

# Narcotics Anonymous and the Pharmacotherapeutic Treatment of Opioid Addiction in the United States

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Great Lakes Addiction Technology Transfer Center

## **Narcotics Anonymous and the Pharmacotherapeutic Treatment of Opioid Addiction in the United States**

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## Preface

In 2010, the author collaborated with Lisa Mojer-Torres on the monograph *Recovery-oriented Methadone Maintenance* and during the same year co-authored a paper with Chris Budnick and Boyd Pickard on the history and culture of Narcotics Anonymous. These separate projects reached a point of confluence when many readers of the monograph responded that one of the greatest barriers to enhancing the recovery orientation of medication-assisted treatment programs was the attitudes toward opioid addiction treatment medications experienced by many of their patients who sought support from recovery mutual aid groups, particularly Narcotics Anonymous (NA). (The restrictions that many local NA groups impose on patients in medication-assisted treatment will be the subject of detailed discussion in this paper.)

Responding to such concerns, the leadership of the Philadelphia Department of Behavioral Health and Intellectual disabilities Services asked the author to prepare a paper on NA's views regarding NA member participation in the pharmacological treatment of opioid addiction and ways in which medication-assisted treatment programs might increase their patients' participation in NA or alternative recovery mutual aid societies. This paper is the product of that invitation. Its purpose is **NOT** to influence NA's views on these issues, but to help explore ways in which addiction professionals and recovery support specialists can enhance the peer-based recovery support available to patients in medication-assisted treatment.

These are, of course, controversial issues that we (author and reader) are about to explore. What follows is not intended as a final statement, but an invitation to sustained reflection and dialogue from multiple quarters on the question of the best ways of achieving long-term recovery from opioid addiction. I still have much to learn about the potential role of medication in recovery initiation and long-term recovery maintenance and look forward to hearing perspectives not represented in this paper. You are welcome to reach me at [bwhite@chestnut.org](mailto:bwhite@chestnut.org)

Bill White  
March, 2011

NARCOTICS ANONYMOUS AND THE PHARMACOTHERAPEUTIC TREATMENT  
OF OPIOID ADDICTION IN THE UNITED STATES

**William L. White, MA**

*Collaboration requires openness to the possibility that our world-view and the cherished concepts we use to describe it may need to become more subtler, more fine-grained, amended or even discarded; and, that approaches which don't work for one person can, equally, be life-saving for others, when all the time our own beliefs, experiences, perhaps even our entire biography, shouts out that this can't be so.*

—Neil Hunt<sup>1</sup>

In 1976, Dr. Thomasina Borkman identified two fundamentally different ways of knowing: science-grounded professional knowledge and the experiential knowledge of peer-based recovery support groups. Where scientific knowledge places great value on understanding a problem from the outside through the lens of objective distance and carefully controlled experiments, experiential knowledge seeks to understand a problem from close-up and inside—from the subjective experience of those who have lived through and solved the problem. Whereas scientific truth is conveyed in the form of data, experiential truth is transmitted through stories and the inherited wisdom of community elders. Science, in its pride of precision, focuses on the segment; experience, in its pride of the pragmatic, focuses on what works as a whole. Science stands and demands, “Where is your proof?” Experience stands in response and proclaims, “I am the proof!” and offers its biographical evidence.<sup>2</sup> In the addictions arena, science and experience meet and at times collide with a third way of knowing drawn from frontline treatment and recovery support practices. While science, experience, and clinical practice can occupy common ground, it is in these divergent sources of knowledge that one can find radically different and competing definitions of *the truth*.

Such differences in worldviews are evident in the chasm between scientific evidence on the pharmacotherapeutic treatment of opioid addiction and attitudes toward these medications expressed within the literature and local group practices of Narcotics Anonymous (NA). Patients in medication-assisted treatment for opioid addiction find themselves caught in the conundrum of conflicting views of the “goodness” or “badness” of these medications, and within conflicting admonitions to increase or decrease their medication doses, to continue or discontinue their medication, and to taper rapidly or taper slowly from their medication. Local NA groups and NA World Services find themselves facing questions about the participation of members on methadone, buprenorphine, and other medications, and questions of how NA's Third<sup>3</sup> and Tenth<sup>4</sup>

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<sup>1</sup> Hunt, N. (2010). Bridging the great divide: Or why the recovery agenda could be an ally of harm reduction movements. Unpublished manuscript, quoted with permission of the authors.

<sup>2</sup> Borkman, T. (1976). Experiential knowledge: A new concept for the analysis of self-help groups. *Social Service Review*, 50, 445-456.

<sup>3</sup> “The only requirement for membership is a desire to stop using.”

<sup>4</sup> “Narcotics Anonymous has no opinion on outside issues; hence the NA name ought never be drawn into public controversy.”

Traditions and its philosophy of abstinence apply to these considerations. Medication-assisted addiction treatment providers seeking locations for service centers find themselves battling the stigma-fueled NIMBY (“not in my back yard”), and at the clinical level find themselves caught in the seemingly 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. Family members and friends are left in a quandary over whether they should support or discourage medication-assisted treatment for opioid addiction. And the public and policy makers are caught in a sea of claims and counterclaims—with each platform speaker claiming ownership of THE TRUTH.

This paper explores this hazardous territory by:

- 1) contrasting the scientific and clinical findings on medication-assisted treatment of opioid addiction with the restrictions many NA groups place on the participation of NA members who are being treated professionally for opioid addiction with methadone or buprenorphine;
- 2) conveying the attitudes toward methadone or buprenorphine that patients have encountered as they have sought support in NA;
- 3) outlining the options that opioid addiction treatment programs may consider in linking patients to, and working with, NA and other recovery mutual aid societies;
- 4) suggesting strategies that patients in medication-assisted recovery may use in navigating the terrain of recovery mutual aid societies; and
- 5) discussing the forces that will influence the future stance of NA and other addiction recovery mutual aid societies toward the medication-assisted treatment of substance use disorders.

The primary audience for this paper includes addiction treatment professionals and peer recovery support specialists whose responsibilities entail linking individuals in medication-assisted treatment with local recovery mutual aid resources.

#### OPIOID ADDICTION AND PHARMACOTHERAPEUTIC TREATMENT: SCIENTIFIC KNOWLEDGE

As most readers of this document are aware, there are primarily four classes of medications used as pharmacotherapeutic agents in the treatment of opioid addiction:

- 1) opioid agonists, e.g., medications such as methadone<sup>5</sup> used as aids in withdrawal from heroin or other short-acting opioids or used as maintenance agents for metabolic stabilization and prevention of relapse;
- 2) partial agonists, e.g., medications such as buprenorphine (trade name Subutex) and buprenorphine and naloxone in combination (trade name Suboxone);

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<sup>5</sup> Roxane Laboratories, the sole distributor of levomethadyl acetate (LAMM), an early alternative to methadone, discontinued sales of LAMM in 2003 following reports of cardiac side effects in some patients.

- 3) 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; and
- 4) alpha-2-adrenergic agonist medications such as clonidine and lofexidine that have been used as adjuncts in opioid detoxification.<sup>6</sup>

This paper will focus on methadone and buprenorphine, since they are the most widely prescribed medications in the treatment of opioid addiction.

Methadone maintenance (MM) was developed as a treatment for heroin addiction in 1964 by Dr. Vincent Dole (an internist), Dr. Marie Nyswander (a psychiatrist), and Dr. Mary Jeanne Kreek (a medical resident) at Rockefeller Institute for Medical Research (now Rockefeller University) and Rockefeller Hospital in New York City. The positive evaluation of MM pilot studies led to its wide diffusion throughout the United States and in countries around the world.

Methadone maintenance proceeds from medication induction to stable maintenance, a process involving the transition from an initial daily dose of 20-30 mg of methadone, through incremental increases, to a personally optimal stabilization dose (60-100 mg per day for most patients). The increased availability of higher-purity heroin in recent years has contributed to the need for higher average doses to achieve stabilization.

Effective methadone maintenance combines medication with ancillary medical and psychosocial support services aimed at remission of opioid addiction and enhancements in global health and functioning.<sup>7</sup> MM is based on the understanding of opioid addiction as a genetically influenced chronic brain disease requiring prolonged, if not lifelong, medication support to ameliorate the profound, persistent, recurring, and potentially permanent metabolic changes resulting from addiction to heroin or other short-acting opioids.<sup>8</sup> In this view, MM is not curative, but provides a platform of sustained neurobiological stability upon which a larger process of biopsychosocial recovery can be initiated by the patient in collaboration with other professional, family, and peer supports.

Since its widespread dissemination in the 1970s and 1980s, methadone maintenance has been provided through a “closed system” of specialized clinics—now known as opioid treatment programs (OTPs)—requiring federal and state licensing.<sup>9</sup> Opioid-addicted patients are not able to be treated for opioid addiction with methadone from a physician’s office except as part of isolated studies of medical maintenance. Today, there are 1,203 OTPs in the United States operating in 47 states (all states except North and South Dakota and Wyoming), as well as the District of Columbia, U.S. Virgin Islands, American Samoa, and Puerto Rico). These OTPs treat more than 280,000 patients on

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<sup>6</sup> Stotts, A.L., Dodrill, C.L., & Kosten, T.R. (2009). Opioid dependence treatment: Options in pharmacotherapy. *Expert Opinions in Pharmacotherapy*, 10(11), 1727-1740.

<sup>7</sup> Kosten, T.R., & George, T.P. (2002). The neurobiology of opioid dependence: Implications for treatment. *Science to Practice Perspectives*, 1(1), 13-20.

<sup>8</sup> Dole, V.P., & Nyswander, M.E. (1967). Heroin addiction—a metabolic disease. *Archives of Internal Medicine*, 120, 19-24; Dole, V.P., Nyswander, M.E., & Kreek, M.J. (1966). Narcotic blockade. *Archives of Internal Medicine*, 118, 304-309.

<sup>9</sup> Jaffe, J.H. & O’Keefe, C. (2003). From morphine clinics to buprenorphine: Regulating opioid agonist treatment of addiction in the United States. *Drug and Alcohol Dependence*, 70, S3-S11.

any given day—23% of all patients in addiction treatment in the United States.<sup>10</sup> Although the theory of MM is based on the ideal of prolonged maintenance for most patients, only 40% of MM patients have been in MM more than two years, and most are treated for less than one year.<sup>11</sup> Many opioid-addicted patients use MM, as other treatments and recovery support groups are used, through a recovery life cycle marked by periods of active involvement interspersed with periods of disengagement.

MM was developed in the wake of a century's worth of opioid addiction treatments that were frequently unattractive, ineffective, exploitive, dangerous, and potentially lethal.<sup>12</sup> Because of the professional and cultural controversies surrounding its use,<sup>13</sup> MM has been evaluated and regulated more rigorously than any other addiction treatment modality. It has been endorsed in technical evaluations by the American Society of Addiction Medicine (1990),<sup>14</sup> the Government Accounting Office Report (1990),<sup>15</sup> the Office of Technology Assessment of the United States Congress (1990),<sup>16</sup> the American Medical Association Council on Scientific Affairs (1994),<sup>17</sup> the National Institutes of Health Consensus Conference on Effective Treatment of Heroin Addiction (1997),<sup>18</sup> the American Public Health Association (1997), the American Medical Association House of Delegates (1997), the Office of National Drug Control Policy (1990, 1999),<sup>19</sup> the National Institute on Drug Abuse (1999),<sup>20</sup> and the World Health Organization (2001).<sup>21</sup>

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<sup>10</sup> Parrino, M. (2008). Coordinating methadone treatment providers and policymakers: Lessons learned over 30 years. *Heroin Addiction and Related Clinical Problems*, 11(1), 43-46; Personal communication with Mark Parrino, February 22, 2011.

<sup>11</sup> DASIS (2006). *The DASIS Report: Facilities operating opioid treatment programs: 2005*. Office of Applied Studies, Substance Abuse and Mental Health Services Administration; Kresina, T.F., Litwin, A., Marion, I., Lubran, R., & Clark, H.W. (2009). United States government oversight and regulation of medication assisted treatment for the treatment of opioid dependence. *Journal of Drug Policy Analysis*, 2(1), Article 2.

<sup>12</sup> Kleber, H., & Riordan, C. (1982). The treatment of narcotic withdrawal: A historical review. *Journal of Clinical Psychiatry*, 43(6), 30-34; White, W. L. (2002). Trick or treat? A century of American responses to heroin addiction. In D. Musto (Ed.), *One hundred years of heroin* (pp. 131-148).

Westport, CT: Auburn House; White, W.L., & Kleber, H.D. (2008). Preventing harm in the name of help: A guide for addiction professionals. *Counselor*, 9(6), 10-17.

<sup>13</sup> 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.

<sup>14</sup> American Society of Addiction Medicine. (1990, Revised 2006). *Methadone treatment of addiction: Public policy statement*. Retrieved November 2, 2009 from <http://www.asam.org/MethadoneTreatmentofAddiction.html>.

<sup>15</sup> U.S. General Accounting Office (1990). *Methadone maintenance: Some treatment programs are not effective; greater federal oversight needed* (GAO Report No. GAO/HRD-90-104).

<sup>16</sup> Office of Technology Assessment, US Congress. (1990). *The effectiveness of drug abuse treatment: Implications for controlling AIDS/HIV infection*. Washington, DC: Office of Technology Assessment.

<sup>17</sup> Yoast R., Williams, M.A., Deitchman, S.C., & Champion, H.C. (2001). Report of the Council on Scientific Affairs: Methadone maintenance and needle-exchange programs to reduce the medical and public health consequences of drug abuse. *Journal of Addictive Diseases*, 20, 15-40.

<sup>18</sup> 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.

<sup>19</sup> Office of National Drug Control Policy. (March, 1999). *Policy paper—Opioid agonist treatment*. Washington, DC: Executive Office of the President, Office of National Drug Control Policy.

<sup>20</sup> National Institute on Drug Abuse. (1983). *Research on the treatment of narcotic addiction—State of the art*. Rockville, MD: US Department of Health and Human Services; National Institute on Drug Abuse. (1999). *Principles of addiction medicine: A research-based guide* (NIH Publication No. 99-1180). Rockville, MD: National Institute on Drug Abuse.

These rigorous reviews confirmed that methadone delivered at sustained, individualized optimum daily dosages and combined with ancillary psychosocial services delivered by competent practitioners:

- 1) decreases the death rate among opioid-dependent individuals by as much as 50%;
- 2) reduces the transmission of HIV, Hepatitis B and C, and other infections;
- 3) eliminates or reduces illicit opioid use;
- 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.<sup>22</sup>

It is noteworthy for our later discussions that, during the transition from the MM pilot studies (mid-1960s) and early replication sites (late 1960s and early 1970s) to mass MM replication (1970s and 1980s), the emphasis in the evaluation of MM shifted from personal recovery (then defined as remission of heroin addiction) to reduction of social harm, measured in terms of reduced costs, reduced crime, and reduced threats to public safety and health.<sup>23</sup> Through much of the evolution of MM, scientists paid little attention to the benchmarks that NA members used to evaluate MM, e.g., achieving complete and sustained abstinence (“clean time” in NA vernacular) and the quality of one’s life and service to others. Also noteworthy from a broader public health perspective is the fact that MM attracted and treats only a quarter of the estimated heroin addicts in the United States—in part because of the social and professional stigma that remains associated with its use as a treatment for addiction.<sup>24</sup>

Buprenorphine is a partial opioid agonist whose safety record and lower potential for misuse (when combined with naloxone) make it an effective alternative to methadone for the detoxification or maintenance stabilization of some opioid addicted patients. Two policy shifts set the stage for the use of buprenorphine in the treatment of opioid addiction in the U.S.: 1) the Drug Addiction Treatment Act (DATA) of 2000, which allowed physicians who have received special training to prescribe Schedule III, IV, and V FDA-approved opioid medications in office-based settings, and 2) the 2002 FDA approval of sublingual (under the tongue) buprenorphine-based medications for the treatment of

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<sup>21</sup> Mattick R.P., Breen, C., Kimber, J., & Davoli, M. (2003). Methadone maintenance therapy versus no opioid replacement therapy for opioid dependence. *Cochrane Database of Systematic Reviews*, (Issue 2):CD002209.

<sup>22</sup> Kreek, M.J., & Vocci, F. (2002). History and current status of opioid maintenance treatments. *Journal of Substance Abuse Treatment*, 23(2), 93-105; Mattick R.P., Breen, C., Kimber, J., & Davoli, M. (2003). Methadone maintenance therapy versus no opioid replacement therapy for opioid dependence. *Cochrane Database of Systematic Reviews*, (Issue 2):CD002209.

<sup>23</sup> White, W., & Torres, L. (2010). *Recovery-oriented methadone maintenance*. Chicago, IL: Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health and Mental Retardation Services, and Northeast Addiction Technology Transfer Center.

<sup>24</sup> Office of National Drug Control Policy (ONDCP) (2003). Drug Policy Information Clearinghouse (2003). *Heroin fact sheet*.

opioid addiction.<sup>25</sup> These policy shifts opened the doors for physicians to prescribe opioid medication for the treatment of opioid addiction within mainstream medical practice—something that had not been legally permissible since the early twentieth century.<sup>26</sup>

The majority of buprenorphine-aided treatment of opioid addiction occurs within what is commonly referred to as office-based opioid treatment (OBOT). On March 31, 2009, certified Opioid Treatment Programs (OTPs)—an outgrowth of the earlier methadone clinic system—were treating 24,173 patients with buprenorphine (up from 5,099 in 2005), compared to 285,686 patients treated with methadone.<sup>27</sup> The DATA 2000 legislation was designed as a first step in moving opioid addiction treatment out of the closed-clinic system and into mainstream medical practice in the United States.<sup>28</sup>

The FDA has now 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.<sup>29</sup> As with MM, outcomes of buprenorphine treatment for opioid addiction, including abstinence rates at final follow-up, improve with the addition of psychosocial interventions.<sup>30</sup> Due to the lack of a centralized reporting system for OBOT, there is no national-level data available on such issues as retention rates, percentage of patients receiving concurrent psychosocial support services, patient evaluation of service quality, or post-treatment recovery outcomes.

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<sup>25</sup> Center for Substance Abuse Treatment. (2004). *Clinical guidelines for the use of buprenorphine in the treatment of opioid addiction* (Treatment Improvement Protocol. (TIP) Series 40; DHHS Publication No. (SMA) 04-3939). Rockville, MD: Substance Abuse and Mental Health Services Administration; Fiellin D. (2007). The first three years of buprenorphine in the United States: Experience to date and future directions. *Journal of Addiction Medicine*, 1(2), 62-67; Wakhlu, S. (2009). Buprenorphine: A review. *Journal of Opioid Management*, 5(1), 59-64.

<sup>26</sup> White, W.L. (2002). Trick or treat? A century of American responses to heroin addiction. In D. Musto (Ed.), *One hundred years of heroin* (pp. 131-148).

<sup>27</sup> SAMHSA, Office of Applied Studies (June 2010), *National Survey of Substance Abuse Treatment Services, 2009. Data on Substance Abuse Treatment Facilities*. Rockville, MD; Also see SAMHSA, Office of Applied Studies (January 28, 2010). *The N-SSATS Report: Overview of Opioid Treatment Programs within the United States: 2008*. Rockville, MD.

<sup>28</sup> Fiellin, D.A. & O'Connor, P.G. (2002). Clinical practice: Office-based treatment of opioid-dependent patients. *New England Journal of Medicine*, 347, 817-823; Wally, A.Y., Alperen, J.K., Cheng, D.M., et al, (2008). Office-based management of opioid dependence with buprenorphine: Clinical practices and barriers. *Journal of General Internal Medicine*, 23, 1393-8.

<sup>29</sup> Ling, W., Cassadonte, P., Bieglow, G., Kampman, K.M., Patkar, A., Bailey, G.L., & Beebe, K.L. (2010). Buprenorphine implants for treatment of opioid dependence. *Journal of the American Medical Association*, 304(14), 1576-1583.

<sup>30</sup> Amato, L., Minozzi, S., Davoli, M., et al, (2004). Psychosocial and pharmacological treatments versus pharmacological treatments for opioid detoxification. *Cochrane Database Syst Rev*, CD005031; Amato, L., Minozzi, S., Davoli, M., Vecchi, S., Ferri, M. & Mayet, S. (2008). Psychosocial combined with agonist maintenance treatment versus agonist maintenance treatments along for treatment of opioid dependence. *Cochrane Database of Systematic Reviews*, Issue, 4, Art. No. CD004147; Tetrault, J.M. & O'Connor, P.G. (2009). Management of opioid intoxication and withdrawal. In: Ries, R.K., Fiellin, D.A., Miller, S.C. & Saitz, R. (Eds.) *Principles of Addiction Medicine*, Fourth Edition. Philadelphia: Wolters Kluwer / Lippincott Williams & Wilkins, p. 589-603.

Available data do suggest that more than 70% of buprenorphine prescribed for opioid addiction is used for maintenance rather than detoxification.<sup>31</sup>

In 2008, approximately 368,962 patients in the United States were treated with buprenorphine (Suboxone, Subutex or generic Subutex) for opioid addiction on any given day,<sup>32</sup> compared to 260,000-280,000 in methadone maintenance and 3,000-4,000 treated with naltrexone).<sup>33</sup> Dr. H. Westley Clark, Director of the Center for Substance Abuse Treatment, recently recounted the rise in prescription of buprenorphine preparations.<sup>34</sup> This evolution is summarized in Table 1.

**Table 1: Buprenorphine Prescription Trends: 2003-2009<sup>35</sup>**

Year	Number of DATA-Certified Physicians	# Patients Treated with Buprenorphine
2003	2,000	20,000
2005	6,500	96,000
2008	16,000	500,000
2009	19,000	640,000

Compared to methadone, buprenorphine is more convenient, safer, less stigmatizing, more effective in suppressing other opioid use, and more acceptable to opioid-dependent individuals.<sup>36</sup> Follow-up studies of 18-60 months reveal good retention rates (38-77%); low rates of continued opioid use (9%); and (in comparisons between people who continue treatment and those who drop out), higher rates of abstinence, involvement in

<sup>31</sup> Arfken, C.L., Johanson, C-E, di Menza, S. & Schuster, C. (2010). Expanding treatment capacity for opioid dependence with office-based treatment with buprenorphine: National surveys of physicians. *Journal of Substance Abuse Treatment*, 39, 96-104.

<sup>32</sup> Arfken, C.L., Johanson, C-E, di Menza, S. & Schuster, C. (2010). Expanding treatment capacity for opioid dependence with office-based treatment with buprenorphine: National surveys of physicians. *Journal of Substance Abuse Treatment*, 39, 96-104; Reuter, N. (2010). *SAMHSA update*. Presented at the NASCSA National Conference, October 19, 2010. According to the National Alliance of Advocates for Buprenorphine Treatment, in the 12-month period ending November 30, 2010, 887,482 patients in the United States received prescriptions for buprenorphine for the 12-month period ending Nov.2010; this does not include dispensing by opioid treatment programs, which is estimated at about 10% more. (These numbers do not include any prescriptions for Buprenex or Butrans (the only buprenorphine products approved for the treatment of pain). About 97% of the prescriptions written are from DATA-2000-certified providers. Although they can still prescribe off-label, it is clear from these figures that all but a small minority of these patients are being treated for opioid addiction. Personal communications with Timothy Lepak, President, National Alliance of Advocates for Buprenorphine Treatment, January-February, 2010.

<sup>33</sup> Center for Substance Abuse Treatment. (2004). *Clinical guidelines for the use of buprenorphine in the treatment of opioid addiction* (Treatment Improvement Protocol (TIP) Series 40; DHHS Publication No. (SMA) 04-3939). Rockville, MD: Substance Abuse and Mental Health Services Administration.

<sup>34</sup> Clark, W. (2010). The state of buprenorphine treatment. Presented at: Buprenorphine in the treatment of opioid addiction: Reassessment 2010, May 10, 2010, Washington, D.C.

<sup>35</sup> Ibid.

<sup>36</sup> Pinto, H., Maskrey, V., Swift, L., Rumball, D, Wagle, A, & Holland, R. (2010). The SUMMIT Trial: A field comparison of buprenorphine versus methadone maintenance treatment. *Journal of Substance Abuse Treatment*, 39, 340-352; Schwartz, R.P., Kelly, S.M., O’Grady, K.E., Mitchell, S.G., Peterson, J.A., Reisinger, H.S., & Brown, B.S. (2008). Attitudes toward buprenorphine and methadone among opioid-dependent individuals. *American Journal of Addiction*, 17(5), 396.

12-Step groups, and employment.<sup>37</sup> Although methadone is more cost-effective and produces higher rates of treatment retention, buprenorphine is attracting and engaging opioid addicted persons at earlier stages of addiction who have not sought, and in many cases would or could not seek, methadone maintenance or other alternative treatments.<sup>38</sup>

Both methadone and buprenorphine are also prescribed for pain—a significant factor given the high co-occurrence of opioid addiction and chronic pain. Methadone and buprenorphine may have special advantages in treating patients with co-occurring pain and may also have advantages in treating opioid-addicted patients with co-occurring psychiatric illness.<sup>39</sup>

Naltrexone is an opioid antagonist that has been used to treat opioid-addicted patients who are averse to maintenance treatment with methadone or buprenorphine or whose life circumstances preclude the use of methadone or buprenorphine. Naltrexone serves as an antidote against relapse by blocking the effects of all opioids. Because of adherence problems (most patients stop taking it early in their treatment) and high drop-out rates, naltrexone is not widely used and is limited primarily to the most highly motivated patients (e.g., physicians recovering from opioid addiction under the supervision of a Physician Health Program).<sup>40</sup>

Apart from concerns that traditional methadone clinics lacked a viable recovery culture, controversies surrounding methadone (and, more recently, buprenorphine) stem in great part from the fact that both medications are opioids, that they maintain a level of physical dependence when they are used as maintenance medications, and that they have the potential for misuse.<sup>41</sup> However, the latest ethnographic study of illicit methadone and buprenorphine use suggests that such use is primarily undertaken for the purpose of self-medication for heroin withdrawal, or self-administered detoxification from heroin, rather than for purposes of intoxication, and that this pattern of use can be a prelude to entry into medication-assisted treatment.<sup>42</sup> The question of how opioid medications that

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<sup>37</sup> Fiellin, D.A., Moore, B.A., Chawarski, M.C., et al, (2008). Long-term treatment with buprenorphine / naloxone in primary care: results at 2-5 years. *American Journal of Addictions*, 17, 116-20; Parran, T.V., Adelman, C.A., Merkin, B., et al, (2010). Long-term outcomes of office-based buprenorphine/naloxone maintenance therapy, *Drug and Alcohol Dependence*, 106, 56-60.

<sup>38</sup> Pinto, H., Maskrey, V., Swift, L., Rumball, D, Wagle, A, & Holland, R. (2010). The SUMMIT Trial: A field comparison of buprenorphine versus methadone maintenance treatment. *Journal of Substance Abuse Treatment*, 39, 340-352; Wakhlu, S. (2009). Buprenorphine: A review. *Journal of Opioid Management*, 5(1), 59-64.

<sup>39</sup> Musselman, D.L., Kell, M.J. (1995). Prevalence and improvement in psychopathology in opioid dependent patients participating in methadone maintenance. *Journal of Addictive Diseases*, 14, 67-82.

<sup>40</sup> Hyman, S.M., Fox, H., Hong, K.A., Doebrick, C. & Sinha, R. (2007). Street and drug-induced craving for opioid-dependent individuals in naltrexone treatment. *Experimental Clinical Psychopharmacology*, 15(2), 134-143; Montoya, I.D., & Vocci, F. (2008). Novel medications to treat addictive disorders. *Current Psychiatry Reports*, 10(5), 392-398).

<sup>41</sup> Center for Substance Abuse Treatment. (2004). *Clinical guidelines for the use of buprenorphine in the treatment of opioid addiction* (Treatment Improvement Protocol (TIP) Series 40; DHHS Publication No. (SMA) 04-3939). Rockville, MD: Substance Abuse and Mental Health Services Administration.

<sup>42</sup> Gwin Mitchell, S.G., Kelly, S.M., Brown, B.S., Schacht, Reisinger, H., Peterson, J.A., Ruhf, A. & Schwartz, R.P. (2009). Uses of diverted methadone and buprenorphine by opioid-addicted individuals in Baltimore, Maryland. *The American Journal on Addictions*, 18, 346-355; Schuman-Oliver, Z., Albanese, M., Nelson, S.E., Roland, L., Puopolo, F., Klinker, L., & Shaffer, H.J. (2010). Self-treatment:

produce physical dependence can be used to treat opioid addiction is best answered through a fundamentally new understanding of the nature of addiction.

For more than a century, *tolerance* (decreasing drug effects resulting from sustained use) and *physical dependence* (neurological adaptation to continued drug use that upon abrupt cessation precipitates acute withdrawal symptoms) constituted critical defining elements of drug addiction, but recent scientific studies are altering that view. Particularly important are the findings that:

- 1) tolerance is a process of neuroadaptation that occurs independently of physical dependence and addiction and, as such, is a poor marker for addiction;
- 2) physical dependence and addiction are not synonymous;
- 3) physical dependence occurs with many medications not usually associated with addiction (e.g., corticosteroids, antidepressants, diabetic medications, heart medications) and can occur with opioids in the absence of addiction (e.g., among patients undergoing prolonged treatment with opioids for pain);
- 4) addiction can occur in the absence of physical dependence; and
- 5) the essence of addiction is not physical dependence, but impaired control over drug use; craving; preoccupation with use; and compulsive use in spite of harm to self, family, and community.<sup>43</sup>

Based on this new understanding, what distinguishes heroin addiction from treatment of heroin addiction with methadone or buprenorphine maintenance is the presence of impaired control, craving, preoccupation, and compulsive use in spite of escalating consequences in heroin addiction, and the virtual absence of these characteristics in the stabilized maintenance patient with no active co-occurring addictions. That stability is due in great part to the unique pharmacological characteristics of methadone and buprenorphine, including their long duration of action and their capacity for dose stabilization (without the need for ever-escalating dosages). Despite their shared status as opioids, methadone and buprenorphine differ dramatically from short-acting opioids in their effects when they are taken within the context of addiction treatment. Also vastly different are the daily lifestyles of the heroin addict and the stabilized methadone or buprenorphine patient. In the current perspective of medical science, the stabilized methadone/buprenorphine patient has a physical dependence on a life-saving medication, but in the absence of any secondary substance use disorder is no longer “addicted” (as “addiction” is now defined).<sup>44</sup>

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Illicit buprenorphine use by opioid-dependent treatment seekers. *Journal of Substance Abuse Treatment*, 39, 41-50.

<sup>43</sup> DuPont, R.L. & Gold, M. (2007). Comorbidity and “self-medication. *Journal of Addictive Diseases*, 26, Supplement No. 1, 13-27; Gourlay, D.L., & Heit, H.A. (2008). Pain and addiction: Managing risk through comprehensive care. *Journal of Addictive Diseases*, 27(3), 23-30; O’Brien, C.P., Volkow, N., & Li, T-K. (2006). What’s in a word? Addiction versus dependence in DSM-V. *American Journal of Psychiatry*, 163(5), 764-765; Savage, S.R., Joranson, D.E., Covington, E.C., Schnoll, S.H., Heit, H.A., & Gilson, A.M. (2003). Definitions related to the medical use of opioids: Evolution towards universal agreement. *Journal of Pain and Symptom Management*, 26(1), 655-667.

<sup>44</sup> “Addiction is a primary, chronic, neurobiological disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving.” Savage, S.R., Joranson, D.E., Covington, E.C., Schnoll, S.H., Heit, H.A., &

As a result of these new understandings, medication-assisted recovery advocates are suggesting that *it is time to shed the fixation on methadone and buprenorphine and to begin to nest these medications within a rich service menu and vibrant recovery culture that can nurture the larger physical, cognitive, emotional, relational, and spiritual processes of long-term recovery.* In their view, *the focus of attention should be on the person, not the prescription.* The medication is simply a tool for subtracting addiction pathology from the life of the patient; the broader service menu and recovery support milieu is about the elements that can then be added to the patient's life to make that life bearable, enjoyable, valuable, and meaningful.<sup>45</sup>

In summary, from the standpoint of science and the best evidence-based clinical practices in addiction treatment, methadone, buprenorphine, and naltrexone collectively play an important role in the treatment of opioid addiction in the United States. In reviews of evidence-based treatment practices, pharmacotherapy for opioid addiction is consistently referred to as the “gold standard,”<sup>46</sup> and evidence-based guidelines for addiction treatment recommend that “pharmacotherapy should be recommended and available for all adult patients diagnosed with opioid dependence and without medical complications.”<sup>47</sup> Given this foundation of evidence, it is also important to note that:

- many people recover from opioid dependence without the aid of medications—both with and without the aid of alternative treatment,
- no one medication has been found to be effective for all patients being treated for opioid addiction,
- patients may transition from one medication to another through the stages of their recovery, and
- many patients effectively combine medications with psychosocial treatment and peer-based recovery mutual aid to support their long-term recoveries.

#### NA PERSPECTIVES ON PHARMACOTHERAPEUTIC TREATMENT: EXPERIENTIAL KNOWLEDGE

Addiction recovery mutual aid societies, particularly 12-Step fellowships, tend to be highly decentralized in their governance structures and extremely diverse in local group practices.<sup>48</sup> Therefore, any statement attempting to define a recovery fellowship's position on a particular issue is likely to be true in one place, but not in another. What

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Gilson, A.M. (2003). Definitions related to the medical use of opioids: Evolution towards universal agreement. *Journal of Pain and Symptom Management*, 26(1), 655-667, p. 662.

<sup>45</sup> For elaboration, see: White, W., & Torres, L. (2010). *Recovery-oriented methadone maintenance*. Chicago, IL: Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health and Mental Retardation Services, and Northeast Addiction Technology Transfer Center.

<sup>46</sup> Stotts, A.L., Dodrill, C.L., & Kosten, T.R. (2009). Opioid dependence treatment: Options in pharmacotherapy. *Expert Opinions in Pharmacotherapy*, 10(11), 1727-1740.

<sup>47</sup> National Quality Forum (2007). *National voluntary consensus standards for the treatment of substance use conditions: Evidence-based treatment practices*. Washington, DC: National Quality Forum.

<sup>48</sup> White, W., & Kurtz, E. (2006). The varieties of recovery experience. *International Journal of Self Help and Self Care*, 3(1-2), 21-61. White, W., Budnick, C., & Pickard, B. (2011). Narcotics Anonymous: Its history and culture. *Counselor*, 12(2), 10-15, 22-27, 36-39, 46-50.

binds such groups and members toward consensus on key issues are the shared understanding of the central mechanism of their recovery program, the unique historical contexts through which they have evolved, the shared elements of the memberships' addiction/recovery experiences, and the principles that have been defined to guide the personal recovery process and the life of the organization. We will use these four elements to examine NA's philosophy of abstinence and why some NA groups choose to restrict the participation of members involved in the pharmacotherapeutic treatment of opioid addiction.

The Essence of NA Recovery: All 12-Step programs are distinguished by the belief that the central mechanism of addiction recovery is a process of spiritual awakening, and that this awakening can occur as an experience of sudden transformational change or (more commonly) unfold over an extended period of time. This spiritual transformation, which is generally viewed as a product of "working" the 12 Steps, begins with an admission of the need for complete surrender ("We admitted that we were powerless over our addiction, that our lives had become unmanageable"). Through this act of submission and the rise of hope ("Came to believe that a Power greater than ourselves could restore us to sanity") comes the willingness to do anything to recover and the acknowledgment that no future drug use of any kind is possible if insanity and death are to be avoided. NA's philosophy of complete abstinence is rooted in the collective experience of its members that all past half measures resulted in pain and tragedy in spite of great and repeated assertions of personal will.

In NA this powerlessness is ascribed to *addiction*, rather than to a particular drug. In this view, either the use of any mood-altering drug or the use of any medication to treat addiction would be considered the antithesis of the first step: a continued effort at control rather than surrender ("We dreamed of finding a magic formula that would solve our ultimate problem—ourselves.")<sup>49</sup> Through this lens any form of drug substitution and any medication used to treat addiction is seen as one more effort at using a material solution—a technological fix—to solve what is at its core a spiritual problem ("Our experience indicates that medicine cannot cure our illness."<sup>50</sup>).

NA views addiction as an all-consuming disease with three distinct elements: physical (compulsion and loss of control over decisions about using), mental (obsession with use), and spiritual (self-centeredness). Within NA the 12 Steps provide the framework through which all of these elements—and addiction itself—are arrested.<sup>51</sup> Changes in personal identity, character, and interpersonal relationships are viewed as all flowing from this deep experience of surrender. For NA members, every aspect of recovery is based on sweeping all drugs from their lives. This decision is not tangential; it is the very essence of the NA program. In fact, abstinence is viewed within NA as the precondition for "the pain of living without drugs or anything to replace them" that stirs the search for a Higher Power and fuels the larger process of personal transformation.<sup>52</sup> (Of interest here is

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<sup>49</sup> *Narcotics Anonymous*, Sixth Edition (2008) Chatsworth, CA: Narcotics Anonymous World Services, Inc., p. 4.

<sup>50</sup> *Narcotics Anonymous*, Sixth Edition (2008) Chatsworth, CA: Narcotics Anonymous World Services, Inc., p. 5.

<sup>51</sup> *Narcotics Anonymous*, Sixth Edition (2008) Chatsworth, CA: Narcotics Anonymous World Services, Inc., p. 20.

<sup>52</sup> *Narcotics Anonymous*, Sixth Edition (2008) Chatsworth, CA: Narcotics Anonymous World Services, Inc., p. 24.

recent scientific evidence in support of spiritual experience as a central mechanism of change through 12-Step recovery programs.)<sup>53</sup>

In asserting this position, NA as an organization is not trying to change the ways in which the professional world or the public views medications used in the treatment of addiction; it is only trying to assert and maintain the integrity of its own approach to recovery. There is no effort on the part of NA to influence medication-assisted treatment as a medical or public policy issue. Any such actions would constitute a violation of NA Traditions. NA defines the limits of its own approach to recovery by saying, in essence, “This is not our way.”<sup>54</sup>

Historical Context: Attitudes toward mood-altering medications among NA members have also been shaped by unique historical influences. In the 1940s and 1950s, NA’s organizational godparent (Alcoholics Anonymous) was becoming increasingly concerned about drug substitution, particularly the misuse of sedatives, among its membership,<sup>55</sup> and “bridge members” recovering from both alcoholism and other drug addictions played a critical role in the founding of NA.<sup>56</sup>

Problems of multiple-drug addiction among key figures involved in the founding of NA led to the insertion of the phrase “powerless over our addiction” into the First Step, rather than the use of such alternatives as “powerless over *alcohol and drugs*,” “...*narcotic drugs*,” or “...*drugs*.” From NA’s earliest days, the *addiction* language confirmed the collective experience of its members that complete abstinence from all intoxicating substances was the foundation of long-term recovery.<sup>57</sup> As NA’s *Basic Text* describes: “We tried substituting one drug for another but this only prolonged our pain....We are people with the disease of addiction who must abstain from all drugs in order to recover.”<sup>58</sup>

NA’s developmental roots (e.g., Addicts Anonymous) can be further traced to the federal “Narcotics Farm” in Lexington, Kentucky, where patients could volunteer to participate in research studies in which they were given a wide variety of drugs, including morphine, heroin, and methadone—the latter then used as an aid in heroin detoxification. NA rose on the heels of decades’ worth of failed efforts to treat opioid addiction with exotic and sometimes fatal withdrawal procedures, serum therapies (in which the skin was blistered, and the serum withdrawn from the blister and then re-injected), chemo-and electro-convulsive therapies, aversion therapy (using a drug—succinyl choline—that paired

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<sup>53</sup> Kelly, J.F., Stout, R.L., Magill, M., Tonigan, J.S. & Pagano, M. (2011). Spirituality in recovery: A lagged mediational analysis of Alcoholics Anonymous’ principle theoretical mechanism of behavior change. *Alcoholism: Clinical and Experimental Research*, 35(3), 1-10.

<sup>54</sup> The key points in this section were suggested by several long-tenured NA members who served as reviewers of an early draft of this paper.

<sup>55</sup> A series of A.A. Grapevine articles on drug use led to the pamphlet: *Sedatives: Are they an A.A. problem?* (1948). New York: Works Publishing, Inc. Revised as *Sedatives and the alcoholic*. (1953).

<sup>56</sup> White, W., Budnick, C., & Pickard, B. (2011). Narcotics Anonymous: Its history and culture. *Counselor*, 12(2), 10-15, 22-27, 36-39, 46-50.

<sup>57</sup> Stone, B. (1997). *My years with Narcotics Anonymous*. Joplin, Missouri: Hulon Pendleton Publishing.

<sup>58</sup> *Narcotics Anonymous*, Sixth Edition (2008) Chatsworth, CA: Narcotics Anonymous World Services, Inc., pp. 14, 18.

heroin/morphine injections with the experience of suffocation), psychosurgery (pre-frontal lobotomies), and the use of amphetamines and barbiturates as treatment adjuncts.<sup>59</sup>

Such “treatments” and their untoward effects have been transmitted through storytelling within the American illicit drug culture and within the evolution of NA. These stories create an atmosphere of suspicion and pessimism surrounding medical treatment of addiction in general, and scientific research on addiction in particular. Given the experience of re-addiction following exposure to a broad menu of medications over the course of this history, there is great skepticism if not outright rejection of claims that medications can serve as sources of support for recovery from opioid addiction.<sup>60</sup> Turning their backs on a century of false professional promises, miracle cures, and claims of new non-habit-forming medications that proved otherwise, NA members turned to one another and to a personally defined Higher Power for a solution to their shared problem.

NA Member Experience: Adding to this historical influence are the biographies of contemporary NA members shared daily within NA meetings across the country. In NA, *truth* consists of knowledge drawn from firsthand experience (inside looking out) and the transmitted wisdom of recovery elders who serve as the repository of the stories of earlier generations of NA members (as conveyed through NA literature and sponsorship rituals). The contemporary foundation of experiential knowledge within NA includes lessons drawn from members who in recent decades have had experience with medications used in the treatment of opioid addiction.

Given the growing body of literature detailing scientific surveys of AA members on a wide variety of issues, it is somewhat surprising that no survey has been conducted on NA member attitudes toward opioid addiction treatment medications. Given the lack of data, it is unclear whether NA attitudes toward methadone and buprenorphine are more or less negative than such attitudes in the culture at large, attitudes that in the United States have historically been quite negative, particularly toward methadone.<sup>61</sup> Table 2 represents a sampling of conversational themes found in NA members’ online discussions about methadone and buprenorphine.<sup>62</sup> Caution is advised in over-interpreting such comments: An ironic facet of a fellowship honoring humility and anonymity is that the first person willing to stand to speak for NA may, if that act is any indication, be the least qualified to do so.

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<sup>59</sup> White, W. L. (2002). Trick or treat? A century of American responses to heroin addiction. In D. Musto (Ed.), *One hundred years of heroin* (pp. 131-148). Westport, CT: Auburn House.

<sup>60</sup> White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems; White, W., Budnick, C., & Pickard, B. (2011). Narcotics Anonymous: Its history and culture. *Counselor, 12*(2), 10-15, 22-27, 36-39, 46-50.

<sup>61</sup> 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. 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.

<sup>62</sup> The quotes in Table 1 not otherwise attributed are excerpted from: *The Methadone Perspective from 18 Recovering Addicts*, retrieved December 31, 2010 from <http://tunlaw.org/methadone.htm>

**Table 2: Views about Methadone and Buprenorphine Expressed by NA Members in Online Discussions**

Proposition	Statements from Online Discussions and Internet Posts
<p>1. Methadone/buprenorphine is a drug, not a medication.</p>	<p><i>Methadone is a drug. Treating addiction with it is like lightly hosing a fire with gasoline.</i></p> <p><i>[Buprenorphine] is a dangerously addictive drug and is in no way a cure for opiate addiction. It is a fresh equivalent to methadone, which was first presented as a cure for heroin addiction. Heroin in its early days was presented as a cure for morphine addiction.</i></p> <p><i>I've been addicted to methadone for over 6 years. I know most people think heroin [treatment] when they hear the word methadone but that's not why I was on it. I am an addict and wanted to get high. Plain and simple.<sup>63</sup></i></p> <p><i>We have people in narcotics anonymous whose drug of choice became methadone and who've successfully quit. Does it sound right for a person currently taking methadone to be chairing a meeting, taking H&amp;I meetings into a treatment facility, speaking to the public about narcotics anonymous and be using methadone, no matter whether its prescribed or not... while there are people there desperately trying to quit/stay quit from the methadone?<sup>64</sup></i></p> <p><i>Drug Substitution (DS) is using drugs.... Honesty, open-mindedness and a willingness to try demand that we draw the line on using drugs and calling it recovery.</i></p>

<sup>63</sup> Retrieved December 23, 2010 / Posted September 16, 2010 from <http://www.nachatroom.org/forum/viewtopic.php?f=4&t=3531&p=5381&hilit=methadone#p5381>

<sup>64</sup> Retrieved December 23, 2010 from <http://www.soberrecovery.com/forums/narcotics-addiction-12-step-support/128061-going-na-meetings-methadone.html>.

Proposition	Statements from Online Discussions and Internet Posts
<p>2. Methadone harms the body and the spirit.</p>	<p><i>Methadone is like making a deal with the DEVIL, it will rob your soul.</i></p> <p><i>Methadone is more addictive than heroin, a stepping stone to heavy alcohol and/or cocaine abuse.</i></p> <p><i>The fact that they are in a permanent buzz will also greatly diminish their initiative and capacity for desire to change. The other major problem is that they are taking a substance into their bodies on a daily basis that is physically debilitating over the long course of usage.</i></p> <p><i>An addict on Methadone maintenance can't be helped anyway because they are too fogged out to break their denial.</i></p>
<p>3. Medication is an inadequate remedy for addiction, and its primary purpose is not personal recovery</p>	<p><i>Drug replacement is cruel and unethical.</i></p> <p><i>Methadone...is a drug used by the medical and political authorities to convince addicts that they are not using a drug. Methadone is genocide. It is the calculated effort of the authorities to deprive ill people of the truth of their illness.</i></p> <p><i>The programs I was involved with were operated by unscrupulous doctors solely as a way to make big money.</i></p> <p><i>Having someone watch me urinate, demanding urine without notice, ordering me to show up at certain times and do certain things like attend counseling was degrading. Having the nurse at the dosing window look into my eyes to evaluate me, and the suspicion shown me was especially hard because I was leaving there for work where I would be working as a nurse too.</i></p> <p><i>It's really like using a band-aid, when you need stitches.</i></p>

Proposition	Statements from Online Discussions and Internet Posts
<p>4. Methadone maintenance inhibits improving quality of life and keeps one tied to the drug culture.</p>	<p><i>Your whole life is going to be overshadowed by the methadone till the day you die.</i></p> <p><i>Methadone usually doesn't work because the addict has not cut loose the dope fiend lifestyle that goes along with using drugs.</i></p> <p><i>Methadone programs always put me in circles with other using addicts.....</i></p> <p><i>Methadone is a highly addictive drug with debilitating long-term health consequences. Ask any addict who has been on a Methadone Maintenance program and they will tell you how most clients in those programs continue to use in spite of the Methadone. Standing in line for your dose is a good place to cop.</i></p>
<p>5. Medication-assisted recovery, if it can even be called recovery, is inferior to abstinence-based recovery.</p>	<p><i>There was never any encouragement to get clean [when I was in methadone treatment]. When I was ready to hang myself, I found Narcotics Anonymous and I've been clean ever since.</i></p> <p><i>The sad part about this whole approach is that these addicts have no idea what complete abstinence is and that it is achievable or desirable. How can this be even remotely considered a viable option compared to the tens of thousands of addicts living completely drug free lives in 12-Step programs such as Narcotics Anonymous or Alcoholics Anonymous?</i></p>

The proposition that these “so-called medications” are just “legal heroin” is rooted in part in the experiences of NA members with histories of opioid addiction who had used illicit methadone and/or buprenorphine for purposes of intoxication, to support their addiction career by staving off heroin withdrawal, or to provide respite (from “the life”) rather than recovery.<sup>65</sup> Given this history, many of these members do not perceive or experience any positive link between methadone or buprenorphine and the achievement of recovery from addiction. Online communications among NA members make it clear that they view medication-assisted treatment of opioid dependence as an extremely inadequate quick fix for a very complex problem—delivered within an exploitive, degrading system. The

<sup>65</sup> See Gwin Mitchell, S.G., Kelly, S.M., Brown, B.S., Schacht Reisinger, H., Peterson, J. A., Ruhf, A. & Schwartz, R. P. (2009). Uses of diverted methadone and buprenorphine by opioid-addicted individuals in Baltimore, MD. *American Journal of Addiction*, 18(5), 346-355.

proposition that medication-assisted treatment creates an inferior level of recovery is based on the pool of collective NA experience that people can live full lives without any drugs, including medications used to treat addiction. Noteworthy by its absence in these criticisms is the argument that methadone is a tool for political pacification of poor communities of color—an argument commonly heard during the early diffusion of methadone maintenance in the United States.<sup>66</sup>

In the absence of scientific surveys, it is unclear whether the attitudes expressed in Table 2 represent a small, vocal minority of NA members or a consensus of NA members as a whole. (Folk wisdom about beliefs within AA and NA is often debunked when scientific surveys of these attitudes are conducted.)<sup>67</sup> Dissenting opinions from those summarized in Table 2 are expressed by NA members even in the primary piece of literature from which many of the quotes in Table 2 were drawn:

*Recovery support groups are a program of attraction rather than promotion. Many of us have had people telling us to get clean for many years before we were graced with recovery. The same, I believe, is true with drug replacement. From what I see, treating addicts as less-than-members while they're on Suboxone does not attract them to the program. Loving them despite their disease does.*

Several points are worthy of note related to the interpretation of the sentiments toward methadone, buprenorphine, and other opioid addiction treatment medications expressed in Table 2. First, the experiential base from which NA members draw their attitudes is that of the minority of members who were regular opioid users before coming to NA (24%). Only slightly more than 10% of NA members report prior use of methadone, though whether this is use related to treatment or illicit use is unclear.<sup>68</sup> Second, some of the noted criticisms of methadone and other medications focus, not on these medications per se, but on the historical clinic system's lack of patient respect and recovery orientation—criticisms shared by NA members and many advocates of medication-assisted recovery.<sup>69</sup> Third, the criticisms reflect attitudes toward methadone that are similar to those held by the public, injection drug users in the illicit drug culture, patients entering MM, and even some staff members working in medication-assisted treatment programs.<sup>70,71</sup> These views are not unique to NA. Finally, and a point we will return to,

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<sup>66</sup> White, W. (in press). Edward C. Senay, M.D.: Lessons from four decades of clinical practice, *Counselor*, (Pioneer Series).

<sup>67</sup> Humphreys, K., Mavis, B.E. & Stoffelmayr, B.E. (1994). Are Twelve Step Programs appropriate for disenfranchised groups? Evidence from a study of posttreatment mutual help involvement. *Prevention in Human Services*, 11(1), 165-179.

<sup>68</sup> *Narcotics Anonymous 2009 Membership Survey*. (2010). Van Nuys, CA: NA World Services, Inc.

<sup>69</sup> See White, W., & Torres, L. (2010). *Recovery-oriented methadone maintenance*. Chicago, IL: Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health and Mental Retardation Services, and Northeast Addiction Technology Transfer Center.

<sup>70</sup> For a review, see White, W. (2009). *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)*. Posted at [www.williamwhitepapers.com](http://www.williamwhitepapers.com)

<sup>71</sup> Appel, P.W., Ellison, A.E., Jansky, H.K., & Oldak, R. (2004). Barriers to enrollment in drug abuse treatment and suggestions for reducing them: Opinions of drug injecting street outreach clients and other system stakeholders. *American Journal of Drug and Alcohol Abuse*, 30(1), 129-153; 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; Murphy, S., & Irwin, J. (1992). "Living with the

these propositions are only peripherally related to the more central question of whether using a particular medication—or any of the medications used to treat addiction—is inherently in conflict with NA’s spiritual framework of addiction recovery.

NA Literature: When the NA By-laws were passed August 17, 1953, they stated: “This society or movement shall be known as Narcotics Anonymous, and the name may be used by any group which follows the 12 Steps and 12 Traditions of Narcotics Anonymous.”<sup>72</sup> The third of NA’s Twelve Traditions reads, “The only requirement for membership is a desire to stop using.” NA’s basic text describes this point as creating a recovery society in which “one addict is never superior to another...every addict can recover in this program on an equal basis.”<sup>73</sup> Tradition Three, adopted in NA a decade before the development of maintenance therapy for opioid addiction, has provided an unequivocal “YES” in answer to the question of whether or not a person in medication-assisted addiction treatment can be a member of NA. But the degree of welcome that such persons experienced there, and the degree of membership participation they would be allowed, would be limited.

NA’s *Basic Text* was first published in 1983 and is currently in its sixth edition.<sup>74</sup> Chapter Ten (More Will Be Revealed), which includes a brief discussion of medication in the context of recovery within NA, makes the following points:

- NA is a program of total abstinence.
- There are times at which medications “may be valid.”
- Use of such medications requires extreme caution.
- To avoid “self-deception,” such situations should be faced with honesty, openness, and support of others in NA.
- Steps can be taken to reduce the risk when choices about medication arise.

The more specific question concerning medications used in the treatment of addiction, only minimally referenced in the *Basic Text*, will be described shortly within this chronology.

NA addressed the broad topic of medication use by NA members in a 1992 pamphlet entitled *In Times of Illness*. The first edition of this pamphlet acknowledged the controversy within NA surrounding the use of medication, extolled the virtue of taking medication only when absolutely necessary, recommended seeking alternatives to mood-altering medications when possible, and encouraged members to seek support within the

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dirty secret”: Problems of disclosure for methadone maintenance clients. *Journal of Psychoactive Drugs*, 24(3), 257-264; Rosenblum, A., Magura, S., & Joseph, H. (1991). Ambivalence toward methadone treatment among intravenous drug users. *Journal of Psychoactive Drugs*, 23(1), 21-27; Stancliff, S., Myers, J.E., Steiner, S., & Drucker, E. (2002). Beliefs about methadone in an inner-city methadone clinic. *Journal of Urban Health*, 79, 571-578; Zweben, J., & Sorensen, J. (1988). Misunderstandings about methadone. *Journal of Psychoactive Drugs*, 20(3), 275-281.

<sup>72</sup> Quoted in White, W., Budnick, C., & Pickard, B. (2011). Narcotics Anonymous: Its history and culture. *Counselor*, 12(2), 10-15, 22-27, 36-39, 46-50.

<sup>73</sup> Narcotics Anonymous World Services, Inc. (2008). *Narcotics Anonymous* (Sixth Edition). Chatsworth, CA, p. 92.

<sup>74</sup> Narcotics Anonymous World Services, Inc. (2008). *Narcotics Anonymous* (Sixth Edition). Chatsworth, CA, p 102-103.

NA fellowship when they are confronted with decisions about mood-altering medications. The pamphlet focused on medications for illness and pain and did not address the question of the use of medication in the treatment of addiction.<sup>75</sup>

In 1996, the NA World Service Board of Trustees issued *Bulletin #29: Regarding Methadone and Other Drug Replacement Programs*. This bulletin reaffirmed via Tradition Three that persons in medication-assisted treatment were welcome to attend NA meetings and that NA has “absolutely no opinion on methadone maintenance or any other program aimed at treating addiction,” but the Bulletin went on to assert NA’s right to limit the participation of NA members who are on “replacement programs.” This acknowledged the growing practice of local NA groups’ prohibiting methadone patients from sharing in meetings, leading meetings, or serving as sponsors or service representatives. The purpose of such restrictions was defined as preserving “an atmosphere of recovery in our meetings.” The Bulletin’s language further characterized persons on medically-supervised methadone or other maintenance medications as being “under the influence of a drug,” “using,” and “not clean.” The Bulletin was clear in affirming NA’s definition of abstinence as precluding the use of methadone as a treatment for opioid dependence.<sup>76</sup> This definition was reaffirmed a year later in NA’s *H & I Service Bulletin #3: H & I Meetings in Methadone Clinics*.

The 2006/2007 NA *Public Relations Handbook* includes a section entitled “Drug Replacement,” noting that people in medication-assisted treatment are welcome at NA meetings, but also reaffirming that NA is a program of complete abstinence, which means “complete abstinence from all mood- and mind-altering drugs, including those used in drug replacement therapies.”<sup>77</sup> It went on to reiterate that “...experience with recovery in NA means that we are able to live free from all drugs without the need to substitute one drug for another.”<sup>78</sup> However, this publication takes a more moderate tone than that of World Services Bulletin # 29, in the acknowledgement that some NA members “have tapered their drug use to abstinence through replacement methods.”<sup>79</sup> The *Handbook* admonishes NA members to avoid telling others to stop taking any medication, but reaffirms that NA “does not endorse the use of any drug.”<sup>80</sup> Regarding the question of people in medication-assisted treatment speaking at meetings, the *Handbook* says: “Sometimes meeting formats ask those who have used drugs not to speak—but it is not our job to judge or evaluate if someone is clean or not.” There is, however, acknowledgement that local groups may choose to exclude those on “drug-replacement medications,” to prevent the NA program from being misrepresented as anything other than a program of complete abstinence.<sup>81</sup>

In 2007, NA World Services issued the pamphlet, *NA Groups & Medication*. This pamphlet consists of two pronouncements. The first is a general statement about medication use by NA members, in which medication is declared an “outside issue” and

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<sup>75</sup> Narcotics Anonymous World Services, Inc. (1992). *In times of illness*. Van Nuys, CA.

<sup>76</sup> Narcotics Anonymous World Services, Inc. (1996). *World Service Board of Trustees Bulletin #29: Regarding methadone and other drug replacement programs*. Retrieved December 22, 2010 from <http://www.na.org/?ID=bulletins-bull29>

<sup>77</sup> NA World Services, Inc. (2006/2007). *Public Relations Handbook*, Chatsworth, CA, p. 67.

<sup>78</sup> Loc. cit.

<sup>79</sup> Loc. cit.

<sup>80</sup> Ibid, p. 56.

<sup>81</sup> Ibid, p. 67.

NA groups are encouraged to approach this issue with a “loving and inclusive attitude” and through the principles of “tolerance, love and compassion.” Regarding restrictions on member activities within NA, it is suggested that local groups “exercise judgment in deciding if a member is able to perform the task associated with the service position, not whether a member is taking medication.” Persons using medications for physical or mental illness are not referred to as still using or compromising their “clean” status. But on the question of methadone and other pharmacotherapeutic agents used in the treatment of addiction, the position set forth in 2007 is quite different. First, there is a clear assertion that NA views the use of medication as a “drug replacement” therapy for addiction differently than the use of medication (even these same medications) for physical or mental illness because of NA’s philosophy of complete abstinence. The second pronouncement concerns the right of local NA groups to restrict participation of NA members taking “replacement” medications is reaffirmed on the grounds that the definition of abstinence precludes taking such medication.

*...many addicts on drug replacement eventually do get clean, stay clean, and find a way of life they thought was unobtainable before coming to NA.<sup>82</sup>*

*Some groups may decide to encourage those on drug replacement to serve as coffee or tea makers, or as a clean-up person, instead of holding leadership positions. These commitments may encourage a desire for complete abstinence through allowing these members to feel part of NA.<sup>83</sup>*

In 2008, the Sixth Edition of NA’s Basic Text was published and included two stories from members on medication, in addition to the earlier-referenced guidance about medications used to treat pain. The story entitled “The Only Requirement” recounts the story of a woman who was receiving methadone treatment and continuing to use other legal and illegal drugs when she first came to NA. She writes about being welcomed into NA and coached through some members’ negative attitudes toward her medication use, having to “run a gauntlet of drug dealers” as she approached and left the methadone clinic, the support she received from NA members through her subsequent decision to taper off methadone, and her continued recovery for 21 years following this tapering process.<sup>84</sup> The second story, entitled “A Serene Heart,” recounts the life of an NA member suffering from addiction and mental illness, early years of stability in NA, a later resurgence of his mental illness, the assistance of NA members in seeking and finding help, and the struggles he experienced integrating medication for mental illness into his NA addiction recovery program.<sup>85</sup>

In 2010, NA published a substantially revised edition of *In Times of Illness*. This pamphlet addresses medication used in the treatment of addiction only in the following brief statement.

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<sup>82</sup> NA World Services, Inc (2007). *NA groups & medication*. Retrieved December 22, 2010 from [http://www.na.org/admin/include/spaw2/uploads/pdf/servicemat/NA\\_Groups\\_and\\_Medication\\_Sep07.pdf](http://www.na.org/admin/include/spaw2/uploads/pdf/servicemat/NA_Groups_and_Medication_Sep07.pdf).

<sup>83</sup> Ibid.

<sup>84</sup> Narcotics Anonymous World Services, Inc. (2008). *Narcotics Anonymous* (Sixth Edition). Chatsworth, CA, pp. 184-186.

<sup>85</sup> Narcotics Anonymous World Services, Inc. (2008). *Narcotics Anonymous* (Sixth Edition). Chatsworth, CA, pp. 254-260.

*Sometimes, with sustained chronic pain in recovery, healthcare providers will prescribe certain medications for pain that are also used as drug replacement medications. It is important to remind ourselves that we are taking this medication as prescribed for physical pain. In this medical situation, these medications are not being taken to treat addiction.<sup>86</sup>*

While the revised *In Times of Illness* suggests to its readers that it may be appropriate to take a medication like methadone for the treatment of pain, it would not be appropriate to take this same medication for the treatment of addiction. There are, however, key principles set forth in this document that NA and other recovery mutual aid groups may one day apply to all medications, including those used in the treatment of addiction. Those principles will be outlined later in this paper.

Seen as a whole, NA literature defines the use of medically supervised methadone maintenance and other pharmacotherapies for opioid addiction as differing little from illicit drug use or alcohol use. It asserts that views restricting the participation of NA members on medications like methadone and buprenorphine are means of asserting NA's philosophy of complete abstinence and maintaining the recovery atmosphere of NA meetings. This stance on medication is not based on a total prohibition of the use of psychoactive medications or, more specifically, of the use of substances that have the potential for creating physical dependence. This becomes clear in light of NA's position on the use of such medications for the treatment of other illnesses, and the fact that NA members can be addicted to nicotine and still speak at meetings, hold service positions, and claim their "clean" status. In addition, NA's concern about addiction treatment medications is explicitly defined, not in terms of intoxication/impairment related to opioid addiction medications, but in terms of the status of using these medications. Historically, this stance has 1) defined the boundaries of "total abstinence" for NA members, 2) protected NA members from relapse associated with the medically prescribed use of psychoactive medication, and 3) created physical and psychological distance between NA members and the licit and illicit drug cultures.

And yet, one still senses within NA literature an undercurrent of ambivalence related to the issue of medication.

*The use of medication is an issue that many members have strong feelings about, but a group is not there to enforce, endorse, or oppose members' personal opinions.<sup>87</sup>*

*Our challenge is to continue to practice tolerance, patience and love, so that we create an atmosphere in which those who want to recover can do so.<sup>88</sup>*

Such ambivalence has also been expressed by individual NA members in the pages of the *NA Way Magazine*.

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<sup>86</sup> Narcotics Anonymous World Services, Inc. (2010). *In Times of Illness*. Van Nuys, CA., P. 34.

<sup>87</sup> NA World Services, Inc (2007). *NA groups & medication*. Retrieved December 22, 2010 from [http://www.na.org/admin/include/spaw2/uploads/pdf/service/NA\\_Groups\\_and\\_Medication\\_Sep07.pdf](http://www.na.org/admin/include/spaw2/uploads/pdf/service/NA_Groups_and_Medication_Sep07.pdf).

<sup>88</sup> NA World Services, Inc (2007). *NA groups & medication*. Retrieved December 22, 2010 from [http://www.na.org/admin/include/spaw2/uploads/pdf/service/NA\\_Groups\\_and\\_Medication\\_Sep07.pdf](http://www.na.org/admin/include/spaw2/uploads/pdf/service/NA_Groups_and_Medication_Sep07.pdf).

*In reference to World Service Board of Trustees Bulletin # 29, "Regarding Methadone and Other Drug Replacement Programs," the members of the World Board should be prepared to justify why they are competent to make a pronouncement on medical treatments, as well as be prepared to support patients who may suffer because of their pronouncement. When a physician prescribes a medication to a patient, no one should alter the treatment except another physician.<sup>89</sup>*

*Some [NA] members may need medication to improve their quality of life. Do we have the capacity to judge the legitimacy of that prescription?...I personally know some members who need to take their medication, and there are a number of us who consider them clean. We believe they have every right to celebrate their clean birthdays in the normal way...If we are able to accept individuals who attend meetings under the influence of drugs all the time, why is it so difficult for us to accept the fact that we have fellow members who legitimately need to take prescribed medication?<sup>90</sup>*

NA's views on methadone and buprenorphine and the scientific/medical view of these medications have developed in virtual isolation from one another, due to several factors: 1) the lack of communication channels between these two worlds, 2) a 12-Step story style that excludes acknowledging external factors (e.g., medication, therapy, religion, participation in other fellowships) that contribute to one's recovery, 3) the avoidance of NA by high-functioning patients in medication-assisted recovery (or their withholding their medication status within NA), and 4) the refusal of many opioid addiction treatment programs to link their patients to NA because of NA's policies on restricted participation of persons on opioid addiction treatment medications.

Science-based approaches to medication-assisted treatment of opioid addiction and NA's spiritual framework of addiction recovery would appear to be—and, in the end, may be—incompatible. But such potential incompatibility is driven, not so much by the views of NA members toward particular medications used in the treatment of opioid addiction, as by the more central premise that NA recovery is rooted in a commitment to abstinence that is itself both a catalyst and an outcome of a process of spiritual surrender. This incompatibility also rests on the experience-based belief within NA that medications have the potential to prevent or blunt the process of spiritual transformation that is at the core of its program.

Whether patients in medication-assisted treatment should or can find sanctuary and support within NA hinges more on the question of whether spiritual and material aids to recovery can be reconciled (e.g., integrated or sequenced) with such treatment than on NA members' understanding of the latest scientific findings on medications used in the treatment of addiction. Before further exploring this question, we will pause to examine the experience of patients in medication-assisted treatment who have reached out to NA for recovery support.

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<sup>89</sup> Abstinence is...(2003). *NA Way Magazine*, 20(1), p. 16.

<sup>90</sup> Who am I to judge? (2003). *NA Way Magazine*, 20(1), p. 15.

## THE PATIENT PERSPECTIVE

Men and women in medication-assisted recovery have historically been silenced by the stigma attached to opioid addiction; the social and professional stigma attached to medication-based treatment of opioid addiction; the enforced silence of those in medication-assisted treatment attending NA; and the lack, until quite recently, of a vibrant recovery advocacy movement that included patients in medication-assisted recovery. Close observers of the life experience of patients in medication-assisted treatment consistently note pervasive themes of stigma and isolation.<sup>91</sup>

*Positing recovery as a journey of self-transformation, the methadone patient subsists in undetermined space—a hinterland beyond the clearly demarcated identity fissures of “addict” or “recovering addict.” In the absence of a proactive recovery culture, the methadone maintenance patient becomes tied to an archetypal “spoiled identity”<sup>92</sup> to be managed and governed rather than retrieved, nurtured and healed.<sup>93</sup>*

There exists not a single, systematic study of the experiences of persons involved in the pharmacotherapeutic treatment of opioid addiction as they seek recovery support through participation in NA or other recovery mutual aid groups. Consequently, four alternative methods were used to solicit patient voices for inclusion in this paper. First, the discussion boards and forums of websites frequented by methadone, buprenorphine, and naltrexone patients, as well as NA Message Boards, were scanned to locate posts from patients' perspectives related to NA and medication. Second, patient-authored articles in newsletters of both opioid treatment programs and patient advocacy groups were reviewed to locate discussions of NA. Third, the author posted signs posted at medication-assisted recovery websites and within a sample of opioid treatment programs, inviting patients to share their experiences within NA with the author. Fourth, the author re-contacted methadone patients who had provided feedback on an earlier publication,<sup>94</sup> inviting them to describe their past or current experiences with NA. While there is no claim that the responses obtained from these methods are representative of the experiences of all patients in medication-assisted recovery, the responses did cluster into clearly identifiable themes and do represent the first effort to assemble patient voices on their experiences in NA.

Seen as a whole, these patients expressed a variety of experiences that included:

- respect and appreciation for NA as a recovery support institution;
- confusion and shame related to what they perceive as their demeaned status within NA;
- hurt, anger, and increased defiance related to limitations on their degree of NA participation due to their medication status; and

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<sup>91</sup> Vigilant, L. G. (2001). "Liquid handcuffs": The phenomenology of recovering on methadone maintenance. *Boston College Dissertations and Theses*.

<sup>92</sup> Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Englewood Cliffs: Prentice-Hall.

<sup>93</sup> S. Bamber, personal communication, March 22, 2010.

<sup>94</sup> White, W., & Torres, L. (2010). *Recovery-oriented methadone maintenance*. Chicago, IL: Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health and Mental Retardation Services, and Northeast Addiction Technology Transfer Center.

- avoidance or abandonment of NA and exploration of other recovery mutual aid alternatives.

These themes are more fully detailed in the comments below—offered here with a minimum of commentary. (Note: Punctuation, capitalization, and spelling errors have been corrected for ease of reading.)

Respect and Appreciation: Several respondents in medication-assisted treatment reported having achieved sustained recovery within NA and expressed great appreciation for NA in spite of some of the attitudes they encountered toward medication. The following comments are representative of that experience.

*I'm currently on suboxone. It saved my life/marriage, along with Jesus Christ and a great NA group.<sup>95</sup>*

*I went to meetings while on methadone and was honest with my sponsor and with my closest support group. I participated in service. I got off methadone without a relapse. I have stayed clean/sober for almost five years, and everything is okay. Thank God people in my NA did not judge me because I was on methadone. It saved my life, along with the 12 Steps and doing service!!!!<sup>96</sup>*

*I have participated in 12-Step-type recovery programs, and I find them a necessary part of treatment. It is a shame that NA and 12-Step groups feel about MM patients like they do, because I think if there was a way to combine the two therapies, there would be more successful recovering opiate addicts out there.<sup>97</sup>*

*I love NA....I've met tons of people in meetings who stick and stay and get recovery who are on suboxone!<sup>98</sup>*

*Everyone [NA members] has been very cool about it [medication], and some are in favor of it and some are not. So everyone has their own opinions, though none of them have knocked me for it [methadone]. Some just say it's a great drug, and it does wonderful things for some people.<sup>99</sup>*

*I really think the best thing for myself has been sticking with NA and working the steps, in addition to the Suboxone. It seems like the ideal treatment, and I don't plan on stopping anything. The Suboxone holds the physical side of my disease intact, while the meetings take care of the mental/spiritual.<sup>100</sup>*

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<sup>95</sup> Retrieved December 23, 2010 from

<http://www.nachatroom.org/forum/viewtopic.php?f=4&t=1224&p=5206&hilit=suboxone#p5206>.

<sup>96</sup> Retrieved December 23, 2010 from <http://www.soberrecovery.com/forums/narcotics-addiction-12-step-support/128061-going-na-meetings-methadone.html>.

<sup>97</sup> Feedback from MM patient to author, May 2010; quoted in: White, W., & Torres, L. (2010). *Recovery-oriented methadone maintenance*. Chicago, IL: Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health and Mental Retardation Services, and Northeast Addiction Technology Transfer Center, p. 103.

<sup>98</sup> Retrieved December 9, 2010 from <http://suboxforum.com/viewtopic.php?t=291>.

<sup>99</sup> Retrieved December 9, 2010 from <http://www.stepsfoundation.com/RecoveryMeetings.htm>.

<sup>100</sup> Retrieved December 9, 2010 from <http://suboxforum.com/viewtopic.php?t=291>.

*Since the summer of 1994, I have been regularly attending NA meetings, usually four to five meetings a week. I go to some regular meetings but also try out new ones. At all these various meetings, they have never told me I cannot share at a table because of being a methadone patient (and, yes, I am honest about it)... I think NA is a wonderful program!*<sup>101</sup>

Tension/Confusion/Shame: Patients in medication-assisted recovery report being shamed in NA and in their broader social worlds for their decision to start and continue in medication-assisted treatment.

*When I heard my former friend say this [you've been fooled by legal drug dealers and are getting high every day], my face turned hot and tingly. I was completely rattled. It shook me up so bad that I couldn't stop thinking about what he said. I really felt bad, because, for a few moments, I agreed with him....It was driving me crazy that I doubted my own sobriety....Then I talked to a few people, which seems to be the best medicine in recovery, and they reminded me of how much of a better person that I have grown into...*<sup>102</sup>

*Some people in the rooms of Narcotics Anonymous believe that I am not clean [because of taking Subutex]. As judgmental as people can be, I know that I can look in the mirror and know that I have not found any reason to put a drink or drug in me for four years.*<sup>103</sup>

*I went to NA meetings, and they told me I wasn't really clean. I had a sponsor and he said the same. One day at the beginning of the meeting, the leader said that, if you're on methadone or suboxone, that please just be quiet and let the others talk, and when you're sober you can talk. Needless to say, after that I pretty much shut them all out. I felt like crap. I was doing really good, too. I still am and have been on suboxone for almost two years now, and I'm still clean.*<sup>104</sup>

*I have been told I was not clean, that I could not speak in meetings or serve in any position, and NA's bulletin #29 was referenced. Online, I have been told by NA members that I was lying to myself and misleading others by saying what MM had done for me, that I should be ashamed, that I was "killing drug addicts," that I was taking "the easier, softer way", that I was "still getting high on a daily basis" and on and on. The judgment was harsh and constant.*<sup>105</sup>

*Now, what about this? I am on methadone for methadone maintenance treatment ...AND pain management! So...Is it only considered that I am "not using" if I am taking it for pain management? So, as long as I take my methadone pills, and I say that I am taking it for pain, then I am "not using." BUT if I take the EXACT SAME drug in the same way, and say that I am on it for "MM," then I am*

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<sup>101</sup>Retrieved December 13, 2010 from [http://www.methadonetoday.org/v1n5\\_4.htm#Narcotics Anonymous NA](http://www.methadonetoday.org/v1n5_4.htm#Narcotics%20Anonymous%20NA).

<sup>102</sup>Forman, M. (2011). Are we really in recovery? *The Net-Work*, 2(1), p. 2.

<sup>103</sup>MM patient communication to author, January 21, 2011.

<sup>104</sup>Retrieved December 9, 2010 from <http://suboxforum.com/viewtopic.php?t=291>.

<sup>105</sup>MM patient communication to the author, December 28, 2010.

"using."<sup>106</sup>

We [methadone patients] were allowed to be at the [NA] meetings but not to be part of it in any way.<sup>107</sup>

I have had some people [in an NA meeting] get up and go to the men's room when it is my turn to speak or when I used to collect a keytag, just so they didn't have to listen to my share.<sup>108</sup>

**Hurt, Anger, and Defiance:** For many people in medication-assisted recovery, the shame elicited by responses to their treatment within evolves into hurt, anger, and—in some cases—defiance.

[In NA, I experienced] much pressure from both moderators and participants that MAT was "continued illicit usage," "trading one addiction for another," "not being clean," with admonitions that I was not permitted to participate in meetings actively but could only "sit, listen, and hopefully learn." Learn what?? To abandon that which I found to be the ONLY thing that kept me out of the demon's hands?!<sup>109</sup>

[Because of the NA attitudes toward medication] I was almost at the point I was ready to just give it up and forget about all of this crap, go off on a binge and hope to be found dead. But I thought it through and realized that it isn't worth throwing away all of the recovery I have made....I have been told to be quiet about my use of suboxone to others. So, that's the way I will play it....I don't care what some of the NA people think; it's just the rejection I felt the most from the ones that initially embraced me and then stepped back that hurt me the most.<sup>110</sup>

When I was going to NA meetings, I felt like I had to hide the fact that I was on methadone. I never told them. I felt if I did they wouldn't take me seriously. Eventually, it made me not want to go to the meetings. I wish they accepted the fact that I'm not in the depths of my addiction or abusing drugs. I am recovering.<sup>111</sup>

It [NA World Services Bulletin #29] encourages a person on methadone to "participate only by listening and by talking with members after the meeting, or during the break only." But they tell us that it is not meant to alienate or embarrass us, but to reserve an atmosphere of recovery in their meetings. This way of thinking has become a constant hurdle for anyone using methadone AS A MEDICATION.<sup>112</sup>

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<sup>106</sup> Retrieved December 9, 2010 from <http://bluelight.ru/vb/showthread.php?t=487993&page=2>.

<sup>107</sup> Personal communication to author from methadone patient, December 23, 2010.

<sup>108</sup> Retrieved December 9, 2010 from <http://www.addictionsurvivors.org/vbulletin/showthread.php?t=20100>.

<sup>109</sup> Personal communication from MM patient to the author, December 27, 2010.

<sup>110</sup> Retrieved December 9, 2010 from <http://www.addictionsurvivors.org/vbulletin/showthread.php?t=20100>.

<sup>111</sup> Retrieved December 9, 2010 from <http://methadone.forumotion.net/do-you-have-any-questions-about-methadone-f5/methadone-anonymous-ms-meeting-t554.htm>.

<sup>112</sup> Qualters, T., Forman, M., Forman, S., & DeLeon, J. (2010). NA says "metha-don't". *The Net-Work*. Retrieved from [http://netsteps.org/uploads/NET\\_Steps\\_PIR\\_newsletter\\_8-2010.pdf](http://netsteps.org/uploads/NET_Steps_PIR_newsletter_8-2010.pdf).

*...HATE this viewpoint [NA Bulletin #29], but I still go to meetings regularly and am able to suggest to folks that they may not want to share that they are on MM/Suboxone due to other people's self-righteous judgments.<sup>113</sup>*

*Some people prefer to remain quiet about their suboxone use, but not me... and I've never had someone tell me to stop suboxone and risk dying. Stand your ground and start practicing self-confidence, be who you are and take what's offered at the [NA] meetings. If there are problems, find another meeting that is beneficial to you.<sup>114</sup>*

*Methaphobia is a state of mind in which someone or a group displays an intense fear, bias, and prejudice against people on methadone and methadone programs....It is up to each person on methadone, world wide, to be an educator and to join in the struggle to end the ignorance that perpetuates methaphobia.<sup>115</sup>*

Abandonment of NA/Embrace of Alternatives: Anger and defiance for many people in medication-assisted recovery takes the form of rejecting NA and seeking other recovery support alternatives.

*I had tried both NA and AA as helps in my recovery, but, because of their strictures against participation by those in MAT, and more, because of their pressure to discontinue MAT, I abandoned this as more of a hindrance to my sobriety than a help.<sup>116</sup>*

*I had been a member of my NA Saturday night meeting at a local church here in [city]. I was so into sobriety that when they asked for service work I jumped at it. They elected me treasurer. At that time, being trusted with any money was a miracle. I felt as if I was a responsible, productive member. That went fine until I disclosed I was on methadone. It was as if a silent bomb went off. Everyone looked at each other as if I was an alien. I was stripped of all privileges and had to give back the key to the church basement. I was horrified and pissed off. I had done a good job. I quit that meeting that night and have not gone back since.<sup>117</sup>*

*I have attended around 500 NA meetings over the past 15 years or so. I had sponsors, worked the steps, read all the literature, and read extensively on the background and development of NA. I no longer attend or consider myself a member.<sup>118</sup>*

*I still went to meetings almost every day, and, when I had enough clean time, I was supposed to speak at a meeting. Just before the meeting, someone asked me if I was still on methadone. Not wanting to lie, I said yes. I was told that I could not speak at any NA meeting because I wasn't really clean! I was going to leave the fellowship, but my recovery is too important to be ruined by some*

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<sup>113</sup> Retrieved December 9, 2010 from <http://bluelight.ru/vb/showthread.php?t=487993&page=2>.

<sup>114</sup> Retrieved December 9, 2010 from <http://www.addictionsurvivors.org/vbulletin/showthread.php?t=20100>.

<sup>115</sup> Sobel, I. (1995). Methaphobia: Us and them. *The Ombudsmen*, (3/4), 5-6. Retrieved December 13, 2010 from [http://www.methadonetoday.org/v1n5\\_4.htm](http://www.methadonetoday.org/v1n5_4.htm). This isn't the correct website for this article.

<sup>116</sup> Personal communication to the author from an MM patient, December 28, 2010.

<sup>117</sup> Personal communication to the author from an MM patient, December 22, 2010.

<sup>118</sup> MM patient communication to author, December 28, 2010.

*ignorant people who know nothing about methadone and don't want to. Soon, however, I started to go to Methadone Anonymous [MA] meetings. At MA, I didn't have to lie about being on methadone and could share about my issues without being judged by anyone because of the type of treatment I am on. Thank God for MA!*<sup>119</sup>

*I have now been clean over two years and am in college. I have a new chance at life, and MA is a big part of the reason for that. I would like to see more MA meetings in the [city] area, because we have so many people who want to go to meetings, but are not willing to be judged and discriminated against at other "fellowships".*<sup>120</sup>

*I have found AA to be more accepting [of medications for opioid addiction] than NA.*<sup>121</sup>

*It is time for people in [medication-assisted] recovery that are not members of 12 Step groups to build their own source of support groups. I think it is completely possible to create meetings for people in medication-assisted recovery in every town in the US. Our recovery is unique and has its own set of problems and solutions. I want and need fellowship from people like me—people on Suboxone, and I need to be able to speak about it as openly as I choose. I have a voice, and it is my right to not be silenced.*<sup>122</sup>

If there was a final theme emerging from the comments of patients collected by the author, it was hope that attitudes toward medication-assisted treatment might one day change in NA.

*It does not matter what the rest of the world thinks about how we recover. What matters is that we do it. Don't let this make you feel every bit of time and energy you have put into getting healthy was not real. Since being in NA, I have noticed that many members frequently relapse, but I am not one of them. I keep my treatment [medication] to myself, and I celebrate my time in recovery because it is REAL. Some day, self-help groups will catch up with the science of addiction recovery....*<sup>123</sup>

*I wish and pray one day NA would understand that a person who takes medication from a doctor does not stop his/her recovery; it helps the person to stay in recovery and take care of themselves at the same time.*<sup>124</sup>

## RESTRICTED NA PARTICIPATION AND RECOVERY OUTCOMES

In formulating policies and practices related to patient referrals to recovery mutual aid groups, medication-assisted treatment programs will need to consider the effects of full versus restricted participation on recovery outcomes. The comments reviewed in the

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<sup>119</sup> Retrieved December 9, 2010 from <http://www.methadonesupport.org/Stories.html>.

<sup>120</sup> Retrieved December 9, 2010 from <http://www.methadonesupport.org/Stories.html>.

<sup>121</sup> Retrieved December 9, 2010 from <http://bluelight.ru/vb/showthread.php?t=487993&page=2>.

<sup>122</sup> Retrieved December 9, 2010 from <http://suboxforum.com/viewtopic.php?t=291>.

<sup>123</sup> Retrieved December 9, 2010 from <http://www.addictionsurvivors.org/vbulletin/showthread.php?t=20100>.

<sup>124</sup> Personal communication to the author from a methadone patient, December 23, 2010.

previous section confirm that many patients in medication-assisted treatment are greatly benefiting from NA, and that there are NA members who were able to taper successfully from medications with the support of NA. (No study has been conducted of the experiences of these latter NA members.) But the comments also raise the question of potential harm that might occur to patients from the attitudes they encounter towards medications within NA—either through the consequences of precipitously terminating their medication use or through being denied the benefits of key ingredients of the NA program.

No studies are available detailing the influence of NA on tapering decisions or comparing the recovery outcomes of patients in medication-assisted treatment and non-restrictive NA groups to the recovery outcomes of medication-assisted patients whose degree of participation in NA is restricted. However, there are studies suggesting the possible effects of restricted participation. First is a collection of studies, small in number compared to studies of AA, that reveal that NA attracts and retains a portion of opioid-dependent persons,<sup>125</sup> and a broader set of studies concluding that participation in NA elevates recovery outcomes for adults<sup>126</sup> and for adolescents.<sup>127</sup> These studies underscore the assertions that access to NA and full participation in NA are important issues for the long-term recovery of patients in medication-assisted treatment.

A second class of studies links these positive effects to several “active ingredients” of 12-Step programs. There are many such ingredients (e.g., public commitment, sustained self-monitoring, spiritual orientation, coping skills, increased self-efficacy, and exposure to sober role models,<sup>128</sup> to name just a few), but there are four such ingredients that relate specifically to the restricted levels of NA participation often faced by patients in medication-assisted treatment. The first is the critical role of identity transformation within

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<sup>125</sup> Best, D. W., Harris, J. C., Gossop, M., Manning, V. C., Man, L. H., Marshall, J., & Strang, J. (2001). Are the Twelve Steps more acceptable to drug users than to drinkers? A comparison of experiences of and attitudes to Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) among 200 substance misusers attending inpatient detoxification. *European Addiction Research*, 7, 69-77.

<sup>126</sup> Gossop, M., Stewart, D., & Marsden, J. (2008). Attendance at Narcotics Anonymous and Alcoholics Anonymous meetings, frequency of attendance and substance use outcomes after residential treatment for drug dependence: A 5-year follow-up study. *Addiction*, 103(1), 119-125; Kelly J. F., & Yeterian, J. (2008). Mutual-help groups. In W. O’Donohue & J. R. Cunningham (Eds.), *Evidence-based adjunctive treatments* (pp. 61-106). New York: Elsevier.

<sup>127</sup> Kelly, J. F., Dow, S. J., Yeterian, J. D., & Kahler, C. W. (2010). Can 12-step group participation strengthen and extend the benefits of adolescent addiction treatment? A prospective analysis. *Drug and Alcohol Dependence*, 110, 117-125; Kelly, J. F. & Myers, M. G. (2007). Adolescents’ participation in Alcoholics Anonymous and Narcotics Anonymous: Review, implications and future directions. *Journal of Psychoactive Drugs*, 39, 259-269; Morgenstern, J., Labouvie, E., McCrady, B., Kahler, C. W., & Frey, R. M. (1997). Affiliation with Alcoholics Anonymous after treatment: A study of its therapeutic effects and mechanisms of action. *Journal of Consulting and Clinical Psychology*, 65(5), 768-777; Sussman, S. (2010). A review of Alcoholics Anonymous/Narcotics Anonymous programs for teens. *Evaluation and the Health Professions*, 33, 26-55.

<sup>128</sup> For reviews, see: Kelly J. F., & Yeterian, J. (2008). Mutual-help groups. In W. O’Donohue & J. R. Cunningham (Eds.), *Evidence-based adjunctive treatments* (pp. 61-106). New York: Elsevier. Moos, R.H. (2008). Active ingredients of substance-focused self-help groups. *Addiction*, 103, 387-396; White, W., & Kurtz, E. (2006). *Linking addiction treatment and communities of recovery: A primer for addiction counselors and recovery coaches*. Pittsburgh, PA: IRETA/NeATTC; White, W. (2009). *Peer-based addiction recovery support: History, theory, practice, and scientific evaluation*. Chicago, IL: Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health and Mental Retardation Services.

addiction recovery<sup>129</sup>—a transformation that occurs in great part through the acts of story-reconstruction and storytelling.<sup>130</sup> Members achieve this through the normal experience of sharing in NA meetings and in being invited to share their stories in a more expansive manner (e.g., at a speaker's meeting or in other NA venues). The second critical ingredient is the use of NA to replace an addiction-supportive social network with a recovery-supportive social network.<sup>131</sup> The third ingredient is participation in rewarding, recovery-focused social activities.<sup>132</sup> The fourth ingredient involves the therapeutic effects of helping. Serving as a sponsor to others elevates the recovery stability of the sponsor,<sup>133</sup> and such helping activity is often subsequently extended to broader patterns of fellowship service and community service.<sup>134</sup>

The therapeutic potency of these four ingredients has been confirmed in the far more extensive studies on Alcoholics Anonymous, particularly in studies focusing on the importance of social network reconstruction<sup>135</sup> and the therapeutic effects of helping.<sup>136</sup> The effect of these key ingredients on recovery outcomes is further underscored by the finding that they are influenced by the frequency and intensity of participation in these activities.<sup>137</sup> In a 33-year follow-up study of recovery from heroin addiction, Yih-Ing Hser found recovery associated with greater self-confidence in the hope of achieving permanent recovery, stronger coping skills, and a non-drug-using social network—all aspects of recovery that are targets of influence within NA.

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<sup>129</sup> McIntosh, J. & McKeganey, N. (2000). Addicts' narratives of recovery from drug use: constructing a non-addict identity. *Social Science and Medicine*, 50, 1501-1510.

<sup>130</sup> Hanninen, V. & Koski-James, A. (1999). Narratives of recovery from addictive behaviors. *Addiction*, 94(12), 1837-1848; O'Halloran, S. (2008). *Talking oneself sober: The discourse of Alcoholics Anonymous*. Amherst, NY: Cambria Press; O'Reilly, E.B. (1997). *Sobering tales: Narratives of alcoholism recovery*. Amherst, MA: University of Massachusetts Press; White, W. (1996). *Pathways from the culture of addiction to the culture of recovery*. Center City, MN: Hazelden.

<sup>131</sup> Davey-Rothwell, M. A., Kuramoto, S. J., & Latkin, C. A. (2008). Social networks, norms, and 12-step group participation. *American Journal of Drug and Alcohol Abuse*, 34, 185-193; Humphreys, K. & Noke, J.M. (1997). The influence of posttreatment mutual help group participation on the friendship networks of substance abuse patients. *American Journal of Community Psychology*, 25, 1-16. Toumbourou, J. W., Hamilton, M., U'Ren, A., Stevens-Jones, P., & Storey, G. (2002). Narcotics Anonymous participation and changes in substance use and social support. *Journal of Substance Abuse Treatment*, 23, 61-66.

<sup>132</sup> Moos, R.H. (2008). Active ingredients of substance use-focused self-help groups. *Addiction*, 103, 387-396.

<sup>133</sup> Crape, B.L., Latkin, C.A., Laris, A.S., & Knowlton, A.R. (2002). The effects of sponsorship in 12-step treatment of injection drug users. *Drug and Alcohol Dependence*, 65, 291-301.

<sup>134</sup> Kurtz, L.F., & Fisher, M. (2003). Participation in community life by AA and NA members. *Contemporary Drug Problems*, 30, 875-904.

<sup>135</sup> Bond, J., Kaskutas, L.A., & Weisner, C. (2003). The persistent influence of social networks and Alcoholics Anonymous on abstinence. *Journal of Studies on Alcohol*, 64(4), 579-588. Laudet, A.B., Cleland, C.M., Magura, S., Vogel, H.S., & Knight, E.L. (2004). Social support mediates the effects of dual-focus mutual-aid groups on abstinence from substance use. *American Journal of Community Psychology*, 34, 175-85. Kaskutas, L.A., Bond, J., & Humphreys, K. (2002). Social networks as mediators of the effects of Alcoholics Anonymous. *Addiction*, 97(7), 891-900.

<sup>136</sup> Zemore, S.E. (2007). Helping as healing among recovering alcoholics. *Southern Medical Journal*, 100(4), 447-450; Zemore, S.E., Kaskutas, L.E., & Ammon, L.N. (2004). In 12-Step groups, helping helps the helper. *Addiction*, 99, 1015-1023.

<sup>137</sup> Gossop, M., Stewart, D., & Marsden, J. (2008). Attendance at Narcotics Anonymous and Alcoholics Anonymous meetings, frequency of attendance and substance use outcomes after residential treatment for drug dependence: A 5-year follow-up study. *Addiction*, 103, 119-125.

It could be argued based on such studies that a warm welcome and full NA membership participation by patients in medication-assisted treatment enhances recovery outcomes via such mechanisms as sustained and strengthened commitment to the recovery process, enhanced self-efficacy, improved coping, recovery-based social supports, and the therapeutic effects of helping others. It could be further argued that a combination of cool welcome and restricted NA participation reduces NA attraction and engagement, denies patients access to recovery-based relationships, and pushes them towards continued enmeshment in the drug culture. NA members in medication-assisted treatment have limited access to several critical ingredients of the NA program, to the extent that they are denied the right to speak in NA, socially ostracized by at least a portion of NA members, and denied access to the therapeutic benefits of helping others. Given these possible outcomes, addiction treatment programs utilizing pharmacological adjuncts within the treatment process will need to assess recovery support options for their patients carefully.

#### OPTIONS FOR OPIOID TREATMENT PROGRAMS (OTPs)

Opioid addiction treatment programs have struggled for decades to give their patients effective links to NA and other communities of recovery.

*Finding the best way to connect patients with the recovery community has been a core issue that we have been working on for the entire 37 years of our existence. Recently we have had success going back to our earlier practice of facilitating onsite groups to assure that the first experience of our resistance patients is a positive one instead of risking the luck of the draw. This is a particular issue for our increasing number of young adults who are so peer oriented.*<sup>138</sup>

In a 2008 survey of OTPs in the United States, 46% of programs reported offering self-help groups to their patients (e.g., AA, NA, MA, SMART Recovery; whether by linkage to community meetings or onsite meetings is unclear), 43% reported offering some form of peer mentoring/support, and 37% reporting using a 12-step facilitation approach to treatment.<sup>139</sup>

There are several strategies that OTPs may utilize in enhancing the availability of peer-based recovery support for the patients and families they serve. All of these strategies rest on three key findings:

- 1) Participation in peer-based recovery support structures elevates recovery initiation and stabilization, facilitates the transition to recovery maintenance, and enhances the quality of personal and family life in long-term recovery.
- 2) Combining participation in recovery mutual aid societies and professionally directed medication-assisted treatment creates recovery outcomes greater than those of either intervention in isolation.

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<sup>138</sup> Personal communication from Dr. George Kolodner, December 7, 2010.

<sup>139</sup> SAMHSA, Office of Applied Studies (January 28, 2010). *The N-SSATS Report: Overview of Opioid Treatment Programs within the United States: 2008*. Rockville, MD.

- 3) The highest rates of patient engagement in recovery mutual aid societies during and following addiction treatment are associated with assertive linkage procedures and sustained recovery coaching.<sup>140</sup>

Some of the more promising practices to enhance medication-assisted patients' participation in NA and other recovery mutual aid groups include the following measures.

- Conduct ongoing professional education to reduce anti-medication biases among staff/volunteers, e.g., stigma attached to high doses, shaming patients for long duration of maintenance, pressure for tapering.
- Create a patient-directed “consumer council” to provide peer recovery support, host recovery celebration events, and recruit stabilized patients to guide new patients into recovery support groups.<sup>141</sup>
- Embrace a “philosophy of choice” based on the assumption that there are multiple (secular, spiritual, and religious) pathways of long-term recovery and that patients may use different recovery support resources at different stages of their recovery careers.<sup>142</sup>
- Conduct a formal evaluation of the attitudes toward medication-assisted treatment among local recovery support fellowships.
- Conduct formal orientation sessions to educate all patients on the value of recovery mutual aid participation and the local and online recovery support options, including secular, spiritual, and religious addiction recovery support groups and groups specifically for people in medication-assisted recovery (e.g., Methadone Anonymous, Mothers on Methadone, Online Steps without Stigma at [www.addictionsurvivors.org](http://www.addictionsurvivors.org)).<sup>143</sup>
- Share the results of the community evaluation as part of the patient orientation process.
- Offer assistance in finding “medication-friendly” recovery support options where patients will be welcomed, respected, and supported.

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<sup>140</sup> For reviews, see White, W. (2009). *Peer-based addiction recovery support: History, theory, practice, and scientific evaluation*. Chicago, IL: Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health and Mental Retardation Services; White, W., & Kurtz, E. (2006). *Linking addiction treatment and communities of recovery: A primer for addiction counselors and recovery coaches*. Pittsburgh, PA: IRETA/NeATTC.

<sup>141</sup> The Net Consumer Council, Evans, A.C., Lamb, R.C., Mendelovich, S., Schultz, C.J. & White, W.L. (2007). *The role of clients in a recovery-oriented system of addiction treatment: The birth and evolution of the NET Consumer Council*. Philadelphia: Philadelphia Department of Behavioral Health and Mental Retardation Services. Posted at [www.williamwhitepaers.com](http://www.williamwhitepaers.com).

<sup>142</sup> White, W. (2008). Toward a philosophy of choice: A new era of addiction treatment. *Counselor*, 9(1), 38-43.

<sup>143</sup> For a guide to all groups, see [www.facesandvoicesofrecovery.org](http://www.facesandvoicesofrecovery.org); for information on Methadone Anonymous see <http://www.methadonesupport.org/state-meetings.html> and 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; McGonagle, D. (1994). Methadone Anonymous: A 12-step program. Reducing the stigma of methadone use. *Journal of Psychosocial Nursing*, 32(10), 5-12.

- Encourage senior members of the Consumer Council to start an on-site MA or NA meeting (initially open only to clinic patients, but more public options could be explored later).<sup>144</sup>
- Work with local H & I Committees (of AA and NA) and other recovery mutual aid service committees, either to host onsite support meetings or to help locate medication-friendly meetings in the community.
- Make available literature of the major recovery mutual aid societies, including all written statements pertaining to medication.
- Avoid mandating AA/NA meetings without knowing which groups welcome and allow full participation of patients in medication-assisted treatment. As one patient suggested to the author:

*I often read of and hear of clinic staff that order their methadone patients to attend NA meetings in order to receive takehomes and other privileges. It always strikes me as appalling that these people seem so unaware of the fact that they are prescribing MM and then sending the patient to a place where they will be shunned for being on MM and told in no uncertain terms that they cannot participate until they stop taking the medication the clinic that sent them there is prescribing.*<sup>145</sup>

- Recruit AA/NA volunteers and current and former patients in long-term recovery who are willing to work with patients, providing linkage to medication-friendly meetings, assistance in negotiating temporary sponsorship, and guidance into the social activities of local communities of recovery.
- Establish paid recovery support specialist (e.g., recovery coach) positions, to provide stage-appropriate recovery education and assertive linkage to communities of recovery.
- Monitor the reported attitudes that each patient experiences in recovery support groups, including attitudes about medication expressed by meeting chairpersons and in communications with sponsors.
- Ensure the availability of professional and peer venues in which patients can discuss medication-related issues, so that these issues do not have to be raised within the context of recovery mutual aid meetings.
- Provide patients with sample scripts that they can use to respond to questions about medication that may arise in the recovery mutual aid context.
- Establish open-ended, professionally led patient/family recovery support groups that, once established, can transition to peer leadership and affiliation with an established recovery support society.
- Create opportunities for patients in medication-assisted recovery to be involved in service work with others seeking or in recovery, and with the larger community.

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<sup>144</sup> Personal communication from Stephen Weinstein, PhD, Department of Psychiatry and Human Behavior, Thomas Jefferson University, February 1, 2011.

<sup>145</sup> MM Patient communication to author, December 28, 2010.

- Develop collaborative relationships with recovery community organizations other than mutual aid groups (e.g., grassroots recovery advocacy and support organizations, recovery community centers, recovery homes, recovery-focused industries, recovery-schools, recovery ministries, and recovery cafés), and assertively link patients with these resources.
- Infuse the treatment milieu with the literature, symbols, slogans, and art of multiple addiction recovery mutual aid societies, and with images that celebrate recovery within and outside of these societies.
- Generate a program-specific recovery culture with its own support meetings, indigenous leaders, literature, symbols, slogans, and art.
- Collect and disseminate program-specific and recovery-focused evaluation data that patients may use to affirm the link between medication-assisted treatment, recovery mutual aid participation, and long-term recovery outcomes.

While these suggestions may be helpful, they will be most effective when they are accompanied by two broader changes within the clinical practices of medication-assisted treatment programs. The first is to redefine these programs' primary missions and identities as those of "addiction treatment programs" rather than "opioid dependence treatment programs." That shift will align these programs more closely with the philosophies of NA and other recovery mutual aid societies. The second broad change is to extend their missions from a focus on acute treatment to a focus on sustained recovery support. This expanded focus sees medication as one entrée in a broad menu of services available to support recovery initiation, the transition to stable recovery maintenance, and the enhanced quality of personal and family life that is possible in long-term recovery. Attitudes toward methadone, buprenorphine, and other medications used in the treatment of addiction will not change until these medications are wrapped in a rich network of ancillary professional and peer-based recovery support services.

With these shifts in place, addiction treatment centers can then define for themselves, their patients and families, the addiction field, allied health professionals, and the public and policy makers the central question that has permeated this paper:

***What, if any, is the difference between a "drug" and a "medication" in the addiction, addiction treatment, and addiction recovery contexts?***

Drugs versus Medications: To the pharmacologist, there may be little difference between a psychoactive *drug* and a psychoactive *medication*. Both encompass substances that alter the physiological functioning of the body and, more specifically, alter mood and mind. But in the context of those suffering from addiction and seeking recovery, the ability or inability to make this distinction can have life or death consequences. It is incumbent on all addiction treatment programs to help their patients understand clearly the distinction between *drug* and *medicine*, between *abstinence* and *using* ("clean" versus "dirty" in NA vernacular, or "medical use" versus "non-medical use" in professional vernacular), and—perhaps most important—the boundary line between *recovery* and continued or resumed addiction.

Robert DuPont, MD, and Mark Gold, MD, two long-tenured and leading addiction treatment experts, offer several useful distinctions between psychoactive medications

that are used to support health and recovery and psychoactive substances, including medicines, that are used as “drugs.” The motivation to use medications is to prevent and treat illness; the motivation to use drugs is brain reward (euphoria). The pattern of using medication is marked by dosages, dosing schedules, and methods of administration that produce steady blood levels of the medication; the pattern of using drugs is marked by dosages and methods administration (e.g., injection, smoking) that create spikes and troughs in blood levels and an associated escalation in the dosage and frequency of administration. Control and monitoring of medication is maintained via open, honest communication with physicians and family members; drug use is characterized by self-monitoring, a progressive loss of control over drug intake, and secrecy and dishonesty related to the presence or patterns of use. The net effect of medication use is a progressive improvement in quality of life; the net effects of drug use is a progressive deterioration in quality of life. Medication is taken within the laws established to govern its manufacture, sale, possession, and use; drug use (other than alcohol use for adults) often involves breeches of law.<sup>146</sup> To these distinctions might be added that taking medication is often nested within other health-promoting and recovery-enhancing behaviors; drug use is often nested within other self-destructive and socially harmful behaviors. Medication use is also nested with a pro-recovery social network; drug use is often nested within a drug-saturated social network.

Distinctions between a drug and a medication are crucial to any recovery mutual aid society’s definitions of “abstinence” and “recovery.” Such distinctions also must be the subject of daily discussions with patients and families within medication-assisted treatment programs, as must the ways in which these programs present themselves to the larger field of addiction treatment, to communities of recovery with whom they wish to collaborate, and to the public and policy makers. Patients in medication-assisted treatment need to understand the definitions of abstinence and recovery, apply the implications of those definitions to themselves, and see “living proof” of the reality and varieties of medication-assisted recovery. Patients need a way to transcend the characterization of medication as “drug replacement” and “harm reduction” and instead associate medication with long-term addiction recovery. They need exposure to a recovery-focused language that can help them re-author their lives. These critical ingredients must first be present within the milieu of medication-assisted treatment programs.

#### OPTIONS FOR PATIENTS

Earlier sections of this paper have highlighted some of the ambivalence, if not outright hostility, that patients in medication-assisted treatment may encounter as they seek support from established recovery mutual aid societies. Patients in medication-assisted treatment have several recovery support options to consider (quotes below are from other patients).

- 1) Explore your options for recovery support by sampling a variety of secular, spiritual, and religious recovery support meetings and the literature of various recovery fellowships. With which of these do you feel the greatest personal fit and the greatest degree of personal acceptance?

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<sup>146</sup> DuPont, R.L. & Gold, M. (2007). Comorbidity and “self-medication. *Journal of Addictive Diseases*, 26, Supplement No. 1, 13-27.

*Look around, because there are more and more...groups starting up [specifically for people in medication-assisted recovery].<sup>147</sup>*

- 2) Identify medication-friendly recovery support resources. Which resources best understand the potentially positive role medication can play in the addiction recovery process? Not all NA groups limit the participation of members receiving medication-assisted treatment, and other recovery fellowships are much more welcoming of people on addiction treatment medications. Find a group that respects your recovery efforts.

*It is important to find a meeting that will not intimidate or judge us based on the **medicine** we take to better our lives. In fact, there are many meetings that support their members despite the **medication** that they may be taking. Remember that everyone in the fellowship are addicts who come together for one universal purpose, which is to stop using no matter what the circumstances and to better our lives by helping one another.<sup>148</sup>*

- 3) Find other people in medication-assisted treatment who share your recovery aspirations. There is a growing number of NA, AA and other recovery fellowship members who are or have been in medication-assisted treatment. Find members who will help you build a recovery program that works for you.
- 4) Remind yourself that negative attitudes toward medication “in the rooms” reflect people’s own efforts to recover and their personal understanding of what that means. Like you, they are seeking recovery in the best way they know.
- 5) Forgive what feels to you like ignorance and bigotry: Anger and resentments are enemies of recovery. Focus on what you share with others in recovery, rather than what separates you.
- 6) Learn your best use of recovery support meetings. Recovery support meetings, particularly NA meetings, are a place for recovery support, rather than medication advice. Such advice should come from addiction-trained physicians. The ways in which medication fits into a larger program of recovery are best addressed in discussions with a trained addictions counselor and, ideally, with your program sponsor.
- 7) Consider other recovery support groups, if your local NA options are particularly hostile towards medication.

*I would counsel, and still do, for them [patients in medication-assisted recovery] to stay clear of ANY involvement in NA/AA, lest it confuse the issues they need to deal with and restrict their options and access to the most effective forms of treatment for*

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<sup>147</sup> June 5, 2010 post at <http://www.topix.com/forum/drug/methadone/T1Q4ABMO8IHD71NOR>.

<sup>148</sup> Qualters, O.T., Forman, M., Forman, S., & DeLeon, J. (2010). NA says “metha-don’t”. *The Net-Work*. Retrieved from [http://netsteps.org/uploads/NET\\_Steps\\_PIR\\_newsletter\\_8-2010.pdf](http://netsteps.org/uploads/NET_Steps_PIR_newsletter_8-2010.pdf).

*their affliction, which is MAT.*<sup>149</sup>

*Some resources I would include might be Women for Sobriety, Rational Recovery, Secular Organization for Sobriety, LifeRing, SMART, Methadone Anonymous.*<sup>150</sup>

*If I can't share and voice how I am doing in one fellowship, then I've gone to other fellowships for the support I need....At MA meetings, we share so honestly about the heavy odds against you and me. People at MA meetings display an intense desire to get well....I've let go of my resentment and I've learned not to fight NA, but to go to MA.*<sup>151</sup>

- 8) Consider online recovery support resources where medication-friendly face-to-face meetings are lacking. A directory of such resources can be found in the recovery mutual aid guide posted and regularly updated at [www.facesandvoicesofrecovery.org](http://www.facesandvoicesofrecovery.org).
- 9) Discuss recovery support options with your counselor or recovery coach, to identify particular groups and meetings that welcome patients in medication-assisted treatment.
- 10) Initially withhold your medication status until you have time to assess a personal fit with a recovery mutual aid fellowship. In each group/meeting you explore, give members time to get to know you personally, and give yourself time to know them. As one patient humorously advised:

*If you are going to the same meeting over and over, they will come to know you and won't mind your methadone cooties so much.*<sup>152</sup>

- 11) Find a sponsor or experienced guide within the group you select, who can help you integrate your medication management within the group's larger framework of recovery. Keep testing these relationships until you find one that really "clicks."
- 12) Consider starting your own group, if you encounter hostile attitudes toward medication in local recovery support meetings and can find no local support options. Information about starting new groups is available at [www.facesandvoicesofrecovery.org](http://www.facesandvoicesofrecovery.org).

#### FUTURE INFLUENCES ON ATTITUDES OF RECOVERY MUTUAL AID SOCIETIES TOWARD MEDICATION-ASSISTED TREATMENT

Before drawing this discussion to a close, we will pause for a moment to identify those forces that are likely to influence future attitudes among American recovery mutual aid groups toward medications used in the treatment of opioid and other addictions. A

<sup>149</sup> MAT patient, personal communication with author, December 28, 2010.

<sup>150</sup> MAT patient, personal communication with author, December 27, 2010.

<sup>151</sup> Sobel, I. (1995). Methaphobia. *Methadone Today*, 1, 1-3, December.

<sup>152</sup> June 5, 2010 post at <http://www.topix.com/forum/drug/methadone/T1Q4ABMO8IHD71NOR>.

number of elements might inhibit any softening of attitudes toward the involvement or participation of patients in medication-assisted treatment for opioid addiction including the strength of the historical bias against the use of medication in the treatment of addiction, prevailing misconceptions about opioid addiction treatment medications (particularly methadone), media coverage of methadone- and buprenorphine-related deaths (most of which are related to the prescription of these medications for pain rather than addiction treatment), and the discovery of any new harmful long-term side-effects related to medications used in the treatment of opioid addiction. However, forces are mounting that will: 1) exert pressure for existing groups to reconsider their stance on addiction treatment medications, 2) contribute to the expansion of existing medication-assisted recovery support groups, and 3) spawn new recovery support structures.

Changing Profile of Opioid Addiction: In 2008 there were 2,176,000 new users of illicit pain killers and 114,000 new heroin users in the United States.<sup>153</sup> The recent dramatic growth of opioid addiction among young people from culturally affluent families and from rural and non-urban communities will create pressure to link medication-assisted treatment with broader sources of psychosocial/spiritual support for long-term recovery. The number of people seeking treatment options for opioid dependence is growing. According to a recent report, the number of methadone patients in the United States increased 26% between 2002 and 2009, to 284,608 patients; and there were 640,000 buprenorphine patients in 2009, treated by 19,500 physicians trained and certified under the Drug Addiction Treatment Act of 2000.<sup>154</sup> Given the time lag between onset of addiction and help-seeking, the number of people seeking medication-assisted treatment of opioid addiction and reaching out to NA and other addiction recovery mutual aid societies can be expected to increase steadily in the coming years.

Pace of New Medication Development: The multi-billion dollar investment in research on the neurobiology of addiction is bearing and will continue to bear the fruit of new medications, new forms of existing medications, new technologies of medication delivery (e.g., aerosols, transdermal patches, high-speed injection, implantable pumps, and long-acting implants), medication combinations, addiction vaccines, the ability to match medications to unique genetic vulnerabilities, and sophisticated protocols combining medications with psychosocial recovery support services.<sup>155</sup> The increased prevalence of polyaddiction among members of NA, AA, and other recovery support fellowships, the likely emergence of new medical treatments for opioid and non-opioid drug addiction, and the growing acceptance of and successful recovery associated with less controversial medications (e.g., the use of naltrexone in the treatment of alcoholism) will further

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<sup>153</sup> SAMHSA (2008). *Results from the 2008 National Survey on Drug Use and Health: National findings* (Office of Applied Studies, NSDUH Series L H032; DHHS Publication No SMA 07-4293). Rockville, MD: Author.

<sup>154</sup> Reuter, N. (2010, October). *SAMHSA Update*. Presentation at the NASCSA National Conference, October 19, 2010 (citing NSSATS 2008 data). According to data presented earlier in this paper, the number of patients treated for addiction with buprenorphine preparations significantly increased in 2010.

<sup>155</sup> Kleber, H.D. (2005). Future advances in addiction treatment. *Clinical Neuroscience Research*, 5, 201-205. Montoya, I.D., & Vocci, F. (2008). Novel medications to treat addictive disorders. *Current Psychiatry Reports*, 10(5), 392-398). Volkow, N. (2010). Treating addiction as a disease: The promise of medication-assisted recovery. Statement of Nora D. Volkow, M.D., Director, National Institute on Drug Abuse, to Committee on Oversight and Government Reform, Subcommittee on Domestic Policy, United States House of Representatives, June 23. Retrieved December 24, 2010 from <http://www.hhs.gov/asl/testify/2010/06/t20100623a.html>.

increase the numbers of those in medication-assisted addiction treatment seeking support from recovery mutual aid groups.

New Definitions of Addiction Recovery: Recent efforts to define recovery as an organizing concept for personal change, professional intervention, scientific research, and social policy have created definitions that encompass medication-assisted pathways of recovery. These definitions do not place the entry point of recovery at the cessation of professionally monitored medication use, but rather focus on broader factors related to sobriety/abstinence (or disease remission) and progress related to global health and positive family/social/community re-integration.<sup>156</sup> That emerging definition conflicts with NA's current definition of abstinence/"clean time."

A recent Betty Ford Institute consensus conference assembled addiction researchers, addiction treatment professionals, and people in recovery to define recovery from substance dependence. The panel defined recovery as "a voluntarily maintained lifestyle characterized by sobriety, personal health, and citizenship,"<sup>157</sup> and then declared that "...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."<sup>158</sup> A recent monograph on recovery-oriented methadone maintenance similarly concluded:

*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...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.*<sup>159</sup>

Changing Culture of Opioid Treatment Programs (OTPs): Historically, NA members' perception of the "methadone clinic" milieu as more a culture of addiction than a culture of recovery was an apt criticism of many clinics. Cautions heard within NA to distance oneself from methadone maintenance expressed concern with both the medication and the milieu. But OTPs are changing amidst increased calls for a "recovery-oriented methadone maintenance" that wraps methadone and other medications within a dynamic, person/family-centered recovery culture that is supportive of global health and quality of

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<sup>156</sup> 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.

<sup>157</sup> 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.

<sup>158</sup> 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; McLellan, A.T. (2010). What is recovery? Revisiting the Betty Ford Institute Consensus Panel definition. *Journal of Substance Abuse Treatment*, 38, 200-201.

<sup>159</sup> White, W., & Torres, L. (2010). *Recovery-oriented methadone maintenance*. Chicago, IL: Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health and Mental Retardation Services, and Northeast Addiction Technology Transfer Center.

life in long-term recovery.<sup>160</sup> The broader spectrum of psychosocial services that was once a standard part of MM has eroded through the 50% reduction in public funding for MM that has occurred over the past three decades.<sup>161</sup>

If a focused recovery orientation becomes widespread within America's OTPs, the psychological and cultural distance between the milieus of NA, AA, and other recovery support groups and the OTP milieu will diminish. This distance will be further closed if funding and regulatory entities begin to require this recovery orientation (along with assertive linkage to in-treatment and post-treatment recovery support resources) as a condition of licensure, accreditation, and service reimbursement.

According to the most recent data on addiction treatment admissions (2007), 70.9% of patients admitted to treatment with heroin as their primary drug of use, and 20% of those admitted with primary use of other opioids, did not receive pharmacotherapy with methadone or buprenorphine. Between one quarter and one third of these patients receive services (detoxification or short-term inpatient or outpatient treatment) that produce high post-treatment relapse rates and little if any measurable effects on long-term recovery outcomes. Of all patients admitted for treatment in 2007 with heroin or other opioids as their primary drugs of use, 60.6% had prior addiction treatment, and more than 13% had **five or more** prior admissions.<sup>162</sup> As pressure builds for improved recovery outcomes, treatment for opioid addiction is likely to involve combining service elements (pharmacotherapy, counseling, peer-based recovery support, and assertive linkage to recovery mutual aid societies) with prolonged monitoring; recovery coaching; and, when needed, early re-intervention. Increased emphasis on the need for prolonged recovery support and growing interest in the role of peer-based recovery support within opioid addiction treatment programs (e.g., interest in the MARS project in New York City)<sup>163</sup> will bring heightened attention to the ways in which patients in medication-assisted treatment are received by particular recovery mutual aid fellowships.

Office-Based Treatment of Opioid Addiction: The current and likely future growth in the office-based treatment of opioid addiction by primary care physicians (buprenorphine), the likely future growth of office-based "medical maintenance" (methadone provided by private physicians to highly stabilized patients), and growing emphasis on adjunctive psychosocial supports for office-based treatment will all serve to increase the number of people in medication-assisted treatment seeking support within local recovery support fellowships. Most of the 17-fold increase in Suboxone prescriptions between 2001 and 2009<sup>164</sup> occurred outside the specialized addiction treatment sector (e.g., in distribution through private physicians, hospitals, and pharmacies).<sup>165</sup> The mainstreaming of

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<sup>160</sup> White, W. & Torres, L. (2010). *Recovery-oriented methadone maintenance*. Chicago, IL: Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health and Mental Retardation Services, and Northeast Addiction Technology Transfer Center.

<sup>161</sup> Jaffe, J.H. & O'Keefe, C. (2003). From morphine clinics to buprenorphine: regulating opioid agonist treatment of addiction in the United States. *Drug and Alcohol Dependence*, 70, S3-S11.

<sup>162</sup> SAMHSA. *Highlights for 2007 Treatment Episode Data Set (TEDS)*. Retrieved January 5, 2011 from <http://oas.samhsa.gov/TEDS2k7highlights/TEDSHigh12k7Tb13.htm>.

<sup>163</sup> See White, W. (2009). *Advocacy for medication-assisted recovery: An interview with Walter Ginter*. Posted at [www.facesandvoicesofrecovery.org](http://www.facesandvoicesofrecovery.org).

<sup>164</sup> Curry, D. (2010, May). *Keynote Address*. Buprenorphine Summit, May 10-11, 2010, Washington D.C.

<sup>165</sup> National Forensic Laboratory Information System (2008). *Special report: Methadone and buprenorphine, 2003-2008*. Washington D.C.: Drug Enforcement Administration, Office of Diversion Control.

medication-assisted treatment for opioid addiction<sup>166</sup> will bring people in medication-assisted treatment into the meeting rooms of NA, AA, and other recovery support fellowships, even in communities that do not have specialized opioid dependence treatment programs.

Medication Integration: The recent trend toward breaking down traditional treatment silos and integrating the option of medication into all addiction treatment settings (e.g., as is occurring in the state of New York) and the subsequent widespread integration of medications into historically medication-free treatment programs (e.g., therapeutic communities) will exert pressure on NA to re-evaluate its medication policies. Also of potential influence will be the emerging call to transcend the traditional polarization between the worlds of “drug-free” treatment and harm-reduction strategies.<sup>167</sup>

Particularly influential in this regard may be the experience of integrating methadone patients into historically drug-free treatment programs. For years these programs refused admission to those patients on the grounds of what turned out to be mistaken fears that: 1) MM patients would be nodding out in groups, 2) MM patients would not be accepted by other patients and staff, 3) MM patients would be encouraged to stop taking their medication, and 4) other patients would seek methadone if they heard positive stories of methadone-assisted recovery.<sup>168</sup> Several studies document the successful integration of medication pharmacotherapy and the psychosocial supports used in medication-free treatment programs, including integration within traditional medication-free therapeutic communities, whose earliest leaders expressed great hostility toward methadone.<sup>169</sup> The conduit for transmitting this experience into NA, AA, and other groups will be the patients, recovering staff, and volunteers from these historically medication-free programs.

Calls to recognize the legitimacy of multiple pathways of long-term recovery, elevate patient choice in addiction treatment and recovery support options, and adhere to mutual respect as an aspirational value guiding relationships between proponents of different

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<sup>166</sup> Mark, T.L., Kassed, C.A., Vandivort-Warren, R., Levit, K.R., & Kranzler, H.R. (2009). Alcohol and opioid dependence medications: Prescription trends, overall and by physician specialty. *Drug and Alcohol Dependence*, 99(1-3), 345-349.

<sup>167</sup> Kellogg, S.H. (2003). On “Gradualism” and the building of the harm reduction-abstinence continuum. *Journal of Substance Abuse Treatment*, 25, 241-247. Kellogg, S.H., & Kreek, M.J. (2005). Gradualism, identity, reinforcements, and change. *International Journal of Drug Policy*, 16, 369-375. Marlatt, G.A., Blume, A.W. & Parks, G.A. (2001). Integrating harm reduction therapy and traditional substance abuse treatment, *Journal of Psychoactive Drugs*, 33(1), 13-21; McLellan, A.T. (2003). What’s the harm in discussing harm reduction: An introduction to a three-paper series. *Journal of Substance Abuse Treatment*, 25, 239-240.

<sup>168</sup> Deal, D., Folks, C., & White, W. (2011). Methadone maintenance patients in a residential rehabilitation program: The Eagleville experience. (Submitted for publication.)

<sup>169</sup> 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; Greenberg, B., Hall, D.H. & Sorensen, J.I. (2007). Methadone maintenance therapy in residential therapeutic community settings: Challenges and promise. *Journal of Psychoactive Drugs*, 39, 203-210. Kaufman, E. (1979). The therapeutic community and methadone: A way of achieving abstinence. *International Journal of the Addictions*, 14, 83-97; 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. Sorensen, J.L., Andrews, S., Delucchi, K.L., Greenberg, B., Guldish, J., Masson, C.L., & Shopshire, M. (2009). Methadone patients in the therapeutic community: A test of equivalency. *Drug and Alcohol Dependence*, 100(1-2), 100-106.

approaches to recovery management will shape an external milieu within which recovery mutual aid societies will be asked more pointed questions about their stance on medications used in the treatment of addiction.<sup>170</sup>

Medication-Assisted Recovery Advocacy Movement: Advocates of medication-assisted recovery have actively participated in Faces and Voices of Recovery since its inception in 2001, and local recovery advocacy organizations have extolled medication-assisted recovery as a legitimate pathway of addiction recovery, even developing consumer guides for medication-assisted treatment.<sup>171</sup> Conditions are poised for the rapid growth and coming of age of the long-incubating medication-assisted recovery advocacy movement.<sup>172</sup> This movement will bring to the public forum the faces and voices of people in medication-assisted recovery who will offer, through the weight of their collective stories, living proof of sustained recovery stability and a quality of personal/family life in recovery comparable to those supporting their recovery within traditional religious, spiritual, and secular recovery mutual aid groups.

The Logic of NA's Central Governing Image: NA is the only major recovery fellowship that from its inception defined the core problem of its membership as "addiction" rather than a particular substance, and that explicitly defined addiction as a "disease" (in spite of frequent erroneous attributions of the disease concept to AA).<sup>173</sup> Jimmy K., the central figure in the founding of NA as it is known today, insisted on this definition in NA's First Step, and his subsequent writings on addiction as a disease anticipated 21<sup>st</sup> century science by decades. He declared:

*Addiction is a disorder in its own right...an illness, a mental obsession and a body sensitivity or allergy to drugs which sets up the phenomenon of craving, over which we have no choice, as long as we use drugs.*<sup>174</sup>

This historical position within NA creates a platform of potential affinity between NA and the latest scientific conceptualizations of addiction, the latter captured in the following key points:

- 1) Addiction is a "disease of the brain."

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<sup>170</sup> Broekaert, E., & Vanderplasschen, W. (2003). Towards the integration of treatment systems for substance abusers: Report on the second international symposium on substance abuse treatment and special target groups. *Journal of Psychoactive Drugs*, 35(2), 237-345.

<sup>171</sup> See PRO-ACT's *Consumer guide to medication-assisted recovery*. Retrieved January 5, 2011 from [http://www.proact.org/consumer\\_guides/consumer\\_guide\\_to\\_medication-assisted\\_recovery/index.cfm](http://www.proact.org/consumer_guides/consumer_guide_to_medication-assisted_recovery/index.cfm).

<sup>172</sup> White, W. (2009). Advocacy for medication-assisted recovery: An interview with Walter Ginter. Posted at [www.facesandvoicesofrecovery.org](http://www.facesandvoicesofrecovery.org); White, W. (2007). *Advocacy and medication-assisted recovery: An Interview with Lisa Mojer-Torres*. Accessed January 14, 2011 at [www.williamwhitepapers.com](http://www.williamwhitepapers.com); Woods, J. (1997). Advocacy and making change: The voice of the consumer. In J. H. Lowinson, P. Ruiz, R. B. Millman, & J. Langrod (Eds.), *Comprehensive textbook of substance abuse* (3<sup>rd</sup> edition, pp. 865-873). Baltimore, MD: Williams and Wilkins.

<sup>173</sup> Kurtz, E. (2002). AA and the disease concept of alcoholism. *Alcoholism Treatment Quarterly*, 20(3/4), 5-40.

<sup>174</sup> Quoted in White, W., Budnick, C., & Pickard, B. (2011). Narcotics Anonymous: Its history and culture. *Counselor*, 12(2), 10-15, 22-27, 36-39, 46-50; Also see Narcotics Anonymous World Service Board of Trustees Bulletin # 17, What is Addiction? Accessed February 4, 2011 at <http://www.na.org/?ID=bulletins-bull17-r>

- 2) This disease is characterized by an “expanding cycle” of neurological dysfunction leading to a progressive erosion of volitional control over drug use and prolonged compulsive drug use in spite of adverse consequences.
- 3) This disorder produces prolonged changes in the brain that are “wide-ranging, complex and long-lasting.”
- 4) These effects contribute to the sustained risk of relapse.
- 5) This prolonged risk requires a program of sustained recovery management to remain in remission and achieve optimum biopsychosocial health.
- 6) For some patients, medications can lower this risk of relapse and contribute to long-term neurological healing and global health.<sup>175</sup>

From NA’s early addiction-as-disease focus, one could argue that medications exist today and may be developed in the future that enhance the effectiveness of, rather than compete with, the NA program for some NA members. One of the potential surprises within the NA culture may be that particular medications actually enhance the ability of some NA members to benefit fully and “get the program,” including many who have previously failed to achieve stable recovery within NA. It will be difficult for NA to continue to assert that addiction is a disease while rejecting all medical treatments that emerge for the treatment of that disease. Ironically, NA and medication-assisted treatment programs share the same challenge in elevating recovery outcomes: conveying the need for prolonged adherence to those activities that sustain recovery stability and quality of life.

Medication and Stigma: Another possible influence on the circumstances of NA members taking physician-monitored addiction treatment medications might be the future degree of social and professional stigma attached to addiction and particular addiction treatment medications. These larger cultural attitudes can exert a profound influence on intragroup relations within recovery mutual aid groups.

*Members of historically disempowered and stigmatized groups are prone to internalize culturally-dominant beliefs about themselves and act those beliefs out in their intragroup relationships. The development of status hierarchies and elaborate pecking orders and displacement of aggression within such groups is common. Such hierarchies have long existed in the American drug culture, from the “righteous dope fiend” to the “gutter hype.” People in addiction recovery without medication support looking down on people recovering from addiction with medication support is the psychosocial equivalent of light-skinned African*

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<sup>175</sup> Volkow, N. (2010). Treating addiction as a disease: The promise of medication-assisted recovery. Statement of Nora D. Volkow, M.D., Director, National Institute on Drug Abuse, to Committee on Oversight and Government Reform, Subcommittee on Domestic Policy, United States House of Representatives, June 23. Retrieved December 24, 2010 from <http://www.hhs.gov/asl/testify/2010/06/t20100623a.html>; Kosten, T.R., & George, T.P. (2002). The neurobiology of opioid dependence: Implications for treatment. *Science to Practice Perspectives*, 1(1), 13-20.

*Americans expressing superiority over dark-skinned African Americans, the house slave looking down on the field slave, and pervasive Black-on-Black crime.*<sup>176</sup>

Through this perspective, one of the functions of the stigma attached to medication-assisted treatment within NA might well be seen as a mechanism to distance NA from the most virulent of the social stigmas attached to addiction and addiction recovery—the association with heroin, injection drug use, and the medications tied to their treatment.

The dissipation of status hierarchies within recovery mutual aid often soften in tandem with the dissipation of social stigma as a global group experience. That process may well be underway in the United States through the new recovery advocacy movement and the participation of NA members (as individuals, rather than as identified NA members) in that movement.

#### CHANGE SCENARIOS: PERSONAL PREDICTIONS

One might easily conclude from the above-described analysis that the stance of many NA groups restricting participation of members taking methadone, buprenorphine, and other medications used in the treatment of opioid addiction will inevitably change to a position of warm welcome and full participation, but I suspect that the future will present a far more complex picture.

As a recovery historian and long-tenured recovery advocate, I am often asked by addiction professionals and recovery support specialists how I think attitudes toward medications will or will not change in the future within recovery support groups, and within NA in particular. Based on my understanding of the history and culture of NA and other respective recovery fellowships, I would suggest five possible scenarios that would have profound implications for addiction professionals and recovery support specialists and the individuals and families they serve. I enter this discussion with some hesitation and caution due to my awareness that predictions can themselves influence the future.

Scenario One: *Warm welcome and full participation will increasingly be extended to patients in medication-assisted treatment within recovery support groups **other than NA**, as long as patients meet other requirements for membership (e.g., “a desire to stop drinking” in AA). I base this prediction on the liberalization of attitudes toward medications used in the treatment of addiction and co-occurring illnesses by other traditional medication-free bastions such as alcoholism treatment programs, therapeutic communities, and Oxford House,<sup>177</sup> as well as in groups such as AA<sup>178</sup> and SMART*

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<sup>176</sup> White, W. (2011). Excerpted from unpublished interview by Stephen Bamber.

<sup>177</sup> At its 2010 Annual Convention, Oxford House abandoned early resolutions banning admission of methadone patients, adopting a policy (Resolution #41) that left the decision to accept new members to the authority of each house.

<sup>178</sup> Tonigan, J.S., & Kelly, J.F. (2004). Beliefs about AA and the use of medications: A comparison of three groups of AA-exposed alcohol dependent persons. *Alcoholism Treatment Quarterly*, 22(2), 67-78; Rychtarik, R.G., Connors, G.J., Dermen, K.H., & Stasiewics, P.R. (2000). Alcoholics Anonymous and the use of medications to prevent relapse: An anonymous survey of member attitudes. *Journal of Studies on Alcohol*, 61, 134-138.

Recovery<sup>179</sup>. AA, for example, has been long portrayed as having a pervasive anti-medication bias, but the latest studies of AA reveal that:

- More than half of surveyed AA members believe that taking anti-craving medications is or might be a helpful form of recovery support, and only 12% of AA members would recommend that another member stop taking such medication;<sup>180</sup>
- neither past nor current AA participation is related to willingness to take naltrexone as a pharmacological adjunct in the treatment of alcoholism<sup>181</sup> or the actual use of such medications;<sup>182</sup>
- attitudes toward the use of medication for alcoholism or emotional problems do not differ by degree (none, limited, continuous) of AA participation;<sup>183</sup> and
- 93% of surveyed AA members believe that members using medication to manage co-occurring psychiatric illness should continue taking these medications.<sup>184</sup>

Although attitudes toward opioid addiction treatment medications will vary from fellowship to fellowship and community to community, the overall trend is likely to be one of liberalization. While alternatives to NA will increasingly be available to patients in medication-assisted treatment for opioid addiction, addiction professionals and recovery support specialists should not expect that the vast proportion of patients will affiliate with these groups because of a weakness in the process of mutual identification.

Scenario Two: *If most NA groups base their stance against full membership for patients in medication-assisted treatment for opioid addiction on arguments that are indistinguishable from criticisms made in the larger culture against these medications, NA's attitude toward medications will become progressively liberalized as these broader cultural attitudes shift under the influence of public education and the development of new, less stigmatized medications.* I am suggesting that anti-medication arguments based on alleged origins of these medications, universal harmfulness of the medications, nefarious government purposes for promoting the medications, and the drug culture that surrounds the medications will simply not stand the test of time in the face of cumulative science and improved practices in addiction treatment programs. Local liberalization of NA group attitudes toward medications would open the doorway for disclosure by current NA members who have withheld their medication status, as well as for the involvement of new members taking these medications. That some of these members will achieve a

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<sup>179</sup> “Advocates the appropriate use of prescribed medications and psychological treatments.” Retrieved January 5, 2011 from <http://www.smartrecovery.org>.

<sup>180</sup> Rychtarik, R.G., Connors, G.J., Dermen, K.H., & Stasiewics, P.R. (2000). Alcoholics Anonymous and the use of medications to prevent relapse: An anonymous survey of member attitudes. *Journal of Studies on Alcohol*, 61, 134-138.

<sup>181</sup> Swift, R.M, Duncan, D., Nirenberg, T., Femino, J (1998). Alcoholic patients' experience and attitudes toward pharmacotherapy for alcoholism. *Journal of Addictive Diseases*, 17, 35-47.

<sup>182</sup> Tonigan, J. S., Toscova, R., & Miller, W. R. (2005). Medication use of past and current AA members. *Alcoholism: Clinical and Experimental Research*, 29(5, Supplement), 383. (Abstract).

<sup>183</sup> Tonigan, J.S. & Kelly, J.F. (2004). Beliefs about AA and the use of medications: A comparison of three groups of AA-exposed alcohol dependent persons. *Alcoholism Treatment Quarterly*, 22(2), 67-78; Tonigan, J.S. & Kelly, J.F. (2003). AA-Exposure and Attitudes of 12-Step Proscriptions About Medications. *Alcoholism: Clinical and Experimental Research*, 26, (5, Supplement). 649A. (Abstract)..

<sup>184</sup> Meissen, G., Powell, T.J., Wituk, S.A. Girrens, K. & Arteaga, S. (1999). Attitudes of AA contact persons toward group participation by persons with a mental illness. *Psychiatric Services*, 50, 1079-1081.

high degree of recovery stability and quality of life and character in the presence of these medications will lead to further liberalization of attitudes toward these medications.

If such liberalization occurred at a global level within NA, NA would likely apply to medications used in the treatment of addiction the suggested principles it has outlined in its Third Tradition (“The only requirement for membership is a desire to stop using”) and in its 2010 pamphlet, *In Times of Illness*. Principles drawn from this pamphlet include the following.

- No mood-altering medications are completely safe for those with a history of addiction; alternatives to mood-altering medications should be taken where possible.<sup>185</sup>
- The decision to take a mood-altering medication should be carefully considered in terms of its potential risks, immediate necessity, and potential benefits, in consultation with medical practitioners and through discussions with sponsors, other trusted NA members, and others who have faced this situation before.<sup>186</sup>
- Physicians should be informed of our addiction histories so that they may consider this in their decisions about medication-based treatment and its alternatives.<sup>187</sup>
- If a decision is made to take medication, these same physicians can help monitor its use and effects on our health and recovery.<sup>188</sup>
- Taking medication as medically prescribed for an illness does not constitute a relapse to drug use.<sup>189</sup>
- “Clean time is an issue for each of us to resolve individually with our sponsor and our Higher Power.”<sup>190</sup>
- “Many NA members have been successful in taking medication as prescribed and maintaining their recovery.”<sup>191</sup>
- NA members should not tell other NA members to stop taking any medication; “We leave medical issues up to doctors.”<sup>192</sup>
- An NA meeting is not a good setting to discuss professional treatment and issues related to medications.<sup>193</sup>
- Mutual identification in NA should be based on what is shared in common, rather than on differences; “As members, we have no reason to judge one another.”<sup>194</sup>

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<sup>185</sup> *In Times of Illness* (2010). Van Nuys, CA: NA World Services, Inc., p. 14, 36.

<sup>186</sup> *Ibid*, p.9, 12, 13, 15, 34.

<sup>187</sup> *Ibid*, p. 23.

<sup>188</sup> *Ibid*, p. 17.

<sup>189</sup> *Ibid*, p. 10.

<sup>190</sup> *Ibid*, p. 12, 17.

<sup>191</sup> *Ibid*, p. 14.

<sup>192</sup> *Ibid*, p. 20.

<sup>193</sup> *Ibid*, p. 22.

<sup>194</sup> *Ibid*, p. 23.

In this scenario, whether these principles will one day also be applied to methadone, buprenorphine, or other emerging medications used in the treatment of addiction will hinge on whether such medications—now viewed as “drugs” —will one day be viewed in NA as “medications.”

There are no studies of NA member attitudes toward and use of medications to treat addiction and related disorders, and ways in which these attitudes have changed over time, to help us make predictions about the future of this issue. There is no way of knowing, for example, whether the most negative attitudes toward methadone and buprenorphine are held by the oldest NA members, or whether younger members in general have more tolerant attitudes toward these medications. Any such age-related demarcation of attitudes might suggest future directions of NA membership attitudes. Given the spread of NA outside the U.S., it is also of interest whether or not attitudes in NA toward medications used in the treatment of addiction vary across cultural contexts. Several European respondents reported to the author that the majority of opioid addicts seeking help in NA within their countries do so while being treated with methadone or other medications and that this has not been a handicap to their participation in or benefit from NA.

If this second scenario came to fruition, many NA members would decry the loss of “real NA” or “pure NA.” This issue could even tap existing tensions and leadership conflicts within NA that might be exploited to create schisms and even purges within local NA groups and NA as a whole. Proponents of Scenario Two counter with the suggestion that the end effect could also be a fellowship whose message of hope reaches a previously disenfranchised group of people in greatest need of NA’s recovery program. In their view, NA could well end up celebrating AA co-founder Bill Wilson’s 1944 declaration:

*Rather shall we reflect that the roads to recovery are many; that any story or theory of recovery from one who has trod the highway is bound to contain much truth.*<sup>195</sup>

While Scenario Two might unfold, and is unfolding locally within particular NA groups, this scenario in the view of this author is unlikely for NA at a global level, since it would violate NA traditions by basing discussions of these medications on what are clearly “outside issues” (e.g., emerging addiction science). Even if this scenario unfolded, it would be up to addiction professionals and recovery support specialists in each local community to assess the degree to which NA is a viable recovery support alternative for patients in medication-assisted recovery and to assess the comparative quality and accessibility of NA alternatives.

**Scenario Three:** *If patients in medication-assisted treatment for opioid addiction are increasingly absorbed into local NA, AA, and other recovery support groups across the country, then no specialized recovery support organizations for persons in medication-assisted recovery will emerge that meets the viability criteria of large membership,*

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<sup>195</sup> Wilson, B. (1988). Comments on Wylie ideas. In *The language of the heart: Bill W.’s Grapevine writings* (pp. 97-99). New York: The AA Grapevine, Inc. (Reprinted from *AA Grapevine*, 1944); Quoted in: White, W., & Kurtz., E. (2010). *A message of tolerance and celebration: The portrayal of multiple pathways of recovery in the writings of Alcoholics Anonymous co-founder Bill Wilson*. Posted at [www.williamwhitepapers.com](http://www.williamwhitepapers.com).

*geographical accessibility, and cultural visibility.* The greatest single threat to the future of MA and other medication-based specialty groups is the potential liberalization of NA attitudes toward medication, and a warm welcome and extension of full participation to persons in medication-assisted treatment for opioid addiction. (See more discussion under Scenario Five). Under Scenarios One and Two, addiction professionals and recovery support specialists will be developing increasing collaborations with local service committees and developing assertive approaches to linking patients to AA, NA, and other existing recovery support meetings.

Scenario Four: *If NA bases its limitations on NA participation by those whose addiction treatment includes medications on its assertion of the spiritual nature of the NA program of recovery, then NA's stance on treatment medications will remain unchanged for the foreseeable future.* In this scenario, NA completely avoids larger arguments about the medical treatment of addiction and reverts to its body of experiential knowledge. That collective experience has been conveyed to the author in numerous communications about this paper from long-tenured NA members. Although these should not be viewed as either a formal position of NA or necessarily representative of prevailing attitudes within NA, the following key themes within these communications do clarify more precisely the perceived contradictions between medication-assisted treatment of opioid addiction and NA's abstinence-based approach to recovery. NA members conveyed to the author these core beliefs:

1. Recovery in NA is achieved through the ongoing pursuit of a spiritual awakening.
2. The catalysts of that spiritual awakening consist of the experience of a degree of personal anguish (hopelessness, helplessness, meaninglessness) that drugs can no longer buffer, acceptance of our brokenness, surrender of all further efforts at control, commitment to do anything to recover, and taking the steps suggested to us in NA's *Basic Text* and by other NA members.
3. The NA approach to producing that spiritual awakening is founded upon the principle of total abstinence from all drugs that satisfy the addict's craving to "get high." The void created by this abstinence produces the urgency to apply the NA program as the solution and sets the stage for that spiritual awakening.
4. Working NA's program of recovery and reaping its greatest rewards requires mental and emotional consciousness—a consciousness blunted under the influence of mind-altering substances. Early in the process, such consciousness often brings about a spiritual and emotional crisis in the recovering person. This crisis is addressed through involvement with the fellowship and work with a sponsor to apply the steps as the solution. Many NA members who have been on medications such as methadone or buprenorphine in the past believe that the use of these substances is not compatible with NA's definition of "total abstinence" because of the effects on consciousness that these drugs produced. In our experience these medications fired a false sense of spirit (induced intoxication), created a state of suspended numbness (in which neither full pain nor full joy was possible), or blurred our perceptions and thinking. We found no medication that could produce the profound sense of freedom and gratitude that comes from working NA's recovery steps.
5. NA members and NA literature consistently stress that our shared views on these medications are strictly a matter of guidance to NA members who are attempting to apply the established NA methodology in their own personal lives. We seek

only to define what recovery means to us within NA and how we have been best able to achieve it. It is this approach that we are trying to preserve within our meetings.

6. NA welcomes those who are using such drugs as methadone or buprenorphine into meetings, into the sponsorship relationship, and into the social fabric of NA. This is seen in NA as being consistent with the tradition which states that “The only requirement for membership is the desire to stop using,” and is strongly defended by most members. These structures may be helpful to those patients. The aspects of the NA program not available to those patients include the celebration of “clean time” and participation in certain service roles that require specified lengths of clean time. Clean time in NA begins when the patient is no longer on these substances. Patients who are prepared to accept this have the greatest chance for full eventual integration into NA, and there are thousands of members who entered NA in just that way.<sup>196</sup>

If these points prevail as the core of NA’s rationale for limiting the participation of members in medication-assisted treatment, this rationale is likely to stand the test of time, for three reasons: 1) these propositions are “true” in the sense that they reflect NA members’ collective experience; 2) these propositions prevent the expression of countervailing experience within NA by distancing and silencing those who have a different experience with these medications; and 3) by basing the rationale exclusively on NA’s internal experience and claiming no opinion beyond that, these propositions prevent the injection of scientific or clinical knowledge into any discussions of the issue.

With this scenario, NA will remain a viable referral source for patients not wanting medications, and for patients on medication who want a framework of support following their decision to taper from medications. Although people with severe and chronic addiction to heroin and other opioids will continue to use NA as a framework for recovery within this scenario, the primary contribution of NA to the problem of opioid addiction would likely be among people with shorter addiction careers, less intense patterns of opioid use, fewer co-occurring medical and psychiatric problems, and greater recovery capital (internal and external resources for initiating and sustaining recovery).

This prediction should not be interpreted as advice to addiction professionals and recovery support specialists to refrain from suggesting NA as a recovery support option to patients in long-term medication maintenance. Including NA as such an option is warranted on the following grounds:

- NA is the largest and most geographically accessible recovery support fellowship in the world for persons in recovery from addictions other than alcohol dependence.
- Not all NA groups restrict the participation of members taking medications used in the treatment of addiction.
- There are patients in medication-assisted addiction treatment who do engage in and benefit from NA.

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<sup>196</sup> Special thanks to one anonymous NA member for helping the author synthesize these points.

- In spite of the professional recommendation of a long duration of medication maintenance, most patients have a goal of ending medication maintenance, and many do so within months rather than years.
- NA can serve as a safety net and point of early re-intervention during and following the medication-tapering process.

Scenario Five: *If NA's stance against full participation of members on addiction treatment medications prevails across the country, then conditions will be ripe for the rise of a new recovery support fellowship specifically for the more than half a million patients in medication-assisted treatment for opioid addiction on any given day, and for the even larger population of patients who have been treated medically for addiction.* This might be a fellowship that already exists, e.g., Methadone Anonymous (MA) or local Medication-Assisted Recovery Support (MARS) groups, or it might be a yet-to-emerge fellowship that might even expand to encompass patients being treated with medications for non-opioid addictions. Since its founding in 1991, MM has established more than 400 MA regular meetings in 25 states.<sup>197</sup>

NA owes its existence to AA's early position that persons with primary drug addictions without a history of alcoholism could adapt AA's program to create a separate fellowship, but that they could not become AA members.<sup>198</sup> In my constant travels over four decades, I have observed that, in communities in which AA allows full membership to people with primary drug addictions without alcoholism, NA flounders, its culture remains weak, and many tenured NA members migrate to AA. Conversely, while AA is quite strict in its interpretation of its Third Tradition, NA tends to thrive and develop its own distinct recovery culture. Ironically, a day may come when MA or other groups thank NA for its role in their development and for policies that some now see as exclusionary and discriminatory. So-called "bridge members" of AA (members who had also had past histories of drug addiction) played critical roles in the founding of today's NA. "Bridge members" of NA (members with past or current involvement in medication-assisted treatment) could play key roles in the vitality and growth of MA or the rise of new medication-assisted recovery support groups.

The 12 Step program is being adapted by MA and other groups based on a different set of experiential arguments. Those with whom I spoke suggested that:

1. NA's attitudes toward methadone are based on the worst of medication-assisted treatment practices, e.g., overmedication (with resulting intoxication, sedation, or zombie-like numbness), undermedication (with its withdrawal distress, prolonged cravings, and likelihood of self-medication), and social milieus that are unquestionably antagonistic to real recovery—practices to which medication advocates also object.
2. The 12 Steps constitute a viable framework of long-term recovery for people in medication-assisted treatment for opioid addiction, including those in long-term

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<sup>197</sup> White, W. (2009). *Peer-based addiction recovery support: History, theory, practice, and scientific evaluation*. Chicago, IL: Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health and Mental Retardation Services.

<sup>198</sup> White, W., Budnick, C., & Pickard, B. (2011). Narcotics Anonymous: Its history and culture. *Counselor*, 12(2), 10-15, 22-27, 36-39, 46-50.

maintenance, those who choose to taper, and those who have completed the tapering process.

3. Spiritual frameworks of recovery and the use of medications in opioid addiction treatment are compatible and, when combined, produced better long-term recovery outcomes than we were able to achieve through either approach alone.
4. Patients who have achieved optimum dose stabilization on methadone or buprenorphine and do not use alcohol or other intoxicating substances do not experience physical, emotional, or cognitive impairment from these medications. They also feel the same range of pain and joy experienced by 12-Step fellowship members who do not take medication to support their recovery.
5. Patients maintained on personally optimal, stabilized doses of methadone or buprenorphine are fully capable of experiencing the process of spiritual awakening and undergoing the radical transformation of identity, character, and relationships that are the hallmarks of 12 Step recovery.
6. Recovery with the aid of medication is no less noble than recovery without the support of medication; these represent differences in individual styles of recovery, rather than differences in the quality of recovery.<sup>199</sup>

The increase in the number of people in medication-assisted recovery from opioid addiction who eschew NA because of its medication policies will increase the representation of these patients in other addiction recovery mutual aid societies and spawn new recovery support fellowships specifically for people in medication-assisted recovery. If these groups become viable, vibrant, larger, and more geographically dispersed, NA—the fellowship that started with a primary focus on recovery from opioid addiction—might become less and less relevant as a recovery support resource for opioid addiction. That potential eventuality rests on three assumptions.

First, the professional treatment of people for severe opioid addiction already includes, and will increasingly include, pharmacotherapy as a central element. Second, addiction treatment programs utilizing medications in the treatment of opioid addiction will not refer patients to recovery support groups that these programs perceive as treating patients with disrespect, or groups that they fear would result in increased problems with medication adherence. Third, the vast majority of patients in medication-assisted treatment of opioid addiction will not affiliate with a recovery support fellowship in which they are not allowed to speak and are denied roles available to other members.

Declarations by NA that it has “absolutely no opinion on methadone maintenance or any other program aimed at treating addiction,” and that MM patients are welcome to attend NA meetings, will continue to be viewed by people in medication-assisted recovery as disingenuous, given NA’s characterization of these patients as “under the influence of a drug,” “not clean,” and “a still-using addict,” and its practice prohibiting such persons from speaking at NA meetings or participating in NA service work.<sup>200</sup> While NA literature affirms that its intent is “not meant to alienate or embarrass,” the voices of patients in

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<sup>199</sup> Acknowledgement: Special thanks to one NA member who helped draft this synthesis of the communications the author had received.

<sup>200</sup> All quotes from: arcotics Anonymous World Service Board of Trustees Bulletin #29, Narcotics Anonymous World Services, 1996, retrieved December 13, 2010 from <http://www.na.org/?ID=bulletins-bull29>.

medication-assisted treatment presented in this paper suggest that this is precisely the way many of these patients experience membership restrictions at a personal level .

Scenario Conclusions: The scenarios outlined above are not mutually exclusive. NA has reached a size and diversity that makes total consensus of thought and practice on any issue unlikely, let alone on an issue as contentious as the one addressed in this paper. The growing varieties of NA experience may or may not in the future include room for people in medication-assisted recovery. Only history can answer the question of whether or not local NA groups' stance on restriction of participation for persons in medication-assisted addiction treatment will come to be viewed on par with early AA groups' restrictive membership rules designed to keep out "*beggars, tramps, asylum inmates, prisoners, queers, plain crackpots, and fallen women*,"<sup>201</sup> or whether that stance will be viewed as a critical step through which NA protected the integrity of its program of recovery and, by doing so, contributed to the development of new addiction recovery support societies. Questions concerning the ways in which addiction professionals and recovery support specialists can best enhance peer-based recovery support resources for the patients with whom they serve exist, and will best be answered at, the local level.

#### SUMMARY OF KEY POINTS

1. The tension that exists between NA and the professional world of opioid addiction treatment is at heart a tension among three very different ways of defining truth: experiential knowledge, scientific knowledge, and clinical knowledge. Collaboration across these worlds requires charting pathways of mutual respect and understanding.
2. The use of opioid agonists (e.g., methadone) and partial agonists (e.g., buprenorphine) has become the "gold standard" for treating addiction to heroin and other short-acting opioids, with nearly one million patients a year being treated with these medications. These medications, particularly methadone, have been endorsed by every medical, scientific, and governmental body that has investigated the problem of opioid addiction.
3. Considerable stigma remains attached to these medications, in part because these substances have been misused in the illicit drug culture, and because their legitimate use as a treatment adjunct involves a sustained physical dependence. Distinguishing illicit and licit use requires distinguishing physical dependence from addiction and developing a professional/personal understanding of the distinction between "medications" and "drugs."
4. NA's objection to medications used in the treatment of opioid addiction (as reflected in many local groups' practice of not allowing persons on these medications to speak in meetings or to be involved in service work) is based on both personal opinions of NA members toward these medications (which are quite similar to opinions in the larger culture), and on a more focused judgment that the use of these medications is inconsistent with NA's philosophy of complete abstinence and its spiritual approach to recovery.
5. Patients in medication-assisted treatment for opioid addiction who have sought support within NA meetings report a mixture of respect and appreciation of NA;

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<sup>201</sup> *Twelve Steps and Twelve Traditions*. (1952). New York: Alcoholics Anonymous World Services, Inc., p. 40.

tension, confusion, and shame elicited by NA's restriction of their participation; hurt, anger, and defiance as a result of those restrictions; and an abandonment of NA and the embrace of alternative sources of recovery support.

6. Restricted levels of NA participation among people in medication-assisted treatment is of concern to addiction professionals and recovery support specialists, due to the fact that the areas of restricted participation constitute "active ingredients" that influence recovery outcomes within NA—suggesting that those with restricted membership may have lower likelihood of recovery, not due to their medication status, but due to their lack of access to these critical ingredients.
7. In response to this situation, addiction treatment programs that utilize these medications have a responsibility to assess the local viability of NA groups as a recovery support framework for their patients, orient all patients regarding their recovery support options, collaborate with patients and local community groups to expand the menu of recovery support options for patients in medication-assisted treatment, and educate members of local communities of recovery about questions that may arise regarding the role of medications in long-term addiction recovery.
8. In response to this situation, patients in medication-assisted treatment of opioid addiction are encouraged to explore and identify medication-friendly recovery support options, understand the motivations that underlie anti-medication biases they may encounter, refine how they present their recovery stories in meetings, explore online recovery support, and consider organizing their own recovery support groups.
9. Future pressure to soften anti-medication biases within recovery mutual aid societies will be exerted by the changing prevalence and profile of opioid addiction, the increasing pace of new medication development, new medication-inclusive definitions of addiction recovery, greater recovery orientation of medication-assisted treatment programs, the growth of office-based treatment of opioid addiction, the trend toward integration of medication as an option within all addiction treatment programs, inclusion of medication advocates within the emerging recovery advocacy movement, and the suggestion that the use of medication is the logical extension of NA's disease conceptualization of addiction.<sup>202</sup>
10. Multiple scenarios are possible related to the future of NA's stance on medications used in the treatment of opioid addiction. The future of NA's stance on medication will be determined primarily based on whether NA defines its position based on arguments related to the broad cultural distaste for these medications, or defines its position based on the incompatibility of medications with NA's spiritual approach to addiction recovery.
11. The ways in which those scenarios unfold will exert great influence on NA and other recovery mutual aid societies, and may also dictate the fate of NA itself, not strictly because of the issue of medication, but in the precision with which this issue will force NA to define and distinguish its program of recovery for itself and the outside world.

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<sup>202</sup> White, W. (2010). The future of A.A., N.A. and other recovery mutual aid organizations. *Counselor*, 11(2), 10-19.

12. Given the size, wide geographical dispersion, and increasing varieties of NA experience, addiction professionals and recovery support specialists are advised to assess local recovery support options for patients in medication-assisted recovery, and to collaborate with patients to expand recovery support options.

. The future of recovery from opioid addiction in the United States lies in creating a broad service menu in which pharmacotherapy, ancillary professional psychosocial support, peer-based recovery support services, and sustained support within one or more recovery mutual aid fellowships can be uniquely combined and sequenced for each patient. Calls for such an expanded service menu are growing and will raise the question of whether the void in recovery mutual aid for people in medication-assisted treatment for opioid addiction will be filled by NA, or by one or more other recovery mutual aid societies.

### **About the Author**

William 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*. He has served as a volunteer consultant to Faces and Voices of Recovery since its inception in 2001. His collected papers on addiction recovery are available for free download at [www.williamwhitepapers.com](http://www.williamwhitepapers.com).

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## Appendix

### Methadone Maintenance, Science, and Recovery Mutual Aid: Key Questions

The most intense stigma related to medications used in the treatment of opioid addiction is reserved for methadone maintenance. The findings of scientific studies of MM over the past four decades provide objective answers to some of the questions that frequently arise about methadone maintenance within discussions among addiction professionals, recovery support specialists, and recovery mutual aid group members, and within sponsor-sponsee communications. The questions raised below constitute “outside issues” that, by their traditions, 12 Step fellowships have no opinion on, and nearly all recovery mutual aid groups caution their members to avoid “playing doctor” by offering medical advice on such issues.<sup>203</sup> That does not change the fact that these questions do arise for patients in medication-assisted treatment as they participate in these groups, and they also arise in informal communications among recovery mutual aid members, addiction professionals, and recovery support specialists.

Questions related to methadone that patients encounter in the context of recovery mutual aid groups, and recent scientific findings related to these questions, are summarized in Table 3. They are summarized here to underscore the important role addiction professionals and recovery support specialists play in educating patients about these issues.

**Table 3: Scientific Findings on Critical Questions Related to Methadone Maintenance**

<b>Key Questions about Methadone Maintenance</b>	<b>Findings from Clinical Studies of Methadone</b>
Why should people enter methadone maintenance when they could participate in a medication-free treatment program or an abstinence-based recovery mutual aid program?	The treatment of opioid addiction in medication-free treatment programs is limited by low attraction, high dropout rates, and high post-treatment relapse rates. <sup>204</sup> Most MM patients have previously participated in one or more medication-free treatment programs, have later resumed opioid addiction, and are now seeking an alternative to such treatments. <sup>205</sup> Nearly a third of opioid-

<sup>203</sup> *In Times of Illness* (2010). Van Nuys, CA: NA World Services, Inc., p. 20; NA World Services, Inc. (2006/2007). *Public Relations Handbook*, Chatsworth, CA, p.56; *The AA Members—Medications and Other Drugs*. (1984). New York: Alcoholics Anonymous World Services, Inc.

<sup>204</sup> White, W., & Torres, L. (2010). *Recovery-oriented methadone maintenance*. Chicago, IL: Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health and Mental Retardation Services and Northeast Addiction Technology Transfer Center.

<sup>205</sup> Weinstein, S., Gottheil, E., Sterling, R.C.& DeMaria, P.A.(1993). Long-term methadone maintenance treatment: Some clinical examples. *Journal of Substance Abuse Treatment*, 10, 277-281.

Key Questions about Methadone Maintenance	Findings from Clinical Studies of Methadone
	<p>addicted patients discharged from medication-free treatment are enrolled in MM within two years of follow-up.<sup>206</sup> Opioid addiction treatment programs emphasizing long-term maintenance have better patient outcomes than those emphasizing abstinence.<sup>207</sup> It is unknown how many MM patients have past involvement in NA prior to their admission to MM. It is also unclear what distinguishes those opioid-dependent persons who achieve stable recovery through a medication-free program or without treatment of any kind from those who fail through other methods but do well in MM.</p>
<p>Wouldn't detoxification be preferable to maintenance?</p>	<p>Detoxification as a self-contained service does little to influence long-term recovery outcomes and as a result is no longer considered a "treatment" for opioid addiction.<sup>208</sup> Brief episodes of biopsychosocial stabilization do not constitute sustainable recovery from opioid addiction and are almost always followed by re-addiction.<sup>209</sup> The most critical issue in achieving long-term recovery is not how to stop use and manage acute withdrawal, but how to avoid resuming use in the weeks, months, and years following recovery initiation.</p>
<p>Won't MM patients' being high (e.g., nodding) or experiencing withdrawal disrupt NA meetings?</p>	<p>MM Patients stabilized on personally optimal doses of methadone do not exhibit intoxication, sedation, or withdrawal distress; such signs indicate over- or</p>

<sup>206</sup> Sorensen, J.L., Andrews, S., Delucchi, K.L., Greenberg, B., Guydish, J., Masson, C.L., & Shopshire, M. (2009). Methadone patients in the therapeutic community: A test of equivalency. *Drug and Alcohol Dependence, 100*(1–2), 100–106.

<sup>207</sup> Ball, J.C., & Ross, A. (1991). The effectiveness of methadone maintenance treatment: Patients, programs, services, and outcomes. New York: Springer-Verlag. For a review of recent studies, see [http://international.drugabuse.gov/collaboration/guide\\_methadone/partb\\_question1.html](http://international.drugabuse.gov/collaboration/guide_methadone/partb_question1.html).

<sup>208</sup> Gossop, M., Green, L., Phillips, G., & Bradley, B. (1989). Lapse, relapse and survival among opiate addicts after treatment. *British Journal of Psychiatry, 154*, 348-353; Sees, K.L., Delucchi, K.L., Masson, C., Rosen, A., Clark, H., Robillard, H., Hall, S.M. (2000). Methadone maintenance vs. 180-day psychosocially enriched detoxification for treatment of opioid dependence: A randomized controlled trial. *Journal of the American Medical Association, 283*(10), 1303-1310; Simpson, D.D., & Sells, B.S. (1990). *Opioid addiction and treatment: A 12-year follow-up*. Malabar, FL: Krieger Publishing.

<sup>209</sup> Center for Substance Abuse Treatment. (2005). *Medication-assisted treatment for opioid 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.

Key Questions about Methadone Maintenance	Findings from Clinical Studies of Methadone
	under-medication, supplemental or secondary drug use, or atypical methadone metabolism—signs warranting clinical evaluation, dose adjustment, or split dosing. MM patients on individualized, optimal doses of methadone who do not use alcohol or other intoxicants are physically and mentally indistinguishable in appearance and functioning from other NA members. <sup>210</sup>
Should NA members/sponsors encourage NA members to cease MM as soon as possible?	NA members should not be “playing doctor,” and there is danger in such encouragement. In MM, the minimum time period required to elevate recovery outcomes is 1-2 years, with outcomes improving more the longer maintenance continues. <sup>211</sup> Most people who begin MM remain in MM less than this optimum time period—the metaphorical equivalent of stopping halfway through a prescribed course of antibiotics, i.e., symptoms are temporarily suppressed but usually return in a more virulent form. The shorter the period of time on MM, the higher the rate of post-MM resumption of opioid addiction. <sup>212</sup>
Should NA members/sponsors express alarm at MM patients on high doses of methadone?	Again, it is not the role of NA members to make such judgments. There are two primary concerns related to higher dosages of methadone: the increased mortality risk during the induction period of MM, and dosages beyond the induction period that impair functional abilities. That said, treatment outcomes improve with

<sup>210</sup> For discussion and multiple citations, see pp. 51-53, White, W., & Torres, L. (2010). *Recovery-oriented methadone maintenance*. Chicago, IL: Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health and Mental Retardation Services and Northeast Addiction Technology Transfer Center.

<sup>211</sup> Greenfield, L., & Fountain, D. (2000). Influence of time in treatment and follow-up duration on methadone treatment outcomes. *Journal of Psychopathology and Behavioral Assessment*, 22(4), 353-364. Weinstein, S., Gottheil, E., Sterling, R.C. & DeMaria, P.A. (1993). Long-term methadone maintenance treatment: Some clinical examples. *Journal of Substance Abuse Treatment*, 10, 277-281; Gottheil, E., Sterling, R.C. & Weinstein, S. (1993) Diminished illicit drug use as a consequence of long-term methadone maintenance. *Journal of Addictive Disease*, 12, 45-57, 1993.

<sup>212</sup> 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; For a recent review of the poor outcomes related to time-limited, low-dose methadone maintenance, see: Mattci, R.P., Ali, R. & Lintzeris, N. (2009). *Pharmacotherapies for the treatment of opioid dependence: Efficacy, cost-effectiveness and implementation guidelines*, Inforna Healthcare.

Key Questions about Methadone Maintenance	Findings from Clinical Studies of Methadone
	<p>dosages high enough to suppress craving and withdrawal and to block the effects of additional opioid use (above 60 mgd for most patients).<sup>213</sup> The norm through much of the modern history of MM has been sub-optimum dosing, which contributes to high rates of continued drug use and high MM dropout rates.<sup>214</sup> Optimum dosages of methadone vary widely due to genetically influenced differences in methadone metabolism.<sup>215</sup> Patients who achieve long-term abstinence following MM are more likely to have been prescribed higher rather than lower doses of methadone.<sup>216</sup> A recent review of follow-up studies to-date concluded, “Long-term methadone maintenance treatment at doses of 80 to 120 mg per day is not toxic or dangerous to any organ system after continuous treatment for 10 to 14 years in adults and 5 to 7 years in adolescents.”<sup>217</sup></p>
<p>Does being on methadone for a prolonged period decrease one’s future chances of achieving abstinence-based recovery? Don’t most heroin addicts “mature out” with increasing age? Might MM prevent this?</p>	<p>No. Voluntary abstinence rates following discharge from MM are similar to abstinence rates following discharge from medication-free treatment.<sup>218</sup> The achievement of abstinence from all drugs</p>

<sup>213</sup> Faggiono, F., Vigna-Taglianti, F., Versino, E., & Lemma, P. (2003). Methadone maintenance at different dosages for opioid dependence. *Cochrane Database of Systematic Reviews*, Issue 3, Article No.: CD002208. DOI: 10.1002/14651858.CD002208.

<sup>214</sup> D’Aunno, T., Foltz-Murphy, N., & Lin, X. (1999). Changes in methadone treatment practices: Results from a panel study 1988-1995. *American Journal of Drug and Alcohol Abuse*, 25, 681-699; D’Aunno, T., & Pollack, H.A. (2002). Changes in methadone treatment practices: Results from a national panel study, 1988-2000. *Journal of the American Medical Association*, 288(7), 850-856. Pollack, H.A. & D’Aunno, T. (2008). Dosage patterns in methadone treatment: Results from a national survey, 1988-2005. *Health Services Research*, 43(6), 2143-2163.

<sup>215</sup> Eap, C., Bourquin, M., Martin, J-L, Spagnoli, J., Livoti, S., Powell, K., & Deglon, J. (2000). Plasma concentrations of the enantiomers of methadone and therapeutic response in methadone maintenance treatment. *Drug and Alcohol Dependence*, 61, 47-54; Levram, O., O’Hara, K., Peles, E., Li, D., Barral, S., Ray, B., Kreek, M.J. (2008). ABCB1 (MDR1) genetic variants are associated with methadone doses required for effective treatment of heroin dependence. *Human Molecular Genetics*, 17(14), 2219-2227.

<sup>216</sup> Dole, V.P. (1994a). Addiction as a public health problem. *Alcoholism: Clinical and Experimental Research*, 15(5), 749-752. Strain, E.D., Bigelow, G.E., Liebson, I.A., & Stitzer (1999). Moderate- vs. high-dose methadone in the treatment of opioid dependence. *Journal of the American Medical Association*, 28(11), 1000-1005.

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	and from successfully tapering from MM is associated with longer time periods in MM. <sup>219</sup> The course of heroin addiction is often measured in decades: In one of the longest follow-up studies, more than half of persons who developed heroin addiction in young adulthood continued heroin use into their 50s and 60s, in spite of repeated treatments and high mortality risks. <sup>220</sup>
Is the decision of an MM patient to begin a tapering process a positive step in the long-term recovery process?	Not always. Tapering is a time of great vulnerability. Without considerable support, most patients who begin tapering do not successfully complete the process and are at high risk of relapse during and following tapering. <sup>221</sup> MM patients' risk of HIV/AIDS and other infections as well as drug-related death rises following termination of MM. <sup>222</sup> The death rate for out-of-treatment methadone patients is 8-20 times that of in-treatment methadone patients. <sup>223</sup> If the termination of MM is considered, it is best achieved after sustained psychosocial rehabilitation and

- <sup>219</sup> Dole, V.P. (1994b). What we have learned from three decades of methadone maintenance treatment. *Drug and Alcohol Review*, 13, 3-4. I was able to find only one study where longer MM treatment predicted greater post-treatment relapse compared to those with shorter MM treatment, but longer MM treatment in this study may have been more a proxy for greater problem severity/complexity than a measure of the effects of MM: Hser, Y-I., Yamaguchi, K., Che, J., & Anglin, M.D. (1995). Effects of interventions on relapse to narcotic addiction: An event analysis. *Evaluation Review*, 19(1), 123-140.
- <sup>220</sup> Hser, Y-I. (2007). Predicting long-term stable recovery from heroin addiction: Findings from a 33-year follow-up study. *Journal of Addictive Diseases*, 26(1), 51-60.
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	recovery stability and with increased support during and following the tapering process. <sup>224</sup>
Does participation in a 12-step program enhance recovery outcomes for MM patients? Do MM patients who participate in NA have better recovery outcomes than those who do not?	Ancillary support services enhance medication-assisted treatment outcomes, <sup>225</sup> with such services including participation in peer-based 12-Step programs such as NA <sup>226</sup> and Methadone Anonymous (MA), <sup>227</sup> as well as professionally directed 12-Step facilitation groups. <sup>228</sup>

<sup>224</sup> Knight, K.R., Rosenbaum, M., Irwin, J., Kelley, M.S., Winger, L., & Washburn, A. (1996). Involuntary versus voluntary detoxification from methadone maintenance treatment: The importance of choice. *Addiction Research*, 3(4), 351-362; Milby, J. B. (1988). Methadone maintenance to abstinence: How many make it? *Journal of Nervous and Mental Disorders*, 176(7), 409-422; Platt, J. J., Widman, M., Lidz, V., & Marlowe, D. (1998). Methadone maintenance treatment: Its development and effectiveness after 30 years. In J.A. Inciardi & L.Harrison (Eds.), *Heroin in an age of crack-cocaine* (pp. 160-187). Thousand Oaks, CA: Sage.

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<sup>228</sup> Ronel, N., Gueta, K., Abramsohn, Y., Caspi, N., & Adelson, M. (2010). Can a 12-step program work in methadone maintenance treatment? *International Journal of Offender Therapy and Comparative Criminology*. Advance online publication. doi:10.1177/0306624X10382570