
Review and Commentary

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

William White, M.A., Marc Galanter, M.D., Keith Humphreys, Ph.D., and John Kelly, Ph.D.

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. 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).

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 addiction.


addiction. This omission, which extends to professional reports on mitigation strategies for opioid addiction, 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.

Recent one-hour specials on ABC and CNN and a CBS 60 Minutes segment 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.

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 treatment 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.

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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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.” 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 trials13, 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 not a professionally-directed treatment for substance use disorders.15

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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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{18}

\textbf{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.\textsuperscript{19} A subsequent survey\textsuperscript{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.\textsuperscript{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.\textsuperscript{22}


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. The number of available NA meetings worldwide has more than doubled in the past 15 years. 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. 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. 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. 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.

**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,” 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

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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, Dexter33
— 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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31 Ibid
   (http://blog.com.blog/6-myths-about-narcotics-anonymous-you-probably-believe)
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. Studies to date have generally shown that Twelve-Step participation by youth and young adults strengthens outcomes beyond that achieved from professional treatment alone. 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.

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.”

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


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. Also of potential assistance is literature NA has developed specifically for youth and their parents or guardians.

**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. 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. 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. Also of note is the increased representation of people of color within qualitative studies of NA-based recovery from opioid addiction. NA is rising and thriving in quite diverse cultural, religious, and political contexts.

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 growth.

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46 Ibid


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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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. 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) BEORE referring clients to local NA meetings.

NA participation is being increasingly integrated with professionally directed addiction treatment. 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.

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. 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. In the most recent NA membership surveys (2015), 68 percent of NA members reported past use of opiates

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.\(^{69}\)


\(^{62}\) Ibid


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. 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. 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. The recurrence of opioid addiction is high under such circumstances. 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.

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. 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

maturity—with 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.\textsuperscript{76}

Attitudes toward maintenance medications vary among NA groups.\textsuperscript{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.\textsuperscript{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.\textsuperscript{79} In a 2014 study, Bergman and colleagues 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.”\textsuperscript{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.\textsuperscript{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


and NA participation rates and may require special supports to enhance Twelve-Step engagement and retention.\textsuperscript{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.\textsuperscript{83} While there have yet to be formal studies on NA members’ attitudes about psychiatric medications comparable to those conducted on AA\textsuperscript{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.”\textsuperscript{85} In a recent survey of 22,803 NA members, 22 percent reported current use of a prescribed medication for a mental health condition.\textsuperscript{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.”\textsuperscript{87}


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\(^{88}\), 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\(^{89}\).

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\(^{90}\). 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\(^{91}\).

While spirituality is unquestionably a component of NA-based recovery\(^{92}\), other mechanisms of change operating within the NA program are congruent with secular approaches to addiction treatment and recovery support\(^{93}\). 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)\(^{94}\). 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 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. 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. 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, as is emphasized in *Living Clean*--NA’s guide for living in recovery.

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. Research to date suggests that participation in NA enhances quality of life in a number of key ways.

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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.100

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.101 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.102 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.103 These effects of NA participation have been documented for adults104 and for adolescents105, and may be further amplified when combined with professional treatment.106

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**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 disorders have concluded that Twelve-Step participation reduces continuing care costs and post-treatment health care costs.107

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.*109

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

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reduction in health care costs—primarily related to cost reductions in inpatient hospital admissions, psychiatric visits, and further substance use treatment.\textsuperscript{110}

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\textsuperscript{111}, 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.

There is a long history of harm in the name of help within a broad spectrum of policy, treatment, and recovery support initiatives.\textsuperscript{112} 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.\textsuperscript{113} 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.\textsuperscript{114}

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\textsuperscript{115}, 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.\textsuperscript{116} 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.*

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.

**About the Authors:** William White, M.A., is Emeritus Senior Research Consultant at Chestnut Health Systems and the author of *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*. Marc Galanter, M.D., is Professor of Psychiatry at New York University School of Medicine, the former president of the American Society of Addiction Medicine, the lead author on several published NA studies, and the author of the recently-released book, *What is Alcoholics Anonymous?* Keith Humphreys, Ph.D., is a Professor in the Department of Psychiatry and Behavioral Sciences at Stanford University, a Senior Research Career Scientist at
the VA Health Services Research Center, a former Senior Policy Advisor at the White House Office of National Drug Control Policy, and the author of *Circles of Recovery*. All of the authors have conducted and published studies of addiction recovery mutual aid organizations. John Kelly, Ph.D., is the Elizabeth R. Spallin Associate Professor of Psychiatry in Addiction Medicine at Harvard Medical School, the founder and Director of the Recovery Research Institute at the Massachusetts General Hospital (MGH), and a former President of the American Psychological Association (APA) Society of Addiction Psychology.