on local mutual support groups is provided simply as one of many community resources. There was more of an emphasis in all the CYT interventions on involvement in drug-free prosocial activities in general than on addiction recovery support group involvement.

J. Ethical Issues. The TC meetings also provided a venue to discuss and formulate responses to some of the complex ethical and legal issues that can arise in the treatment of adolescent substance abuse (White, 1993). Considerable time was spent discussing questions such as:

- What are the boundaries of confidentiality regarding disclosure of information about an adolescent to his or her parents?
- Do parents have a legal/ethical right to the results of their child's urine tests?
- What circumstances would constitute a duty to report or duty to intervene?
- What obligations, if any, do therapists have in responding to an adolescent's disclosures of past or planned criminal activity?
- How should therapists respond to reports of abuse of adolescents by a parent or to failures by child protection agencies to intervene to ensure the safety of the adolescent?

Discussion

Carroll and colleagues (1994, 1996, 1997) are to be commended for helping transfer the technology model of psychotherapy research to addiction treatment outcome studies. The CYT study greatly benefited from the earlier experience of Project MATCH in the use of this model. This paper has described a structure (the interface between a cross-site and cross-intervention TC group and the CYT executive committee) and a process (monthly meetings of all the TCs and monitoring visits at each CYT study site) that were used to control contextual elements surrounding the experimental interventions. Our goal was to hold these contextual elements constant across the interventions in order to enhance our ability to measure the differences the experimental interventions produced on outcome measures. We wanted differences in outcomes to reflect differences in the interventions themselves and not factors incidental to the interventions.

While there were major research design elements (consistency in clinical data collection instruments and procedures, inclusion and exclusion criteria, and followup procedures) that helped control such variance across sites and interventions, we also sought to identify more subtle areas of potential contamination of the study. By generating consistent cross-intervention procedures to respond to lateness, missed sessions, disruptiveness, intoxication, and concurrent participation in other services, we were able to ensure a consistent and a more precise definition of the dose and type of services provided in, and collateral to, each intervention. By developing and monitoring safety net procedures across the sites and interventions, we were able to ensure timely and appropriate responses to the placement of a client in an inappropriate outpatient modality who needed a higher level of care and to respond to acute episodes of clinical deterioration that warranted a similar change in the level of care. We found that the

collaborative work of the TCs helped enhance the methodological rigor of the CYT study and helped establish a sound clinical infrastructure upon which each of the interventions was tested.

There are many aspects of the clinical management of the CYT project other than the efficacy of the particular interventions used that may have wide applicability to the field of adolescent substance abuse treatment. It is our view that many of the procedures to provide overall clinical management of randomized field trials have great clinical utility and are likely to become future baseline clinical practices in the treatment of adult and adolescent substance abuse disorders.

The technology model that, to date, has been used primarily as a means of ensuring methodological rigor in multisite field trials seems to us to have enormous advantages for enhancing the quality of treatment and should be studied for potential adaptation to mainstream clinical practice. Those looking for ways to enhance the quality of adolescent substance abuse treatment would be well served to explore how the elements of this model could become part of the future definition of treatment as usual. Parents seeking help to address the substance abuse-related problems of their son or daughter ought to be able to expect that the theory behind the treatments they are offered can be articulated and that their active ingredients can be defined. They should further be able to expect that these treatments have some degree of scientific support for their effectiveness and that they will be delivered in a manner consistent with procedures whose effectiveness has been validated.

Increased demands for such accountability and fidelity by parents, policy makers, and funding agencies will likely make manual-based therapies the rule in the future, along with the training and adherence measures that accompany them. The technical aspects of cross-site clinical management of the CYT project have much to offer the field as a whole. The use of standardized assessment instruments that are capable of providing comprehensive assessment and treatment planning data should become a requirement of all adolescent treatment programs in the next decade. We further commend the use of central (and booster) training, videotaping and adherence ratings as standard practices in supervision, and cross-site supervision as marvelous tools for training and professional development. Finally, we believe that rigorous followup (monitoring, feedback, and, where indicated, early reintervention) should move from the realm of clinical research to being an expectation, if not a requirement, of mainstream clinical practice. The idea of providing services without measuring outcomes will be incomprehensible in the very near future, and the technology to perform this task is rapidly emerging. Morale among staff working in the CYT project remained high, in part because of the near universal belief in the historical importance of this study and the climate of excitement and discovery that permeated the project. We believe that small field-based experiments to answer critical clinical questions, opportunities for cross-site sharing, and the opportunity to work on papers and presentations can similarly contribute to staff morale within local service organizations. We believe this milieu of curiosity, discovery, and contribution is transferable

and sustainable in natural clinical settings. Routine outcome monitoring and field-based experiments, like the other items in this discussion, must simply be moved from the arena of clinical research to the arena of standard clinical practice. This transfer of technology from the research environment to the clinical practice environment, however, will not be simple.

If there is a single weak link in the current practice of addiction treatment that will slow this technology transfer, we believe it is in the arena of clinical supervision. Comprehensive assessments, science-guided treatment planning, empirically validated and manual-based therapies, regular adherence measurement and monitoring, using clients' response-to-treatment data to individualize and refine standard interventions, and rigorous posttreatment followup (and early reintervention, where called for) all flow from the clinical infrastructure at the core of which is a clinical supervisor. If we can elevate the quality of clinical supervision in the field—the selection, training, and support of clinical supervisors to do true clinical supervision—to that of clinical supervision in controlled clinical trials, we will be able to channel knowledge from clinical research to clinical practice.

Conclusions

Clearly defining the demographic and clinical characteristics of client populations, presenting the active ingredients in a manual format and procedures inherent in particular treatments for those populations, monitoring therapists' adherence to such procedures, controlling contextual influences that can influence treatment outcomes, and conducting rigorous and sustained followup to determine clients' responses to particular interventions collectively hold great promise in moving the treatment of adolescent substance abuse from the status of a folk art to that of a clinical science. The technologies used to build this science may themselves offer great potential in enhancing the quality of adolescent substance abuse treatment programs if they can be adapted for routine use in the clinical setting. The CYT study confirms the importance that these new tools can and will have in the future clinical management of adolescent substance abuse treatment.

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Abstract

Treatment researchers are increasingly advocating the use of evidenced-based treatment manuals. Here we describe therapist reactions to the use of manual-guided therapies in a multisite, randomized field experiment that evaluated five outpatient treatment protocols for adolescents who abuse or are dependent on marijuana. Data are summarized from qualitative interviews with 16 therapists and 3 case managers who provided the treatments. All of those interviewed felt that the manuals provided a structure to their therapeutic work, and the majority felt they were able to address individual patient needs. Therapists' reactions did vary depending on the type of manual they used (e.g., session-based, principle-based, or procedure-based). Recommendations for the development and use of manual-guided therapies to improve adolescent substance abuse treatment are discussed.



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Project SAFE
A Developmental Model of Recovery

William L. White, Maya Hennessey, Deborah Oberg, and Diane Sonneville
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Early Project SAFE reports raised a number of theoretical questions about the nature of addiction and recovery in women, and called for the construction of a research-grounded developmental model of recovery that could illuminate the styles and processes of addiction recovery among Project SAFE clients. In the absence of quantitative research data, stories and perceptions about stages in the recovery process for SAFE women were solicited from child welfare workers, outreach workers and treatment staff at all of the SAFE sites. This qualitative data was then organized into a beginning conceptualization of the stages of change experienced by most women involved in this project. This brief paper represents an attempt to provide a theoretical framework from which the recovery of Project SAFE women can be understood and from which interventions can be strategically selected and appropriately timed.

Recovery as a Developmental Process

There are a number of key propositions central to a developmental model of addiction recovery. Those most crucial to organizing the experience of women in Project SAFE include the following:

- Addiction recovery, like the active process of addiction, is often characterized by predictable stages and milestones.
- The movement through the stages of recovery is a time-dependent process.
- Within each stage of recovery are developmental tasks, skills to be mastered, certain perspectives to be developed, certain issues to be addressed, before movement to the next stage can occur.
- The nature of the developmental stages of recovery are shaped by the characteristics of the individual; the nature, intensity and duration of drug use; and the social milieu within which recovery occurs.
- Developmental stages of recovery, while highly similar within subpopulations of addicts, may differ widely from subpopulation to subpopulation.
- Treatment interventions must be strategically selected to resolve key issues and achieve

mastery over key developmental tasks inherent within each individual's current stage of recovery.

- Treatment interventions appropriate to one stage of recovery may be ineffective or pose iatrogenic risks when utilized in another stage of recovery.

These propositions are consistent with the growing body of research on stages of change.

What follows is not a developmental model of recovery for women. The proposal of such a model would imply that women experiencing substance use disorders present with gender-defined and gender-shared problems that are unaltered by other dimensions of individual character and experience. Such a model would also imply that there is a shared developmental trajectory (a singular pathway) of recovery for all women and that there exists a narrowly proscribed treatment technology to provide guidance through this developmental process. What follows is a developmental model of recovery for *persons* who share certain experiences and characteristics. There are many women for whom this model would not apply and many men for whom it would. The fact that more women than men share the core characteristics defined below is a function not of gender biology but of the social, economic and political oppression within which women are born and within which they must seek their individual destinies.

The Core of Shared Experiences and Adaptations

The developmental trajectory of addiction recovery is shaped by the totality of experiences each person brings to the recovery process and, in particular, what each person brings by way of "recovery capital." Recovery capital is the total amount of internal and external resources a person can bring to bear on the initiation and maintenance of recovery (Granfield and Cloud, 1996). Populations for who share similar levels of recovery capital, similar assets and life experiences and circumstances, often share similar developmental processes of recovery.

Project SAFE women were often involved in a complex web of interlocking relationships (and problems) spanning several generations. The women who entered Project SAFE shared many experiences that shaped their perceptions of self, the self-drug relationship and the self-world relationship. It is impossible to understand the nature of addiction and recovery in these women without understanding the core experiences of their lives. Such core experiences include:

- Early and continuing losses
- Parental addiction and/or psychiatric illness
- Physical/sexual trauma
- Predatory social environments
- Recapitulation of family trauma in adult intimate relationships

When clinicians within Project SAFE compared the experience of SAFE women with the non-addicted women they had counseled who had not been involved in the abuse or neglect of their children, significant differences emerged. While women from both groups reported experiencing sexual abuse in childhood, the women of Project SAFE women reported an earlier age of onset of sexual abuse, multiple rather than single perpetrators of abuse, long duration of abuse (often measured in years), the presence or threat of physical violence as a dimension of the abuse, more boundary invasive forms of sexual abuse, and either being blamed or not believed when they broke silence about the abuse. What distinguishes Project SAFE women is not the occurrence of physical or sexual abuse or early childhood losses in their lives, events that many women experience, but the intensity and duration of these experiences.

Project SAFE clients tended to share both certain conditions and events in their lives and

certain meanings attached to these experiences. The experiences catalogued above created shared beliefs about themselves and the outside world. These beliefs became mottos for living and a major barrier to recovery:

- I am unlovable; I am bad.
- There is no physical or psychological safety.
- If I get close to people, they will die or leave me.
- My body does not belong to me.
- I am not worthy of recovery.
- Everybody's on the make; no one can be trusted.

Dependency as the Core Developmental Dimension for SAFE Women

In clinical staffings of Project SAFE women, the words “dependency, passivity, learned helplessness and learned hopelessness” were frequent refrains. It is our belief that shifts in this dependency dimension mark the essence of the developmental process of recovery for SAFE women.

In America, there is a deep paradox related to dependency. The culture highly values self-reliance and autonomy, but prescribes roles to women which inhibit self-assertion and encourage service and sacrifice to others. Women who most inculcate those values ascribed to women are branded as “pathologically dependent.” Women who challenge these values through self-assertion are often accused of somehow hurting their men, their children, their communities and their society. While most women experience some aspects of this cultural double-bind, some experience an intensified version of this self-dwarfing process. For the majority of women in Project SAFE, family of origin experiences began what became an escalating pattern of self-diminishing dependency upon people and things outside the self. Such patterns involve:

- An inability to state one's own wishes, needs, or ideas due to fear of conflict or rejection.
- A diminished capacity to define or assert one's own values and beliefs (to be self-directed).
- A severely diminished experience of self-legitimacy and self-value.
- An inability to pursue self-fulfilling, self-nurturing activities without fear and guilt.
- Achievement of esteem through identification with a person, group, or institution.
- A fear that life success or self-accomplishment will be followed by punishment or abandonment.
- An inability to initiate action to resolve one's own problems.
- A programmed preference for passivity, withdrawal and helplessness when confronted by problems and challenges.

We do not view such dependency patterns as inherent in the biology or character of women. We view such patterns as flowing from self-obliterating family and cultural systems. They are survival adaptations. They are strategies of self-protection. They are defenses against physical and psychological assault. Self-defeating patterns of dependency are highly adaptive, and passivity can serve as an alternative protective device to challenging and confronting family or cultural rules. Passivity and dependence often serve as homeostatic mechanisms within a marital/family system. Ego-sacrificing acts of women often serve to boost the egos of others.

This dependency dimension influences the manner in which these women must be engaged in the change process. Interventions, such as traditional confrontation approaches that heighten guilt and inadequacy, are misguided and harmful for this population. The dependency dimension influences the changing role of the treatment program staff in the long-term recovery

process. In the developmental stages outlined below, we have charted a progression from self-defeating dependence to healthy inter-dependence. The desirable and achievable goal of the change process extols not autonomy and self-reliance, but reciprocity and mutuality. This process is depicted as a movement from the denial and abuse of self to an affirmation of self within the context of mutually respectful intimate, family, and social relationships.

The Limitations of Stage Theory

In 1969, Elizabeth Kubler-Ross published her now classic work *On Death and Dying* in which she described five stages of grief and mourning (denial, anger, bargaining, depression and acceptance). Many counselors have for years used this theoretical framework to assist them in working with grieving clients. Used appropriately, this theoretical model has helped many clinicians both understand and mediate the healing process involved in traumatic loss. Applied to restrictively, this theoretical model has been misapplied by some clinicians to program the grief experience of clients for whom alternative styles of healing may be more naturally appropriate. Similarly, stages of change theories have been very popular in the addiction treatment field in recent years. But we have also used such models used to exclude clients (defining “pre-contemplative” clients as inappropriate for admission to treatment) rather than to enhance their readiness for change.

Models, as metaphors of collective experience, can be tools of empowerment for both clinicians and clients, particularly when the model fully embraces the experiences and needs of both. When a model doesn't fit the experience and needs of the client, its application can result in unsuccessful treatment or harmful treatment.

The construction of a developmental model of recovery for women in Project SAFE is an important milestone in the evolution of this project. It provides the theoretical foundation for what works and doesn't work in our interventions with these women and their families. It provides the framework that vindicates our movement outside the traditional boundaries of traditional theories and techniques to meet the needs of these women. The developmental model of recovery which follows should, however, not be viewed as a road map of recovery for all women, nor should the stages outlined be utilized as a prescriptive recipe whose ingredients and preparation procedures must always be the same. Our model is a road map that has utility only when it precisely reflects the clinical terrain within which we are working. When this terrain changes via core characteristics and experiences of women in Project SAFE, then the model should be adapted or discarded.

In our observation of and involvement with Project SAFE women over the past sixteen years, we have seen six identifiable stages in the movement from addiction to stable recovery. These stages and the roles helping professionals can play in each stage are described briefly below. The stages are a composite of what we have seen with Project SAFE women. Some women skipped certain stages. Others varied the sequence. Still others went through several cycles of these stages during their SAFE tenure. The stages overlap and there are not always clear points of demarcation separating one from the other. For example, early stage issues of safety and trust don’t completely dissipate. They simply require less emotional effort as the ever-present roar of “don't trust” subsides to a whisper.

Stage 1: Toxic Dependencies

If there is any phrase that captures the pre-treatment status of Project SAFE women, it is “toxic dependencies.” They bring dependencies on alcohol, cocaine, heroin and other psychoactive drugs that have interfered with many areas of their lives. They exhibit a propensity to involve themselves in toxic, abusive relationships with men and women. They also exhibit a propensity to involve themselves in toxic relationships with “enabling institutions” whose effect is to sustain rather than break this larger pattern of dependency. The Project SAFE client has

little sense of self outside these dependent relationships with chemicals, people and institutions.

The themes of death, loss, abandonment, and violation of trust in her life are constants that progressively diminish self-respect and self-esteem. Whether manipulated through nurturing or through violence, she has learned that the world is a predatory jungle in which physical and psychological safety is never assured. Out of self-protection, a secret self is created and encapsulated deep within this woman. She protects and hides this self from exposure to outsiders. Her true self can never be rejected because it will never be revealed. Sealed in fear and anger, this secret self becomes so deeply hidden that the woman herself loses conscious awareness of its existence.

The locus of control during active addiction is increasingly of external origin. Her relationship with drugs cannot be internally controlled by acts of will or resolution. Her relationships with others are marked by inconsistency and unpredictability of contact. Everything in her life seems to be shaped by outside forces and persons. By the time a woman comes in contact with Project SAFE, the power to shape her own destiny has been obliterated by the chaos of her life. Her life is buffeted by the conflicting forces of her drugs, her drug using peers, her family, her intimate partner, and a growing number of social institutions closing in on her lifestyle.

Amidst this backdrop of chaos, she slides into increased passivity, increased hopelessness and helplessness and increased dependence on drugs and toxic relationships. There is pain in great abundance, but insufficient hope to fuel sustained self-assertion into recovery. “Powerlessness” for this woman is a fact of life, not a clinical breakthrough. The spark that can ignite the recovery process must come from without, not within. For social agencies to wait for this woman to “hit bottom,” in the belief that increased pain will motivate change is delusional and criminal. Where the internal locus of control has been destroyed, the client can “live on the bottom,” having lost everything short of her own life, and still not reach out for recovery. It is not a shortage of pain, but a shortage of hope and a lost capacity to act, that serve as the major obstacles to change. More potential sources of external control eventually emerge through crises related to homelessness, acute medical problems, arrest, victimization by violence, or through the abuse and/or neglect of her children.

Family of origin relationships are quite strained for SAFE women. Family members either share the client's lifestyle or have disengaged out of discomfort with the client's drug use and lifestyle. And yet, family members may be pulled back in during episodes of crisis to take rescuing action on behalf of the client. The social worlds vary for SAFE women. Some are socially isolated, enmeshed in a solitary world of drug use surrounded only by a few primary relationships with active users or persons who support, via enabling, their continued drug use. Other SAFE women are deeply enmeshed in a culture of addiction, an exciting world of people, places and activities all of which reinforce sustained drug use. The drugs and the roles and relationships in the culture of addiction all hold out the promise of pleasure and power but alas, as a metaphor for her life, bring betrayal in the form of pain and loss.

The etiology of the neglectful/abusive behavior exhibited by the SAFE client toward her children springs from multiple sources: the emotional deficits and debilities resulting from her own family of origin experiences, the lack of appropriate parenting skills, environmental chaos that competes with parenting responsibilities, increased loss of control over the drug relationship, and sustained exposure to a predatory drug culture. She constitutes the ultimate paradox of motherhood. Scorned and shamed by those who don’t know her (“How could a mother neglect her child because of a drug?”), her desire to remain the mother of her children will remain the primary external force that sustains her through the change process.

In short, the woman who will come in contact with Project SAFE is compulsively involved in dependent relationships with abusable substances and abusing people, lives in environments that are chaotic and traumatizing, and is constitutionally incapable of a self-initiated, spontaneous break in this dependent lifestyle. All of her experiences have confirmed that the world is a physically and psychologically dangerous place. Her contacts with helping

professionals during this stage are likely to be marked by passive compliance (role playing) or by open disdain and distrust.

There is, however, as much strength in this profile as pathology. The ultimate pathology is the environmental pathology which demanded that SAFE women sacrifice their esteem and identity as an act of survival. While the consequences of these adaptations may appear as pathological personality traits to those unfamiliar with such traumatizing environments, seen from another perspective, these are stories of survival and incredible resiliency. The strength inherent in sheer survival is the seed from which the recovery process will eventually sprout. That seed must be acknowledged, nurtured and channeled into the change process.

Stage 2: Institutional Dependency

The initiation of sobriety and the period of early recovery for SAFE women is marked by decreasing dependence upon drugs and unhealthy relationships, and an increasing dependence upon Project SAFE staff and the institution within which it is nested. Stage 2 is marked by the following three phases: 1) testing and engagement, 2) stabilization, and 3) reparenting.

Rarely if ever do Project SAFE women present with a high level of motivation for change. The earliest stage of engagement is usually induced by external fiat (court mandated treatment or fear of losing children) or through the persistence of an outreach worker. Whether presenting with superficial compliance or open hostility, the engagement period is a ballet of approach-avoidance and ambivalence. The tipping of the scales are often shaped by the relative interactions of hope and pain. There is a hope-pain synergism (illustrated below) that dictates the outcome of our efforts at engagement.

The Hope-Pain Matrix

High Pain HP	Low Hope LH	HP-LH most typical initial pattern encountered with SAFE women. External control and hope-engendering relationships key ingredient to treatment engagement
High Hope HH	Low Pain LP	HH-LP represents honeymoon phase in drug relationship. Drug relationship experienced as solution rather than problem. Poor treatment success; high risk of relapse.
HP-HH produces high internal motivation and rapid engagement in treatment. Good treatment prognosis.	LH-LP represents post-honeymoon phase of drug relationship. Trust building by OR workers can set stage for treatment engagement during crisis.	

Where there is high pain and high hope, a rarity, engagement can be quick and intense. Where there is low pain and low hope, there is minimal chance of treatment initiation. It is in the combinations of high pain and low hope and high hope and low pain, that the intervention technology of outreach can work its magic of persistence and consistent positive regard to alter the equation to get treatment engagement. (See Chapter Six for a discussion of this technology.)

The earliest relationship between SAFE women and the treatment milieu is one of great ambivalence. Clients maintain a foot in both worlds (addiction and treatment) gingerly testing each step forward and backward. In this transition period can be found enormous incongruities and contradictions, e.g., clients who want to keep using drugs AND keep coming to treatment, clients who want staff to go away because staff make them feel good and hopeful. While this ambivalence may have its subtleties, it is most often played out behaviorally in dramatic fashion, e.g., missed days of treatment attendance, splitting in anger and then calling to seek reconciliation, relapse behavior, etc. True emotional engagement is rarely a bolt of lightning event. It is much more likely to be a slow process of engagement with every stage marked by testing behaviors.

The earliest experiences of positive regard and hope experienced by Project SAFE women can trigger strong counter reactions. The woman who too quickly reveals her secret self may react in anger (temper tantrums) or in flight (missed meetings). The hope-instilling positive regard from SAFE staff may escalate a client's self-defeating patterns of living, e.g., setting others up to reject her as a confirmation of her life positions that trust is foolish and nowhere is safe. When staff refuse to be driven back by these exaggerated defense structures, the client is forced to experience herself differently and to rethink her beliefs about herself and the world. This testing, experiencing acceptance and rethinking process may go on in its most intense forms for weeks before a woman fully commits herself to the SAFE program. For women who get through this initial stage, testing may resurface later during critical developmental milestones in the recovery process. For women who cannot resolve this trust/safety issue, their drug using lifestyle will continue unabated.

In the stability phase, outreach and case management services provided through project

SAFE have reduced the environmental chaos (housing, transportation, legal threats, etc.) to manageable levels and overall treatment efforts have created an initial (but still fragile) emotional bond between the client and the treatment team. As external threats to safety and survival subside, the Project SAFE client begins to master the personal and social etiquette of SAFE participation, e.g., regular attendance, group participation, etc. As soon as sobriety and environmental stability begins, emotional thawing and volatility escalates.

This can be a stage of raw catharsis. Pent-up experiences unleash powerful emotions when first aired to the outside world through storytelling. With the experience of safety, clients can begin peeling away and revealing layers of the secret self only to discover dimensions that were unknown even to themselves. Healing of this pain will occur in levels through all of the stages described in this model. At Stage 2, the most crucial dimension is the experience of acceptance by others following self-disclosure. There is, at this stage, a sense that shared pain is diminished pain, and that secrets exposed to the light of disclosure lose their power to haunt and control.

There are several dimensions of reparenting within Project SAFE spread over the developmental stages of recovery outlined here. At this early stage, Project SAFE takes over a parental role with project clients, tending to issues of survival and safety. It is a nurturing, "doing for" process. At an emotional level it involves experiencing unconditional "thereness" -- the consistent physical and emotional presence of the program in the life of the client. It involves the experience of consistency, a non-voyeuristic and non-judgmental openness to their life stories, and the ability to tolerate testing, but still set limits. It is the experience that one can mess up, but not jeopardize one's status as a family (SAFE) member. As clients become more receptive to this emotional nurturing, they may regress and become quite dependent upon the program. This escalating dependence should be seen not in terms of pathology, but in terms of a developmental process of healing. It is through this increased dependence, and the needs that are being met through it, that the client begins to fully disengage from active involvement in the culture of addiction. The program must now meet all those needs which the client formally met within the society of addicts. The program must be available to fully fill this vacuum at this stage if contact with the culture of addiction is to be broken. Does that mean that a stage of "doing for" the client, a stage of consciously cultivating client dependence upon the treatment institution, is clinically warranted? YES!

Key developmental tasks that must be mastered by the client during Stage 2 include:

- Resolving environmental obstacles to recovery.
- Working through the ability to maintain daily sobriety.
- Relationship building with staff that transcends stereotyped role behaviors of "client" and "professional helper" (movement beyond compliance).
- Learning etiquette of program participation.
- Breaking contact and asserting isolation from culture of addiction.
- Exploring limits of safety in the treatment environment via storytelling and boundary testing.
- Accepting nurturing from project staff.
- Verbalizing, rather than acting out, compulsions of fight or flight.

During Stage 2, clients still have little sense of personal identity. Where identity in Stage 1 was formed through identification with a drug, a drug culture, and a small number of highly abusive relationships; identity in Stage 2 comes through drug abstinence, identification with a treatment culture, and a small number of highly nurturing relationships. Denial dissipates during Stage 2 and personalized talk about alcoholism/addiction reflects the growing recognition of "addict" as an element of identity. Clients still need external sources of control over their behavior, although these sources begin shifting from negative (judicial coercion) to positive

(regard for relationships with staff).

Clients who get stuck in Stage 2 (and programs which conceive of Stage 2 as the terminal stage of treatment) contribute to the growing population of chronically relapsing clients who, fail to function either in the culture of addiction or in the society at large, become institutionalized clients in the substance abuse treatment system.

Stage 2 begins the reconstruction of the relationships between the SAFE mother and her children. With the resolution of environmental chaos, the initiation of sobriety, and early engagement in treatment, the most dysfunctional aspects (neglect and abuse) of the parent-child relationship have been addressed, but it may be some time before quality parenting will appear. Early recovery parenting efforts often reflect a lack of basic parenting skills and efforts to compensate for guilt related to past drug-related deficiencies in parental effectiveness, e.g., overprotection or overindulgence. As the mother herself experiences re-parenting in relationships with staff, she becomes more empowered to mirror these experiences with her children, e.g., feedback, nurturing, boundary setting, problem solving, etc.

Stage 3: Sisterhood

In Stage 3, relationships of mutual respect and trust established between the client and the Project SAFE staff begin to be extended to encompass other women clients in the SAFE project (one's treatment peers). The earliest efforts in these peer to peer relationships are marked by diminished capacity for empathy, the inability to listen to another with the roar of one's own ego in check, the lack of social etiquette, and the need to clearly proscribe the limits of trust. Clients speak at the same time, fail to respond emphatically to painful self-disclosure, make commitments to each other that are broken, react to feedback with verbal attack or threats of violence or flight, etc. It is the treatment milieu that must provide the skill development and the relationship building processes to weld these disparate individuals into a mutually supportive group.

Over time, clients begin to extend their trust and dependence upon staff to a growing reliance on the help and support of their treatment peers. Within the structure of the treatment milieu, they move from the position of "none can be trusted" to a realistic checking of who can be trusted and the limits of that trust. The early friendships between treatment peers constitute the embryo of what will later be a more fully developed culture of recovery. As skills increase, the client learns to not only speak, but to listen; to not only receive feedback, but to offer feedback; to not only receive support, but to give support. It is crucial that treatment staff provide permission and encouragement for decreased dependence upon staff and increased dependence on other health-enhancing relationships within and beyond the treatment milieu.

The peer milieu is an important vehicle through which Project SAFE women wrestle with some of their most troublesome treatment issues. This is the milieu within which sexual abuse and other family of origin pain is explored. It is here that they can grieve their many losses. This is the arena within which abusive adult relationships are mutually confronted. This is the arena in which clients come together collectively to fight back against shame and stigma to restore their honor and self-respect both as women and as mothers.

During this stage, there is an intense exploration of victimization issues. Stories of victimization are shared. Catharsis of pain and anger is achieved. A "sisterhood of experience" is achieved. Early identity reconstruction focuses on victimization issues. Individual and collective identity focuses heavily on what has been done to them. Projection is the dominant defense mechanism. The client sees herself in trouble due to persons, institutions and circumstances over which she has no control. It will be some time before this focus can shift to her responsibilities, her choices, her role in her current life position.

Key developmental tasks that must be mastered during Stage 3 include:

- Extension of self-disclosure to treatment staff to treatment peers.
- Early relationships with recovering role models encountered within the treatment site.
- Exploration of victimization issues.
- Rapid expansion of social skills (parallels period of early adolescent development).
- Treatment agency focused lifestyle develops as alternative to culture of addiction.
- Shift in relationships from drug-oriented to recovery-oriented.

Stage 3 is the first time SAFE clients begin to experience themselves as part of a broader community of recovering women. Identity and esteem are increasingly based on identification with this community. The shift in identity from “addict” to “recovering addict” marks a beginning stage in the reclamation of the self. These shifts in identity are not without their risks as we shall see in the next Stage.

Major risks of relapse during Stage 3 come from panic, secondary to emotional self-disclosure, relationship problems between treatment peers, and failure to sever or reframe past drug-oriented intimate and social relationships.

Stage 4: Selfhood and Self-help

Where Stage 3 focused on shared experiences, SAFE clients in Stage 4 begin some differentiation from the treatment group. There is more focus on personal, as opposed to collective experience. The “victim” identity diminishes during this stage and there is a greater focus on self-responsibility. This stage involves an exploration and expiation of emotion surrounding one’s own “sins” of commission or omission. Treatment time shifts from what “they” did to what “I” did. There is a confessional quality to early work in this stage with, self-forgiveness being a critical milestone. There is, for the first time, a shift in focus from personal problems to personal aspirations. This stage marks the beginning reconstruction of self that will continue throughout the lifelong recovery process.

In Stage 4, Project SAFE women begin to experiment with the development of health-enhancing relationships outside the treatment milieu. Having developed some sense of safety and identity within the treatment milieu, they seek to extend this to the outside world by finding networks of long-term support. The two most frequent structures utilized by Project SAFE clients for such support in Stage 4 are self-help groups and the church. This is a critical stage through which the emotional support the SAFE client has received from treatment staff and treatment peers is extended for the first time to a broader community beyond the treatment site. There is also a focus on rebuilding strained or ruptured family relationships during this period. With sustained sobriety and program involvement and obvious changes in her lifestyle, estranged family members once again open themselves to re-involvement with SAFE clients.

Self continues to be defined in Stage 4 through external relationships. A period, perhaps even a sustained period, of extreme dependence upon this support structure, while criticized by persons not knowledgeable about the developmental stages of recovery, can be the critical stage in the movement towards long-term recovery. During this period, the client's whole social world may be shaped within the self-help or religious world. This period constitutes a period of decompression from the toxicity of the culture of addiction and a period of incubation within which the self and self-world relationship are reconstructed.

If the shift in dependence from the treatment milieu to outside supports is made too quickly, the client will experience this encouragement for outside relationships as abandonment by the treatment staff. Traditional short-term treatment models that encourage this shift at a very early stage in recovery may inadvertently recapitulate the client's fear and experience of loss and abandonment. In Project SAFE, we found that these relationships needed to supplement, rather than replace, those primary relationships of support within the treatment milieu.

There is a reassessment and decision point during Stages 3 and 4 as whether to move forward in the recovery process or to retreat back into the world of addiction. During these stages, the full implications of the recovery lifestyle become clear. There is fear that long term recovery is still not a possibility. There is fear of the future unknown and their ability to handle it. As bad as the past is, it continues to exert its seductive call as a world they know better than any other. If treatment contact and support is prematurely ended during this stage, relapse is likely.

Stage 5: Community Building

In Stage 5, SAFE women extend their system of supports into the broader community. It is at this stage that clients must figure out how to maintain sobriety while fully living in the world. It is a stage of lifestyle reconstruction. Friendships that are based neither on active addiction nor shared recovery are explored and developed. The earliest activities within this stage may begin very early or very late in the recovery process. For SAFE women, the earliest activities are often initiated via outreach workers. Tours of community institutions, getting a library card, going on picnics, bargain hunting at garage sales and flea markets, and experimenting with drug-free leisure may all be aspects of community building initiated through the treatment experience. A major aspect of Stage 5 is the establishment of drug free havens and drug free relationships that can nurture long-term recovery. Another aspect of this stage is the repositioning of the family in the community, re-establishing old healthy linkages to community institutions and building new linkages.

It is important that treatment staff possess a sensitivity to non-traditional pathways to recovery. Many recovering women may set the roots of their recovery in institutions other than traditional self-help groups. The church served as a primary support institution to many SAFE women, either as an adjunct or an alternative to traditional addiction self-help groups.

The parenting of SAFE mothers changes in a number of ways during these later stages of recovery. Earlier stages set the groundwork through the acquisition of basic parenting skills and working through stages of overindulgence and overprotection. The emotional needs of the mother are so intense early in the recovery process, that it is very difficult for her to maintain a sustained focus on the needs of her children. In Stage 5, however, the intensity of these internal needs have been addressed to allow for a much richer quality in the relationship between the client and her children. Where she achieved consistent physical presence in earlier stages of recovery, she now creates a consistent emotional presence in the life of her children.

There is also a shift in Stage 5 in the relative health of the client's intimate relationships. Abusive relationships which may continue into the early stages of recovery have now been changed or severed. Some, at this stage, will have gone through experimentation with a variety of relationships, some will have found a primary long-term relationship, while others may find themselves content for the time being to seek their destiny without the security or burden of a primary relationship.

Stage 6: Interdependence

Stage 6 in the developmental progression of recovery for SAFE women, constituted not by a fixed point of achievement, but entry into a lifelong process of doubt, struggle, and growth. The shift from the earliest stages is one from self-negating dependence to self-affirming inter-dependence. This stage is marked by the emergence and continued evolution of an identity that transcends both the addictive history and the history of involvement with helping institutions. In a literal sense, this self-emergence is really not a "recovery" process, since recovery implies a recapturing or retrieval of something one once had. This is not retrieval of an old self; it is the creation of a new self. It is more a process of "becoming" than a process of "recovering."

Due to the lack of long-term follow-up studies of Project SAFE, we don't know a lot about this stage of recovery for SAFE women. We do have inklings of some of the elements within this

stage as more and more women stay in touch with the staff over a period of years. It seems to be marked by:

- Movement toward one's personal aspirations, often reflected in achievement of some personal milestone, e.g., completing high school, getting into college, and gaining employment.
- Working through the tendency to substitute drugs with other excessive behaviors, e.g., workaholism, food, and sex.
- A maturing out of the narcissistic preoccupation with self that characterized active addiction and the early stage of recovery.
- The creation of a social network in which relationships are characterized by mutual respect and support.
- The organization of one's life around a set of clearly defined values and beliefs.
- The emergence of acts of service to other people (including, for some, coming back years later to work as outreach workers in Project SAFE).

There is tremendous diversity in how women within Project SAFE have experienced, or failed to experience, the recovery process. For some, sobriety and the enhancement of parental functioning were introduced into an otherwise unchanged life. For others, Project SAFE would represent the beginning of a life-transforming recovery process. It is our hope that this paper has captured some of the shared experiences that transcend this diversity.



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Alcoholism/Addiction as a Chronic Disease:

From Rhetoric to Clinical Reality[1]

William L. White, MA, Michael Boyle, MA and David Loveland, MA[2]

Abstract

Although characterized as a chronic disease for more than 200 years, severe and persistent alcohol and other drug (AOD) problems have been treated primarily in self-contained, acute episodes of care. Recent calls for a shift from this acute treatment model to a sustained recovery management model will require rethinking the natural history of AOD disorders; pioneering new treatment and recovery support technologies; restructuring the funding of treatment services; redefining the service relationship; and altering methods of service evaluation. Recovery-oriented systems of care could offer many advantages over the current model of serial episodes of acute care, but such systems will bring with them new pitfalls in the personal and cultural management of alcohol and other drug problems.

Alcoholism and other addictions have long been characterized as chronic diseases, but their treatment continues to be marked by serial episodes of acute care (O'Brien and McLellan, 1996; Kaplan, 1997; McLellan, et al, 2001). There is growing disillusionment with this acute care model of intervention, and rising interest in the stages and processes of long term addiction recovery. This confluence may mark an emerging shift from a treatment paradigm to a recovery

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paradigm in the clinical management of severe and enduring AOD problems. This essay will: 1) outline the history of the conceptualization of addiction as a chronic illness, 2) identify current clinical practices that continue to reflect an acute model of intervention, 3) summarize key concepts that undergird the shift toward a recovery management intervention model, 4) explore areas of contemporary clinical practice that will change within this new recovery focus, and 5) discuss potential pitfalls in the movement toward a recovery management.

I. Addiction as "Chronic" Disease: A Brief History

The conceptualization of repeated and destructive episodes of drunkenness as a disease rather than a vice (or as a vice that could become a disease) rose in the late eighteenth century at a time American alcohol consumption virtually exploded (Rorabaugh, 1979; Levine, 1978). The late eighteen and nineteenth century writings of Anthony Benezet, Benjamin Rush, Samuel Woodward and William Sweetser conceptualized the nature of this newly perceived disease and catalogued the consequences that resulted from prolonged and repeated intoxication. Collectively, these writings portrayed intemperance as a disease that is chronic and progressive (Benezet, 1774; Rush, 1814; Sweetser, 1828; Woodward, 1838).

In the mid-to-late nineteenth century, this disease received new medical labels: *dipsomania*, *chronic alcoholism*, some of which--*inebriism, inebriety*—reflected the extension of the disease concept to embrace addiction to narcotics, cocaine, chloral and ether (Crothers, 1893; White, In Press). During this same period, the disease concept of inebriety spawned a network of inebriate homes, inebriate asylums and private addiction cure institutes. Nineteenth century addiction medicine journals and texts characterized alcohol and other drug addiction as a chronic, relapsing disease (Marcet, 1868; Brown, 1872; Crothers, 1893; Parrish, 1883). In 1879, Dr. T.D. Crothers, editor of the *Journal of Inebriety*, typified comparison of addiction to other chronic medical disorders during this era:

> *The permanent cure of inebriates under treatment in asylums will compare favorably in numbers with that of any other disease of the nervous system which is more or less chronic before the treatment is commenced.*

The disease concept fell out of favor in the early decades of the twentieth century. A wave of therapeutic pessimism and new alcohol and other drug prohibition laws led to a collapse of most treatment institutions collapsed. A reformulated disease concept emerged following the repeal of Prohibition that, by defining alcohol problems in terms of a vulnerable minority rather than the alcohol itself, provided a way to address alcohol problems while escaping a century of acrimonious Wet-Dry debates (Roizen, 1991). This reborn disease concept became the centerpiece of the "modern alcoholism movement" (Anderson, 1942; Mann, 1944). The documents of this movement consistently depict alcoholism as a disease and, more specifically, a chronic disease. As early as 1938, a report of the Scientific Committee of the Research Council on Problems of Alcohol noted:

> *An alcoholic should be regarded as a sick person, just as one who is suffering from tuberculosis, cancer, heart disease, or other serious chronic disorders* (quoted in Johnson, 1973).

In the late 1940s and 1950s, Pioneer House, Hazelden, and Willmar State Hospital developed what came to be known as the "Minnesota Model" of chemical dependency treatment. This model, which philosophically dominated the treatment of alcoholism in the second half of the twentieth century, was a reaffirmation of the belief that alcoholism was a "chronic, primary, progressive disease" (Cook, 1988; Spicer, 1993). The conceptualization of addiction as a chronic disease subsequently became the rhetorical centerpiece of late twentieth century policy

positions taken by such organizations as the National Council on Alcoholism and Drug Dependence and the American Society of Addiction Medicine (1976, 1990). The proposition that addiction was a disease and the characterization of its chronicity (Vaillant, 1983; Lewis, 1993; Leshner, 1997) subsequently came under serious attack (Fingarette,1989; Peele, 1989; Peele and Brodsky, 1992; Schaler, 2000) and sparked acrimonious debates regarding the nature of severe and persistent alcohol and other drug problems and how such problems could be best resolved (White, 2001a).

II. Rhetoric versus Clinical Practice

In spite of the recent challenges, the long tradition of depicting addiction as a chronic, relapsing disease continues. Treatment practices, however, continue to be designed and delivered in self-contained, acute episodes of care (Ethridge, et al, 1995). Historically, professionals *assess* and *admit* a *patient* to a course of inpatient or outpatient *treatment*, *discharge* that patient to *aftercare*, and then evaluate whether treatment "worked" by measuring the effect of this single episode of care upon the patient's post-treatment alcohol/drug consumption and psychosocial adjustment over a brief follow-up period. Such a model of intervention assumes an intervention process whose beginning, middle and end can be plotted over a brief period of time, not unlike interventions used to treat acute trauma, appendicitis, or a bacterial infection.

Refusing to admit clients to treatment because of "poor prognosis" (prior treatment "failures") and administratively discharging clients for using alcohol or other drugs (exhibiting inability to abstain/loss of control) also reflect the failure to perceive these conditions as chronic in character. Where durability and exacerbation of symptoms in other chronic disease states is viewed as validating evidence of the disorder and grounds for an altered type and intensity of service intervention, the display of, or exacerbation of, symptoms in the addiction treatment arena has historically constituted grounds for service refusal or termination.

Arguments over whether addiction treatment should be inpatient or outpatient, whether it should consists of 5 days or 28 days or 5 sessions or 10 sessions, or whether cognitive behavioral therapy is more effective than family therapy or "step work" are all arguments inside the acute care treatment paradigm. Even extended treatment, where it still exists, is often simply a longer version of the same cycle of admit, stabilize, and discharge in which clients briefly participate in "aftercare" and mutual aid groups. In spite of the treatment field's rhetoric that addiction is a chronic disease, its primary interventions do not reflect a model of chronic disease management.

For fear of overstating this point, it should be noted that there are episodes in the history of addiction treatment and recovery that do exemplify a vision of long-term recovery management. Nearly all of the alcoholic mutual aid societies in American history have taken this longer view of chronic disease (recovery) management (White, 1998; White, 2001d). When Synanon, the first ex-addict directed therapeutic community, encountered a high relapse rate among its first graduates, it shifted its goal of returning rehabilitated addicts to the larger community and replaced that goal with the creation of an alternative drug free community where one could live forever (Mitchell, Mitchell and Ofshe, 1980). Methadone maintenance, as pioneered by Dole and Nyswander, reflected a medically-directed model of long term addiction recovery management (Dole, 1988, 1997).

What these quite different approaches share in common is that they were all severely criticized for their longer vision of recovery management. Mutual aid groups have been (and continue to be) criticized for shifting the addict's dependency on a drug to prolonged dependency on the support group, Synanon was criticized for its failure to return addicts to the larger

community, and methadone was criticized for the very aspects that exemplified the chronic disease management model: prolonged maintenance of narcotic addicts on a stabilizing, opiate agonist and sustained psychosocial supports. This history would suggest that new efforts to shift from an acute to chronic disease management model of addiction treatment might well face similar resistance.

III. Toward a Chronic Disease/Recovery Management Model

If one were searching for a pivotal breakthrough of consciousness about the distinction between acute and chronic models of addiction disease intervention, it might very well be found in George Vaillant's 1983 work, *The Natural History of Alcoholism*. Vaillant's longitudinal study of alcoholism and recovery challenged three historical assumptions about the disorder and its treatment: 1) alcoholism can be effectively treated with a single episode of acute care, 2) a treatment episode that is followed by relapse is a failure, and 3) repeated relapses following multiple episodes of acute treatment mean that either the condition or the particular patient is untreatable (Vaillant, 1983). Vaillant's overall work was so pregnant with new ideas that his challenge of these basic premises was lost.

The acute care model of intervening in alcohol- and other drug-related (AOD) problems dominated the explosive growth of treatment in the 1970s and 1980s. In failing to consistently initiate enduring sobriety following a single episode of treatment, the model, by consequence rather than intent, blamed clients for poor clinical outcomes. The model also contributed to the rise of therapeutic pessimism within the larger culture, and helped fuel an ideological and financial backlash against the addiction treatment industry in the 1990s (White, 1998). As an aggressive system of managed care dramatically shortened both inpatient and outpatient treatment, there was growing unease within the treatment community regarding the practice of placing clients with high problem severity and duration through multiple episodes of unlinked, brief treatment that for many did little to alter the long term course of their disorders. This practice proved as demoralizing to treatment staff as it was to the clients and families to which it was applied.

In the October 4, 2000 issue of the *Journal of the American Medical Association (JAMA)*, a potentially historic article appeared entitled "Drug Dependence, a Chronic Medical Illness: Implications for Treatment, Insurance, and Outcomes Evaluation" that was authored by Drs. McLellan, Lewis, O'Brien, and Kleber. The report marks the most complete elaboration to date of the concept of chronic addiction disease. The *JAMA* article reflects several factors now pushing the addiction treatment field away from an acute care model and toward a chronic disease (recovery management) model of problem intervention.

First, there is a growing recognition that managing severe and persistent AOD problems through single or serial episodes of acute treatment is clinically ineffective and constitutes poor stewardship of individual, family and community resources. The "treatment research conducted at the University of California's Drug Abuse Research Center underscores several key points in this emerging view:

- A single, acute intervention rarely has sufficient effect to initiate stable and enduring recovery in those with severe and persistent alcohol and other drug problems.
- Multiple episodes of treatment may be viewed not as failures but as incremental steps in the developmental process of recovery.
- Treatment episodes may have effects that are cumulative (Hser, et al, 1997).

Second, there is a growing recognition that addiction disorders are often chronic and relapsing in nature (Simpson, et al, 1986), have much in common with other chronic diseases (O'Brien and McLellan, 1996), and that new technologies of managing chronic disease could and should be adapted for the treatment of addiction (Lewis, 1993; McLellan, Lewis, O'Brien, and Kleber, 2000).

Third, the same managed care system that has lowered treatment dose and intensity and shifted the focus of intervention from one of recovery to that of cost-containment has spawned a treatment renewal movement and a new grassroots recovery advocacy (consumer) movement. These movements are developing a deeper understanding of the long term addiction recovery process and how indigenous community resources may support this time-enduring process (White, 2000c).

Federal and state agencies that fund addiction treatment services have also begun to re-evaluate the traditional acute models of professional intervention. In Illinois, the Department of Human Service's Office of Alcoholism and Substance Abuse has funded the Behavioral Health Recovery Management (BHRM) project to conduct such a re-evaluation. The BHRM project is a multidisciplinary effort to develop service principles and clinical care practice guidelines for the long-term management of severe and persistent behavioral health disorders (Boyle, White, and Loveland, 2000). Such efforts are part of a more global interest in models of "disease management" that hold promise in improving the quality of health care while reducing health care costs (Lazarus, 2001).

IV. The Nature of Chronic Disease

Chronic diseases are disorders whose symptoms and their severity ebb and flow over an extended period of time; such disorders are often characterized by periods of remission and relapse of varying duration over an extended period of one's life. There are hundreds of thousands of people who have achieved stable and sustained recovered from severe and persistent AOD problems. Many individuals who never achieve full remission can and do achieve long periods of symptom remission and an enhanced quality of life.

Acute Versus Chronic Disorders *Problematic alcohol and other drug use may be just that—problematic--without constituting a chronic disorder. Alcoholism/addiction exists within a larger arena of persons who experience alcohol- and drug-related problems.* Models of sustained recovery management should not be applied to transient, though problematic, episodes of excessive AOD use. Many persons have utilized natural supports, mutual aid involvement or a single episode of treatment to initiate permanent resolution of their AOD-related problems.

Acute disease is culturally viewed as something that happens to you; chronic disease is viewed as a defect in who you are. The challenge of chronic disease management is to manage the disease without turning a person into a thing and contributing to the social stigma associated with the condition.

The Etiology of Chronic Disease *Chronic addiction disease emerges and intensifies through the interaction of multiple factors*: the potency of the infectious agent (the drug), the biological and developmental vulnerability of the host; and the physical, political, economic, and social/cultural environment in which the person-drug relationship occurs.

A large number of chronic diseases have been called "diseases of lifestyle" because they are characterized by risk/resiliency factors related to such areas as daily diet, work habits, frequency and type of exercise, sleep patterns, medication compliance, style of stress

management, drug use, exposure to environmental toxins, specifically contra-indicated (high risk) behaviors, and family and social relationships (Nicassio and Smith, 1995).

The Onset of Chronic Disease *Chronic diseases can have either a sudden onset or a gradual onset* (Rolland, 1987).

The process through which an acute disorder migrates to the status of a chronic disorder is not fully understood. There is in all probability a priming dose of symptom activation necessary to move an acute disorder to the status of a chronic disease. Each acute episode of a chronic disease lowers the kindling point of symptom activation for the next episode. The priming process varies by many factors, including age of exposure. The lower the age of onset of regular use, the greater the potential for addictive disease and the greater the severity and chronicity of addictive disease (Chou and Pickering, 1992; Grant and Dawson, 1997). The kindling point can be raised by postponing age of onset of regular drug use and by enhancing biological resistance (medication, exercise, diet), cognitive abilities (coping and problem solving skills) and social supports (pro-recovery family and peer relationships).

Disease Course and Variability *Chronic diseases exhibit a high degree of variability in pattern of onset, course (life trajectory), intensity, and outcome.* Chronic diseases may present as steadily self-accelerating (progressive), constant, or with alternating cycles of symptom remission and symptom reactivation (relapse) (Rolland, 1987). Most chronic diseases are also subject to unexplained, sustained remission—what in the addiction literature has been referred to as spontaneous remission, auto-remission, natural recovery, maturing out or self-cure (Granfield and Cloud, 1999). Chronic addiction disease also varies widely in its degree of incapacitation and in the speed and timing of such incapacitation. Addiction disease varies in physiological severity (morphological changes that threaten biological homeostasis and viability), functional severity (impact on quality of life and performance of life roles), and burden of illness (costs to the individual, family and society) (Rolland, 1987; Stein, et al., 1987; Starfield, 1974). Such variability demands a high level of commitment to individualized assessment and treatment--both across clients and at different points of time in the life of the same client.

Disease/Problem Co-existence and Interaction *Chronic diseases heighten vulnerability for other acute and chronic diseases.* Alcoholism and other addictions invite other diseases that debilitate and threaten premature death. Acute and chronic diseases interact in ways that amplify their combined intensity and duration and the costs incurred in their management (Stein, et al, 1987). The longer an addiction disease is active, the higher the risk for acute physical toxicity (overdose), chronic physical toxicity (addiction-related tissue damage, e.g., cancer, emphysema, liver disease), behavioral toxicity (trauma or death via accident / violence), infectious diseases (e.g., HIV/AIDS, hepatitis B and C, tuberculosis), and co-morbid psychiatric illness. All programs serving individuals with severe and persistent AOD disorders must become dual and multiple disorder programs that serve the whole person/family through integrated models of care (Lebowitz and Harris, 2000; Drake, et al, 1998; Minkoff, 1989; Norquist, Lebowitz, and Hyman, 1999; Osher, 1996).

Family and Intimate Social Networks and Chronic Diseases *The individual and collective resources of families and social networks are strained (and drained) by adaptation to chronic disease.* A family's capacity for adaptation changes across the family life cycle (Goodheart and Lansing, 1997). The family's style of adaptation to a chronic illness is often shaped by the transgenerational history of responding to crisis, illness, loss and death (Rolland, 1987). Chronic disease of a family member can, by disrupting family rituals, re-aligning family

roles; and by altering the allocation of family resources, impact the health and development of all family members as well as the health of adult intimate relationships and parent child relationships.

V. Concepts and Principles of Recovery Management

The shift from acute intervention models to recovery management models of intervening in severe and persistent AOD problems requires new ways of conceptualizing these problems and their resolution or amelioration.

Disease Management *Persons suffering from chronic, incurable disorders need models of intervention that focus on the management of these disorders rather than the cure or treatment of these disorders. Disease management or, as we prefer, recovery management, provides an alternative to the traditional mode of reacting to life-impairing and life-threatening episodes of chronic disorders with unrelated, serial episodes of acute, emergency-oriented care.*

Recovery management implies a longer term vision of influencing the course of a disorder to enhance length and quality of life. It is about learning, in the absence of a cure, to contain a disorder and to optimize personal and family health over time.

Chronic Disease and Recovery The shift from perceiving and treating addiction as an acute disorder to treating it as a chronic condition requires a shift in focus from the pathology of addiction to the nature of, and processes involved in, long term addiction recovery. It extends the concepts of "addiction career" and "treatment career" (Hser, et al., 1997) to encompass a third concept, "recovery career." There are a number of concepts that constitute important building blocks in the construction of recovery-oriented systems of care for severe and persistent AOD problems.

- There are many pathways and styles of recovery (White, 1990, 1996) and many legitimate sobriety-based support structures. Recovery styles and viable support structures vary by developmental age, gender, ethnicity, social class, and profession and they vary by one's "recovery capital" (the intrapersonal, interpersonal and community resources that can be brought to bear on the initiation and maintenance of recovery) (Granfield and Cloud, 1999).
- The mechanisms and processes that sustain recovery are different than the factors that initiate recovery (Humphreys, et al, 1995).
- Addiction recovery can be self-directed and incremental in nature (Prochaska, DiClimente, and Norcross, 1992), a process of unconscious "drift" (Granfield and Cloud, 1999), or a process of sudden, climactic transformation (Miller and de Baca, 2001).
- Addiction recovery most often involves a process of developmental change, the stages of which can be identified and to which stage-appropriate interventions can be designed and delivered (Brown, 1985; DiClimente, et al, 1992)
- Recovery can be professionally-guided (treatment), peer-guided (mutual support groups) or "solo"/"natural" (use of resources within the self and family/social network). Factors that distinguish those in the former from the latter include problem severity, co-morbidity, levels of family/social/occupational support, and social class (Sobell, et al, 1993; Sobell et al, 1996a; Larimer and Kilmer, 2000).
- Styles of recovery vary considerably based on whether one does or does not

incorporate addiction/recovery as a core element of personal identity, and whether one does or does not maintain active contact with other recovering people as a recovery maintenance activity. These dimensions of style may evolve through the stages of recovery.

- Recovery outcomes vary considerably in terms of primary and secondary drug consumption: abstinence, subclinical (nonproblematic) use, and problem reduction (partial recovery). Recovery outcomes also vary in the broader dimensions of global (cognitive, emotional, family, social, occupational) functioning.
    - Post-treatment outcomes are characterized by subgroups who:1) sustain problematic use, 2) sustain uninterrupted abstinence, and 3) who in the weeks/months/years following treatment vacillate between problematic use, non-problematic use, and experiments in abstinence. Fluid states of addiction/recovery typified by this sizeable third group offer significant opportunities to enhance outcomes via recovery management models of intervention.
    - A vision of long term, staged recovery posits treatment and support services (e.g., harm reduction, motivational interviewing, pharmacological adjuncts, cognitive-behavioral therapies, mutual aid groups) not as competing and mutually exclusive technologies but as interventions that can be matched, not just to different individuals, but to the same individual at different stages of his or her addiction/recovery careers.

Because recovery-oriented systems of care are shifting from a treatment lexicon to a recovery lexicon, it will be tempting to view the recovery model as simply a new “buzz” word for treatment as usual. To do so would be a failure to recognize the quite fundamental conceptual and technical shifts implicit within the recovery model.

VI. Toward a Recovery-Oriented Model of Care

The shift from an acute treatment model to a recovery management model requires a fundamental redefinition of the service target; the nature, timing and duration of services; the locations in which services are delivered; the composition of the service delivery team, and the methods and criteria through which services are evaluated. We have been involved at many levels with recovery management models and believe the following are among the most significant of the changes in clinical practice that follow their implementation. We will focus this discussion on how the actual processes of service delivery change rather than on how the move to recovery-oriented systems of care will reshape health care policy and the organization and financing of such services.

1. Service Integration *Recovery management models seek to strategically combine and refine the resources of human service agencies, primary health care providers, and indigenous supports into an integrated system of care that can address stage-specific needs across the span of long term recovery.* Strategies of integration include the creation of multi-agency service delivery teams, cross-training of service professionals, and integrated (and often centralized) outreach, case management, and recovery support services. The primary mechanisms of service integration include a global assessment process/instrument, regular interdisciplinary conferences with the client/family, and the use of a single treatment/recovery plan that directs the allocation of resources drawn from multiple service institutions and indigenous support structures. There is growing evidence that integrated models of care are superior in terms of clinical outcomes and stewardship of community resources than are models that rely on either

parallel or serial models of treating chronic and co-occurring problems (Miller, 1994; RachBeisel, Scott and Dixon, 1999; Drake, et al., 1989; Drake, et al, 2001).

2. Identification and Engagement *Recovery management models utilize population-based identification strategies, assertive community outreach, low thresholds of service entry, multiple points of entry, patient registries, and seamless movement between levels of care to locate, engage, retain and re-engage people with AOD problems.* These interventions recognize and seek to work through the many sources of personal ambivalence and environmental obstacles that impede recovery. Engagement is viewed not as an event, but as a process that continues throughout the recovery management partnership.

The very things that are the hallmark of effective brief interventions--feedback of risk, emphasis on personal responsibility, prescriptive advice, a menu of change options, expression of empathy and encouragement, and enhancement of self-efficacy via expression of confidence in client's ability to change (Bien, Miller, and Tonigan, 1993) are all integrated within this process of engagement. Such outreach and engagement techniques have been found effective in initiating change in multiple populations: women, ethnic minorities, youth, and drug injectors (Brown and Needle, 1994).

3. Assessment *Assessment activities within recovery management models are a continuous rather than an intake activity, are global rather than categorical, and integrate traditional "treatment plans" into a larger "recovery plan."* The high degree of individual variability in AOD problems, the changing status of these problems over time, unique patterns of problem co-occurrence, and concerns regarding the misapplication of recovery management approaches all require rigorous, ongoing and global assessment activities. Global assessment assumes that the germination and development of severe AOD problems spring from multiple elements of the personal, family and cultural ecosystem and that the resources needed to resolve these problems are located within these same arenas.

Recovery management models integrate the traditional medical model "treatment plan" with the "recovery plan" utilized within social model alcoholism treatment programs (Borkman, 1998b). In contrast to a treatment plan, the recovery plan: 1) is prepared and regularly updated by the client, 2) documents the goals and planned activities of the client, and 3) covers such life domains of the client as finances, social life, legal difficulties, education, employment, and spirituality (Borkman, 1998a). Recovery management models provide a structured and individualized transition between professionally-directed treatment planning and self-directed recovery planning.

4. Definition of "Client" *In recovery management models, the definition of "client" shifts from the symptomatic individual to the family and cultural milieu and the individual nested within it.* In recovery management, family members and social network members are all co-providers of recovery support services and legitimate recipients of services in their own right. Recovery priming can occur by moving the family and social network toward greater health and understanding of addiction disease even without the symptomatic individual's direct participation. The focal point of action in the recovery management model is not on what the treatment professional does but on the client and family's capacity to self-direct their own recovery.

5. Service Goals *The mission of recovery management is to help each person suffering from addiction disease to achieve their optimal long term outcome (as measured by the quality*

and duration of life, achievement of personal goals, and his or her impact on family and society). Recovery management strategies are aimed at multiple stage-specific goals:

- slowing the speed of disease acceleration and the speed of decline in biopsychosocial functioning,
- initiating, strengthening and extending periods of symptom remission (reducing the number, intensity and duration of relapse events),
- preventing the onset of, or reducing the severity of, co-morbid conditions,
- producing full and sustained symptom remission where possible,
- achieving the maximum level of age (stage)--appropriate functioning and health for the individual/family, and
- reducing the personal, family and social costs associated with addiction and recovery management.

The focus of recovery management is on reducing addiction-related mortality, decreasing the duration and degree of addiction-related incapacitation, and promoting the development of long term processes of disease stabilization and recovery. Recovery management services seek to enhance the capacity of each client/family to achieve their highest degree of functioning, regardless of whether that level is one of full or partial recovery.

6. Service Scope and Technologies *For clients whose patterns of AOD use reflect chronicity and severity, the best strategy for long term recovery is proactive engagement, disease stabilization (acute treatment), recovery management education, ongoing recovery support, monitoring with feedback, and, when necessary, early re-intervention and re-stabilization.* Recovery management doesn't so much replace the acute model as much as wrap that model in a larger continuum of support services and shift the focus from one of treating the acute manifestations of addiction to building a life of recovery.

These "recovery support services" focus on eliminating barriers to recovery and on enhancing what Granfield and Cloud (1999) have christened "recovery capital"—the intrapersonal, interpersonal and environmental resources that can be drawn upon to aid recovery. Such services encompass traditional clinical services but extend further into such areas as sober housing, pro-recovery educational and employment opportunities, day care and transportation services, and pro-recovery leisure activity. The essence of recovery management involves sustained monitoring of the status of a chronic disease, sustained monitoring of the effectiveness of recovery management strategies, and continual, stage-appropriate refinements in recovery support services.

7. Timing and Duration of Services *The temporal focus of recovery management services is on interrupting the acceleration of AOD problems before the crises that generally initiate acute treatment episodes and sustaining support long after such episodes are traditionally defined as completed.*

By metaphorically changing the role of the addiction treatment specialist from that of an emergency room physician to that of a primary physician managing the long-term course of diabetes or hypertension, the recovery management model renders the concepts of "discharge" and "aftercare" anachronistic. In the recovery management model, all care is an element of continuing care. Continued telephonic, electronic (e-mail) and postal delivery of recovery education; monitoring; support; and, where needed and desired by the client and not otherwise available in the community, ongoing face-to-face group and individual support, are routine

elements of the recovery management model. Within this model, intensity of services decrease over time but the commitment to and access to sustained recovery support remains constant.

8. Delivery Locus *The locus of service activity within the recovery management model combines the primary health care institution (the inpatient/residential institution and the centralized outpatient clinic) with home-based, neighborhood-based service delivery, with a particular emphasis on the latter.* Two principles—personal autonomy and pro-recovery social support—guide recovery management models. First, persons suffering from AOD problems and addictive diseases seeking help are served within the least restrictive, least isolating and least coercive environments and methods possible. Second, transfer of learning is directly related to the degree of physical, psychological, and cultural distance between service delivery site and the client's natural environment. In the recovery management model, services are delivered as close as possible to the natural living environment of the client. Any isolation of the client from that environment is accompanied by intensive transition services aimed at transferring learning from the institutional environment to the client's natural environment. In the recovery management model, as much effort is spent focusing on developing ecosystem supports for recovery as is spent on focusing on pro-recovery, intrapersonal changes.

9. Service Relationship *With recovery management, the service relationship shifts from a "dominator model" to a "partnership model."* The traditional relationship between addiction treatment providers is time-limited, hierarchical, and commercialized. Power, status and strength lie on one side of the relationship and stigma, powerlessness and problems lie on the other side. The patient seeks the help of the expert who diagnoses the patient, prescribes what the patient must do to get well, and then seeks to manipulate the patient's compliance.

Recovery management replaces this expert-centered service relationship with what Eisler (1987) has characterized as a "Partnership Model" and what Lazarus (2001) has characterized as "consumercentric care." The focus is on creating a collaborative alliance that shifts the focus of recovery from the treatment professional to the person seeking and experiencing recovery. The service professional shifts from the roles of diagnostician and "treater" to the roles of long term ally and recovery consultant. One of the essential dimensions of recovery management is continuity of contact over time in a primary service relationship.

This partnership requires the deep involvement of clients in the design, implementation, and evaluation of services. In the recovery management model, treatment professionals and their institutions become students and allies of the growing consumer/survivor movement in the United States (Anthony, 1993; Kaufmann, 1999; Chamberlin, 1990; White, 2000c). The recovery management model could help the field of addiction treatment face in the twenty-first century what it has never faced in its history: a strong consumer movement led by recovering people/families who are knowledgeable, articulate, well-organized, and angry at their historical exclusion from policy and clinical decision-making.

10. The Role of Community in Recovery *The goal of recovery management is not to forever enmesh all persons with severe and persistent AOD problems in professionally-directed treatment services; it is to open resources in the wider community that will enhance each client's own capacity for recovery self-management. The goal is to help nest the client within a physical, psychological and social space where long term recovery can be nurtured. This involves enmeshing the client in recovery-supportive relationships that are natural (rather than professionalized), enduring (rather than transient) and reciprocal (rather than fiduciary and commercialized).*

The community, when organized and educated, can be a reservoir of hospitality and support for recovering people. Professionally directed treatment services should be the last, not the first, line of defense in the management of chronic addictive diseases. The first lines of resources for the management of alcohol and other drug problems consists of the individual's own natural resiliencies, family and intimate social networks, and other non-professional support systems within the individual's natural environment. Interventions that inadvertently undermine and replace the natural support functions of the self, the family, and the community with professionalized and commercialized supports fail both on technical and ethical grounds (McKnight, 1995).

11. The Recovery Management Team *The recovery management model places greater emphasis on the use of the client, his or her family, natural helping systems within the community, and on indigenous recovering people within the recovery management team.* In the future, many recovery support services will be provided by recovered and recovering persons and by recovery-based service organizations which will utilize recovering individuals, family members and other "folk healers" from within the community as recovery support specialists. Such individuals will fill both volunteer and paid staff positions.

12. Service Evaluation *The evaluation of recovery management strategies involves the client/family as the primary evaluator, measures client/family functioning over a much longer (5-15 years) period of time (Vaillant, 1983), and assess the synergistic interaction and cumulative effects of multiple interventions. If the transition to a recovery management model is achieved, addiction treatment and recovery support services will be judged by the same standards that are used to evaluate the treatment and management of other chronic diseases (as advocated by O'Brien and McLellan, 1996).*

The essence of the acute care model is to deliver a single treatment episode, and then to evaluate that episode based on symptom remission or reactivation during the months following "discharge" from that service episode. In contrast, the recovery management model assumes that a return of symptoms following a single treatment episode does not mean that a particular intervention was a failure, nor that sustained remission following an intervention reflects success where earlier episodes had failed. Recovery management models assume that symptom remission or relapse can occur independent of service interventions and that interventions can have delayed, cumulative or synergistic effects. The focus thus shifts to evaluating extra-treatment factors as well as evaluating particular combinations and sequences of interventions as they interact with the evolving life of the client/family.

Recovery management models include consumer participation and use of consumer-influenced evaluation criteria (Sloves, 2000). Like the assessment process, evaluation shifts from an end-of-service-episode or follow-up event to a continuous process and shifts from a categorical evaluation (focus on presence or absence of alcohol/drug use) to a global evaluation (focus on the health, quality of life and social functioning of the individual/family as well as the impact of intervention on the community, e.g., social costs, reduced threats to public safety).

VII. Pitfalls

The chronic disease recovery management model described in this paper is not without its potential pitfalls.

Funding: Virtually all funding of addiction treatment is currently set up to reimburse episodes of acute care provided by categorically segregated service specialists. A shift to the recovery management model will require population-based funding for longitudinal care

delivered by multiple providers organized into integrated systems of care (Pawlson, 1994). Fundable services will need to include outreach, early intervention, case management, monitoring, harm reduction services, and a broad spectrum of recovery support services. There is a danger that the recovery management model could be manipulated by funding organizations to eliminate high intensity/high cost components of service continuum. There is also a danger that a greater responsibility for recovery support could be shifted to the community while all the financial resources remain within professional agencies and managed care entities.

Service Capacity: The shift from an acute intervention to a recovery management model will require new strategies for defining and managing service. Recovery management will require larger caseloads as service professionals maintain contact with a mix of people in widely varying stages of recovery. The increased numbers of people will be mirrored by a smaller percentage of clients with high intensity service demands. This will require new systems of defining and managing service caseloads.

Stigma and Therapeutic Pessimism: If not handled with great care, the "chronicity" language may undermine belief in the potential for permanent resolution of addiction (Brown, 1998). We feel very strongly that the presentation of this model needs to be framed as "recovery management" and not "chronic disease management" to both consumers and the community. We must be able to convey two messages: 1) uninterrupted remission of addiction is possible and a reality in the lives of hundreds of thousands of people, and 2) active recovery management can reduce the frequency, intensity and duration of relapse episodes as it enhances the quality of life and global functioning of those persons who have yet to achieve uninterrupted sobriety.

Iatrogenic Effects from Model Misapplication: There is a danger that a chronic disease management model will be misapplied to individuals whose AOD problems represent not chronic disorders but transient problems that will quite likely spontaneously remit with time and maturation or respond to brief intervention. The potential indiscriminate application of a chronic disease management model to children and adolescents presenting with AOD use is of particular concern.

Service Provider Accountability: "Chronic Disease" could become a shroud that hides and decreases the accountability of service providers for clinical outcomes. Service providers cannot be allowed to blame clients and the nature of their disorder on poorly designed and executed service technologies. Recovery management models should be subjected to more, not less, accountability for long term clinical outcomes (Brown, 1998).

Financial Exploitation: The chronic disease / recovery management model could be financially exploited by treatment institutions who "capture" a population of chronic alcoholics/addicts and provide a high frequency of long term billable services rather than linking these clients to indigenous resources that would diminish their need for these agency-provided services.

Ethical Dilemmas: The recovery management model raises a whole spectrum of ethical issue that will need to be addressed. These include:

- What is the boundary between appropriately assertive outreach and inappropriately intrusive outreach ("stalking")?
- When are we doing too much or too little?
- What relationship boundaries should guide this prolonged "partnership" with clients/families?
- Does a client have the right to not be "monitored and managed?"
- Who is the client (when an agency is contracted to provide prolonged case management services to reduce a client's threat to public safety or to reduce the

client's consumption of scarce community resources)?

From Dynamic to Static Model: There is a danger that clinical care guidelines used within the recovery management model could reduce the treatment of complex disorders to "cookbook medicine." This is not a rational for avoiding evidence based practice guidelines, but a caution that an adequate "toolbox" must be complemented with clinical training and clinical supervision to assure proper clinical judgement in applying techniques in an individualized manner.

Staff Support: In an acute care model, staff working with the most difficult of clients take solace from the fact that this involvement is short term and will be replaced in a few weeks with a new, perhaps less difficult client. The recovery management model will place staff in contact with these most difficult clients for much more prolonged periods of time. Without special supports (clinical supervision, team models of service deliver, etc.), this model could face challenges related to staff morale and retention. Continuity of contact is crucial to the success of the recovery management model; staff turnover must be kept at a low level.

VIII. Summary

Chronic diseases possess many characteristics that distinguish them from acute disorders. They tend to have complex etiologies in which behavioral choices play a role in symptom onset, severity and duration. Their courses are prolonged and often characterized by periods of remission and relapse. They lack definitive cures but can be effectively managed by combinations of interventions. Although severe AOD problems have long been characterized as chronic diseases, their treatment has more closely resembled acute care interventions. The shift to a (chronic disease) recovery management model will require changing our very understanding of the nature of severe and persistent AOD problems and changing the timing and duration of service intervention, the composition of the service delivery team and the methods and criteria used to evaluate our interventions into these problems.

While traditional models of care will continue to meet the needs of many individuals who have sufficient "recovery capital" to resolve their AOD-related problems through a single episode of care, clients who do not respond to such acute care will require recovery management models that sustain contact longer and place greater emphasis on recovery education, long-term monitoring and support, and early re-intervention. The potential pitfalls in this shift toward recovery management models include the demands that will be required to change how services are funded and organized, the potential misapplication of chronic disease models to persons whose AOD-related problems are transient in nature, and the need to manage new and complex ethical issues that will arise within the context of long term service relationships. Models of recovery management offer great promise in the future treatment of severe and persistent alcohol and other drug problems. We must be careful, however, in reaching for this future to not lose what is most valuable within the current system of care.

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Selected Papers of William L. White

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Adolescent Substance Use Disorders: From Acute
Adolescent Substance Use Disorders:
From Acute Treatment to Recovery Management

William L. White, M.A., Michael L. Dennis, Ph.D., and Mark D. Godley, Ph.D.

Abstract

A surge in adolescent alcohol and illicit drug use during the 1990s triggered renewed calls for evidence-based intervention programs and sparked an unprecedented federal investment in treatment-related adolescent research. This article discusses some of the major findings of this research (particularly the just-completed Cannabis Youth Treatment study) with particular reference to their implications for the design of community-based services for substance-involved youth and families. For adolescent substance use disorders characterized by high severity and chronicity, co-morbidity, and low family and social network support, the authors call for supplementing traditional, acute models of brief intervention with more time-sustained, ecologically-focused models of recovery management.



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The Cannabis Youth Treatment study: Implications for Employee Assistance Programs

William L. White, M.A., David A. Sharar, M.S., Ph.D. Candidate, Michael Dennis, Ph.D. and Jean Donaldson, M.A.

A resurgence of youthful illicit drug experimentation during the past decade has sparked an increase in the number of drug-related evaluations and consultations conducted by employee assistance (EA) professionals. One of the most frequent and troublesome of such requests involves the parent who is concerned about his or her child's experimentation with cannabis (marijuana, hashish, blunts). During the past two decades, America has witnessed the increased availability and potency of cannabis and a significant lowering of the age of onset of regular cannabis use. American teenagers report more past-month cannabis use than all other illicit substances combined and more daily use of cannabis than alcohol. These changes have brought an increase in cannabis-related problems among young people. Cannabis is now the leading substance reported in adolescent arrests, emergency room admissions, and public treatment admissions, the latter having increased 115% (from 51,081 to 109, 875) between 1992 to 1998.[i] These changes have brought an increase in cannabis-related problems among young people and concerns about how to address these problems within the family, school, workplace, and the wider community.

As concerns about youthful cannabis use have risen, EA professionals have been called upon to help young employees, parents concerned about their children and by employers desiring a drug-free workplace. The consultations offered by EA professionals have been handicapped by the absence of reliable, science-based information regarding the short and long-term effects of cannabis and the effectiveness of various prevention and intervention programs. To magnify this challenge, EA professionals have been under considerable pressure to reduce the escalating costs associated with the treatment admissions and re-admissions for adolescent psychiatric and substance use disorders. This article will try to answer two questions within this larger arena of concern:

1) Are there relatively brief (6-12 week) low cost interventions that are effective in treating adolescent cannabis abuse and dependence?
2) What role can the EA professional play in supporting the long-term recovery of adolescents during and following their treatment for cannabis abuse or dependence?

The CYT Study

In 1997, the Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration (SAMHSA) responded to requests for the development of evidence-based treatments for cannabis abuse/dependence by funding the Cannabis Youth Treatment (CYT) study. The CYT study is the largest and most scientifically rigorous randomized study of adolescent substance abuse treatment ever conducted in community-based settings.

The CYT study randomly assigned 600 adolescents who met DSM-IV criteria for cannabis abuse or dependence to one of five types of short-term, outpatient treatment. Each of the experiments compared the effectiveness of various treatments and each experiment was replicated in a community-based clinic and in a major medical research center. The treatments varied in theoretical orientation, delivery format (individual, group, family), and service components and duration (6 to 13 weeks). Service procedures within each of the five treatments were meticulously detailed in treatment manuals to enhance model fidelity as they were being implemented and tested across the study sites. Copies of the five treatment manuals utilized within the CYT study are available at no cost from the National Clearinghouse for Alcohol and Drug Information (1-800-729-6686).

Seventy-one percent of youth admitted to the CYT study completed treatment and more than 90% of the study group were interviewed 3, 6, 9, and 12 months following their discharge to evaluate the sustained effects of treatment. The adolescents treated had an average age of 16, were predominantly male (83%), white (61%), enrolled in school (87%), involved in the juvenile justice system (62%), and, of particular interest to EA professionals, had an unexpectedly high rate of employment (47%).

During the three-month treatment phase, all interventions reduced cannabis use and cannabis-related problems and these reductions were sustained through the twelfth month of follow-up. From intake to 12 months, participation in treatment was also significantly associated with reductions in family problems, attention deficit and hyperactivity problems, arguing/ violence, illegal activity, school absenteeism, and school problems. The CYT study also underscored the role adolescent treatment can play in enhancing the productivity of parents. In the three months following the treatment of their child in the CYT study, parents reported a 42% reduction in their days of stress at home and a 57% reduction in their days of missed work (compared to the three months prior to treatment). Thirty-month interviews to re-assess all these factors are now being conducted.

Implications for EAPs

There are many lessons to be drawn from the CYT study, but three lessons have special implications for those working within employee assistance programs.

Lesson 1. ***Cannabis-related disorders constitute serious, debilitating disorders that can dramatically affect the developmental trajectory of adolescents and the overall health of their families.***

While marijuana use is trivialized and sometimes glamorized in the popular media, its regular use can produce serious effects

on personal, interpersonal, family and occupational functioning. These effects can be dramatically amplified through lowered age of onset of regular use, greater frequency of use, and through interaction with co-occurring mental disorders. Among those already at risk for them, marijuana use is one of the main predictors of the early onset and severity of schizophrenia and other severe mental disorders. Weekly or more frequent cannabis users are far more likely than non-users to have problems at home, school, or with the law -- problems that rapidly declined among those youth who stopped using marihuana following their treatment in the CYT study.

EA professionals have an important role in carrying the message to employers, employees, their families, and allied professionals that problems related to cannabis use are on the increase and that adolescents who continue to use cannabis in spite of adverse consequences should be recognized as needing intervention on par with adolescents with other drug choices generally perceived as more dangerous than cannabis. The significant problems experienced by the adolescents and families in the CYT study challenge the still prevalent "it's only marijuana" response (particularly among "Baby Boomer" parents) to adolescent cannabis use. The message that adolescent cannabis use can constitute a serious, debilitating disorder needs to be widely disseminated through the normal EA channels of communication: employee newsletters, web based information services, drug-free workplace training seminars, wellness workshops, and supervisor referral training sessions.

Lesson 2. The severity of adolescent cannabis problems and their responses to treatment are quite variable.

The five CYT treatments were all relatively brief (6-13 weeks), affordable, and able to positively impact many of the youth seeking treatment services. Each was associated with major (50% or more) reductions in cannabis use, symptoms of dependence or abuse, behavioral problems, family problems, school problems, and illegal activity. At 12 months, nearly a third of those youth completing CYT treatment were living in the community without any marijuana use or substance related problems. The good news of adolescent treatment is that there are brief, low cost treatments that can have a significant impact on the lives of many young people and their families.

The more troublesome side of the treatment outcome story is that, for another subgroup of adolescents, cannabis use has become a more chronic condition. In CYT, 41% of the adolescents had failed multiple prior efforts to quit cannabis use, a quarter had been to formal treatment before, and a third were re-admitted to treatment in the year following their discharge from the CYT study. This does not mean that there is no hope for the resolution of such chronic problems, but it does suggest that different models of intervention over a longer period of time will be required to fully resolve such problems.

EA professionals face two significant challenges in the application of Lesson 2: (1) locating providers who offer effective treatments for adolescent substance use disorders, and (2) convincing insurance and managed care gatekeepers to authorize more intensive interventions over longer periods of time (particularly inpatient or residential stays) for those adolescents with more chronic cannabis use conditions.

As EA professionals develop or revisit their community resource referral network, they should take the time to educate adolescent treatment providers about the CYT research that empirically supports the effectiveness of brief interventions for nearly a third of adolescents, while emphasizing

that many others will require more intensive, variable, and longer programs of recovery. It is also important for EA professionals to present the CYT findings to benefit designers, managed care plans, and self-insured employers in an attempt to structure access and coverage in a way that acknowledges the realities and pattern variability of adolescent recovery from cannabis abuse and dependence. EA professionals can play an important role in overcoming the current pessimism about treatment effectiveness and advocate for the implementation of evidence-based, low cost treatments that can effectively serve many adolescents and their families. At the same time they also need to recognize that, for some adolescents, cannabis use can constitute a more chronic, relapsing condition.

Lesson 3: Nearly half of treated adolescents vacillate between periods of recovery and periods of drug use and drug-related problems in the year following their first treatment episode. Post-treatment recovery support services could greatly benefit these youth and their families.

Treatment is often viewed as a time-limited event that either works (complete and enduring abstinence following treatment) or does not work (any drug use following treatment). This dichotomized view is challenged by the findings of the CYT study. Following their treatment in the CYT study, 60% of adolescents had some period of recovery but the pattern of recovery was quite variable. Twenty-nine percent went into recovery but later relapsed; 7% went into recovery, relapsed, but then got back into recovery; 15% failed to respond to treatment right away but improved in the months following treatment; and 9% recovered right away and stayed in recovery through the first year following treatment.

These different patterns of response underscore how fluid and fragile the post-treatment period is for most youth. Such fluidity calls for new service models that resemble not the "diagnose, treat, discharge" approach of the hospital emergency room, but approaches used in the longer term management of chronic disorders like diabetes, hypertension and asthma. These latter approaches focus on problem stabilization, recovery education, ongoing monitoring and support, and, when needed, early re-intervention. These approaches are also consistent with emerging behavioral health technologies drawn from the concept of disease management that seek to improve clinical and financial outcomes in the treatment of problems marked by high severity and chronicity.

EA professionals that offer (or have the potential to influence) managed behavioral health plan designs can encourage the development of disease/recovery management tracks as an alternative to traditional "compliance-based" utilization management that focuses on controlling micro-managed "units of service" toward the goal of reducing acute symptoms. Although some adolescents can greatly benefit from receiving brief, low cost treatment, the indiscriminate application of this approach is inconsistent with the variable patterns of cannabis use and recovery among adolescents found in the CYT study. The effectiveness of adolescent behavioral health treatment could be improved and its costs decreased if EA professionals took a more active role in developing recovery support structures specifically for adolescents within local communities.

EAPs can play a significant role in tipping the scales toward sustained recovery by: a) linking adolescents and their parents to indigenous sobriety-based support structures where they are available in the

community, b) linking adolescents and their families to professionally-directed treatment services, c) educating adolescents, families, and "gatekeepers" about the course and treatment of AOD problems, d) conducting longer term, more intensive follow-up and early re-intervention services for treated youth, e) working with benefits managers and insurance vendors to design plans that can support post-treatment recovery monitoring and support. In the world of adolescent treatment, so-called "aftercare" services are best viewed not an adjunct to treatment, but as one of the most crucial elements of successful treatment.

Conclusion

Adolescent cannabis abuse and dependence is a major problem that consumers of EA services are confronting with increasing frequency. While evidence-based, brief outpatient treatments for these problems do now exist, they will not replace the need for sustained recovery support systems in the adolescent's natural environment. EA professionals can help create strong cultures of recovery within their local communities and can play important roles in recovery management through post-treatment follow-up, the provision of individual and family support, and educating employers and purchasers about post-treatment services that while necessary for sustained recovery are often not authorized or reimbursed. Providing such sustained recovery management supports may go a long way in breaking the cycle of repeated, self-encapsulated episodes of high cost acute care for adolescent substance use disorders.

The all-to-frequent revolving door of addiction treatment challenges the "treatment works" slogan and contributes to therapeutic pessimism among company managers, human resource and EA professionals, the public, treatment providers and, most importantly, the youth and families who consume addiction treatment services. The fact that adolescents (and adults) may require more than one treatment intervention before their AOD-problems are fully resolved does not mean that treatment does not work, but it does call for rethinking the nature of addictive disorders and a redesign of both treatment and our approaches to managing care. The finding of the CYT study that a high percentage of adolescents remain precariously balanced between recovery and reactivation of abuse and dependence following completion of professionally-directed treatment suggests a potentially important role for the EA professional in linking these youth and families with on-going recovery support services following treatment. EA professionals can also use CYT findings to achieve clinical improvements and cost reductions by shaping benefit plans that reflect both the utility of brief interventions and, for some, the necessity of *disease and recovery management approaches* to the resolution of substance use disorders.

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(CYT) Experiment: Rationale, Study Design, and Analysis Plans. Addiction; and 3) Tims, F., Dennis, M., Hamilton, N., Buchan, B., Diamond, G., and Funk, R. (in press) Characteristics and Problems of 600 Adolescent Marijuana, Abusers in Outpatient Treatment. Addiction. More information is on the web about the PETS (www.samhsa.gov/centers/csat) and CYT studies (www.chestnut.org/li/cyt).

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[i] Dennis, M.L., Dawud-Noursi, S. & Muck, R. (in press). The need for developing and evaluating adolescent treatment models. In S.J. Stevens & A.R. Morral (Eds.), Adolescent drug treatment: theory and implementation in ten national projects. Binghamton, NY: Haworth

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Alcoholism/Addiction as a Chronic Disease: From Rhetoric to Clinical Reality[1]

William L. White, MA, Michael Boyle, MA and David Loveland, MA[.2]

Abstract

Although characterized as a chronic disease for more than 200 years, severe and persistent alcohol and other drug (AOD) problems have been treated primarily in self-contained, acute episodes of care. Recent calls for a shift from this acute treatment model to a sustained recovery management model will require rethinking the natural history of AOD disorders; pioneering new treatment and recovery support technologies; restructuring the funding of treatment services; redefining the service relationship; and altering methods of service evaluation. Recovery-oriented systems of care could offer many advantages over the current model of serial episodes of acute care, but such systems will bring with them new pitfalls in the personal and cultural management of alcohol and other drug problems.

Key Words: chronic disease, disease management, recovery management

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Human Services= Office on Alcoholism and Substance Abuse. The views expressed here are those of the authors and do not necessarily reflect the policies of IDHS/OASA.

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Although characterized as a chronic disease for more than 200 years, severe and persistent alcohol and other drug (AOD) problems have been treated primarily in self-contained, acute episodes of care. Recent calls for a shift from this acute treatment model to a sustained recovery management model will require rethinking the natural history of AOD disorders; pioneering new treatment and recovery support technologies; restructuring the funding of treatment services; redefining the service relationship; and altering methods of service evaluation. Recovery-oriented systems of care could offer many advantages over the current model of serial episodes of acute care, but such systems will bring with them new pitfalls in the personal and cultural management of alcohol and other drug problems.

Alcoholism and other addictions have long been characterized as chronic diseases, but their treatment continues to be marked by serial episodes of acute care (O'Brien and McLellan, 1996; Kaplan, 1997; McLellan, et al, 2001). There is growing disillusionment with this acute care model of intervention, and rising interest in the stages and processes of long term addiction recovery. This confluence may mark an emerging shift from a treatment paradigm to a recovery paradigm in the clinical management of severe and enduring AOD problems. This essay will: 1) outline the history of the conceptualization of addiction as a chronic illness, 2) identify current clinical practices that continue to reflect an acute model of intervention, 3) summarize key concepts that undergird the shift toward a recovery management intervention model, 4) explore areas of contemporary clinical practice that will change within this new recovery focus, and 5) discuss potential pitfalls in the movement toward a recovery management.

I. Addiction as "Chronic" Disease: A Brief History

The conceptualization of repeated and destructive episodes of drunkenness as a disease rather than a vice (or as a vice that could become a disease) rose in the late eighteenth century at a time American alcohol consumption virtually exploded (Rorabaugh, 1979; Levine, 1978). The late eighteen and nineteenth century writings of Anthony Benezet, Benjamin Rush, Samuel Woodward and William Sweetser conceptualized the nature of this newly perceived disease and catalogued the consequences that resulted from prolonged and repeated intoxication. Collectively, these writings portrayed intemperance as a disease that is chronic and progressive (Benezet, 1774; Rush, 1814; Sweetser, 1828; Woodward, 1838).

In the mid-to-late nineteenth century, this disease received new medical labels: *dipsomania*, *chronic alcoholism*, some of which--*inebriism*, *inebriety*-reflected the extension of the disease concept to embrace addiction to narcotics, cocaine, chloral and ether (Crothers, 1893; White, In Press). During this same period, the disease concept of inebriety spawned a network of inebriate homes, inebriate asylums and private addiction cure institutes. Nineteenth century addiction medicine journals and texts characterized alcohol and other drug addiction as a chronic, relapsing disease (Marcet, 1868; Brown, 1872; Crothers, 1893; Parrish, 1883). In 1879, Dr. T.D. Crothers, editor of the *Journal of Inebriety*, typified comparison of addiction to other chronic medical disorders during this era:

> *The permanent cure of inebriates under treatment in asylums will compare favorably in numbers with that of any other disease of the nervous system which is more or less chronic before the treatment is commenced.*

The disease concept fell out of favor in the early decades of the twentieth century. A wave of therapeutic pessimism and new alcohol and other drug prohibition laws led to a collapse of most treatment institutions collapsed. A reformulated disease concept emerged following the repeal of Prohibition that, by defining alcohol problems in terms of a vulnerable minority rather than the alcohol itself, provided a way to address alcohol problems while escaping a century of acrimonious Wet-Dry debates (Roizen, 1991). This reborn disease concept became the centerpiece of the "modern alcoholism movement" (Anderson, 1942; Mann, 1944). The documents of this movement consistently depict alcoholism as a disease and, more specifically, a chronic disease. As early as 1938, a report of the Scientific Committee of the Research Council on Problems of Alcohol noted:

> *An alcoholic should be regarded as a sick person, just as one who is suffering from tuberculosis, cancer, heart disease, or other serious chronic disorders* (quoted in Johnson, 1973).

In the late 1940s and 1950s, Pioneer House, Hazelden, and Willmar State Hospital developed what came to be known as the "Minnesota Model" of chemical dependency treatment. This model, which philosophically dominated the treatment of alcoholism in the second half of the twentieth century, was a reaffirmation of the belief that alcoholism was a "chronic, primary, progressive disease" (Cook, 1988; Spicer, 1993). The conceptualization of addiction as a chronic disease subsequently became the rhetorical centerpiece of late twentieth century policy positions taken by such organizations as the National Council on Alcoholism and Drug Dependence and the American Society of Addiction Medicine (1976, 1990). The proposition that addiction was a disease and the characterization of its chronicity (Vaillant, 1983; Lewis, 1993; Leshner, 1997) subsequently came under serious attack (Fingarette,1989; Peele, 1989; Peele and Brodsky, 1992; Schaler, 2000) and sparked acrimonious debates regarding the nature of severe and persistent alcohol and other drug problems and how such problems could be best resolved (White, 2001a).

II. Rhetoric Versus Clinical Practice

In spite of the recent challenges, the long tradition of depicting addiction as a chronic, relapsing disease continues. Treatment practices, however, continue to be designed and delivered in self-contained, acute episodes of care (Ethridge, et al, 1995). Historically, professionals *assess* and *admit* a *patient* to a course of inpatient or outpatient *treatment*, *discharge* that patient to *aftercare*, and then evaluate whether treatment "worked" by measuring the effect of this single episode of care upon the patient's post-treatment alcohol/drug consumption and psychosocial adjustment over a brief follow-up period. Such a model of intervention assumes an intervention process whose beginning, middle and end can be plotted over a brief period of time, not unlike interventions used to treat acute trauma, appendicitis, or a bacterial infection.

Refusing to admit clients to treatment because of "poor prognosis" (prior treatment "failures") and administratively discharging clients for using alcohol or other drugs

(exhibiting inability to abstain/loss of control) also reflect the failure to perceive these conditions as chronic in character. Where durability and exacerbation of symptoms in other chronic disease states is viewed as validating evidence of the disorder and grounds for an altered type and intensity of service intervention, the display of, or exacerbation of, symptoms in the addiction treatment arena has historically constituted grounds for service refusal or termination.

Arguments over whether addiction treatment should be inpatient or outpatient, whether it should consists of 5 days or 28 days or 5 sessions or 10 sessions, or whether cognitive behavioral therapy is more effective than family therapy or "step work" are all arguments inside the acute care treatment paradigm. Even extended treatment, where it still exists, is often simply a longer version of the same cycle of admit, stabilize, and discharge in which clients briefly participate in "aftercare" and mutual aid groups. In spite of the treatment field's rhetoric that addiction is a chronic disease, its primary interventions do not reflect a model of chronic disease management.

For fear of overstating this point, it should be noted that there are episodes in the history of addiction treatment and recovery that do exemplify a vision of long-term recovery management. Nearly all of the alcoholic mutual aid societies in American history have taken this longer view of chronic disease (recovery) management (White, 1998; White, 2001d). When Synanon, the first ex-addict directed therapeutic community, encountered a high relapse rate among its first graduates, it shifted its goal of returning rehabilitated addicts to the larger community and replaced that goal with the creation of an alternative drug free community where one could live forever (Mitchell, Mitchell and Ofshe, 1980). Methadone maintenance, as pioneered by Dole and Nyswander, reflected a medically-directed model of long term addiction recovery management (Dole, 1988, 1997).

What these quite different approaches share in common is that they were all severely criticized for their longer vision of recovery management. Mutual aid groups have been (and continue to be) criticized for shifting the addict's dependency on a drug to prolonged dependency on the support group, Synanon was criticized for its failure to return addicts to the larger community, and methadone was criticized for the very aspects that exemplified the chronic disease management model: prolonged maintenance of narcotic addicts on a stabilizing, opiate agonist and sustained psychosocial supports. This history would suggest that new efforts to shift from an acute to chronic disease management model of

addiction treatment might well face similar resistance.

III. Toward a Chronic Disease/Recovery Management Model

If one were searching for a pivotal breakthrough of consciousness about the distinction between acute and chronic models of addiction disease intervention, it might very well be found in George Vaillant's 1983 work, *The Natural History of Alcoholism*. Vaillant's longitudinal study of alcoholism and recovery challenged three historical assumptions about the disorder and its treatment: 1) alcoholism can be effectively treated with a single episode of acute care, 2) a treatment episode that is followed by relapse is a failure, and 3) repeated relapses following multiple episodes of acute treatment mean that either the condition or the particular patient is untreatable (Vaillant, 1983). Vaillant's overall work was so pregnant with new ideas that his challenge of these basic premises was lost.

The acute care model of intervening in alcohol- and other drug-related (AOD) problems dominated the explosive growth of treatment in the 1970s and 1980s. In failing to consistently initiate enduring sobriety following a single episode of treatment, the model, by consequence rather than intent, blamed clients for poor clinical outcomes. The model also contributed to the rise of therapeutic pessimism within the larger culture, and helped fuel an ideological and financial backlash against the addiction treatment industry in the 1990s (White, 1998). As an aggressive system of managed care dramatically shortened both inpatient and outpatient treatment, there was growing unease within the treatment community regarding the practice of placing clients with high problem severity and duration through multiple episodes of unlinked, brief treatment that for many did little to alter the long term course of their disorders. This practice proved as demoralizing to treatment staff as it was to the clients and families to which it was applied.

In the October 4, 2000 issue of the *Journal of the American Medical Association (JAMA)*, a potentially historic article appeared entitled "Drug Dependence, a Chronic Medical Illness: Implications for Treatment, Insurance, and Outcomes Evaluation" that was authored by Drs. McLellan, Lewis, O'Brien, and Kleber. The report marks the most complete elaboration to date of the concept of chronic addiction disease. The *JAMA* article reflects several factors now pushing the addiction treatment field away from an acute care model and toward a chronic disease (recovery management) model of problem intervention.

First, there is a growing recognition that managing severe and persistent AOD problems through single or serial episodes of acute treatment is clinically ineffective and constitutes poor stewardship of individual, family and community resources. The "treatment careers" research conducted at the University of California's Drug Abuse Research Center underscores several key points in this emerging view:

- A single, acute intervention rarely has sufficient effect to initiate stable and enduring recovery in those with severe and persistent alcohol and other drug problems.
- Multiple episodes of treatment may be viewed not as failures but as incremental steps in the developmental process of recovery.
- Treatment episodes may have effects that are cumulative (Hser, et al, 1997).

Second, there is a growing recognition that addiction disorders are often chronic and relapsing in nature (Simpson, et al, 1986), have much in common with other chronic diseases (O'Brien and McLellan, 1996), and that new technologies of managing chronic disease could and should be adapted for the treatment of addiction (Lewis,1993; McLellan, Lewis, O'Brien, and Kleber, 2000).

Third, the same managed care system that has lowered treatment dose and intensity and shifted the focus of intervention from one of recovery to that of cost-containment has spawned a treatment renewal movement and a new grassroots recovery advocacy (consumer) movement. These movements are developing a deeper understanding of the long term addiction recovery process and how indigenous community resources may support this time-enduring process (White, 2000c).

Federal and state agencies that fund addiction treatment services have also begun to re-evaluate the traditional acute models of professional intervention. In Illinois, the Department of Human Service's Office of Alcoholism and Substance Abuse has funded the Behavioral Health Recovery Management (BHRM) project to conduct such a re-evaluation. The BHRM project is a multidisciplinary effort to develop service principles and clinical care practice guidelines for the long-term management of severe and persistent behavioral health disorders (Boyle, White,

and Loveland, 2000). Such efforts are part of a more global interest in models of "disease management" that hold promise in improving the quality of health care while reducing health care costs (Lazarus, 2001).

IV. The Nature of Chronic Disease

Chronic diseases are disorders whose symptoms and their severity ebb and flow over an extended period of time; such disorders are often characterized by periods of remission and relapse of varying duration over an extended period of one's life. There are hundreds of thousands of people who have achieved stable and sustained recovered from severe and persistent AOD problems. Many individuals who never achieve full remission can and do achieve long periods of symptom remission and an enhanced quality of life.

Acute Versus Chronic Disorders *Problematic alcohol and other drug use may be just that-problematic-without constituting a chronic disorder. Alcoholism/addiction exists within a larger arena of persons who experience alcohol- and drug-related problems.* Models of sustained recovery management should not be applied to transient, though problematic, episodes of excessive AOD use. Many persons have utilized natural supports, mutual aid involvement or a single episode of treatment to initiate permanent resolution of their AOD-related problems.

Acute disease is culturally viewed as something that happens to you; chronic disease is viewed as a defect in who you are. The challenge of chronic disease management is to manage the disease without turning a person into a thing and contributing to the social stigma associated with the condition.

The Etiology of Chronic Disease *Chronic addiction disease emerges and intensifies through the interaction of multiple factors*: the potency of the infectious agent (the drug), the biological and developmental vulnerability of the host; and the physical, political, economic, and social/cultural environment in which the person-drug relationship occurs.

A large number of chronic diseases have been called "diseases of lifestyle" because they are characterized by risk/resiliency factors related to such areas as daily diet, work habits, frequency and type of exercise, sleep patterns, medication

compliance, style of stress management, drug use, exposure to environmental toxins, specifically contra-indicated (high risk) behaviors, and family and social relationships (Nicassio and Smith, 1995).

The Onset of Chronic Disease *Chronic diseases can have either a sudden onset or a gradual onset* (Rolland, 1987).

The process through which an acute disorder migrates to the status of a chronic disorder is not fully understood. There is in all probability a priming dose of symptom activation necessary to move an acute disorder to the status of a chronic disease. Each acute episode of a chronic disease lowers the kindling point of symptom activation for the next episode. The priming process varies by many factors, including age of exposure. The lower the age of onset of regular use, the greater the potential for addictive disease and the greater the severity and chronicity of addictive disease (Chou and Pickering, 1992; Grant and Dawson, 1997). The kindling point can be raised by postponing age of onset of regular drug use and by enhancing biological resistance (medication, exercise, diet), cognitive abilities (coping and problem solving skills) and social supports (pro-recovery family and peer relationships).

Disease Course and Variability *Chronic diseases exhibit a high degree of variability in pattern of onset, course (life trajectory), intensity, and outcome.* Chronic diseases may present as steadily self-accelerating (progressive), constant, or with alternating cycles of symptom remission and symptom reactivation (relapse) (Rolland, 1987). Most chronic diseases are also subject to unexplained, sustained remission-what in the addiction literature has been referred to as spontaneous remission, auto-remission, natural recovery, maturing out or self-cure (Granfield and Cloud, 1999). Chronic addiction disease also varies widely in its degree of incapacitation and in the speed and timing of such incapacitation. Addiction disease varies in physiological severity (morphological changes that threaten biological homeostasis and viability), functional severity (impact on quality of life and performance of life roles), and burden of illness (costs to the individual, family and society) (Rolland, 1987; Stein, et al., 1987; Starfield, 1974). Such variability demands a high level of commitment to individualized assessment and treatment--both across clients and at different points of time in the life of the same client.

Disease/Problem Co-existence and Interaction *Chronic diseases heighten vulnerability for other acute and chronic diseases.* Alcoholism and other addictions invite other diseases that debilitate and threaten premature death. Acute and chronic diseases interact in ways that amplify their combined intensity and duration and the costs incurred in their management (Stein, et al, 1987). The longer an addiction disease is active, the higher the risk for acute physical toxicity (overdose), chronic physical toxicity (addiction-related tissue damage, e.g., cancer, emphysema, liver disease), behavioral toxicity (trauma or death via accident / violence), infectious diseases (e.g., HIV/AIDS, hepatitis B and C, tuberculosis), and co-morbid psychiatric illness. All programs serving individuals with severe and persistent AOD disorders must become dual and multiple disorder programs that serve the whole person/family through integrated models of care (Lebowitz and Harris, 2000; Drake, et al, 1998; Minkoff, 1989; Norquist, Lebowitz, and Hyman, 1999; Osher, 1996).

Family and Intimate Social Networks and Chronic Diseases *The individual and collective resources of families and social networks are strained (and drained) by adaptation to chronic disease.* A family's capacity for adaptation changes across the family life cycle (Goodheart and Lansing, 1997). The family's style of adaptation to a chronic illness is often shaped by the transgenerational history of responding to crisis, illness, loss and death (Rolland, 1987). Chronic disease of a family member can, by disrupting family rituals, re-aligning family roles; and by altering the allocation of family resources, impact the health and development of all family members as well as the health of adult intimate relationships and parent child relationships.

V. Concepts and Principles of Recovery Management

The shift from acute intervention models to recovery management models of intervening in severe and persistent AOD problems requires new ways of conceptualizing these problems and their resolution or amelioration.

Disease Management *Persons suffering from chronic, incurable disorders need models of intervention that focus on the management of these disorders rather than the cure or treatment of these disorders. Disease management or, as we prefer, recovery management, provides an alternative to the traditional mode of reacting to life-impairing and life-threatening episodes of chronic disorders with unrelated,*

serial episodes of acute, emergency-oriented care.

Recovery management implies a longer term vision of influencing the course of a disorder to enhance length and quality of life. It is about learning, in the absence of a cure, to contain a disorder and to optimize personal and family health over time.

Chronic Disease and Recovery The shift from perceiving and treating addiction as an acute disorder to treating it as a chronic condition requires a shift in focus from the pathology of addiction to the nature of, and processes involved in, long term addiction recovery. It extends the concepts of "addiction career" and "treatment career" (Hser, et al., 1997) to encompass a third concept, "recovery career." There are a number of concepts that constitute important building blocks in the construction of recovery-oriented systems of care for severe and persistent AOD problems.

- There are many pathways and styles of recovery (White, 1990, 1996) and many legitimate sobriety-based support structures. Recovery styles and viable support structures vary by developmental age, gender, ethnicity, social class, and profession and they vary by one's "recovery capital" (the intrapersonal, interpersonal and community resources that can be brought to bear on the initiation and maintenance of recovery) (Granfield and Cloud, 1999).
- The mechanisms and processes that sustain recovery are different than the factors that initiate recovery (Humphreys, et al, 1995).
- Addiction recovery can be self-directed and incremental in nature (Prochaska, DiClimente, and Norcross, 1992), a process of unconscious "drift" (Granfield and Cloud, 1999), or a process of sudden, climactic transformation (Miller and de Baca, 2001).
- Addiction recovery most often involves a process of developmental change, the stages of which can be identified and to which stage-appropriate interventions can be designed and delivered (Brown, 1985; DiClimente, et al, 1992)
- Recovery can be professionally-guided (treatment), peer-guided (mutual support groups) or "solo"/"natural" (use of resources within the self and family/social network). Factors that distinguish those in the former from the latter include problem severity, co-morbidity,

levels of family/social/occupational support, and social class (Sobell, et al, 1993; Sobell et al, 1996a; Larimer and Kilmer, 2000).

- Styles of recovery vary considerably based on whether one does or does not incorporate addiction/recovery as a core element of personal identity, and whether one does or does not maintain active contact with other recovering people as a recovery maintenance activity. These dimensions of style may evolve through the stages of recovery.

- Recovery outcomes vary considerably in terms of primary and secondary drug consumption: abstinence, subclinical (nonproblematic) use, and problem reduction (partial recovery). Recovery outcomes also vary in the broader dimensions of global (cognitive, emotional, family, social, occupational) functioning.
- Post-treatment outcomes are characterized by subgroups who: 1) sustain problematic use, 2) sustain uninterrupted abstinence, and 3) who in the weeks/months/years following treatment vacillate between problematic use, non-problematic use, and experiments in abstinence. Fluid states of addiction/recovery typified by this sizeable third group offer significant opportunities to enhance outcomes via recovery management models of intervention.
- A vision of long term, staged recovery posits treatment and support services (e.g., harm reduction, motivational interviewing, pharmacological adjuncts, cognitive-behavioral therapies, mutual aid groups) not as competing and mutually exclusive technologies but as interventions that can be matched, not just to different individuals, but to the same individual at different stages of his or her addiction/recovery careers.

Because recovery-oriented systems of care are shifting from a treatment lexicon to a recovery lexicon, it will be tempting to view the recovery model as simply a new "buzz" word for treatment as usual. To do so would be a failure to recognize the quite fundamental conceptual and technical shifts implicit within the recovery model.

VI. Toward a Recovery-Oriented Model of Care

The shift from an acute treatment model to a recovery management model requires a fundamental redefinition of the service target; the nature, timing and duration of services; the locations in which services are delivered; the composition of the service delivery team, and the methods and criteria through which services are evaluated. We have been involved at many levels with recovery management models and believe the following are among the most significant of the changes in clinical practice that follow their implementation. We will focus this discussion on how the actual processes of service delivery change rather than on how the move to recovery-oriented systems of care will reshape health care policy and the organization and financing of such services.

1. Service Integration *Recovery management models seek to strategically combine and refine the resources of human service agencies, primary health care providers, and indigenous supports into an integrated system of care that can address stage-specific needs across the span of long term recovery.* Strategies of integration include the creation of multi-agency service delivery teams, cross-training of service professionals, and integrated (and often centralized) outreach, case management, and recovery support services. The primary mechanisms of service integration include a global assessment process/instrument, regular interdisciplinary conferences with the client/family, and the use of a single treatment/recovery plan that directs the allocation of resources drawn from multiple service institutions and indigenous support structures. There is growing evidence that integrated models of care are superior in terms of clinical outcomes and stewardship of community resources than are models that rely on either parallel or serial models of treating chronic and co-occurring problems (Miller, 1994; RachBeisel, Scott and Dixon, 1999; Drake, et al., 1989; Drake, et al, 2001).

2. Identification and Engagement *Recovery management models utilize population-based identification strategies, assertive community outreach, low thresholds of service entry, multiple points of entry, patient registries, and seamless movement between levels of care to locate, engage, retain and re-engage people with AOD problems.* These interventions recognize and seek to work through the many sources of personal ambivalence and environmental obstacles that impede recovery. Engagement is viewed not as an event, but as a process that continues throughout the recovery management partnership.

The very things that are the hallmark of effective brief interventions--feedback of risk, emphasis on personal responsibility, prescriptive advice, a menu of change options, expression of empathy and encouragement, and enhancement of self-efficacy via expression of confidence in client's ability to change (Bien, Miller, and Tonigan, 1993)Bare all integrated within this process of engagement. Such outreach and engagement techniques have been found effective in initiating change in multiple populations: women, ethnic minorities, youth, and drug injectors (Brown and Needle, 1994).

3. Assessment *Assessment activities within recovery management models are a continuous rather than an intake activity, are global rather than categorical, and integrate traditional "treatment plans" into a larger "recovery plan."* The high degree of individual variability in AOD problems, the changing status of these problems over time, unique patterns of problem co-occurrence, and concerns regarding the misapplication of recovery management approaches all require rigorous, ongoing and global assessment activities. Global assessment assumes that the germination and development of severe AOD problems spring from multiple elements of the personal, family and cultural ecosystem and that the resources needed to resolve these problems are located within these same arenas.

Recovery management models integrate the traditional medical model "treatment plan" with the "recovery plan" utilized within social model alcoholism treatment programs (Borkman, 1998b). In contrast to a treatment plan, the recovery plan: 1) is prepared and regularly updated by the client, 2) documents the goals and planned activities of the client, and 3) covers such life domains of the client as finances, social life, legal difficulties, education, employment, and spirituality (Borkman, 1998a). Recovery management models provide a structured and individualized transition between professionally-directed treatment planning and self-directed recovery planning.

4. Definition of "Client" *In recovery management models, the definition of "client" shifts from the symptomatic individual to the family and cultural milieu and the individual nested within it.* In recovery management, family members and social network members are all co-providers of recovery support services and legitimate recipients of services in their own right. Recovery priming can occur by moving the family and social network toward greater health and understanding of addiction disease even without the symptomatic individual's direct participation.

The focal point of action in the recovery management model is not on what the treatment professional does but on the client and family's capacity to self-direct their own recovery.

5. Service Goals *The mission of recovery management is to help each person suffering from addiction disease to achieve their optimal long term outcome (as measured by the quality and duration of life, achievement of personal goals, and his or her impact on family and society).* Recovery management strategies are aimed at multiple stage-specific goals:

- slowing the speed of disease acceleration and the speed of decline in biopsychosocial functioning,
- initiating, strengthening and extending periods of symptom remission (reducing the number, intensity and duration of relapse events),
- preventing the onset of, or reducing the severity of, co-morbid conditions,
- producing full and sustained symptom remission where possible,
- achieving the maximum level of age (stage)--appropriate functioning and health for the individual/family, and
- reducing the personal, family and social costs associated with addiction and recovery management.

The focus of recovery management is on reducing addiction-related mortality, decreasing the duration and degree of addiction-related incapacitation, and promoting the development of long term processes of disease stabilization and recovery. Recovery management services seek to enhance the capacity of each client/family to achieve their highest degree of functioning, regardless of whether that level is one of full or partial recovery.

6. Service Scope and Technologies *For clients whose patterns of AOD use reflect chronicity and severity, the best strategy for long term recovery is proactive engagement, disease stabilization (acute treatment), recovery management education, ongoing recovery support, monitoring with feedback, and, when necessary, early re-intervention and re-stabilization.* Recovery management doesn't so much replace the acute model as much as wrap that model in a larger continuum of support services and shift the focus from one of treating the acute manifestations of addiction to building a life of recovery.

These “recovery support services” focus on eliminating barriers to recovery and on enhancing what Granfield and Cloud (1999) have christened “recovery capital”--the intrapersonal, interpersonal and environmental resources that can be drawn upon to aid recovery. Such services encompass traditional clinical services but extend further into such areas as sober housing, pro-recovery educational and employment opportunities, day care and transportation services, and pro-recovery leisure activity. The essence of recovery management involves sustained monitoring of the status of a chronic disease, sustained monitoring of the effectiveness of recovery management strategies, and continual, stage-appropriate refinements in recovery support services.

7. Timing and Duration of Services *The temporal focus of recovery management services is on interrupting the acceleration of AOD problems before the crises that generally initiate acute treatment episodes and sustaining support long after such episodes are traditionally defined as completed.*

By metaphorically changing the role of the addiction treatment specialist from that of an emergency room physician to that of a primary physician managing the long-term course of diabetes or hypertension, the recovery management model renders the concepts of “discharge” and “aftercare” anachronistic. In the recovery management model, all care is an element of continuing care. Continued telephonic, electronic (e-mail) and postal delivery of recovery education; monitoring; support; and, where needed and desired by the client and not otherwise available in the community, ongoing face-to-face group and individual support, are routine elements of the recovery management model. Within this model, intensity of services decrease over time but the commitment to and access to sustained recovery support remains constant.

8. Delivery Locus *The locus of service activity within the recovery management model combines the primary health care institution (the inpatient/residential institution and the centralized outpatient clinic) with home-based, neighborhood-based service delivery, with a particular emphasis on the latter.* Two principles-personal autonomy and pro-recovery social support-guide recovery management models. First, persons suffering from AOD problems and addictive diseases seeking help are served within the least restrictive, least isolating and least coercive environments and methods possible. Second, transfer of learning is directly related to the degree of physical, psychological, and cultural distance between service

delivery site and the client's natural environment. In the recovery management model, services are delivered as close as possible to the natural living environment of the client. Any isolation of the client from that environment is accompanied by intensive transition services aimed at transferring learning from the institutional environment to the client's natural environment. In the recovery management model, as much effort is spent focusing on developing ecosystem supports for recovery as is spent on focusing on pro-recovery, intrapersonal changes.

9. Service Relationship *With recovery management, the service relationship shifts from a "dominator model" to a "partnership model."* The traditional relationship between addiction treatment providers is time-limited, hierarchical, and commercialized. Power, status and strength lie on one side of the relationship and stigma, powerlessness and problems lie on the other side. The patient seeks the help of the expert who diagnoses the patient, prescribes what the patient must do to get well, and then seeks to manipulate the patient's compliance.

Recovery management replaces this expert-centered service relationship with what Eisler (1987) has characterized as a "Partnership Model" and what Lazarus (2001) has characterized as "consumercentric care." The focus is on creating a collaborative alliance that shifts the focus of recovery from the treatment professional to the person seeking and experiencing recovery. The service professional shifts from the roles of diagnostician and treater to the roles of long term ally and recovery consultant. One of the essential dimensions of recovery management is continuity of contact over time in a primary service relationship.

This partnership requires the deep involvement of clients in the design, implementation, and evaluation of services. In the recovery management model, treatment professionals and their institutions become students and allies of the growing consumer/survivor movement in the United States (Anthony, 1993; Kaufmann, 1999; Chamberlin, 1990; White, 2000c). The recovery management model could help the field of addiction treatment face in the twenty-first century what it has never faced in its history: a strong consumer movement led by recovering people/families who are knowledgeable, articulate, well-organized, and angry at their historical exclusion from policy and clinical decision-making.

10. The Role of Community in Recovery *The goal of recovery management is not to forever enmesh all persons with severe and persistent AOD problems in*

professionally-directed treatment services; it is to open resources in the wider community that will enhance each client's own capacity for recovery self-management. The goal is to help nest the client within a physical, psychological and social space where long term recovery can be nurtured. This involves enmeshing the client in recovery-supportive relationships that are natural (rather than professionalized), enduring (rather than transient) and reciprocal (rather than fiduciary and commercialized).

The community, when organized and educated, can be a reservoir of hospitality and support for recovering people. Professionally directed treatment services should be the last, not the first, line of defense in the management of chronic addictive diseases. The first lines of resources for the management of alcohol and other drug problems consists of the individual's own natural resiliencies, family and intimate social networks, and other non-professional support systems within the individual's natural environment. Interventions that inadvertently undermine and replace the natural support functions of the self, the family, and the community with professionalized and commercialized supports fail both on technical and ethical grounds (McKnight, 1995).

11. The Recovery Management Team *The recovery management model places greater emphasis on the use of the client, his or her family, natural helping systems within the community, and on indigenous recovering people within the recovery management team.* In the future, many recovery support services will be provided by recovered and recovering persons and by recovery-based service organizations which will utilize recovering individuals, family members and other "folk healers" from within the community as recovery support specialists. Such individuals will fill both volunteer and paid staff positions.

12. Service Evaluation *The evaluation of recovery management strategies involves the client/family as the primary evaluator, measures client/family functioning over a much longer (5-15 years) period of time (Vaillant, 1983), and assess the synergistic interaction and cumulative effects of multiple interventions. If the transition to a recovery management model is achieved, addiction treatment and recovery support services will be judged by the same standards that are used to evaluate the treatment and management of other chronic diseases (as advocated by O'Brien and McLellan, 1996).*

The essence of the acute care model is to deliver a single treatment episode, and then to evaluate that episode based on symptom remission or reactivation during the months following "discharge" from that service episode. In contrast, the recovery management model assumes that a return of symptoms following a single treatment episode does not mean that a particular intervention was a failure, nor that sustained remission following an intervention reflects success where earlier episodes had failed. Recovery management models assume that symptom remission or relapse can occur independent of service interventions and that interventions can have delayed, cumulative or synergistic effects. The focus thus shifts to evaluating extra-treatment factors as well as evaluating particular combinations and sequences of interventions as they interact with the evolving life of the client/family.

Recovery management models include consumer participation and use of consumer-influenced evaluation criteria (Sloves, 2000). Like the assessment process, evaluation shifts from an end-of-service-episode or follow-up event to a continuous process and shifts from a categorical evaluation (focus on presence or absence of alcohol/drug use) to a global evaluation (focus on the health, quality of life and social functioning of the individual/family as well as the impact of intervention on the community, e.g., social costs, reduced threats to public safety).

VII. Pitfalls

The chronic disease recovery management model described in this paper is not without its potential pitfalls.

Funding: Virtually all funding of addiction treatment is currently set up to reimburse episodes of acute care provided by categorically segregated service specialists. A shift to the recovery management model will require population-based funding for longitudinal care delivered by multiple providers organized into integrated systems of care (Pawlson, 1994). Fundable services will need to include outreach, early intervention, case management, monitoring, harm reduction services, and a broad spectrum of recovery support services. There is a danger that the recovery management model could be manipulated by funding organizations to eliminate high intensity/high cost components of service continuum. There is also a danger that a greater responsibility for recovery support could be shifted to the

community while all the financial resources remain within professional agencies and managed care entities.

Service Capacity: The shift from an acute intervention to a recovery management model will require new strategies for defining and managing service. Recovery management will require larger caseloads as service professionals maintain contact with a mix of people in widely varying stages of recovery. The increased numbers of people will be mirrored by a smaller percentage of clients with high intensity service demands. This will require new systems of defining and managing service caseloads.

Stigma and Therapeutic Pessimism: If not handled with great care, the "chronicity" language may undermine belief in the potential for permanent resolution of addiction (Brown, 1998). We feel very strongly that the presentation of this model needs to be framed as "recovery management" and not "chronic disease management" to both consumers and the community. We must be able to convey two messages: 1) uninterrupted remission of addiction is possible and a reality in the lives of hundreds of thousands of people, and 2) active recovery management can reduce the frequency, intensity and duration of relapse episodes as it enhances the quality of life and global functioning of those persons who have yet to achieve uninterrupted sobriety.

Iatrogenic Effects from Model Misapplication: There is a danger that a chronic disease management model will be misapplied to individuals whose AOD problems represent not chronic disorders but transient problems that will quite likely spontaneously remit with time and maturation or respond to brief intervention. The potential indiscriminate application of a chronic disease management model to children and adolescents presenting with AOD use is of particular concern.

Service Provider Accountability: "Chronic Disease" could become a shroud that hides and decreases the accountability of service providers for clinical outcomes. Service providers cannot be allowed to blame clients and the nature of their disorder on poorly designed and executed service technologies. Recovery management models should be subjected to more, not less, accountability for long term clinical outcomes (Brown, 1998).

Financial Exploitation: The chronic disease / recovery management model could be financially exploited by treatment institutions who "capture" a population of chronic alcoholics/addicts and provide a high frequency of long term billable services rather than linking these clients to indigenous resources that would diminish their need for these agency-provided services.

Ethical Dilemmas: The recovery management model raises a whole spectrum of ethical issue that will need to be addressed. These include:

- What is the boundary between appropriately assertive outreach and inappropriately intrusive outreach ("stalking")?
- When are we doing too much or too little?
- What relationship boundaries should guide this prolonged "partnership" with clients/families?
- Does a client have the right to not be "monitored and managed?"
- Who is the client (when an agency is contracted to provide prolonged case management services to reduce a client's threat to public safety or to reduce the client's consumption of scarce community resources)?

From Dynamic to Static Model: There is a danger that clinical care guidelines used within the recovery management model could reduce the treatment of complex disorders to "cookbook medicine." This is not a rational for avoiding evidence based practice guidelines, but a caution that an adequate "toolbox" must be complemented with clinical training and clinical supervision to assure proper clinical judgement in applying techniques in an individualized manner.

Staff Support: In an acute care model, staff working with the most difficult of clients take solace from the fact that this involvement is short term and will be replaced in a few weeks with a new, perhaps less difficult client. The recovery management model will place staff in contact with these most difficult clients for much more prolonged periods of time. Without special supports (clinical supervision, team models of service deliver, etc.), this model could face challenges related to staff morale and retention. Continuity of contact is crucial to the success of the recovery management model; staff turnover must be kept at a low level.

VIII. Summary

Chronic diseases possess many characteristics that distinguish them from acute disorders. They tend to have complex etiologies in which behavioral choices play a role in symptom onset, severity and duration. Their courses are prolonged and often characterized by periods of remission and relapse. They lack definitive cures but can be effectively managed by combinations of interventions. Although severe AOD problems have long been characterized as chronic diseases, their treatment has more closely resembled acute care interventions. The shift to a (chronic disease) recovery management model will require changing our very understanding of the nature of severe and persistent AOD problems and changing the timing and duration of service intervention, the composition of the service delivery team and the methods and criteria used to evaluate our interventions into these problems.

While traditional models of care will continue to meet the needs of many individuals who have sufficient "recovery capital" to resolve their AOD-related problems through a single episode of care. Clients who do not respond to such acute care will require recovery management models that sustain contact longer and place greater emphasis on recovery education, long-term monitoring and support, and early re-intervention. The potential pitfalls in this shift toward recovery management models include the demands that will be required to change how services are funded and organized, the potential misapplication of chronic disease models to persons whose AOD-related problems are transient in nature, and the need to manage new and complex ethical issues that will arise within the context of long term service relationships. Models of recovery management offer great promise in the future treatment of severe and persistent alcohol and other drug problems. We must be careful, however, in reaching for this future to not lose what is most valuable within the current system of care.

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Adolescent Substance Abuse Treatment: Expectations Versus Outcomes

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Alcohol- and other drug-related problems are once again demanding priority attention of student assistance professionals. After a decade of decline (1981-1991), youthful drug experimentation rose through the 1990s. Between 1991 and 1999, past-year illicit drug use increased from 29% to 42% for high school seniors and from 11% to 21% among 8th graders. Concern also rose regarding an expanding illicit drug menu, heightened drug potency, and lowered age of onset of alcohol and other drug use. At the opening of the twenty-first century, 7,066,000 (3.2%) of U.S. adolescents meet diagnostic criteria for past year substance dependence and another 8,105,000 (3.6%) meet criteria for substance abuse. While the number of adolescents entering treatment each year has risen to 150,000, this is less than 10% of those in need of treatment for substance abuse or dependence.

To assist the student assistance (SA) professional in educating parents about the nature and treatment of adolescent substance abuse disorders, we conducted two focus groups. The first contained parents of children undergoing treatment at Chestnut Health Systems. This focus group identified the most common questions parents have about substance use disorders and their treatment. The second focus group included three senior research scientists (Michael Dennis, PhD, Mark Godley, PhD, and Susan Harrington Godley, RhD) within Chestnut Health Systems' Lighthouse Institute who possess extensive experience in conducting adolescent treatment outcome studies. We asked these research scientists what insights from their studies were most important for parents to understand. Here are the highlights of what we discovered.

The Parents: Perceptions and Expectations

The concerns of parents coming to grips with the substance use of their children fall into three broad areas. The first concerns focused on the sources of such use. Source questions reflected the parents' feelings of culpability and, for some, their need to project blame on others for the problems of their children. These questions reflected the difficulties parents have understanding the potentially complex roots of adolescent substance use.

The second set of questions raised by parents involved how best to respond to their child's drug use. When professional treatment was under consideration, the parents had a whole range of other questions regarding the availability, length, nature and costs of various treatments. They also raised questions about how to determine the quality of a treatment program, and they raised concerns about the security of the treatment environment (e.g., physical safety, exposure to drugs).

The third set of concerns identified in the parent focus group involved what all this meant for the future of their children and their families. Here they discussed their expectations for what a desirable treatment outcome would be and what such treatment would mean for the future of their son or daughter. When given a list of possible treatment outcomes and the freedom to add others, parents overwhelmingly focused on "no alcohol or drug use following treatment" as the only acceptable primary treatment outcome. Secondary expectations included increased happiness of their son or daughter, increased trust between parent and child, improved relationship with a step-parent, greater respect for authority, greater self-respect of child, and better choices of friends. What is interesting about this list is that all of the secondary choices are measured in gradations of change, whereas the primary expectation constitutes intolerance for anything short of complete and enduring abstinence. (The option of "significantly reduced alcohol and drug use" and "absence of alcohol- and drug-related problems" were not considered acceptable outcomes by any parents in the focus groups). We shall discuss shortly whether these parental expectations of substance abuse treatment are realistic and the role the SA professional can play in clarifying and refining these expectations.

In summary, parents of substance-involved adolescents need help understanding the sources and significance of substance use, the potential options for addressing substance abuse, the most likely outcomes of professional intervention, and what role they should play during and after such an intervention.

The Research Scientists: Lessons for Parents

When we asked the research scientists at Chestnut Health Systems to share the most important conclusions they had drawn from their studies of adolescent treatment, including the Center for Substance Abuse Treatment's recently completed Cannabis Youth Treatment (CYT) study (see www.chestnut.org/li/cyt), they offered the following twelve lessons for parents and those who work with substance-involved adolescents.

1. *Many adolescents mature out of substance-related problems in the transition into adult role responsibilities.* This fact does not offset the risks of substance-related developmental delays, disability and/or death that can result from such use. Parents would be ill-advised to assume that substance experimentation is simply a "passing phase" that will dissipate over time without enduring harm. There is a poor understanding of the line between volitional substance experimentation and the emergence of a serious substance use disorder characterized by compulsivity and chronicity.

2. *For other adolescents, substance abuse already constitutes a chronic, debilitating disorder.* In the CYT study, 41% of adolescents who had been diagnosed with cannabis abuse or dependence reported having failed prior attempts to stop drug use, 25% had prior episodes of formal treatment, and 33% were re-admitted to treatment during the year following their treatment in the CYT study.

3. *Many factors increase the risk of substance-related problems and inhibit the process of maturing out.* The most significant of these factors include a family history of alcohol and other drug problems, early age of initiation of regular use, co-occurring emotional/behavioral problems, and a low level of positive family and peer support. In the presence of these factors, substance-

involved adolescents may need significant and ongoing support to initiate and sustain recovery.

4. *The earlier the intervention (in terms of age and months/years of use) with a substance use disorder, the better the clinical outcomes and the shorter the addiction career.* These research findings suggest the potential utility of standardized screening instruments for early identification, the use of global assessment instruments to evaluate at-risk adolescents, and strong linkages between schools and substance abuse treatment and recovery resources.

5. *There are evidence-based, brief therapies that are effective for many substance-involved adolescents.* In a twelve-month follow-up of 600 adolescents who completed one of five brief (5-13 sessions) outpatient treatments within the Cannabis Youth Treatment study, 24% of participants either achieved sustained recovery or achieved recovery after one or more brief post-treatment relapses. (The treatment manuals utilized in this study are available by calling 1-800-729-6686).

6. *Viewed as a whole, the most common outcomes of adolescent treatment are enhancements in global functioning (increased emotional health and improved functioning in the family, school, and community) and reduced substance use (to approximately 50% of pre-treatment levels) rather than complete and enduring cessation of alcohol and other drug use*. Post-treatment abstinence and relapse are not static phenomena, but alternating states for many adolescents. A study that examined outcomes three months following discharge from treatment found that 17% of the adolescents reported no use or problems following treatment, 53% reported minor relapse (isolated use without heavy use or associated problems), 18% reported moderate relapses (weekly use with some associated problems in past month), and 11% reported major relapses (heavy or daily use with problems experienced on most days of use). The implication of these figures is not that treatment is ineffective for the majority of adolescents, but that, like other chronic disorders, multiple episodes of intervention may be required to resolve severe and persistent substance use disorders. The predictable time point at which recovery is fully stabilized (point at which risk of subsequent relapse dramatically declines) is not known for adolescents. No such longitudinal studies have been completed. The SA professional can help parents develop realistic expectations of treatment and understand that relapse is often a part of the process of long-term recovery.

7. *All treatment programs are not the same*. Those programs with the best clinical outcomes: a) treat a larger number of adolescents, b) have a larger budget, c) use evidence-based therapies, d) offer specialized educational, vocational, and psychiatric services, e) employ counselors with two or more years' experience working with adolescents, f) offer a larger menu of youth-specific services (e.g., art therapy, recreational services), and g) are perceived by clients as empathic allies in the recovery process.

8. Most adolescents are precariously balanced between recovery and relapse in the months following treatment. The period of greatest vulnerability for relapse is in the first 30 days following treatment; the adolescents' status at 90 days following treatment is highly predictive of their status at one year following treatment. The fragility of early recovery is underscored by the fact that few treated adolescents participate at any significant level in professionally directed aftercare groups or mutual aid groups such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA).

9. The stability of recovery is enhanced by post-treatment monitoring and periodic recovery checkups. Assertive continuing care is characterized by sustained continuity of contact and support, and assumption of responsibility for such contact by the service professional rather than the adolescent. Placing recovery support services within the adolescent's natural environment (e.g., recovery home rooms, in-school recovery meetings, and

recovery schools) also offers great promise for boosting treatment outcomes.

10. *The adolescent's post-treatment peer adjustment is a major determinant of treatment outcome. Adolescents who experience major relapse have the highest density of drug users in their post-treatment social milieu.* Adolescents entering recovery often find themselves in a social limbo. They may have been rejected by their non-using peers, are trying to disengage from their drug-using peers, and have yet to establish a peer-oriented recovery network. Finding ways to re-negotiate contact with the existing peer network and getting linked to other recovering adolescents may be crucial for adolescents caught between these social worlds. Parents can help manage the risks of this limbo period by supporting involvement in relationships and activities that do not involve alcohol or other drug use. While a change in friends is a common recommendation for adolescents entering recovery, the truth is that few adolescents are able to completely change their social networks. We need to find ways to work with such networks to enlist their support and neutralize their ability to sabotage recovery efforts.

11. *The post-treatment home environment also plays a significant role in recovery/relapse outcomes.* Parents can do everything right and still have an adolescent relapse following treatment, but there are things parents can do to help tip the scales toward post-treatment recovery. We know, for example, that relapse among adolescents is more common in homes with less family cohesion and more family conflict, and where parents are consuming alcohol or other drugs in the home. The best advice we can give parents wishing to support their child's recovery is to: a) refrain from using alcohol or other drugs in the home, b) become involved in their child's recovery activities, c) actively monitor their child's recovery progress, d) recognize and praise positives in the child's post-treatment adjustment, e) participate in their own family recovery meetings, and f) help their child develop pro-recovery supports outside the family.

12. *Recovery mutual aid networks (AA, NA, etc.) can offer considerable support for long-term recovery, but they suffer from low teen participation rates and their effect is dependent upon intensity and duration of participation*. Recovery outcomes improve with increased meeting attendance and participation, increased knowledge of a particular recovery program (e.g., reading AA literature, AA sponsorship), and involvement in pro-recovery social activities.

The Future of Adolescent Treatment

There are a number of prospects for improving adolescent recovery outcomes. These include refinements in treatment methods (particularly the use of evidence-based, manual-guided therapies); better pharmacological adjuncts to treat both substance dependence and co-occurring psychiatric disorders; the development of systems for post-treatment monitoring; support and early re-intervention; and building youth-oriented recovery cultures within local communities (within the neighborhoods, schools, and churches). We envision a day when SA professionals all across America will join hands with parents, treatment professionals, and research scientists to make this vision a reality.

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Methadone and the Anti-medication Bias in Addiction Treatment

William L. White and Brian Coon

An Introductory Note: This article is long overdue. Like many addiction counselors personally and professionally rooted in the therapeutic community and Minnesota model programs of the 1960s and 1970s, I exhibited a rabid animosity toward methadone and protected these beliefs in a shell of blissful ignorance. That began to change in the late 1970s when a new mentor, Dr. Ed Senay, gently suggested that the great passion I expressed on the subject of methadone seemed to be in inverse proportion to my knowledge about methadone. I hope this article will serve as a form of amends for that ignorance and arrogance. (WLW)

There is a deeply entrenched anti-medication bias within the field of addiction treatment. This bias is historically rooted in the iatrogenic insults that have resulted from attempts to treat drug addiction with drugs. The most notorious of these professional practices includes: coaching alcoholics to substitute wine and beer for distilled spirits, treating alcoholism and morphine addiction with cocaine and cannabis, switching alcoholics from alcohol to morphine, failing repeatedly to find an alcoholism vaccine, employing aversive agents that linked alcohol or morphine to the experience of suffocation and treating alcoholism with drugs that later emerged as problems in their own right, e.g., barbiturates, amphetamines, tranquilizers, and LSD. A history of harm done in the name of good culturally and professionally imbedded a deep distrust of drugs in the treatment of alcohol and other drug addiction (White, 1998). This article will explore how this anti-medication bias has influenced the perception of methadone maintenance treatment (MMT) by policy makers, addiction treatment professionals, MMT consumers and the public.

Methadone Maintenance Treatment

The United States has a long history of attempting to stabilize the functioning of opiate-dependent individuals with daily doses of prescribed narcotics. Nineteenth century physicians routinely provided such maintenance, and 44 communities operated morphine maintenance clinics between 1919 and 1924. Attempts at morphine and heroin maintenance were plagued by the pharmacological properties of the drugs—properties that left patients cycling each day through periods of acute intoxication and acute withdrawal. Mid-twentieth century

studies of non-maintenance treatments for opiate addiction consistently reported relapse rates in the upper 90th percentiles (White, 1998).

In the mid-1960s, Drs. Vincent Dole, Marie Nyswander and Mary Jeanne Kreek pioneered the use of methadone, a long-acting synthetic narcotic, in the treatment of heroin addiction. In contrast to morphine and heroin, blockade dosages (80-120 mg/day) of methadone lasted 24-36 hours, allowing opiate-dependent patients a window of stable functioning that prevented the twin impairments of narcotic intoxication and withdrawal sickness. What was most striking about opiate-dependent patients on methadone was their "physiological normality" (Dole, 1988). The positive evaluations of these early MMT trials led to the emergence of methadone as a major opiate treatment modality during the 1970s and 1980s. Today, approximately 179,000 of the more than 900,000 opiate addicts in the United States are enrolled in MMT (Kreek and Vocci, 2002).

MMT rests on three propositions: 1) opiate addiction is a brain disorder; 2) optimal daily doses of methadone normalize the metabolic processes of persons whose endogenous opioid receptor systems have been compromised by prolonged opiate use, and 3) methadone-induced metabolic stability provides a safe, homeostatic platform upon which more global efforts at physical and psychosocial rehabilitation can be constructed.

The Good: Clinical and Cost Effectiveness

No addiction treatment modality has been more extensively and rigorously evaluated than methadone maintenance. Nearly every major health policy body has reviewed the evidence on MMT, including the National Institute on Drug Abuse, American Medical Association, American Society of Addiction Medicine, Institute of Medicine, National Academy of Sciences, National Institute on Health Consensus Panel, and the Office of National Drug Control Policy. These collective reviews conclude that orally administered methadone can be provided for a prolonged period at stable dosages (without the escalation in tolerance seen with morphine or heroin), with a high degree of long-term safety, and without significant effects on psychomotor or cognitive functioning. These reviews also confirm that MMT delivered at optimal dosages by competent practitioners: 1) decreases the death rate of opiate-dependent individuals by as much as 50%; 2) reduces transmission of HIV, 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.

The full positive effects of MMT documented in the literature are not automatic. They are contingent upon access to MMT, adequate dosages of methadone, competent staff, and a full range of psycho-social rehabilitation services in addition to prescribed methadone. They are also contingent upon continued involvement in MMT. Rates of relapse following termination of MMT are high even for clients clinically judged to have a good prognosis for recovery without methadone. The effectiveness of methadone as a biologically normalizing agent and the continued need for it by many patients has prompted addictionologist Dr. Avram Goldstein (2001) to compare the role of methadone in the treatment of the opiate-dependent person with the role of insulin in the treatment of the diabetic.

The positive evaluations of MMT rest primarily on what it reduces and eliminates (e.g., heroin use, crime, HIV transmission) rather than on what it adds to the quality of individual, family and community life. As a field, we know almost nothing about the pathways, styles and development stages of recovery for MMT patients and their families. The absence of pathology tells us nothing about the reconstruction of character, personal identity and interpersonal

relationships within methadone-assisted recovery. People in stable, long-term, methadone-assisted recovery are as invisible in the research literature as they are in the larger culture. Their stories need to be told.

The Bad: Over-regulation and Inferior Clinical Practices

The bad news about MMT, in contrast to much public and professional opinion, has little to do with methadone per se, but a great deal to do with the policy, regulatory and clinical milieu in which methadone has been delivered. The problem is that what we know scientifically about MMT has not been reflected in MMT-related public policies and clinical practices. The bad news of MMT is not that people are on methadone, but that hundreds of thousands who need MMT can't get access to it and confront unconscionably long waiting lists for services. (This parallels the period in which oncology patients suffered and died needlessly from lack of access to chemotherapies with proven efficacy.) All of the major reviews of MMT have concluded that the historical over-regulation of MMT by federal and state authorities has hampered the spread and operation of MMT programs and created exorbitant demands on the daily lives of MMT patients. Other problems found in some MMT clinics include:

- exorbitant clinic fees
- suboptimal dosages (20-40 mg/day), particularly within MMT programs that serve African Americans (While suboptimal doses result in withdrawal symptoms, self-medication with unprescribed drugs, and premature disengagement from treatment, a 1988 survey found 79.5% of MMT patients receiving suboptimal doses; 35.5% of MMT patients surveyed in 2000 were receiving suboptimal doses, D'Aunno and Pollack, 2000.)
- staff manipulation of methadone dosage to reward or punish client attitudes/behaviors
- inflexible and inconvenient pick-up/take-home schedules that interfere with employment, education and family obligations
- inadequate treatment of co-occurring physical and psychiatric disorders
- MMT staff who are ill-trained and lacking in cultural competence
- inadequate levels of psycho-social therapy and recovery support services
- tolerance of deviant behavior (drug selling, prostitution) within the MMT clinic milieu, and
- arbitrary limitations on length of MMT services (e.g., six months), inappropriate pressure for cessation of methadone use, and premature discharge.

Our greatest concern with MMT is not about the utility of long-term opiate maintenance, but on the lack of a vibrant culture of recovery to surround this pharmacological adjunct. The existence of programs that were little more than methadone filling stations contributed to the poor professional and public reputation of MMT. This is not a problem with methadone, but a problem of poor policy (MMT as a crime control strategy versus a recovery program) and poor clinical technology (the failure to imbed methadone within a comprehensive menu of habilitation and recovery support services).

The Ugly: Professional and Public Stigma

The ugly side of MMT can be found in the misconceptions, controversies and stigma that continue to surround it. Myths and misconceptions about methadone among heroin addicts and even among those enrolled in MMT (e.g., "methadone eats your bones and teeth") might be considered comic if they did not affect help-seeking and retention behaviors. (Most symptoms attributed to methadone are related to initial over- or under-dosing, untreated medical conditions previously masked by heroin use, and interactions

between methadone and other drugs (Goldsmith, et. al., 1984).

The broader social stigma of methadone traps the MMT patient in a marginal world. MMT patients are rejected by the addict culture whose members chastise the MMT patient for having "sold out" (surrendered their autonomy to the "orange handcuffs" and the oppressive bureaucracy in which it is contained). They are rejected by the mainstream recovery culture (e.g., MMT patients can attend NA meetings, but only those who are abstinent from all drugs, including Methadone, are welcome to speak). Finally, they are rejected by the civilian culture (persons with no addiction/recovery experience) whose members continue to see MMT patients as "junkies" who have done nothing but replace an illicit drug with a licit substitute.

Studies find the lives of even the most stable MMT patients "shrouded in anguish and secrecy" not because of their past addiction or current treatment, but because of how both are socially and professionally perceived. At a concrete level, this stigma subjects MMT patients to discrimination related to employment, housing and public benefits, and denies them access to a broad spectrum of human services, including access to treatment for co-occurring psychiatric and substance use disorders (e.g., alcoholism and cocaine addiction). As a result, people in methadone-assisted recovery carefully hide their patienthood from their employers and co-workers, their friends and even their own family members (Murphy and Irwin, 1992).

Ironically and tragically, the one place MMT patients might be expected to find tolerance and empathy—within the addiction treatment and recovery community—they are all too often castigated, viewed as not being abstinent, and denied the status and legitimacy of a person in recovery. Such anti-methadone attitudes even infect some MMT programs! MMT patients are particularly prone to internalize the negative judgements of addiction professionals, given the purported "expert" source of such critiques. Within the worlds of addiction treatment and mutual aid societies, recovery for the person in MMT is often viewed as beginning when the individual stops taking methadone. Paradoxically, addiction scientists view such cessation as a potential and often predictable precursor to the reactivation of heroin addiction. And perhaps most tragically, stabilized MMT patients, uneducated about the purpose and pharmacology of methadone, interpret their lack of craving, not as a sign of treatment effectiveness, but as a sign that they no longer need treatment.

The Future

The winds of positive change in the world of MMT are clearly evident in an altered framework of regulatory monitoring that promises a more patient-centered focus, new accreditation standards and processes that are intended to elevate the quality of MMT, the re-evaluation of anti-methadone policies by American drug courts and probation departments (see *Ending Discrimination Against People with Alcohol and Drug Problems 2003*--a publication of Join Together), improved training of MMT staff, the growing consensus that methadone dosages should be set not by regulatory fiat but based on objective, quantifiable individual factors (differences in methadone metabolism as determined by serum blood levels, for example), and in efforts to enrich the available psychosocial and recovery support services within MMT programs. Change is also evident in efforts to expand the pharmacological adjuncts (e.g., buprenorphine) used in the treatment of opiate addiction and in the growing number and sophistication of MMT-based professional advocacy groups (e.g., the American Association for the Treatment of Opioid Dependence), consumer advocacy groups (e.g., National Alliance of Methadone Advocates, Advocates for the Integration of Recovery and Methadone (AFIRM), (Woods, 1997), and methadone-based recovery mutual aid societies (e.g., the more than 600 Methadone Anonymous chapters).

We envision a future in which a growing vanguard of people in methadone-assisted recovery will step into the public

light to offer their own transformed lives and their renewed health and retrieved citizenship as living proof of the potential benefits of MMT. We envision a day in the near future when stable MMT patients will be cared for in office-based settings by their primary care physician or addictionologist. Challenging these positive signs are two troubling conditions: 1) the great misconceptions that continue to surround MMT and 2) the many opiate-dependent people who are denied access to care or who continue to receive substandard care (D'Aunno and Pollack, 2002).

As addiction treatment evolves into a field of evidence-based clinical practices, addiction professionals will encounter scientific findings that challenge bigotries and biases that have long masqueraded as professional wisdom. It is time for all of us look at the evidence on MMT and recognize its potential value and legitimacy. It is time we work to upgrade the quality of MMT. It is time we warmly welcome people in medication-assisted recovery through the doorways of local communities of recovery. It is time we end the pariah status of those in methadone-assisted recovery.

William L. White is a Senior Research Consultant at Chestnut Health Systems and the author of *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*. **Brian F. Coon** is the Administrative and Clinical Supervisor of the methadone maintenance program at the Peoria, IL. Human Service Center.

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Questions and Answers About Adolescent Substance Use Problems and their Treatment

Richard A. Risberg & William L. White
Chestnut Health Systems

This is one of two pamphlets that was written specifically for parents and guardians of adolescent substance users. This pamphlet—Pamphlet 1--is designed for the parent who has questions about adolescent substance use or is participating in an initial substance use assessment. The second pamphlet—Pamphlet 2—is designed more for the parent whose adolescent will be entering treatment. Some of the same questions and answers appear in both pamphlets.

Introduction

When an adolescent develops alcohol or other drug-related problems, every aspect of their personal, family, and social life can be affected. It is normal for parents discovering such problems to feel confused, angry, frustrated, afraid, and guilty. Many parents are also unsure about how they should respond to this problem and what community resources might be of help.

There are several steps that parents can take in responding to adolescent substance use. They can educate themselves about adolescent substance use problems, become familiar with various intervention options, and learn how they can help resolve the problem. This pamphlet is intended to provide information that can help with this process. It answers many commonly asked questions about adolescent substance use and the treatment of substance use problems.

If you have additional questions, please call Chestnut Health Systems (CHS) at (309) 827-6026 and ask to speak to one of our case managers. The case manager can answer your questions and help you decide if your son or daughter would benefit from professional assessment and treatment services.

I. Identifying Substance-related Problems

Isn't alcohol/drug experimentation normal for adolescents?

A majority of adolescents experience some alcohol or illicit drug use prior to graduating from high school. In a 2001 survey, 80% of high school seniors reported having used alcohol (64% reported having

been intoxicated) and 54% of seniors reported having used an illicit drug. These high "lifetime exposure" figures hide the fact that regular use of alcohol and other drugs occurs at much lower rates. Less than 5% of youth use illicit drugs (mostly marijuana) daily. While some exposure to alcohol and drug use is common in the transition from adolescence to young adulthood, most youth do not use them in the amount or frequency that leads to problems.[1] However, it is important to note that "normal" experimental use can cause problems and may need to be addressed in a treatment setting.

Don't some kids just grow out of alcohol or drug problems?

Yes. The majority of young people who use alcohol and other drugs excessively during their adolescent and young adult years mature out of such use. They reach a decision to stop alcohol and drug use completely or they gradually reduce the frequency and intensity of such use[2] as they mature and take on adult responsibilities (e.g., full time employment, a stable intimate relationship, parenthood, and involvement in community civic activities). This fact does not diminish the risks and prolonged consequences that can result from adolescent substance use including developmental delays, school problems, family discord, life-altering events such as arrest and incarceration, and even injury or death.[3] Responsible parents should not ignore adolescent substance use and related problems. The risks are high. Substance use problems can quickly escalate in the absence of consequences.

What are the differences between those young people who grow out of these problems and those for whom these problems continue to get worse?

Why some adolescents experiment with alcohol and drugs and mature out and others develop severe and prolonged substance use problems is not fully understood. Youth who resolve substance-related problems on their own do seem to differ significantly from those who require treatment for such problems. Members of the latter group are more likely to have:

- family histories of alcohol and other drug problems;
- begun substance use at an earlier age;
- more severe substance problems;
- serious co-occurring psychological problems;
- less family and social supports for problem resolution;[4,5] and
- physical changes from continued drug use that makes it more difficult to quit using as the brain adapts to the presence of the drug in the body. There are real changes in how the brain functions.

How do kids get involved and develop problems with alcohol and other drugs? Does this problem mean that we somehow failed as parents?

Some youth may have a higher biological risk for such problems based on a family history of alcohol and other drug problems. Youth with family histories of alcohol and drug addiction are 4-5 times more likely to develop substance use problems than youth without such family histories. Some young people develop dependencies on alcohol and other drugs as a byproduct of their effort to relieve the distress of personal or family problems. Adolescents can also develop substance problems through involvement with a peer group in which substance use is a normal way to have fun. In this pattern, substance use serves as a ticket of social membership and personal identity that can bring unintended consequences. Other youth begin using drugs or alcohol as a form of juvenile protest—a misguided declaration of independence.

Parents of youth in treatment sometimes say that they feel they have

somehow failed as parents. What parents have done or failed to do may or may not have anything to do with their son or daughter's substance use. No treatment professional will blame you or want you to blame yourself if your child has developed a problem. There are many pathways that can lead to adolescent problems with alcohol and other drugs, and these problems unfold in different patterns that require different types of treatment. The important thing is to move forward. The assessment of an adolescent's substance use by a trained professional can help identify the most appropriate treatment approach and offer parents guidance on how best to respond to such problems.

What are the warning signs of substance use problems?

Indications of substance use problems can occur in three areas. The first is in the adolescent's physical relationship with the drug. Warning signs include:

- increased tolerance (the need for increased quantities of a drug to produce the desired effect);
- cravings (physiological hunger for the drug); and
- withdrawal (physical and emotional distress following cessation of drug use).

The second sign of a problem is a reduced ability to control drug consumption. This can take two forms:

- inability to abstain from using (daily or frequent use in spite of resolutions to stop or cut down), and
- loss of control over use (use may not be that frequent, but when use does occur, binging takes place).

In the latter pattern, the adolescent can choose to use or not use but cannot consistently control how much alcohol or drugs will be consumed once use begins. The third indication of a substance use problem is an increase in the number and seriousness of consequences from alcohol or drug use. Problems in one or two life areas are typical of early stage problem development, but over time all areas of the adolescent's life are often affected. An early treatment intervention may arrest the progression to more severe life problems. Treatment is not just for "addicts and alcoholics". Less intensive levels of care—versus residential treatment—are designed to help adolescents before substance use becomes an addiction.

Why did it take so long for us to recognize this problem?

When a substance-related crisis brings this problem into visibility, parents are often shocked to learn how long substance use has been going on. The early signs of substance use are often very subtle and not easily distinguishable from the usual growing pains and transitions of adolescence. Also, adolescents are exceptionally skilled at hiding the presence, intensity, and consequences of alcohol and drug use from their parents.

When do we need professional help for a substance use problem?

Treatment programs are for adolescents who have lost voluntary control over their alcohol or drug use and whose use is creating problems in their life. Parents should seek professional help for their son or daughter when alcohol and other drug use continues in spite of adverse consequences and when the natural resources of the family, extended family, and the community (e.g., Alcoholics Anonymous, Narcotics Anonymous, faith-based support groups) have not been sufficient to resolve the problem. Unfortunately, many adolescents are unwilling to become involved with social support groups or the family does not know how to address substance use issues. There are early intervention programs designed for youth who are at an early stage of problem

development. The goal of these programs is to intervene before more formal and sustained treatment is necessary. Keep in mind that many substance-involved youth have not yet lost voluntary control, but are in need of better decision-making skills and/or education about the effects that substances can have on one's life.

Professionals can help determine if an early intervention program or more formal treatment services are most appropriate for your son or daughter. Parents are strongly encouraged to contact treatment professionals when in doubt about the seriousness of their adolescent's substance use. A comprehensive assessment will determine the extent of substance use problems and the presence of any other problems that may contribute to their difficulties (e.g., emotional or behavioral problems).

What if my son or daughter does not want to stop using alcohol and other drugs?

Motivation to stop using alcohol or other drugs is not a precondition for seeking professional help. Adolescents nearly always enter treatment due to the influence of others, whether it be parents, the school, court services, or another community system.[6] Most adolescents entering treatment do not want to quit or are ambivalent about the prospects of stopping their alcohol and drug use. After all, substance use is a behavior that has met needs for them and that they enjoyed. But through education and support, many young people reassess their relationship with alcohol and drugs and develop a desire to live a more fulfilling, drug-free life. The goals of treatment are to help the adolescent become aware of the need for change, help them move toward making changes, and to learn how to maintain the changes over time.[7]

II. Getting Help

Where can we get help when our child is experiencing substance-related problems? What are the characteristics of the most successful adolescent treatment programs?

There are several established criteria to help parents assess the quality of adolescent treatment programs. In Illinois, programs should be licensed by the Illinois Office of Alcoholism and Substance Abuse. Programs that are accredited by the Joint Commission on Accreditation of Health Care Organizations or the Council on Accreditation of Rehabilitation Facilities have demonstrated that they meet requirements for a quality program in a number of areas. The program's counselors should have relevant college education, special licenses/certifications in addiction counseling, and significant experience in working with substance-involved youth. Treatment programs that have the best treatment outcomes use:

- comprehensive assessment processes;
- focus on the special developmental needs of adolescents (family and group-oriented treatment);
- address co-occurring emotional/behavioral problems;
- provide strong programming in classroom academics and vocational counseling;
- have flexible policies regarding rule violations; and
- have well-organized monitoring and recovery support services that continue after their initial treatment.[8-10]

What happens during the initial assessment visit?

A parent's first contact with Chestnut Health Systems (CHS) is usually a telephone call with a case manager. The case manager will ask questions to determine if an assessment is needed. An appointment is scheduled to evaluate the nature and severity of the problem. The assessment consists of a comprehensive,

two-hour client interview. The interview questions were developed by the research division of CHS, is used by over 50 treatment programs in the United States, and has proven to be an exceptional aid in the assessment of adolescent substance use problems and emotional and behavioral problems. Parents are also interviewed and asked to complete questionnaires so that the assessor has an accurate picture of the adolescent's strengths and problems.

How is it decided if my child needs treatment and what kind of treatment he or she will receive?

There are standard criteria developed by the American Psychiatric Association[11] used to identify substance use problems. The assessment interview and information gathered from you and any other referral sources (e.g., court services) helps determine whether your son or daughter meets criteria for treatment and what kind of treatment might be most appropriate. Following this evaluation, the staff at Chestnut will provide you their conclusions and recommendations. Not all adolescents who are assessed are recommended for treatment and some are referred elsewhere for other services such as family counseling or for a psychiatric evaluation.

The treatment recommendation for substance problems can range from an hour of individual counseling each week to several months in residential treatment. As problem severity increases, so does the intensity of treatment that may be required. The level of intensity of care is based on guidelines developed by physician members of the American Society of Addiction Medicine[12] (ASAM) that are used by treatment providers throughout the United States.

Why do central Illinois service providers refer adolescents for treatment to CHS?

CHS is a major provider of treatment in central and southern Illinois. Referrals are made to CHS because:

- It is one of the oldest specialized adolescent programs in the country;
- It is one of the largest adolescent treatment facilities in the state;
- It provides financial assistance for those who cannot afford treatment;
- It has a reputation for working successfully with a wide variety of adolescents and their families; and
- CHS has been identified as an exemplary program by an independent review board[13] and has evaluated many of its services through federal fun.[14]

What will treatment cost? What do these costs include?

Treatment costs are covered either by insurance, grants, public aid, or by self-pay. Grants are available to those who qualify and cover up to 95% of the cost of treatment. Most individuals qualify for financial assistance. The rates insurance companies pay vary widely. If you have insurance, talk with them about your coverage for the specific level of care that is being recommended. For specifics about the cost of treatment at CHS, you can contact the Client Intake Assistant at (309) 827-6026. You also will meet with the Client Intake Assistant during the admission process. This person can answer your questions about costs.

Treatment fees have been designed to include nearly all the costs incurred during treatment. The most common other cost is for urine tests that are used to test for substance use during treatment. Some insurance providers do not cover the costs of these tests. Medical costs such as from injuries or for medication may not be covered. Our financial staff will work with you and your insurance provider to see if services for your son or daughter can be covered by various public funds and grants that support treatment services at CHS.

III. Does treatment work?

What can we realistically expect for the emotional energy, time, and money that we may invest in treatment?

Adolescent treatment can be measured in terms of several potential post-treatment outcomes: abstinence, reduced frequency and intensity of drug use, reduced alcohol- and other drug-related problems, and changes in personal health, personal achievement (academic/vocational performance) and interpersonal relationships. The major reviews of adolescent treatment research have drawn the following conclusions:

- All studies report significant reductions in the frequency and intensity of alcohol and other drug use following treatment.[6] Most studies also report significant reductions in related problems (psychological adjustment, school performance, family relationships, criminality) following treatment.[15] Treatment is superior to no treatment even when abstinence is not achieved, with post-treatment drug use reductions of around 50% of pre-treatment levels among those adolescents who use following treatment.[10]
- A review of studies that monitored adolescents following treatment found an average abstinence rate of 38% at one year following treatment, with different programs varying in abstinence rates. The rate of sustained abstinence after one year following residential treatment was 14-47% (data was from four studies). Adolescent outpatient rates of sustained abstinence are even lower. Only a minority of outpatients achieve abstinence at the time they are discharged from treatment.[10]
- No single treatment modality has proven its superiority over other treatment modalities in controlled studies. There is no clear indication at present regarding which particular modality is best for a particular individual. This is why programs like CHS combine many interventions to achieve the best possible outcomes.
- Post-treatment relapse rates for adolescents are high and can fluctuate over time. Relapse rates can be reduced by providing continuing care for monitoring, support, and if necessary, re-intervention.[16, 17]

What do I do now?

If you have concerns that your son or daughter's alcohol and drug use is a problem, by all means talk to someone about this. Talk to individuals you know and trust, whether that be other family members, your priest or pastor, or a school counselor. If you feel you and your child would benefit from a comprehensive assessment, call the adolescent program of Chestnut Health Systems at (309) 827-6026. Ask to speak with a case manager. We have been assisting families like yours for the past thirty years.

Sources for Further Information

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Narcotics Anonymous World Services. (1987). Narcotics Anonymous (5th ed.). Chatsworth, CA: Author.

www.alcoholics-anonymous.org

www.chestnut.org (Chestnut Health Systems)

www.jcrinc.com (Joint Commission on Accreditation of Healthcare Organizations. Information is available

on how to choose a quality behavioral health care provider.)

www.na.org (Narcotics Anonymous)

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I. Identifying Substance-related Problems

What are the differences between those young people who grow out of substance use problems (i.e., are able to stop using without any formal treatment) and those for whom these problems continue to get worse?

Why some adolescents experiment with alcohol and drugs and mature out and others develop severe and prolonged

substance use problems is not fully understood. Youth who resolve substance-related problems on their own do seem to differ significantly from those who require treatment for such problems. Members of the latter group are more likely to have:

- family histories of alcohol and other drug problems;
- begun substance use at an earlier age;
- more severe substance problems;
- serious co-occurring psychological problems;
- less family and social supports for problem resolution;[1,2] and
- physical changes from continued drug use that make it more difficult to quit using as the brain adapts to the presence of the drug. There are real changes in how the brain functions.

When do we need professional help for a substance use problem?

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How is it decided if my child needs treatment and what kind of treatment he or she will receive?

There are standard criteria developed by the American Psychiatric Association[5] used to identify substance use problems. The assessment interview and information gathered from you and any other referral sources (e.g., court services) helps determine whether your son or daughter meets criteria for treatment and what kind of

treatment might be most appropriate. Following this evaluation, the staff at Chestnut will provide you their conclusions and recommendations. Not all adolescents who are assessed are recommended for treatment and some are referred elsewhere for other services such as family counseling or for a psychiatric evaluation.

The treatment recommendation for substance problems can range from an hour of individual counseling each week to residential treatment. As problem severity increases, so does the intensity of treatment that may be required. The level of intensity of care is based on guidelines developed by physician members of the American Society of Addiction Medicine[6] (ASAM) that are used by treatment providers throughout the United States.

Why do central Illinois service providers refer adolescents for treatment to CHS?

CHS is a major provider of treatment in central and southern Illinois. Referrals are made to CHS because:

- It is one of the oldest specialized adolescent programs in the country;
- It is one of the largest adolescent treatment facilities in the state;
- It provides financial assistance for those who cannot afford treatment;
- It has a reputation for working successfully with a wide variety of adolescents and their families; and
- CHS has been identified as an exemplary program by an independent review board[7] and has evaluated many of its services through federal funds.[8]

What if there is a waiting list at CHS and we need to get our adolescent into treatment as soon as possible? What can we do?

CHS can usually provide all levels of outpatient services in a timely manner, but because of its reputation, CHS often has a waiting list for adolescent and adult residential treatment services. CHS staff will work with you to obtain whatever level of services will best suit your family. If the need is for residential services and CHS has a waiting list, our staff will help you find other residential services in Illinois or will provide intensive outpatient treatment or outpatient treatment until a residential admission can be arranged.

III. Treatment Components and the Role of the Family in Treatment

What is treatment? What activities occur during treatment?

There are different levels or types of treatment. Adolescents may begin in one type and then be transferred to another type. The types of treatment are:

- Early Intervention (EI): The adolescent sees an Intervention specialist and participates in substance-related educational and skills-building programs at their school. CHS has EI specialists in many area schools.
- Detoxification: The individual is supervised during the initial withdrawal from alcohol and other drugs. Adolescent detoxification must occur in a hospital setting if withdrawal symptoms are life threatening or severe in nature.
- Outpatient Treatment: The adolescent attends from one to eight hours of individual and group counseling per week, including skills groups.
- Intensive Outpatient Treatment: The adolescent attends from nine to twelve hours of counseling and skills groups each week.
- Day Treatment: The adolescent attends residential groups from approximately 8 am to 9 pm, Monday through Friday and some weekend groups while returning

home each evening to sleep.

- Residential Treatment: The adolescent lives at the treatment facility while participating in day and evening treatment and recovery support activities.

Treatment in all levels of care can involve many different service components, including:

- Skills groups on topics such as emotions, communication, anger and stress management, drug education, self-esteem, HIV/TB education, relapse prevention, family relationships, leisure activities, and basic life skills.
- Individual and group counseling.
- Family education and counseling.
- Working with other agencies or individuals who are involved in the client's life (e.g., probation officers, school personnel, the family physician or psychiatrist, and social workers). This ensures a broad treatment approach that involves all people who have an interest in the young person's well-being.

Each adolescent has personal goals and objectives that the adolescent, the family, and the counselor identify and review throughout treatment.

How long are treatment services provided at CHS?

The length of treatment services varies by the type of treatment. The average length for outpatient treatment is four months, for intensive outpatient treatment it is four to six weeks, for day treatment it is two to six weeks, and for residential treatment it is one to four months. Often adolescents will participate in more than one type of treatment (e.g., residential treatment followed by intensive outpatient or outpatient services). The counselor, adolescent, and the adolescent's family jointly decide when discharge from treatment is appropriate. This decision is based on the adolescent's progress while in treatment.

What are the backgrounds of treatment counselors?

Many primary counselors at CHS have completed or are completing a Master's degree in the behavioral sciences such as counseling or social work, and are in the process of obtaining licensure by the state of Illinois. Some counselors have Bachelor's degrees and have earned or are working on becoming a state-certified addictions counselor. Any staff person who provides direct services to the clients must be certified or licensed by the state within two years of their date of hire. Some staff members are also in long-term recovery. All CHS staff participate in regular continuing education and training.

Will my child be taking any medications? If so, will he/she need to continue taking medication after treatment?

An adolescent may take medication as part of his or her treatment if a psychiatrist or physician prescribes it and both the parent/guardian and the adolescent agree with the recommendation. The potential benefits and risks and side effects of any medication are explained before the decision to use it is made. Some of these medications may need to continue to be taken after treatment.

Most of the time medications are used for treating co-occurring disorders that may be related to the onset or intensity of substance use, such as depression or Attention-Deficit/Hyperactivity Disorder (ADHD). Adolescents in treatment are monitored as to their need for a psychiatric evaluation that may lead to the recommendation for medication.

Will my child be locked up during his/her treatment? If not, can he or she leave at any time?

CHS is not a locked facility and clients can leave at any time. However, the doors

and windows are alarmed. The alarms alert staff if an adolescent runs or leaves their residential unit. When possible, staff will try to help the adolescent re-assess their decision to leave. Of course many adolescents face legal and family consequences if they leave treatment before a mutually agreed upon discharge date.

Will my son or daughter be safe while they are in treatment (free from exposure to drug use, violence, intimidation, sexual harassment)?

We try very hard to create a safe environment that is structured and consistent. Adolescents are monitored at all times, and staff members are trained to deal with aggressive behavior before it becomes a serious problem. CHS staff strive to ensure that alcohol and drugs are not brought into the facility. Respect for others is an overriding principle of CHS services and is stressed to both staff and clients. But in fact, drugs are occasionally brought into the facility by adolescents. And on rare occasions, adolescents are involved in fighting. Such situations are responded to immediately. It is fair to say that CHS staff do their best to be on guard for these problems.

How will I know if my son or daughter is doing well in treatment and is making positive changes?

You will be expected to stay in frequent contact with your son or daughter's counselor through telephone calls and scheduled meetings. You may also be asked to attend the Family Night program each Tuesday night and/or to participate in regular family counseling sessions. Your counselor will keep you informed of your son or daughter's difficulties and progress. Parents of youth in intensive or outpatient treatment will receive a check sheet every week that provides a summary of the adolescent's progress. For parents whose son or daughter is in residential care, how your son or daughter behaves on weekend passes is often a good indicator of how they are doing in treatment. Parents are also provided urine screen results that confirm abstinence or identify any continuing drug use.

Will I learn how best to help my son or daughter?

Yes, through sessions with your child's counselor and/or through the Family Night program. The Family Night program or family counseling sessions are designed to help you more effectively deal with your son or daughter and to understand what goes on in treatment. Family counseling sessions provide opportunities for you to discuss parenting issues and how to be supportive. Particular attention is given to the support systems that will be required to sustain the gains your child has made during their treatment at CHS.

What can parents do during the time the adolescent is in residential treatment?

First of all, enjoy the increased peace and quiet at home! You can clarify your expectations/rules with the adolescent while they are still in treatment. Talk with your son or daughter about how they can rebuild trust and gain greater freedoms. The adolescent's counselor will help you do this. Attending the Family Night program and/or family counseling sessions will help you deal with your anger, fear, and uncertainty.

Let your son or daughter know that you appreciate his or her commitment to participate in treatment. Remember, it is normal for adolescents to be unsure or ambivalent about stopping alcohol and drug use. It is important that you let your child know in a calm way where you stand on substance use and the rules that need to be followed in your home. Arguments and ultimatums are rarely effective in convincing adolescents to stop using.

Becoming more aware of the positive changes in your son or daughter will probably take some practice on your part, but it is a very good way for you to help the adolescent maintain the positive changes they are making while in treatment. This may require a change in your attitude and focus.

Ask your son or daughter about changes they are making, openly acknowledge and celebrate these changes, and talk about how you can be supportive.

What will treatment cost? What do these costs include?

Treatment costs are covered either by insurance, grants, public aid, or by self-pay. Grants are available to those who qualify and cover up to 95% of the cost of treatment. Most individuals qualify for financial assistance. The rates insurance companies pay vary widely. If you have insurance, talk with them about your coverage for the specific level of care that is being recommended. For specifics about the cost of treatment at CHS, you can contact the Client Intake Assistant at 309-827-6026. You also will meet with the Client Intake Assistant during the admission process. This person can answer your questions about costs.

Treatment fees have been designed to include nearly all the costs incurred during treatment. The most common other cost is for urine tests that are used to test for substance use during treatment. Some insurance providers do not cover the costs of these tests. Medical costs such as from injuries or for medication may not be covered. Our financial staff will work with you and your insurance provider to see if services for your son or daughter can be covered by various public funds and grants that support treatment services at CHS.

IV. Post Treatment Issues: Beginning the Recovery Process

What happens after treatment?

What happens after treatment is critical to maintaining the recovery of your son or daughter and is addressed during treatment. At CHS, each adolescent develops a "recovery plan" that identifies what he/she needs to do after leaving treatment to sustain long-term recovery. The recovery plan details the activities that will guide your child and your family during the weeks and months following treatment. You and your adolescent are encouraged to contact the adolescent's counselor if any questions or concerns arise following discharge from residential or outpatient treatment.

The most critical period in predicting long-term recovery is the first 90 days following treatment, so every effort is made to positively shape this initial post-treatment period. It is during this period that your son or daughter will either revert back to old attitudes, behaviors, and relationships or strengthen new attitudes and behaviors and find people in the community (e.g., AA/NA members, family doctors or psychiatrists, school teachers and counselors, coaches, probation officers, church members, non-using friends, and supportive family members) to support the changes initiated during treatment.

What should we do to prepare for our son or daughter's return home from residential treatment?

Talk with your son or daughter about returning home while they are still in treatment. Discuss trust issues, house rules, the client's continuing care and recovery plan, and your expectations about communication (e.g., honesty, openness) among family members. Sometimes a simple contract is helpful in clearly identifying expectations and mutual responsibilities. The Family Night program and/or family counseling sessions address these issues and will offer you considerable guidance.

Many parents find it helpful to meet with other parents whose children are in recovery. These meetings are sometimes available through a treatment center or through groups like Al-Anon or Families Anonymous.

Should we remove all alcohol and other drugs from our home?

Relapse prevention is about reducing the risk of relapse. Many "persons, places, and things" become associated with drug

use for your son or daughter. Avoiding these "triggers" reduces the risk of relapse. We have found that adolescents who reside in homes in which alcohol and other drugs are openly consumed have lower post-treatment recovery rates than adolescents residing in homes with no such use.[9] The removal of such items from your home is not a signal that you don't trust your child; it is a sign of your commitment to do everything you can to support your child's recovery.

What should I anticipate when my son or daughter leaves treatment? How can I support my child's recovery process?

You may be worried that your son or daughter will return to using. While this is understandable, it is important that you project an image of "cautious optimism" as a means of projecting hope and support to your child. You can provide optimism, hope, and support at the same time you provide consistency and structure by way of clear expectations and parental supervision.

You and the adolescent can continue to maintain contact with your counselor after treatment ends. Adolescents attend many groups that directly address developing a recovery environment—a system of social supports that will help them maintain sobriety as they move back into a "normal" lifestyle. Many clients leave treatment while still involved with the legal system. This is generally a good situation since legal supervision and random urine screens help deter relapse.

Perhaps the most common concern that parents struggle with is their son or daughter wanting to associate with old using friends. Keep in mind that most adolescents who relapse do so through associating with drug-using friends. It is probably not surprising that most adolescents do not want to change friends or think that they need to.[10] It is strongly recommended that parents encourage the development of new, recovery-supportive social relationships. Encourage your son or daughter to spend time with friends who do not use and to try new activities where they might make new, non-using friends.

Adolescent substance users frequently complain of being bored. Help them identify activities that will broaden their interests and structure their time. Part-time or full-time jobs are good for recovery and for avoiding boredom.

It is difficult to find the line between being supportive of your child and wanting to control your son or daughter's life. Drawing that line at a place that is tolerable and helpful to you and your child is difficult. How to best achieve this is a frequent topic of Family Night and family counseling sessions. The key is mutual communication about what you and your child are feeling. Once mutual goals and communication are established, parents and children are often pleasantly surprised at the insights and suggestions offered to each other.

Will I ever be able to trust my son or daughter again?

It is reasonable for you to expect your son or daughter to earn back your trust. Discuss with them what specific behaviors would be needed for them to do so. Help them understand that it will take time and consistent success on their part before they earn back your full trust.

What signs of continued progress should we expect following treatment? What are some indicators of a successful treatment experience?

Recovery is a long-term process and treatment is only a first, though important, step in this process. Success is best measured in terms of reduced life problems and enhanced quality of personal and family life. Some reasonable expectations and indicators of success include:

- Abstinence or significantly reduced use of drugs and alcohol (many adolescents move into recovery by incremental improvements before achieving full recovery stability);
- Better management of strong emotions;
- Improved academic and work

performance;
- A shift from anti-social to pro-social attitudes and behaviors;
- Improved family communication and relationships;
- Increased clarity and motivation related to personal goals;
- Decreased contact with the drug culture (e.g., former drug-related relationships, places, music, dress);
- Increased capacity for caring and respect toward others; and
- Follow-through on recovery social support meetings.

What warning signs should I watch for that would indicate a continuing problem following treatment? How should a parent respond if relapse occurs?

The key is to focus on the overall functioning of your son or daughter rather than on a single troublesome attitude or behavior. Warning signs of relapse can be reflected in what your child is or is not doing. The former include physical and emotional changes, changes in interpersonal relationships (e.g., increased detachment from or conflict in family relationships, social isolation or resumption of pro-drug peer relationships), and changes in functioning (e.g., decreased academic or vocational performance). The latter include failure to maintain pro-recovery relationships and activities. Parents should be concerned anytime they see a return of old attitudes and behaviors previously associated with drug use and related problems. Typically when relapse occurs, problems will surface in more than one life areas. The period of greatest risk for relapse is the first 30 days following the completion of treatment.[9, 11, 12]

If you believe or know your son or daughter has relapsed, we encourage you to contact your CHS counselor who can provide guidance on how best to respond to this situation. Many adolescents experience relapse of varying degrees of duration and intensity before establishing stable, enduring recovery. The key is to intervene early and decisively in ways that solidify this recovery process. Perhaps most important is the understanding that post-treatment relapse does not signal a complete failure but the need to re-evaluate and refine the long-term recovery plan.

How can relapse be prevented?

There are several things you can do to help prevent the adolescent's return to alcohol and drug use:

- Continue to acknowledge the positive attitudes and behaviors exhibited by your child;
- Express your concerns about relapse warning behaviors not as accusations but as "I statements". For example, "When one of your old friends calls, I worry that they are trying to get you back into using drugs."
- Encourage participation in pro-recovery relationships and activities;
- Help with recovery activities via transportation; avoid family activities that conflict with key recovery activities;
- Model pro-recovery relationships and activities by participating in your own family recovery activities (e.g., Al-Anon or Families Anonymous meetings);
- Talk with them about their short and long-term goals. Help them develop plans to accomplish their goals; and
- Accept that you cannot control your son or daughter, and that in the final analysis, it is their choice whether they resume using.

What will help my child maintain the gains he or she made during treatment?

An adolescent's adjustment during the first ninety days following completion of formal treatment is very important to the long term outcome of treatment. Youth who have made a good adjustment in this period tend

to sustain this stability over time. Activities that can enhance this adjustment include participation in continuing care groups at the treatment agency, involvement in mutual aid societies (e.g., Alcoholics Anonymous and Narcotics Anonymous), participation in pro-social activities in the school and wider community, and developing and maintaining relationships that are supportive of recovery.

Participation in recovery mutual aid groups is consistently associated with post-treatment abstinence in adults, and there is mixed research findings about adolescent participation in self-help.[13-16] There is some evidence to suggest that as severity of substance use problems increases, the appropriateness of participating in self-help groups increases. In other words, adolescents who are recommended for residential treatment would likely profit more from self-help group attendance than those who were recommended for a less intensive level of treatment such as outpatient.

Support groups like AA and NA have long served as a source of mutual support for recovery. AA was founded in 1935 and has a worldwide membership of more than 2 million. Over 51,000 weekly AA meetings are held in the United States and over 103,000 worldwide. NA was founded in 1953 and has more than 31,000 weekly meetings in over 100 countries. Both AA and NA have young peoples' meetings in many communities in the U.S. While there are secular alternatives to AA and NA (e.g., Women for Sobriety, Secular Organization for Sobriety) and more explicitly religious alternatives (e.g., Alcoholics Victorious, Overcomers Anonymous), few of these alternative groups have special support groups for adolescents and young adults.

Some helpful sources of information for you include the national offices of Alcoholics Anonymous (212-870-3400), Al-Anon (888-4AL-ANON), and Narcotics Anonymous (888-773-9999). Locations and times of local meetings can be obtained by calling the listing of these groups (i.e., "Alcoholics Anonymous" or "Narcotics Anonymous") in the yellow and white pages of your phone book. Local meeting schedules are available at the meetings and often at treatment facilities.

Will my son/daughter go to mutual support meetings (e.g., AA or NA) forever?

This varies considerably. Some youth choose to continue their affiliation with recovery support groups as they get older, while others are able to disengage from such groups while sustaining their personal recovery. What will be important is for your son or daughter to develop a personalized style of recovery that works.

V. Does treatment work?

What can we realistically expect for the emotional energy, time, and money that we will invest in treatment?

Adolescent treatment can be measured in terms of several potential post-treatment outcomes: abstinence, reduced frequency and intensity of drug use, reduced alcohol- and other drug-related problems, and changes in personal health, personal achievement (academic/vocational performance) and interpersonal relationships. The major reviews of adolescent treatment research have drawn the following conclusions:

- All studies report significant reductions in the frequency and intensity of alcohol and other drug use following treatment.[3] Most studies also report significant reductions in related problems (psychological adjustment, school performance, family relationships, criminality) following treatment.[17] Treatment is superior to no treatment even when abstinence is not achieved, with post-treatment drug use reductions of around 50% of pre-treatment levels among those adolescents who use following treatment.[18]
- A review of studies that monitored adolescents following treatment found an average abstinence rate of 38% at one year following

treatment, with different programs varying in abstinence rates. The rate of sustained abstinence after one year following residential treatment was 14-47% (data was from four studies). Adolescent outpatient rates of sustained abstinence were even lower. Only a minority of outpatients achieve abstinence at the time they are discharged from treatment.[18]

- No single treatment modality has proven its superiority over other treatment modalities in controlled studies. There is no clear indication at present regarding which particular modality is best for a particular individual. This is why programs like CHS combine many interventions to achieve the best possible outcomes.
- Post-treatment relapse rates for adolescents are high and can fluctuate over time, suggesting the need for sustained monitoring and support following primary treatment.[12, 19]

Are outcomes for young people following treatment different than for adults?

Adolescents and adults who enter treatment can be divided into five outcome groups:

- those who completely abstain following treatment;
- those whose use and problems quickly return and remain at pre-treatment levels;
- those who experience brief lapses shortly after treatment but move into stable recovery;
- those who do well for a time after treatment but then relapse back to active addiction; and
- those who vacillate between periods of recovery and periods of relapse.

What distinguishes adolescents from adults is the smaller number of adolescents who maintain complete abstinence following treatment and the larger number who have brief lapses before moving into stable recovery. In a study of 600 adolescents treated for cannabis abuse or dependence, only 9% achieved sustained abstinence the year following admission to treatment, while 51% experienced some period of recovery during that year. Again, this indicates the need for continued monitoring and support following the completion of primary treatment.

Something else that we know about adolescents is that adolescents who have minor relapses are more like adolescents who do not relapse rather than like those who have moderate or major relapses.[9] This suggests that a minor relapse does not necessarily mean that an adolescent will get worse or return to pre-treatment levels of substance use. Encouragement and support can help the adolescent get back on track.

What factors influence treatment outcomes? How are outcomes influenced by characteristics of youth undergoing treatment?

Factors most consistently related to positive treatment outcome include lower problem severity, fewer emotional/psychological problems, better pre-treatment school performance, treatment completion, participation in post-treatment continuing care, employment, and family and peer support for sustained recovery. Some studies have found post-treatment outcomes influenced by the number of drug-using friends during the first six months following treatment.[20] Five factors have been linked to post-treatment recovery for adolescents: involvement with a drug-free peer group, mutual aid group involvement, family support for abstinence, work/job support for abstinence, and school involvement.[11] Program characteristics associated with improved outcomes include a larger budget, more experienced staff, and program comprehensiveness (range of services).[21]

Are residential programs more successful than outpatient programs?

Residential/inpatient and outpatient treatment outcomes cannot be compared. In most programs, adolescents admitted to the former have more severe substance use problems and are more likely to have additional life problems.[20]

Are there predictable stages of family recovery?

It is our experience that the period of greatest change within the family is the first year of recovery. This is the period in which trust is being re-established and when recovery shifts from a fragile experiment to a stable lifestyle. The good news is that recognizing the problem and participating in treatment and recovery mutual aid activities can strengthen families.

What do I do now?

Your son or daughter may not be motivated to change his or her substance use patterns, or he or she may be ambivalent about stopping drug and alcohol use. Adolescents may argue, beg, manipulate, try to cut a deal, make promises, and/or threaten in an attempt to avoid entering treatment. You need to follow through with the recommendation for treatment. You cannot make him or her stop using, but you can set limits as to what he or she must do in order to avoid consequences. Consequences might include not being able to remain in your home or not allowing your son or daughter to get their driver's license. Many parents also have the legal system as a "motivator" for their son or daughter to follow through with the treatment recommendation. Use the legal system (i.e., contact the probation officer; report illegal activities) to help the adolescent understand the seriousness of his or her problems and the consequences of the choices he or she makes (e.g., jail or treatment).

You have already taken steps that indicate you are supportive of your son or daughter. Bringing your son or daughter in for an assessment and talking with staff about the treatment recommendation are interventions in themselves. You have let your adolescent know that you see his or her substance use and related problems as unacceptable. It may be a long road. Keep in mind that CHS staff members will do all they can to support you and help your son or daughter learn to live without using substances. If you have any questions, call (309) 827-6026. Someone will help you. We have been assisting families like yours for the past thirty years.

Sources for Further Information

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www.chestnut.org (Chestnut Health Systems)

www.jcrinc.com (Joint Commission on Accreditation of Healthcare Organizations. Information is available on how to choose a quality behavioral health care provider.)

www.na.org (Narcotics Anonymous)

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Predicting Violent Behavior in Adolescent Cannabis Users: The GAIN-CVI

Chestnut Health Systems

Abstract

Substance use and interpersonal violence have exerted a profound impact on American society and the criminal justice system in recent decades. From 1989 to 1998, the number of adolescent drug law violations rose 148%, and the adolescent violent crime index rose 33% during this same period (Stahl, 2001; Loeber & Farrington, 1998). In spite of their frequent co-occurrence, considerable controversy exists on the exact relationship between substance use, criminality and interpersonal violence.

Simplistic models of causation (substance use causes crime/violence) and intervention (treat the substance use and the risk of crime/violence will desist or dramatically diminish) have given way to more complex models that posit multiple etiological pathways to criminality and violence, multiple clinical subpopulations of offenders, and integrated models of intervention into substance use, crime and violence (White, Loeber, Stouthamer-Loeber, and Farrington, 1999).

The latter models have the advantage of being able to concentrate criminal justice resources on those substance-involved offenders who are at highest risk for reoffending and at highest risk for involvement in future violent acts. This article tests Moffitt's (1993) taxonomy of antisocial behavior by examining the factors that are correlated with criminal activity and violence among adolescents entering substance abuse treatment. Using data from the Center for Substance Abuse Treatment's (CSAT) Cannabis Youth Treatment Study, we predict how changes in social environment affect criminality and violence over time in a population of 600 adolescents treated for cannabis abuse or cannabis dependency.

Emerging Models of Effective Adolescent Substance Abuse Treatment

By Michelle K. White, MS, William L. White, MA, and Michael L. Dennis, PhD

Increased substance-use experimentation and substance-related problems among adolescents during the 1990s led to a significant increase in the number of youth seeking treatment services in the United States. In the wake of these trends, addiction counselors have been challenged to respond to the needs of clients who present with lowered age of problem development and problems of greater severity and complexity. Fortunately, there is a growing body of research to help addiction counselors meet this challenge.

The number of published studies evaluating the effectiveness of adolescent substance abuse treatment has grown tremendously over the past 30 years, with most of that growth occurring since 1997. More than 65 percent of all adolescent treatment effectiveness studies were published within the past 5 years, with 14 published studies between 1970 and 1997, and 26 studies published between 1998-2002 (Dennis, 2002). The earlier studies were methodologically limited by small sample size, unmanualized treatment approaches, and marginal follow-up rates (Dennis, Dawud-Noursi, Muck & McDermeit, 2003; Ozechowski & Liddle, 2000). These weaknesses limited their scientific integrity and replicability, as did the fact that most of the tested interventions were of adolescent responses to treatment models originally developed for adults (Deas & Thomas, 2001; Muck, Zempolich, et al., 2001). In response to these issues, the Center for Substance Abuse Treatment (CSAT), National Institute on Drug Abuse (NIDA), and National Institute on Alcohol Abuse and Alcoholism (NIAAA)[1] began funding adolescent-specific treatment studies during the 1990s. In what has been called a renaissance of knowledge in the field (White, Dennis, & Tims, 2002), more than 100 adolescent treatment studies have been funded by these three agencies since 2002 (Dennis, November 2002).

In this article, we provide a summary of emerging models of adolescent substance abuse treatment drawn from 34 epidemiological, clinical, and pharmacological studies originally reviewed in "The Effectiveness of Adolescent Substance Abuse Treatment: A Brief Summary of Studies through 2001" (Dennis & White, 2002) prepared for Drug Strategies' "Treating Teens: A Guide to Adolescent Drug Programs" (2003). The full report (available at www.drugstrategies.org) includes a detailed abstract of each study and additional summary materials.

Reviewing the literature

To identify these 34 studies, we examined 21 prior literature reviews and bibliographies, and then conducted electronic searches using the major literature search databases. We then circulated the list among a large cadre of adolescent substance abuse

treatment researchers and practitioners who are members of the Society for Adolescent Substance Abuse Treatment Effectiveness (SASATE) (see Muck & Butler, page 13 of this issue, for further information) electronic mailing list to identify additional published studies. The resulting review focused particularly on studies of the effectiveness of adolescent substance abuse treatment; the review does not include evaluations of corrections-based treatment programs, prevention programs, early intervention programs, or school/recreational/camp-type programs.

Description of included studies

The studies in this review varied in purpose, scope, duration of intervention and duration of post-treatment follow-up. The majority of studies (21) compared two or more behavioral treatment models within or across levels of care in a single program setting; 10 studies evaluated particular approaches across multiple sites, and three tested pharmacological treatments with a small number of participants. The studies included:

- 10 studies of outpatient behavioral therapies
- 9 studies of outpatient family therapies
- 8 studies of "other" outpatient therapies
- 8 studies of "other" short-term residential programs
- 5 studies of "other" long-term residential programs
- 4 studies of residential 12-step programs
- 3 studies of therapeutic community programs
- 3 studies of psychopharmacological treatments
- 3 studies of continuing care programs
- 2 studies of treatment engagement programs
- 1 study of a 12-step centered outpatient therapy[2]

Behavior therapies included Adolescent Community Reinforcement Approach (ACRA), Adolescent Group Therapy (AGT), Cognitive Behavior Therapy (CBT), Motivational Enhancement Therapy (MET) and Relapse Prevention (RP). Family therapies included Conjoint Family Therapy (CFT), Functional Family Therapy (FFT), Family Systems Therapy (FST), Multidimensional Family Therapy (MDFT), and Multi-Systemic Therapy (MST). "Other" programs using blended approaches included Chestnut Health System's outpatient program and Thunder Road's short-term residential program. Twelve-step models were described as Chemical Dependency (CD) Counseling, Hazelden Model, or Minnesota Model programs. Therapeutic communities approaches included Dynamic Youth Services, Gateway, Operation PAR, and Phoenix Academy.

Psychopharmacological studies tested the effects of treating adolescent substance use disorders with lithium, sertraline, and fluoxetine. Continuing care models studied included the Assertive Continuing Care (ACC) approach. Engagement programs included the Strategic Structural Systems Approach. Many of the treatment manuals used within these studies are available from the following Web sites:

- Chestnut Health System's bookstore: www.chestnut.org/li/bookstore
- United States Department of Health and Human Services and SAMHSA's National Clearinghouse for Alcohol and Drug Information: www.health.org
- SAMHSA's Model Programs Web site: http://modelprograms.samhsa.gov

The number of research participants fluctuated from study to study. For example, one controlled trial of sertraline included 10 participants, while a large multisite study of 30 inpatient and residential programs followed 1,483 adolescents. The number of follow-up interviews conducted and length of follow-up period also varied greatly. Six studies completed interviews at treatment intake and treatment completion only. Of the 29 studies that conducted later follow-up interviews, 10 studies followed up with participants for only 6 months or less after treatment intake, and only four studies followed up with participants for longer than 15 months after treatment intake. Three of these four had 5-year follow-up periods. Follow-up rates also varied significantly, with one study following up only 25 percent of participants, and two studies achieving 100 percent follow-up rates (at only 3 months post-intake).

The average follow-up rate across all studies and all follow-up periods was 80 percent. Initial treatment effects reported ranged from an increase of 15 percent in drug use following treatment to a reduction in drug use of up to 67 percent during the active phase of treatment. This averaged out to a 30 percent reduction of drug use across all of the studies reviewed. Long-term effects, in the few studies that measured them, showed evidence of both sustained effects of treatment in some adolescents and deteriorating effects over time in others, with most adolescents moving in and out of relapse and recovery, rather than remaining stationary either in recovery or relapse.

Lessons learned from the literature

Despite tremendous diversity among the studies described in the previous section, several consistent findings are summarized below:

1) *Adolescents need developmentally appropriate assessment tools and treatment protocol.* While the field has advanced in taking into account the special developmental needs of adolescents, research studies underscore the significant differences that exist between adolescent and adult substance use disorders and their effective treatment.

2) *Multiple co-occurring problems are the norm among adolescents with substance abuse problems.* This near-universal finding calls for both the use of global (multidimensional) assessment instruments and the use of integrated multi-agency, multidisciplinary service teams. In addition, several adolescent case studies of between 1 and 5 subjects indicate that medication may be used to effectively treat depression and other mental health disorders that co-exist with addiction. These findings, if confirmed, underscore the potential of integrated

psychiatric and substance abuse treatment teams in the treatment of adolescent substance use disorders. (See Kaminer, pages 62-68, for more information on co-occurring disorders in adolescents.)

3) *Adolescents are involved in multiple systems competing to control their behavior.* Most adolescents with substance use disorders are trying to meet the needs and demands of many — family, peers, school, work, the criminal justice system, and often mental health and behavioral health counselors/program requirements, but researchers to date have not adequately studied adolescents' lives in their contexts, instead looking only from the view of the treatment system. The Robert Wood Johnson Foundation has launched "Reclaiming Futures," an innovative approach with juveniles in the justice system in 10 U.S. cities. The comprehensive, integrated approach builds from an ecological model and seeks to use community collaborations to improve upon current attempts to treat the large number of adolescents in the juvenile justice system who also abuse alcohol and/or drugs (see pages 69-73 of this issue, for more information).

4) *Adolescents' responses to treatment are highly variable.* Treatment effects range from no effect to sustained abstinence and all points in between (e.g., early abstinence followed by clinical deterioration, clinical deterioration followed by sustained abstinence, cycling in and out of abstinence and substance use).

5) *Relapse and continued problems are the norm among adolescents who have received substance abuse treatment.* Although treatment interventions produce positive and sustained effects in some adolescents, relapse continues to be common following treatment, particularly in the first 3-12 months after treatment. Recovery for many adolescents takes multiple attempts and episodes of care spanning many years. This finding suggests the need for assertive post-treatment monitoring, sustained recovery support services, and early re-intervention when indicated.

6) *The most effective treatment models share common elements.* The most effective treatment models in the studies reviewed here addressed engagement and motivation for treatment; used a manual-guided, developmentally appropriate treatment protocol; involved families in the treatment process; utilized more quality assurance and clinical supervision; and were assertive in providing continued care after treatment.

7) *Common elements also exist among interventions that showed no change or minimal change in substance use or symptoms.* Interventions that relied on passive referrals, educational units alone, "probation services as usual," or unstandardized "outpatient services as usual" did not produce reductions in drug use or related problems.

In short, we are learning much about the nature and complexity of adolescent substance use disorders, and we are beginning to find more effective approaches for their treatment. Research to date suggests that the most effective

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adolescent treatments of the future will use multi-dimensional assessment tools and assertive systems of outreach and engagement; will be multidisciplinary, developmentally appropriate, family-centered, and closely supervised for model fidelity and appropriate individualization; and will use systems of assertive continuing care and support following acute intervention and problem stabilization.

Applying the research

While the Drug Strategies review is purposefully not all-inclusive and our search stopped with published findings at the end of 2001, it yields several striking findings about the state of adolescent treatment research:

Federal and state support

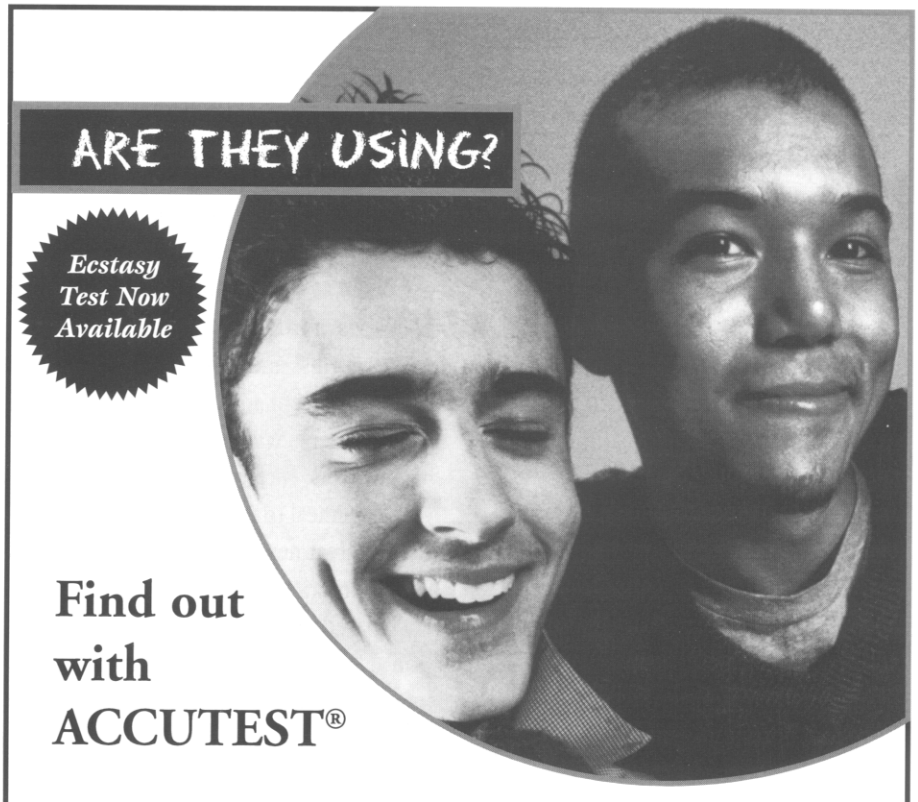
The growing level of federal and state support for adolescent substance abuse treatment research is historically unprecedented and should reap substantial dividends in the very near future. That explosion of new knowledge will potentially widen the gap between clinical research and clinical practice and create growing demands for the use of evidence-based clinical protocol in the treatment of adolescent substance use disorders.

Technology transfer

The ability to get new research findings into the field is hampered by the half-decade process between study initiation, study completion and the publication of findings and the need for more sophisticated ways to transfer new learning into the multiple systems in which adolescents are involved. Finding ways to speed the processes of knowledge development and dissemination constitutes a major challenge of the next decade.

Methodological limitations

Many of the studies included in this review have constraints on the ability to generalize findings due to small sample sizes, high rates of refusal to participate, use of unstandardized measures, a lack of measures of comorbidity, ill-defined treatment interventions, minimal information on services received, minimally supervised or unsupervised therapies, high rates of treatment dropout (20-50 percent), high rates of research study attrition (25-54 percent), and the lack of control groups — all leading to potentially large and unknown bias. In addition, current research is often limited to studies of a group of adolescents at treatment entry and exit, or studies comparing two kinds of treatment against each other. This kind of study does not inform the field about whether these interventions are better than any existing practices or how multiple interventions compare with one another. The methodological rigor of adolescent studies has increased and will increase with the growing federal and state investment in adolescent treatment, and this enhanced rigor will increase the confidence with which researchers can report study implications to frontline clinicians.



Promising areas

Based on our review of adolescent treatment outcome studies, we would suggest that the future adolescent substance abuse treatment research agenda include the following items:

- Replication studies on effectiveness of evidence-based, manual-guided therapies in different service-delivery settings such as criminal justice settings, student assistance programs, child welfare agencies, and health clinic settings.
- Studies that identify the potential of enhanced effects from particular combinations and sequences of service interventions, e.g., combining pharmacological treatment with behavioral treatment.
- Studies that test the ability of enhanced treatment-engagement protocols, assertive aftercare protocols, sustained recovery support services, and early re-intervention protocols to help resistant clients engage in treatment, help sustain longer periods of recovery, and help clients who have relapsed re-engage in treatment services.
- The development of knowledge about the cost and cost-effectiveness of adolescent substance abuse treatment models to help guide the expansion of adolescent services in an efficient way.
- Studies of the pathways, processes, stages, and styles of long-term recovery throughout the life course beginning in adolescence.
- Continued research and dissemination of developmentally appropriate, standardized biopsychosocial instrumentation that can be used for adolescent research as well as diagnosis, placement, and treatment planning.
- The development of a common database containing information on the needs and effectiveness of different types of adolescent treatment that can be used for benchmarking and evaluating the effectiveness of both new experimental programs and existing programs.
- The development of standardized and sophisticated training and quality assurance models to transfer clinical research protocols into service delivery settings.

As ambitious as this sounds, much of this work is currently underway. A randomized trial comparing five different outpatient treatments as part of CSAT's Cannabis Youth Treatment (CYT) study and an evaluation of ten different exemplary treatment programs currently in practice (the Adolescent Treatment Models (ATM) study) have recently been completed. These studies used the same follow-up time points and measures [the Global Appraisal of Individual Needs (GAIN); Dennis et al., 2002 — see www.chestnut.org/li/gain for more information]. The GAIN is also being used as part of dozens of studies ranging across levels of care, systems, and population. There have also been recent advances in pharmacological treatments with adolescents, particularly with work currently underway as part of NIDA's clinical trials network.

The treatment of adolescent substance use disorders is rapidly evolving into a science-based professional specialty. Addiction counselors have much new information to draw upon to enhance their clinical effectiveness in working with adolescents, and the quantity of such information will explode in the next decade. The greatest beneficiaries of this new information are and will continue to be the young people and their families served by addiction counselors across the country.

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Footnotes

[1]For more information on these agencies and recently funded adolescent treatment studies, see http://www.samhsa.gov/centers/csat2002/csat_frame.html; http://www.nida.nih.gov; and http://www.niaaa.nih.gov. See also Muck and Butler, page 12 of this issue, for a description of studies currently underway.

[2]The numbers add up to more than 34 due to multiple treatment types being evaluated within a single study.



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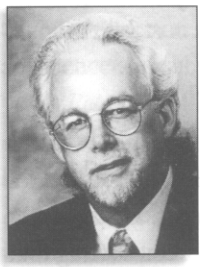

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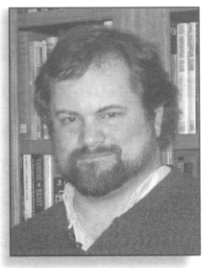

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Riverside Hospital: The Birth of Adolescent Treatment

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An earlier article in this column on the history of adolescent treatment and its current renaissance (White, Dennis, & Tims, 2002) noted that adolescents have been admitted to adult treatment programs since the opening of the inebriate homes and asylums in the mid-nineteenth century. This practice eventually led to calls for specialized adolescent treatment programs. This article explores the history of the first such program. The story of Riverside Hospital is a fascinating one that contains many lessons with contemporary import.

The Story of Riverside Hospital

In the early 1950s, the citizens of New York City became alarmed by a surge in adolescent heroin addiction. Adolescents were admitted to the addiction units of Bellevue Hospital and Kings County Hospital, but there was universal agreement on the need for a resource designed specifically to treat the problem of narcotic addiction among the very young. This recognition led to the opening of Riverside Hospital on July 1, 1952.

Riverside Hospital's 141-bed facility was divided into four wards: three for adolescent males and one for adolescent females. There were also separate recreation and educational buildings, a chapel, and housing for staff who worked at the facility. The grounds contained tennis and handball courts, basketball courts, and a baseball diamond. The facility was staffed by 300 employees organized within multidisciplinary teams that sought to integrate the technical knowledge of all team members in the treatment planning process (Gamso & Mason, 1958). The program was initially designed on the assumption that clients would be voluntary and motivated to become drug-free, but adolescent addicts admitted to Riverside Hospital were almost always admitted under duress. Most of the adolescents treated at the hospital came from a small number of census tracts that were among the poorest and most crowded in New York City (Wakefield, 1992).

Riverside should have worked. It had strong community support. It utilized a state-of-the-art theoretical framework to treat addiction. Patients were medically detoxified

and offered the opportunity to remain for a six-month individualized rehabilitation program consisting of psychological therapy, educational classes, and structured leisure. The program was staffed by a multidisciplinary team of physicians, psychiatrists, psychologists, social workers, nurses, welfare caseworkers, teachers, clergy, and lay volunteers. Every effort was made to work with the families of the adolescents in treatment, and efforts were made to follow adolescents after treatment through a community clinic located in Manhattan. Riverside's program appeared to be the ideal model of treatment. It should have worked, but in the eyes of local leaders, it did not. Riverside Hospital was closed in 1961; when a follow-up study of 247 former patients revealed that 97% of those treated had continued their addiction following treatment (Maddux, 1978) (This section abstracted from White, 1998, pp. 235-236).

The Lessons of Riverside

The story of Riverside contains many of the promises and pitfalls of today's adolescent treatment. Here are nine important lessons that can be mined from this story.

1. There is a reservoir of community concern and compassion that can be tapped to create resources for the treatment of adolescent substance use disorders. For nearly a decade, Riverside Hospital shone as a symbol of community recognition and response to the problem of adolescent opiate addiction. The Hospital was birthed via the mobilization of key sources of power and influence—parents; schools; the medical, legal and social service communities; private philanthropists; and the media. Since the opening of Riverside Hospital, that reservoir of concern and those sources of support have been tapped in hundreds of communities across the U.S. While the Riverside experience confirms that communities will respond to salvage their children if assured there are methods to achieve that goal, it also confirms that the processes required to sustain community support for adolescent treatment institutions are qualitatively different than those required to birth such institutions.

2. Addiction disrupts all aspects of an adolescent's life, and that impairment is best addressed within multidimensional assessment processes and multidisciplinary models of intervention. Riverside Hospital was ahead of its time in the use of such procedures. The youth entering today's addiction programs are again teaching us that multiple problems require integrated strategies and solutions.

3. Medically-facilitated detoxification does not by itself constitute a treatment for addiction. Detoxification, unconnected to other levels of care and support, is best viewed as a recurring addiction career milestone rather than a port of entry into long-term recovery. The follow-up data on Riverside patients painfully revealed that brief detoxification and psychological stabilization are not a sufficient foundation for sustained recovery. The same is true today.

4. Coerced entry into treatment and superficial compliance with institutional rituals of treatment should not be mistaken as a foundation for post-treatment recovery. The criminal justice system continues to be the primary source of referral for adolescents entering treatment. Coercion can bring adolescents to treatment, but only special interventions to engage and enhance motivation for change can shift resistance or superficial compliance into sustainable recovery.

5. Recovery initiation in an institutional setting is rarely sustainable for adolescents without continued recovery support services in the adolescent's natural environment. Riverside Hospital tried to offer post-treatment support via a single community clinic but it placed the responsibility for initiating clinic contact with adolescents who had little motivation to do so once back in their natural environments. While such passive aftercare programs have continued into the present era, there are recent calls for models of assertive continuing care that provide a high level of post-treatment, professionally directed

monitoring and recovery support services (White & Godley, 2003).

6. The treatment of adolescent substance use disorders must be based on an understanding of the ecology of adolescent addiction and recovery. The staff of Riverside Hospital, in attributing the sources and solutions of addiction as residing within the adolescent, failed to address the family, social, cultural and economic contexts within which addiction flourishes. While family models of treatment have since become an important element in modern adolescent treatment, there remain few models that actively shape the adolescent's post-treatment social environment. Such models would mediate peer sources of recovery support and sabotage and would enhance youth-oriented supports within local communities of recovery.

7. Short-term treatment outcomes are not necessarily predictive of long-term outcomes. The documentation of high, short-term relapse rates and the failure to conduct more time-sustained outcome studies leave unanswered the true effects of treatment at Riverside Hospital. Such short-term outcomes fail to measure delayed effects of treatment (e.g., recovery following post-treatment relapse, clinical deterioration following initial recovery experiments, cycles of recovery initiation and relapse) and the potential cumulative effects of two or more treatment episodes. Such effects are of great interest to those currently conducted adolescent treatment outcome studies.

8. Short term strategies that generate support for treatment may not work in the long run. Treatment institutions that promise a permanent reversal of severe and persistent addiction through a brief, single episode of institutional treatment sow the seeds of subsequent therapeutic pessimism and a backlash against the institution. Attributing responsibility for treatment failure on the intractability of addiction or the characterological foibles of clients provides a temporary reprieve from institutional accountability for the design and execution of its clinical protocol, but this fuels changing views of addiction (which becomes seen as untreatable), addicts (who are no longer seen as worthy of care) and treatment institutions (who are no longer seen as culturally viable or valuable). The high relapse rates at Riverside were viewed not as a unique failure of this institution, but as confirmation of the "once an addict, always an addict" adage. That view contributed to Riverside's closure and added ideological support for passage of draconian drug laws that transferred large numbers of young addicts into state and federal prisons. In the eyes of the community, Riverside's closure seemed to confirm the correctness of this strategy. It is with an understanding of these longer-term cultural processes that poorly designed, poorly delivered, and over-sold treatments harm substance-involved adolescents, their families and their communities.

9. Pioneer programs often experience threats to their existence from both within and without. The demise of Riverside Hospital was preceded by the fall of other pioneer institutions (e.g., The New York State Inebriate Asylum) (Crowley & White, in press), and the void it left was filled by other institutions (e.g., Synanon, Janzen, 2001) that experienced a similar fate.

Adolescent treatment institutions have risen and fallen in the past. It is not enough to rebuild a network of youth-oriented addiction treatment programs. We must find a way to increase the effectiveness of such programs and realistically define their value and niche within local communities across the country. We must create effective programs to sustain adolescent recovery in the community and find ways to sustain support for such programs during periods that community and cultural attention is drawn to other issues.

William L. White is a Senior Research Consultant at Chestnut Health Systems and the author of *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*.

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A Brief History and Some Current Dimensions of Adolescent Treatment in the United States

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Introduction

The development of a national system for treating adolescent substance use disorders actually began more than a century ago. In this chapter, we will provide a brief history of adolescent substance use and its clinical management, an overview of the state of adolescent treatment system development in the United States, describe the characteristics of substance-involved adolescents entering specialty treatment and the levels of care within which they are treated, and discuss how recent research findings are beginning to influence clinical responses to alcohol and other drug problems among adolescents.

A Brief History of Adolescent Treatment. Growing concerns about "drunkard children" in the late eighteenth and early nineteenth centuries fueled minimum drinking age and temperance education laws, the inclusion of young people in cadet branches of recovery-oriented societies such as the Washingtonians and the Ribbon Reform Clubs, and the admission of adolescents into the nation's first inebriate homes and asylums (Mosher, 1980; White, 1998). Opiate addiction among disaffiliated urban youth garnered early twentieth century attention via reports of rising juvenile arrests and the rejection in thousands of World War I draftees due to heroin addiction (Musto, 1973; Terry & Pellens, 1921). Efforts to treat juvenile addiction included hospital detoxification and enrolling addicted adolescents in the morphine maintenance clinics that operated across the nation between 1919-1924. During this time approximately 7,500 narcotic addicts were registered at the Worth Street Clinic in New York City and 743 of these were under the age of 19 (Hubbard, 1920).

Juvenile narcotic addiction declined in the 1930s and 1940s but rose again in the early 1950s. Admissions of persons under age 21 at the two U.S. Public Health Hospitals (narcotics farms) in Lexington, Kentucky and Forth Worth, Texas increased from 22 in 1947 to 440 in 1950. In the 1950s, alarm over juvenile narcotic use triggered the opening of addiction wards in some urban community hospitals (e.g., Chicago's Bridewell Hospital, Detroit Receiving Hospital, and New York City's Manhattan General) and sparked faith-based addiction

counseling ministries (e.g., St. Mark's Clinic in Chicago, the Addicts Rehabilitation Center and Exodus House in New York City, and Teen Challenge (Conferences, 1953; White, 1998). Adolescents and adults were treated in these programs together as only one specialized adolescent treatment facility existed in the 1950s.

The opening of Riverside Hospital in New York City in 1952 marked the birth of specialized treatment for adolescent substance use disorders. Riverside's 140-bed facility offered a multidisciplinary staff to provide detoxification; psychiatric and medical evaluation; psychological testing; and an inpatient program of therapeutic, educational, vocational and recreational activities followed by outpatient visits at community clinics. In spite of its "state-of-the-art" status, Riverside was closed in 1961 after a follow-up study of former patients documented a 97 percent relapse rate (Gamso & Mason, 1958). Other mid-century events that influenced the future evolution of adolescent treatment included the development of "young peoples' meetings" within Alcoholics Anonymous and Narcotics Anonymous, the development of modified therapeutic communities for adolescents (Jainchill, 1997), and the appearance of adolescent chemical dependency programs based on the "Minnesota Model" (Winters et al., 2000).

Alarm about polydrug experimentation by adolescents in the 1960s undergirded federal and state support for the expansion of treatment services in the 1970s, but support for specialized adolescent treatment services waned as youthful drug experimentation declined in the 1980s (National Institute of Drug Addiction [NIDA], 1999). Between the 1960s and mid-80s, the treatment of adolescent substance use disorders continued to be provided primarily in adult substance use units using adult models of treatment. A 1985 federal report on adolescent treatment services lamented the lack of treatment programs in the U.S. designed specifically for adolescents (Friedman & Beschner, 1985).

This situation changed as adolescent experimentation with marijuana, LSD, methamphetamine, "club drugs" (MDMA/"ecstasy", GHB, rohypnol), and dissociative anesthetics (PCP, ketamine) rose in the 1990s. Between 1991 and 1999, past year illicit drug use rose from 29% to 42% among high school seniors and from 11% to 21% among eighth grade students. National high school survey data also revealed high rates of binge drinking (consuming five or more drinks in one drinking episode): 15% of 8th graders, 26 percent of 10th graders, and 31% of 12th graders (NIDA, 1999). At the height of this surge in drug use (1992-1998), the number of youth admitted to substance treatment in the U.S. increased 53% (from 96,787 to 147,899), fueled by marijuana-related juvenile arrests and treatment referrals from the criminal justice system (Office of Applied Studies [OAS], 2003).

The resurgence in youthful polydrug experimentation led to a greater emphasis on systems of prevention (Drug Free Schools and Community Act-1986), early intervention (the proliferation of student assistance programs via the National Association of Student Assistance Professionals-1994), an expansion of public and private programs that specialized in the treatment of adolescent substance use disorders, and an increase in the number of controlled studies evaluating the efficacy and effectiveness of adolescent treatment. This surge in treatment and research activity was guided by the collective efforts of the National Institute on Alcohol Abuse and Alcoholism, the National Institute on Drug Abuse, and the Center for Substance Abuse Treatment. In the opening decade of the twenty-first century, the treatment of adolescent substance use disorders is transitioning from folk art status to a subspecialty of the larger addiction treatment effort. Increasingly it is noted that adolescent treatment is becoming a professionalized, and science-guided endeavor (White, Dennis & Tims, 2002).

The Adolescent Treatment System

Adolescents experiencing substance-related problems in the United State can be

found in multiple health and social service systems. They are served by a host of child welfare and juvenile justice youth service agencies, publicly funded addiction treatment agencies, private addiction treatment agencies that cater to insured and private pay insured families, and by more than one third of the juvenile correctional facilities (37%) that provide on-site substance abuse treatment (Office of Applied Studies [OAS], 2002).

More than 145,000 adolescents each year are treated in publicly funded addiction treatment programs in the United States (Office of Applied Studies [OAS], 2000). The number of adolescent specialty programs and overall adolescent admissions rose rapidly through the late 1980s and 1990s. A comparison of Substance Abuse and Mental Health Services Administration's (SAMHSA) national treatment center directories reveals that the number of self-identified adolescent specialty programs increased from 2,874 to 4,291 (a 49% increase) between 1987 and 2003. The growth of adolescent treatment was not the same across different regions of the country. While the number of adolescent specialty units actually decreased in seven states between 1987 and 2003, figure 1 shows that growth occurred across each region of the U.S., ranging from an 84% increase in the Pacific Region to only 2% in the New England. (See Figure 1)

The 2002 National Survey of Substance Abuse Treatment Services (N-SSATS; SAMHSA, 2003) provides a window into the current status of adolescent treatment in the United States. The survey identified 18,204 institutions that provide substance abuse treatment services and 13,720 participated in the survey. Services to adolescents were provided by 37 % of the surveyed facilities. Adolescent substance abuse treatment services were provided by private non-profit facilities (37% survey response rate), private for profit facilities (36% responded); local government facilities (42% responded), 167 of 441 state-operated facilities (38% responded), federal facilities (8% responded), and tribal owned facilities (64% responded). Substance abuse treatment services for adolescents were more likely to be provided in facilities that offered both substance abuse treatment and mental health services (50%) than in substance abuse treatment only (33%), mental health services only (34%), or general health care facilities (22%).

Most of what we know about adolescent treatment in the United States is based on surveys and studies of the publicly funded programs. Surveys of private sector treatment programs documented a dramatic growth in private for-profit addiction treatment during the 1980s but did not segregate data for adolescent specialty units (Yahr, 1988). While many private treatment programs closed in the early 1990s in the face of an aggressive system of managed behavioral health care, the private sector continues to provide a significant source of specialized adolescent treatment. The most recent data on private programs is contained in the National Treatment Center Study (NTCS) conducted by the University of Georgia and the Georgia Institute of Technology (Roman, Blum, Johnson, & Neal, 2002).

The NTCS surveyed 400-private programs specializing in addiction treatment during three waves of data collection between 1997-98 and 2000-01. The survey findings revealed considerable institutional turnover in the private sector with approximately one fourth of the 1996 programs surveyed closed by the 2001 survey. (Roman et al., 2002). The number of private programs providing adolescent treatment only remained at four programs between the 1996 and 2001 surveys; however 38% of the programs offered a separate treatment track for adolescents by the 2000-01 survey. For the preparation of this chapter Johnson (2003) has contributed several adolescent program findings from the NTCS survey results. While the small number of programs specializing in adolescent treatment should be interpreted with caution, the NTCS survey provides a better understanding of current private treatment and allows us to compare some dimensions of private programs to publicly funded programs.

Private Sector Adolescent Treatment. Adolescents constitute more than half of admissions in only four percent of the 450 private programs surveyed; only one percent of private addiction treatment facilities specialize exclusively in adolescent treatment. There has been considerable growth in the number of private programs treating adolescents (38% of total) but the number of designated adolescent beds to total facility beds is actually declining (Johnson, 2003). Similarly, 40% of publicly funded treatment programs admit adolescents, with two thirds of these offering a specialized treatment track for adolescents (OAS, 2003).

The number of beds devoted to adolescent treatment within private centers averages 17 and ranges from 2 to 88. Utilization rates (daily census divided by number of beds) for specialized adolescent units ranges between 33% and 36% within the surveys. The average length of stay within private inpatient adolescent specialty units increased from 17.6 days in 1995 to 21.1 days in 2000. Daily rates for inpatient treatment ranged from $357-$1045 per day (Roman and Blum, 1997; Roman et al., 2002). Payor sources in the specialty adolescent programs (when compared to private adult addiction treatment units) have a higher percentage of Medicaid reimbursement and charity write-offs and a lower percentage of self-pay (Medicaid 45%; Private Indemnity Insurance 2%; HMOs 10.2%; POSs-7.5%; Self-Pay 17.5%; and Charity 17.5%) (Johnson, 2003).

Referral Source. The primary referral sources of adolescents into private specialty treatment are the legal system (36%), schools (34%), and social service agencies (29%). In contrast, the primary referral sources for adolescents into publicly funded treatment are the: legal system (41%), school/community agencies (22%), and self/family (17%), other substance abuse providers (6%) (OAS, 2000).

Characteristics of Clients Entering Treatment. While national data is lacking on demographic characteristics of adolescents entering private treatment, those entering public treatment are primarily male (70%), racially diverse (63% Caucasian/non-Hispanic, 15% African American, 11% Hispanic, and 5% other races), and range in age from early to late adolescence (25% age 14 or younger; 75% ages 15-17) (Dennis, Dawud-Noursi, et al, 2002).

Presenting Problems. Adolescents are entering private addiction treatment due to dependence upon cannabis (66%), alcohol (34%), cocaine (15%) and opiates (6.5%) (exceeds 100% because of multiple drug choices). These findings compare to the following drug choices for adolescents entering publicly funded treatment: cannabis (54%), alcohol (24%), cocaine (2%), opiates (1%), and stimulants (3%) (Johnson, 2003; OAS, 2000). Dennis and his colleagues (2003) summarized changes in drug of choice characteristics between 1992 and 1998 adolescent treatment admissions. Especially noteworthy is the reversal between alcohol as the dominant drug in 1992 (56% of admissions) decreasing to 24% of admissions in 1998 while marijuana increased as the drug of choice for admissions during this period, from 23% to 54%. Just over half (54.5%) of adolescents admitted to private treatment programs have a co-occurring psychiatric disorder. Studies of youth admitted to public sector treatment programs (e.g, Dennis, Godley, & Titus, 1999) have found higher rates of co-morbid problems, e.g., other substance use disorders, internal emotional disorders (major depression, generalized anxiety, suicidal thoughts or actions, traumatic stress disorders), and external behavioral disorders (conduct disorder, attention deficit-hyperactivity disorder), and high rates of victimization. In terms of prior treatment for substance use disorders, 71% of adolescents admitted to private programs compared to 29% of adolescents admitted to public treatment have one or more prior episodes of treatment (Johnson, 2003; OAS, 2000).

Levels of Care. Addiction specialists recommend that placement in a level of care (e.g., outpatient, intensive outpatient, residential) should be based on a number of presenting characteristics including the adolescent's substance use

diagnosis/severity, intoxication and withdrawal risk, biomedical issues, psychological problems, treatment acceptance and resistance, relapse potential, environmental risk, legal pressure, and school or vocational pressure (American Society of Addiction Medicine [ASAM], 1996). Adolescents presenting with complex problems across multiple ASAM dimensions are more likely to be placed in residential treatment while those with fewer/less severe problems are placed in a lower level of care such as outpatient treatment. Levels of care provided were not broken out for the adolescent programs within the NTCS surveys but public surveys reveal the following adolescent admission pattern to adolescent treatment: outpatient (69%), intensive outpatient (11%), long-term residential (9%), short-term residential (6%), and detoxification (6%), (Dennis, Dawud-Noursi, et al, 2003). Changing reimbursement policies that required greater justification for costlier treatment and the introduction of the ASAM Patient Placement Criteria (1996) encouraged adolescent treatment providers in both the private and public sector to move from providing a single level of care (e.g., residential only) to providing multiple levels of care.

ASAM placement recommendations support the practice of continuing or "step down" care in the treatment of substance use disorders (both adult and adolescent). Under this plan, a client successfully discharged from residential treatment would be referred to a "lower" level of care such as Intensive Outpatient or Outpatient treatment and so on.

Treatment Approach. Descriptions of private programs for adolescent treatment center around a 12-step foundation that involves confrontational group therapy, family and individual psychotherapy, and pharmacological adjuncts (Johnson, 2003). Funded by SAMHSA's Center for Substance Abuse Treatment, Stevens and Morral (2003) provide a description of current best practice approaches for ten outpatient, intensive outpatient, and residential treatment programs. Unlike private programs the Minnesota Model/12 step programs are likely to be viewed as one of several approaches used with adolescents in treatment rather than the foundation of the treatment experience. Social learning theory, self-efficacy, social skills training within group and individual treatment is evident. Cultural appropriateness is frequently mentioned in the training and therapeutic approaches in the publicly funded programs, however pharmacotherapy, while evident, appears to be used less than in the private programs. The lower use of pharmacotherapy in public programs may be due to less affiliation with medical resources than private programs. Whatever the reasons for this trend, it is disturbing given the higher rates of co-occurring disorders noted in the publicly funded programs. Continuing care services exist in public and private programs to the extent that they follow an ASAM placement model and make "step down" referrals to less intensive levels of care when clients are successfully discharged. The extent to which such transfers are successful is not fully known but one study indicates a need for greater attention to this (Godley et al., 2002). Except to the extent that clients participate in mutual aid support groups, long-term disease management strategies (e.g., recovery monitoring and support) do not appear to be available in either private or public treatment models.

Treatment Staff. Staff working in private specialty adolescent units (compared to staff working in private adult units) are less likely to be in recovery, less likely to be a certified counselor, but more likely to have a Master's degree and more likely to turnover (29% versus 19% annual turnover). There is no comparable national studies of publicly funded facilities regarding treatment staff. Although, little national information is available on treatment staff qualifications and stability in publicly funded programs, McLellan (2003) recently reported counselor turnover in these programs as high as 50%. High rates of staff turnover in publicly funded programs due to low salaries and difficult working conditions have also been noted in state evaluation reports (Carlson, Deck, &

Wadeson, 2001; Northrup & Heflinger, 2000).

Summary. Several conclusions can be drawn comparing public and private treatment using the N-SSSATS, TEDS and NTCS data. The overwhelming majority of adolescents treated for substance use disorders in the United States are treated within the network of publicly funded programs, but the differences between public and private treatment (e.g., characteristics of clients, staff qualifications and staffing patterns, treatment duration and outcomes) remain relatively unexplored. It does appear, from available data, that adolescents entering publicly funded treatment are less likely to have had prior treatment episodes, but are more likely to be referred from the criminal justice system or by self/family referral, and more likely to present with a co-occurring disorder.

From Science to Service

The past 30 years of adolescent treatment evaluation spans early studies that included adolescents (the Drug Abuse Reporting Program (DARP) in the early 1970s, the Treatment Outcome Perspective Study (TOPS) in the late 1970s and early 1980s, the Service Research Outcome Study (SROS) and National Treatment Improvement Evaluation Study (NTIES) that extended into the 1990s. All of these studies evaluated adolescents as a small subset of the larger treatment population. Over the past 15 years increased attention to adolescent treatment evaluation and research has resulted in a host of adolescent-specific, longitudinal outcome studies and randomized clinical trials (Hser, Grella, Hubbard et al., 2001; Brown et al., 2001; Williams & Chang, 2000; Deas & Thomas, 2001; Muck et al., 2001). While not perfect, the recent generation of studies are methodologically more rigorous than their predecessors. The cumulative effect of these studies has been a growing body of scientific knowledge that is slowly influencing funding policy and practice. Considerable efforts are underway by various federal agencies, scientific committees, and professional associations to forge an evidence-based system of adolescent treatment. Led by the National Institute on Alcoholism and Alcohol Abuse, the National Institute on Drug Abuse, the Robert Wood Johnson Foundation, and the Center for Substance Abuse Treatment each of these national organizations have funded major initiatives designed to improve clinical practice.

With increasing frequency treatment provider associations (e.g., The National Association of Addiction Treatment Providers), trade publications (e.g., *The Counselor*) and provider agencies across the country are exploring the practical implications of available scientific studies. Some of the most significant of these findings (for reviews, see Deas and Thomas, 2001; Muck, et al., 2001; Williams & Chang, 2000; Winters, 1999) and their implications for clinical practice include the following.

Early Age of Onset. A significant factor affecting adolescent substance use disorders and their treatment is the lowered age of onset of alcohol and other drug use (White, 1999). Several recent studies have documented progressive declines in the age of substance use initiation during the second half of the twentieth century (Presley, Meilman, & Lyerla, 1991; Dennis, Babor, Roebuck, & Donaldson, 2002; National Institute on Drug Abuse, 1999; Substance Abuse and Mental Health Services Administration, 1999). A tri-generational study of those born before 1930, between 1930 and 1949, and after 1949 found a progressive decline in the age of onset of regular alcohol consumption and a parallel increase in the probability of developing an alcohol-related problem before age 25 (Stoltenberg, Hill, Mudd, Blow, & Zucker, 1999). Lowered age of onset of drug use is particularly prominent among juveniles entering the criminal justice system and addiction treatment programs (U.S. Department of Justice, 1994). In a national study of the treatment of adolescent substance use disorders, 80% of the 600 youth admitted to the study began regular substance use between the ages of 12 and 14 (Dennis, Titus, et al., 2002).

Concern about lowered age of onset of substance use springs from studies suggesting that precocious drug experimentation is related to: juvenile offending and school failure (Fergusson, Lynskey and Horwood, 1996), risk of adult alcohol dependence (Chou and Pickering, 1992; Grant & Dawson, 1997; Dennis, et al., 2000), faster progression of substance-related problems (Kreichbaun & Zering, 2000), greater problem severity (Chen & Millar, 1998; National Institute on Alcohol Abuse and Alcoholism, 2003), increased health risk behaviors (DuRant, Smith, Kreiter, and Krowchuk, 1999), greater medical and psychiatric comorbidity (Fergusson, Lynskey and Horwood, 1996; Warren, et al, 1997; Sobell, Sobell, Cunningham, & Agrawal, 1998), and increased risk of future alcohol-related accidents and violence (Hingson, Heeren, Jananka, & Howland, 2000; Hingson, Heeren, & Zakocs, 2001). There is also evidence suggesting that early age of onset may be linked to poorer treatment outcomes (Keller, Lavori, Beardslee, Wunder, & Hasin, 1992; Kessler, et al., 2001; Chen & Millar, 1998).

In summary, the evidence suggests that decreased age of onset leads to increased risk of a subsequent substance use disorder, increases in the developmental speed and severity of substance-related problems and compromises treatment outcomes. The practical implications of this research auger for the need to intensify prevention programs as well as youth-oriented outreach and early intervention programs. Realization of the risks associated with precocious substance use has contributed to the development of a growing national network of school-based student assistance programs and the development of more effective youth screening instruments and brief interventions. In 2003 the Center for Substance Abuse Treatment (CSAT) funded 22 adolescent grants to implement standardized screening, assessment and brief treatment for low problem severity youth to test the effectiveness of an early intervention model.

Course and Outcome. There is growing evidence that adolescent substance use disorders can appear as transient or chronic problems. Where the former are amenable to resolution through maturation or relatively brief intervention (Temple and Fillmore, 1985-86), the latter constitute problems characterized by escalating severity and prolonged duration. In the recently completed Cannabis Youth Treatment (CYT) study of outpatient interventions, 41% of adolescent participants diagnosed with cannabis abuse or dependence reported they had failed prior attempts to stop drug use, 25% had prior episodes of formal treatment, and 33% were re-admitted to treatment during the year following their treatment in the CYT study (Dennis, et al, 2000). Those suffering more chronic substance use disorders can be distinguished by greater personal vulnerability (e.g., lower age of onset, family history of addiction), greater medical and psychiatric co-morbidity, and less personal, family and social assets to support recovery and resolve problems (Godley et al., 2003). This suggests the need to differentiate these two populations and to develop intervention modalities more appropriate for this high problem severity/duration group. Interventions for the latter will likely address a broad spectrum of problems and involve interventions of greater intensity and duration.

Other problems of youth and families interact (as causes and consequences) of adolescent substance use disorders to compromise clinical outcomes**.** Unfortunately, co-morbidity is the norm among adolescent admissions to treatment (Hoffmann, Mee-Lee, and Arrowood, 1993; Hser, et al., 2001). Of the 600 adolescents admitted to the CYT study, 95% reported one or more (83% had three or more) other problems, e.g., alcohol use disorders, other substance use disorders, internal emotional disorders (major depression, generalized anxiety, suicidal thoughts or actions, traumatic stress disorders), external behavioral disorders (conduct disorder, attention deficit-hyperactivity disorder), victimization, and violence (Dennis, et al,

2000). These findings reinforce the need for multidimensional screening and assessment procedures, and the need for multi-disciplinary, if not multi-agency intervention models that can provide an integrated response to adolescent clients who present with multiple, co-occurring problems.

Engagement. The earlier noted roles of courts, schools and parents in the referral of adolescents to treatment suggest that most adolescents enter treatment under coercive influences. Voluntarily engaging adolescents and eliciting positive involvement of those coerced to treatment is a considerable challenge. Findings from the DATOS-A studies suggest that such engagement and involvement is enhanced by building rapport between the adolescent and the service team, enhancing the adolescent's confidence in his or her ability to change and encouraging and strengthening the adolescent's commitment to change (http://www.datos.org). Outreach services (e.g., home visits) and case management services have also been found to exert a positive influence on treatment engagement and retention (Szapocznik et al., 1988; Henggeler, Borduin, Melton et al., 1991; Godley et al., 1994; Garner, Godley & Funk, 2002).

Variability of Treatment Effectiveness. All treatment programs are not the same. Friedman and Glickman (1986) conducted one of the first studies that attempted to link clinical outcomes to characteristics of particular treatment programs. They found that programs with the best clinical outcomes: a) treat a larger number of adolescents, b) have a larger budget, c) use evidence-based therapies, d) offer specialized educational, vocational, and psychiatric services, e) employ counselors with two or more years' experience working with adolescents, f) offer a larger menu of youth-specific services (e.g., art therapy, recreational, and other prosocial activities and services), and g) are perceived by clients as empathic allies in the recovery process (Friedman and Glickman, 1986).

Lack of Theoretical Superiority. No theoretical model or clinical protocol of adolescent treatment has proven itself superior to others in the treatment of all adolescent substance use disorders. While some reviews attributed slight superiority to family therapies (Williams & Chang, 2001) more recent randomized trials have not shown a clearly superior treatment approach for substance-involved adolescents (Dennis, et al, 2000). In the absence of superior outcomes for a particular model, communities may be encouraged to develop a menu of early intervention, treatment, and post-treatment recovery support services that meet other criteria, e.g., cultural viability, cost-effectiveness.

Post-treatment Functioning. Following treatment, most adolescents are precariously balanced between recovery and reactivation of substance use and related problems. The percentage of treated adolescents in stable recovery erodes in the years following treatment while others who relapsed and continued to use relatively early after treatment move into stable recovery in the years following treatment (Brown, A'Amico, McCarthy, and Tapert, 2001). Also noteworthy is the relatively low percentage of treated adolescents who participate in professionally directed aftercare groups or mutual aid groups such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) relative to adults (Godley, Godley, & Dennis, 2001; Donovan, 1998). Recovery mutual aid groups can help support long-term recovery following primary treatment (Hoffman and Miller, 1992; Hoffman, et al, 1993), but they suffer from low post-treatment affiliation and high attrition rates. These findings suggest the need for more formalized programs of continuing care, the creation of more indigenous, youth-specific recovery support groups, and more active linkage to such resources during the treatment process.

Post-treatment Support. Post-treatment monitoring and recovery support services can enhance the stability and durability of recovery, however, there is little evidence from controlled studies to support this clinical and correlational observation (Donovan, 1998). In practice, step-down continuing care is recommended by ASAM and is considered to be standard practice.

Retrospective studies of statewide datasets (Godley, 2003) as well as prospective follow-up studies of post residential functioning and services (Godley, Godley, & Dennis, 2001) suggests that the actual rate of linkage to a continuing care service within 90 days of discharge from residential treatment is less than 40 percent. These findings suggest the need for improved approaches to step-down care linkage. Assertive continuing care approaches that shift the responsibility for continued contact from the client to the treatment professional and involve extended telephone follow-up and/or home visits for monitoring, recovery education, support, and early re-intervention are currently being tested. In a randomized study of adolescent post-residential continuing care services, 94% of an assertive continuing care (ACC) group received monitoring and other continuing care services compared to 54% of the "usual continuing care"(UCC) group. During a 90 day continuing care test phase the median number of face-to-face contacts for the ACC group was 10 compared to 2 for the UCC group. At the end of the active continuing care phase, 52% of ACC group members were still abstinent from marijuana compared to 32% in the UCC group (Godley, Godley, Dennis, Funk & Passetti, 2002). Organizing post-treatment recovery support services within the adolescent's natural environment (e.g., recovery home rooms, in-school recovery meetings, recovery schools) also offers promise for preventing relapse and boosting post-treatment recovery. More research is needed to evaluate proactive continuing care and recovery management to strategies to determine if this approach results in long-term improved clinical outcomes and a better stewardship of community resources

Post-treatment Environment. Peer group, social networks, and family environment have high salience to most adolescents. It is, therefore, not surprising that treatment outcome is heavily influenced by the adolescent's post-treatment family and social environment. Adolescents who experience major relapse experience higher rates of parental substance use and family conflict and a higher density of drug users in their post-treatment social milieu (Hoffman, et al, 1993; Brown et al., 2001; Godley et al., 2003). This suggests the need for models of intervention that can alter these family and peer environments. Few treated adolescents completely change their social networks. Future research is needed to find ways to lessen the risk in the adolescent's recovery environment. Additionally, creative methods of working with the adolescent's peer network are also needed. For example, is it possible to recruit close using peers into treatment as well as the primary client? Could one or more close peers be enlisted to attend recovery support meetings to assist the primary client? Finding new ways to work with the adolescent's social and peer networks is an outstanding need to further support and maintain treatment gains experienced during treatment.

Summary

Resources for the treatment of adolescent substance use disorders have increased over the past century in tandem with the increased visibility and cultural alarm regarding adolescent substance-related problems. The United States now has a multi-branched and growing system of adolescent treatment services that spans public and private sectors and offers services in both specialty and non-specialty service settings. Most adolescents are entering treatment due to alcohol and/or cannabis-related problems (and, to a lesser degree, other illicit drugs), but present with a wide array of co-occurring problems and obstacles to recovery. Multiple levels of specialized care are available but most adolescents being treated via outpatient counseling. The number and methodological rigor of adolescent treatment outcome studies have increased dramatically in recent years. The findings of these studies suggest the need for earlier systems of problem identification and intervention, a model of sustained recovery support for adolescents presenting with high problem severity and complexity, and sustained interventions with the adolescent's post-treatment family and social environment. In

the opening decade of the twenty-first century, the treatment of adolescent substance use disorders is itself maturing into a professionalized and science-guided service arena.

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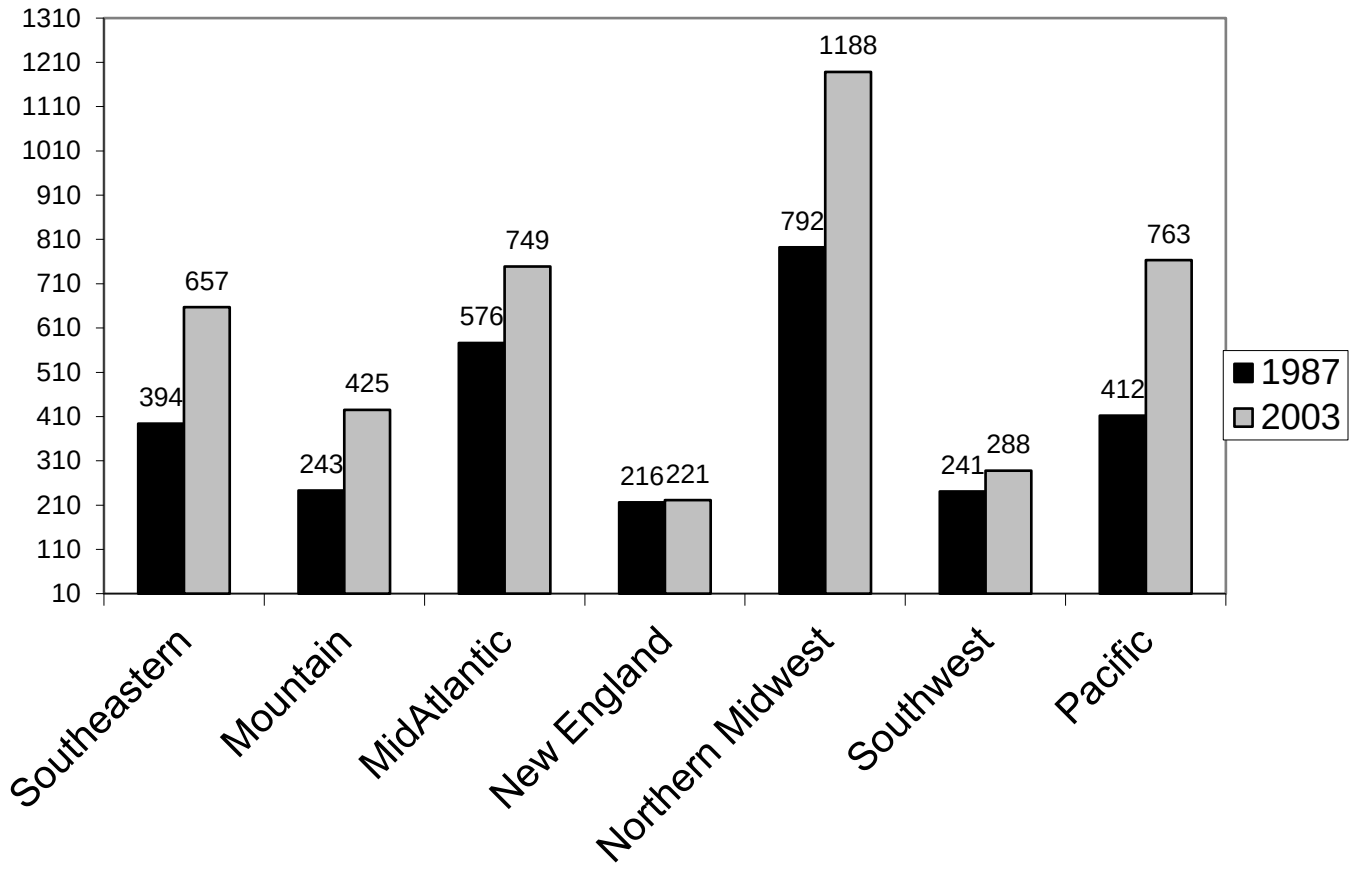
Figure 1. Increase in adolescent treatment programs from 1987 – 2003 *Return to article*





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Ethical, Legal and Policy Issues in the Treatment of Co-occurring Substance Use and Psychiatric Disorders among Adolescents

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Introduction

Complex ethical and legal issues arise in the treatment of co-occurring substance use and psychiatric disorders among adolescents. This chapter charts that ethical and legal terrain, outlines general and specific response procedures and concludes with a discussion of some of the broader policy issues raised by the co-occurrence of substance use and psychiatric disorders among adolescents. The ethical and legal issues discussed here will focus primarily upon those related to consent procedures, parental involvement in treatment, threats to the safety of the adolescent or the community, and service relationship boundaries.

Many of the most difficult situations that arise in the context of adolescent treatment contain a combination of complex clinical, ethical, legal and administrative issues. Working through such complexity and the potential for one dimension to obscure other dimensions can be aided by the use of one or more ethical decision-making models (Wagner, 2001). In our earlier work (White & Popovits, 2001), the authors proposed a three-step model to help identify the existence and potential severity of ethical/legal conflicts and to generate response alternatives. The first step in that model involves analysis of a situation to determine the potential and degree (minimal, moderate, significant) of benefit and harm that could accrue to the adolescent, his or her family, the service delivery staff, the service institution, the professional field and the larger community. The second step identifies any universal or culturally relevant values that apply to the situation and explores the actions that would flow out of the application of those particular values. (See Table 1)

Table 1
Universal Values Imbedded within Professional Codes of Ethics

Autonomy (Freedom over one's destiny)
Obedience (Obey legal and ethically permissible directives)

Conscientious Refusal (Disobey illegal or unethical directives)
Beneficence (Do good; help others)
Gratitude (Pass good along to others)
Competence (Be knowledgeable and skilled)
Justice (Be fair; distribute by merit)
Stewardship (Use resources wisely)
Honesty and Candor (Tell the truth)
Fidelity (Keep your promises)
Loyalty (Don't abandon)
Diligence (Work hard)
Discretion (Respect confidence and privacy)
Self-improvement (Be the best that you can be)
Nonmaleficence (Don't hurt anyone)
Restitution (Make amends to persons injured)
Self-interest (Protect yourself)

Source: White & Popovits, 2001.

The addition of culturally relevant values suggests that actions that could be beneficial within the dominant cultural context might do harm or injury when misapplied to another context, e.g., relationship engagement/disengagement rituals, nuances of verbal intimacy or physical touch, or gift giving and receiving. The third step identifies existing ethical codes, laws, regulations, organizational policies or historical practices that apply to the situation in question. Models of ethical decision-making can provide great assistance, particularly when used within the more general prescriptions to 1) seek consultation, 2) increase documentation and 3) debrief each incident for its organizational policy and clinical practice implications.

As long-tenured ethical and legal consultants to behavioral health organizations, we have found that ethical and legal issues involved in the treatment of adolescents are less well marked, more frequent and more complex than those encountered in the treatment of adults, and that ethical and legal issues arising in the treatment of adolescents with co-occurring disorders are among the most difficult. The latter is related to more difficult determinations of competence (both developmentally and in terms of mental status), the involvement of multiple systems of care/supervision with frequently conflicting policies, potentially greater threats to self and public safety and the need for more nuanced and prolonged management of service relationship boundaries. In the discussions below, we will try to illuminate some of the poorly lit ethical and legal pitfalls within this territory.

Consent to Treat and Informed Consent

The most common legal question raised about treating adolescents pertains to the issue of consent. So many clinicians are perplexed by the multiple legal meanings and applications of consent which are further exacerbated by the complex rules relating to a minor's legal right, ability and capacity to execute consents. "Consent" means the voluntary agreement by a person who possesses and exercises sufficient mental capacity to make an intelligent choice to do something proposed by another. Consent implies that this agreement is unclouded by fraud, duress or mistake.

The legal concept of consent requires a provider to obtain a patient's permission prior to treating. Without it, physical touching has been ruled by courts to constitute battery. This is why virtually all treatment centers have patients execute "Consents to Treatment". A Consent to Treatment form typically describes the "informed consent process" and the voluntary nature of the treatment program, references client rights and confidentiality, addresses cooperation in treatment, expressly authorizes specific treatment services, including a number of psychiatric and medical services, discusses withdrawal of consent, and may include specific consent provisions relating to photographs, transportation, personal property and financial responsibility.

As mentioned above, informed consent is one element embodied within the consent to treatment. "Informed Consent" is a fundamental principle grounded in both the law and ethics. Patients should be provided sufficient information to enable them to make

an informed choice regarding a proposed course of treatment by balancing the probable risks against the probable benefits. This principle of informed consent requires disclosure of: the nature and purpose of the procedure/treatment, the risks and consequences, the alternatives and the risks of no treatment (Popovits, 2004).

Those issues related to a minor's ability to provide consent to treatment are determined by state law. For example, under Illinois law (410 ILCS 210/4), a minor 12 years of age or older who is determined to be an addict, alcoholic or intoxicated person under the Alcoholism and Other Drug Abuse and Dependency Act, or who may have a family member who is a substance abuser, may consent to receiving medical care or counseling related to the diagnosis or treatment of the disease. The consent of the parent or legal guardian of a minor is not necessary to authorize medical care or counseling related to the diagnosis or treatment of substance abuse or the effects on the minor of substance abuse by a member of the minor's family. The minor's consent is valid and binding as if the minor had achieved his or her majority and the minor's consent is not voidable or subject to later disaffirmance because of his or her age. Other states however, may only permit a minor to enter treatment with a written consent signed by the parents. Even in the those states that permit minors to consent on their own to treatment, because of liability concerns the facility will often have both the minor and the parent sign the consent for treatment. These legal requirements vary among states so be sure to check your applicable state laws. Requiring dual signatures of the minor and the parents for consents, including waivers for recreation activities, field trips, sports participation or use of exercise equipment is also common. Generally, such consents outline the specific activity the patient will be engaged in (using the gym), any inherent risks in that activity (such as an injury), and a release of the provider from liability for engaging in that activity. For adolescents, a provider will usually request that both the adolescent and the parents sign the waiver. Guardians or authorized agents may also sign the consent. It is also a good idea for the provider to have a witness sign a consent that includes any waiver provisions. It is important to understand that "waivers" are not bulletproof vests shielding the provider from lawsuits or liability. Although in our experience, it often deters the patient or family from bringing claims. In those cases where the Consent to Treatment may also include provisions granting special permission for other medical care, dental care, photographing or videotaping of the minor for staff education, training and supervision purposes, the authors recommend signing by the parent or guardian. In these cases, the minor's signature generally would not be legally required but it is recommended so the minor is aware of his or her rights and responsibilities relating to those issues identified.

Consent for Disclosure

A "consent for disclosure" is yet another type of consent which has separate and distinct legal meaning. Federal confidentiality statutes and regulations, as well as the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Standards, govern written consents for disclosure. These "written consents" authorize the provider to disclose information about the patient that would otherwise not be legally permissible. To satisfy the requirements under the HIPAA Privacy Standards, many treatment facilities are now referring to consents for disclosure as "authorizations". A facility may also call these legal documents "releases". What is important is not the title or name on the document but the elements included (Popovits, 2005).

42 C.F.R Part 2.31 specifies the required elements for a valid written consent and 45 C.F.R. Part 164.508 sets forth the authorization requirements mandated by the HIPAA Privacy Standards. The authorization must be written in plain language and may contain additional elements as long as they

do not contradict the required elements of both 42 C.F.R. Part 2 and the HIPAA Privacy Standards. An authorization may be combined with another authorization to create a compound authorization, except that authorizations for use or disclosure of psychotherapy notes may be combined only with another authorization for psychotherapy notes. An authorization cannot be combined with any other type of written permission for the same research study. A multi-party authorization is permissible if the information to be disclosed and the purpose for the disclosure are the same for all parties. However, if the client revokes the authorization for one party, the entire authorization is revoked (Popovits, 2005).

In determining whose written consent is required for the disclosure of information when the client is a minor, the federal confidentiality regulations (42 C.F.R. 2.14) defer to state law. The federal confidentiality regulations provide that parental or guardian consent for disclosure (for purposes herein, this includes consent by any other person legally responsible for the minor) is required only if the applicable state law requires parental or guardian consent before providing substance abuse treatment to a minor. A "minor" is defined as a person who has not attained the age of majority specified under applicable state law. If there is not specified an age of majority under applicable state law, then 18 years will be the requisite age. It is also important to note that if the state allows minors this right, it generally applies to minors between twelve to eighteen years of age. For children under twelve, parents would typically sign in their stead because the child would be deemed incapable of offering consent under the law.

Thus, if a minor client acting alone has the legal capacity under state law to apply for and receive substance abuse treatment, written consent for disclosure may be given by the minor only; parental or guardian consent will not be required under the federal confidentiality rules. This restriction includes the disclosure of privileged client information to the parent or guardian of the minor client for the purpose of obtaining financial reimbursement. However, the federal regulations do not prohibit a program from refusing to provide treatment until the minor consents to the disclosure necessary to obtain reimbursement. Programs must be careful about the refusal to provide treatment based upon their State Substance Abuse Agency contracts or other applicable funding source agreements. Alternatively, if the state law requires the consent of the parent or guardian for a minor to obtain substance abuse treatment, written consent for disclosure must be given by both the minor and his or her parent or guardian.

The federal regulations also provide an exception if a minor has applied for services and refuses to consent to parental notification. The program may contact the parent without the minor's consent only if the program director: believes that the minor, because of extreme youth or medical condition, does not have the capacity to decide rationally whether to consent to parental notification; and the disclosure is necessary to cope with a substantial threat to the life or well-being of the minor or someone else.

Special Consents Issues Concerning Adolescents

Additional issues arise when adolescents are receiving substance abuse treatment and are wards of a state child welfare agency or are currently part of the criminal justice system. Criminal justice consents differ from other consents in that the disclosure is made only to those individuals within the criminal justice system who have a need for the information in connection with their duty to monitor the patient's progress, provided that the patient has signed a written consent meeting the general requirements of the regulations. There are three items that are different about criminal justice consents: (1) the duration is typically tied to the proceeding; (2) these consents are NOT revocable; and (3) the persons receiving the information can redisclose the information in connection with their official duties. When an adolescent is a ward of a child welfare agency, the child welfare agency acts in the role of a guardian,

and must be informed of, and give consent to, any treatment or research projects in which the adolescent may participate.

Consent for Research Purposes

The principles of effective consent discussed above also apply to an informed consent given for research purposes. However, the unique issues and possible intrusions that may occur when involving human subjects require additional safeguards to ensure that those subjects are fully informed of the risks involved in consenting to be a part of a research project. At its most basic, informed consent recognizes the right of all persons to be treated with respect, and to treat all persons in an ethical manner that protects them, to the greatest extent possible, from harm. However, the need for protection increases depending on the level of autonomy of the subject. Persons who are completely autonomous (able to deliberate about personal goals and act on such deliberation) need less protection from the point of view that their reasoned opinions and choices should be given weight, and these persons should be given the freedom to act on their considered judgments unless there are other compelling reasons not to do so. On the other hand, some persons who have decreased autonomy require more extensive protection. Prisoners, for example, may be coerced or unduly influenced into entering research projects that may be detrimental to them. Children in general are perceived as possessing diminished capacity to understand and knowingly balance the risks that research may present. The federal regulations governing the protection of human subjects (45 CFR Part 46) detail specific requirements of research informed consents. (See also Scott & White, 2005).

Dual Disorder Clients

Obtaining an informed consent can be especially difficult when dealing with patients who have a dual diagnosis of both mental illness and substance abuse. The difficulty is in determining whether the consent is truly informed if they are mentally impaired. Often, if mental impairment is due to substance use alone, consent can be obtained and then revisited when the patient is no longer under the immediate influence of an illegal substance. However, in a dual diagnosis patient the underlying mental illness may be present even after the substance use has ended, or the mental illness has been exacerbated by the use of illegal substances. Such issues may call into question the legal capacity to execute a valid consent. In these cases, the provider should first determine whether the substance abuse or the mental illness is the “primary” disorder. To make a proper identification, a thorough psychiatric and drug history must be taken. If a determination is made that the primary disorder is psychiatric, then the client must be stabilized before substance abuse treatment should be attempted. Once the mental illness has been addressed, the client is more likely to be able to provide an informed consent to enter into treatment. (See also White & Popovits, 2001).

Parental Involvement

A growing number of adolescent programs that we consult with are insisting on parental involvement in treatment as a precondition for admission of an adolescent. They view such involvement as crucial to the transfer of learning from the institutional environment to the child’s natural environment and crucial to the achievement of long-term recovery. Even where family environments are not conducive to recovery and the treatment goal is the physical and emotional emancipation of the adolescent from the family, communications between the treatment staff and the family are often needed to achieve this goal. Parental involvement is becoming the norm as more treatment programs develop family-oriented treatment philosophies and utilize particular family therapy approaches.

Protection of Child and Community

Our laws, from their Anglo-Saxon beginnings to their present incarnation, are

based on the notion of protection. Governments enact laws on the basis that they have an obligation to protect all citizens and, in particular, children and adolescents, from harm. This concept assumes that governments, acting on behalf of their citizens, know what is best for them and therefore enact laws to protect them. Most of these laws are enacted on a state level, and therefore the kinds of laws and extent of protection vary from state to state.

Added to this is the notion that a parent, like the state, knows what is best for their children and should therefore be allowed to make decisions for their children's best interests, including decisions concerning their health. However, in juxtaposition to the role of parent, and state, as the protector of children is the position that children, especially adolescents, should be allowed to make their own decisions regarding their lives, including decisions concerning their health. These two positions are often at odds with one another and lead to the current patchwork of state laws that provide a varying degree of rights to adolescents concerning their own health issues.

Lastly, the state also has a heightened interest in the protection of adolescents from other adolescents who, in the eyes of the state, may pose risks to the majority of the population, whether through drug use, sexually transmitted diseases, gang activity, or other socially unacceptable activities. The problem however is that the state, in enacting laws that "protect" others from a perceived threat, often infringe on the rights of the adolescents who are perceived as a threat. In this context, consent and reporting requirements attempt to strike a balance between protection and the ability to make one's own choices, while maintaining confidentiality and lessening the stigma for those who are receiving substance abuse treatment. In the following section we discuss unique problems that may arise when dealing with adolescents in a treatment setting that require actions by providers that, while protecting adolescent patients, may conflict with the goals of confidentiality.

Child Abuse Reporting

Reports of incidents of suspected child abuse or neglect made to the appropriate state or local authorities as required by state law are permissible under the federal confidentiality regulations. No patient consent, court order, or other authorization is needed. However, the restrictions on disclosure continue to apply to the original alcohol or drug abuse patient records maintained by the program, including their disclosure and use for civil or criminal proceedings that may arise out of the report of suspected child abuse and neglect. Note that this exception does not apply to the reporting of other types of suspected abuse or neglect, such as elder abuse or domestic violence (White & Popovits, 2001).

Responding to Self-injury and Threats to Injure Others

A patient who has been using illegal substances often does so to numb or mask some kind of emotional pain or injury. When the coping mechanism of substance use is gone, these feelings can become overwhelming, and a newly sober patient needs to develop skills to deal with these feelings. Sometimes, these feelings can overwhelm a patient, leading to a threat or attempt to injure oneself or another. Add to this the often intense and shifting emotional states that typical adolescents manifest, and a potentially volatile situation can unfold. Ideally, staff can verbally deescalate the situation and help the patient achieve control. However, sometimes the use of restraint or seclusion is necessary for the patient's safety or for the safety of others.

Special Problems Related to Isolation and Restraint

While balancing the need to prevent injuries to patients while using restraint and seclusion, there is also a need to protect patients from harming themselves or others. Adolescent substance abuse treatment patients are considered especially

vulnerable, and those that provide treatment services are therefore subject to additional scrutiny, no more so than in the area of restraint and seclusion. The Centers for Medicare and Medicaid Services ("CMS") are in the process of enacting rules concerning the use of restraint and seclusion in Psychiatric Residential Treatment Facilities ("PRTF's") that provide inpatient psychiatric services for individuals under 21. If your facility receives Medicaid funding, you need to determine if your state classifies your facility as a PRTF, thus triggering applicability of a number of federal requirements discussed below.

Due to the potential for serious psychological or physical injury that may result from the use of restraint or seclusion, CMS has established additional safeguards for providers who treat patients under 21 years of age. The proposed regulations establish Conditions of Participation ("COP's") that must be adhered to when using restraint and seclusion. The COP's cover the following areas: resident protections; orders for the use of restraint and seclusion; consultation with a treatment team physician; monitoring of residents in and or immediately following restraint or seclusion; requirements for notifying parents or legal guardians; application of time out; post-intervention debriefing; medical treatment for injuries resulting from an emergency safety intervention; facility reporting requirements; and facility responsibility in educating and training its staff. States have also begun conducting unannounced surveys of covered providers to ensure compliance.

Consent for Medical Treatment during Addiction Treatment

While the focus of many consents is the need for substance abuse treatment, patients often, due to their substance abuse, neglect their health or exacerbate existing health problems. Therefore, while the patient may need substance abuse treatment, it is possible that they will also need medical treatment for a variety to aliments. Many state licensure regulations require a physical examination upon intake, as well as TB tests. Depending on the results of the exam and the patient history, additional tests or x-rays may also be needed. The patient may also need dental care or eye care. From a medical perspective, a thorough examination is necessary to properly document the patient's health. However, in order to successfully treat a patient who is recovering from substance abuse, the patient needs to be made whole both physically and mentally. If the program treats only the substance abuse issue, without addressing other health issues, the probability of a relapse or unsuccessful treatment episode is increased because the patient is physically less able to continue their sobriety.

Medical treatment issues are even more complex when they involve adolescent patients. States differ on when, and what kind, of medical treatment they should allow a minor to consent to without the involvement of a parent. Some states allow minors to authorize any type of medical care, including contraception. Many states allow minors to consent to only general medical treatment without parental consent. Other states only allow "mature" minors to make healthcare decisions. A mature minor has been determined to be sufficiently mature to make their own healthcare decisions without parental involvement. However, what constitutes a mature minor is left to individual determination by a judge. Still other states only allow "emancipated" minors to make healthcare decisions. An emancipated minor, unlike a "mature" minor, is usually defined by state statute. Generally, the youth must be at least 16, live apart from their parents, and be economically self-sufficient.

However, despite laws that allow minors to make medical decisions, parents or guardians will likely wish to be informed of any medical treatment their child may receive. Programs try to avoid this dilemma by requiring parent or guardian consent to any necessary medical treatment upon intake of the adolescent patient. However, programs may be faced with the scenario where a client requests treatment without the consent or notification of their parents or

guardians. Programs need to weigh the best interests of the patient, as well as complying with state law. Lastly, in some cases the federal confidentiality regulations also allow the program to notify a parent or guardian if the program director believes that, because of extreme youth or medical condition, the adolescent does not have the capacity to decide rationally whether to consent to parental notification, and the disclosure is necessary to cope with a substantial threat to the life or wellbeing of the minor or someone else.

Sexual Activity between Clients in Treatment

Any provider of adolescent treatment recognizes that hormones are raging in this population. Sexual experimentation occurs among adolescents in general and when confined to a residential setting where the youth may be less than enthusiastic about participation, the temptation to engage in sexual activity exponentially increases.

Obviously, sexual activity between clients in a program raises numerous legal and ethical concerns for the program as well as the patients. First and foremost, a program has a responsibility to protect patients while they are residents of the program. It can be argued that not prohibiting sexual activity between clients is harmful to them due to their vulnerability and immaturity, regardless of whether there was mutual consent. Also, it can be physically harmful to patients because of the spread of HIV and other sexually transmitted diseases as well as other health concerns such as hepatitis or pregnancy. Legally, while there are technically no prohibitions against minors having sex, depending on the minor's age they may be charged with statutory rape, regardless of the consent of either party.

Ethically, patients in substance abuse treatment are emotionally vulnerable and are trying to cope with a variety of emotions. Adolescents in such a state can be presumed to be unprepared to make a reasoned decision regarding their sexuality. Additionally, if the patient also has a dual diagnosis, their mental health issues could result in poor judgment or impulse control, leading to irresponsible sexual encounters. Furthermore, the goal of treatment is to teach the patient how to deal with the pressures of life and their own personal problems without resorting to the use of illegal substances. Arguably, impulsive sexual encounters are another way to avoid feelings or mask issues without the use of an illegal substance, and may reflect a breakdown in the recovery process.

Health Issues

All states have statutes regarding public safety and mandatory reporting of communicable diseases to public health officials. Most states also have laws that explicitly allow adolescents to consent to treatment for sexually transmitted diseases, and to contraceptive services. However, state laws vary widely on the level of consent, the age of consent, and to which services a minor may be allowed to consent.

At the federal level, Title X of the Public Health Services Act, passed in 1970, provides that all clinics that receive federal funding must provide confidential sexual health services to all clients, regardless of age. However, numerous efforts have been made to limit this mandate to include parental involvement. Many adults advocate laws that conclude parental involvement, whether through notification or consent, on the basis that government policies that give minors the right to consent to sexual health services without parental involvement undermine parental authority and condone sexual activity. Without such access, adolescents may avoid obtaining contraceptives or sexually transmitted disease treatment because they do not want to involve their parents. (Maradiegue, 2003).

Facilities need to be cognizant of peer pressure among adolescents for gang activities, cult or other ceremonial activities, and acts of self-mutilation that are becoming more commonplace among our youth. We have learned of adolescents engaging in devil worshipping ceremonies exchanging blood, only to learn that one of the youths, who had hepatitis, freely shared his fluids but

failed to share his hepatitis status with his peers. Transmission of communicable diseases does not just occur by sexual activity. Make sure to keep razors and shaving equipment locked up and inventoried. Be mindful of silverware leaving your dining halls. Check belongings upon returns from passes.

Runaways

Adolescents who run away from treatment pose serious ethical and legal issues for programs. Programs may use temporary restraint to deter a patient from leaving the program (see the discussion of restraint and seclusion above), but patients often find a way to leave the program without being detected, or while on an outing or otherwise while off the program premises. Staff members will need to determine when and how to contact law enforcement and other individuals (parents, guardians, child welfare caseworkers, or probation officers) when an adolescent patient leaves the program. The program should also have a valid consent in place authorizing them to contact the parent or guardian. Additionally, the program will need to decide whether, if the patient is found or returns to the program, the program will allow the patient to return to treatment. The program will need to weigh the circumstances surrounding the incident, the patient's need for treatment, the patient's chances of successfully complying with their treatment goals, and the disruption to other patients. Many safety committees within facilities also view runaway/AMA trends as a key quality improvement indicator to monitor. Strategies to reduce runaways have included increased monitoring and motivation enhancement, staff training in de-escalation issues, locked doors and the use of security cameras.

Smoking Policies in Inpatient/Residential Treatment

While treatment programs have long focused on alcohol and other substance abuse issues, tobacco use has become a more recent focus of treatment efforts. Tobacco use has long been viewed as an acceptable crutch for recovering addicts. However, with increased awareness of the negative health effects of smoking, treatment providers have begun to counsel patients on these negative effects and the addictive nature of smoking. For adolescents, this issue is even more pertinent because many studies show that if adolescents can be persuaded to not use cigarettes by the time they reach the age of 18, they are much less likely to take up smoking as adults. Additionally, use of nicotine by anyone under the age of 18 is illegal in all 50 states.

Federal attempts to limit adolescents' access to cigarettes gained significant momentum in 1992 with the passage of the Synar Amendment. This Amendment made substance abuse funding from the Substance Abuse and Mental Health Services Administration ("SAMHSA") contingent on states enacting and enforcing laws prohibiting the sale of tobacco to minors. However, state enforcement continues to be uneven, and federal support has been unsuccessful because of limited authority to implement sanctions and limited funding to support states efforts to curb cigarette sales to minors (Brainard, 2003).

Ethically, providers are obligated to help adolescents avoid or stop using nicotine. While focusing on other drug dependence issues is important, the cessation of nicotine use is no less important for the overall health of adolescents. Many providers are faced with a dilemma, however, when many of their staff smoke in the building or on the grounds. In response, some providers have declared their buildings smoke-free in an effort to eliminate conflicting messages and to promote abstinence (Patten, Order-Connors & Sussman, 2004).

Discharging Adolescents to the Correct Party

Providers are required to provide for the safety of their adolescents clients while they are in treatment. This requirement extends to their discharge. Providers must

ensure that clients leave the program in the company of a parent or guardian that has legal custody of the client. This can become an issue where, for instance, the parents are divorced and it is unclear who has custody of the child, of if the parents are absent and another family member or friend comes to pick up the child. It should be clarified at intake which persons are legally authorized to pick up the adolescent at discharge. However, in instances where the authorized parent or guardian is not available, if that person cannot be contacted, it may be necessary for the program to retain custody of the child until an appropriate party is identified who can take custody of the child. If the child is released to someone who, it is later learned, did not have legal custody to take the child at discharge, the program could be held liable for any negative outcome that may result from that discharge. Alternatively, if upon discharge the parent or guardian who arrives to take custody of the child appears impaired or otherwise unable to safely take the adolescent, the program may again have to retain custody of the child, or find a suitable temporary placement until other arrangements can be made.

Relationship Boundaries

At their most primary level, professional codes of ethics seek to prevent harm and injury that can occur in the name of help. Such codes implicitly affirm the potential for harm within professional interventions and explicitly assert that the potential for such harm must be actively managed. A focal point of that management is the relationship between service provider and service recipient. Two related concepts, *boundary* and *dual relationship*, are central to this management process.

Boundary is the demarcation of roles within the professional helping relationship. The ongoing management of this boundary governs the pace and degree of intimacy in the service relationship. Dual relationships occur when a service provider occupies more than one role relationship with a client and his or her family and, as a result, blurs this boundary. Because multiple role relationships compromise the service provider's objectivity and often threaten the client's/family's comfort and safety, professional certification/licensure bodies either prohibit or discourage entering into or continuing a counseling relationship when a non-clinical relationship also exists.

Relationship boundary problems frequently arise in the treatment of adolescents with co-occurring disorders. These problems flow from the clinical characteristics of clients (e.g., histories of traumatic victimization, chaotic relationships, emotional volatility), the duration of the service relationship (often more prolonged) and the nature of the service relationship (often quite intense). The personal and professional histories of service providers (e.g., persons in various stages of personal/family recovery from substance use or psychiatric disorders) can also heighten the potential for problems of transference and countertransference.

A continuum of intimacy exists within service relationships: 1) a zone of safety for clinician and client (actions that are always okay), 2) a zone of vulnerability resulting from increased attachment or sudden disengagement (actions that are sometimes okay and sometimes not okay), and 3) a zone of abuse resulting from harmful intimacy or precipitous detachment (actions that are never okay) (Milgrom, 1992). The boundaries between these zones are not always clear, can vary from client to client, and can also vary with the same client at different stages in the service relationship.

Some of the most common boundary problems that arise in behavioral health treatment include a lack of clarity about when an individual's status as a client begins and ends (if ever); social encounters with clients; preexisting relationships with clients or their families; dual service relationships (e.g., serving as a client's counselor and A.A. sponsor, simultaneously seeing a client/family at an agency and in private practice); gift giving and receiving; and the emotional, social, financial or sexual exploitation of clients. In reviewing complaints of ethical breaches filed with

state licensing boards for addiction counselors, sexual exploitation is the most frequent cause of such complaints (St. Germaine, 1996).

Boundary violations, whether in the form of sexual exploitation or clinical abandonment, often constitute the end stage of the intensification or weakening of the service relationship rather than an event without history or context. As such, there are progressive warning signs of such drift that can be self-monitored or monitored in clinical supervision. Warning signs of enmeshment include preoccupation with a client, paternalistic ownership of a client, increased frequency and durations of sessions with a client, deprofessionalization of contact setting, heightened self-disclosure, sexualization of session content, heightened dependence of client on therapist, reluctance in bringing the case to supervision, resistance to terminate or refer, and courtship behavior (dressing up, frequent calls/cards, gifts, verbal intimacy, escalation of touch). Signs of failure to engage or disengagement include tardiness or refusal in returning calls to a client, lowered frequency and duration of sessions, hostile countertransference resulting in administrative discharge, precipitous termination following exhaustion of benefits, objectification of client (focus on diagnosis/disease rather than the person), complaints of therapist disinterest (e.g. daydreaming or dozing in sessions) and medicating rather than listening to the client (White, 1995).

We have found several strategies helpful in minimizing relationship boundary problems in the treatment of adolescent behavioral health disorders. The foundational strategy is the development of an organizational code of professional practice that explicitly defines the service relationship standards to which all organizational members will be held accountable. These codes define "client" (who is encompassed in that term, when that status begins and ends), establish policies governing dual relationships and outline the problem solving process staff are expected to use when relationship boundary questions arise. Other helpful strategies include orientation to the code of professional practice for all new employees and volunteers, refresher training on relationship boundary management for all staff, rigorous clinical supervision (that includes the identification and active management of transference and countertransference), the use of a corporate compliance officer to investigate allegations of inappropriate professional conduct and access to an outside consultant to process decision-making on difficult ethical/legal issues. A central theme within all training and supervision is the nature of the fiduciary relationship that exists between the behavioral health service provider and the behavioral health service recipient and the demands that this fiduciary responsibility dictate in establishing and maintaining appropriate boundaries within the service relationship.

The authors have experimented with a variety of training formats on boundary issues and have found two that work very well. The first is a critical incident (events that posed a threat of injury to clients, service staff, the service organization, the professional field and the community) approach in which staff members work in small groups to respond to an ethical dilemma presented in the form of a case study. Groups are asked to identify the ethical issues in the situation (who can be harmed and to what degree), identify ethical principles that apply, identify legal standards and professional or organizational standards that would apply to the situation and decide how they would respond to the situation. We have found this format very effective in heightening ethical sensitivities and sharpening ethical decision-making abilities.

A second format is the use of worksheets that explore the appropriateness or inappropriateness of very specific behaviors. Using a format developed by Milgrom (1992), we provide a list of verbal communications (e.g., "You are a beautiful person." "I really care about you." "You are very special to me."), a list of physical contacts (e.g., patting a client on the back, reaching over and patting a client's knee,

holding a client's hand, touching a client's face), or a list of boundary decisions (e.g., giving your home or cell phone number to a client, giving a client a gift, accepting a gift from a client) and then ask staff individually or in small groups to decide whether each action is always okay, sometimes okay or never okay for their service role and service relationships. When "sometimes okay" is chosen, staff must further define under what circumstances the action would be okay and when it would not be okay. We have found this format the most successful vehicle for exploring the subtleties of relationship boundary management in the treatment of adolescents with complex behavioral health disorders.

There are several frontier issues in the service relationship arena in which the ethical and legal responsibilities have not yet been well defined. These include 1) the application or misapplication of professional codes of ethics to peer-based recovery support specialists (paid and volunteer), 2) the degree of responsibility in milieu-oriented programs to manage the relationship boundaries between adolescent clients (e.g., preventing exploitation of one client by another), and 3) ethical issues that arise in the relationships between clients and research staff who are conducting long-term follow-up studies of treated adolescents (White, 2004; Scott & White, 2004).

Policy Issues

This text has provided an in-depth overview of the diverse patterns in which substance use disorders and other psychiatric disorders interact to create unique challenges to youth, their families, their communities and the state and national infrastructures that have been established to respond to these problems. The policy issues raised by these discussions are substantial. It is quite clear that adolescent clients and families with multiple problems (many of which have complex intergenerational histories) are becoming the norm in caseloads across health and social service systems, and that these categorically segregated service systems are ill-prepared to respond to the wide range of intense needs experienced by these young people and their families. Studies of specific youth problems (e.g., substance use, depression, suicide, truancy/dropout, criminality and violence, homelessness, HIV/AIDS) consistently note the synergistic interaction of numerous problems and the repeated recycling of these adolescents and their families through multiple silos of specialized care that do little to stem the trajectory of relapse and problem intensification. If there is a vision that emerges from these chapters it is of an integrated system of care based on a comprehensive, strengths-based assessment; the delivery of evidence-based treatments delivered by a multidisciplinary (and often multi-agency team); and sustained post-treatment monitoring, support and, when needed, early re-intervention. Fulfilling that vision will require a comprehensive national youth policy, an integration if not consolidation of youth and family serving agencies, the development of integrated funding streams and a shift from acute models of problem stabilization to models of sustained recovery management aimed at the achievement of global health for the adolescent and his or her family. Such a shift will address both the issue of access to services for co-occurring disorders (particularly in rural and historically disempowered communities) and the quality of those services. Many frontline clinicians continue to dream of a system that can facilitate the long-term recovery of adolescents with co-occurring disorders and that is also potent enough to break intergenerational cycles of problem transmission within families and communities.

A national youth policy and integrated systems of care that bring together formal youth serving agencies (e.g., health and human service, criminal justice, child protection) and also integrate indigenous sources of community support (e.g., recovery mutual aid societies, advocacy organizations, churches) will challenge the historical isolation of those with co-occurring disorders. A major challenge will be how to reconcile confidentiality and privacy laws

and regulations whose effect have been to isolate those with psychiatric and substance use disorders from the effects of stigma with new clinical philosophies that focus on enmeshing individuals and their families in a natural web of community support. As we move toward the latter, a major obstacle may be the very laws and regulations we have implemented with the noblest of intentions. This shift will also require an examination of the legal and ethical guidelines that govern our relationships with other professionals and organizations.

These chapters reveal the emergence of treatment protocol based on the best scientific studies. A significant research agenda continues in the area of co-occurring disorders in adolescents, but the need to transfer what is currently know about these disorders and their treatment from the standpoint of science is now upon us. A major policy issue is how this new emerging knowledge can move from research centers to frontline clinicians across the country. That transfer of clinical technology will require infusion of this new information into manual-guided clinical protocol, the integration of these training manuals within education and training institutions, the certification of youth workers in these evidence-based practices and the development of supervisory mechanisms for monitoring clinician fidelity to clinical protocol.

On the ethical front, we see a number of needed technical developments. There exists no ethical casebook focused specifically on the ethical issues that arise in the treatment of adolescent substance use or psychiatric disorders, and there is no model code of ethics specifically defined for agencies serving youth with substance use and psychiatric disorders. Particularly needed is a model code of ethics for the new "recovery coach" or "recovery support specialists" roles that we see being added to multidisciplinary service teams. Filled by volunteers or paid workers without formal clinical training, these positions can play an important role in the delivery of non-clinical, post-treatment support services, but the individuals filling these roles need guidance on the ethical and relationship boundary issues that arise in this work. Without such guidance, these workers, their clients and their institutions are vulnerable to harm.

Every movement into new clinical frontiers, and every movement toward new clinical service models, moves us as individuals and organizations into unexplored ethical and legal territory. We can minimize harm to multiple parties in this process through the development of codes of professional practice, the orientation and training of all staff and volunteers, the delivery of rigorous supervision, the provision or legal and ethical consultation and the debriefing of all critical incidents.

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Physicians Health Programs: What Counselors Can Learn from These Remarkable Programs

William L. White, M.A., Robert L. DuPont, M.D. & Gregory E. Skipper, M.D

Despite their advanced training, physicians are not immune to the perils of addiction. The prevalence of substance use disorders among physicians is similar to that in the general population, and substance-related problems continue to be among the chief reasons physicians are referred to their licensing boards for disciplinary action (Flaherty & Richman, 1993; Brewster, 1986; Hughes, Brandenberg, Baldwin, et al., 1992). Obviously physicians do not fit the typical, and erroneous, stereotype of addicts (i.e., poorly educated and from lower social classes); however, physicians have their own special risk factors, including easy access to controlled substances and, as a group, relatively high rates of alcohol consumption. Plus, physicians entering addiction treatment report particularly high rates of problem complexity, e.g., family histories of addiction, multiple drug choices, co-occurring medical/psychiatric conditions, and other significant obstacles to successful recovery (Domino, Hornbein, Pollissar, et al., 2005).

Despite these risk factors, the documented long-term recovery rates for physicians are among the highest reported--between 70-96% (Talbott, Gallegos, Wilson, & Porter, 1987; Gastfriend, 2005; Domino, et al., 2005). This article explores the sources of such high recovery rates, including active case management, aggressive and prolonged monitoring, contingency management linked to contractually stipulated and clearly defined consequences (not only for return to alcohol or other drugs but also for leaving the monitoring system), plus the requirement of active participation in 12-step programs or other community recovery fellowships. We believe that this comprehensive system of care is worthy of careful examination for components that might be emulated by the addiction treatment system at large (DuPont, McLellan, Skipper, & White, 2006).

Addicted Physicians: The Early History

Health care professionals have a long and colorful history of substance abuse in America. Addiction touched the lives of some of the nation's most prominent physicians, including Dr. William Halsted (1852-1922), the father of scientific surgery in America. The nation's early medical journals included essays on the treatment of addicted physicians (Mattison, 1883; Crothers, 1899), and recovering physicians played an important role in the birth of

addiction medicine, particularly as practiced within late nineteenth century private addiction cure institutes (White, 2000). Although there were physicians, such as Dr. J.T. Mattison, who specialized in the treatment of addicted physicians, there was no larger response to this problem by early medical societies until the late 1800s when medical boards increased in number and developed programs to assure physician competence.

Concern about addicted physicians increased after the repeal of alcohol prohibition, but so did the hope for recovery following the co-founding of Alcoholics Anonymous (1935) by Dr. Robert Holbrook Smith, a proctologist, and the subsequent founding of the International Doctors in A.A. (IDAA) (1949) by Dr. Clarence Pearson. Members of the IDAA played an unheralded role in the subsequent development of physician health programs and in the development of the broader field of addiction treatment in the twentieth century.

Three events set the stage for the development of physician health programs: the rise of formal industrial alcoholism programs, the development of private and public addiction treatment programs and the development of family-based and peer-based professional intervention technologies. The earliest physician health programs (known then as impaired physician programs or physician assistance programs) were modeled after the industrial alcoholism programs that predated modern employee assistance programs. Many of the core elements of these early programs, such as personalized contact on the jobsite with co-workers who are in recovery with the explicit goal of saving the addicts career, were largely lost in the later evolution of EAPs. These features have been retained in physicians health programs (PHPs).

Although the Federation of State Medical Boards called for model physicians assistance programs as early as 1953, it was not until the 1970s that such programs began to emerge. Four events furthered the rapid growth of PHPs: 1) the American Medical Association's (AMA) Council of Mental Health's 1974 report that addressed physician impairment, 2) the AMA's 1973 report on "The Sick Physician," 3) the U.S. Disabled Doctors Act of 1974 that promoted mandatory reporting of impaired physicians and whistleblower immunity, and 4) the AMA's 1975 and 1977 conferences on impaired physicians. As a result of these events, State Medical Society Physician Health Committees were established in most states in the 1970s and were followed by the rapid growth of formal PHPs and the development of specialized treatment programs for addicted physicians. In 1990, the nation's PHPs were linked organizationally by the formation of the Federation of State Physician Health Programs.

The PHP Model

Modern PHPs typically provide a range of services including: 1. Educational programs that promote early referral, 2. Professional intervention services, 3. Referral to formal evaluation, 4. Referral to formal treatment, and 5. Long-term monitoring.

Educational Programs: Educational programs are provided by PHPs for numerous reasons and there are usually ample opportunities since the Joint Committee on Accreditation of Healthcare Organizations, and others, require all accredited hospitals to provide Continuing Medical Education for their doctors and other staff regarding physician impairment. Educational programs provide an excellent opportunity for "marketing" and for the PHP staff to become known and trusted, and to explain who, how, and when to refer. Early referral of physicians with substance use problems before actual impairment and patient harm occurs is obviously desirable. Providing copious education to every willing hospital, medical group, county medical society, etc, is an excellent way to spread the word about the program, and PHPs take advantage of these opportunities.

Professional intervention services: When a physician is referred to a PHP, a preliminary assessment is performed to verify that the referral is legitimate and

appropriate. Illegitimate referrals are rare but can occur from disgruntled spouses, political enemies, etc. If a referral is deemed legitimate and warranted, a professional intervention is conducted. A professional intervention is simply one in which the physician is presented with information about the program, the fact that concerns have been raised, that the concerns appear legitimate (even if not accurate), and the procedures and policies of the PHP are explained. These procedures and policies provide protection and advocacy for the physician if the physician voluntarily follows recommendations.

Referral to formal evaluation: PHP policies usually specify that a formal evaluation at an approved evaluation site is the next step. If the evaluation fails to identify a problem, this fact can be used to exonerate the physician by the PHP and to squelch the original complaint—a situation that is rare but does happen. Either way, the PHP can assist the physician by documenting the results of the evaluation as well as how the findings have been handled.

Referral to formal treatment: PHPs assure that the physician receives credible care by referring to an approved treatment center.

Long-term monitoring: PHPs include long-term monitoring that includes regular random drug testing, reports from a worksite monitor, group attendance with documentation of attendance, and other recovery oriented activities.

Outcomes: Treatment outcome studies of addicted physicians suggest both high success rates (Shore, 1987; Talbott, et al., 1987; Smith & Smith, 1991; Domino, et al., 2005) and that PHP participation is the likely key to high abstinence rates (Gastfriend, 2005).

Key Ingredients

So what are the key ingredients of PHPs that lead to their successes? Studies have yet to be conducted that isolate the most potent ingredients of PHPs; however, we propose they include many practices that addiction counselors and the treatment programs that employ them could incorporate into their own work. Eight such practices are detailed below.

1. Find a motivational fulcrum. The PHP utilizes a crisis-induced window of opportunity to transition those they serve from the experience of pain to the experience of hope. The common message is, “You are in a bind, and we can help because we represent a legitimate process and a group of physicians who have escaped the very pain that you are now experiencing.” The PHP intervention focuses on the arena in which the person’s identity is most enmeshed, in this case the status-imbued practice of medicine and the potential loss of identity, income and social standing that would follow license revocation. Even where contact with the PHP is voluntary, these potential realities remain an omnipresent sub-theme of the assistance process. What counselors can take from this is the importance of contingency management, i.e. linking recovery to meaningful positive rewards and relapse to negative consequences. Establishment of a clear behavioral contingency agreement, on paper, signed by the physician and the PHP director, clearly identify required aftercare activities and commitment to regular drug testing--a tangible measure of sobriety and of relapse. This reinforces important mediums of continued recovery and provides a source of support and re-motivation during early recovery. The stakes involved in this contingency are best if they are specific and serious, for example, loss/retention of intimate relationship, job/career, children, freedom, or privileges. Counselor folklore is replete with admonitions that no one can get sober except for themselves, but lighting the sobriety fire requires kindling and a source of ignition that is specific to each client. Contingency management techniques are becoming more widely accepted as their effectiveness is confirmed in traditional treatment settings (Petry, et al., 2006).

2. Provide comprehensive assessment and treatment. Another key component used effectively by PHPs is the

provision of comprehensive formal evaluation and treatment that address the full scope of problems identified in the evaluation. What the mainstream treatment system can take from this is the need to move from categorical to global evaluation protocols and the need to widen the menu of available services. What distinguishes the settings in which doctors are treated from the mainstream treatment system is not that the treatment for physicians is more expensive (a factor that does not always translate to better quality), but that it is far more intensive and comprehensive, e.g., more likely to be prolonged (if needed) and to include concurrent psychiatric evaluation and treatment plus rigorous family programs and treatment of any other problematic condition (i.e. chronic pain, sexual disorders, etc) (Skipper 1995).

3. Provide viable role models and peer-based recovery coaching. PHPs rely on physician-to-physician identification and communication, provide positive role models of physicians in long-term recovery, and provide peer-based recovery coaching into and throughout the recovery process. In most PHPs, there is a staff member or case manager who fills the role as a recovery coach who solicits input from the family and professional peers and offers the physician a regular report card, e.g., "Here's where you are very strong right now, and here are some areas in which you could do better." Such feedback coming from other physicians also in recovery and tested allies and advocates provides a potent vehicle of support that could be matched by few other sources. As counselors, we would be well served by asking ourselves, "How does this person define himself or herself at the most fundamental level (age, gender, race/ethnicity, family, sexual orientation, drug choice, profession, geography, life-shaping event, etc.)?" With this information we can more effectively explore how to mobilize people in recovery who share those qualities in support of the client's recovery. PHPs have done a brilliant job aligning comprehensive support for American physicians with substance use disorders.

4. Modify lifestyles to reduce relapse risk and enrich recovery. PHPs ask each physician to consider recovery-enhancing practice modifications and lifestyle changes. The former could include such options as a change in medical specialty, prescribing restrictions, external monitoring of prescribing practices, or a change in institutional affiliation or work schedule. The goal is to set the physician up for success—both in his/her recovery and his/her practice.

5. Assertively link to recovery support groups. PHPs rely on active (linkage to a particular person/group/meeting) rather than passive (verbal encouragement for participation) referrals to Twelve Step and other recovery mutual aid groups. They also link each member to professionally-directed group therapy with other physicians in recovery and monitor physician attendance at such meetings. The PHP encourages participation in peer-based recovery support groups, e.g., (Caduceus Meetings or International Doctors in Alcoholics Anonymous). The goal is to link each individual client with people who will reinforce their identity as a recovering physician and to lead these same individuals into relationship with the larger recovery community.

6. Sustain monitoring and support and, when necessary, re-intervene. Post-treatment monitoring and support enhances long-term recovery outcomes (Dennis, Scott & Funk, 2003), and PHPs are unique in the length of time they monitor and support persons in recovery. The monitoring function involves periodic interviews as well as random urine, saliva, sweat patch and hair testing for five years or more. PHP staff members respond to any positive drug screen with an appropriate level of re-evaluation of the physician, encouragement to seek further treatment if needed, and the ever present potential, if warranted, of referral to the licensing board if recommendations are not followed. Every physician knows that referral to the licensing board could result in loss of license.

Such surveillance and support does not completely eliminate relapse. Surveys reveal that up to 25% of physicians in PHPs

experience at least one relapse (Domino et al., 2005), but because of the monitoring and re-interventions, most physicians eventually establish stable recovery, avoid posing threats to the safety of their patients, and retain their license to practice medicine. Active and sustained monitoring insures early identification of relapses, which in PHPs typically lead to increased support and re-intervention. This may be the component that most distinguishes PHPs from many mainstream addiction treatment programs, other employee assistance programs, drug court and other criminal justice programs, and intervention programs in the child welfare system, all of which offer less rigorous, intensive and enduring systems of monitoring and support.

7. Re-intervene at a higher level of intensity. Another distinguishing feature of PHPs is that relapse and re-intervention are followed by reevaluation and the possibility of more intensive, prolonged, and specialized treatment rather than a re-admission and replication of the same treatment that was provided earlier. This blend of support and accountability, alliance and toughness distinguishes PHPs from other interventions that seek but too often fall short of creating and sustaining these important ingredients.

8. Integrate these elements, where possible, within a comprehensive program. Many persons achieving successful recovery experience elements of what we have described here, but the PHPs are distinguished by their inclusion of these elements within an integrated program. The level of cohesion and coordination that comes from such integration may itself contribute to the PHP's high long-term recovery rates. The best drug courts and the more innovative programs in the child welfare system share similar direction and integration. Where such elements are lacking, counselors could well serve their clients by providing the connective tissue and leadership within multi-agency intervention models that utilize an integrated service plan and contain the potent ingredients we have described here.

Summary

Addicted physicians involved in physicians health programs have exceptionally high long-term recovery rates. They recover in such high numbers not necessarily because they are physicians, but more likely because they participate in programs that differ significantly from standard treatment in the United States (Gold, Logan, Bruijnzeel, & DuPont, 2006). The seven components of PHPs that we consider to be the keys to quality enhancement are: 1) use of a motivational fulcrum, 2) comprehensive assessment and treatment, 3) peer-based recovery coaching, 4) lifestyle modifications, 5) assertive linkage to communities of recovery, 6) sustained monitoring, support and early re-intervention, and 7) service integration. These active ingredients of the care provided by Physicians' Health Programs merit serious study by those of us invested in improving the quality of addiction treatment for all Americans.

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Addiction as a Chronic Disorder: Key Messages for Clients, Families and Referral Sources

William L. White, MA and A. Thomas McLellan, PhD

Modern medicine has recognized that chronic diseases cannot and should not be treated and managed like acute disorders.

Acute disorders such as bacterial infections, broken bones and even emotional trauma from shock or injury, can typically be traced to a clearly identifiable source (e.g., an infectious agent, physical trauma) and can be "cured" through treatment and recovery processes that span a relatively short period of time. The onset, course and resolution of acute disorders may be intense and disruptive, but they generally leave no lasting mark on one's identity or functional capabilities. The treatment process essentially returns the body to its original state - the treated individual is no more (or less) susceptible to a return of the disease or condition than an individual who never had the disease. Thus, while a treated individual may again break a bone or get another infection - this is considered a new occurrence and not a relapse.

In contrast, chronic diseases such as diabetes, asthma or heart disease spring from and are complicated by, multiple biological, psychological and social factors - some of which cannot be clearly identified. Many times "lifestyle" or personal behavioral choices are intimately involved in the onset and course of these disorders. While there are usually several potentially effective treatments for chronic disorders, they are of necessity more complex and protracted than acute treatments and they do not produce the same kinds of outcomes as acute treatments.

All chronic treatments, regardless of disease, share three important features. First, they can usually remove or reduce the symptoms of the disease - but cannot affect the root causes of the disease. For example, beta blockers reduce blood pressure and insulin improves the body's ability to digest sugars and starches - as long as the affected individual continues the treatment. However, these treatments do not return the affected individual to normal.

The second feature associated with all chronic treatments is that they require significant changes in lifestyle and behavior on the part of the patient to maximize their benefit. Again, even if individuals with diabetes regularly takes their insulin as prescribed, this will not stop disease progression if they do not also reduce sugar and starch intake, increase exercise and reduce stress levels.

The third feature derives from the first two. Because of the complexity of factors that can lead to a chronic illness and because of the need for ongoing medical care and lifestyle change, it should not be surprising that relapses are very likely to occur in all chronic illnesses. For these

reasons, most contemporary treatment strategies in chronic illness involve regular in-person and/or telephone monitoring of medication adherence; coupled with encouragement and support for pro-health changes in diet, exercise and stress levels. Increasingly, family members are being trained to also provide continuing monitoring and support for the behavioral changes necessary to maintain symptom remission and sustain good quality of life. .

As is evident from this short preface, the onset and course of chronic illnesses are not like those of acute illnesses; and for these reasons chronic care has to be quite different from acute care. While many in our field have come to consider some (not all) forms of addiction as chronic - this change in thinking has not been followed by changes in treatment strategy, monitoring methods, insurance coverage or outcome expectations. With this as background, the current article: 1) summarizes the history of the conceptualization of severe alcohol and other drug dependence as a chronic disease, 2) updates the scientific evidence comparing alcohol and drug dependence to diabetes mellitus, hypertension and asthma, and 3) identifies the central messages that addiction professionals can communicate to clients, families and referral sources regarding addiction treatment and long-term recovery management strategies.

Historical Background

The earliest conceptualizations of chronic drunkenness as a medical condition by Drs. Benjamin Rush and Thomas Trotter were followed by more substantive treatises by Drs. M. Huss, W. Marcet, T.D. Crothers and others, all of whom noted the prolonged course of alcohol dependence and the professional challenges involved in its treatment. The origins of terms such as *habituation*, *inebriety, dipsomania*, *alcoholism* and *addiction* were rooted in efforts to convey a condition far more complex and enduring than the threat posed by an episode of acute alcohol or other drug intoxication. The recognition of the chronicity and complexity of severe alcohol and other drug problems led to the calls for special institutions for the care of the inebriate (Woodward, 1838) and the subsequent birth of inebriate homes, inebriate asylums and private addiction cure institutes (White, 1998).

There were several early pioneers who suggested that the treatment of addiction should mirror the treatment of other chronic diseases. In 1828, Dr. J.H. Kain penned an essay on the treatment of intemperance in which he invoked the medical maxim, “chronic diseases require chronic cures” (p. 295). Dr. T.D. Crothers expressed similar sentiments in an 1879 editorial in the *Journal of Inebriety*:

> *The permanent cure of inebriates under treatment in asylums will compare favorably in numbers with that of any other disease of the nervous system which is more or less chronic before the treatment is commenced.* (p.249)

Such comparisons of addiction to other chronic disorders were lost in the larger collapse of the inebriate asylum movement in the opening decades of the twentieth century.

As interest in alcoholism as a public health problem arose again in the mid-twentieth century, alcoholism was again compared to other chronic diseases. A 1938 report of the Scientific Committee of the Research Council on Problems of Alcohol concluded, “An alcoholic should be regarded as a sick person, just as one who is suffering from tuberculosis, cancer, heart disease, or other serious chronic disorder@ (Johnson, 1973, p. 244). Also worthy of note is a 1947 article by Dr. R.E. Duncan published in the *Kansas City Medical Journal.* Duncan declared that alcoholism is a “chronic affair” and that “chronic conditions must be approached on a long range basis.@ He further concluded, “to foster complete recovery, treatment must be continued for years after the patient has been sobered” (pp.11-12). Duncan was one of the first practitioners to explore the full clinical implications of the chronicity of addiction. During this same period, Charles Franco, an early industrial alcoholism pioneer, wrote a 1951 article “Chronic

Alcoholism as a Medical Problem in Industry." He called for recognizing alcoholism "as much a disease as diabetes or tuberculosis." (Duncan, 1951, p. 48)

One other important historical footnote from the mid-twentieth century was the 1942 publication of Howard Haggard and E.M. Jellinek's *Alcohol Explored*. In this text, which was overshadowed by Jellinek's later book *The Disease Concept of Alcoholism* (1960), Haggard and Jellinek suggest that "The progress of research has been impeded by two conceptions: the first that all habitual excessive drinking is a disease, and the second that it is the same disease" (p.143). This statement anticipated much of the later debate over the question of whether alcoholism is a disease and whether all alcohol problems can comfortably fit within a "disease" or "chronic disease" rubric. Our focus in this article is not on what addiction is—a disease, illness, disorder, habit, problem, etc.—but on the temporal course of addiction and how the span of the disorder from onset through sustained recovery can be most effectively managed at personal and professional levels.

Treatment in an Acute Care Model

The emphasis on alcoholism as a chronic disease was lost in the larger battle to convey to the American public and policy makers that alcoholism was a disease (Mann, 1944). This effort spanned the 1940s-1960s and led to landmark legislation in 1970 that set the stage for the rise of community-based, time-limited addiction treatment in the United States. This was followed by a rapid process of professionalization and commercialization and subsequent emergence of an aggressive system of managed behavioral health care in the U.S. Despite (or perhaps because of) these forces, nearly all modalities of addiction treatment migrated toward an acute care (AC) model of intervention--even traditionally long-term modalities such as therapeutic communities and methadone maintenance.

The AC model is characterized by the following central elements:

- Services are delivered "programmatically" in a uniform series of encapsulated activities (screening, admission, a single point-in-time assessment, treatment procedures, discharge, and brief "aftercare" followed by termination of the service relationship).
- A professional expert directs and dominates the assessment, treatment planning and service delivery decision-making throughout this process
- Services transpire over a short (and historically ever-shorter) period of time -usually as a function of a pre-arranged, time-limited insurance payments designed specifically for addiction disorders and "carved out" from general medical insurance..
- The individual/family/community is given the impression at discharge ("graduation") that "cure has occurred:" long-term recovery is now self-sustainable without on-going professional assistance.
- Post-treatment relapse and re-admissions are viewed as the failure (non-compliance) of the individual rather than potential flaws in the design or execution of the treatment protocol.

By the later 1990s, the assumptions of the AC model began to be questioned (O'Brien & McLellan, 1996; Hser, Anglin, Grella, et al, 1997; Stout, Rubin, Zwick, et al, 1999). These early critiques were followed by widespread calls to extend the design of addiction treatment from an AC model to a model of sustained recovery management (McLellan, Lewis, O'Brien, & Kleber, 2000; White, Boyle, & Loveland, 2002; Godley, Godley, Dennis, et al, 2002; Dennis, Scott & Funk, 2003; Compton, Glantz, & Delaney, 2003; White, 2005; McKay, 2005; Dennis, Scott, Funk, & Foss, 2005; Scott, Dennis, & Foss, 2005; Flaherty, 2006; Dennis & Scott, 2007). One call to redesign addiction treatment was the publication of "Drug Dependence, a Chronic Medical Illness" in the *Journal of the American Medical Association* (McLellan, Lewis, O'Brien & Kleber,

2000). In the next section, we will summarize and update the major findings of this seminal article.

Addiction as a Chronic Medical Illness

It is important to state at the outset that not all alcohol- and drug-related (AOD) problems inevitably become chronic disorders; and that clinical research has not yet been able to clearly predict which early cases will ultimately become chronic. Many substance use problems are developmental and as such are often outgrown in the successful transition from adolescence into adulthood. Others occur in tandem with major life transitions (e.g., death of a loved one, divorce, job loss) and are resolved by time, natural support, brief professional intervention or peer-based intervention by others in recovery (Burman, 1997; Granfield & Cloud, 1999, Bien, Miller & Tonigan, 1993; Bernstein, Bernstein, Tassiopoulos, et al, 2005). Similarly, many of those who experience a period of high blood pressure will essentially get over this problem through change of lifestyle, loss of weight and increased physical activity. It is not currently possible to predict who will go on to develop chronic hypertension.

For many reasons, most of those entering addiction treatment are characterized by greater personal vulnerability for AOD problems (e.g., family history of AOD problems, early onset of AOD use, traumatic victimization), greater problem severity (e.g. substance dependence), greater problem complexity (e.g., concurrent medical/psychiatric illness, multiple drug use), and fewer personal and family resources to initiate and sustain a long-term recovery process (Bischof, Rumpf, Myer, et al, 2004; Granfield & Cloud, 1999). There are striking similarities between substance dependence as seen in the clinical setting and other chronic illnesses such as 2 diabetes mellitus, hypertension and asthma (McLellan, Lewis, O'Brien & Kleber, 2000). Severe substance dependence and these other primary chronic illnesses:

- Are influenced by genetic heritability and other personal, family and environmental risk factors.
- Can be identified and diagnosed using well-validated screening questionnaires and diagnostic checklists.
- Are influenced by behaviors that begin as voluntary choices but evolve into deeply ingrained patterns of behavior that, in the case of addiction, are further exacerbated by neurobiological changes in the brain that weaken volitional control over these contributing behaviors..
- Are marked by a pattern of onset that may be sudden or gradual.
- Have a prolonged course that varies from person to person in intensity and pattern.
- Are accompanied by risks of profound pathophysiology, disability and premature death.
- Have effective treatments, self-management protocols, peer support frameworks and similar remission rates, but no known cures.

These similarities between serious substance dependence and other chronic illnesses are striking. It is important to note that even substantial similarity does not mean that similar disease processes are at work across these conditions. However, at the very least, the similarities argue for consideration of the same kinds of chronic or continuing care strategies for alcohol and drug dependence that have been employed in other chronic diseases. If substance dependence *is like other chronic illnesses*, then this raises two important implications: 1) acute care models of intervention for severe substance dependence may reduce substance use temporarily but those reductions are not likely to sustain once care stops; and 2) methods used in the treatment of other chronic illnesses might be effectively adapted to enhance long-term recovery from substance dependence. These implications offer an explanation of the generally

high and rapid rates of relapse following cessation of most available addiction treatments (McLellan et al., 2000): there is simply no quick fix for the most severe forms of this disorder.

Changes in Service Infrastructure and Practices

Recent years have been marked by pilot efforts to move addiction treatment beyond the acute biopsychosocial stabilization and patient education toward the goal of long-term recovery as measured by stable sobriety, global (physical, emotional, relational, spiritual) health and citizenship (Betty Ford Institute Consensus Panel, 2007). Efforts to create "recovery-oriented systems of care" are underway at national, state and local levels (Clark, 2007; Kirk, 2007; Evans, 2007).

However, it should be obvious at this point that elevating long-term recovery rates for severe substance dependence will require fundamental changes in the national, state and local infrastructure of addiction treatment as well as changes in front-line service practices (Roman & Johnson, 2002; D'Aunno et al., 1998; McLellan, Carise & Kleber, 2003) and service relationships (McLellan et al., 2005). Table 1 illustrates the direction of desired infrastructure changes that addiction professionals can anticipate if the field can muster the collective will and resources to affect such changes.

Table 1: Infrastructure Changes Required for Shift toward Recovery Management

Element of Service Infrastructure	**Change Required**
Operational Stability, Leadership Development & Succession Planning	Increased continuity of ownership & leadership of addiction treatment programs; a new generation of leaders committed to recovery-focused system transformation, replacement of the current mass exodus of long-tenured leaders at all levels and across all roles in the field.
Institutional Mission, Core Values & Service Philosophy	Shift in focus from acute stabilization to long-term individual (and ideally) family recovery; articulation of core recovery values that will drive system transformation processes; integration of clinical models of intervention with public health and community development models that seek to alter the community recovery environment.
Policy-making Processes	Diverse representation of people (individuals/families) in recovery at all levels of system decision-making.
Service Integration / Holistic Care	Development of multi-agency, interdisciplinary, cross-trained teams and integrated funding streams. Integration of primary medical and psychiatric care within specialized addiction treatment settings - and vice versa.
Funding Philosophies and Mechanisms	Shift by government and private sources from purchasing time, or session-limited units of service - to purchasing an integrated program of management and support for long-term recovery; shift in emphasis from treatment intensity (crisis stabilization) to treatment extensity (prolonged recovery maintenance)
Regulatory Standards and Monitoring Protocol	Integration of chronic care principles into monitoring standards; shift from focus on program policy development and procedural efficiency to intermediate and distal recovery outcomes.
Workforce Preparation & Stabilization	Greater emphasis on recovery principles and processes in preparatory education and training; new training programs for peer-based recovery support specialists (e.g., recovery coaches); initiatives seeking to lower turnover of service personnel to achieve continuity of contact in recovery support relationships.

System Relationships	Shift from paternalism to partnership—from hierarchical control to reciprocal respect.
Information Technology	Computer-based clinical management information systems capable of evaluating individual, unit and organizational performance based on key recovery indicators.
Evaluation & Research	All treatment providers will monitor and report aggregate recovery outcome data at regular intervals for all those receiving care; funding of state and national recovery research agendas, e.g., detailed recovery prevalence data, documentation of long-term pathways and styles of recovery.

In the shift from an acute care to recovery management model, changes in local programmatic and service practices will be required in several critical areas. These changes will focus on such treatment system performance indicators as the following (White, Boyle, Loveland, 2003; Evans, 2007; White, in press):

- Attraction: Identifying and engaging individuals and families at an earlier stage of AOD problem development (e.g., via assertive community education, screening and outreach programs)
- Engagement: Enhancing access, therapeutic alliance, and retention (e.g., expedited service initiation, focus on relationship-building and regular re-motivation, altered policies related to administrative discharge)
- Assessment: Developing assessment protocols that are global, family-centered, strengths-based and continual.
- Service Planning: Transitioning from professional-developed treatment plans to client-directed recovery plans.
- Service Menu: Focusing on service elements that have measurable effects on recovery outcomes; expanding the service menu to include non-clinical, peer-based recovery support services.
- Service Duration: Shifting from “emergency room” models that emphasize brief, crisis-oriented services to “recovery models” that emphasizes long-term, lower intensity recovery maintenance services.
- Service Location: Extending the reach of services from the institutional environment to the natural environments of individuals and families, e.g., expansion of neighborhood-based, work-based and home-based services.
- Service Relationship: Shifting from a professional expert model to a long-term recovery partnership/consultant model; philosophy of choice for individuals and families.
- Continuing Care: Shifting from “aftercare” as an unfunded afterthought to assertive models of continuing care for all clients (regardless of discharge status), e.g., post-treatment monitoring, stage-appropriate recovery education and coaching, personal linkage to communities of recovery and, when needed, early re-intervention. Expanded use of cell phones and Internet for long-term monitoring and support.
- Relationship to the Community: Increasing utilization of indigenous recovery support resources in the community, e.g., recovery support groups, recovery community organizations (e.g., recovery support centers), recovery homes, recovery schools, recovery industries, and recovery ministries.

Communicating about Addiction as a Chronic Disease

Many communications about addiction and especially communications comparing it to other chronic illnesses can arouse strong feelings and unintended, harmful implications. Because of the significant family and social problems associated with addictive disorders, strong feelings are aroused when these conditions are discussed as "illnesses" or "chronic diseases." To many in the public at large this represents inappropriate "medicalization;" abrogation of personal responsibility for those affected; and a ready-made excuse for ineffective treatment for the treatment field. Perhaps worse, many individuals with substance use disorders who have gained and maintained recovery may resent the idea that they have a "continuing chronic illness."

Thus, care must be taken in how the chronic nature of addiction is communicated to the policy makers and the public, clients, family members, referral sources and to those working on the front lines of addiction treatment. In the service of better communication we first discuss what this concept of addiction as a chronic illness does NOT imply; followed by ten concepts and correlates that may be helpful in thinking about and discussing appropriate and effective continuing care for chronic forms of this illness.

Things NOT Implied or Suggested by the Concept of Addiction as a Chronic Illness

- All AOD problems are NOT chronic, most do NOT have a prolonged and progressive course - some do and research is needed to identify early signs of chronic progression.
- All persons with AOD problems do NOT need specialized, professional, long-term monitoring and support - many recover on their own, with family or peer support; again research is needed to identify who is most likely to need intensive, professional care.
- Among those who do need treatment, relapse is NOT inevitable and all persons suffering from substance dependence do NOT require multiple treatments before they achieve stable, long-term recovery.
- Even among those who do relapse following treatment, families, friends, and employers should NOT abandon hope for recovery. (Community studies of recovery from alcohol dependence report long-term recovery rates approaching or exceeding 50% Dawson, Grant, Stinson, et. al., 2005).
- Having the serious chronic illness of addiction, DOES NOT reduce personal responsibility for continuous efforts to manage that illness - just as those with serious diabetes or hypertensive disease must also manage their illnesses.
- Appropriate treatment for chronic addiction is NOT simply a succession of short term detoxifications or treatment stays. Appropriate continuing care requires personal commitment to long-term change, dedication to self management, community and family support and monitoring.
- Current addiction treatment outcomes are NOT acceptable simply because they are comparable to those achieved with other chronic disorders.

Things that ARE Important In Considering the Concept of Addiction as a Chronic Illness

- Chronic Diseases Vary. Not everyone at risk for a chronic disease contracts the disease or experiences the same course of the disease. Chronic diseases exhibit a high degree of variability in pattern of onset, course and intensity (self-accelerating, constant, alternating cycles of remission and relapse, or decelerating). Each case of chronic disease varies in physiological severity, functional impairment, and the financial/emotional burden placed on the individual, family and society (Stein, et al, 1987). The course of chronic disorders is influenced by the interaction of such factors as type

and degree of biological vulnerability, age of onset, problem severity, problem complexity (e.g., presence of co-occurring disorders) and degree of individual, family and community *recovery capital* (assets that can be drawn upon to initiate and sustain recovery) (Granfield & Cloud, 1999). Adding to the burden of chronic disorders is their propensity to beget other acute and chronic disorders such as depression and chronic pain.

- Chronic diseases require prolonged and active management. Chronic disorders require strategic, sustained stewardship of personal, family and community resources. Core strategies for achieving long-term recovery from chronic disorders include stabilization of active episodes, global assessment, enhancement of global health, sustained professional monitoring and early re-intervention, continuity of contact in a primary recovery support relationship, and development of a peer-based recovery support network. Choices for the treatment and management of chronic disorders diminish through disease progression and expand with sustained stabilization and enhancements in global health.

- Both full and partial recoveries are possible. There are permanent solutions to severe alcohol and other drug problems. Millions of individuals and families throughout the world live full lives in long-term recovery from these problems. Their increasingly public stories, even more than the accumulation of scientific studies, offer living proof of this proposition. Partial recoveries are also possible. An essential strategy of chronic disease management is optimizing personal functioning and quality of life even after abstinence has been achieved. Recovery management strategies for persons with the most severe and persistent disorders include multiple goals: reducing the number, intensity, and duration of relapse episodes; strengthening and extending the length of remission periods; reducing the personal and social costs associated with relapse; reducing the propensity for drug substitution and other excessive behaviors during early periods of recovery initiation; and enhancing the quality of personal/family life through both the remission and relapse phases of the disorder. Partial recovery may constitute a prelude to resumed substance dependence, a permanent state, or a stage of ambivalence and instability that precedes the achievement of full recovery.

- Recovery processes vary. There are multiple pathways, patterns and personal styles of long-term recovery (White & Kurtz, 2006). The time and resources required to fully resolve alcohol and other drug problems vary from individual to individual. Greater time and resources are often required as substance use disorders become more severe and complex and as a personal, family and community recovery capital diminish. Beyond this general guideline, there is no way to predict who will sustain recovery following a single effort, who will achieve recovery after multiple efforts or who will fail to achieve recovery.

- Lapses after recovery initiation are common but not inevitable. A lapse (episode of alcohol or drug use) or relapse (resumption of compulsive use and its related problems) following treatment does not mean that there is no hope for recovery. A significant portion of persons currently in long-term recovery experienced one or more lapse/relapse episodes before achieving sustainable sobriety. Such events do call for renewed intervention, a refinement in strategies of recovery maintenance, and greater resources for long-term support.

- Natural support matters. The prospects of long-term recovery for individuals are enhanced by sustained family and social support. Family members and friends can take concerted action to shorten a loved one's addiction career (the span of time from problem

onset to stable recovery maintenance) and to enhance the health of all family members and the family unit.

- Intervening early makes a difference**.** Recognizing and intervening in the alcohol and other drug problems of a family member can shorter his or her addiction career. There are brief windows of opportunity within the course of addiction that can be capitalized upon to help initiate and solidify long-term recovery.

- Personal and family recovery take time. Some of the personal/family problems that preceded or that developed after the onset of alcohol and other drug problems continue into the early years of recovery. The resolution of these problems requires time, sustained effort, and, quite often, professional help.

- Professional and peer support helps. Individual and family recoveries are enhanced by sustained professional and peer support. Monitoring the status of a chronic disease, the effectiveness of the efforts to manage it, and changing physical, psychological, behavioral and environmental risk factors are crucial elements in chronic disease management. Sustained participation in peer-based recovery support groups and other recovery community institutions (e.g., recovery homes, recovery schools, recovery ministries) can elevate long-term recovery rates. Primary physicians, addiction professionals and other frontline health care providers constitute and important resource for long-term recovery check-ups and support.

- Recovery is a marathon that can bring unexpected gifts. Recovery from severe alcohol and other drug problems, like recovery from other primary health problems such as diabetes, asthma or heart disease, requires sustained vigilance and effort. Recovery gives back to individuals and families what was taken through the addiction process. Some individuals and families will be stronger, healthier and live more personally meaningful and fulfilled lives as a result of their shared recovery experience.

A Historical Opportunity

Re-engineering addiction treatment into a system of sustained recovery support will be both a major challenge and an important opportunity for society. We invite those on the frontlines of addiction treatment to join us in writing this new future for addiction recovery in America.

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Selected Papers of William L. White

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The Recovery Paradigm and the Future of Medication-assisted Treatment.

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It is an honor to have been asked to stand before you this morning. I have worked in the addictions field as a clinician, researcher and educator for the past 40 years, but I am speaking to you today primarily as a recovery advocate and a treatment and recovery historian.

My presence here today could not have been predicted in my early career. As someone deeply entrenched in the philosophies of the therapeutic community and Minnesota Model alcoholism programs of the late 1960s and early 1970s, I regularly expressed the great hostility towards methadone and other medications that was then typical of those settings. I experienced a turning point in those attitudes when I returned to school in 1976 under the mentorship of Dr. Ed Senay, one of the early clinical pioneers in modern addiction medicine. In one of our early meetings, I launched into one of my anti-methadone rants. After quietly listening to me, Dr. Senay said, "Young man, your passion on this subject is in inverse proportion to your knowledge" and began my prolonged re-education about medication-assisted treatment. That education has been deeply influenced by relationships with people whose long-term recoveries have been aided by medication and by dedicated professionals working on the front lines of medication-assisted treatment. My words today are part of a long series of amends for the harm that may have been caused by my early professional ignorance and arrogance.

In the next few minutes, I would like to share three key points for your consideration.

The first and most important of these points is that there is a transformation underway in the conceptual center of the addictions field. The emerging shift in focus from pathology and intervention to the pathways, processes, styles and stages of long-term recovery will profoundly influence the future of medication-assisted treatment and recovery in the United States.

This shift has been influenced by the growth, philosophical diversification, and the growing cultural and political consciousness of American communities of recovery. We

are witnessing historically important growth of recovery mutual aid fellowships and broader recovery community institution building. We are seeing dramatic growth in recovery homes and colonies, recovery schools, recovery industries, faith-based recovery ministries, recovery media and entertainment, recovery community centers and cafes, and online recovery communities. In the past decade we have also witnessed the birth and rapid maturation of a new grassroots recovery advocacy movement. The cultural and political mobilization of people in recovery, their families and allies is evident in new and renewed recovery advocacy organizations, multiple recovery summits, and increasingly well-organized anti-stigma, advocacy campaigns and recovery celebration events. Let's put this movement in historical context. In 1976, 52 prominent Americans stepped forward to publicly declare their recovery from alcoholism as part of the National Council on Alcoholism's Operation Understanding. That event was a historical milestone in the history of recovery in the Unites States. Last September, more than 40,000 recovering people and their families and friends marched in recovery celebration events across the country. American communities of recovery are awakening as a cultural and political force.

Evidence of a resulting shift in our organizing center is evident in many quarters. *R**ecovery*** is emerging as an organizing paradigm for behavioral healthcare systems transformation. We are witnessing **c**alls to shift the design of addiction treatment from models of acute or palliative care to a model of sustained "Recovery Management" and to reconstruct addiction treatment as a "Recovery-oriented System of Care." We are seeing intensified calls for a "recovery-focused research agenda" to guide this systems transformation process. And we are seeing an increased recovery orientation within the historical methadone advocacy community—as indicated by the National Alliance of Methadone Advocates rechristening itself the National Alliance for Medication-assisted Recovery.

Three recent milestones illustrate the import of these trends to the future of medication-assisted recovery.

The first milestone was the founding of Faces and Voices of Recovery in 2001 as the organizational center of the recovery advocacy movement. At the core of the historical recovery summit in St Paul, Minnesota that created Faces and Voices of Recovery was the idea that there are multiple pathways and styles of long-term recovery-- including medication-assisted recovery—and that all are cause for celebration. By involving people in medication-assisted recovery within Faces and Voices of Recovery at the highest levels, a historical link was forged between the work of early methadone advocates and the larger recovery advocacy movement. Members of innumerable twelve-step fellowships, secular recovery fellowships, religious recovery fellowships and medication-assisted recovery fellowships are marching side-by-side sharing the identity of "people in recovery." This is historically unprecedented and would not have been possible without the work of skilled advocates like Lisa Mojer-Torres, Walter Ginter and Joyce Woods. Today, I bring you warm greetings from and an invitation for continued participation in Faces and Voices of Recovery and other American recovery advocacy organizations.

A second important milestone is the recent work at federal, state and local levels to create recovery-oriented systems of care and to define and advance the role of medication-assisted treatment and recovery within such systems of care. The leadership of Dr. H. Westley Clark at CSAT, Dr. Tom Kirk in Connecticut, Dr. Arthur Evans in Philadelphia, and Karen Carpenter-Palumbo in New York are particularly noteworthy. CSAT's funding of the Medication Assisted Recovery Services Project (MARS) in New York City in 2006 under the innovative Recovery Community Services Program (RCSP) may prove a particularly important milestone. MARS is piloting a model peer-based recovery support services project operated for and by methadone patients that could be widely replicated and adapted.

These federal, state and local initiatives are now set to transform behavioral health care in the United States.

In a third milestone, several states, CSAT and a key private organization have involved diverse stakeholders in efforts to define recovery. At the September 2006, Betty Ford Institute recovery definition consensus conference, discussions touched on some of the most controversial issues within the addictions field. The resulting consensus definition was subsequently published in *Journal of Substance Abuse Treatment Betty Ford Institute Consensus Panel,* 2007). It defines recovery in terms of three core components: sobriety, personal health and citizenship. The paper goes on to explicitly state:

"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."

Such a definition coming from an institution so linked to mainstream treatment in the United States would have been unthinkable only a few years ago.

These three milestones illustrate that something quite fundamental is shifting within the worlds of addiction treatment and recovery in America.

My second point is to urge you to become students of and contributors to this emerging recovery paradigm. The shift in thinking and practice is far more than superficial rhetoric. It involves substantial changes in service philosophies, service practices, service relationships, regulatory policies, and financing strategies. To illustrate this point, let me outline a few changes that are underway.

- We are seeing increased recovery representation with treatment organizations through such mechanisms as governing board representation, recovery advisory boards, consumer councils, a renewal of alumni associations and volunteer programs, and increased recruitment of recovering people into service roles.
- There is a significant increase in assertive community education and outreach to reduce stigma, shorten addiction careers and lengthen recovery careers. Rather than waiting for people to "hit bottom" (pain-based interventions), we are showing people an achievable vision of the top (hope-based interventions).
- Streamlined approaches to service access/intake are increasing.
- We are seeing new strategies to mobilize family/community resources within the treatment and extended recovery support process.
- We are seeing new approaches to integrating addiction medicine, addiction psychiatry, primary health care and peer-based recovery support services.
- We are seeing the service relationship shift from a professional expert model to a partnership/consultation model emphasizing client choice (e.g., rapid transition from professionally-directed treatment planning to client-directed recovery planning).
- We are seeing new approaches for assertively linking clients to indigenous communities of recovery and growing support for the development of new medication-based recovery support communities
- We are seeing increases interest in post-treatment monitoring and support, stage-appropriate recovery coaching, and, when needed, early re-intervention (to include recovery check-ups for 5 years following discharge from treatment).

We must collaborate with the individuals and families we serve to define what this long-term recovery orientation means in the context of medication-assisted treatment. Proponents (recipients and providers) of medication-assisted treatment

must become active participants and leaders in this movement or risk being further marginalized by this movement.

There is growing consensus that recovery is far more than the removal of addictive substances from an otherwise unchanged life. The early cultural and professional misunderstandings and stigma attached to methadone led to justifications 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. To achieve that, we will need to extend our vision beyond programs of medication management toward the broader vision of sustained and person/family-centered recovery management.

My third and final point is that this shift towards a recovery paradigm constitutes a historical window of opportunity to destigmatize medication-assisted treatment and recovery.

This window of opportunity can be maximized by redirecting public attention from those patients who have yet to achieve stability and who receive the most media attention, and shining a light on those methadone maintenance patients who have achieved optimal dose stabilization and quality of life. By casting light on current and former methadone maintenance patients in sustained recovery, and celebrating their successes, we have an opportunity to change how our field and our culture perceive medication-assisted recovery. Such stories will help us transcend the dichotomized and increasingly stagnant "harm reduction versus abstinence" debates.

I don't think this will happen through our efforts alone. In fact, I believe that the future of this opportunity rests to a great degree with the individuals and families we now serve and have served in the past. It is time a vanguard of people in long-term medication assisted recovery, who are personally called, whose life circumstances allow, and who are prepared and supported for this role, to stand collectively and tell their recovery stories to this country. Our job is to help create a cultural climate in which those stories can be safely told and to help with that preparation and support process. It is time to end the iconic image of medication-assisted recovery from as a shadowed face sipping methadone. It is time that image became one of the faces and voices of real people expressing the role medication-assisted treatment played, or continues to play, in their recovery from addiction.

That day will not come without the support of those of you in this room. The time for such a movement is now. It is time we connect the field's pharmacological treatments to the larger and more enduring process of addiction recovery. That vision must and will be fulfilled.

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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)

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Executive Summary

Introduction

The purpose of this document is to: 1) review 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 treatment and long-term medication-assisted recovery, and 2) outline strategies that could be used by the Philadelphia Department of Behavioral Health and Mental Retardation Services and its many community partners to reduce addiction/recovery-related stigma.

Stigma Basics

- 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 (escape from pain versus a search for pleasure), 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 women perceived to have failed their 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.
- Heroin addiction and its treatment have been trapped between medical and moral/criminal models of problem definition and resolution.
- 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 it.
- 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 par with hospitals or outpatient medical clinics.
- The professional status of methadone treatment has suffered from the absence of theoretical models of opioid addiction treatment and recovery that transcend a focus on the medicine to address the larger movement towards 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) protest (advocacy), 2) education, and 3) increased 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, 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). 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 "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) compulsive 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 prototypes of all those in methadone-assisted treatment/recovery and all methadone clinics.
- 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 imbedded within the illicit drug culture of the United States in ways that inhibit treatment seeking and contribute to early treatment termination.
- These myths span the origin of methadone, methadone's pharmacological properties and long-term effects, and the motivations for the proliferation of methadone maintenance 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 strategies of information dissemination within local cultures of addiction that challenge these myths.

Examples of Addiction-Related Stigma/Discrimination

- Addiction/treatment/recovery-related stigma is manifested in a broad range of attitudes, behaviors, and policies that range from social shunning to discrimination in such areas as access to medical/dental care, governmental benefits, training/employment opportunities, and housing and homelessness services.
- Stigma/discrimination related particularly 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 AA/NA meetings, and loss of child custody due to participation in MMT.
- Stigma-influenced methadone maintenance treatment practices include arbitrary dose restrictions, restrictions on duration of MMT, lowering methadone dose, 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 clear messages related to the nature of addictive disorders, the nature of

addiction recovery, the role of medication in recovery, 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 capable of 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 policy advocacy, and 7) campaign evaluation.
- The implementation 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.

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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)

William L. White, MA

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."[2]

The purpose of this document 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 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.[3] It involves processes of labeling, stereotyping, social rejection, exclusion, and extrusion—the essential ingredients of discrimination.[4]

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)

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- *Self-stigma* (personal feelings of shame and self-loathing related to regret over misdeeds and "lost time" in one's life due to addiction).[5]

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.[6] There is no physical or psychiatric condition more associated with social disapproval and discrimination than alcohol and/or other drug dependence.[7] 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.[8]

Stigma and Recovery: Addiction-related social stigma extends to people who have achieved stable recovery from addiction.[9] 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.[10] The intensity of stigma varies by problem intensity and different styles of recovery. Stigma attached to natural recovery may be less due to the perception of it as more noble (a pulling oneself up by the bootstraps) and its potential status as a proxy for less problem severity. 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.[11]

Courtesy Stigma: The social stigma attached to addiction can be experienced by families, organizations (e.g., addiction treatment programs), neighborhoods, and whole communities.[12] Goffman[13] referred to this stigma by association as "courtesy stigma."[14]

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.[15]

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[10] Woods, J. (2009). Personal communication, July 27, 2009.

[11] 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.

[12] 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.

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

[14] 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.

[15] 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.

Many family member behaviors that have been historically defined as "enabling" or "co-dependent" are better understood as attempts to protect the family from the stain of social stigma.[16] The "courtesy stigma" experienced by family members as embarrassment and shame often gets 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, e.g., effects on how addiction professionals perceive themselves in relation to other fields and disciplines and how 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 how 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[17] and the centuries-long misrepresentation ("firewater myths") of the nature of alcohol problems in Native American communities.[18]

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.[19] 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 a mental illness or physical disability.[20] 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 whether 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.[21] 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 of addiction-related stigma being 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.[22] 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

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[16] *The stigma of substance abuse: A review of the literature*. (1999). Toronto, Canada: Centre for Addiction and Mental Health.

[17] White, W., & Sanders, M. (2002) Addiction and recovery among African Americans before 1900. *Counselor, 3*(6), 64-66.

[18] 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.

[19] 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.

[20] 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.

[21] Husak, D. N. (2004). The moral relevance of addiction. *Substance Use and Misuse*, *39*(3), 399-436.

[22] Woods, J. (2009). Personal communication, July 27, 2009.

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 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 stigmatized substances and injection drug use the most stigmatized method of ingestion.[23] The manner in which stigma triggered by such panics 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.[24] The attribution of "badness" (social stigma) has for most of the past century been most intense for those persons who regularly self-inject heroin.[25]

By extension, greater addiction-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.[26] 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."[27] 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.[28]

Multidimensional Stigma: The weight of addiction-related social stigma is not equally applied. Its burdens fall heaviest on those with the least 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

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[23] 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.

[24] 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.

[25] 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.

[26] 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.

[27] 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.

[28] 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.

perceived as conflicting with gender-linked role responsibilities, e.g., addicted pregnant women/mothers.[29] Persons experiencing such layered, multidimensional stigma are less likely to seek addiction treatment than persons experiencing a single discredited condition.[30] The social stigma attached to addiction begins primarily at the point of admission to treatment (a social signal of problem severity) and intensifies with multiple treatment episodes (a social signal of treatment failure).[31] One MAT patient distinguished the "inner shame" experienced during active addiction from the "public shame when you're in the clinic."[32]

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.[33]

Stigma, Treatment-Seeking, and Long-Term Health: Stigma can elicit social isolation, reduce help-seeking, and compromise long-term physical and mental health status.[34] Social stigma is a major factor in preventing individuals from seeking and completing addiction treatment[35] and from utilizing harm reduction services such as needle exchange programs.[36] 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.[37] Treatment seeking is also reduced by the perception that drug treatment program staff will "treat you like a little, nasty dope fiend."[38]

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[29] 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.

[30] 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.

[31] 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.

[32] 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.

[33] 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.

[34] 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.

[35] 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.

[36] Simmonds, L., & Coomber, R. (2009). Injecting drug users: A stigmatized and stigmatizing population. *International Journal of Drug Policy, 20*(2), 121-130.

[37] 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.

[38] 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.

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.[39]

Vigilant[40] 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 by the public, health care professionals, and the recovery 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 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.[41] Methadone clinics have not achieved the social status of a medical clinic because they have not been allowed to operate like a medical clinic. 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 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.[42] 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.[43]

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[39] 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.

[40] Vigilant, L. G. (2001). "Liquid handcuffs": The phenomenology of recovering on methadone maintenance. *Boston College Dissertations and Theses.*

[41] Vigilant, L. G. (2001). "Liquid handcuffs": The phenomenology of recovering on methadone maintenance. *Boston College Dissertations and Theses.*

[42] Best, D. (2009). Personal communication.

[43] 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.

> *…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*.[44]

Such focus on control versus care may be even more exaggerated for female patients, leaving unattended many obstacles to participation and recovery, e.g., child care, transportation, caretaking responsibilities, sabotage from addicted partners, threats of partner violence, and difficulties paying for treatment.[45]

The professional status of methadone treatment has suffered from the absence of theoretical models of addiction treatment and recovery that integrate the prevailing pre-occupation 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.[46] The lack of such theoretical models and the performance expectations emanating from such models breeds clinics in which patients' contact with their counselor is rare, brief, and superficial and in which other 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."[47] 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[48] 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 social network to the recovery/clinic community in order to avoid the social stigma attached to addiction and methadone treatment.
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

[44] 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.

[45] Fraser, J. (1997). Methadone clinic culture: The everyday realities of female methadone clients. *Qualitative Health Research, 7*(1), 121-139.

[46] Hagman, G. (1995). A psychoanalyst in methadonia. *Journal of Substance Abuse Treatment, 12*(3), 167-179.

[47] 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.

[48] Vigilant, L. G. (2001). "Liquid handcuffs": The phenomenology of recovering on methadone maintenance. *Boston College Dissertations and Theses.*

urination to confirm that urine for drug testing is "fresh" and not being surreptitiously substituted).

Dr. Robert Newman[49] places Viglant's work within an important historical perspective. Newman argues that the original model of methadone maintenance was corrupted as it was mainstreamed.[50] 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, and 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.*[51]

Payte[52] 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*.[53]

Personal Responses to Stigma: There is a high degree of variability in how persons in methadone maintenance respond to stigma. Users 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).[54] Personal strategies to deal with stigma include:

- Secrecy/concealment (e.g., concealing one's status of taking methadone at AA and NA meetings)
- Social withdrawal (e.g., avoiding new friendships; avoidance of recovery support meetings)
- Preventative disclosure (selective disclosure to test acceptability)
- Compensation (using personal strengths in another area to counter the imposed stigma)

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[49] Newman, R.G. (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.

[50] 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.

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

[52] 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.

[53] 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.

[54] Gourlay, J., Ricciardelli, L., & Ridge, D. (2005). Users' experiences of heroin and methadone treatment. *Substance Use and Misuse, 40*(12), 1875-1882.

- Strategic interpretation (comparing oneself to others within the stigmatized group rather than to those in the larger community)
- Political activism.[55]

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.[56]

Stigma and Cultures of Addiction: Social stigma contributes to the propensity of persons with drug dependencies to become enmeshed in illicit drug subcultures.[57] 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.[58] 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 less in control of their drug use.[59] Such attitudes can get played out within the social pecking order of drug treatment milieus. "Street cultures" are also imbedded with myths designed to inhibit treatment-seeking, contribute to ambivalence about treatment, and increase the likelihood of treatment disengagement, e.g., street myths about methadone—"it rots your teeth and bones," etc.[60]

Many individuals enmeshed in such cultures progressively diminish their contact with the mainstream culture and become as dependent on the culture of addiction as the drugs in their lives. As drug-related personal impairment escalates, individuals may experience rejection and isolation from both the mainstream society and from the illicit drug cultures that have sheltered them.[61] 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 if recovery and community reintegration are to be achieved and sustained. Stigma

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[55] 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.

[56] Schur, E. M. (1971). *Labeling deviant behavior: Its sociological implications*. New York: Harper & Row Publications.

[57] 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.

[58] 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.

[59] 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.

[60] Rosenblum, A., Magura, S., & Joseph, H. (1991). Ambivalence toward methadone treatment among intravenous drug users. *Journal of Psychoactive Drugs*, *23*(1), 21-27.

[61] 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.

is a major obstacle to successfully traversing the physical, psychological, and social space between these two worlds.[62] Methadone advocate Walter Ginter recently reflected on this journey:

> *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*.[63]

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.[64]

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.[65] One major strategy, seeking to inculcate the belief that alcohol and drug addiction is a disease, may help alleviate personal shame,[66] but has not been consistently shown to produce sympathetic attitudes toward those with severe alcohol and other drug problems.[67] 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.[68]

One of the most effective strategies to reduce social stigma is to increase interpersonal contact between mainstream citizens and members of the stigmatized group.[69] 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 mutually judged to be a positive experience.[70] 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

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

[63] Ginter, W. (2009). Personal Communication (Interview), June 22, 2009.

[64] Fraser, S., & Valentine, K. (2008). *Substance and substitution: Methadone subjects in liberal societies.* New York: Macmillan.

[65] Corrigan, P. W., & Penn, D. L. (1999). Lessons from social psychology on discrediting psychiatric stigma. *American Psychologist*, *54*, 765-776.

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

[67] 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.

[68] 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.

[69] 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.

[70] 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.

houses.[71] Reducing social distance and increasing interpersonal contact are important goals of any anti-stigma campaign. Individuals can express negative feelings toward a particular group while simultaneously having positive regard for individuals of that group. As such relationships increase, the sentiment towards 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.[72]

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:

1. The drug is associated with a hated subgroup of the society or a foreign enemy.
2. The drug is identified as solely responsible for many problems in the culture, i.e., crime, violence, insanity.
3. The survival of the culture is pictured as being dependent on the prohibition of the drug.
4. The concept of "controlled" usage is destroyed and replaced by a "domino theory" of chemical progression.
5. The drug is associated with corruption of young children, particularly their sexual corruption.
6. Both the user and supplier of the drug are defined as fiends, always in search of new victims; usage of the drug is considered "contagious."
7. Policy options are presented as total prohibition or total access.
8. Anyone questioning any of the above assumptions is bitterly attacked and characterized as part of the problem that needs to be eliminated.[73]

These themes shape what Lindesmith[74] referred to as "dope fiend mythology"—a "body of superstition, half-truths and misinformation" that claims 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.[75] Modern studies of the historical origin of these myths have placed their beginnings within the Federal Bureau of Narcotics' early and mid-

[71] Jason, L. A., Roberts, K., & Olson, B. D. (2005). Attitudes towards recovery homes and residents: Does proximity make a difference? *Journal of Community Psychology*, *33*(5), 529-535.

[72] 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.

[73] White, W. (1979). Themes in chemical prohibition. In *Drugs in perspective*. Rockville, MD: National Drug Abuse Center/National Institute on Drug Abuse.

[74] Lindesmith, A. R. (1940). Dope fiend mythology. *Journal of Criminal Law, Criminology and Police Science*, *31*, 199-208.

[75] 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.

twentieth century anti-drug campaigns,[76] but similar myths were also promulgated by the leaders of nineteenth century anti-alcohol, anti-tobacco, anti-opium, and anti-cocaine campaigns.[77] 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 new drugs announced as breakthroughs in the treatment of alcohol and other addiction that 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.[78] The history of such iatrogenic insults bodes caution and close scientific scrutiny of any new drug claimed as a treatment for drug addiction.[79] But that same history also suggests that new drugs of unsurpassed effectiveness could be developed that could 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.[80] These campaigns have generated policies of isolation, control, and punishment of drug users.[81] 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."[82] 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.[83] 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.

Efforts to increase or reduce stigma attached to illicit drug use may have intended or unintended side-effects.[84] Two examples illustrate this point. First, efforts to decrease illicit drug use by portraying the drug user as physically diseased, morally depraved, and criminally

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[76] 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.

[77] White, W. (1979). Themes in chemical prohibition. In *Drugs in perspective*. Rockville, MD: National Drug Abuse Center/National Institute on Drug Abuse.

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

[79] White, W. L. & Kleber, H. D. (2008) Preventing harm in the name of help: A guide for addiction professionals, *Counselor*, *9*(6), 10-17.

[80] 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.

[81] White, W. (1979). Themes in chemical prohibition. In *Drugs in perspective*. Rockville, MD: National Drug Abuse Center/National Institute on Drug Abuse.

[82] Husak, D.N. (2004). The moral relevance of addiction. *Substance Use and Misuse, 39*(3), 399-436.

[83] 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.

[84] Room, R. (2005). Stigma, social inequality and alcohol and drug use. *Drug and Alcohol Review, 24*(2), 143-155.

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 re-enter mainstream community life. Second, community education efforts aimed at reducing stigma could increase drug use.[85] This could 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?"[86] Efforts by one group to define another group as deviant can serve psychological, political, and economic interests. Put simply, stigmatizing others often serves to increase the self-esteem of the stigmatizer.[87] 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.

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 opinion being manipulated by hidden financial interests, e.g., developers who would profit from gentrification of a neighborhood targeted for a new addiction treatment facility.[88]

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 who notify neighbors before entrance into the community experience great 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.[89] Many facilities are well-accepted in their

[85] Gerber, J. (1973). Role of the ex-addict in drug abuse intervention. *Drug Forum*, *2*(2), 105-106.

[86] Weinstein, 2009, personal communication.

[87] 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.

[88] Joseph, H. (2009). Personal Communication (Interview), June 5, 2009.

[89] Zippay AL. (2007). Psychiatric Residences: Notification, NIMBY, and Neighborhood Relations.

communities, and acceptance is associated with public concepts of "social responsibility and collective care."[90] Acceptance is highest among community residents who are younger, 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.[91] By enhancing positive recovery outcomes, larger facilities (eight or more residents) generate fewer neighborhood complaints related to criminal or aggressive behavior.[92]

Local opposition to the opening of a new methadone clinic has been linked to fear of increased drug use and crime, fear of 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.[93] 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 avoid loitering outside 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).[94]

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.[95]

> *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*.[96]

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,*

Psychiatric Services 58, 109–113. http://www.psychservices.psychiatryonline.org/

[90] Zippay, A. & Lee, S.K. (2008) Neighbors' perceptions of community-based psychiatric housing. *Social Service Review* 82(3), 395-417.

[91] 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 towards mental health facilities in the community. *Health and Social Care in the Community*, *4*(5), 290-299.

[92] 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.

[93] 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.

[94] 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.

[95] 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.

[96] Repper, J., & Brooker, C. (1996). Public attitudes towards mental health facilities in the community. *Health and Social Care in the Community*, *4*(5), 290-299.

quality of life, political interests, rights and moral issues…There is a need to break out of adversarial approaches towards cooperation.[97]

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 has the responsibility of developing a level of prevention, early intervention, treatment, and recovery support services commensurate with the vulnerability for 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 as to where such resources are located.
- Neighborhoods/communities have a right to be involved in planning decisions related to the siting of new addiction treatment and recovery support resources.
- 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 a new treatment or recovery support facility have a right to a fair hearing in which they can present how that facility meets current legal/regulatory requirements and how the facility will benefit the community via services, jobs, and economic resources.[98]

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).[99] 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.[100] 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.[101]

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[97] Repper, J., & Brooker, C. (1996). Public attitudes towards mental health facilities in the community. *Health and Social Care in the Community*, *4*(5), 290-299.

[98] White, 2009 Personal Communication to Dr. Arhur Evans

[99] 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.

[100] 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.

[101] 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

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 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 little expectation among patients or staff that tapering will be successful.[102] Professional congratulations to the person who similarly reduced and ended his or her recovery support meeting participation would be currently unthinkable.[103]

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.*[104]

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.[105]

Patients entering methadone treatment are as likely to be seeking respite as recovery.[106] Entrance into addiction treatment can be a milestone in one's addiction career as well as a potential milestone of recovery.[107] 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.

Conceptual Underpinnings of MAT-Linked Stigma

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with the dirty secret": Problems of disclosure for methadone maintenance clients. *Journal of Psychoactive Drugs*, *24*(3), 257-264.

[102] 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.

[103] Woods, J. (2009). Personal communication, July 27, 2009.

[104] Ginter, W. (2009). Personal Communication (Interview), June 22, 2009.

[105] Kaltenbach, K. (2009). Personal Communication, October 12, 2009.

[106] 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.

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

Social and professional stigma, particularly stigma associated with methadone treatment, is buttressed by a set of core assumptions or beliefs. Table 1 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.[108]
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.[109]	2. Opioid addiction is at its core more a physiological than psychological disorder,[110] but recovery rates in MAT can be compromised by high rates of co-occurring medical and psychiatric disorders.[111] MAT outcomes are enhanced when methadone is wrapped in a broader menu of medical, psychiatric, and social services.[112] 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.
3. Methadone simply replaces one drug/addiction for another, i.e.,	3. Injected heroin produces intense euphoria, whereas oral consumption of appropriate doses of methadone in an

[108] 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.

[109] 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.

[110] 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.

[111] Cacciola, J. S., Alterman, A. I., Rutherford, M. J., McKay, J. R., & Milvaney, F. D. (2001). *Drug and Alcohol Dependence*, *61*, 271-280.

[112] 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.

"methadone is like the alcoholic replacing Bourbon with Scotch."[113]	opioid-tolerant patient produces a normalizing rather than euphoric effect.[114] Because of this, most patients on methadone view methadone as a "medication" rather than a "drug."[115] Methadone and buprenorphine are best thought of as addiction-ameliorating medications rather than addiction-inducing drugs.[116] Methadone, like other legal medication, 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"[117] have more to do with the rigorous demands of the MMT clinic structure than 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[118] found rates of long-term abstinence (defined in this study as abstinence from all opiates <u>including</u> 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."[119] In a study published this 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

[113] Marion, I.J. (2009). Personal communication with author, June 24, 2009.

[114] Zweben, J. (1991). Counseling issues in methadone treatment. *Journal of Psychoactive Drugs*, *23*(2), 177-190.

[115] McGonagle, D. (1994). Methadone Anonymous: A 12-Step program. *Journal of Psychosocial Nursing*, *32*(10), 5-12.

[116] 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.

[117] Baldino, R.G. (2000). *Welcome to Methadonia: A social worker's candid account of life in a methadone clinic*. Harrisburg, PA: White Hat Communications.

[118] 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.

[119] 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.

	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."[120] 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 towards global health and community integration within the definition of recovery.[121]
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.[122] Two-thirds of methadone treatment patients receive inadequate daily dosages of methadone—dosages below 80 mg/day[123]—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.[124] The effective duration of methadone maintenance associated with the best long-term recovery outcomes is at least one year of participation.[125] In 2002, the average length of time from admission

[120] 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.

[121] 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.

[122] 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.

[123] 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.

[124] 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.

[125] Simpson, D. D., & Joe, G. W. (2004). A longitudinal evaluation of treatment engagement and recovery stages. *Journal of Substance Abuse Treatment*, *27*, 99-121.

	to discharge in outpatient methadone maintenance was 175 days.[126]
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.[127] The choice to end MAT is a decision to be made by the patient in consultation with his or her physician, but 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.[128]

> *…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*.[129]

The stigma attached to heroin addiction has been extended to methadone treatment and intensified through such language as *methodonia*, *methodonian,* and *deathadone.* Books with

[126] 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.

[127] 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.

[128] 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/namadocuments/ps04client_v_patient.html.

[129] Fraser, S., & Valentine, K. (2008). *Substance and substitution: Methadone subjects in liberal societies.* New York: Macmillan.

titles like *Methadone: A Technological Fix*,[130] 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,"[131] and methadone treatment is commonly portrayed as ineffective through such popular films as "Sid and Nancy," "Trainspotting," and "Permanent Midnight."[132] 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.[133]

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.[134] 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.

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.[135]
2. Methadone is addicting.	2. Prolonged use of methadone, like 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

[130] Nelkin, D. (1973). *Methadone maintenance: A technological fix*. New York: George Braziller.

[131] Joseph, H. (1995). *Medical methadone maintenance: The further concealment of a stigmatized condition*. Unpublished doctoral dissertation, City University of New York.

[132] Cape, G. S. (2003). Addiction, stigma, and movies. *Acta Psychiatrica Scandinavica, 107*(3), 163-169.

[133] 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.

[134] 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.

[135] 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.

	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.[136] 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 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 then later stop using methadone as a recovery adjunct while maintaining successful long-term recovery.
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.[137]	7. The safety of methadone, including its safety for pregnant women and the infants they deliver, has been established in innumerable scientific studies.[138] Most side-effects reported by

[136] A few commentators suggested that this has recently begun to change and that trends in this area should be closely monitored.

[137] 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.

[138] 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*

	MAT 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."[139] 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.[140]
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.[141]
10. Methadone blunts the emotions, e.g., references to "methadone mummies."	10. MAT patients actually report increased capacity to acknowledge and express emotion.[142] The blunting of emotion could 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	11. "This image of the methadone client as a 'loser,' without 'heart,' and unable to 'make it on the streets anymore,' is

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.

[139] 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.

[140] Marion, I.J. (2009). Methadone: Myths and Facts (Presentation slides).

[141] Best, D. (2009). Personal communication.

[142] 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.

longer "take care of business" on the streets.[143]	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."[144]
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 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 this community being victimized by scientific and medical enterprises, e.g., withholding medical treatment from 399 African American sharecroppers in the Tuskegee Syphilis Study.[145]

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.[146]

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:

[143] 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.

[144] 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.

[145] 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.

[146] 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.

- 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[147]
- 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
- Denial of the right to speak and assume leadership roles in local AA/NA meetings
- Denial of detoxification services in acute medical facilities for other addictive substances (e.g., medical management of alcohol withdrawal) while being maintained on one's prescribed and stabilized dose of methadone[148]
- 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.[149] 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)

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[147] 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.

[148] 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.

[149] 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 heroin: Review of treatment for heroin addiction. *Journal of the American Medical Association*, *300*, 414-321.

- 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*, *retreads*)
- 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[150]
- "Blind dosing" without patient's 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
- 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.[151]

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.[152]

Methadone-specific stigma can also affect methadone treatment organizations and their staff. Organizational effects can include community resistance to opening of a new methadone treatment site, resistance to 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

[150] NAMA (1994) Discharge from treatment for drug use. Policy statement # 3. Retrieved May 25, 2009 from http://www.methadone.org/namadocuments/ps03discharge_from.html.

[151] 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.

[152] 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.

Anti-stigma campaigns in the addictions arena have historically focused on a core set of ideas.[153] 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:

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.[154]

The "new addiction recovery advocacy movement" is similarly based on a set of core ideas:

New Recovery Advocacy Movement 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.[155]

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 could be formulated and condensed to form operational slogans.

The Nature of Addictive Disorders

[153] Johnson, B. (1973). *The alcoholism movement in America: A study in cultural innovation.* Unpublished doctoral dissertation, University of Illinois, Urbana, Illinois.

[154] 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.

[155] 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.

- The decision to initially consume or not consume alcohol, tobacco, and other drugs is, in most but not all circumstances, a voluntary choice.[156]
- This initial choice may be consciously influenced by moral or religious values,[157] but more often reflects behavior directed at normal needs and experiences, e.g., pleasure seeking, social inclusion, personal identity, relief of 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 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.[158]

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.

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.
- There are stabilizing medications available for the treatment of severe opioid addiction, and even more effective medications may become available in the future.

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[156] 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.

[157] Husak, D. N. (2004). The moral relevance of addiction. *Substance Use and Misuse, 39*(3), 399-436.

[158] 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.

- 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.[159]
- 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.[160]
- The dosages required to achieve these effects vary from individual to individual.[161]
- Appropriate oral doses of methadone do not produce an experience of sedation or euphoria in individuals who are opiate-tolerant;[162] stabilized patients not using other substances are capable of experiencing the full range of emotional and physical pain.[163]
- Methadone maintenance combined with needed ancillary medical, psychological, and social services is the most effective method of treating chronic heroin addiction.[164]
- 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,[165] as well as the World Health Organization and other governmental health policy groups around the world.
- 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.[166]
- Methadone is the safest medication available to treat heroin addiction in pregnant women.[167]
- 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 transmission of HIV (4-6 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

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[159] 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.

[160] 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.

[161] 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.

[162] 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.

[163] 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.

[164] 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.

[165] White, W., & Coon, B. (2003). Methadone and the anti-medication bias in addiction treatment. *Counselor*, *4*(5), 58-63.

[166] 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.

[167] 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.

productive behavior via employment and academic/vocational functioning, 6) improves global health and social functioning, and 7) is cost-effective.[168]

- 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.[169]
- 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 only effective when consumed on a sustained daily basis. Relapse rates are high following cessation of methadone maintenance, and mortality rates rise following medical withdrawal.[170] People should not be precipitously encouraged to end such treatment.[171] 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.[172]
- 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 to self-medicate opiate-dependent individuals who cannot procure heroin or other short-acting opioids or to self-medicate individuals who cannot get into a methadone maintenance program.[173]

Stigma as a Barrier to Recovery

[168] 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.

[169] 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.

[170] 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.

[171] Cooper, J. R. (1992). Ineffective use of psychoactive drugs: Methadone is no exception. *Journal of the American Medical Association*, *267*(2), 281-282.

[172] 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.

[173] 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.

- 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.[174]
- The stigma attached to addiction perpetuates the very problem it is intended to discourage.
- There is substantial shame imbedded 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.[175]

An Addiction/Treatment/Recovery Campaign

The stigma attached specifically to methadone maintenance is imbedded 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."[176]

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.[177]
- 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.[178]
- 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.
- 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.

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[174] Lavack, A. (2007). Using social marketing to de-stigmatize addictions: A review. *Addiction Research and Theory, 15*(5), 479-492.

[175] 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.

[176] 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.

[177] Joseph, H. (1995). *Medical methadone maintenance: The further concealment of a stigmatized condition*. Unpublished doctoral dissertation, City University of New York.

[178] 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.

A Menu of Potential Strategies: Listed below is a menu of potential strategies that could be refined and implemented to achieve the goals outlined above. These potential strategies are offered as a starting point for local discussion.

Recovery Representation and Community Mobilization

1. Assure broad representation of people in medication-assisted recovery and professional representation from medication-assisted treatment providers within DBH/MRS 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.[179] (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).[180]

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 an existing treatment program or site location for new programs—proactive management of "Not in my backyard" (NIMBY) resistance by establishing principles on locating addiction treatment and recovery support resources. (This may be best addressed within a Task Force that explores siting issues for all health and social service programs.) Those principles identified earlier in this paper could 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 Philadelphia media outlets.

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[179] 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.

[180] Ginter, W. (2009). Personal Communication (Interview), June 22, 2009.

--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.
--Imbed information on opioid addiction and medication-assisted recovery in mainstream healthcare outlets, e.g., medical clinics, pharmacies, health fairs, etc.
--Target those zip codes in the city of Philadelphia 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.[181]

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;[182] 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 could be used by outreach workers to challenge "street mythologies" on methadone and other medications used in the treatment of addiction.

Professional Education

1. Create opportunities for people throughout the DBH/MRS system to be exposed to the faces and voices of people in long-term medication-assisted recovery.

2. Assure 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.[183] Provide a centralized orientation on a monthly basis for all new staff entering the Philadelphia treatment system that includes the above information.[184]

3. Provide structured opportunities for staff exchanges between medication-assisted and drug-free treatment programs that include opportunities for formal and informal

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[181] 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.

[182] 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.

[183] 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.

[184] 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 give 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.

interactions with staff and patients. Assure 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.[185]

4. Assure 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 Philadelphia-area 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 of 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.

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 for pregnant and parenting women.[186]

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."[187]

[185] 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.

[186] Dr. Karol Kaltenbach, 2009, personal communication

[187] 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.

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. Using 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 that 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 name the drug or activity to be given up, e.g., Narcotics Anonymous, Cocaine Anonymous, Crystal Meth Anonymous, Gamblers Anonymous. This is not the explicit intent of Methadone Anonymous, but that is what is currently being conveyed via its name.[188]

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 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*.[189]

> *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*.[190]

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 relegate medication as one of many tools that can help 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

[188] 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.

[189] 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.

[190] Joseph, H. (2009). Personal Communication (Interview), June 5, 2009.

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.)[191]

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 delivery institutions, schools, churches, neighborhood centers, and other community service organizations.[192] Expand medical methadone maintenance—methadone provided to the most stabilized patients via a monthly visit to a private health practitioner.[193]

3. Prohibit the exclusion of persons on methadone or buprenorphine by any organization receiving DBH/MRS funding. This would add DBH/MRS authority to existing regulations prohibiting organizations receiving city/state/federal dollars to discriminate against MAT recipients. Any communication from DBH/MRS 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 use of "warm welcome" procedures, including casual dress by security personnel.

5. Facilitate (by DBH/MRS) 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 inclusion of people in medication-assisted recovery within existing or emerging recovery advocacy organizations.

2. Encourage (DBH/MRS) medication-assisted treatment providers to continue their advocacy activities through the Pennsylvania Association for the Treatment of Opioid Dependence (PATOD) and the American Association for the Treatment of Opioid Attendance (AATOD) related to federal, state, and local policy/regulatory/funding/research issues.

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[191] 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.

[192] 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.

[193] 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. 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.[194] 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 these same multiple levels. DBH/MRS is committed to mobilizing the citizens of Philadelphia 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. Toward that end, DBH/MRS will 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.*

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[194] 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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A Dialogue on Psychopharmacology in Behavioral Healthcare: The Acceptance of Medication-Assisted Treatment in Addictions

William White, Mark Parrino, and Walter Ginter

I. Introduction

A. Our review focuses on the evolution, current status, and degree of acceptance of medications in the treatment of substance use disorders (particularly of opioid addiction); current barriers to medication utilization; potential strategies to enhance utilization; and principles that could be incorporated into clinical practice guidelines for medication-assisted treatment. Issues related to efficacy, indications and contraindications, court-mandated treatment, cultural perspectives, and use across the developmental life cycle are addressed in other papers.

II. Historical Perspectives on the Use of Medications in the Treatment of Addiction

A. Recovery Initiation versus Recovery Maintenance: Successful withdrawal to a drug-free state (the primary preoccupation of 19th century treatment of opioid addiction) does not constitute a state of sustainable recovery and should not, by itself, be considered a treatment for addiction.[1]

B. Medication Acceptance and Recovery Role Models: When visible recovery role models promote an ineffective medication, the medication's lack of scientific support does little to reduce its potential cultural popularity (e.g., the Keeley Cure in the 1880s and 1890s); where medication-assisted recovery role models are professionally and culturally invisible, scientific evidence alone will not lead to a medication's professional or cultural acceptance (e.g., methadone).[2]

C. Cultural Ambivalence: Failure to fully embrace medications as an adjunct in the treatment of addiction is fueled by continued cultural dissension about whether the cultural ownership of alcohol and other drug (AOD) problems should reside with medicine, religion, or law, e.g., is the addicted person best viewed as a patient, a sinner, or a criminal?

D. Stigma Unbound: The social and professional stigma attached to particular drugs, particular patterns of addiction, and the medications used to treat addiction is inextricably linked to public perception of those most associated with the drug. Issues of race, gender, sexual orientation, social class, and religion profoundly influence such perceptions and must be disentangled in any effort to reduce stigma. Drug addiction is one of the most socially stigmatized conditions, e.g., viewed as more blameworthy and more dangerous than mental illness.[3]

E. Science and Stigma: Scientific validation of a medication's positive effects on clinical and recovery outcomes does not mean inevitable acceptance by policymakers, service professionals, patients, patients' families, or the public. Historically, stigma trumps science. The greatest reduction in medication-related stigma comes not from acceptance of the belief that addiction or mental illness are brain diseases, but through identification with a beloved figure in recovery or persons in recovery from one's family, social, or occupational network that benefited from the particular medication.[4] Stigma flourishes in the absence of clear, consistent, multi-year educational campaigns that convey and affirm the validity of scientific studies of addiction and its effective treatment.

F. Fear of Harm in the Name of Help (Iatrogenesis): Resistance/ambivalence to medications is related to the long history of harm in the name of help within the history of addiction treatment and the resulting distrust of science in general and medications in particular within the addictions arena.[5]

1. Announcements of medication breakthroughs related to addiction treatment are notoriously unreliable due to the cyclical stages of overselling, financial exploitation, disillusionment, and a backlash of therapeutic pessimism, e.g., fraudulent miracle cures; the alcoholism vaccine; carbon dioxide therapy, insulin therapy; early excessive claims for lithium, valium, etc. in the treatment of alcoholism.[6]
2. Medications once used in addiction treatment were later integrated into the illicit drug culture as intoxicants, e.g., cannabis, cocaine, heroin, amphetamines, barbiturates, LSD.[7]
3. Past medications used in addiction treatment have resulted in severe toxicity and lethality.[8]
4. Medications have often been nested within broader patterns of treatments with reported iatrogenic effects, e.g., prolonged institutionalization, sterilization, electro- and chemo-convulsive therapies, psychosurgery, and psychologically invasive therapy techniques.[9]
5. One of the legacies of this history is that existing and new breakthroughs in the pharmacotherapeutic treatment of addiction may fail to be accepted and mainstreamed into clinical practice not because of lack of clinical effectiveness but due to unfounded fear of their potential iatrogenic effects.[10]
6. That early ineffective, harmful, and/or fraudulent medications used in the treatment of addiction wrapped themselves in the mantle of science (via fraudulent advertising or bad science) requires current clarification of who has the medical and moral authority within the US to make the definitive declaration of a medication's effectiveness or ineffectiveness.

G. Intergenerational Transmission of Resistance: Fear of medications has been passed down intergenerationally within communities of recovery (from grandsponsors to sponsors to sponsees), and across generations of addiction professionals (professional elders to new counselors).[11] Addictions counselors receive little training related to addiction treatment

medications,[12] which, combined with fear of using medications, produces a fundamental lack of curiosity about treatment options.

H. Management of Resistance: Fear of medications is best managed by acknowledging and respecting its historical legitimacy and through rigorous programs that ensure medication efficacy, effectiveness, and safety.

I. Experiential versus Scientific Knowledge: Tension within the addictions treatment/recovery field has existed for more than 160 years between fundamentally different ways of knowing: experiential knowledge and scientific knowledge (and the synthesis of the two within the realm of clinical knowledge).[13] Efforts to reduce medication-related stigma and enhance medication acceptance must work through these different mediums of knowing, e.g., inclusion of scientific proof (efficacy and effectiveness studies) and living proof (the faces and voices of people in medication-assisted recovery).

J. Medication and Pleasure: People addicted to alcohol and other drugs are culturally perceived as hedonists concerned only with their relentless pursuit of unearned pleasure. Cultural acceptance of a medication used to treat addiction is thus contingent upon the medication being perceived as not providing further pleasure or, preferably, denying pleasure from drug use (e.g., naltrexone in the treatment of opioid addiction), or punishing further drug use (e.g., disulfiram in the treatment of alcohol addiction). Any medication depicted as a "replacement" or "substitute" for a primary intoxicant will be culturally rejected (e.g., methadone perceived as "legal heroin" and rejected on the grounds that it extends such unearned pleasure). Such rejection is unwittingly reinforced by otherwise knowledgeable addiction treatment professionals equating the effects of heroin and methadone and viewing medication-assisted recovery as not "real" recovery.

K. Profile Transformation of Opioid Addiction: The aging of long-tenured opioid addicts, the dramatic increase in Caucasian prescription opioid addiction, and the rise of the latter in non-urban areas and its rise among older adults mark significant trends in the history of opioid addiction in the US with unclear effects on the future of professional and social stigma, treatment issues (e.g., pain management), and trends in the use of medications in addiction treatment.[14]

III. Current Status of Medication-Assisted Treatment of Substance Use Disorders

A. Varieties: Medications used in the treatment of addiction span:

- *opioid agonists*, e.g., medications such as methadone (Methadose® and Dolophine®) used as aids in withdrawal from heroin or other short-acting opioids or used as maintenance agents to achieve metabolic stability, suppress cravings, and reduce the risk of relapse.
- *partial agonists*, e.g., similarly used medications such as buprenorphine (trade name Subutex®) and buprenorphine and naloxone combination (trade names Suboxone®, Depakote®).
- *opioid antagonists*, e.g., medications such as naltrexone that block the pharmacological effects of heroin and other opioids for 24-48 hours, or, in extended depot (injected/implanted) form, for up to four weeks.
- *alpha-2-adrenergic agonists* such as clonidine and lofexidine that have been used as adjuncts in opioid detoxification.

- *medications for management of acute withdrawal*, e.g., the use of benzodiazepines and anticonvulsant medications (carbamazepine, valproate) in alcohol withdrawal.[15]
- *aldehyde dehydrogenase (ALDH) inhibitors*, such as disulfiram (Antabuse®), that provide a chemical shield against impulsive use by eliciting toxic reactions (e.g., flushing, nausea/vomiting, increased heart rate) to even a small intake of alcohol;[16] disulfiram also has been used to prevent drinking-related relapse to cocaine use.[17]
- *Anti-craving agents*, e.g., naltrexone (ReVia®, Vivotrol®, and Depade®), nalmefene, and acamprosate (Campral®) used in the treatment of alcoholism to reduce post-withdrawal cravings for alcohol and reduce the rewarding effects of alcohol.[18]
- *Medications for co-occurring disorders*, e.g., antidepressants, mood stabilizers, and neuroleptic (anti-psychotic) and other medications used to treat co-occurring psychiatric disorders.[19]
- *Medications for nicotine dependence*, e.g., nicotine-based gums, patches, nasal sprays, inhalers, lozenges, tablets, sustained release bupropion hydrocholoride (e.g., Zyban®), varenicline (e.g., Chantix®), and clonidine.[20]

B. Scope and Limits: Most medications in current use in the treatment of addiction are used primarily in the treatment of opioid and alcohol addiction. Few evidence-based medications exist for the treatment of other substance use disorders, but there are medications that hold promise for future treatment.[21]

- There are 1,203 opioid treatment programs (OTPs) 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.[22]
- A 2009 analysis provides the latest profile of OTPs in the US:
  -- OTPs constitute only 8% of all U.S. addiction treatment facilities, but OTP patients constitute 23% of all patients in addiction treatment.

  -- 50% of OTPs are operated by for-profit organizations.

  -- Half of all OTP patients pay out-of-pocket for their own treatment, at an average annual cost of $4,176 per year.

  -- 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.[23]

- Suboptimal dosing has been a pervasive theme within the modern history of methadone maintenance[24]—a significant concern given the critical role optimal dose stabilization plays in achieving the best clinical outcomes.[25]
- In 2008, approximately 368,962 patients in the US were treated with buprenorphine (Suboxone®, Subutex®, or generic Subutex) for opioid addiction on any given day;[26] in the 12-month period ending November 30, 2010, 887,482 patients in the United States received prescriptions for buprenorphine.[27]
- Prescriptions for all alcoholism medications and buprenorphine for opioid addiction rose from 541,000 in 2003 to 2,620,000 in 2007 (42.9% average annual growth rate); alcohol treatment medications rose from 393,000 in 2003 to 720,000 in 2007 (12.9% average annual growth rate). These rates remain small compared to the size of the population experiencing substance use disorders.[28]

- The use of disulfiram, naltrexone, and selective serotonin reuptake inhibitors (SSRIs) actually declined between 1994 and 2004 within private addiction treatment programs, but a 2006 report found private sector treatment programs more likely to adopt the use of disulfiram, naltrexone, and SSRIs than public programs. Even with philosophical adoption at program level, only a small percentage of patients are actually prescribed these medications.[29] Knudsen and colleagues reported that less than 50% of private addiction treatment programs used medications for the treatment of alcohol or opioid addiction.[30]
- Rates of adoption of medications by addiction treatment programs in 2007 were as follows: agonist medications (18.1%); naltrexone (21.2%); disulfiram (24.2%). Medication adoption was associated with accreditation, having a physician on staff or available contractually, and having Master's-level counselors.[31] Adoption of buprenorphine has been associated with additional factors: use of naltrexone, for-profit status, hospital affiliation, and provision of services of acute withdrawal.[32]
- In 2007, 49.7% of addiction treatment programs reported using SSRIs for treatment of a co-occurring mood disorder with use greatest in private nonprofit facilities, facilities that conducted psychiatric evaluations at intake, and facilities using a medical model and providing access to physicians; lowest rates of use were in for-profit facilities and in facilities with higher percentages of criminal justice referrals.[33]
- SSRIs are the most frequently used medication in addiction treatment, and centers that use SSRIs are more likely to later adopt the use of other medications.[34]

C. Other Emerging Trends:

- There is a clear trend toward the use of medications in combination.[35]
- There are early signs that the addiction field is moving to transcend categories of "drug free" and medication-assisted treatment and to define recovery for patients in the latter within the context of medication maintenance rather than cessation of such maintenance.[36]
- The mainstreaming of addiction medications into primary care without availability of ancillary support services or only limited scope and duration of such services[37] is resulting in using medication for brief respites in addiction careers (a safety net when drug money runs out) rather than for recovery initiation. The mainstreaming of such medications has been driven by Congressional legislation (Drug Abuse Treatment Act of 2000) with the interest of having physicians in private practice treat chronic opioid addiction. The legislation did not encourage the use of medication in tandem with other well-researched ancillary support services, based on federal publications such as the *Principles of Drug Addiction Treatment* by the National Institute on Drug Abuse. The legislation was limited in indicating that a physician, who would receive a waiver under the legislation, would only need to demonstrate a "capacity to refer a patient" for other services aside from the medication that was being prescribed within the practice setting. The policy issues in this area would appear to focus on access to treatment as opposed to the quality of treatment that is given to the individual.

IV. Degree of Current Acceptance/Obstacles to Acceptance of Medication-Assisted Treatment

A. General: The major barrier to adoption of medication-assisted treatment of substance use disorders is the prevailing belief that drug addiction should not be

treated (or replaced) with another "drug" and the failure to distinguish self-administration of a psychoactive substance as a "drug" from the professionally supervised use of a "medication."[38]

B. Those in Need of Treatment:

- Medication-assisted treatment (with methadone or buprenorphine) voluntarily attracts more people addicted to heroin and other short-acting opioids than any other addiction treatment modality, but the majority of those addicted to heroin or prescription opioids are not currently in treatment.[39]
- 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 methadone maintenance (MM) is a "last resort" inhibit timely treatment seeking by those who could benefit from MM
- Surveys of opioid users confirm the perception of benefits of methadone maintenance but also reveal concerns about the perceived negative physical effects of methadone, the perception that methadone is more addictive than heroin, and the time demands of methadone maintenance clinic compliance.[40]

C. Patients Enrolled in Treatment:

- A major obstacle to medication adherence is the failure of patients and their families to understand opioid addiction as a brain disease and the importance of medication adherence in successful recovery management.
- Patient non-adherence is a major concern in the pharmacotherapeutic treatment of all substance use disorders.[41]
- Problems with patient adherence to medication protocols are being transcended by new depot formulations that do not require daily self-administration.[42]
- Social/professional stigma attached to the medication is a universal feature of the experience of methadone maintenance patients in the United States.[43]
- Patient misconceptions and shared street lore about methadone contribute to premature treatment termination. Patient surveys find that while many believe methadone has positively affected their lives, they also believe that methadone could hurt their health and that its use should be terminated as soon as possible.[44]
- Nearly 60% of methadone patients are "fully compliant" in spite of a regimen more demanding than that required of virtually any other medication protocol.[45]
- 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.[46] Access to buprenorphine is limited by its relatively high cost.[47]
- A number of policymakers are reluctant to engage the state legislative bodies as a means of ensuring that access to such care is provided. It is generally tolerated that many residents of a state will travel to an adjoining state to gain access to care. The state of Mississippi provides a case in point where one certified Opioid Treatment Program exists in the state, and it is known that many of its residents travel to adjacent states such as Alabama and Louisiana to gain access to care.

D. Scientific and Regulatory Panels:

- Scientific reviews of the pharmacotherapeutic treatment of alcohol dependence have affirmed the value of four medications: 1) disulfiram (where not medically contraindicated and for those with family/clinical support to supervise consumption), 2) acamprosate, 3) oral naltrexone, and 4) once-monthly injectable, extended release naltrexone.[48] Some efficacy has also been demonstrated for topiramate, baclofen, ondansetron, and quetiapine in the treatment of alcohol dependence.[49]
- Methadone maintenance has been evaluated and endorsed in scientific and technical reviews of the American Society of Addiction Medicine (1990), the Government Accounting Office Report (1990), the Office of Technology Assessment of the United States Congress (1990), the American Medical Association Council on Scientific Affairs (1994), the National Institutes of Health Consensus Conference on Effective Treatment of Heroin Addiction (1997), the American Public Health Association (1997), the American Medical Association House of Delegates (1997), the Office of National Drug Control Policy (1990, 1999), the National Institute on Drug Abuse (1999), and the World Health Organization (2001).[50]
- The FDA has approved three forms of buprenorphine for such treatment: sublingual tablets of buprenorphine (Subutex), a tablet combination of buprenorphine and naloxone (Suboxone) designed to reduce problems of diversion and illicit use; and a sublingual film of buprenorphine and naloxone (Suboxone). Buprenorphine implants are also being tested for potential use in the treatment of opioid addiction.[51]

E. Addiction Treatment Professionals and Organizations:

- In general, addiction treatment professionals are more supportive of the use of medications for co-occurring disorders than for the treatment of addiction.[52]
- Counselors with greater levels of education and experience have the most positive attitudes toward the role of medications in recovery initiation and maintenance.[53]
- Duration of methadone maintenance declines in tandem with increased abstinence-orientation of the program philosophy[54] of counselors[55] and of physicians[56]—a factor of great concern given high relapse and mortality rates following cessation of methadone maintenance.[57]
- While 70% of patients being treated for co-occurring substance use and psychiatric disorders receive medication, only 34.4% of patients treated for opioid dependence and 24% of patients being treated for alcohol dependence in the US receive medication.[58]
- Subtherapeutic dosing (below 60 mgd) and professional pressure on patients to taper continue to prevail in many opioid treatment programs in spite of efforts to reduce such practices.[59] The ambiguity and conflict over the precise goals of addiction treatment (and their measurement) complicate the evaluation of medication-assisted treatment of addiction.[60] Such ambiguity reflects and contributes to conflicting policy and clinical treatment goals. Illustratively, in the field of general healthcare, physicians in hospitals will work to treat patients who may continue to be “non-compliant” with recommended treatment regimens, e.g., the hypertensive patient who fails to eat healthy foods or exercise. Rarely does the physician terminate the use of hypertensive medication even in non-compliant patients. In contrast, within the opioid addiction treatment arena, patients have often been expelled from methadone treatment for non-compliance, and programs who continue to provide medication in the face of non-compliance are chastised as providing harm reduction rather than effective clinical care.

- Many addiction treatment programs and recovery support institutions that do not use medications refuse to admit methadone patients in need of their services or to refer their own patients who could benefit from adjunctive, medication-assisted treatment.[61]
- The historically negative attitudes of residential treatment programs toward methadone may be softening,[62] and there are increased efforts to integrate methadone patients into residential treatment programs.[63]
- 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.[64]
- Counselor recovery status does not predict attitudes towards buprenorphine, but degree of adherence to a 12-step treatment philosophy is associated with less acceptance of buprenorphine.[65]
- New consensus definitions of recovery are recognizing the recovery status of medication-stabilized patients who meet other criteria for recovery.[66]

F. Treatment Referral Resources and External Authorities:

- Many criminal justice and child welfare authorities refuse to accept medication-assisted treatment, place arbitrary limitations of time on such treatment, or require reductions in medication dosage as a condition of "graduation" or release. There is enormous suspicion among representatives from such systems to even acknowledge the use and value of such medications to treat chronic opioid addiction. The general view is that it does not even fall within the parameters of their responsibility. As a jail administrator once put it, "How can we be expected to solve the problem that the general society can't even touch?"

G. Diverse Communities of Recovery:

- Attitudes within Alcoholics Anonymous and SMART Recovery[67] toward the use of medications for the treatment of alcohol dependence and co-occurring psychiatric disorders have become more accepting.[68]
- Narcotics Anonymous (NA) Bulletin # 29 characterizes persons on medically supervised methadone or other maintenance medications as being "under the influence of a drug," "using," and "not clean" and affirms that NA's definition of abstinence precludes the use of methadone as a treatment for opioid dependence.[69]
- Prevailing attitudes toward methadone and more recently buprenorphine are drawn from members' past use of these medications within the illicit drug culture for purposes of intoxication, respite rather than recovery, or self-managed withdrawal. The resulting perception of these medications as part of "the life" will not change through exposure to scientific studies of methadone but by relationships with people for whom these medications have been or are a crucial support in their recoveries.[70]
- Although methadone patients seeking recovery support from local NA groups may be denied the right to speak in meetings, the right to hold service positions, or the right to serve as a sponsor to other NA members, there are patients in medication-assisted treatment who continue to use NA for support—sharing or withholding their medication status.[71]
- Addiction professionals are caught in "contradictory expectations that they embrace the latest scientific findings on opioid addiction treatment while assertively linking

their patients to recovery mutual aid groups whose attitudes and practices may contradict these very findings."[72]

- Patients in medication-assisted treatment for opioid addiction have created their own education and advocacy organizations (e.g., 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], and Advocates of Recovery through Medicine [ARM, founded in 1999-2000]), as well as organizations inspired by patient advocates (National Alliance of Advocates for Buprenorphine Treatment, founded 2005).[73]
- There are recovery mutual aid groups and related peer recovery support specifically for people in medication-assisted recovery (e.g., Methadone Anonymous, Medication Assisted Recovery Support),[74] and protocols have been suggested for increasing involvement of patients in medication-assisted treatment in mainstream recovery mutual aid fellowships.[75]
- Persons in medication-assisted recovery have filled leadership positions within advocacy organizations such as Faces and Voices of Recovery.
- Consumer guides on medication-assisted treatment are being developed by grassroots recovery community organizations.[76]

H. Public/Local Communities:

- Media portrayal of methadone maintenance continues to focus on the least stabilized patients and the lowest quality treatment programs, e.g., *Methadonia*. Generally speaking, there have been a far greater number of lurid stories about patients in treatment in community-based settings than stories of successful recovery.
- Methadone maintenance patients experience discrimination in such arenas as education, employment, housing, health care, and government benefits.[77]
- Opioid treatment programs face significant Not-In-My-Backyard (NIMBY)-related resistance related to initial siting and relocation decisions.[78] Many local community planning commissions have adopted zoning ordinances against the development of Opioid Treatment Programs. Fortunately and more recently, such zoning ordinances have been overturned in the courts as a violation of the Americans With Disabilities Act.

I. Policymakers and Payors:

- It is a point of interest that the Nixon Administration funded the major expansion of methadone maintenance treatment through the Special Action Office for Drug Abuse Prevention (SAODAP).
- Congress subsequently approved legislation in 1974 regulating the Opioid Treatment System—a network of local clinics then known as Methadone Maintenance Programs. State policymakers also developed regulations to govern the use of medications like methadone.
- In spite of the evidence in support of the use of these medications, which clearly reduce costs to the government at all levels in addition to the society, there are still many states that will not provide third-party public reimbursement (Medicaid) for such treatment services. Accordingly, most patients in proprietary treatment programs make out-of-pocket payments since there is no insurance available to them. Additionally, where states do provide access to such third party

reimbursement, such systems become vulnerable to cyclic swings in funding cutbacks. State legislators typically look to cut such entitlement program reimbursement if access to care increases, placing a further drain on resources.

- Only 5 state Medicaid programs offer coverage for all recommended nicotine cessation pharmacotherapies as well as individual and group counseling; 38 states offered coverage for one form of treatment (medication or counseling).[79] Most health plans cover medications for alcohol dependence, one-third exclude buprenorphine for treatment of opioid dependence, and 55% place it in the highest cost tier.[80]
- Some government agencies (e.g., Department of Transportation) discriminate against MM patients for reasons not supported by medical science (e.g., refusal of a commercial driver license (CDL) to a highly stabilized methadone patient). In an interesting policy divergence, state legislators are passing restrictions for CDL use intrastate (Maine 2011) based on the fact that methadone is being prescribed increasingly for pain management. There have also been sporadic reports of methadone implicated in vehicular accidents and deaths. It is interesting to note that CDL restrictions do not apply to other equally powerful prescription opioids.
- There is a trend toward increased support of medication-assisted treatment by single state authorities overseeing addiction treatment, but adoption efforts lack a clear strategy.[81]
- There is no other area of medical practice other than methadone maintenance in which government policymakers have dictated to physicians who they may medicate, how many patients they can medicate, at what dosage, what laboratory tests must be conducted, what ancillary services must be provided, and the length of treatment.[82] To some degree and as a twist of public policy face, such requirements may have inadvertently protected the integrity of the treatment system. One piece of evidence that clearly comes to the surface is the recent and significant increase in the prescribing of methadone for pain management from 2000 to 2010. There have been four nationally published reports on the topic of methadone-associated mortality, clearly indicating that the increase in mortality is directly connected to the prescribing of methadone for pain management as opposed to addiction treatment. According to recent national data, there are more than twice as many patients receiving methadone for pain management as there are patients in registered Opioid Treatment Programs.
- There is greater concern with diversion of medication into the illicit drug culture than in how to increase access to medication-assisted treatment. This anomaly was noted in the Institute of Medicine report on Federal Regulation of Methadone Treatment (1995). While there may have been early concerns by enforcement agencies at the federal and state level about methadone diversion from the Opioid Treatment Programs, such concerns are not in evidence at the time of this writing. There is, however, increasing concern about the diversion of methadone via its prescription for pain management.

J. Obstacles to Acceptance of Medication-Assisted Treatment

- There is fear on the part of addiction counselors that smoking cessation during treatment will increase risk of relapse to other drug use. Smoking remains a part of the staff culture in some addiction treatment programs; 20.5% of addiction counselors smoke. There is the perception that it is not important to compare smoking to other drug addictions and concern that there is no time or reimbursement for smoking-related counseling.[83]

- The perception of addiction as a characterological weakness (e.g., self-centeredness, hedonism, recklessness, laziness) and that medication is a technological substitute that may prevent the needed transformation in character, values, and relationships.[84]
- "Inconsistent with our treatment philosophy" remains a major obstacle to the adoption of medications in the treatment of addiction.[85]
- Major barriers for out-of-treatment persons who could benefit from but do not seek methadone maintenance include waiting lists, lack of insurance or income to pay fees, lack of photo identification, fear of a rigorous and potentially prolonged treatment, and fear of stigma attached to methadone maintenance.[86]
- Physicians and other health care personnel are resistant to treating patients with chemical addictions because of their beliefs that such patients will "be drug seeking, demanding, manipulative, irresponsible, and respond poorly to treatment."[87]
- Obstacles to prescribing addiction treatment medications include physician perceptiveness of their limited effectiveness, inadequate marketing and information dissemination about the medications, concerns about adverse side effects, and concerns about the high price of some medications.[88]
- Lack of organizational/leadership support within addiction treatment programs is a critical factor in failure to adopt pharmacotherapeutic treatment of substance use disorders, e.g., adoption of naltrexone in treatment of alcohol dependence.[89]

K. Summary of Methadone Maintenance Status: Trapped between medical and moral/criminal models of problem definition and resolution, 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 scientific studies supporting it; 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 par with hospitals or outpatient medical clinics.[90]

V. Strategies for Increased Medication Acceptance

A. Design, conduct, and evaluate a national educational campaign on the role of medication and adjunctive support services in long-term recovery with sub-campaigns aimed at key social institutions: government, law, medicine, social services, business and industry, faith communities, media outlets, electronic social networks, and communities of recovery.

- Develop PSAs related to medications, treatment, and recovery for use in public campaigns, e.g., Recovery Month PSAs.

B. Encourage and support patient advocacy, e.g., medication-assisted recovery advocacy organizations and involvement of patients/families in medication-assisted treatment within the recovery advocacy movement.

C. Continue research on clinical effectiveness and cost-effectiveness with greater emphasis on clarity of indication and contraindications and effects on long-term recovery outcomes,[91] clearer science-based clinical guidelines on the use of medications in the treatment of adolescent substance use disorders,[92] and science-based guidelines to assist patients who are considering tapering off of their medication.

- Address question of optimal duration of medication maintenance based on scientific studies that have evaluated outcomes across periods of maintenance.[93]

D. Create rapid response team to respond to media stories and public presentations that include erroneous information about medications used in the treatment of addiction, including overselling of what a medication can do in the absence of other treatment and recovery supports.

E. Promote broad strategies of quality improvement. Medication adoption could be enhanced by increasing accreditation of addiction treatment programs; increasing percentage of trained Master's level addiction counselors; enhancing counselor retention; increasing representation and broadening role of physicians in addiction treatment; and building linkages with primary care physicians.[94]

F. Emphasize the conceptualization of addiction as a chronic disease. Recent efforts to recast addiction as a chronic illness and to shift addiction treatment from models of acute care to models of sustained recovery management may provide a more viable framework to understand the role of medications in long-term recovery from addictions.[95] Educate patients, families, professionals, policymakers, and the public about addiction medications whose positive effects, like those in treatment of asthma, hypertension, and diabetes, last only as long as they continue to be self-administered as prescribed—sustained self-care versus cure.

G. Disseminate information about addiction treatment outcomes with and without medication assistance, e.g., attraction to treatment; treatment duration; recovery, re-addiction, and mortality rates.

H. Promote recovery-oriented methadone maintenance[96] to elevate the quality of medication-assisted treatment of opioid addiction and transcend the isolation of OTPs from the larger addictions treatment field, local recovery mutual aid societies, and other local community institutions. Examples include:

-- Emphasize what medication in combination with clinical and peer support can add to one's life rather than what it reduces or deletes from one's life.

-- Stop kicking people out of treatment for exhibiting symptoms of the disorder for which they are being treated.[97]

-- Implement research-based protocols to enhance retention of patients in medication-assisted treatment.[98]

-- Provide a broad menu of medical, social, and peer recovery support services with the medication protocol.[99]

-- Conduct rigorous post-treatment monitoring and early re-interventions with all admitted patients to reduce post-discharge mortality rates and increase long-term recovery outcomes.[100]

I. Elevate medication-assisted recovery outcomes via assertive post-treatment monitoring, support, assertive linkage to recovery communities, and when needed, early re-intervention for all patients regardless of discharge status.[101]

J. Promote regulatory reform to increase access to interim methadone maintenance and office-based medical management of stabilized patients.

K. Promote smoking cessation within addiction treatment: Provide regulatory and financial incentives to integrate the following into all addiction treatment programs: smoking-related education/training of all addiction professionals; comprehensive smoking bans in all addiction treatment campuses; evaluation of smoking status and degree of motivation to quit of all patients at intake; education linking smoking cessation to recovery prognosis; and a motivational intervention that includes advice on how to stop smoking, smoking-related counseling, and availability of pharmacotherapy to aid smoking cessation.[102]

L. Elevate the availability and quality of patient education.

- Develop presentation materials and self-instructional materials on medication-assisted treatment that challenge myths and folklore, present an accurate picture of the scientific studies of addiction treatment medications, and convey the faces and voices (experience, strength, and hope) of persons in medication-assisted treatment.
- Explore ways to nationally replicate the Medication Assisted Recovery Support (MARS) model of peer education. (Note: SAMHSA has approved the use of 2011 RCSP Supplemental Funding to create the MARS Training Institute at the Albert Einstein College of Medicine. Staff and patients from ten methadone programs around the US will be brought to the Bronx to learn how to create MARS-type Peer Recovery Support Programs around the US.)
-

M. Elevate medication-focused professional education and training.

- Expand brief physician training with mentoring from more experienced physicians (e.g., wide replication of process used in Buprenorphine Office-Based Practice Trial and NIDA's Clinical Trials Network (CTN) process to enhance adoption of the use of buprenorphine).[103]
- Enhance knowledge and skills of addiction professionals related to pharmacotherapy by integrating related education/training in all addiction studies programs and requiring medication updates as part of regular CEU requirements from credentialing and licensing bodies.
- Develop a packaged training program on medication-assisted treatment and recovery to be disseminated through the Addiction Technology Transfer Centers to addiction treatment referral sources, with a special emphasis on the criminal justice system and child welfare system.
-

N. Educate policymakers.

- Extol cost-effectiveness of pharmacotherapeutic treatment of addiction[104] and effects of health care reimbursement policies on help-seeking.[105]
- Assure availability of insurance benefits and public funding (e.g., Medicaid) for medications and other ancillary supports used in the treatment of addiction.[106]

O. Utilize patients in recovery as educational and advocacy resources. We view

the use of patients who currently use or have used medication as a critical support to their recoveries as key resources in all of the above strategies.

- Engage Faces and Voices of Recovery and AATOD to provide leadership development and public/professional education skills of current and former patients

in medication-assisted recovery, e.g., expand work that AATOD has done with Vista Pharmaceuticals to train patient advocates to speak in public about MAT.

VI. Principles Related to Practice Guidelines for Medication-Assisted Treatment of Substance Use Disorders

A. Formulate principles that can be used in the development of practice guidelines, such as:

- Care not control: The clinical rationale for the use of medications must be reframed from what they suppress (e.g., withdrawal symptoms, crime, infectious disease transmission) to what they promote (metabolic stabilization, recovery initiation/maintenance, enhanced quality of personal/family life).
- Patient choice/partnership: There needs to be a balance of responsibility between caregiver and patient as the individual is admitted into a therapeutic environment and is encouraged to remain as long as the individual will benefit from such care. It springs from a dynamic of compassionate care as opposed to controlling the individual, while preserving the elusive balance of engaging the patient during different periods in the treatment and recovery process.
- Safety via monitoring and supervision.
- Treatment alternative or treatment adjunct: Medications may be considered an adjunct to other treatment or an alternative to specialized addiction treatment (e.g., the effectiveness of naltrexone in the treatment of alcohol dependence without specialized behavioral/counseling interventions).[107] Psychosocial support services can be added to medications (e.g., methadone maintenance) to enhance recovery outcomes.[108]
- Dose and duration: Patients, families, referral sources, treatment providers, and policymakers need to be educated on the importance of optimal doses of medications and optimal duration of medication support.
- Availability and scope of ancillary services: The clinical balance here is understanding when such services are critical and when they are no longer necessary for the patient. This is the art of treatment that draws upon scientific evidence and clinical experience.
- Potent service combinations and sequences: Medication and particular psychosocial supports may generate better outcomes than either intervention in isolation.
- Culture of recovery: Medications need to be wrapped within a vibrant culture of recovery that supports sustained remission of substance use disorders and enhancements in global health and quality of life.
- Continuity of contact and support over time and across treatment episodes.
- Recovery planning: Very early in treatment, patients need to be involved in the development of a lifetime recovery plan, which should include getting the most out of treatment and then eventually moving on to tapering or medical maintenance depending on the individual.

SUMMARY

Given what has been stated throughout the course of this paper, there is a need to provide a broad and sustained public and professional education about what addiction is, how it differs from use and dependence, and the positive role that medications can play in long-term addiction recovery. There are positive trends toward gradual increases in understanding

of addiction as a medical disorder; however, these can only be maintained through sustained efforts at professional and public education.

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Selected Papers of William L. White

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Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

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Smoking and Addiction Recovery II: For Addiction Professionals

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For decades, people in recovery from addictions to other drugs have had their lives cut short by tobacco-related diseases. These dear friends, patients, and colleagues died from nicotine addiction, but it could also be said they died from blindness—the failure to see nicotine as an addictive drug and the failure to see smoking cessation within the rubric of *addiction recovery*. For years, such casualties could be written off to the lack of knowledge about smoking and health and the lack of knowledge about the effects of smoking on recovery from other addictions. That simply is no longer the case. Science has weighed in on these issues and the findings are excruciatingly clear. This is the second of a two-part series of papers that summarize these findings for people seeking and in addiction recovery (and their families) and for addiction treatment professionals. Here is what the research of recent decades has concluded about nicotine addiction within the context of specialty-sector addiction treatment in the United States.

How we as addiction professionals respond or fail to respond to the issue of nicotine addiction exerts significant effects on the long-term health outcomes of those we serve.

- Low Natural Cessation Rates: In addiction treatment programs in which smoking is not addressed, smoking cessation rates are very low (e.g., 3%) following discharge from treatment.[1]
- Inadvertent Message: The failure to address smoking within the rubric of addiction treatment and recovery conveys the messages that smoking is not a "real addiction" and that smoking cessation is not an important ingredient of recovery or health and quality of life in recovery.[2]

Historically, the use of tobacco has been promoted within the addiction treatment milieu and within recovery mutual aid societies.

- A Changing World: This stance is changing in tandem with the advances of addiction science, the maturation of addiction treatment as a professional field, and the changing cultural attitudes toward smoking.[3]

In spite of these changes, addiction professionals are not provided training on the treatment of nicotine addiction, and the rate of adoption of comprehensive services related to nicotine addiction remains low among addiction treatment providers in the US.[4]

The development of nicotine addiction by non-smokers during and following addiction treatment may constitute a harmful side effect of such treatment.[5]

The response of addiction treatment programs to nicotine addiction of their patients has been influenced by historically high rates of nicotine addiction among the addiction treatment workforce.

- High Smoking Rates: 20.5% of addiction counselors surveyed in the US currently use tobacco products; 47.7% are former tobacco users: 89% of recovering counselors are current or former smokers compared to 42% of the U.S. general population.[6]
- Effects on Clinical Effectiveness: Addiction counselors addicted to nicotine are less likely than counselors who are non-smokers to encourage their patients to stop smoking.[7]

Addiction professionals are becoming more supportive of the integration of smoking cessation services within addiction treatment programs.[8]

- Changing Attitudes: Addiction counselors' attitudes toward the integration of smoking cessation within addiction treatment become more positive following trials of such integration.[9]
- Changing Policies/Practices: Addiction counselors are less likely to be a current smoker if they work within a program that offers comprehensive supports for smoking cessation.[10]

A historical barrier to integrating smoking cessation into addiction treatment programs is the myth that quitting tobacco use during early recovery initiation increases the risk of relapse to other drugs.[11]

- Misguided Cautions: As many as a third of addiction treatment patients have been warned by an addiction counselor, an AA or NA sponsor, or a friend to postpone smoking cessation until after stable recovery has been achieved from other addictions.[12]
- Fact versus Folklore: Smoking cessation does not compromise treatment and recovery outcomes for other drug addictions.[13]

Smoking cessation during early recovery from other drug dependencies may actually enhance post-treatment and long-term recovery outcomes.

- Successful Smoking Cessation: Smoking cessation programs delivered during addiction treatment are effective in initiating cessation of smoking, but longer term strategies of support (e.g., booster sessions, recovery checkups) are needed to improve long-term cessation rates.[14]
- Improved Recovery Rates: Smoking cessation interventions provided during addiction treatment increase the rates of long-term abstinence from alcohol and illicit drugs by as much as 25%.[15]

The majority of addiction counselors now believe that providing supports for recovery from nicotine addiction during treatment for other addictions will improve post-treatment recovery outcomes for all substances.[16]

Staff perceptions that most people admitted to addiction treatment do not want to stop smoking are challenged by recent scientific surveys.

- Patient Wishes: Between 44-80% of patients have a desire to stop smoking.[17]
- Patients with Co-occurring Disorders: That desire to stop smoking extends to patients with co-occurring psychiatric illnesses.[18]

No-smoking policies in addiction treatment programs do not decrease admissions or increase discharges against medical advice or administrative discharges.[19]

The use of tobacco products by addiction professionals is an issue of professional ethics as well as an issue of personal lifestyle choice.[20]

A growing number of addiction counselors are refusing to model a behavior (smoking) that could take years from their own lives and the lives of those who could be influenced by their example.[21]

- Ethical Sensitivity: Addiction counselors are making the decision to stop smoking as a way to escape the contradictions of exhibiting daily addictive behavior while working as an addictions treatment professional.
- Professional Advocacy: Addiction professionals are also taking a stronger advocacy role in pushing comprehensive smoking cessation services for addiction treatment service providers and recipients.[22]

Major policy bodies that have investigated the problem of nicotine addiction among those dependent upon alcohol and other drugs have recommended that smoking cessation be integrated into addiction treatment, including

- Practice Guidelines of the American Psychiatric Association (2006),
- National Institutes on Health State-of-Science Conference Statement on Tobacco Use (2006), and
- The Public Health Service Guidelines for Smoking Cessation (2008).[23]

What You Can do as An Addictions Professional

1. Seek education and training on nicotine addiction and smoking cessation counseling.

- Highly Recommended: Abrams, D.B., Niaura, R., Brown, R.A., Emmons, K.M., Goldstein, M.G., & Monti, P.M. (2003). *The tobacco dependence treatment handbook: A guide to best practices*. New York: Guilford.

2. Practice the 5 As (Ask, Advise, Assess, Assist, and Arrange) of smoking cessation support with all those with whom you work.[24]

- ***Ask:*** *Systematically identify all tobacco users at every visit. (Implement an office-wide system that ensures that, for every patient at every clinic visit, tobacco-use status is queried and documented.)*
- ***Advise:*** *In a clear, strong, and personalized manner, urge every tobacco user to quit.*
- ***Assess:*** *Determine willingness to make a quit attempt. (Ask every tobacco user if he or she is willing to make a quit attempt within the next 30 days.)*
- ***Assist:*** *Aid patient in quitting (help the patient with a quit plan; provide practical counseling; provide intra-treatment social support; help patient obtain extra-treatment social support; recommend evaluation for use of approved pharmacotherapy; and provide supplementary materials).*
- ***Arrange*** *for continued follow-up and support.*[25]

3. Model nicotine abstinence and share your "experience, strength, and hope" related to smoking cessation.

4. Advocate for smoke-free workplace policies and for the integration of comprehensive approaches to smoking cessation within the rubric of addiction treatment within your organization and through your professional associations.

5. Share the info in this pamphlet series with your clients and your professional peers.

Dedication: To Charlie B.

Acknowledgement: Many of the findings in this review were abstracted from the published studies and accompanying literature citations of Hannah K. Knudsen, PhD (Department of Behavioral Science and Center on Drug and Alcohol Research, University of Kentucky) and her colleagues. These studies, which were supported by the National Institute on Drug Abuse, have significantly advanced our understanding of the barriers to implementing comprehensive smoking cessation supports within addiction treatment programs in the United States. Her contributions in leading this research are gratefully acknowledged. I'm also indebted to the research that has been collected and synthesized by the American Legacy Foundation (see http://www.legacyforhealth.org/) and to David B.Abrams, PhD, for his many helpful suggestions. Development of this series of papers was supported by the Philadelphia Department of Behavioral Health and Intellectual disAbility Services.

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Smoking and Addiction Recovery: For People in Recovery

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For decades, people in recovery from addictions to other drugs have had their lives cut short by tobacco-related diseases. These dear friends, patients, and colleagues died from nicotine addiction, but it could also be said they died from blindness—the failure to see nicotine as an addictive drug and the failure to embrace the need for smoking cessation within our understanding of *recovery*. For years, such casualties could be written off to the lack of knowledge about smoking and health and the lack of knowledge about the effects of smoking on recovery from other addictions. That simply is no longer the case. Science has weighed in on these issues, and the findings are excruciatingly clear. Here are the facts.

Nicotine is an addictive drug.[i]

- Genetic Influences: Genetic vulnerability plays a role in who starts smoking, who develops nicotine dependence, and who succeeds with particular approaches to quitting.[ii] Families with histories of alcohol addiction have high rates of nicotine addiction—even among family members who are not dependent on alcohol.[iii]
- Difficulty Quitting: Most smokers regret starting to smoke (90%), want to quit and have made a prior attempt to quit (70%),[iv] or are currently trying or planning to quit (40%).[v] A higher percentage of people successfully recover from alcohol and other substance use disorders than successfully quit smoking.[vi]
- Cycles of Use and Abstinence: Like other addictions, recovery from nicotine addiction involves cycles of abstinence, lapse, relapse, remorse, remotivation, and new abstinence attempts.[vii] Those who attempt to quit smoking report an average of 8-11 quit attempts before succeeding, with most relapsing within the first eight days following their last cigarette.[viii]

Nicotine has been, until recently, a celebrated drug.

- Hidden Addiction: The problem with drugs that have been so celebrated—

culturally praised, commercially promoted, and politically protected—is that we have not defined them as *drugs*, have not regulated them as we have other drugs, have not defined their compulsive use as *addiction*, and as a result, have only recently begun to fully understand their relationship to disease and premature death.[ix]

Nicotine addiction is declining, but remains a significant public health problem.

- Current Progress: Although the rate of smoking for adults in the US has declined from its peak of 45% in 1954 to 20.6% in 2009, 46.6 million Americans are currently addicted to nicotine.[x]

The medical consequences of nicotine addiction remain a leading cause of death in the United States.

- Disease and Death from Nicotine Addiction: Tobacco use accounts for more sickness and disease than the combined use of alcohol and other drugs.[xi] Medical disorders related to nicotine addiction cause more than 430,000 deaths each year in the United States;[xii] cigarette smoking is the leading preventable cause of death in the United States.[xiii] One-third to one-half of lifelong smokers will die of smoking-related illnesses.[xiv]
- Added Risk from Co-addiction: Combining nicotine addiction with other drug addictions amplifies the health risk of both addictions.[xv] For example, the risk of laryngeal cancer for those who are both heavy drinkers **and** heavy smokers is four times greater than for those who are either heavy drinkers or heavy smokers.[xvi]

Co-addiction is the norm.

- Smoking and Drinking: Nicotine use increases alcohol consumption; alcohol consumption increases nicotine consumption and the rewarding effects of nicotine.[xvii] Alcohol dependent smokers are more severely dependent upon nicotine,[xviii] are less likely to stop smoking,[xix] and as a result, bear a greater burden of nicotine-related diseases and deaths.
- Smoking and Psychiatric Illness: Overall, 40% of smokers in the US have a substance use or psychiatric disorder.[xx]
- Smokers in Addiction Treatment: Between 70-80% of people entering addiction treatment smoke—nearly 4 times the rate for all adults.[xxi]
- Co-addiction and Prognosis for Quitting: Smoking cessation rates are extremely low for alcohol and drug dependent persons not in recovery from these disorders; recovery from other alcohol/drug dependence may be a precondition for smoking cessation for most addicted smokers.[xxii]

Nicotine addiction (smoking) is a major cause of death among people in recovery from other addictions.

- Causes of Death Following Addiction Treatment: People treated for alcohol or drug dependence are more likely to subsequently die from smoking-related diseases than from alcohol or drugs other than nicotine. [xxiii]

Many of the pioneers of twentieth century addiction treatment and recovery mutual aid societies died of smoking-related disorders.

- Bill Wilson (emphysema) and Dr. Robert Holbrook Smith (cancer), co-founders of Alcoholics Anonymous;

- Mrs. Marty Mann (cancer), founder, National Council on Alcoholism and Drug Dependence;
- Danny C. (cancer) and Jimmy K. (emphysema and cancer), key figures in the founding of Narcotics Anonymous;
- Charles Dederich (cardiovascular disease), founder of Synanon;
- Dr. Marie Nyswander (cancer), co-developer of methadone maintenance; and
- Senator/Governor Harold Hughes (emphysema), sponsor of landmark alcoholism treatment legislation and founder of the Society of Americans for Recovery.[xxiv]

Quitting smoking reduces the risk of relapse and increases one's odds of sustained recovery from alcohol and other drug addictions.[xxv]

- Risk of Continued Smoking: Smoking cessation in early recovery does not increase craving for or urges to drink alcohol.[xxvi] Continued smoking following treatment for alcohol and drug dependence is a risk factor for resumption of alcohol and other drug use.[xxvii]
- Improved Recovery Rates: Quitting smoking in tandem with efforts to cease alcohol and other drug use does not threaten such recovery efforts and in fact, increases one's chances of recovery.[xxviii] Smoking cessation improves recovery rates of other addictions.[xxix]

There are medications and counseling available that can increase the odds of permanent smoking cessation.

- Value of Medication: Medications can double the chances of successfully quitting,[xxx] and nicotine replacement medications may be particularly important for smokers with a history of alcohol and/or drug problems.[xxxi]
- Value of Medication and Counseling: Smokers who combine medications and counseling have the highest success rates.[xxxii]
- Value of Physician Guidance: Smokers with co-occurring addictions are five times more likely to successfully quit smoking if they are counseled by a primary care physician. [xxxiii]

People in recovery from addiction to alcohol and other drugs are incorporating recovery from nicotine addiction within their personal understanding of recovery. This is revealed by:

- the rise of smoking cessation with length of abstinence from alcohol and other drugs,[xxxiv]
- the growth of non-smoking meetings within recovery fellowships,
- some people in recovery changing their sobriety/clean dates to reflect the date they stopped all addictive drug use—including nicotine use, and
- addiction professionals broadening their understanding of "recovery" to encompass smoking cessation.[xxxv]

The health benefits of smoking cessation include increased life expectancy; reduced risk of heart disease, heart attacks, strokes, and cancer;[xxxvi] as well as a more rapid process of brain recovery from addiction.[xxxvii]

10 Suggestions for People in Recovery Who Wish to Quit Smoking

1. Expect success in quitting. Full and permanent recovery from nicotine addiction is possible for people recovering from other addictions. More than 48 million Americans have successfully quit smoking,[xxxviii] and persons with a history of other drug addictions can also successfully quit.[xxxix]

You can do this, but it will require sustained effort. Do not be discouraged. Many of us had to keep quitting until we quit completely and permanently.

2. Educate yourself. Do an internet search on "smoking cessation" and get more facts on the effects of smoking cessation on your health.

3. Prepare yourself by making a quit plan that includes these steps.

- Focus. (Write down all the reasons you want to quit smoking.)
- Set a quit date.
- Announce your quit date to others.
- Take preliminary steps, e.g., start decreasing the number of cigarettes you smoke each day; create a smoking diary by recording when you smoke, noting times, places, people, situations; experiment by eliminating a few of those "special" cigarettes (during phone calls, work breaks; while driving; after a meal; after sex—you know the ones I am talking about).
- Talk to your partner. (If you live with a smoker, explore whether you want to quit together. You will be five times more likely to give up smoking if he or she also quits.[xl])
- Talk to your doctor about your decision and the options for medications that may be of help to you.
- Line up additional sources of support. Line up lots of support and be prepared to combine multiple methods of support, such as self-instructional materials, medications, counseling, and mutual support (e.g., Nicotine Anonymous). Although the majority of people who quit smoking do so without assistance,[xli] the use of self-help groups, medications, counseling, and other aids to support smoking cessation have increased dramatically over the past three decades[xlii] and will increase your chances of being successful.

4. Apply principles and practices that have helped you recover from other addictions.[xliii] Although persons with additional drug addictions tend to have more severe nicotine dependencies, people in recovery from such addictions may be able to mobilize skills and supports that helped them recover to aid in their efforts to quit smoking.[xliv]

5. Talk with other people in recovery who have stopped smoking. Ask them to share their experiences and suggestions related to quitting.

6. Identify your most powerful smoking triggers. Use your smoking diary to identify the people, places, things, times, situations, and feelings most associated with smoking and minimize contact with these, particularly during the first 30 days of not smoking.

7. Minimize and manage cravings by doing the following:

- Closely adhere to medications if you are using them to suppress cravings.
- Use thought stopping (an internal shout "Stop!") that can be further enhanced by wearing a rubber band on your wrist and snapping it every time you think of having a cigarette. (I know this sounds silly, but it really works in extinguishing cravings.)
- Combine thought stopping with thought substitution—have a single thought (mantra) or image you can bring to mind as an alternative to thinking about smoking that strengthens your resolve to quit.
- When you experience a craving, change your physical environment for a few minutes.
- Increase your water intake—this may help with nicotine detoxification and carrying a bottle of water and drinking from it gives you an oral substitute and an alternative activity for your hands.

- Substitute oral activity for smoking during the early weeks of not smoking, e.g., sugarless gum, mints, toothpicks, straws, healthy snacks (e.g., carrot sticks).
- Increase your exercise.
- Carry an icon with you that you can draw on for strength, e.g., photo of a loved one, photo of someone who died of nicotine addiction, a worry stone, a recovery chip.
- Structure your time to remain in non-smoking environments (e.g., non-smoking recovery support meetings), particularly for the first month.
- Use other techniques, including breathing exercises, visualization, and daily sharing with a quit mentor.

8. Anticipate the need to relearn how to do some daily tasks without smoking. (Smoking had become so integrated into my writing rituals for so many years, I had to quite literally relearn how to write when I quit smoking.)

9. Plan rewards for yourself to celebrate key recovery milestones, e.g., first day, first week, first month.

10. For other great suggestions, check out www.helpusquit.org or http://www.becomeanex.org/ and join the Ex Community.

Dedication: This series of papers is dedicated to Charlie B.

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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 a force of nature and for me the living proof of the critical role medication can play in long-term addiction recovery.

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

1. Key recovery-focused practices within first and second generation MMT programs diminished during the mass replication of MMT, 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 (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).

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. 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.

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.

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 contact with individuals/families whose long-term recoveries have been aided by medication.

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 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 following this initial request.) 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.

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.

I don't expect everyone to agree with these propositions, but I do hope they will stir you to read the monographs Lisa and I have written and to discuss them within your programs and your local communities. They can be downloaded for free 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.

Opioid maintenance and recovery-oriented systems of care: it is time to integrate

A. Thomas McLellan and William White

There is international interest in recovery as an organizing construct for addiction-related public policy; and for the redesign of addiction treatment. England's Recovery Orientated Drug Treatment Expert Group, established by the NTA to explore and integrate the recovery construct, is an important milestone in these international efforts.

A recovery orientation in public policy and in treatment systems is a particularly refreshing approach to problems of addiction. Many public policies seek to punish addictive behaviors and remove the addicted from view. Some treatment systems focus only on remitting the most obvious and problematic symptoms of addiction. In contrast, recovery-orientated treatment systems offer an integrated approach to promoting the health of the addicted individual as well as the improved function of the family and community through a focus on social contribution. Emerging recovery definitions emphasize that recovery is more than the removal of destructive alcohol and/or drug use from an otherwise unchanged life. Recovery is a broader process that involves a radical reconstruction of the person-drug relationship, progressive improvement in global health and the reconstruction of the person-community relationship.

Recovery and Opioid Maintenance Treatment

It is in the context of a recovery-orientated treatment approach that the treatment of heroin addiction with an opioid medication has been so clinically controversial and politically divisive. Synthetic opioids were introduced over sixty years ago to help physicians reduce mortality, pain and fear of withdrawal among heroin addicted individuals. From that day to this there have been political battles between those who favor and those who oppose the long-term (maintenance) use of methadone or buprenorphine in the treatment of heroin addiction. These 'methadone wars' have been waged largely on ideological and political grounds questioning the morality of 'substituting one opiate for another' or the political cruelty of 'forcing societal values about abstinence on those who are struggling with a brain disease'. The results have been polarization within the treatment and policy fields, stigmatization of individuals who need care and confusion among the public. The emotional charge and the moralistic nature of these battles have also constrained the nature of the scientific evaluation, prevented rational discussion and ultimately retarded progress in our field.

In this divisive and corrosive context the work of the Expert Group has been truly refreshing. It is progressive and valuable to ask practical, sensible questions regarding whether, how and under what conditions opioid maintenance medication can promote recovery – and to address those questions through empirical examination of the evidence on these issues. Several conclusions emerge from an unbiased, unemotional examination of the large body of data reviewed in this report.

First, the original clinical purpose of opioid medications was simply to provide metabolic stabilization as a means of engaging seriously and complexly addicted individuals into a therapeutic process and a personal recovery process that involved far more than just medication. There is no doubt that these medications are effective in achieving these ends and are often life-saving. It is also clear that these initial medication effects are not synonymous with recovery. Recovery is much more than physiological or even emotional stabilization. It has been defined in various ways but one recent version describes recovery as a "voluntary lifestyle characterized by sobriety, health and citizenship". The most ardent proponent would not claim that the simple administration of even significant doses of any opioid maintenance medication should be expected – by itself – to reliably induce this type of lifestyle. There is no type of treatment yet that can reliably induce recovery. Even 12-step treatment, the treatment most widely associated with recovery, cannot claim successful, sustained recovery in more than 25–30% of those who enter such treatment. The important point in the above definition is that recovery is not defined by a particular method by which one comes into recovery – only by the qualities of the life itself.

So, does being maintained on an opioid medication prevent an addicted individual from entering into a recovery lifestyle? The answer from the data reviewed is a qualified 'no'. The qualifications come from

both the desires of the patients who enter; and the therapeutic goals of the programs that provide opioid maintenance care. Many of the seriously addicted patients who enter opioid maintenance treatment do not want a recovery lifestyle. Data reviewed from large-scale studies in three continents show that many long-term opioid maintained patients continue alcohol and drug use and unemployment; and thus would not be considered by the above definition to be 'in recovery'. But these same data also show that a significant proportion of opioid maintained patients eliminate all substance use, obtain employment, care for their families and eliminate criminal activity – results which are quite consonant with recovery. Thus, it is neither the presence nor the absence of an opioid medication that defines recovery – it is other important qualities of the lifestyle.

But is the quality of 'medication-assisted recovery' really the same; and is it as enduring as recovery without the assistance of an opioid medication? There is no empirical answer to this question at this time; but it is an important issue for study. At a conceptual level, few would argue that an otherwise abstinent opioid addicted person who took statins for high cholesterol, insulin for diabetes, SSRIs for depression or a nicotine patch to prevent return to smoking would still be considered 'in recovery'. Is that same, otherwise abstinent individual who takes maintenance doses of methadone or buprenorphine as prescribed so very different?

An important question addressed in the report from the Expert Group is whether there are clinical services and administrative practices which can increase the likelihood of recovery within opioid maintenance treatment? Here again, the answer from the data reviewed is a qualified 'yes'. Opioid maintenance programs which set recovery goals, offer supportive services and promote pro-social behavioral change facilitated by individual and family counseling – are more likely to produce – or perhaps attract – patients who ultimately meet the definition of recovery. Again the qualification is that not all patients want a recovery lifestyle and not all providers accept recovery as a requirement for effective opioid maintenance treatment. Should there really be only one acceptable treatment goal and only one approved form of care? Recall that proper dosing with an opioid medication has been proven to protect individuals from withdrawal, overdose and also to reduce many of the associated public health and public safety behaviors (e.g. injection related infections, drug-related crime, etc.). Many patients and providers believe that these benefits are adequate in themselves. It seems clear again that being maintained on an opioid maintenance medication neither assures nor eliminates the potential for a patient to be in recovery – his/her recovery status is best defined by the other lifestyle qualities.

In turn, this leads to the final set of questions which also cannot be answered by the evidence thus far available and assembled by the Expert Group. Does a treatment program have the obligation or the right to demand recovery from its patients? Many opioid maintenance providers are hesitant to make demands on patients for recovery-orientated behavioral changes under fear of jeopardizing the significant gains already achieved through 'low threshold' treatments. Other providers of abstinence-orientated treatments believe it is better to discharge patients who lapse to drug use, in order to protect and preserve an abstinence-orientation for the remaining individuals in treatment. Are the public health benefits from medication-alone threatened by clinical or administrative requirements for recovery-orientated changes? These empirical questions have not been asked, perhaps because of the charged political climate in this field. In this context, the work of the NTA and its advisors may have helped us move toward a time when different therapeutic philosophies are accepted and even matched to the needs of patients; and research can help each type of provider examine these issues in an empirical manner with the objective of better matched and balanced treatment/rehabilitation options in the future.

Conclusion

Recovery status is best defined by factors other than medication status. Neither medication-assisted treatment of opioid addiction nor the cessation of such treatment by itself constitutes recovery. Recovery status instead hinges on broader achievements in health and social functioning – with or without medication support.

Rather than seeing addiction treatments with and without medication as philosophically incompatible, the Expert Group suggests it is more useful to consider medications and all other therapeutic components of contemporary care, as a menu of medical and non-medical recovery support options that can be combined, separated and sequenced to meet their individual/family needs over the course of the recovery process. Why would we deny any patient attempting to recover from any disease, the ability to access an effective medication to aid them in their recovery? At

the same time, the way to get the most from opioid maintenance treatment is by continuing to motivate patients who are receiving the pharmacological benefits of craving reduction and overdose protection, toward the broader but harder-earned benefits of full recovery

Recovery-focused systems of care have the potential to significantly elevate the quality of addiction treatment and the quality of life in individuals, families and communities affected by addiction to alcohol and/or other drug problems. But our scientific knowledge about addiction-related pathology has not yet been extended to understanding the pathways, stages and styles of long-term recovery across diverse clinical populations and promoted in different ways. It is our expectation that, as the work of the Expert Group moves forward, a recovery-focused research agenda will emerge to guide and refine research, treatment and policy. Such an agenda is emerging in the US as we go through our own process of exploring how to increase the recovery orientation of addiction treatment. We look forward to international collaboration on pursuing such an agenda.



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

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Abstract

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

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

Recovery as an Organizing Paradigm

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

These activities were influenced by and unfolded within larger transformations within the culture of recovery in the United States. Such changes included the growth and diversification of recovery mutual aid societies, the rise and increased vibrancy of a new recovery advocacy movement, the growth of grassroots recovery community organizations, new recovery support institutions (e.g., recovery community centers, recovery homes, recovery schools, recovery industries, recovery ministries, recovery cafes), and a more fully developed culture of recovery with its own history, heroes, values, language, literature, and folkways that transcended those of particular recovery mutual aid societies.[9] It is within this context that the addictions field has witnessed increased interest in the varieties of recovery experience,[10] expansion of peer-based recovery support services,[11] pioneering models of post-treatment monitoring and support,[12-15] and calls for a recovery research agenda.[16] Also of note are efforts to apply the recovery concept in different clinical and cultural contexts.[17]

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

Medication and Recovery in Historical Context

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

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

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

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

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

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

Medication and the Question of Recovery Status

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

Groups associated with mainstream, abstinence-based treatment, such as the Betty Ford Institute Consensus Panel, have in recent years taken the position that the remitted, stabilized methadone maintenance patient who does not use alcohol or illicit drugs and who takes methadone and other prescribed drugs only as indicated by competent medical practitioners meets the first of these defining elements of recovery.[26] For MAT patients who achieve recovery via these three dimensions, continued participation in medication maintenance or eventual tapering and recovery without medication support represent varieties of recovery experience and matters of personal choice, not the boundary of passage from the status of addiction to the status of recovery.

Defining recovery within the context of MAT requires cultural and professional understanding of the distinction between *addiction* and *physical dependence* and, for the MAT patient/family, an understanding of the distinction between use of a *medication* as an aid to recovery and use of a *drug* as a threat to recovery. Debate will continue into the foreseeable future over whether the terms *recovery* and *remission* should be synonymous or whether recovery involves more than remission (and whether *recovery* applies only to abstinence-based remissions). These are important distinctions. Remission involves the subtraction of pathology

from a patient's life; recovery conveys ingredients added to a patient's life, e.g., remission plus the achievement of global (physical, emotional, relational, spiritual) health, social functioning, and enhanced quality of personal/family life in the community. The emerging three-component definition of recovery has profound implications for the future design, conduct, and evaluation of addiction treatment and related recovery support services.

Recovery in the Context of Methadone Maintenance

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

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

ROMM is a framework for the treatment of opioid addiction that combines pharmacotherapy and a sustained menu of professional and peer-based recovery support services to assist patients and families in initiating and maintaining long-term addiction recovery—during medication maintenance and, for those who choose to taper, throughout and following the tapering process.

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

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

Table 2: ROMM Service Practices

Recovery-oriented MAT seeks to:
attract people at an earlier stage of problem development via programs of assertive community education, screening, and outreach; ensure rapid service access for individuals and families seeking help; resolve obstacles to initial and continued treatment participation; achieve safe, individualized, optimum dose stabilization;

engage and retain individuals and families in a sustained recovery-focused service and support process;
assess patient/family needs using assessment protocols that are global, family-centered, strengths-based, and continual;
transition each patient from a professionally-directed treatment plan to a patient-directed recovery plan;
expand the service team to include primary care physicians, psychologists, social workers, peer recovery support specialists, and indigenous healers;
shift the service relationship from a professional/expert model to a long-term recovery partnership/consultation model marked by mutual respect, hope, and emotional authenticity;
ensure minimum (at least one year) and optimum (individualized) duration of treatment via focused retention strategies and assertive responses to early signs of disengagement;
shift the treatment focus from an episode of care to the management of long-term addiction/treatment/recovery careers;
expand the service menu to include ancillary medical/psychiatric/social services and non-clinical, peer-based recovery support services;
extend the locus of service delivery beyond the OTP to non-stigmatized service sites and neighborhood-based, church-based, work-based, home-based, and technology-based (phone/Internet) recovery support services;
assertively link patients/families to recovery community support resources;
engage the community through anti-stigma campaigns and recovery community development activities;
provide post-treatment monitoring and support and stage-appropriate education, support, and (if and when needed), early re-intervention for all patients regardless of discharge status; and
evaluate MM treatment using proximal and distal indicators of long-term personal and family recovery (Excerpted from White & Mojer-Torres, 2010, with permission).[18]

Changes in service practices within ROMM are best thought of not as innovations but as a retrieval and extension of the best practices within the history of addiction treatment in general and MAT in particular. The conceptual and practice silos of medication-assisted treatment and "drug free" treatment will progressively dissipate within the addiction treatment field.[30,31] All people seeking help will have access to a comprehensive menu of professional and peer-based recovery services. Formerly siloed MAT patients will have access to a full menu of psychosocial support services, and formerly siloed "drug free" treatment settings will provide pharmacotherapeutic support for those who can benefit from it. Such integration will parallel methods that are now standard practice in the treatment of other chronic health disorders such as asthma, diabetes, hypertension, and cancer.

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

Stigma, Recovery, and Patient Advocacy

Addiction- and MAT-related social stigma contributes to social isolation, reduces help-seeking, and undermines long-term recovery, particularly among those with multiple discrediting identifiers, e.g., addiction, MM treatment, psychiatric illness, HIV/AIDS, minority status, poverty,

homelessness. Persons in MAT, particularly those enrolled in MM, have never received full status as a "patient," and the OTP has yet to be viewed as a place of healing on par with hospitals or outpatient medical clinics. The historical stigma attached to methadone and the broader arena of medication-assisted treatment has denied MAT patients the status of recovery and left them isolated from mainstream community life and existing in limbo between cultures of addiction and cultures of recovery.

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

Three broad social strategies have been used to address stigma related to addiction and related disorders and their treatment: 1) personal or mass protest (advocacy), 2) public and professional education, and 3) strategies that increase interpersonal contact between stigmatized and non-stigmatized individuals and groups.[32] It is unlikely that the recovery status of the MAT patient will be fully embraced by policy makers, the public, addiction professionals, and recovery communities until a vanguard of present and former MAT patients and their families stand together publicly to declare, "We are the evidence"—the living proof of the role methadone and other medications can play in long-term recovery from opioid addiction. Stigma-related research would suggest that changes in attitudes toward MAT are most likely to occur not from acceptance of addiction as a brain disease, but through identification with an admired public figure or persons in recovery from one's family, social, or occupational network who have benefited from MAT.[33-37]

Summary

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

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Recovery as an Organizing Paradigm

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

These activities were influenced by and unfolded within larger transformations within the culture of recovery in the United States. Such changes included the growth and diversification of recovery mutual aid societies, the rise and increased vibrancy of a new recovery advocacy movement, the growth of grassroots recovery community organizations, new recovery support institutions (e.g., recovery community centers, recovery homes, recovery schools, recovery industries, recovery ministries, recovery cafes), and a more fully developed culture of recovery with its own history, heroes, values, language, literature, and folkways that transcended those of particular recovery mutual aid societies.[9] It is within this context that the addictions field has witnessed increased interest in the varieties of recovery experience,[10] expansion of peer-based recovery support services,[11] pioneering models of post-treatment monitoring and support,[12-15] and calls for a recovery research agenda.[16] Also of note are efforts to apply the recovery concept in different clinical and cultural contexts.[17]

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

Medication and Recovery in Historical Context

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

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

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

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

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

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

Medication and the Question of Recovery Status

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

Groups associated with mainstream, abstinence-based treatment, such as the Betty Ford Institute Consensus Panel, have in recent years taken the position that the remitted, stabilized methadone maintenance patient who does not use alcohol or illicit drugs and who takes methadone and other prescribed drugs only as indicated by competent medical practitioners meets the first of these defining elements of recovery.[26] For MAT patients who achieve recovery via these three dimensions, continued participation in medication maintenance or eventual tapering and recovery without medication support represent varieties of recovery experience and matters of personal choice, not the boundary of passage from the status of addiction to the status of recovery.

Defining recovery within the context of MAT requires cultural and professional understanding of the distinction between *addiction* and *physical dependence* and, for the MAT patient/family, an understanding of the distinction between use of a *medication* as an aid to recovery and use of a *drug* as a threat to recovery. Debate will continue into the foreseeable future over whether the terms *recovery* and *remission* should be synonymous or whether recovery involves more than remission (and whether *recovery* applies only to abstinence-based remissions). These are important distinctions. Remission involves the subtraction of pathology

from a patient's life; recovery conveys ingredients added to a patient's life, e.g., remission plus the achievement of global (physical, emotional, relational, spiritual) health, social functioning, and enhanced quality of personal/family life in the community. The emerging three-component definition of recovery has profound implications for the future design, conduct, and evaluation of addiction treatment and related recovery support services.

Recovery in the Context of Methadone Maintenance

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

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

ROMM is a framework for the treatment of opioid addiction that combines pharmacotherapy and a sustained menu of professional and peer-based recovery support services to assist patients and families in initiating and maintaining long-term addiction recovery—during medication maintenance and, for those who choose to taper, throughout and following the tapering process.

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

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

Table 2: ROMM Service Practices

Recovery-oriented MAT seeks to:
attract people at an earlier stage of problem development via programs of assertive community education, screening, and outreach; ensure rapid service access for individuals and families seeking help; resolve obstacles to initial and continued treatment participation; achieve safe, individualized, optimum dose stabilization;

engage and retain individuals and families in a sustained recovery-focused service and support process;
assess patient/family needs using assessment protocols that are global, family-centered, strengths-based, and continual;
transition each patient from a professionally-directed treatment plan to a patient-directed recovery plan;
expand the service team to include primary care physicians, psychologists, social workers, peer recovery support specialists, and indigenous healers;
shift the service relationship from a professional/expert model to a long-term recovery partnership/consultation model marked by mutual respect, hope, and emotional authenticity;
ensure minimum (at least one year) and optimum (individualized) duration of treatment via focused retention strategies and assertive responses to early signs of disengagement;
shift the treatment focus from an episode of care to the management of long-term addiction/treatment/recovery careers;
expand the service menu to include ancillary medical/psychiatric/social services and non-clinical, peer-based recovery support services;
extend the locus of service delivery beyond the OTP to non-stigmatized service sites and neighborhood-based, church-based, work-based, home-based, and technology-based (phone/Internet) recovery support services;
assertively link patients/families to recovery community support resources;
engage the community through anti-stigma campaigns and recovery community development activities;
provide post-treatment monitoring and support and stage-appropriate education, support, and (if and when needed), early re-intervention for all patients regardless of discharge status; and
evaluate MM treatment using proximal and distal indicators of long-term personal and family recovery (Excerpted from White & Mojer-Torres, 2010, with permission).[18]

Changes in service practices within ROMM are best thought of not as innovations but as a retrieval and extension of the best practices within the history of addiction treatment in general and MAT in particular. The conceptual and practice silos of medication-assisted treatment and "drug free" treatment will progressively dissipate within the addiction treatment field.[30,31] All people seeking help will have access to a comprehensive menu of professional and peer-based recovery services. Formerly siloed MAT patients will have access to a full menu of psychosocial support services, and formerly siloed "drug free" treatment settings will provide pharmacotherapeutic support for those who can benefit from it. Such integration will parallel methods that are now standard practice in the treatment of other chronic health disorders such as asthma, diabetes, hypertension, and cancer.

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

Stigma, Recovery, and Patient Advocacy

Addiction- and MAT-related social stigma contributes to social isolation, reduces help-seeking, and undermines long-term recovery, particularly among those with multiple discrediting identifiers, e.g., addiction, MM treatment, psychiatric illness, HIV/AIDS, minority status, poverty,

homelessness. Persons in MAT, particularly those enrolled in MM, have never received full status as a "patient," and the OTP has yet to be viewed as a place of healing on par with hospitals or outpatient medical clinics. The historical stigma attached to methadone and the broader arena of medication-assisted treatment has denied MAT patients the status of recovery and left them isolated from mainstream community life and existing in limbo between cultures of addiction and cultures of recovery.

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

Three broad social strategies have been used to address stigma related to addiction and related disorders and their treatment: 1) personal or mass protest (advocacy), 2) public and professional education, and 3) strategies that increase interpersonal contact between stigmatized and non-stigmatized individuals and groups.[32] It is unlikely that the recovery status of the MAT patient will be fully embraced by policy makers, the public, addiction professionals, and recovery communities until a vanguard of present and former MAT patients and their families stand together publicly to declare, "We are the evidence"—the living proof of the role methadone and other medications can play in long-term recovery from opioid addiction. Stigma-related research would suggest that changes in attitudes toward MAT are most likely to occur not from acceptance of addiction as a brain disease, but through identification with an admired public figure or persons in recovery from one's family, social, or occupational network who have benefited from MAT.[33-37]

Summary

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

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Integration of Parenting Skills Education and Intervention in Addiction Treatment

Abstract

OBJECTIVES: Children of parents with substance use disorders are at risk for various adverse outcomes, and maladaptive parenting behaviors seem to be an important mediator of this risk. Although numerous research studies have highlighted the promise of parenting interventions in modifying parenting behavior, very little is known about the integration of parenting skills education and interventions into addiction treatment programs.

METHODS: In this study, a convenience sample of 125 addiction treatment programs in the United States was drawn. A key staff member was interviewed to gather basic information about the extent and nature of parenting skills education and interventions offered at their program. In addition, respondents were asked to rate the importance of parenting skills relative to other addiction treatment priorities.

RESULTS: Descriptive analyses revealed that 43% reported some form of parenting classes, but few used a structured curriculum.

CONCLUSIONS: Given the known beneficial influence of effective parenting practices on reducing adverse childhood outcomes, it is surprising that relatively few substance abuse treatment programs have adopted structured parenting skills interventions as part of their standard service offerings. More research is warranted on the extent to which parenting skills interventions are integrated into the continuum of services available to parents with a substance use disorder.



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Why does the addiction treatment field continue to tolerate smoking instead of treating it?

Thomas F. Hilton, PhD and William L. White, MA

Introduction

Treated addicts who never smoked, or quit smoking, have been found to recover faster and remain abstinent longer than those who continue smoking. There is growing epidemiological evidence that smoking cessation is associated with successful recovery (Lemon, Friedmann, & Stein, 2003), and clinical outcomes research shows improved recovery outcomes for those who quit smoking (Bobo, McIlvain, Lando, Walker, & Leed-Kelly, 1998; Burling, Marshall, & Seidner, 1991; Hurt et al.,1994; Martin et al., 1997; Prochaska, Delucchi, & Hall, 2004; Stuyt, 1997; Toneatto, Sobell, Sobell, & Kozlowski, 1995). Several studies have reported that a majority of clients entering addiction treatment want to quit smoking as well as cease using other drugs (See Knudsen, Boyd, & Studts, 2010), and yet, smoking cessation has not been widely implemented as a routine clinical intervention in addiction treatment. While this situation may reflect a lack of leadership by federal and state agencies, professional organizations, and funding and regulatory bodies (Coffman, et al. 2011; Muilenburg, Eby, & Conway, 2011), Brett Fuller and his colleagues (2007) found that smoking cessation activities in addiction treatment are directly related to counselor attitudes about smoking and addiction. A better-informed addiction counselor workforce may well achieve what administrators and public health officials have been unable to do: integrate smoking cessation with addiction treatment.

This paper will briefly review the attitudes of addiction treatment clients, counselors, and administrators toward smoking, review health facts regarding smoking among persons experiencing or recovering from other substance use disorders, and examine smoking cessation through the growing understanding of the neuroscience of addiction. The paper will conclude with a discussion of what might be done to integrate the treatment of tobacco addiction within current addiction treatment.

Client Smoking Rates and their Consequences

A recent review of 40 studies reported that between 70% and 90% of people entering addiction treatment are smokers (Guydish et al., 2011)—more than triple the 20.6% national smoking prevalence rate. Smoking rates appear to be particularly high

(about 90%) and smoking quit rates particularly low among methadone maintenance patients (Guydish et al., 2011; Okoli et al., 2010). Such findings are alarming. Tobacco use kills more Americans each year than alcohol and drugs combined (Degenhardt & Hall, 2010; U.S. Department of Health and Human Services, 2000), and persons discharged from addiction treatment are more likely to die of tobacco-related diseases than they are from the consequences of other drug use (See review in Richter, Ahluwalia, Mosier, Nazier, & Ahluwalia, 2002). Smokers die an average of 22 years sooner than nonsmokers (Neumark, Van Etten, & Anthony, 2000), and the quality of their last years is often severely compromised due to the effects of such conditions as lung and esophageal cancers, respiratory disorders, heart disease, and strokes.

Field Perceptions of Smoking and Recovery

During the past three decades, studies have consistently reported addiction counselor fears that integrating nicotine addiction with treatment for other drugs would be anti-therapeutic (Bobo & Gilchrist, 1983; Bobo, Slade, & Hoffman, 1995; see also the review by Guydish et al., 2011). Some counselors and administrators have also viewed smoking as a therapeutic coping strategy that actually aids recovery from other addictions (Coffman et al., 2011; Walsh, Bowman, Tzelepis, & Lecathelinais, 2005). In a 2010 study of addiction counselor attitudes toward smoking and treatment outcomes, nearly 40% of those surveyed did not report a positive link between smoking cessation and client recovery outcomes (Knudsen & Studts, 2010). In a just-published study of 261 addiction counselors and 80 clinical supervisors, an improved rate of addiction recovery was not listed among the top 12 positive outcomes of smoking cessation (Eby, Sparks, Evans, & Selzer, 2012). More than 60% of counselors also report reservations about the effect a smoking ban might have on patient enrollment (Muilenburg et al., 2011). Another barrier to integrating smoking cessation into addiction treatment may well be addiction counselors' own rate of nicotine addiction, which is higher than the national average (Rothrauff & Eby, 2011). Studies have consistently shown that smoking counselors are less likely to encourage smoking cessation among their clients (Bobo & Gilchrist, 1983). But attitudes toward smoking among counselors may be changing. In a recent national survey, only 8% of counselors opposed integrating smoking cessation with drug and alcohol treatment, while only 19% objected to the notion that tobacco cessation was as important to treat as other drugs (Muilenburg et al., 2011).

Research versus Practice

Studies of clients entering addiction treatment consistently find that most clients want to stop smoking as well as stop alcohol and other drug use. Studies by Teater and Hammond (2010) as well as Toussaint, VanDeMark, Silverstein, and Stone (2009) found that most addiction treatment patients are interested in smoking cessation as well as achieving abstinence from illicit drugs. A meta-analysis study by Prochaska et al. (2004) found that smoking cessation during addiction treatment has no effect on rates of treatment retention or completion.

There is no scientific evidence that smoking is a helpful crutch in getting off or staying off alcohol and other drugs. The success of integrated smoking cessation and addiction treatment programs reviewed by Hall and Prochaska (2009) refutes the notion that smoking reduces post-detoxification cravings or emotional distress. A NIDA Clinical Trials Network study showed that integrated tobacco treatment did not interfere with drug treatment effectiveness, including for patients enrolled in agonist-assisted recovery (Reid et al., 2008). In fact, evidence is mounting that continued smoking retards the pace of recovery, and may actually be a significant factor in addiction relapse. Baca and Yahne (2009) reviewed smoking cessation studies between 1990 and 2008, and concluded that

data overwhelmingly showed that addiction treatment clients who never smoked or ceased smoking enjoyed longer recovery periods than those who continued to smoke.

Given the compelling evidence that smoking is neither healthy nor aids recovery from other addictions and the high tobacco-related mortality rates of those treated for other addictions, one might speculate that smoking cessation efforts would be rising. Alas, that does not seem to be the case. In fact, there is some evidence of backsliding. A 2011 report of a national study showed that nicotine replacement therapy was offered in 38% of addiction treatment programs, but after four years, the percentage had dropped to 34% (Knudsen & Studts, 2011). Earlier findings from this same study showed that only 19% of addiction counselors work in a setting in which there is a comprehensive ban on tobacco use (Knudsen et al., 2010). Another national survey found that 45% of addiction treatment facilities did not offer smoking cessation, that about the same percentage did not screen for smoking at intake, and that 38% still allowed clients to smoke in the facility (Vashisht et al., 2011).

Addiction Recovery and Smoking – What Neuroscience Research Is Telling Us

The notion that smoking undermines recovery and that smoking is a central issue that should be addressed in addiction treatment is not new. More than 20 years ago, the late Bob Battjes, a NIDA public health officer, published an article in *Addictive Behaviors* calling for the integration of smoking cessation in alcohol and drug addiction treatment (Battjes, 1988). Five years later, a special issue of the *Journal of Substance Abuse Treatment* included 19 articles supporting the integration of smoking cessation within addiction treatment (Karan, 1993). David Kalman published a review in 1998 addressing smoking and recovery in *Substance Use & Misuse* citing numerous studies showing that integrated treatment is successful with no affect on retention in treatment. In the more than two decades since those early calls for integrating smoking cessation with addiction treatment, the field has showed relatively little change (Knudsen, Studts, & Studts, 2012). Although integrated drug and alcohol treatment has moved from rarity to common practice, integration of tobacco cessation continues to elude widespread implementation.

All addiction involves overlapping brain systems (Koob & Le Moal, 2008). It is as illogical to treat alcohol and drug addiction while ignoring tobacco addiction as it would be to treat cocaine addiction while ignoring opiate addiction. There is growing evidence that nicotine dependence can undermine recovery from other drug addictions. At a molecular level, Li and Wang (2007) concluded that the protein profiles of smokers were indistinguishable from individuals addicted to alcohol and drugs. At the neuronal level, a 2010 review by Maldonado and Berrendero summarized an addictive cycle of electrochemical stimulation in the brain responsible for modulating the dopamine system. Their empirically derived model involves both the same cannabinoid and opioid receptors associated with opiate addiction, and shows the same reaction when the brain is exposed to nicotine as when exposed to other drugs. They even cite evidence that smoking-associated environmental cues interact with drug-associated cues to sustain addiction.

Eminent neuroscientists George Koob, editor of *Addiction Medicine*, and Nora Volko, Director of the *National Institute on Drug Abuse*, have both individually and jointly published articles about how the brain's reward system uses dopamine and other neurotransmitters to create the vicious cycle that results in addiction. One brain study in particular is worth mentioning. Scott et al. (2007) found that smoking (nicotine) activated opioid receptors and stimulated dopamine neurotransmission in the human brain. That smoking increases vulnerability to relapse via dopamine is consistent with the popular Incentive-sensitization theory of alcohol and drug addiction in neuroscience (Gardner, Tapper, King, DiFranza, &

Ziedonis, 2009; Robinson & Berridge, 1993, 2001). Our key point here is that dopamine and related neurological systems seem to be the biological epicenter of all addictive processes. Thus, keeping that addictive neurological process of drug abstaining individuals stoked with addictive substances such as nicotine is self-defeating based on the fact that nicotine interferes with a return to normal dopamine functioning in the brain.

Addiction Recovery and Smoking – What Health Services Research Is Telling Us

There is growing empirical evidence that smoking interferes with recovery (Patkar et al., 2003; Sullivan & Covey, 2002; Toneatto et al., 1995). A 2007 five-year follow-up with 598 drug and alcohol patients found that 53% were smoking at five-year follow-up. Those who smoked were less likely to be abstinent in the past 30 days and had higher Addiction Severity Index Scores than non-smokers (Satre, Kohn, & Weisner, 2007).

Neuroscience, treatment, and recovery outcomes research all provide compelling evidence that leaving any drug in the brain is likely to interfere with abstinence from all of them. Studies have shown that smoking cessation improves treatment outcomes for alcoholism (Bobo et al., 1998; Sobell, Sobell, & Kozlowski, 1995) and other drug addictions. A 2004 meta-analysis of 19 clinical trials concluded that smoking cessation during addiction treatment was associated with a 25% increase in rates of long-term recovery (Prochaska et al., 2004). The success of integrated programs reviewed by Hall and Prochaska (2009) also refutes the notion that smoking is a necessary crutch to help with post-detoxification craving. A NIDA Clinical Trials Network study showed that integrated tobacco treatment did not interfere with drug treatment effectiveness including clients enrolled in agonist-assisted recovery (Reid et al., 2008).

The belief of some counselors in the therapeutic effects of smoking during addiction recovery (as documented by Bobo & Gilchrist, 1983; Bobo et al., 1995; and Guydish et al., 2011) is simply not supported by scientific studies of smoking and recovery outcomes. Hall and Prochaska have systematically addressed those misconceptions in their 2009 review of the research literature and presented data to refute them. A second 2009 review by Baca and Yahne outlined numerous studies showing that nonsmoking addiction treatment clients enjoyed longer recovery periods for both alcohol and drugs than smokers. Studies in both the US and Europe included in these reviews confirm that integrating nicotine treatment with addiction and/or mental illness treatment does not increase dropouts or otherwise adversely affect treatment outcomes for comorbid conditions.

Addiction Treatment and Smoking Interventions

Some counselors may be concerned that there are no effective treatments for nicotine addiction, but there is a mountain of research indicating the effectiveness of nicotine replacement therapy (NRT) for helping smokers stop, including smokers addicted to other drugs (Wu, Wilson, Dimoulas, & Mills, 2006). Most behavioral interventions have been shown to be effective in trials as well (Baca & Yahne, 2009), but these effects have been generally modest unless paired with NRT (Agboola, McNeil, Coleman, & Bee, 2010; Campbell, Krumenacker, & Stark, 1998). Nicotine replacement therapy seems to be the most popular approach currently used by addiction treatment providers (Knudsen & Studts, 2011); however, as in the case of illicit drug addiction treatments, there is a vast array of efficacious interventions for smoking cessation, and smokers need to be encouraged to persevere until they find one that works well for them (Ahmed & Hilton,

1982; Marlatt & Witkiewitz, 2005; Shiffman, 1993).

Fiore and Baker (2011) published a handy overview of cessation treatment in the *New England Journal of Medicine*. The article includes tables with step-by-step guidance for healthcare providers in their interaction with smokers, contains an easy-to-understand summary of cessation medications that includes doses and applications, and even offers a table of side effects of treatments. The 2009 Baca and Yahne article cited earlier is filled with advice aimed at helping addiction professionals integrate smoking cessation with addiction treatment.

The US Public Health service has a downloadable book in PDF form containing clinician guidelines for helping smokers quit. It is available through the Agency for Healthcare Research and Quality at http://www.ahrq.gov/path/ tobacco.htm. The National Cancer Institute also sponsors www.smokefree.gov, which contains online tools for smokers.

One tactic that makes sense when dealing with drug addicted clients is to exploit the intent to treat that motivated enrolling in a program to get drug free, and point out that nicotine, like heroin, cocaine, etc., is a highly addictive drug that may interfere with a client's ability to maintain illicit drug abstinence. Such discussions can be guided by easily understood explanations of the dopamine system such as the one available on the university of Texas website, http://www.utexas.edu/research/asrec/dopamine.html, or NIDA's website http://m.drugabuse.gov/publications/teaching-packets/neurobiology-drug-addiction.

Concluding Remarks

This review has outlined scientific evidence challenging the contentions that smoking is a therapeutic aid in recovery from other addictions and that smokers entering addiction treatment do not want to quit smoking. Evidence was also presented that smoking cessation enhances long-term addiction recovery outcomes, that effective smoking cessation treatments currently exist, and that such approaches can be effectively integrated into mainstream addiction treatment settings. What is lacking at this time is not science, but the will of leaders in the field to act on the available science. It is time, no past time, to integrate smoking cessation within addiction treatment. We call on all addiction professionals to step forward and assist with this critical milestone in the history of addiction treatment and recovery.

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From Bias to Balance: Further Reflections on Addiction Treatment Medications

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The iconic image that pervades pharmacotherapy of opioid addiction is a shadowed face drinking a pale green liquid from a plastic medicine cup. The image of a faceless, voiceless person is apt as the historical stigma attached to the use of medications in the treatment of opioid use disorder is so great that few have braved stepping into the light to share their lived experience of medication-assisted recovery. Poised on opposing sides of this image are medication haters and medication advocates, each offering radically different views on the potential value, risks, and limitations of medication support in recovery from opioid addiction. One finds on both sides people who have negative and positive personal and professional experiences in the use of these medications, people grinding innumerable ideological axes, and people whose organizational destinies, personal careers, and financial interests are vested in the outcome of decisions to use or not use medication as an aid to addiction recovery.

For years, I have tried to forge bridges of communication across the polarized, vitriolic debates surrounding the use of medications in the treatment of addiction. I have illuminated the history and current status of medications in the treatment of addiction (White, 2014; White, 2012; White, Parrino, & Ginter, 2011) and reviewed the policies toward medication of major recovery mutual aid societies (White, 2011). I have championed the value of key medications and the legitimacy of medication-assisted recovery (White, 2007; McLellan & White, 2012). And I have called on medication-centered addiction treatment providers to dramatically expand the scope of their recovery support menus and elevate the quality of their service practices (See White & Torres, 2010). This latest missive seeks to lessen the challenges and confusion faced by affected individuals and families as they sort the pro-medication and anti-medication polemics within public, professional, and social media.

The intended goal of this paper is to help recovery advocates understand some of the complexities and limitations involved in the use of medications and to better understand the positions of some who reject the use of medications as a panacea for opioid and alcohol use disorders. The hope is that recovery advocates can help educate

affected individuals and families on the limitations of medications at the same time they assert their potential value. There is limited long-term value in replacing a mindless ant-medication bias with an equally mindless pro-medication bias. The challenge for recovery advocates is to forge a source of reliable information between the extremes of "Never" among the rabid medication haters and "Always and Forever" among the most passionate medication advocates. In our efforts to promote the legitimacy of multiple pathways of recovery—including medication-supported recovery, we need far more nuanced discussions of the potential value, the limitations, and the possible contraindications of medications across the stages of recovery. And those discussions must begin with the premise that the sources of the deeply rooted biases against and for the use of medications in treating addiction are far more complex than simply the ignorance or embrace of the latest scientific evidence on addiction treatment and recovery.

Medications (e.g., methadone, buprenorphine, and naltrexone) in the treatment of opioid addiction are frequently characterized as the "gold standard" in the scientific and medical literature and popular media (Kampman et al., 2015), Research reviews of psychosocial treatment approaches to opioid use disorders conclude that "many empirically-supported approaches for non-opioid SUD have weak or insufficient evidence to support their utility for opioid use disorder…" (Bergman, Ashford, et al, 2019). Yet, considerable resistance to the use of medications to treat opioid addiction can be found in the United States among the public, people seeking recovery, members of abstinence-based recovery mutual aid groups, addiction treatment professionals, and allied health professionals (White, 2011; Bergman et al, 2019; White, Parrino, & Ginter, 2011; Roman, et al., 2011; Kepple, et al., 2019; Andraka-Christou, et al,m 2019). Media coverage as well as technical reports on the surge in opioid addiction and related deaths consciously or inadvertently convey the impression that the "opioid epidemic" could be resolved if we could just get enough naloxone, methadone, buprenorphine, and naltrexone disseminated across the country. These same reports state or imply that the major obstacles to such dissemination are ignorance and social/professional stigma.

While not discounting the need for public and professional education on opioid addiction and wide dissemination of the scientific evaluations of opioid addiction treatments, there are less mentioned impediments related to the use of medications that deserve prominence within our discussions of the potential role of medications in recovery from opioid addiction. Below is a brief sampling of such issues with related suggestions for recovery advocates and recovery support specialists.

History of Iatrogenesis (treatment-caused harm)

Medications originally lauded as addiction cures have later emerged as drugs with considerable addiction liability in their own right. This history includes the use of cocaine and methamphetamines in the treatment of morphine addiction, morphine used in the treatment of alcohol addiction, and the broader pattern of harm from a wide spectrum of psychotropic substances used to treat opioid or alcohol addiction (e.g., hallucinogens, sedatives, anxiolytics, and neuroleptics). Knowledge of the iatrogenic effects of earlier treatments is deeply imbedded within cultures of addiction and recovery in the U.S. That collective, intergenerational memory elicits suspicion of any new medication claiming to be a cure or treatment for addiction. This does not mean that new medications should be automatically dismissed, only that they be subjected to rigorous and sustained scientific, clinical, and personal investigation. It also means that any initial distrust of medications from members of recovery communities should be respected by recovery advocates as grounded in the experiential knowledge of those communities. Our first task is to listen and

learn, mirroring the very thing we are asking of members of these communities.

Claims of new medical breakthroughs in the treatment of opioid addiction should be viewed skeptically until controlled studies as well and clinical and personal experience justify their value across diverse populations and cultural contexts. Historically, highly amplified claims of such breakthroughs are notoriously unreliable. The downside of this history is that if we view the present and future only through this lens of the past, we may dismiss without investigation major breakthroughs in addiction treatment and recovery. Any potential harm from medications must be viewed within the context that this same potential exists for psychosocial interventions in addiction (Moos, 2005).The key is our ability to objectively portray the potential value and risks of ALL treatment and recovery support options so that affected persons can make informed choices.

Complex Personal Histories

People addicted to opioids have commonly used methadone and buprenorphine within the illicit drug culture as a substitute for heroin or prescription opioids, to stave off acute withdrawal, or as an attempted self-cure (Chilcoat, et al, 2019). The fact that methadone and/or buprenorphine are so intertwined within addiction histories explains the confusion, suspicion, or outright animosity when these now christened "medications" are offered as a treatment for addiction. Working through resistance to medications in the face of such resistance or ambivalence requires understanding, time, and skill, as well as respect for patient preferences regarding treatment options. The above-noted history of addiction medications and such personal addiction histories offer context on why members of particular recovery mutual aid groups may be resistant to the use of maintenance medications in the treatment of addiction. It is important that recovery advocates understand the sources of such views if they are to escape responding to such views with little more than condescension and contempt.

A distinction that some have found helpful is between past use of a "drug" for addiction maintenance and the use of professionally prescribed and supervised "medication" for recovery support—even when the "drug" and the "medication" may involve the same substance. What differs is the motivation for use, the context of use (the presence of medical supervision), reliable purity, a personally optimal dosage that provides metabolic stabilization without impairment from intoxication or withdrawal, method of administration, and availability of ancillary psychosocial recovery supports (For elaboration, see White & Torres, 2010).

When recovery advocates encounter such categorical resistance, the essential tasks are to listen, acknowledge the limitations of medication-assisted treatment for some populations, express gratitude that some people have been able to achieve recovery without medication support, elicit as clearly as possible the sources of resistance to medication support, provide facts that heighten incongruity and ambivalence about value of medication for some people, share successful stories of medication-assisted recovery, and create opportunities for contact with people who have achieved such recoveries. Every effort should also be made to discourage people in recovery from encouraging others to cease medication use or lower their dosage of medication: in one study, 25% of people taking buprenorphine and also attending NA meetings had been encouraged to stop or decrease medication use (Monico et al, 2015).

Indications and Contraindications

A standard practice with all medications is to define the precise condition a medication is best suited to treat and those patients who, because of potential harm, should not be prescribed the medication. After more than a century of treating opioid addiction with medications, and with full knowledge that people recover from opioid addiction with and without medication

support, we as a professional field still have not clinically defined who is most indicated and contraindicated for pharmacotherapy of opioid addiction. Answering this question would mark a major step forward within the addictions field. The potential risks and benefits of medication support in the treatment of opioid addiction are not uniform across clinical populations. Concern about potential iatrogenic effects of addiction pharmacotherapy have limited access to medication for some populations, e.g., adolescents, young adults, people with early and lower severity opioid dependence (Gonzales-Castaneda, et al, 2019).

The question of potential degree of help or harm of medications in the treatment of addiction is unanswerable without also asking, "For whom?", "For what purpose?", "For how long?", and "At what cost?". Science- or experience-based assistance with this pro-con analysis is particularly needed for the youngest patients seeking treatment for an opioid use disorder, who are presently underrepresented in their access to and utilization of medication support (Hadland et al., 2018). Clearer answers to these questions might alter the situation in which only 35% admitted for opioid use disorder treatment have medications included as a component of their treatment (cited in Bergman, 2019).

Recovery advocates need to have a general knowledge of the evolving science and cumulative clinical experience on indications, contraindications, side-effects, and the overall benefits and risks associated with addiction treatment medications, as well as how to assertively link individuals and families to addiction medicine specialists who can offer a more in depth review of these issues. Advocates can play an important role in advocatinmg research to answer many critical questions related to the pharmacotherapy of opioid addiction with and without tandem delivery of psychosocial recovery supports.

Optimum Duration of Medication and Social Support

The addiction treatment field has yet to reach consensus on the optimal duration of medication support in the treatment of opioid use disorder. There is widespread belief that patients are kept ("parked") on medication forever, but the reality is that many if not most patients who begin medication support for opioid addiction will cease taking such medication within a matter of months. A recent study of more than 4,800 adolescents and young adults diagnosed with opioid use disorder (Hadland, et al, 2018) found that only 24% received pharmacotherapy and of those who did median retention was less than six months for those prescribed buprenorphine or naltrexone and less than a year for those provided methadone. The median duration of treatment for those who received only behavioral health services was just over two months. Treatments for opioid use disorders in the U.S.—those with and without medication support—do not maintain continuity of professional contact remotely close to the established period of recovery stability, which for opioid use disorders is five years of continuous remission (Hser, 2007; Evans & Hser, 2018; for review for all SUDs, see White, 2008).

Although the National Institute on Drug Abuse recommends a minimum of one year of medication maintenance to achieve optimum clinical outcomes[1], as many as half of patients in the U.S. who begin medication support for treatment of opioid use disorder cease medication use within twelve months of induction (Kelly et al., 2011). A recent randomized trial comparing methadone and buprenorphine six-month treatment retention found a 26% dropout rate for

[1] https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/frequently-asked-questions/how-long-does-drug-addiction-treatment; Australian authorities recommend a minimum of 2-3 years of medication support for optimal long-term outcomes: https://www1.health.gov.au/internet/publications/publishing.nsf/Content/drugtreat-pubs-methrev-toc~drugtreat-pubs-methrev-4

methadone and a 54% dropout rate for buprenorphine. In one large study involving more than 700 buprenorphine patients, 25% of patients dropped out in the first 30 days (Hser et al., 2014). An analysis of discharge data from 108,732 U.S. patients discharged from medication-assisted opioid therapy in 2014 is quite telling. Only 19.1% of those patients were discharged with a treatment completed discharge status; 37.6% left against professional advice, and 9.1% were administratively discharged by the treatment facility. Within this same sample, only 23.8% had a treatment duration of more than a year and 50.1% had a treatment duration of less than 90 days.[2]

A critical question, given these rates and timing of discontinuance, is what happens to patients clinically following cessation of medication maintenance. Studies of the natural course of addiction/recovery following cessation of medication support suggest that these medications are "corrective but not curative." This means that for most patients the gains made from addiction medications—like medications used in the treatment of diabetes, hypertension, and numerous psychiatric conditions—are effective only during the period of medication maintenance, with risks of clinical deterioration rising following medication cessation (Evans & Hser, 2018).

An early review of the outcomes of patients discharged from methadone maintenance drew three conclusions: 1) most patients leaving methadone maintenance were not clinically assessed as ready for discharge, 2) the majority of those who began a planned tapering process dropped out before completing that process, and 3) the majority of patients who completed a planned tapering process relapsed to heroin use following discharge (Magura and Rosenblum 2001). Such studies confirm the view of methadone and other agonist and partial agonist medications as corrective but not curative and underscore the need for a full treatment menu and assertive post-treatment recovery support services.

The characteristics of those who drop out of addiction pharmacotherapy and those who are retained are quite different. A recent study of retention in office-based opioid treatment with buprenorphine found the following characteristics associated with shorter retention: Black/Hispanic race/ethnicity, younger age, positive hepatitis C antibody status, and unemployment (Weinstein et al., 2017). Earlier reviews linked shorter retention and persistent opioid addiction to greater clinical severity and complexity, e.g., histories of physical/sexual victimization, co-morbid psychiatric disorders, and lower recovery capital (Hser et al., 2013).

Due to lost tolerance for opioids and rate of recurring opioid use, mortality risks are particularly high in the four weeks following cessation of medication maintenance, risks also shared in the same time period following release from a prison, hospital, or inpatient or residential addiction treatment program (Sordo et al., 2017). Inadequate attention has been given to the process of medication tapering when patients choose to sustain their recovery without medication. Rapid tapering, when attempted clinically (or as a result of sudden patient disengagement) or administratively (most often for continued drug use, violation of clinic rules, or non-payment of services—"feetox") increases risk of adverse events (e.g., opioid-related emergency hospitalization as well as death from overdose). A recent study (Mark & Parish, 2019) of patients who had quickly tapered off high doses of opioids found that more than half experienced a subsequent opioid-related hospitalization or emergency department visit.

[2] Source: Rod Funk, Chestnut Health Systems, analysis of TEDS 2014 discharge data. SAMHSA (2016). Treatment Episode Data Set Discharges (TEDS-D) 2014 data set. Rockville, MD: Author. Retrieved from: https://www.datafiles.samhsa.gov/study-dataset/treatment-episode-data-set-discharges-2014-teds-d-2014-ds0001-nid17151

High treatment attrition, combined with the lack of psychosocial support during and following medication maintenance, contributes to the high addiction recurrence and mortality rates following medication cessation—death rates as high as four times that of patients remaining in treatment (Zanis & Woody, 1998; Sordo, et al., 2017). Public and professional perception of such high morbidity and mortality rates contribute to the negative perception of the long-term value of medication as a treatment for opioid addiction. The resulting bias against medication is not a product of public, professional, or patient ignorance, but results from fundamental design flaws in the pharmacotherapy of opioid addiction. If more positive attitudes toward medication support for recovery from opioid addiction are to be achieved, it will require enhanced strategies of treatment engagement and retention; amplified psychosocial supports to enhance medication adherence, global health, and social functioning (particularly for those with the most severe, complex and chronic disorders and for those choosing to taper off medication); and assertive monitoring and support following cessation of medication maintenance. (See White & Torres, 2010). It is important to disentangle one's views about a medication from the clinical structures within which that medication is delivered.

Action items for recovery advocates related to duration of medication support include the following:

- Educating key constituencies that the benefits of addiction medications accrue with duration of medication support and that medication discontinuance is associated with increased risks of clinical deterioration, addiction recurrence, and death (particularly in the first month of medication cessation),
- Encouraging research to further clarify the extent to which the ideal duration of medication support varies across clinical populations and to isolate those candidates most and least likely to sustain recovery without medication support,
- Collaborating with medication providers on expanding supports for patients during and following medication tapering,
- Collaborating with medication providers to assure that all patients, including drop-outs and those discharged for rules violations, are provided post-treatment monitoring, support, and early re-intervention services, and
- Advocating against arbitrary limits on duration of medication maintenance in the treatment of addiction.

Medications and Clinical Complexity

FDA-approved medications for treatment of addiction are drug specific meaning that their positive effects extend only to a certain class of drugs, e.g., the use of methadone or buprenorphine to produce functional stabilization and suppression of craving of heroin or other opioids. While valuable, such specificity limits their clinical utility due to the following: 1) polydrug use (compared to mono-drug use) is the norm for people entering addiction treatment, a clinical profile challenging the very concept of "drug of choice,"[3] 2) polydrug use is associated with greater psychopathology, high impulsivity and risk-taking, lower rates of treatment completion, and higher rates of post-treatment addiction recurrence, 3) polydrug use is associated with higher risks of in-treatment and post-treatment mortality, and 4) varying drug combinations and sequences pose different clinical challenges affecting the design of treatment and recovery support services (Wang et al., 2017). The effectiveness of medications aimed at opioid and alcohol use disorders is undermined by the presence of so-called "secondary" drug use via two mechanisms:

[3] See following for multiple drug use patterns among treatment admissions: https://www.samhsa.gov/data/sites/default/files/TEDS2012N_Web.pdf

1) functional impairment due to continued or escalating use and increased untoward effects of "secondary drugs" for which no medications are available, and 2) recurrence of primary drug use while under the influence of secondary drugs, e.g., alcohol use increasing risk of recurring opioid use (Staiger et al., 2013).

Long-term follow-up studies of people with opioid use disorders find that of the substantial portion (between a third and half) of those who achieve stable recovery (five plus years of opioid abstinence) are marked by far less problem severity and complexity and greater recovery capital (e.g., education, employment, family and social support) than those who do not achieve such abstinence (Zhu et al., 2018; Hser et al., 2001; Drake et al., 2015). Tragically, those patients with the most severe and complex clinical profiles are most likely to be administratively discharged from medication-assisted treatment, drop out of such treatment, and die following treatment disengagement (Svensson & Andersson, 2012).

Also unclear are the potential differences between those who achieve stable recovery from an opioid use disorder via addiction pharmacotherapy and those who achieve such sustained recovery without medication support. Nearly 40% of Narcotics Anonymous (NA) members report regular use of narcotics prior to their NA involvement, and NA members report an average of 8.2 years of continuous recovery.[4] This would seem to challenge the dour prospects of recovery from opioid addiction without medication support that one finds dominating professional and popular literature, yet such recoveries from opioid use disorders within NA remain a rare focus of scientific study (White et al., 2016). Additional research comparing and contrasting these varieties of recovery experience (with and without medication support) could have profound implications for the future design of addiction treatment and recovery support services.

The overwhelming majority of addiction medication providers assert the value of psychosocial interventions as a critical component of addiction treatment, but little more than a third report that their organizations and local communities have the resources to provide such interventions for patients using medication to support recovery from an opioid disorder (Lin et al., 2019; Kermack et al., 2017). While the value of adjunctive professional counseling continues to be debated, with research studies showing mixed results, there have yet to be studies combining medication, counseling, harm reduction education, recovery mutual aid participation, and peer-based recovery support services. Collaborations between medication providers, local harm reduction and recovery advocacy organizations, and local recovery mutual aid groups hold promise in filling this void in adjunctive services.

Action items for recovery advocates based on these findings include the following:

- Inform people involved in broad patterns of polydrug use who are considering medications for opioid or alcohol use disorders of the limited value of these medications for other patterns of drug use and encourage them to seek multimodality/integrated treatment that can address the full scope of their drug use and related problems.
- Inform people involved in broad patterns of polydrug use about the effects of polydrug use on recovery outcomes and, in particular, the increased risk of death from overdose and other causes that are linked to such patterns of use.
- Encourage treatment programs relying upon medications as their primary treatment intervention to broaden clinical menus to address polydrug use

[4] https://www.na.org/admin/include/spaw2/uploads/pdf/pr/MembershipSurvey_2016.pdf

and commonly co-occurring medical and psychiatric disorders.

- Encourage and support local treatment programs to create high intensity support tracks—integrating medication, harm reduction interventions, high-intensity clinical care, and peer recovery support services—for those individuals with the most complex clinical profiles.
- Encourage local treatment programs to explore programmatic alternatives to administrative discharge.
- Encourage research on the course of recovery from opioid use disorder following cessation of medication support and studies comparing and contrasting successful opioid recovery with and without medication support across levels of problem severity.
- Encourage creation of medication-friendly groups within existing recovery support groups and specialized groups for those in medication-assisted recovery, e.g., Methadone Anonymous, Moms on Methadone, Medication-Assisted Recovery Anonymous, and Medication Assisted Recovery Communities.
- Redirect drug-specific moral panics within local communities toward long-term solutions to the full spectrum of substance-related problems.[5]

Medication versus the Medication Milieu

Negative attitudes toward medications used in the treatment of addiction have been inordinately influenced by the regulatory, financing, and clinical policies within which these medications have been delivered. Negative personal experiences with addiction pharmacotherapy are often based on such things as:

- Inadequate orientation to medication side-effects and poor clinical management of such effects when they occur,
- Clinic location, medication pick-up requirements, and clinic hours that interfere with work, educational pursuits, and family life,
- Arbitrarily high or low medication dosing polices[6] that leave one either impaired by sedation or impaired by breakthrough withdrawal, cravings, and persistent drug-seeking impulses,
- Clinics that serve only as medication dispensaries without an expanded menu of services to support long-term personal and family recovery,
- Punitive induction procedures in which one can be punished (e.g., medication dose reduction) or discharged for positive drug screens or for violating clinic policies[7],
- Personally invasive drug testing procedures imposed on a population with high rates of past sexual victimization (e.g., observed urine drops),
- Poorly trained counselors who function more as behavioral police (focus on coercion and control) than as therapists or clinical advocates,
- Excessive medication costs (pharmaceutical profiteering) combined with clinic management more concerned with payment and profit than clinical progress, and
- Clinic milieus more infused with a culture of active addiction than a vibrant culture of recovery support.

[5] Drug epidemics, rather than spontaneously remitting or responding to policy or professional interventions, most often morph into something else, e.g., cocaine and methamphetamine surges setting the stage for subsequent surges in opioid use. Communities that focused all of their attention in responding to surges in opioid addiction and related deaths will be demoralized when the opioid surge morphs into rapid increases in cocaine and methamphetamine use

[6] Lower medication dosage policies lead to higher rates of opioid and other drug use and higher rates of treatment disengagement (Hser et al., 2014; Timko et al., 2015).

[7] For insight into the harmful effects of involuntary discharge from medication-assisted treatment, see Svensson & Anderson, 2012.

Educating multiple parties about the value of medications in the treatment of opioid use disorders will be ineffective as long as these very real contextual factors are ignored. The status and image of medications in the treatment of addiction will not be elevated until there is a parallel elevation of the quality of care and professional status of those organizations and individuals providing the medication. The potential value of medications in the treatment of addiction will remain limited as long as we fail to address the contextual conditions in which medications are nested. Lacking that, the view of medications such as methadone and buprenorphine will continue to be shaped by the least stabilized patients and the lowest quality service providers.

One of the most important things recovery advocates who support the legitimacy and value of medication-assisted recovery can do is enter into collaborations aimed at elevated the quality of medication assisted addiction treatment.

The Mathematics of Medication

There exists no professional consensus on the domains and measurement instruments that should be used to evaluate the effectiveness of addiction treatment, just as there is no uniform definition of recovery from opioid dependence and the measurable benchmarks of such recovery (Wiessing et al., 2017). To date, scientific studies of methadone, buprenorphine, and naltrexone have emphasized what these medications can subtract from one's life during the period of their use. These studies note the association between medication adherence and elimination or reductions in illicit opioid use, mortality risk, criminality, HIV and hepatitis C infection and transmission risks, emergency services use, and reductions in overall health care costs (reviewed in White and Torres, 2010 and White, Parrino, and Ginter, 2011). Each of these outcomes is a valuable in its own right, but collectively they do not address whether anything is being added to the lives of medicated patients. Studies noting an enhanced quality of physical and emotional health as a result of addiction pharmacotherapy are far less likely to be conducted, professionally cited, or noted in press coverage of the value of medications in the treatment of addiction. This leaves affected individuals and families unclear of many key questions. What are the larger outcomes of medication support in terms of long-term abstinence or remission of the opioid use disorder? What are the long-term effects of medication maintenance on global health and social functioning? To what extent does medication support help repair and elevate the person-family-community relationship, including parent-child relationships? These are questions that remain unclear to potential service consumers as they weigh treatment options and the pro-medication and anti-medication polemics.

Beyond these subtraction and addition effects lies a larger question: Might uniquely combining and sequencing medication and psychosocial supports across the stages of recovery produce dramatically enhanced outcomes (a multiplication effect) beyond those being achieved when these services are provided only in mutually-exclusive silos? The future of treatment for the most severe, complex, and chronic substance use disorders may well lie within the answer to that question.

Recovery advocates and recovery support specialists can play important bridge roles in integrating medication-focused treatment, professionally-directed psychosocial interventions, harm reduction services, and peer-based recovery support services. Such experiments are underway and warrant rigorous evaluation of their effects on long-term recovery outcomes.

Medications in Perspective

Medications can play a valuable role in harm reduction, recovery initiation, and recovery maintenance for populations for whom they are indicated and acceptable, but we do a disservice to those populations, their families, and their communities if we portray medication alone as a panacea for the cure of all opioid addiction and fail to carefully communicate both the potential value and

the limitations of medications. Issues like the above need to be part of our nuanced discussions with those we serve. We similarly do a disservice if we let anti-medication polemics go unchecked within our local and national conversations.

Medications are best viewed as an integral component of the recovery support menu rather than being THE menu, and their value will depend as much on the quality of the milieus in which they are delivered as any innate healing properties that they possess. If the effectiveness of medication-assisted treatment (MAT) programs is compromised by low retention rates, low rates of post-med. recovery support services, and high rates of post-medication addiction recurrence, as this review suggests, then why are we as recovery advocates not collaborating with MAT patients, their families, and MAT clinicians and program administrators to change these conditions?

People seeking recovery from opioid use disorders and their families are in desperate need of science-grounded, experience-informed, and balanced information on treatment and recovery support options—information free from the taint of ideological, institutional, or financial self-interest. In an ideal world, recovery advocates would be a trustworthy source of such information.

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How Many Recovery Attempts Does it Take to Successfully Resolve a Drug or Alcohol Problem? Estimates and Correlates from a National Representatives Study of Recovering U.S. Adults

Abstract

BACKGROUND: Alcohol and other drug (AOD) problems are commonly depicted as chronically relapsing, implying multiple recovery attempts are needed prior to remission. Yet, although a robust literature exists on quit attempts in the tobacco field, little is known regarding patterns of cessation attempts related to alcohol, opioid, stimulant, or cannabis problems. Greater knowledge of such estimates and the factors associated with needing fewer or greater attempts may have utility for health policy and clinical communication efforts and approaches.

METHODS: Cross-sectional, nationally representative survey of U.S. adults (N = 39,809) who reported resolving a significant AOD problem (n = 2,002) and assessed on number of prior serious recovery attempts, demographic variables, primary substance, clinical histories, and indices of psychological distress and well-being.

RESULTS: The statistical distribution of serious recovery attempts was highly skewed with a mean of 5.35 (SD = 13.41) and median of 2 (interquartile range [IQR] = 1 to 4). Black race, prior use of treatment and mutual-help groups, and history of psychiatric comorbidity were associated with higher number of attempts, and more attempts were associated independently with greater current distress. Number of recovery attempts did not differ by primary substance (e.g., opioids vs. alcohol).

CONCLUSIONS: Estimates of recovery attempts differed substantially depending on whether the mean (5.35 recovery attempts) or median (2 recovery attempts) was used as the estimator. Implications of this are that the average may be substantially lower than anticipated because cultural expectations are often based on AOD problems being "chronically relapsing" disorders implicating seemingly endless tries. Depending on which one of these estimates is reported in policy documents or communicated in public health announcements or clinical settings, each may elicit varying degrees of help-seeking, hope, motivation, and the use of more assertive clinical approaches. The more fitting, median estimate of attempts should be used in clinical and policy communications given the distribution.

Kopel, J. & White, W. L. (2019) Evidence and narrative based medicine: A synthesis for addiction medicine? *Alcoholism Treatment Quarterly*,
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ABSTRACT

Within primary health care, evidenced-based medicine (EBM) remains the primary methodology for examining the efficacy of medical treatments. Although EBM has dramatically improved treatment outcomes, it fails to reflect the full spectrum of factors involved in the care and healing of patients. As a result, many physicians have adopted narrative based medicine (NBM) within their clinical practice and research. Unlike EBM, NBM focuses on examining the intertwining narratives found between physician patient relationships and society. In the framework of NBM, the physician aims to utilize the narratives of themselves and their patients to address the relational and psychological dimensions involved in both treatment and healing. Currently, there is a growing movement that seeks to reconnect EBM care models of addiction treatment to the larger and more enduring lived experience of personal and family recovery. Such a synthesis could counter the limitations of both EBM and NBM within the future of medicine.



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Psychedelics and Addiction Recovery: A Bibliography of Classic and Contemporary Literature

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Abstract

Background and Objectives: Physician health programs (PHPs) have demonstrated efficacy, but their mechanism of influence is unclear. This study sought to identify essential components of PHP care management for substance use disorder (SUD), and to assess whether positive outcomes are sustained over time.

Methods: Physicians with DSM-IV diagnoses of Substance Dependence and/or Substance Abuse who had successfully completed a PHP monitoring agreement at least 5 years before the study ($N = 343$) were identified as eligible. Of the 143 (42%) that could be reached by phone, 93% ($n = 133$; 86% male) completed the anonymous online survey.

Results: Virtually all PHP program components were rated as being at least "somewhat helpful" in promoting recovery, with the plurality of respondents rating almost all components as "extremely helpful." The top-rated components were: signing a PHP monitoring agreement, participation in the PHP, formal SUD treatment, and attending 12-step meetings, with each receiving a mean rating of at least 6.2 out of 7. Notably, 88% of respondents endorsed continued participation in 12-step fellowships. Despite the significant financial burden of PHP participation, 85% of respondents reported they believed the total financial cost of PHP participation was "money well spent."

Discussion and Conclusions: Components of PHP monitoring were viewed as acceptable and helpful to physicians who completed the program, and outcomes were generally sustained over 5 years. More studies are needed to confirm these preliminary findings.

Scientific Significance: This study documents the perceived cost-benefit of participation in a PHP among a small sample of program completers.

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Abstract

The treatment of opioid use disorders (OUD) has historically been delivered in two contrasting formats: medication-centered interventions with minimal psychosocial support or the provision of psychosocial and spiritual support without medication access. Few models exist of high-intensity integration of medication and psychosocial support. Congress 60, a non-governmental organization in Iran, exemplifies one such integrative approach. The present study profiles the history, governance structure, clinical philosophy, and treatment methods of Congress 60 and reviews published research to date on Congress 60. Congress 60 embodies a unique theoretical rationale for time-limited medication support, a novel medicinal maintenance agent, an extended medication tapering process, and an expansive definition of recovery (including smoking cessation) – nested within a vibrant, peer-based, family-focused system of psychosocial and spiritual support. The cumulative experience of Congress 60 could inform future efforts to integrate OUD medications and psychosocial support services.