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Review and Commentary

The Paucity of Attention to Narcotics Anonymous in Current Public, Professional, and Policy Responses to Rising Opioid Addiction

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Recent surges in opioid addiction and opioid overdose deaths in the United States have triggered considerable public and professional alarm, including their emergence as an issue in the 2016 Presidential campaign.[1] Public health responses have focused primarily on 1) suppression of illicit opioid markets, 2) public education on opioid addiction risks, 3) prescription medication disposal campaigns, 4) opioid-focused physician training and prescription monitoring, 5) new non-opioid protocols for non-cancer pain management, 6) introduction of abuse-deterrent opioid formulations, 7) increased legal access and distribution of naloxone (Narcan®) for overdose intervention, and 8) efforts to expand access to addiction treatment—particularly medication-assisted treatment (MAT).[2]

As long-tenured addiction researchers, the authors have supported these efforts, but have been struck by the scant attention given to the role recovery mutual aid organizations such as Narcotics Anonymous (NA) can play and are playing in the national response to opioid addiction. If NA is mentioned at all in public or policy discussions of opioid addiction, it is as a fleeting reference to its existence as a post-treatment referral option, or, more frequently, in criticism of its alleged hostility toward maintenance medications in the management of opioid

[1] Brady, K.T., McCauley, J.L., & Back, S.E. (2016). Prescription opioid misuse, abuse, and treatment in the United States: An update. *American Journal of Psychiatry*, *171*(1), 18-26; Maxwell, C. (2015). The pain reliever and heroin epidemic in the United States: Shifting winds in the perfect storm. *Journal of Addictive Diseases*, *34*(2-3), 127-40; Rudd, R.A., Aleshire, N., Zibbell, J.E., & Gladden, R.M. (2016). Increases in drug and opioid overdose deaths – United States, 2000-2014. *MMWR Morbidity and Mortality Weekly Report*, *64*(50-51), 1378-82. Haddon, H. (2015). Drug deaths becoming a 2016 presidential election issue. *The Wall Street Journal*, November 3, 2015. Accessed May 16, 2016 at http://www.wsj.com/articles/drug-deaths-becoming-a-2016-presidential-election-issue-1446596075.

[2] Binswanger, I.A., & Gordon, A.J. (2016). From risk reduction to implementation: Addressing the opioid epidemic and continued challenged to our field. *Substance Abuse*, *37*(1), 1-3; Califf, R.M., Woodcock, J., & Ostroff, S. (2016). A proactive response to prescription opioid abuse. *New England Journal of Medicine*. doi: 10.1056/NEJMsr1601307; Clarke, J.L., Skoufalos, A., & Scranton, R. (2016). The American opioid epidemic: Population health implications and potential solutions: Report from the National Stakeholder Panel. *Population Health Management*, *19*, Suppl 1, S1-S10; Compton, W.M., Boyle, M., & Wargo, E. (2015). Prescription opioid abuse: Problems and responses. *Preventive Medicine*, *80*, 5-9; Dowell, D., Haegerich, T.M., & Chou, R. (2016). CDC guideline for prescribing opioids for chronic pain—United States—2016. *Journal of the American Medical Association*, *315*(15), 1624-1645; Kunins, H.V. (2015). Abuse-deterrent opioid formulations: Part of a public health strategy to reverse the opioid epidemic. *JAMA Internal Medicine*, 175(6), 987-8; Nelson, L.S., Juurlink, D.N., & Perrone, J. (2015). Addressing the opioid epidemic. *Journal of the American Medical Association*, 314(14), 1453-4; Voon, P. & Keer, T. (2013). "Nonmedical" prescription opioid use in North America: A call for priority action. *Substance Abuse Treatment, Prevention, and Policy*, *8*, 39.

addiction.[3] This omission, which extends to professional reports on mitigation strategies for opioid addiction[4], is puzzling given that NA is the one surviving recovery mutual aid organization whose birth in the early 1950s focused almost exclusively on recovery from heroin and other opioid addiction.[5]

Recent one-hour specials on ABC[6] and CNN[7] and a CBS *60 Minutes* segment[8] on prescription opioid and heroin addiction as well as numerous shorter reports all failed to even acknowledge the existence of NA or other recovery mutual aid fellowships devoted specifically to supporting recovery from addiction to opioids (e.g., Heroin Anonymous, Methadone Anonymous, Advocates for the Integration of Recovery and Methadone, and Mothers on Methadone). Further, brief mention of "AA and other Twelve-Step programs" when they do occur in media, professional, and policy discussions convey the impression of NA as an Alcoholics Anonymous (AA) clone and fail to convey NA's distinct history, culture, and program of recovery.[9]

The present commentary explores potential misconceptions about NA that may account for this lack of attention to NA as a recovery support resource for opioid addiction. While research on NA remains limited compared to the prodigious volume of studies of AA, the discrepancies between public and professional observations we have heard stated about NA are striking when compared to the findings of NA studies conducted in recent decades. Below we review eleven such discrepancies.

Misconception 1: *NA is a <u>treatment</u> for opioid addiction and other substance use disorders.* Understanding NA first requires understanding the difference between "treatment" and what have been generically christened recovery self-help groups, or more accurately, mutual help or mutual aid societies.[10]

Treatment takes place within the context of a business environment and a fiduciary relationship that is externally regulated and monitored through the mechanisms of professional accreditation and state licensing standards. Treatment is theory-driven; delivered by licensed or certified professionals; and involves a formal diagnosis, a treatment plan, and service documentation within a formal medical record. It involves payment (often substantial), is governed by professional standards of ethics, is focused primarily on recovery initiation and

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[3] Manchikanti, L., Helm, S., Fellows, B., Janata, J.W., Pampati, V., Grider, J.S., & Boswell, M.V. (2012). Opioid epidemic in the United States. *Pain Physician*, *15*:ES9-ES38; Olsen, Y. & Sharfstein, J.M. (2014). Confronting the stigma of opioid use disorder—and its treatment. *Journal of the American Medical Association*, *311*(14), 13931394. Also see http://khn.org/news/opioid-epidemic-spurs-rethink-on-medication-and-addiction/

[4] SAMHSA (2016) Substance Abuse and Mental Health Services Administration. (2016). Sublingual and transmucosal buprenorphine for opioid use disorder: Review and update. *Advisory*, *15*(1), 1-12; Volkow, N.D., & McLellan, A.T. (2016). Opioid abuse in chronic pain—misconceptions and mitigation strategies. *New England Journal of Medicine*, *374*, 1253-63.

[5] Humphreys, K. (2004). *Circles of recovery: Self-help organizations for addictions*. Cambridge: Cambridge University Press; White, W. (2014). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

[6] ABC David Muir Reporting, *20/20. Breaking Point: Heroin in America*, March 11, 2016.

[7] CNN *Anderson Cooper 360*. *Prescription Addiction: Made in the U.S.A.*, May 11, 2016.

[8] CBS *60 Minutes*. *The Heroin Epidemic*, April 24, 2016.

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

[10] Humphreys, K., Wing, S., McCarty, D., Chappel, J., Galant, L., Haberle, B.,…Weiss, R. (2004). Self-help organizations for alcohol and drug problems: Toward evidence-based practice and policy. *Journal of Substance Abuse Treatment*, *26*(3), 151-158.

stabilization, and is accessible only at limited times and for a limited (and historically ever-briefer) duration.

Recovery mutual aid societies, including NA, take place within the context of a voluntary community of shared experience whose members regularly meet to offer support to one another. NA defines itself as a "Fellowship of men and women who are learning to live without drugs."[11] Recovery mutual aid societies are not externally regulated, are based on experiential rather than expert knowledge, make no formal diagnoses, maintain no medical records, and require no service fees. Member and group actions are guided by core values ("traditions"), group conscience, and informal etiquette. Their primary focus is on recovery maintenance, support for daily coping, and enhanced quality of personal and family life in long-term recovery.[12]

Twelve-Step Facilitation (TSF) is a professionally-directed, manualized treatment for substance use disorders whose primary mechanisms of change involves orienting patients about Twelve-Step recovery principles and assertively linking patients to Twelve-Step groups such as AA and NA. TSF has been rigorously studied, including within randomized clinical trials[13], and is recognized as an "evidence-based" treatment within the Substance Abuse and Mental Health Service Administrations (SAMHSA) National Registry of Evidence Based Programs and Practices (NREPP). Although TSF is not AA or NA, its benefits when formally tested using mediational analyses are explained by TSF patients' greater involvement in AA and NA following the intervention.[14] NA, per se, however, is not considered an evidence-based treatment because Narcotics Anonymous is <u>not</u> a professionally-directed treatment for substance use disorders.[15]

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[11] Narcotics Anonymous World Services, Inc. (NAWS, 2008c). *Narcotics Anonymous (6th ed.)*. Chatsworth, CA: Narcotics Anonymous World Services, Inc., p. 10.

[12] White, W. (2014). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

[13] See for example: Crits-Christoph P., Siqueland, L., Blaine, J., Frank, A., Luborsky, L., Onken, L.S., Muenz, L.R., Thase, M.E., Weiss, R.D., Gastfriend, D.R., Woody, G.E., Barber, J.P., Butler, S.F., Daley, D., Salloum ,I., Bishop, S., Najavits, L.M., Lis, J., Mercer, D., Griffin, M.L., Moras, K., & Beck, A.T. (1999). Psychosocial treatments for cocaine dependence: National Institute on Drug Abuse Collaborative Cocaine Treatment Study. *Archives of General Psychiatry*, *56*(6), 493-502; Donovan, D.M., Daley, D.C., Brigham, G.S., Hodgkins, C.C., Perl, H.I., Garrett, S.B., Doyle, S.R., Floyd, A.S., Knox, P.C., Botero, C., Kelly, T.M., Killeen ,T.K., Hayes, C., Kau'iBaumhofer, N., Seamans, C., & Zammarelli, L. (2013). Stimulant abuser groups to engage in 12-Step: A multisite trial in the National Institute on Drug Abuse Clinical Trials Network. *Journal of Substance Abuse Treatment*. *44*, 103–114; Project Match Research Group. (1997). Matching alcoholism treatments to client heterogeneity: Project MATCH posttreatment drinking outcomes. *Journal of Studies on Alcohol, 58*, 7–29; Project MATCH Research Group. (1998). Matching alcoholism treatments to client heterogeneity: treatment main effects and matching effects on drinking during treatment. *Journal of Studies on Alcohol. Vol. 59;* Litt, M.D., Kadden, R.M., Kabela-Cormier, E., & Petry, N.M. (2009) Changing network support for drinking: Network support project two-year follow-up. *Journal of Consulting & Clinical Psychology*, *77*(2), 229-42; Walitzer, K.S., Dermen, K.H., & Barrick, C. (2009). Facilitating involvement in Alcoholics Anonymous during out-patient treatment: a randomized clinical trial. *Addiction*, 104(3), 391-401.

[14] Litt, M.D., Kadden, R.M., Kabela-Cormier, E., & Petry, N.M. (2009) Changing network support for drinking: Network support project two-year follow-up. *Journal of Consulting & Clinical Psychology*, *77*(2), 229-42; Walitzer, K.S., Dermen, K.H., & Barrick, C. (2009). Facilitating involvement in Alcoholics Anonymous during out-patient treatment: a randomized clinical trial. *<u>Addiction</u>*, *104*(3), 391-401; Longabaugh, R., Wirtz, P.W., Zweben, A., & Stout, R.L. (1998). Network support for drinking, Alcoholics Anonymous and long-term matching effects. *Addiction, 93*, 1313–1333.

[15] Nowinski, J., & Baker, S. (2012). The twelve Step facilitation handbook: A systematic approach to recovery from substance dependence. Hazelden Publishing; Ries, R.K., Galanter, M., & Tonigan, J.S. (2008). "Twelve-step facilitation." *The American psychiatric publishing textbook of substance abuse treatment*, 373-386.

Considerable harm to individuals, families, organizations, and communities can accrue from ill-defined boundaries between professionally-directed addiction treatment (and allied professional services) and addiction recovery mutual aid. When addiction treatment drifts across the border into mutual aid (e.g., clinical abandonment), those served fail to receive care at current standards of acceptable practice, and they pay for activities that are free within mutual aid organizations. When mutual aid drifts across the line into treatment, those served can be harmed by untrained peers acting beyond the limits of their education, training, and experience, e.g., practicing medicine, psychology, social work, or addiction counseling without proper credentials.[16]

NA is not a *treatment* for opioid addiction, though it can serve as an adjunct or, in some cases, an alternative to such professional treatment—the latter noted by the 15 percent of surveyed NA members who report no prior history of addiction treatment.[17] The potential potency of combining professional treatment and NA effects is enhanced when addiction treatment providers use assertive rather than passive styles of linkage to local NA resources.[18]

Misconception 2: *NA meetings and the NA program are not widely accessible.* U.S. population surveys on the degree of Twelve-Step group exposure in the general population are limited. Room and Greenfield reported in 1993 that 9 percent of the adult population had attended an Alcoholics Anonymous meeting in their lifetime, and that 2.8 percent reported lifetime attendance at NA or another Twelve-Step group other than AA.[19] A subsequent survey[20] reported that 6.4 percent of the adult population had attended self-help meetings for a substance use problem (with no breakdown by particular mutual aid fellowship). We know of no subsequent national population studies on the national prevalence of NA exposure. In 2004, there were an estimated 185,000 NA members.[21] In 2010, SAMHSA reported that 2.3 million American adults had sought help for a substance use problem through a mutual aid group such as AA or NA during the previous 12 months, but did not provide an NA-specific membership estimate.[22]

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[16] Kurtz, E. (1996). Spirituality and recovery: The historical journey. Blue Book (National Clergy Conference on Alcoholism), *47*, 5-29; White, W. (2014). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

[17] Galanter, M., Dermatis, H., Post, S. & Santucci, C. (2013). Abstinence from drugs of abuse in community-based members of Narcotics Anonymous. *Journal of Studies on Alcohol and Drugs, 74*, 349-352.

[18] Timko, C., & DeBenedetti, A. (2007). A randomized controlled trial of intensive referral to 12-Step self-help groups: one-year outcomes. *Drug and Alcohol Dependence*, *90*, 270-279; Timko, C., DeBenedetti, A., & Billow, R. (2006). Intensive referral to 12-step self-help groups and 6-month substance use disorder outcomes. *Addiction*, 101, 678-688; White, W., & Kurtz, E. (2006). *Linking Addiction Treatment and Communities of Recovery: A Primer for Addiction Counselors and Recovery Coaches*. Pittsburgh, PA: IRETA/NeATTC

[19] Room, R., & Greenfield, T. (1993). Alcoholics anonymous, other 12-step movements and psychotherapy in the US population, 1990. *Addiction*, *88*(4), 555-562.

[20] Kessler, R. C., Mickelson, K. D., & Zhao, S. (1997). Patterns and correlates of self-help group membership in the United States. *Social Policy*, *27*(3), 27-45.

[21] Humphreys, K., Wing, S., McCarty, D., Chappel, J., Galant, L., Haberle, B.,…Weiss, R. (2004). Self-help organizations for alcohol and drug problems: Toward evidence-based practice and policy. *Journal of Substance Abuse Treatment*, *26*(3), 151-158.

[22] SAMHSA (2010) *Substance Abuse and Mental Health Services Administration. Results from the 2009 National Survey on Drug Use and Health: Volume 1. Summary of national findings (NSDUH Series H-38A, HHS Publication No. SMA 10-4856)*. Rockville, MD: Office of Applied Statistics.

There are presently more than 67,000 NA meetings per week in 139 countries, with 27,475 weekly NA meetings in U.S. states and territories.[23] The number of available NA meetings worldwide has more than doubled in the past 15 years.[24] These face-to-face meetings are supplemented by a growing network of online NA meetings and chatrooms, NA telephone meetings, and a growing portfolio of NA literature.[25] Also of note is the ever-expanding range of other recovery support activities organized by NA members outside the official structure of NA. Such activities include NA-themed social media activity on Facebook, YouTube, Pinterest, and Twitter; posted NA talks and informational podcasts; NA apps; social clubs for NA members; and a wide spectrum of social activities organized by and for NA members.[26] NA, like other Twelve-Step programs, has also witnessed the development of a parallel program to support family members affected by addiction (i.e., Nar-Anon).

Though increasingly rare, the absence of local NA resources should not preclude referral to other recovery mutual aid organizations. Co-attendance or sequential attendance across Twelve-Step groups and between secular, religious, and spiritual recovery mutual aid groups out of preference, necessity, or convenience is not uncommon.[27] A recent study of individuals dependent on drugs other than alcohol who were attending AA meetings revealed recovery outcomes similar to those involved only in NA, and the former group did not have higher drop-out rates than those attending NA.[28]

Misconception 3*: NA suffers from a lack of members in long-term recovery. (Variations: There are no "oldtimers" in NA like those found in AA. There is too much street culture in NA. Opioid addicts should be referred to AA rather than NA because AA has a stronger recovery culture. I referred a client to NA, and they were offered drugs at their first meeting. Don't most NA members have criminal backgrounds? My clients would be offended by the profanity at NA meetings.*) The only requirement for participation in NA is "a desire to stop using"[29], which means that there will be people present at NA meetings who have not yet achieved stable abstinence. These individuals are usually a small minority at any meeting and, if not, other meetings should be sought out. It may be hard for a newcomer to distinguish between established

[23] Narcotics Anonymous World Services, Inc. Public Relations Office (NAWS, 2016). Personal communications, Jane Nickels, April 23, May 13, 2016).

[24] White, W., , C., & Pickard, B. (2013). Narcotics Anonymous comes of age: A 60th anniversary professional tribute. *Counselor*, *14*(50), 54-57.

[25] Narcotics Anonymous World Services, Inc. (NAWS, 2011). Membership survey. Retrieved March 2, 2013 from http://www.na.org/admin/include/spaw2/uploads/pdf/PR/NA_Membership_Survey.pdf; White, W., Budnick, C., & Pickard, B. (2011). Narcotics Anonymous: Its history and culture. *Counselor*, *12*(2), 10-15, 22-27, 36-39, 46-50.

[26] Hall, M. J., & Tidwell, W. C. (2003). Internet recovery for substance abuse and alcoholism: An exploratory study of service users. *Journal of Substance Abuse Treatment*, *24*(2), 161-167.

[27] 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; Horvath, T. (2014). The dual citizenship phenomenon. Accessed April 10, 2016 at: http://www.rehabs.com/pro-talk-articles/the-dual-citizenship-phenomenon-2/; White, W. L. (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.

[28] Kelly, J.F., Greene, M.C. & Bergman, B.C. (2014). Do drug-dependent patients attending Alcoholics Anonymous rather than Narcotics Anonymous do as well? A prospective, lagged, matching analysis. *Alcohol and Alcoholism*, 1-9, doi:10.1093/alcalc/agu066

[29] Narcotics Anonymous World Services, Inc. (NAWS, 2008c). *Narcotics Anonymous (6th ed.)*. Chatsworth, CA: Narcotics Anonymous World Services, Inc., p. 60.

NA members and those like he or she who are just arriving. This is particularly true where a treatment center or a drug court sends 20 people into an NA meeting that has 15 regular members. Under such circumstances, a newcomer may be offered drugs, but not by regular NA members. Cooperation between local NA groups and NA referral sources can go a long way in minimizing such incidents.

The average duration of continuous abstinence of NA members has increased as NA has matured as a global fellowship, just as this rate increases over time as NA groups are established in other countries and, in particular, local communities. Globally, NA members currently have an average of more than eight years of continuous abstinence. Ninety-one percent of NA members have more than one year of continuous abstinence, and 47 percent of NA members have 11 or more years of continuous abstinence.[30] This pattern of recovery stability within NA is also reflected in a pervasive service ethic: 85 percent of NA members have a service and/or sponsorship commitment.[31] Helping others within and beyond NA, above and beyond attendance at NA meetings, has been found to be a strong indicator of recovery stability.[32]

The image that *NA* is only appropriate for "hard core drug addicts"--an impression regularly reinforced via television portrayals of NA, e.g., *Breaking Bad*, *Nurse Jackie*, *Dexter*[33] —is challenged by the wide range of problem severity and problem duration reported by NA members prior to their involvement in NA. Only 15 percent of NA members attended their first NA meeting at the suggestion or mandate of the criminal justice system; most arrive at their first NA meeting through suggestion of an NA member, a family member, or an addiction treatment professional. NA's latest membership survey reveals that 76 percent of current NA members are employed or in school, and 63 percent of NA members have completed an associate (or trade school) degree, a college degree, or a graduate degree.[34] As NA's own literature suggests:

> *Admittedly there is a stereotype of the "typical" candidate for NA—urban, criminal, a needle-user—and that narrow vision does describe some of us, but we are also professionals, parents, and students, and so on, living in cities, small towns, and rural communities in countries all over the world*.[35]

Scientific evidence to date, limited as it is, confirms such diversity of NA membership.

Misconception 4: *Opioid-dependent youth should not be referred to NA due to concerns about its effectiveness and safety.* Three reviews of the research literature affirm the potential value of mutual aid group participation in enhancing recovery of adolescents with substance use disorders.[36] Studies to date indicate that youth who attend Twelve-Step groups after residential

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[30] Narcotics Anonymous World Services, Inc. Public Relations Office (NAWS, 2016). Personal communications, Jane Nickels, April 23, May 13, 2016).

[31] Ibid

[32] 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*(3), 291-301.

[33] Withers, R. (2014). Six myths about Narcotics Anonymous you probably believe. Accessed April 11, 2016 at (http://blog.com.blog/6-myths-about-narcotics-anonymous-you-probably-believe)

[34] Narcotics Anonymous World Services, Inc. Public Relations Office (NAWS, 2016). Personal communications, Jane Nickels, April 23, May 13, 2016).

[35] Narcotics Anonymous World Services, Inc. (NAWS, 2008). *Narcotics Anonymous (6th ed.)*. Chatsworth, CA: Narcotics Anonymous World Services, Inc., p. xviii.

[36] Bekkering, G.E., Mariën, D., Parylo, O., & Hannes, K. (2016). The effectiveness of self-help groups for adolescent substance misuse: A systematic review. *Journal of Child & Adolescent Substance Abuse*, *0*(0), 1-16;

treatment are more likely to remain abstinent, engage in less frequent substance use, and have better post-treatment outcomes than those who do not participate in such groups.[37] Studies to date have generally shown that Twelve-Step participation by youth and young adults strengthens outcomes beyond that achieved from professional treatment alone.[38] Reviews of teen involvement in Twelve-Step meetings have drawn similar conclusions about their potential value, particularly for youth presenting with the most severe and complex substance use disorders. However, we are aware of no study that looked specifically at these outcomes for opioid dependent youth. Youth dropping out of NA and AA most often do so from boredom or a sensed lack of fit with its Twelve-Step program than from any expressed concern about their safety.[39]

A study of the safety of youth participating in NA concluded that such safety concerns were rare (though more common than in AA), and, that decisions to discontinue NA participation were unrelated to any safety issues. The study authors concluded that "youth should not be discouraged from attending AA or NA groups due to safety concerns" but also recommended "clinicians should continue to monitor adolescents' Twelve-step experiences and assess the specific nature of any reported concerns."[40]

Twelve-Step groups and meetings can vary in their degree of safety and recovery orientation.[41] The perceived attraction, value, and safety of NA and other mutual aid meetings for youth are enhanced in groups with closer age homogeneity.[42] Safety concerns can be

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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*(3), 259-269; Sussman, S. (2010). A review of Alcoholics Anonymous/ Narcotics Anonymous programs for teens. *Evaluation & the Health Professions*, *33*(1), 26-55.

[37] Kelly, J.F., & Urbanoski, K. (2012). Youth recovery contexts: The incremental effects of 12-step attendance and involvement on adolescent outpatient outcomes. Alcoholism: Clinical & Experimental Research, *36*(7), 1219-1229; Kelly, J.F., Brown, S.A., Abrantes, A., Kahler, C.W., & Myers, M.G. (2008). Social recovery model: An 8-year investigation of youth treatment outcome in relation to 12-step group involvement. *Alcoholism: Clinical & Experimental Research*, *32*(8), 1468-1478. Kelly, J. F., & Myers, M. G. (1997). Adolescent treatment outcome in relation to 12-step group attendance. Abstracted in *Alcoholism: Clinical and Experimental Research*, 21, 27A. Kelly, J.F., Myers, M.G., & Brown, S.A. (2000). A multivariate process model of adolescent 12-Step attendance and substance use outcome following inpatient treatment. *Psychology of Addictive Behaviors*, *14*, 376-389; Kelly, J. F., Myers, M. G., & Brown, S. A. (2002). Do adolescents affiliate with 12-step groups? A multivariate process model of effects. *Journal of Studies on Alcohol*, 63(3), 293-304; Kelly, J.F., Myers, M.G., & Brown, S.A. (2005). The effects of age composition of 12-Step groups on adolescent 12-Step participation and substance use outcome. *Journal of Child and Adolescent Substance Abuse*, *15*, 63-72.

[38] 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*(1-2), 117-125; Kelly, J.F., Stout, R.L., & Slaymaker, V. (2013). Emerging adults' treatment outcomes in relation to 12-step mutual-help attendance and active involvement. *Drug and Alcohol Dependence*, *129*(1-20, 151-7; Kingston, S., Knight, E., Williams, J., & Gordon, H. (2015). How do young adults view 12-Step programs. A qualitative study. *Journal of Addictive Diseases*, *34*(4), 311-22.

[39] Kelly, J.F., Yeterian, J., & Rodolico, J. (2008). What do adolescents exposed to Alcoholics Anonymous [and Narcotics Anonymous] think about 12-step groups? *Substance Abuse*, *29*(2), 53-62.

[40] Kelly, J.F., Dow, S.J. Yeterian, J.D., & Myers, M. (2011). How safe are adolescents at AA and NA meetings? A prospective investigation with outpatient youth. *Journal of Substance Abuse Treatment*, *40*(4), 419-428; Kelly, J.F., Urbanoski, K.A., Hoeppner, B.B., & Slaymaker, V. (2012). "Ready, willing, and (not) able" to change: young adults' response to residential treatment. *Drug and Alcohol Dependence*, *121*(3), 224-30.

[41] Sussman, S. (2010). A review of Alcoholics Anonymous/ Narcotics Anonymous programs for teens. *Evaluation & the Health Professions*, 33(1), 26-55.

[42] Kelly, J. F., Myers, M. G., & Brown, S. A. (2002). Do adolescents affiliate with 12-step groups? A multivariate process model of effects. *Journal of Studies on Alcohol*, *63*(3), 293-304; Labbe. A.K., Greene, C., Bergman, B.G.,

addressed through discussion of safety prior to linkage to NA, linkage to meetings with strong recovery cultures and substantial youth representation, and ongoing monitoring of any safety issues that arise following referral.[43] Also of potential assistance is literature NA has developed specifically for youth and their parents or guardians.[44]

Misconception 5: *NA does not effectively serve women, ethnic minorities, and other historically disenfranchised populations.* NA membership is the most culturally diverse of any major addiction recovery mutual aid organization. NA membership is 41 percent women—the highest rate of any abstinence-based recovery support group other than Women for Sobriety.[45] Twenty-five percent of NA members are people of color, including 11 percent African American, 6 percent Hispanic, 3 percent Asian, 1 percent Native American, and 4 percent multiracial.[46] The increased cultural diversity of NA is underscored by the growth of NA meetings within communities of color, the cultural diversity represented in the stories in *Narcotics Anonymous* (the 6th Edition of NA's Basic Text), and the growth of common needs meetings for women, youth, LGBT, agnostics, veterans, people living with HIV / AIDS, and various professional groups.[47] Also of note is the increased representation of people of color within qualitative studies of NA-based recovery from opioid addiction.[48] NA is rising and thriving in quite diverse cultural, religious, and political contexts.[49]

Compared to women in AA, women in NA are younger, more ethnically diverse, less educated, less likely to be married, more likely to earn less than $20,000 per year, more likely to be addicted to multiple substances, and more likely to have experienced physical abuse or assault. Early feminist criticisms of Twelve-Step programs as disempowering and apolitical have given way to a deeper appreciation of how NA participation can serve as a platform for personal

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Hoeppner, B. & Kelly, J.F. (2013). The importance of age composition of 12-step meetings as a moderating factor in the relation between young adults' 12-step participation and abstinence, *Drug and Alcohol Dependence*, *133*(2), 541-7; Passetti, L. L., & White, W. L. (2008). Recovery support meetings for youths: Considerations when referring young people to 12-Step and alternative groups. *Journal of Groups in Addiction and Recovery*, *2*(2-4), 97-121.

[43] White, W. (2016) Recovery and personal safety, Accessed April 16, at http://www.williamwhitepapers.com/blog/2016/02/recovery-and-personal-safety.html

[44] Narcotics Anonymous World Services, Inc. (NAWS, 2008a). *By young addicts for young addicts*. Van Nuys, CA: Narcotics Anonymous World Services, Inc.; Narcotics Anonymous World Services, Inc. (NAWS, 2008b). *For the parents or guardians of young people in NA*. Van Nuys, CA: Narcotics Anonymous World Services, Inc.

[45] Narcotics Anonymous World Services, Inc. Public Relations Office (NAWS, 2016). Personal communications, Jane Nickels, April 23, May 13, 2016).

[46] Ibid

[47] Narcotics Anonymous World Services, Inc. (NAWS, 2016). *Special interest meetings*. Retrieved April 16, 2016 at: https://www.na.org/?ID=bulletin18

[48] Flaherty, M.T., Kurtz, E. White, W.L., & Larson, A. (2014). An interpretive phenomenological analysis of secular, spiritual, and religious pathways of long-term addiction recovery. *Alcoholism Treatment Quarterly*, *32*(4), 337-356.

[49] Flora, K., & Raftopoulos, A. (2007). First description of Narcotics Anonymous and Alcoholics Anonymous members in Greece: Prior treatment history and opinions about professionals. *Contemporary Drug Problems*, *34*(1), 163-170; Galanter, M. (2016). *What is Alcoholics Anonymous? A path from addiction to recovery*. New York: Oxford University Press; Raftopoloulos, A., & Flora, K. (2011). Substance use related behavior of the members of Narcotics Anonymous and Alcoholics Anonymous in Greece. *Journal of Psychoactive Drugs*, *43*(3), 238-244. Ronel, N. (1997). The universality of a self-help program of American origin: Narcotics Anonymous in Israel. *Social Work Health Care*, *25*(3), 87-101; Toumbourou, J., 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*(1), 61-66; Wells, B. (1987). Narcotics Anonymous (NA): The phenomenal growth of an important resource. *British Journal of Addiction*, *82*(6), 581-582.

transformation and broader community involvement and activism. Studies of women in NA reveal there is a long history of women's leadership within NA and that women in NA value both general and women's meetings, while using the latter to address some of the special recovery issues faced by women in NA, e.g., overcoming trauma and victimization, gender oppression, and shame.[50]

Other populations who have found NA a useful recovery support resource include military veterans[51] and physicians participating in physician health programs.[52]

Misconception 6: *NA is anti-treatment*. NA members have considerable direct experience with addiction treatment. More than 85 percent of NA members have been in addiction treatment prior to joining NA, and 25 percent report prior psychiatric treatment.[53] Nearly half (46 percent) of current NA members report attending their first NA meeting as a result of referral of a treatment or counseling agency.[54]

NA members with whom we discussed this misconception noted that negative comments about treatment can be sometimes heard at NA meetings and in pre and post meeting communications as well as in online exchanges between NA members. Such communications range from the projected blame of the newcomer (for past failed efforts to sustain abstinence) to legitimate concerns NA members express about treatment program policies or practices they have experienced in the past, including administrative discharge policies (being kicked out of treatment for confirming their diagnosis), financial exploitation (i.e., exorbitant costs, profiteering, charging fees for Twelve-Step activities), and being mandated by a treatment program to go to AA without the option of NA meeting attendance. NA members can also be heard expressing concerns with treatment programs that prohibit visits with sponsors during inpatient treatment, schedule groups that conflict with NA meeting times, host staff-led "NA meetings" closed to those not in treatment, and group transport practices—often arriving late and leaving early, while denying their patients the benefits of pre- and post-meeting social interaction. Also heard are expressed concerns about the actions of addiction treatment staff, e.g., attending NA meetings with clients without clarifying whether the staff member is in the meeting as an NA member or as a treatment professional, wearing a treatment center nametag while in the meeting, and not clarifying when they are speaking as an NA member or as an addiction professional.

While NA Traditions dictate no opinion on issues outside of NA and a stance of non-affiliation with any "related facility or outside enterprise"[55], there are NA meetings held within

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[50] Sanders, J. (2011). Feminist perspectives on 12-step recovery: A comparative descriptive analysis of women in Alcoholics Anonymous and Narcotics Anonymous. *Alcoholism Treatment Quarterly*, *29*, 357-378; Sanders, J. (2014). *Women in Narcotics Anonymous: Overcoming stigma & shame*. New York, NY: Pelgrave Macmillan a division of St Martin's Press LLC.

[51] Galanter, M., Dermatis, H., & Sampson, C. (2014). Narcotics Anonymous: A comparison of military veterans and non-veterans. *Journal of Addictive Diseases*, *33*(3), 187-95.

[52] Merlo, L.I., Campbell, M.D., Skipper, G.E., Shea, C.L., & DuPont, R.L. (2016). Outcomes for physicians with opioid dependence treated without agonist pharmacotherapy in Physician Health Programs. *Journal of Substance Abuse Treatment*, *64*, 47-54.

[53] Galanter, M., Dermatis, H., Post, S., & Sampson, C. (2013). Spirituality-based recovery from drug addiction in the Twelve-Step fellowship of Narcotics Anonymous. *Journal of Addiction Medicine*, *7*(3), 189-195.

[54] Narcotics Anonymous World Services, Inc. Public Relations Office (NAWS, 2016). Personal communications, Jane Nickels, April 23, May 13, 2016).

[55] Narcotics Anonymous World Services, Inc. (NAWS, 2008c). *Narcotics Anonymous (6th ed.)*. Chatsworth, CA: Narcotics Anonymous World Services, Inc., p. 69.

addiction treatment facilities, and NA has developed a strong service culture that includes Hospitals and Institutions (H & I) subcommittees that bring the NA message of recovery to people who do not have access to regular NA meetings.[56] Collaboration between treatment facilities and NA is enhanced when the former provide their clients basic information on NA and its culture (e.g., reviewing the NA pamphlet *An Introduction to NA Meetings*) BEFORE referring clients to local NA meetings.

NA participation is being increasingly integrated with professionally directed addiction treatment.[57] Many new developments within the addiction treatment field, such as the shift from acute care models of treatment to models of sustained recovery management, are highly congruent with NA principles. For example, NA's early conceptualization of addiction as a chronic disease analogous to cancer, diabetes, and heart disease requiring lifelong and assertive self-management predates the modern conceptualization of addiction as a chronic disorder by decades.[58]

Misconceptions 7: *People addicted to opioids do not seek help from NA due to its stance on maintenance medications. People in medication-assisted treatment for opioid addiction should not be referred to NA due to NA's attitudes toward maintenance medications.* NA has outlined its stance on maintenance medications in three earlier publications (*In Times of Illness*, *Bulletin #29: Regarding Methadone and Other Drug Replacement Programs,* and *NA Groups and Medication*), and is in the process of drafting a new statement *Narcotics Anonymous and Persons Receiving Medication Assisted Treatment*. These publications define the NA program as one of complete abstinence, including abstinence from maintenance medications used in the treatment of addiction. NA is particularly well-suited for individuals addicted to opioids who find medication-assisted treatment (MAT) undesirable or who are in safety sensitive occupations that would preclude MAT.[59] NA extends a warm welcome to people prescribed such medications who hope to later sustain recovery without such medication and who wish to explore NA as a long-term recovery support solution.

The number of people in medication-assisted treatment for opioid addiction who are dissuaded from seeking help from NA because of NA's stance on maintenance medications is unknown, though their presence has been reported in the professional literature.[60] In the most recent NA membership surveys (2015), 68 percent of NA members reported past use of opiates

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[56] Narcotics Anonymous World Services, Inc. (NAWS, 1997). *Hospitals & Institutions Handbook*. Retrieved April 24, 2013 from http://www.na.org/admin/include/spaw2/uploads/pdf/handbooks/H&I%20Handbook.pdf

[57] Troyer, T. N., Acampora, A. P., O"connor, L. E., & Berry, J. W. (1995). The changing relationship between therapeutic communities and 12-step programs: A survey. *Journal of Psychoactive Drugs*, *27*(2), 177-180; Monico, L.B., Gryczynski, J., Mitchell, S.G., Schwartz, R.P, O'Grady, K.E., & Jaffe, J.H. (2015). Buprenorphine treatment and 12-Step meeting attendance: Conflicts, compatibilities, and patient outcomes. *Journal of Substance Abuse Treatment*, *57*, 89-95.

[58] Narcotics Anonymous World Services, Inc. (NAWS, 2008). Narcotics Anonymous (6th ed.). Chatsworth, CA: Narcotics Anonymous World Services, Inc.; McLellan, A.T., Lewis, D.C., O'Brien, C.P., & Kleber, H.D. (2000) Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation., *Journal of the American Medical Association*, *284*(13), 1689-1695.

[59] Merlo, L.I., Campbell, M.D., Skipper, G.E., Shea, C.L., & DuPont, R.L. (2016). Outcomes for physicians with opioid dependence treated without agonist pharmacotherapy in Physician Health Programs. *Journal of Substance Abuse Treatment*, *64*, 47-54.

[60] White, W. L. (2011). *Narcotics Anonymous and the pharmacotherapeutic treatment of opioid addiction*. Chicago, IL: Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health and Intellectual disability Services.

or opioids, and 22 percent of members reported opiates as their primary drug.[61] Only a small percentage of members (less than one percent) reported in the most recent NA membership survey that they were currently using prescribed methadone or buprenorphine.[62]

A recent study of NA and other Twelve-Step participation among people in methadone or buprenorphine maintenance treatment revealed a high rate of past year NA or other Twelve-Step attendance and positive self-evaluations of the role of NA participation in recovery stability and quality of life. However, this same study revealed a significant portion of NA-involved patients in methadone maintenance who did not disclose their medications status within the context of Twelve-Step participation.[63] A recent study found that clinicians rarely discuss such disclosure issues with patients when linking patients in medication-assisted treatment to NA.[64] Another recent study found that opioid-addicted patients in buprenorphine treatment had improved outcomes when concurrently participating in Twelve-Step recovery support meetings.[65]

In a 2008 survey of opioid treatment programs in the United States, 46 percent of programs reported offering recovery support groups to their patients either through linkage to community meetings or onsite meetings, 43 percent offered some form of peer mentoring/support, and 37 percent reported using a Twelve-Step Facilitation approach to treatment.[66]

The Twelve Steps have been adapted for specific use with people in medication-assisted treatment[67], and traditional abstinence-based treatment programs (e.g., Hazelden Betty Ford) have begun integrating Twelve-Step recovery principles and the use of selected maintenance medications as adjuncts in the treatment of opioid addiction.[68] Also of note is the predicted expansion of MAT for opioid addiction within the criminal justice system.[69]

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[61] Narcotics Anonymous World Services, Inc. Public Relations Office (NAWS, 2016). Personal communications, Jane Nickels, April 23, May 13, 2016).

[62] Ibid

[63] White, W., Campbell, M.D., Shea, C., Hoffman, H.A., Crissman, B., & DuPont, R.L. (2013). Co-participation in 12 Step mutual aid groups and methadone maintenance treatment: A survey of 322 patients. *Journal of Groups in Addiction and Recovery*, *8*(4), 294-308.

[64] Suzuki, J. & Dodds, T. (2016). Clinicans recommendation of 12-step meeting attendance and discussion regarding disclosure of buprenorphine use among patients in office-based opioid treatment. *Substance Abuse*, *37*(1), 31-4.

[65] Monico, L.B., Gryczynski, J., Mitchell, S.G., Schwartz, R.P, O'Grady, K.E., & Jaffe, J.H. (2015). Buprenorphine treatment and 12-Step meeting attendance: Conflicts, compatibilities, and patient outcomes. *Journal of Substance Abuse Treatment*, 57, 89-95.

[66] SAMHSA, Office of Applied Studies (January 28, 2010b). *The N-SSATS Report: Overview of Opioid Treatment Programs within the United States: 2008*. Rockville, MD.

[67] 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; Ginter, W. (2012). Methadone Anonymous and mutual support for medication-assisted recovery. *Journal of Groups in Addiction and Recovery*, *7*(2-4), 189-201; Glickman, L, Galanter, M., Dermatis, H., & Dingle, S. (2006). Recovery and spiritual transformation among peer leaders of a modified Methadone Anonymous group. *Journal of Psychoactive Drugs*, *38*(4), 531-533; Glickman, L, Galanter, M., Dermatis, H., Dingle, S., & Hall, L. (2004). Pathways to recovery: Adapting 12-step recovery to methadone treatment, *Journal of Maintenance in the Addictions*, *2*, 77-90; McGonagle, D. (1994). Methadone Anonymous: A 12-step program. Reducing the stigma of methadone use. *Journal of Psychosocial Nursing*, *32*(10), 5-12.

[68] Seppala, M. (2013). A comprehensive response to the opioid epidemic: Hazelden's approach. *Minnesota Medicine*, *96*(3), 45-7; White, W. (2015). Recovery-focused addiction psychiatry: An Interview with Dr. Marvin Seppala. *Alcoholism Treatment Quarterly*, *33*(4), 458-473. Also See: Obuchowsky, M., & Zweben, J.E. (1987). Bridging the gap: The methadone client in 12-Step programs, *Journal of Psychoactive Drugs*, *19*(3), 301-302; Sorensen, J.L., Deitch, D.A., & Acampora, A. (1984). Treatment collaboration of methadone maintenance programs

The issue of recovery support for people in MAT is a critical one given the number of affected people--estimated in 2011 at more than 230,000 patients enrolled in methadone maintenance and more than 800,000 patients receiving prescriptions for buprenorphine.[70] Equally critical is the fact that the vast majority of people who begin treatment with methadone, buprenorphine, or naltrexone do not remain on these medications for prolonged periods of time.[71] A major problem with MAT is disengagement from MAT prior to recovery stabilization. In 2011, there were more than 75,000 discharges from Opioid Treatment Programs in the U.S., with average treatment duration of 133 days. Only 12 percent of those discharged completed treatment as planned, and 80 percent reported no mutual aid involvement in the month prior to discharge.[72] The recurrence of opioid addiction is high under such circumstances.[73] Referral to NA or alternative mutual aid resources is highly indicated as a source of enhanced recovery stability during medication maintenance and a source of sustained recovery support during and following tapering of medication maintenance.[74]

The key to mutual aid engagement and sustained affiliation, whether we are talking about women, youth, people of color, people with co-occurring disorders, or people in MAT, is the chemistry of mutual identification. Mutual identification involves each newcomer experiencing both a level of attraction that leads to one's choosing affiliation and a sense that one has been chosen by the group for inclusion, e.g., a sense of belonging and coming home.[75] Crucial to achieving recovery from opioid addiction is a sense of such connection with the larger mainstream community or finding the social space where a recovery process can be incubated to

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and therapeutic communities. *American Journal on Drug and Alcohol Abuse*, *19*(3), 347-359; Sorensen, J.L., Deitch, D.A. & Acampora, A. (1984). From maintenance to abstinence in a therapeutic community: Preliminary results. *Journal of Psychoactive Drugs*, *16*(1), 73-77; Zweben, J.E., Aly, T., Martin, J., Wengrofsky, S., Bacci, J., & Meddaugh, R. (1999). Making residential treatment available to methadone clients. *Journal of Substance Abuse Treatment*, *17*(3), 249-56.

[69] Ludwig, A.S., & Peters, R.H. (2014). Medication-assisted treatment for opioid use disorders in correctional settings: An ethics review. *International Journal of Drug Policy*, *25*(6), 1041-6.

[70] White, W., Parrino, M., & Ginter, W. (2011). A dialogue on the psychopharmacology in behavioral healthcare: The acceptance of medication-assisted treatment in addictions. Commissioned briefing paper for SAMHSA's A Dialogue on Psychopharmacology in Behavioral Healthcare conference, October 11-12, 2011. Accessed April 19, 2016 at http://www.williamwhitepapers.com/pr/2011%20SAMHSA%20Acceptance%20of%20Medication-assisted%20Treatment.pdf.

[71] Deck, D., & Carlson, M.J. (2005). Retention in publicly funded methadone maintenance treatment in two Western states. *Journal of Behavioral Health Services & Research*, *32*(1), 43-60; Gryczynski, J., Mitchell, S.G., Jaffe, J.H., Kelly, J.H., Myers, C.P., O'Grady, K.E., Olsen, Y.K., & Schwartz, R.P. (2013). Retention in methadone and buprenorphine treatment among African Americans, *Journal of Substance Abuse Treatment*, *45*(3), 287-92.

[72] SAMHSA, (2014). Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS): 2011. *Discharges from Substance Abuse Treatment Services. BHSIS Series S-70, HHS Publication No. (SMA) 14-4846.* Rockville, MD: Substance Abuse and Mental Health Services Administration, pp. 49-50.

[73] Fiellin, D. A., Schottenfeld, R. S., Cutter, C. J., Moore, B. A., Barry, D. T., & O'Connor, P. G. (2014). Primary care-based buprenorphine taper vs maintenance therapy for prescription opioid dependence: A randomized clinical trial. *JAMA Internal Medicine*, *174*(12), 1947–1954; Magura, S., & Rosenblum, A. (2001). Leaving methadone treatment: Lessons learned, lessons forgotten, lessons ignored. *Mount Sinai Journal of Medicine*, *68*, 62-74.

[74] White, W. L., & 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.

[75] Kurtz, E. (1996). Spirituality and recovery: The historical journey. *Blue Book* (National Clergy Conference on Alcoholism), 47, 5-29; Labbe, A.K., Slaymaker, V., & Kelly, J.F. (2014). Toward enhancing twelve-step facilitation among young people: A systematic qualitative investigation of young adults' 12-step experiences. *Substance Abuse*, 35(4), 399-407.

maturity—within NA, another mutual aid setting, a treatment milieu, or within one's own family and social network. Key processes within NA-based recovery include a reconstruction of personal identity and reconstruction of one's social relationships—both of which flow from mutual attraction, mutual identification, and reciprocal person-community connection.[76]

Attitudes toward maintenance medications vary among NA groups.[77] Addiction professionals can attend open NA meetings and discuss this issue with medication-assisted treatment (MAT) providers and patients to identify NA meetings that are more medication-friendly and to identify local mutual aid alternatives where such alternatives are needed for people in medication-assisted recovery.[78]

Misconception 8: *People with a co-occurring psychiatric illness should not be referred to NA because they will be encouraged to cease using their medications.* Drug use disorders, and opioid use disorders in particular, often present with a co-occurring psychiatric illness. [79] In a recent study, Bergman and colleagues (2014) concluded that young adult patients with co-occurring substance use and psychiatric disorders "participate and benefit as much as SUD-only patients, and may benefit more from high levels of active involvement, particularly having a Twelve-step sponsor."[80] In studies of Twelve-Step participation among people with co-occurring disorders that employed multiple points of evaluation, the most common finding is that Twelve-Step participation at each point of evaluation predicts abstinence at the following point of evaluation.[81] The one counter-finding in these studies is that, compared to other psychiatric diagnoses, people with a diagnosis of schizophrenia or schizoaffective disorder have lower AA

[76] 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*(2), 185-93.

[77] Narcotics Anonymous World Services, Inc. (NAWS, 2016, PR Pamphlet Draft). *Narcotics Anonymous and persons receiving medication assisted treatment*. Chatsworth, CA: Narcotics Anonymous World Services, Inc.

[78] White, W. L. (2011). *Narcotics Anonymous and the pharmacotherapeutic treatment of opioid addiction*. Chicago, IL: Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health and Intellectual disability Services.

[79] Seal, K.H., Shi, Y., Cohen, G., et al. (2012). Association of mental health disorders with prescription opioids and high-risk opioid use in veterans of Iraq and Afghanistan. *Journal of the American Medical Association*, *307*(9), 940-947; Grant, B.F., Stinson, F.S., Dawson, D.A., Chou, P., Ruan, J., & Pickering, R.P. (2004). Co-occurrence of 12-month alcohol and drug use disorders and personality disorders in the United States: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Archives of General Psychiatry*, *61*(4), 361-368; Regier, D.A., Farmer, M.E., Rae, D.S., Locke, B.Z., Keith, S.J., Judd, L.L., & Goodwin, F.K. (1990). Comorbidity of mental disorders with alcohol and other drug abuse: Results from the Epidemiologic Catchment Area (ECA) Study. *Journal of the American Medical Association*, *264*(19), 2511-2518.

[80] Bergman, B.G., Greene, M.C., Hoeppner, B.B., Slaymaker, V., & Kelly, J. (2014). Psychiatric comorbidity and 12-step participation: A longitudinal investigation of treated young adults. *Alcoholism: Clinical and Experimental Research*, *38*(2), 501-510, quotation from page 510. For similar findings, see: Green, C.A., Yarborough, M.T., Polen, M.R., Janoff, S.L., & Yarborough, B.J. (2015). Dual recovery among people with serious mental illness and substance problems: A qualitative analysis. *Journal of Dual Diagnosis*, *11*(1), 33-41; Laudet, A. B., Magura, S., Vogel, H. S., & Knight, E. L. (2003). Participation in 12-step-based fellowships among dually-diagnosed persons. *Alcoholism Treatment Quarterly*, *21*(2), 19-39; Timko, C., Cronkite, R.C., McKellar, J., Zemore, S. & Moos, R. (2013). Dually diagnosed patients' benefits of mutual-help groups and the role of social anxiety. *Journal of Substance Abuse Treatment*, 44(2), 216-23.

[81] Bogenschutz, M. P., Rice, S. L., Tonigan, J. S., Vogel, H. S., Nowinski, J., Hume, D., & Arenella, P. B. (2014). 12-step facilitation for the dually diagnosed: a randomized clinical trial. *Journal of Substance Abuse Treatment*, *46*(4), 403-411.

and NA participation rates and may require special supports to enhance Twelve-Step engagement and retention.[82]

Magura and colleagues found that participation in a Twelve-Step program for people with co-occurring psychiatric and substance use disorders (i.e., Double Trouble in Recovery) improved medication adherence.[83] While there have yet to be formal studies on NA members' attitudes about psychiatric medications comparable to those conducted on AA[84], NA's official position on the use of psychiatric medications is clear: "Some members recover in NA with mental illness that requires medication. Just as we wouldn't suggest that an insulin-dependent diabetic addict stop taking their insulin, we don't tell mentally ill addicts to stop taking their prescribed medication. We leave medical issues up to doctors."[85] In a recent survey of 22,803 NA members, 22 percent reported current use of a prescribed medication for a mental health condition.[86]

In our research and clinical activities over the collective span of more than four decades, we have witnessed significant shifts in NA attitudes toward psychotropic medications. There have been quite legitimate concerns that symptoms common to early recovery were being pathologized into self-contained illnesses and suppressed with blunt instrument medications that actually inhibited or slowed the recovery process. Such concerns have decreased as psychiatric training and psychiatric medications have improved and as NA experience has grown related to its members effectively managing concurrent psychiatric disorders.

Misconception 9: *People should not be encouraged to attend NA unless they have a pre-existing religious orientation that would make a Twelve-Step program acceptable to them.* NA's Basic Text includes the recovery story of an atheist in NA, and it outlines NA's stance on religion and spirituality.

> "At some point, we realized that we needed the help of some Power greater than our addiction. Our understanding of a Higher Power is up to us. No one is going to decide for us. We can call it the group, the program, or we can call it God. The only suggested guidelines are that this Power be loving, caring and greater than ourselves. We don't have to be religious to accept this idea."[87]

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[82] Jordan, L. C., Davidson, W. S., Herman, S. E., & BootsMiller, B. J. (2002). Involvement in 12-step programs among persons with dual diagnoses. *Psychiatric Services, 53*(7), 894–896.

[83] Magura, S., Laudet, A.B., Mahmood, D., Rosenblum, A., & Knight, E. (2002). Adherence to medication regimens and participation in dual-focus self-help groups. *Psychiatric Services, 53*(3), 310-316.

[84] 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*(8), 1079–81; Rychtarik, R. G., Connors, G. J., Demen, K. H., & Stasiewicz, 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*(1), 134-138; 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.

[85] Narcotics Anonymous World Services, Inc. (2010). *In times of illness*. Van Nuys, CA. Narcotics Anonymous World Services, Inc., p. 20.

[86] Narcotics Anonymous World Services, Inc. Public Relations Office (NAWS, 2016). Personal communications, Jane Nickels, April 23, May 13, 2016).

[87] Narcotics Anonymous World Services, Inc. (NAWS, 2008c). *Narcotics Anonymous (6th ed.).* Chatsworth, CA: Narcotics Anonymous World Services, Inc., p. 24.

The degree to which NA's perceived religious/spiritual orientation inhibits attraction to NA or contributes to NA drop-out is unclear. Some studies report that past religious involvement is a predictor of Twelve-Step group engagement[88] (Kelly & Moos, 2003; Kelly, Pagano, Stout, & Johnson, 2011), while others have found that people with less religious orientation who participate in Twelve-Step groups experience benefits similar to those with greater religious orientation (Brown, et al., 2001; Christo & Franey, 1995; Winzelberg & Humphreys, 1999).

More than half (65 percent) of NA members describe themselves as "spiritual but not religious," only 25 percent of NA members report monthly church attendance, and 4 percent describe themselves as neither spiritual nor religious (Galanter, Dermatis, Post & Sampson, 2013). Also of note is the growth of NA in more secular (e.g., the UK) and non-Christian (e.g., Iran) countries, the acceptability of and positive responses to NA and other Twelve-Step programs among persons being treated for drug dependence in those countries, and the enhanced five-year post treatment recovery outcomes among those participating in NA in those countries (Best, Harris, Gossop, Manning, Man, Marshall, & Strang, 2001; Gossop, Stewart, & Marsden, 2007).

While spirituality is unquestionably a component of NA-based recovery (Galanter, Dermatis, Post, & Sampson, 2013; Zemore, 2007), other mechanisms of change operating within the NA program are congruent with secular approaches to addiction treatment and recovery support (Moos, 2007). There is a growing secular wing within Twelve-Step programs (e.g., AA Agnostica, NA meetings for agnostics) and increased evidence of a shared spirituality across secular, spiritual, and religious frameworks of recovery. This shared foundation of experience is reflected in the prepositions *within* (discovery of inner strengths), *between* (mutual identification), *beyond* (higher purpose and meaning) and in six shared dimensions of the recovery experience: release (freedom from addiction), gratitude, humility, tolerance, forgiveness, and being-at-home (connection to community) (Kurtz & White, 2015). The degree to which such secularization has and will affect NA has not been investigated. There is also a growing network of secular recovery mutual aid organizations in the U.S. (e.g., Women for Sobriety, Secular Organizations for Sobriety, SMART Recovery, Lifering Secular Recovery), but the extent to which these organizations are or could be a resource for individuals seeking recovery from opioid addiction has not been investigated.

Misconception 10: *NA (Twelve-Step) involvement is another form of dependency (one addiction for another) that personally and politically disempowers its members, compromises quality of life, and perpetuates social isolation within a drug-oriented social network.*

Some individuals entering NA leave behind lives completely dominated by addiction, including prolonged enmeshment in cultures of addiction. It is not unusual for such individuals for a time to become deeply enmeshed in NA as an alternative culture (White, 1996). Some of these individuals remain enmeshed in an NA-dominated lifestyle in ways that casual observers might cast as "addicted to NA," but it is our collective observation from decades of professional observation that most NA members maintain mutually supportive NA relationships while progressively integrating into the larger life of the community. Studies of the effects of NA participation on community participation and community service have concluded that the

[88] Kelly, J. F., & Moos, R. (2003). Dropout from 12-step self-help groups: Prevalence, predictors, and counteracting treatment influences. *Journal of Substance Abuse Treatment*, 24(3), 241-250; Kelly, J.F., Pagano, M.E., Stout, R.L., & Johnson, S.M. (2011). Influence of religiosity on 12-Step participation and treatment response among substance-dependence adolescents. *Journal of Studies on Alcohol and Drugs, 72*, 1000-1011.

majority of NA members initiate wider community involvement and service after their involvement in NA, and also note that such involvement came at the encouragement of NA sponsors and other NA members.[89] Such community involvement can be a key element in forging a pro-social identity in recovery and creating more positive community attitudes towards people in addiction recovery.[90] The finding that NA involvement enhances community involvement suggests an opposite effect from what has been alleged. Even when continued enmeshment in NA is required for recovery stability, most would consider this a far better alternative than being drawn back to the social world of active addiction and its eventual consequences on health, social functioning, and mortality.

Most NA meetings are more focused on recovery-based coping than a detailed recounting of drug use tales that might serve as triggers for drug-craving and drug-seeking (such "drugalogs" are discouraged within NA). As a whole, NA meetings are more focused on how one lives without drugs than the details of how one lived with them[91], as is emphasized in *Living Clean*--NA's guide for living in recovery.[92]

People treated for drug dependence who participate in weekly NA following treatment are more likely to achieve sustained abstinence than those who do not participate in NA.[93] Research to date suggests that participation in NA enhances quality of life in a number of key areas, including reduced drug craving, reduced HIV/HCV risk, and enhancement of emotional health (decreased anxiety and depression and increased self-esteem), housing stability, stability of intimate relationships, family unification and support, social network reconstruction, connection to community, and enhanced life meaning and purpose via service to others.[94]

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[89] Kurtz, L. F., & Fisher, M. (2003a). Participation in community life by AA and NA members. *Contemporary Drug Problems, 30*(4), 875-904; Kurtz, L.F., & Fisher, M. (2003b). Twelve-Step recovery and community service. *Health & Social Work, 28*(2), 137-145.

[90] Best, D. (2016). An unlikely hero? Challenging stigma through community engagement. *Drugs and Alcohol Today, 16*(1), 106-116.

[91] Withers, R. (2014). Six myths about Narcotics Anonymous you probably believe. Accessed April 11, 2016 at (http://blog.com.blog/6-myths-about-narcotics-anonymous-you-probably-believe)

[92] Narcotics Anonymous World Services, Inc. (2012). *Living clean: The journey continues*. Van Nuys, CA. Narcotics Anonymous World Services, Inc.

[93] Christo, G., & Franey, C. (1995). Drug users' spiritual beliefs, locus of control and the disease concept in relation to Narcotics Anonymous attendance and six-month outcomes. *Drug and Alcohol Dependence, 38*(1), 51-56; Galanter, M., Dermatis, H., Post, S., & Santucci, C. (2013). Abstinence from drugs of abuse in community-based members of Narcotics Anonymous. *Journal of Studies on Alcohol and Drugs, 74*, 349-352; 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; Fiorentine, R. (1999). After drug treatment: Are 12-step programs effective in maintaining abstinence? *American Journal of Drug and Alcohol Abuse, 25*(1), 93-116.

[94] Christo, G., & Sutton, S. (1994). Anxiety and self-esteem as a function of abstinence time among recovering addicts attending Narcotics Anonymous. *British Journal of Clinical Psychology, 33*, 198-200; Narcotics Anonymous World Services, Inc. (NAWS, 2013). Membership survey. Retrieved April 17, 2016 from https://www.na.org/admin/include/spaw2/uploads/pdf/PR/NA_Membership_Survey.pdf; DeLucia, C., Bergman, B.G., Formoso, D., & Weinberg, L. (2015). Recovery in Narcotics Anonymous from the perspectives of long-term members. *Journal of Groups in Addiction & Recovery, 10*(1), 3-22; Humphreys, K., Wing, S., McCarty, D., Chappel, J., Galant, L., Haberle, B.,…Weiss, R. (2004). Self-help organizations for alcohol and drug problems: Toward evidence-based practice and policy. *Journal of Substance Abuse Treatment, 26*(3), 151-158; Orwat, J., Samet, J. H., Tompkins, C. P., Cheng, D. M., Dentato, M. P., & Saitz, R. (2011). Factors associated with attendance in 12-step groups (Alcoholics Anonymous/Narcotics Anonymous) among adults with alcohol problems living with HIV/AIDS. Drug and Alcohol Dependence, *113*(2-3), 165-171; Rafalovich, A. (1999). Keep coming back - Narcotics Anonymous narrative and recovering-addict identity. *Contemporary Drug Problems, 26*, 131-157;

The mechanisms of change within NA include meeting attendance, mutual identification/affiliation, step work, spiritual awakening, identity reconstruction, and the therapeutic effects of helping others.[95] These processes of change resemble elements found within evidence-based treatments for substance use disorders, e.g., exposure to abstinence norms and role models, abstinence-specific social support, goal-setting, monitoring, contingent reinforcement, self-efficacy, acquisition of coping skill, and exposure to pleasurable drug-free activities.[96] Such effects experienced within NA are a function of both intensity of involvement (number of meetings and other Twelve-Step activities) and duration of recovery support activities, underscoring the fact that recovery stabilization and enhanced quality of life require both active participation and time.[97] These effects of NA participation have been documented for adults[98] and for adolescents[99], and may be further amplified when combined with professional treatment.[100]

Misconception 11: *NA does not have a role in reducing the social costs of opioid addictions nor in other social contributions.* No specific studies of the economic and social contributions of NA have been conducted, but studies of AA and Twelve-Step programs for those with co-occurring

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Sibthorpe, B., Fleming, D., & Goould, J. (1994). Self-help groups: A key to HIV risk reduction for high risk drug users? *Journal of AIDS*, *7*(6), 592-598.

[95] 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*(3), 291-301; Galanter, M., Dermatis, H., & Sampson, C. (2014). Narcotics Anonymous: A comparison of military veterans and non-veterans. *Journal of Addictive Diseases*, *33*(3), 187-95; Rafalovich, A. (1999). Keep coming back - Narcotics Anonymous narrative and recovering-addict identity. *Contemporary Drug Problems*, *26*, 131-157; Toumbourou, J., 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*(1), 61-66.

[96] Moos, R. H. (2007). Theory-based processes that promote the remission of substance use disorders. *Clinical Psychology Review*, *27*(5), 537-51; Moos, R. H. (2008). Active ingredients of substance use-focused self-help groups. *Addiction*, *103*, 387-396.

[97] 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; Timko, C., DeBenedetti, A., & Billow, R. (2006). Intensive referral to 12-step self-help groups and 6-month substance use disorder outcomes. *Addiction*, *101*, 678-688.

[98]Christo, G., & Franey, C. (1995). Drug users' spiritual beliefs, locus of control and the disease concept in relation to Narcotics Anonymous attendance and six-month outcomes. *Drug and Alcohol Dependence*, *38*(1), 51-56; Christo, G., & Sutton, S. (1994). Anxiety and self-esteem as a function of abstinence time among recovering addicts attending Narcotics Anonymous. *British Journal of Clinical Psychology*, *33*, 198-200; 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.

[99]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*(1-2), 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*(3), 259-269; Sussman, S. (2010). A review of Alcoholics Anonymous/ Narcotics Anonymous programs for teens. *Evaluation & the Health Professions*, *33*(1), 26-55.

[100] Chen, G. (2006). Social support, spiritual program, and addiction recovery. *International Journal of Offender Therapy & Comparative Criminology*, *50*(3), 306-23; Krentzman, A. R., Moore, B. C., Robinson, E. A. R., Kelly, J., Kurtz, E., Laudet, A.,…Zemore, S. (2011). How Alcoholics Anonymous and Narcotics Anonymous work: Cross-disciplinary perspectives. *Alcoholism Treatment Quarterly*, *29*(1), 75-84.

disorders have concluded that Twelve-Step participation reduces continuing care costs[101] and post-treatment health care costs.[102]

The potential reduction of social costs related to opioid addiction is substantial given NA's contribution to long-term recovery outcomes, its geographical availability, and its 24-hour accessibility at no cost to the government or private insurers. Humphreys and Moos sum up the work to-date on the potential cost-offsets from adult recovery mutual aid participation:

> *Certain tasks supportive of recovery, such as encouragement, social activities, friendship, monitoring and spiritual support, can probably be accomplished by peer-based services as well as they can by health care professionals, and at greatly reduced cost. This has a 2-fold benefit: greater likelihood of long-term recovery for the addicted individual and greater targeting of scarce professional resources to those patients who require such assistance….self-help group involvement is a useful method of extending the benefits of treatment while lowering its ongoing costs.*[103]

Similar to adult findings, Mundt and colleagues examined the effects of Twelve-Step participation among youth following treatment for a substance use disorder within one of four Kaiser Permanente Northern California treatment programs. They found that health care costs declined in tandem with increases in Twelve-Step meeting attendance. At one-year follow-up, those adolescents who attended 10 or more Twelve-Step meetings experienced a 65 percent reduction in health care costs—primarily related to cost reductions in inpatient hospital admissions, psychiatric visits, and further substance use treatment.[104]

The integration of NA and other recovery mutual aid organizations within current health reform efforts (e.g., assertive linkage to NA by primary care physicians) could play a potentially critical role in reducing the social costs of opioid addiction in the United States[105], to say nothing of what NA-guided recoveries would add to local and national economies via income generation and taxes, business development, and charitable contributions.

Seen as a whole, the above misconceptions state or imply the potential for detrimental effects of NA participation. These and other related criticisms of NA can be subjected to scientific analysis within the context of future NA studies.

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[101] Humphreys, K., & Moos, R.H. (2007). Encouraging posttreatment self-help group involvement to reduce demand for continuing care services: Two year clinical and utilization outcomes. *Alcoholism: Clinical and Experimental Research, 31*(1), 64-68.

[102] Humphreys, K., & Moos, R.H. (1996). Reduced substance-related health care costs among voluntary participants in Alcoholics Anonymous. *Psychiatric Services, 47*(7), 709-713; Humphreys, K. & Moos, R.H. (2001). Can encouraging substance abuse patients to participate in self-help groups reduce demand for health care: A quasi-experimental study. *Alcoholism: Clinical and Experimental Research, 255*, 711-6.

[103] Humphreys, K. & Moos, R.H. (2007). Encouraging posttreatment self-help group involvement to reduce demand for continuing care services: Two year clinical and utilization outcomes. *Alcoholism: Clinical and Experimental Research, 31*(1), 64-68. Quotation from page 67.

[104] Mundt, M.P., Pathasarathy, S., Chi, F.W., Sterling, S., & Campbell, C.I. (2012). 12-step participation reduces medical costs among adolescents with a history of alcohol and other drug treatment. *Drug and Alcohol Dependence, 126*(1-2), 124-30.

[105] Kelly J. F., & Yeterian, J. (2012). Empirical awakening: The new science on mutual help and implications for cost containment under health care reform. *Substance Abuse, 33*, 85-91.

There is a long history of harm in the name of help within a broad spectrum of policy, treatment, and recovery support initiatives.[106] Recent reviews of iatrogenic (treatment-caused) effects of professionally-directed psychosocial interventions for substance use disorders note that 7-15 percent of patients experience clinical deterioration during or immediately following such interventions.[107] Although reports of such harm within NA, and more frequently AA, can be found in online discussions and a growing body of Twelve-Step backlash literature, the existence, nature, and prevalence of such injuries have not been reported in the scientific literature, with the exception of one adolescent study noted above on safety at AA and NA meetings.[108]

In closing, there are limitations on all of the above-cited evidence, but these studies represent the most current and credible scientific data available on NA and the effects of NA participation on recovery outcomes. The number and methodological rigor of AA studies have increased exponentially[109], and we expect the same for NA studies of the future. NA World Services is collaborating with addiction researchers to expand the number and quality of studies conducted on NA.[110] Such studies will help separate what we know from the standpoint of science about NA from the far more widely disseminated myths, misconceptions, and speculations.

Conclusions

Media coverage and professional discourse related to opioid-related deaths and devastation heighten awareness and fear, but all too often reveal little if any information on the lived solutions to opioid addiction as experienced within NA and other peer-based recovery support institutions. As one anonymous reviewer of this paper attested:

> *Stories on addiction and recovery in the press have tended to focus on late addiction and early recovery and/or celebrities, because that's where the drama is. A focus on the lives of people in long term recovery are dramatic only by virtue of contrast with their former lives of active addiction, but just aren't as sexy as a good, recent crash and burn followed by the hopefulness of a person fresh out of treatment. These untold long-term recovery stories, however, are where the real hope lies….Telling that story is where the press could make a significant contribution toward the common good.*

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[106] White, W. (2014). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems; White, W.L., & Kleber, H.D. (2008). Preventing harm in the name of help: A guide for addiction professionals. *Counselor, 9*(6), 10-17. .

[107] Moos, R. H. (2005). Iatrogenic effects of psychosocial interventions for substance use disorders: Prevalence, predictors, prevention. *Addiction, 100*(5), 595-604; Ilgen, M. A., & Moos, R. (2006). Exacerbation of psychiatric symptoms during substance use disorder treatment. *Psychiatric Services, 57*, 1758-1764.

[108] 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*(1-2), 117-125.

[109] Kelly J. F., & Yeterian, J. (2012). Empirical awakening: The new science on mutual help and implications for cost containment under health care reform. *Substance Abuse, 33*, 85-91.

[110] Galanter, M., Dermatis, H., Post, S., & Sampson, C. (2013). Spirituality-based recovery from drug addiction in the Twelve-Step fellowship of Narcotics Anonymous. *Journal of Addiction Medicine, 7(3)*, 189-195.

We believe the reviewed misconceptions about NA contribute to the paucity of such attention. Increased coverage of people in long-term recovery from opioid addiction and the role of NA and other recovery support institutions in such achievement would help move the national conversation on opioid addiction from a focus on the problem to a focus on the lived solutions that now exist in communities across America. NA has distinguished itself for more than 60 years as an organization with the singular goal of supporting addiction recovery. It is time such contributions were more fully appreciated at public and professional levels, more research attention was conducted on NA, and NA resources were more fully integrated within public health responses to rising opioid addiction.

How might the individual, family, and community trajectory of opioid addiction be altered if every naloxone administration, every treatment admission and discharge (regardless of modality or setting), every drug-related visit to a general practitioner or health clinic, and every drug-related HIV or HCV screening were accompanied by assertive linkage to NA or other recovery mutual aid resources? We believe it is time to test that potential. Forging an assertive, long-term public health response to opioid addiction will require more than a rising sense of urgency; it will require forging partnerships with those individuals and organizations who understand the need for such urgency in its most human terms.

There is a pervasive pessimism about the long-term prospects of recovery from opioid addiction. Tens of thousands of NA members in long-term recovery from opioid addiction stand as a living refutation of such pessimism. That fact is the least told story in media and professional discussions of opioid addiction. Innumerable individuals, families, and communities will be ill-served if we neglect the role NA and other recovery mutual aid organizations can play in supporting long-term recovery from opioid addiction.

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