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Recovery-Oriented Methadone Maintenance

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Introduction

There are growing calls to shift the acute-care model of addiction treatment to a model of sustained recovery support analogous to the long-term management of other chronic diseases. A new monograph has just been published by two of the Center of Substance Abuse Treatment's Addiction Technology Transfer Centers and the Philadelphia Department of Behavioral Health and Mental Retardation Services. The papers contained in this monograph explore what this shift means to the design and delivery of methadone maintenance (MM) treatment and the status of MM treatment and MM patients in the United States.

The papers have two primary audiences. For addiction treatment professionals and recovery support specialists who have not worked in methadone maintenance treatment, our goals are to:

- provide a primer on the historical evolution and current scientific status of MM treatment,
- explore the controversies surrounding recovery status and methadone maintenance, and
- enlist readers' support for a model of recovery-oriented methadone maintenance (ROMM).

For addiction treatment professionals, recovery support specialists, and patients and their families directly involved with MM treatment, our goals are to:

- document the dissipation of recovery orientation within the evolution of MM treatment,

- engage readers' support to revive and extend such a recovery orientation,
- discuss MM in the context of recent efforts to define and measure addiction recovery,
- describe core clinical practices within MM that would change in the shift toward a model of ROMM, and
- outline strategies to address the professional and social stigma attached to methadone, MM treatment, and MM patients.

The present article provides readers of *Counselor* with an Executive Summary of three of the four papers contained in this new monograph. Those wishing to read the complete monograph may download it for free at either http://attcnetwork.org/regcenters/index_greatlakes.asp or www.williamwhitepapers.com

Executive Summary

Recovery-Oriented Methadone Maintenance Treatment: I. Historical Context

Recovery-Oriented Methadone Maintenance

Recovery-oriented methadone maintenance (ROMM) is an approach to the treatment of opioid addiction that combines methadone pharmacotherapy and a sustained menu of professional and peer-based recovery support services to assist patients and families in initiating and maintaining long-term addiction recovery—recovery defined here as remission of primary and secondary substance use disorders, enhancement of personal/family health and functioning, and positive community reintegration.

Distinctiveness of ROMM

ROMM provides an alternative to acute care (heroin detoxification or short-term maintenance) and palliative care (medication maintenance as a strategy of personal pacification and

social control). ROMM is a person-centered model of long-term recovery management.

Opioid Addiction as a Chronic Disease

It was the dream of those who developed methadone maintenance that chronic opioid addiction would one day be addressed with the same treatment philosophies and strategies used to manage other chronic medical disorders. Within this framework, the methadone maintenance patient is viewed on par with patients requiring normalizing doses of insulin, anti-convulsive medication, or hypertensive medication and psychosocial support services. Fulfillment of that vision has been thwarted by the strong anti-medication bias that pervades the history of addiction treatment and recovery in the United States.

Early Treatment History

The treatment of opioid addiction in the United States spans nineteenth-century institutional treatment (inebriate homes, inebriate asylums, and private addiction cure institutes); detoxification by private physicians; exotic and sometimes lethal medical withdrawal procedures; fraudulent proprietary home cures; early twentieth-century morphine maintenance clinics; mid-twentieth-century prison-based treatment (“narcotics farms”); and experiments with aversive conditioning, electroconvulsive treatments, psychosurgery, and psychoanalysis. All were characterized by high rates of resumed opioid addiction following treatment cessation.

The Context for Methadone Treatment

Methadone maintenance was pioneered in the mid-1960s in the wake of a dramatic rise in heroin addiction following the Second World War. Therapeutic pessimism regarding traditional approaches to treatment prompted calls by major policy bodies for new experiments in the maintenance of persons chronically addicted to heroin and other opioids. Methadone maintenance developed amidst competing approaches to this problem: mass incarceration, Narcotics Anonymous, ex-addict-directed therapeutic communities, hospital-based detoxification, alternative pharmacotherapies, experiments with civil commitment, and faith-based outpatient counseling clinics.

The Origin of Methadone Maintenance

Methadone maintenance (MM) was pioneered in 1964 by Dr. Vincent Dole, Dr. Marie Nyswander, and Dr. Mary Jeanne Kreek at Rockefeller Institute for Medical Research (now Rockefeller University) and Rockefeller Hospital. Following early studies on its safety and effectiveness, MM was integrated into multi-modality treatment systems in New York, Illinois, Connecticut, Massachusetts, Pennsylvania, and Washington D.C. and then more widely disseminated in the 1970s within a growing national network of addiction treatment programs in the United States.

Early Theoretical Foundations

MM was based on a metabolic theory of addiction that viewed heroin addiction as a genetically influenced, chronic brain disease requiring sustained medical management—a problem of sickness rather than sinfulness. Metabolic stabilization and maintenance (via individualized, optimal daily oral doses of methadone) were viewed as essential for most patients to achieve successful long-term recovery. MM was defined as “corrective but not curative.” It was believed that many, if not most, MM patients would require prolonged if not lifelong pharmacotherapy to sustain their recoveries. In the early-stage theory of MM treatment, biological stabilization was expected to be followed by psychosocial rehabilitation and community reintegration—processes requiring a broad menu of ancillary services and supports.

Early Recovery Orientation

Recovery-oriented practices (those now known to be linked to elevated long-term recovery outcomes) within the early MM model included: 1) rapid access to treatment in early sites (e.g., New York City, Washington D.C.); 2) patient involvement in clinical decision-making; 3) methadone doses (usually 80-120 mgd with no dose ceilings) capable of suppressing withdrawal distress, reducing craving, and inducing a “blockade effect” to other opioids; 4) therapeutic responses to any continued drug use; 5) a chronic care perspective that placed no arbitrary limits on duration of MM participation; 6) emphasis on creating a strong therapeutic alliance

with each patient; 7) use of recovering staff as role models; 8) development of programs for populations with special needs; and 9) the broader mobilization of community resources to respond to addiction, including long-term recovery support needs.

Diffusion of MM

Public and political alarm about heroin-related crime and about heroin use by US soldiers in Vietnam spurred federal investment in addiction treatment and the subsequent diffusion of methadone maintenance in the United States. The number of methadone patients in the US grew from fewer than 400 patients in 1968 to more than 80,000 patients in 1976, with much of that expansion occurring in New York City.

Decreased Recovery Orientation

The regulation and mass diffusion of MM in the 1970s and 1980s was accompanied by changes in treatment philosophy and clinical protocols. The most significant of these changes in terms of recovery orientation included a shift in emphasis from personal recovery to reduction of social harm; increased preoccupation with regulatory compliance; widening variation in the quality of MM programs; the reduction of average methadone doses to subtherapeutic levels; arbitrary limits on the length of MM treatment; pressure on patients to taper and end MM treatment; the erosion of ancillary medical, psychiatric, and social services; and a decreased emphasis on therapeutic alliance between MM staff and MM patients.

The definition of *recovery* during this period shifted from a focus on global health and functioning to an almost exclusive preoccupation with abstinence—then defined as including cessation of methadone pharmacotherapy. The public face of MM became defined by the worst MM clinics and the least stabilized MM patients. Professional, political, and public support for MM as a medical treatment for opioid addiction declined through the late 1970s and early 1980s until the value of MM was revived in the late 1980s as a public health strategy to address the spread of HIV/AIDS. In spite of these challenges, many MM treatment staff continued to promote a vision of recovery, and many MM patients achieved but were forced

to hide their achievement of that vision to avoid the social and professional stigma attached to MM.

Methadone Critics

The inevitable backlash to early media reports of methadone as a miracle cure for heroin addiction spawned numerous critics of methadone maintenance treatment. Critics of medication-assisted treatment, many of whom were competing for cultural and economic ownership of the problem of heroin addiction, alleged that MM: 1) substitutes one drug/addiction for another; 2) conveys a societal attitude of permissiveness towards drug use; 3) fails to address the characterological or social roots of heroin addiction; 4) cognitively, emotionally, and behaviorally impairs MM patients; 5) is a tool of racial oppression and genocide; 6) is financially exploitive; and 7) as a result of these factors, is morally unacceptable.

The Revitalization of MM

Since the early 1990s, there has been a revitalization of MM in the United States. This process has included: 1) the scientific reaffirmation of the effectiveness of MM by prominent scientific, professional, and governmental bodies; 2) increased advocacy efforts by MM patients; 3) an expansion of national MM treatment capacity—most notably within the private sector; 4) national efforts to professionalize and elevate the quality of newly rechristened and accredited Opioid Treatment Programs (OTPs); and 5) an expansion of pharmacotherapy choices in the treatment of opioid addiction, e.g., buprenorphine/Suboxone/Subutex. These developments occurred amidst renewed efforts to publicly and professionally portray opioid addiction as a brain disease that can be medically managed with the aid of methadone and other pharmacotherapies. In spite of such advancements, resistance and hostility toward methadone continue from many quarters.

Recovery-Oriented Methadone Maintenance

Two trends are reshaping the future of MM in the United States: 1) a clearer articulation of addiction as a chronic disorder that is best treated through methods used to manage other chronic disorders, and 2) the emergence of recovery as an organizing

paradigm for the addictions field. If sustained, these trends will profoundly change the nature of all addiction treatment, including MM treatment.

The Future of MM

The future of MM in the United States rests on the collective ability of OTPs to forge a more person-centered, recovery-focused medical treatment for opioid addiction and to confront methadone-related social stigma through assertive campaigns of public education and political/professional influence. It also rests on the mobilization of a grassroots advocacy movement of MM patients and their families. An important next step in the developmental history of MM is to define *recovery* within the context of methadone maintenance and within the broader pharmacotherapeutic treatment of substance use disorders.

Recovery-Oriented Methadone Maintenance Treatment: II. Recovery and Methadone

Defining Recovery within the Context of MM

Controversy and stigma continue to surround the use of methadone maintenance as a medical treatment of opioid addiction, in spite of more than four decades' worth of scientific evidence of its effectiveness. Methadone patients continue to be socially marginalized, and their recovery status continues to be debated—even within the professional field of addiction treatment and within communities of recovery. The question of the recovery status of methadone patients cannot be answered without a clear understanding of what constitutes *recovery* from opioid addiction. The definition of recovery applied to the patient in medication-assisted recovery from opioid addiction should be the same as that applied to recovery from any other substance use disorder.

Recovery as More than Intent

Recovery from opioid addiction is more than exhibiting motivation to stop or decelerate drug use. Defining recovery in terms of “he/she is trying” sets a low bar for expectations related to the

methadone maintenance patient's health, functioning, and quality of life. Defining recovery only as a motivational state also contributes to the professional and social stigma attached to methadone, MM treatment, and the MM patient and inhibits MM patients' positive reintegration into the community.

Recovery as More than Remission

Recovery from opioid addiction is also more than remission, with remission defined as the sustained cessation or deceleration of opioid and other drug use/problems to a subclinical level—no longer meeting diagnostic criteria for opioid dependence or another substance use disorder. Remission is about the subtraction of pathology; recovery is ultimately about the achievement of global (physical, emotional, relational, spiritual) health, social functioning, and quality of life in the community.

Core Elements of Recovery

Recent attempts to define addiction recovery (e.g., Betty Ford Institute Consensus Conference, CSAT Recovery Summit, United Kingdom Drug Policy Commission) have focused on three essential elements: a) the resolution of drug-related problems (most often measured in terms of sobriety/abstinence or diagnostic remission), b) improvement in global health, and c) citizenship (positive community re-integration).

Methadone and Recovery

There is growing professional consensus that the stabilized methadone maintenance patient who does not use alcohol or illicit drugs, and who takes methadone and other prescribed drugs only as indicated by competent medical practitioners, meets the first criterion for recovery. MM patients stabilized on medically supervised, individualized, optimum doses do not experience euphoria, sedation, or other functional impairments from the use of methadone as a medication. For the stabilized MM patient, methadone is NOT a substitute for heroin: the motivations for, effects of, and cultural symbolism of using methadone as a medication are vastly different from those associated with heroin use.

Distinguishing Physical Dependence and Addiction

Physical dependence and addiction are not the same: the stabilized methadone maintenance patient—here defined as the patient who does not use alcohol or illicit drugs and takes methadone and other prescribed drugs only as indicated by competent medical practitioners—does not, like many pain patients maintained on opioid medications, meet key definitional criteria for addiction (e.g., obsession with using, loss of volitional control over use, self-accelerating patterns of use, compulsive use in spite of escalating consequences).

Recovery Status of the MM Patient

Denying “abstinence” or “drug free” status to stabilized MM patients (who do not use alcohol or illicit drugs and who take methadone and other prescribed drugs only as indicated by competent medical practitioners) based solely on their status as methadone patients inhibits rather than supports their long-term recoveries.

Varieties of Medication-Assisted Recovery

For stabilized MM patients, continued methadone maintenance or completed tapering and sustained recovery without medication support represent varieties/styles of recovery experience and matters of personal choice, not the boundary and point of passage from the status of addiction to the status of recovery.

MM Patient and Communities of Recovery

The stabilized MM patient is caught in an ambiguous world—separated from cultures of active drug use, denied full membership in cultures of recovery, and socially stigmatized in the larger community. It is time for recovering MM patients to be welcomed into full membership in the culture of recovery and afforded opportunities to pursue full citizenship in their local communities.

Family Recovery in the MM Context

Rarely has the concept of recovery been applied to the families of MM patients. Opioid addiction severely wounds family and kinship relationships—wounds that feed the intergenerational transmission of drug-related problems. Family recovery involves

healing those wounds; reconstructing family roles, rules, and relationships; and enhancing the resistance/resilience/health of all family members. The ultimate aim of family recovery is breaking the intergenerational transmission of drug-related problems.

Seeking a Vanguard of MM Patients

It is unlikely that the recovery status of the MM patient will be fully embraced by policy makers, the public, addiction professionals, and recovery communities until a vanguard of present and former MM patients and their families stand together to offer living proof of the role methadone can play in long-term recovery from opioid addiction. The faces and voices of healthy, fully functioning MM patients will be the most powerful antidotes to the stigma attached to opioid addiction and methadone maintenance treatment.

Multiple Pathways of Recovery

There are multiple pathways and styles of long-term addiction recovery, and all should be cause for celebration. The MM patient who is stabilized on his/her optimal dose of methadone, abstains from the use of alcohol and other intoxicating drugs, and shows evidence of improving global health and social functioning is in recovery or recovering. Long-term recoveries from opioid addiction with or without the use of methadone (or naltrexone or buprenorphine/Suboxone/Subutex) represent personal styles of recovery and should not be framed in categories of superiority or inferiority, right or wrong, or recovery inclusion or recovery exclusion. Rather than a source of disqualification from recovery status, methadone, provided as a medication under competent medical supervision at proper dosages with appropriate ancillary psychosocial support services, aids long-term recovery from opioid addiction and should be so recognized.

Recovery Definition and the Design of Opioid Treatment Programs

Achieving this vision of recovery as remission, global health, and citizenship for the mass of MM patients will require expanding and elevating the range and quality of clinical and peer-based recovery support services available to MM patients and their families.

It will also require creating the physical, psychological, and cultural space in local communities within which medication-assisted recovery can flourish.

Recovery-Oriented Methadone Maintenance: III. A Vision Statement

The Management of Chronic Disease

Addiction to heroin or other short-acting exogenous opioids shares many of the characteristics of other chronic illnesses. Principles and practices that characterize the effective management of other chronic primary diseases can be adapted to effectively manage and improve long-term recovery outcomes in the treatment of chronic opioid addiction.

Methadone Maintenance and Recovery Management

Recapturing and extending methadone maintenance as a person-centered, recovery-focused treatment of opioid addiction—referred to here as recovery-oriented methadone maintenance (ROMM)—will require a realignment of addiction- and recovery-related concepts, a realignment of core clinical and recovery support practices, and a realignment of the context in which treatment occurs (e.g., policies, regulatory guidelines, funding mechanisms, community recovery support resources). Eight arenas of service practice will be profoundly transformed in the move toward ROMM: 1) attraction, access, and early engagement; 2) assessment and service planning; 3) service team composition; 4) service relationships; 5) service quality and duration; 6) locus of service delivery; 7) assertive linkage to recovery community resources; and 8) long-term recovery check-ups, stage-appropriate recovery support, and when needed, early re-intervention.

Attraction, Access, and Early Engagement/Retention

Methadone maintenance treatment voluntarily attracts more people addicted to heroin and other short-acting opioids than any other addiction treatment modality, but most people in need of treatment for opioid addiction are not currently in treatment, will seek treatment only at late stages of their addictions, will drop out of

treatment before optimum therapeutic effects are achieved, and will experience prolonged addiction/treatment careers before recovery stability is achieved. A key strategy of ROMM is to attract, engage, and retain patients at the earliest stages of problem development, toward the twin goals of shortening addiction careers and extending recovery careers.

Promising practices in enhancing treatment attraction include educational campaigns to reach injection drug users, designed to dispel myths and misconceptions about MM treatment, and assertive community outreach teams that provide visible role models of medication-assisted recovery, engage active users in a “recovery priming” process, mobilize family and kinship support, and resolve obstacles to treatment participation. Access to MM could be increased via expanded public and private funding of MM treatment, distribution of coupons for free treatment, reduction of regulatory obstacles that inhibit rapid access, expedited admission (e.g., interim maintenance—methadone without counseling), and moving stabilized patients to medical maintenance (methadone provided by trained primary care physicians). Promising practices related to engagement and retention in MM include individualized and higher methadone doses (above 60 mgd), increased patient choices, telephone and email prompts following missed appointments, patient education related to the safety and benefits of MM, provision of sustained peer-based recovery coaching, and provision of mental health services for co-occurring mental illness.

Assessment and Service Planning

Practices aimed at increasing the recovery orientation of the assessment and service planning process within MM treatment include shifting from categorical to global assessment instruments and interview protocols; defining the family (as defined by the patient) rather than the individual as the unit of service; using a strengths-based assessment process to identify personal, family, and community/cultural assets that can be mobilized to support recovery initiation and maintenance; viewing assessment as a continual rather than a single-point-in-time intake process (based on the understanding that service needs change across the developmental stages of

recovery); and transitioning from professionally directed treatment plans to patient-directed recovery plans.

Composition of the Service Team

Treatment of chronic diseases, in contrast with the treatment of acute disease or trauma, involves a broader multidisciplinary team and a greater emphasis on peer-support for long-term recovery management. Implementing models of ROMM will involve key staffing changes within OTP programs, including a greater role of addiction medicine specialists in patient/family/community education, increased involvement of primary care physicians, co-location of OTPs and primary health care clinics, greater inclusion of family/child therapists, increased use of current and former patients in medication-assisted recovery as staff and volunteers, and the use of indigenous healers drawn from diverse cultural communities, e.g., leaders of recovery-focused religious and cultural revitalization movements.

The Service Relationship

Service relationships within chronic disease management are distinctive in their duration (measured in years or decades), the degree of intimacy that develops between the service providers and the patient and family, and the broader focus of the relationship—the global health and functioning of the patient and family rather than treatment of a particular health defect. Positive indicators of recovery-oriented service relationships include increased levels of recovery representation at OTP governance, leadership, and service delivery levels; respect for patient opinions and preferences via a choice philosophy; changes in administrative discharge policies; reduced incidence of administrative discharges and other premature disengagements from service; elevating patients' hopes and possibilities; transitioning patients from professionally directed treatment plans to patient-directed recovery plans; and an emphasis on sustained continuity of contact and support across the stages of long-term recovery.

Service Quality/Duration

ROMM involves ensuring six critical areas of service practice:
1) dosing policies that ensure safe induction (optimum, individualized,

and effective dose stabilization); 2) addiction counseling that is focused on building and sustaining a recovery process/partnership rather than the mechanics of dosing or service contact documentation; 3) expanding ancillary resources to address co-occurring medical, psychiatric, and other substance-related problems; vocational/employment/education needs; need for peer-based recovery support; and the needs of patients' families/children; 4) ensuring an adequate period of dose stabilization and psychosocial rehabilitation before any efforts to taper from MM (at least 1-2 years to achieve the best long-term recovery outcomes) and offering increased supports during and following the cessation of methadone maintenance; 5) increasing the percentage of MM patients who successfully complete treatment; and 6) building a strong culture of recovery within the MM service milieu.

The Locus of Service Delivery

ROMM anticipates a greater focus on delivery of recovery support services outside the clinic and the greater integration of medication and other recovery support services within non-stigmatized community environments. Promising practices in this area include shifting from siloed OTPs toward the integration of MM within comprehensive addiction treatment and recovery support centers, the expansion of office-based treatment and medical maintenance, and greater use of neighborhood- and home-based recovery support services. The focus of ROMM is on firmly nesting recovery within the natural environment of each patient or in helping develop an alternative environment in which long-term recovery can be nurtured.

Assertive Linkage to Recovery Community Resources

Peer-based recovery support resources are growing rapidly in the United States via the expanding network of addiction recovery mutual-aid groups, the philosophical diversification of these groups, the emergence of a new addiction recovery advocacy movement, new recovery community institutions, and the emergence of new peer-based service roles (e.g., the recovery coach).

Promising practices for ROMM in this area include active liaison between OTPs and the service committees of local recovery

mutual-aid societies, encouraging/supporting the development of groups specifically for persons in medication-assisted recovery, assertive linkage of patients to the resources of local communities of recovery (including medication-friendly recovery support meetings), using volunteer or paid peer recovery coaches to facilitate patient connections to recovery community resources, coaching patients on ways of addressing medication issues at recovery support meetings, hosting onsite peer recovery support meetings at or near OTPs, sponsoring educational events on medication-assisted recovery for recovery community members, inclusion of indigenous healers and healing practices within OTPs, using patient/alumni councils to visibly celebrate patient recovery milestones, and visibly participating (OTP staff and MM patients/families) in local recovery celebration events.

Long-term Recovery Check-Ups; Stage-Appropriate Recovery Education and Support; and, When Needed, Early Re-Intervention

Most people addicted to opioids experience prolonged addiction careers marked by cycles of treatment, periods of abstinence, resumption of opioid addiction, and treatment re-entry. Assertive approaches to in-treatment and post-treatment monitoring significantly enhance long-term recovery outcomes. We envision a future in which a system of recovery check-ups, peer-based recovery support, stage-appropriate recovery education, assertive linkage to communities of recovery, and early re-intervention will reduce post-treatment mortality and enhance the long-term recovery outcomes of MM patients.

Summary

Put simply, ROMM seeks to:

- attract people at an earlier stage of problem development via programs of assertive community education, screening, and outreach;
- ensure rapid service access for individuals and families seeking help;

- resolve obstacles to initial and continued treatment participation;
- achieve safe, individualized, optimum dose stabilization;
- engage and retain individuals and families in a sustained recovery-focused service and support process;
- assess patient/family needs using assessment protocols that are global, family-centered, strengths-based, and continual;
- transition each patient from a professionally directed treatment plan to a patient-directed recovery plan;
- expand the service team to include primary care physicians, psychologists, social workers, peer recovery support specialists, and indigenous healers;
- shift the service relationship from a professional/expert model to a long-term recovery partnership/consultation model marked by mutual respect, hope, and emotional authenticity;
- ensure minimum (at least one year) and optimum (individualized) duration of treatment via focused retention strategies and assertive responses to early signs of disengagement;
- shift the treatment focus from an episode of care to the management of long-term addiction/treatment/recovery careers;
- expand the service menu to include ancillary medical/psychiatric/social services and non-clinical, peer-based recovery support services;
- extend the locus of service delivery beyond the OTP to non-stigmatized service sites and neighborhood-based, church-based, work-based, home-based, and technology-based (phone/Internet) recovery support services;
- assertively link patients/families to recovery community support resources;
- engage the community through anti-stigma campaigns and recovery community development activities;
- provide post-treatment monitoring and support and stage-appropriate education, support, and (if and when needed), early re-intervention for all patients regardless of discharge status; and

- evaluate MM treatment using proximal and distal indicators of long-term personal and family recovery.

Care will need to be taken to avoid potential unintended consequences of this heightened recovery orientation, e.g., the abandonment of patients who do not yet share this vision of a recovery-transformed life.

It is the authors' hope that readers of *Counselor* will review the new monograph and freshly evaluate the potential role of methadone and other medications in long-term addiction recovery.

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