Long-Term Strategies to Reduce the Stigma Attached to Addiction, Treatment, and Recovery within the City of Philadelphia
(With Particular Reference to Medication-Assisted Treatment/Recovery)

William L. White, MA
Senior Research Consultant, Chestnut Health Systems
Consultant, Philadelphia Department of Behavioral Health
and Mental Retardation Services

The guiding vision of our work must be to create a city and a world in which "people with a history of alcohol or drug problems, people in recovery, and people at risk for these problems are valued and treated with dignity, and where stigma, accompanying attitudes, discrimination, and other barriers to recovery are eliminated."[1]

[1] Substance Abuse and Mental Health Services Administration (SAMHSA). (2002). *National Recovery Month helps reduce stigma.* Substance Abuse and Mental Health Services Administration. Retrieved June 17, 2009 from http://www.hazelden.org/web/public/ade20909.page.

Long-Term Strategies to Reduce the Stigma Attached to Addiction, Treatment, and Recovery within the City of Philadelphia
(With Particular Reference to Medication-Assisted Treatment/Recovery)

William L. White, MA

Executive Summary

Introduction

The purpose of this document is to: 1) review the historical and scientific research on the social/professional stigma related to addiction, with a particular focus on the stigma experienced by people in medication-assisted treatment and long-term medication-assisted recovery, and 2) outline strategies that could be used by the Philadelphia Department of Behavioral Health and Mental Retardation Services and its many community partners to reduce addiction/recovery-related stigma.

Stigma Basics

- Stigma involves processes of labeling, stereotyping, social rejection, exclusion, and extrusion as well as the internalization of community attitudes in the form of shame by the person/family being discredited.
- The social stigma attached to addiction constitutes a major obstacle to personal and family recovery, contributes to the marginalization of addiction professionals and their organizations, and limits the type and magnitude of cultural resources allocated to alcohol- and other drug-related problems.
- Social stigma attached to addiction is influenced by perceptions of the role of choice versus compulsion in addiction, the motivation for initial drug use (escape from pain versus a search for pleasure), and whether addiction is related to a socially defined “good” or “bad” drug.
- The social stigma attached to addiction is greatest for those experiencing multiple discrediting conditions, e.g., combinations of addiction, psychiatric illness, HIV/AIDS, minority status, poverty, homelessness, and women perceived to have failed their gender-role expectations due to addiction.
- Addiction-related social stigma elicits social isolation, reduces help-seeking, and compromises long-term physical and mental health outcomes.
- Heroin addiction and its treatment have been trapped between medical and moral/criminal models of problem definition and resolution.
- Methadone maintenance has never achieved full legitimacy as a medical treatment by the public, health care professionals, and the recovery community in spite of the overwhelming body of scientific evidence supporting it.
- The person enrolled in methadone maintenance has never received full status as a “patient,” and the methadone clinic has yet to be viewed as a place of healing on par with hospitals or outpatient medical clinics.

- The professional status of methadone treatment has suffered from the absence of theoretical models of opioid addiction treatment and recovery that transcend a focus on the medicine to address the larger movement towards global health and community integration.
- Personal strategies to deal with stigma include secrecy/concealment, social withdrawal, selective disclosure, over-compensation in other areas, and political activism.
- Three broad social strategies have been used to address stigma related to behavioral health disorders: 1) protest (advocacy), 2) education, and 3) increased interpersonal contact between stigmatized and non-stigmatized groups.

Historical/Sociological Perspectives

- The social stigma attached to certain patterns of psychoactive drug use has a long history in the United States and is inseparable from cultural strain related to such issues as race, religion, social class, gender roles, and intergenerational conflict.
- The social stigma attached to methadone is rooted in a larger anti-medication bias within the history of addiction treatment.
- Social stigma toward alcohol and other drug (AOD) addiction may be defined as a negative social force (an obstacle to problem resolution) or as a positive social force (discouragement of drug use; social pressure for help-seeking). How do addiction treatment professionals, recovery advocates, and preventionists avoid working at cross-purposes in their educational efforts in local communities?
- Any campaign to counter addiction/treatment/recovery-related stigma must ask two related questions: 1) "What is the source of stigma?" and "Who profits from stigma?"

Conceptual Underpinnings of the Social Stigma Attached to Medication-Assisted Treatment (MAT)

- Social and professional stigma, particularly stigma associated with methadone treatment, is buttressed by a set of core assumptions or beliefs.
- These assumptions and beliefs include the following: 1) compulsive drug use is a choice, 2) methadone is a "crutch," 3) methadone simply replaces one drug/addiction for another, 4) methadone prolongs rather than shortens addiction careers, 5) low doses and short periods of methadone maintenance result in better rates of long-term recovery, and 6) methadone maintenance patients should be encouraged to end methadone treatment as soon as possible.
- These propositions have been and are being challenged by a growing body of scientific research on methadone and medication-assisted treatment and recovery.

Semantic and Visual Images Underpinning MAT-Related Stigma

- The stigma attached to heroin addiction has been extended to methadone treatment and intensified through language and images within the professional and popular media that represent the least stabilized methadone patients and the

lowest quality methadone clinics as the prototypes of all those in methadone-assisted treatment/recovery and all methadone clinics.
- The stigma attached to heroin addiction is internalized and results in an elaborate pecking order within the illicit heroin culture; such pecking orders can be acted out with negative consequences within the milieu of methadone maintenance treatment.
- Any campaign to address the social stigma attached to medication-assisted treatment and recovery must transform the ideas, words, and images attached to this approach to treatment and this pathway of recovery.

Street Myths and Stigma

- Stigma attached to methadone maintenance treatment has been imbedded within the illicit drug culture of the United States in ways that inhibit treatment seeking and contribute to early treatment termination.
- These myths span the origin of methadone, methadone's pharmacological properties and long-term effects, and the motivations for the proliferation of methadone maintenance in poor communities of color.
- Any effective anti-stigma campaign aimed at establishing the legitimacy and effectiveness of medication-assisted treatment and recovery must include strategies of information dissemination within local cultures of addiction that challenge these myths.

Examples of Addiction-Related Stigma/Discrimination

- Addiction/treatment/recovery-related stigma is manifested in a broad range of attitudes, behaviors, and policies that range from social shunning to discrimination in such areas as access to medical/dental care, governmental benefits, training/employment opportunities, and housing and homelessness services.
- Stigma/discrimination related particularly to participation in methadone maintenance includes: denial of access to methadone maintenance or medically-supervised withdrawal in jail, denial of admission to other addiction treatment modalities and recovery support services, denial of pain medication, denial of the right to speak and assume leadership roles in local AA/NA meetings, and loss of child custody due to participation in MMT.
- Stigma-influenced methadone maintenance treatment practices include arbitrary dose restrictions, restrictions on duration of MMT, lowering methadone dose, disciplinary discharge for drug use, and shaming rituals (public queues to receive methadone, supervised consumption, separate bathrooms for staff and patients, observed urine drops for drug testing, discouragement of peer fraternization).

Conceptual Underpinnings of a Campaign to Eliminate Stigma Related to Methadone

- A campaign to lower stigma related to medication-assisted treatment/recovery must involve a set of clear messages related to the nature of addictive disorders, the nature of addiction recovery, the role of medication in recovery, and a statement of the harmful effects of stigma on treatment/recovery outcomes and on the family and larger community.
- These core ideas must be science-based, clear, capable of translation into educational slogans, and capable of altering perceptions, attitudes, and actions (as measured by pilot testing).

An Addiction/Treatment/Recovery Campaign

- The guiding vision of the proposed campaign is to create a city and a world in which "people with a history of alcohol or drug problems, people in recovery, and people at risk for these problems are valued and treated with dignity, and where stigma, accompanying attitudes, discrimination, and other barriers to recovery are eliminated."[2]
- The campaign goals are to: 1) enhance public and professional perceptions of the value of medication-assisted treatment, 2) enhance the perceived value of medication-assisted treatment within the heroin using community, 3) put a face and voice on medication-assisted recovery and portray the contributions of people in medication-assisted recovery to their communities, and 4) increase the participation of medication-assisted treatment providers within local community activities.
- The strategies proposed for the campaign span the following areas: 1) recovery representation and community mobilization, 2) community education, 3) professional education, 4) non-stigmatizing, recovery-focused language, 5) treatment practices, 6) local, state, and policy advocacy, and 7) campaign evaluation.
- The implementation of these strategies will require a vanguard of people in methadone-assisted recovery to involve themselves in a larger recovery advocacy movement. Efforts must be made to encourage and support that vanguard.

Acknowledgement: Development of this paper was sponsored by the Philadelphia Department of Mental Health and Mental Retardation Services.

[2] Substance Abuse and Mental Health Services Administration (SAMHSA). (2002). *National Recovery Month helps reduce stigma*. Substance Abuse and Mental Health Services Administration. Retrieved June 17, 2009 from http://www.hazelden.org/web/public/ade20909.page.

Long-Term Strategies to Reduce the Stigma Attached to Addiction, Treatment, and Recovery within the City of Philadelphia
(With Particular Reference to Medication-Assisted Treatment/Recovery)

William L. White, MA

Introduction

When Dr. Arthur Evans, Jr., assumed leadership of the Philadelphia Department of Behavioral Health and Mental Retardation Services in 2004, he initiated a broad community-visioning exercise that ignited a "recovery-focused systems transformation" process. Systems transformation involves aligning concepts, contexts (policies, regulatory guidelines, funding mechanisms), and service practices to: 1) identify and engage individuals and families affected by alcohol and other drug (AOD) problems, 2) help these individuals and families initiate and sustain a process of long-term recovery, and 3) enhance the quality of personal/family life in long-term recovery. The emerging vision in Philadelphia was to create a city and a world in which "people with a history of alcohol or drug problems, people in recovery, and people at risk for these problems are valued and treated with dignity, and where stigma, accompanying attitudes, discrimination, and other barriers to recovery are eliminated."[3]

The purpose of this document is twofold. First, it provides an overview of key findings drawn from historical and scientific research on social/professional stigma related to addiction to illicit drugs, with a particular focus on the stigma experienced by people in medication-assisted treatment and long-term medication-assisted recovery. Second, it outlines a menu of potential strategies that could be implemented by the Philadelphia Department of Behavioral Health and Mental Retardation Services and its many community partners to reduce this stigma. The document was prepared with input from local and national addiction treatment professionals and recovery advocates and is intended as a starting point for further discussions and strategy development meetings that will be facilitated by the Philadelphia Department of Behavioral Health and Mental Retardation Services.

Stigma Basics

Stigma Defined: Stigma is the experience of being "deeply discredited" due to one's "undesired differentness." To be stigmatized is to be held in contempt, shunned, or rendered socially invisible because of a socially disapproved status.[4] It involves

[3] Substance Abuse and Mental Health Services Administration (SAMHSA). (2002). *National Recovery Month helps reduce stigma*. Substance Abuse and Mental Health Services Administration. Retrieved June 17, 2009 from http://www.hazelden.org/web/public/ade20909.page.

[4] Goffman, E. (1963). *Stigma: Notes on the management of a spoiled identity*. Englewood Cliffs: Prentice-Hall.

processes of labeling, stereotyping, social rejection, exclusion, and extrusion—the essential ingredients of discrimination.[5]

There are three types of personal stigma:

- *Enacted stigma* (direct experience of social ostracism and discrimination)
- *Perceived stigma* (perception of stigmatized attitudes held by others toward oneself)
- *Self-stigma* (personal feelings of shame and self-loathing related to regret over misdeeds and "lost time" in one's life due to addiction).[6]

Self-stigma, or internalized stigma, results from the internalization of community attitudes by the person being discredited.

Stigma and Addiction: There is an extensive body of literature documenting the stigma attached to alcohol and other drug problems.[7] There is no physical or psychiatric condition more associated with social disapproval and discrimination than alcohol and/or other drug dependence.[8] The social stigma attached to addiction constitutes a major obstacle to personal and family recovery, contributes to the marginalization of addiction professionals and their organizations, and limits the type and magnitude of cultural resources allocated to alcohol- and other drug-related problems.[9]

Stigma and Recovery: Addiction-related social stigma extends to people who have achieved stable recovery from addiction.[10] In fact, people in recovery may have a greater fear of stigma and experience stigma more intensely precisely because of their recovery status and all that they now have to lose.[11] The intensity of stigma varies by problem intensity and different styles of recovery. Stigma attached to natural recovery may be less due to the perception of it as more noble (a pulling oneself up by the bootstraps) and its potential status as a proxy for less problem severity. At the same time,

---

[5] Sayce, L. (1998). Stigma, discrimination and social exclusion: What's in a word? *Journal of Mental Health, 7*, 331-343. van Olphen, J., Eliason, M.J., Freudenberg, N., & Barnes, M. (2009). Nowhere to go: How stigma limits the options of female drug users after release from jail. *Substance Abuse Treatment Prevention and Policy, 4*. Retrieved from http://www.substanceabusepolicy.com/content/pdf/1747-597X-4-10.pdf.

[6] Luoma, J. B., Twohig, M. P., Waltz, T., Hayes, S. C., Roget, N., Padilla, M., et al. (2007). An investigation of stigma in individuals receiving treatment for substance abuse. *Addictive Behaviors, 32*(7), 1331-1346. Vigilant, L. G. (2004). The stigma paradox in methadone maintenance: Naïve and positive consequences of a "treatment punishment" approach to opiate addiction. *Humanity and Society, 28*(4), 403-418.

[7] Dean, J. C., & Rud, F. (1984). The drug addict and the stigma of addiction. *International Journal of Addictions, 19*(8), 859-869. McLaughlin, D., & Long, A. (1996). An extended literature review of health professionals' perceptions of illicit drugs and their clients who use them. *Journal of Psychiatric and Mental Health Nursing, 3*(5), 283-288. Sobell, L. C., Sobell, M. B., & Toneatto, T. (1992). Recovery from alcohol problems without treatment. In N. Heather, W. R. Miller, & J. Greeley (Eds), *Self control and addictive behaviors* (pp. 198-242). New York: Maxwell Macmillian.

[8] Corrigan, P. W., Watson, A. C., & Miller, F. E. (2006). Blame, shame and contamination: The impact of mental illness and drug dependence stigma on family members. *Journal of Family Psychology, 20*(2), 239-246.

[9] Woll, P. (2005). *Healing the stigma of addiction: A guide for treatment professionals.* Chicago, IL: Great Lakes Addiction Technology Transfer Center.

[10] Tootle, D. M. (1987). Social acceptance of the recovering alcoholic in the workplace: A research note. *Journal of Drug Issues, 17*, 273-279.

[11] Woods, J. (2009). Personal communication, July 27, 2009.

natural recovery is often viewed by the public as less credible and durable than recovery from severe AOD problems initiated through professional treatment.[12]

Courtesy Stigma: The social stigma attached to addiction can be experienced by families, organizations (e.g., addiction treatment programs), neighborhoods, and whole communities.[13] Goffman[14] referred to this stigma by association as "courtesy stigma."[15]

The social stigma attached to families affected by addiction carries the implication that the family somehow failed to prevent this problem, contributed to its onset, and/or played a role in inciting or failing to prevent relapse episodes. Children may be socially shunned due to the perception that they have been contaminated by the addiction of their parents or siblings.[16]

Many family member behaviors that have been historically defined as "enabling" or "co-dependent" are better understood as attempts to protect the family from the stain of social stigma.[17] The "courtesy stigma" experienced by family members as embarrassment and shame often gets displaced on the family member experiencing AOD problems in the form of anger and exclusion. Family members thus sacrifice their own family member to escape or lessen their own social condemnation.

Addiction-related courtesy stigma can also extend to particular organizations, neighborhoods, and communities. Professionals who work with stigmatized groups may also be affected by this same stigma, e.g., effects on how addiction professionals perceive themselves in relation to other fields and disciplines and how they are perceived by others. A particular neighborhood can be stigmatized when AOD problems become part of its public identity through repeated portrayal of the neighborhood's challenges with no references to its strengths. Examples of how whole communities can be stigmatized by addiction-related stigma include the historical portrayal of the surge in cocaine use in the late 19th and early 20th centuries and again in the 1980s as a distinctly African American problem[18] and the centuries-long misrepresentation ("firewater myths") of the nature of alcohol problems in Native American communities.[19]

Stigma and Choice: Addiction has been alternately defined as a problem of vulnerability (an involuntary medical/psychiatric disease) and a problem of culpability (a

---

[12] Cunningham, J. A., Sobell, L. C., & Chow, V. M. (1993). What's in a label? The effects of substance types and labels on treatment considerations and stigma. *Journal of Studies on Alcohol, 54*(6), 693-699.

[13] Luoma, J. B., Twohig, M. P., Waltz, T., Hayes, S. C., Roget, N., Padilla, M., et al. (2007). An investigation of stigma in individuals receiving treatment for substance abuse. *Addictive Behaviors, 32*(7), 1331-1346.

[14] Goffman, E. (1963). *Stigma: Notes on the management of a spoiled identity*. Englewood Cliffs: Prentice-Hall.

[15] Also see: Barton, J. A. (1991). Parental adaptation to adolescent drug abuse: An ethnographic study of role formulation in response to courtesy stigma. *Public Health Nursing, 8*(1), 39-45.

[16] Corrigan, P. W., Watson, A. C., & Miller, F. E. (2006). Blame, shame and contamination: The impact of mental illness and drug dependence stigma on family members. *Journal of Family Psychology, 20*(2), 239-246.

[17] *The stigma of substance abuse: A review of the literature*. (1999). Toronto, Canada: Centre for Addiction and Mental Health.

[18] White, W., & Sanders, M. (2002) Addiction and recovery among African Americans before 1900. *Counselor, 3*(6), 64-66.

[19] Coyhis, D. & White, W. (2006). *Alcohol problems in Native America: The untold story of resistance and recovery-The truth about the lie*. Colorado Springs, CO: White Bison, Inc.

voluntary, self-inflicted moral lapse/character defect/vice/habit). The former model provides pathways of return to health; the latter proscribes sequestration and punishment as blame for moral/criminal liability, as a means of rehabilitation, and/or as a method of suppressing excessive substance use in the community.[20] Stigma rises for some but not all disorders in which the individual is perceived as having personally contributed to the onset of the disorder. People with substance use disorders are less likely to be offered help by other citizens than are people with a mental illness or physical disability.[21] The stigma attached to drug dependence and arguments for and against the personal or social harm or value of such stigma hinge to a great degree on widely varying views on whether the degree to which those with significant alcohol and other drug problems have voluntary control over their drug use.

Stigma and Motivation for Drug Use: American attitudes toward addiction have varied based on the motivation for drug use, with relief of pain viewed as more excusable than the search for unearned pleasure.[22] Where pain-related addiction elicits compassion, addiction that results from the search for pleasure elicits condemnation and social marginalization. At the same time, cultural phobia related to opioid addiction and fear of addiction-related stigma being attached to prescription opioid use has resulted in the underuse of opioid medication in the treatment of acute and chronic pain from both physician hesitation to prescribe opioids and patient ambivalence about taking opioid medications.[23] Perhaps the best example of this is patients' resistance to their physicians' suggestions that they take methadone for chronic pain because of the patients' association with methadone as that "junkie drug." This is further exacerbated by public and professional confusion on the difference between *physical dependence* on an opioid medication and opioid *addiction* (See later discussion).

Stigma and "Badness": American social policies on licit and illicit drugs have long been bifurcated by the notion of *good drugs* and *bad drugs*, with drugs in the latter category rated across degrees of badness. Good drugs have been celebrated, commercialized, and taxed as a source of government revenue with control mechanisms relying primarily on the social and legal definitions of who can use, when use can occur, where use can occur, how much can be consumed, and under what conditions use can and cannot occur. Bad drugs (and their users) have been demonized and prohibited, with the space between good and bad occupied by tolerated drugs (discouraged but not prohibited, e.g., tobacco) and instrumental drugs (approved for use only under special circumstances, e.g., prescription drugs). Historically, heroin and crack cocaine have been the most stigmatized substances and injection drug use the most stigmatized method of ingestion.[24] The manner in which stigma triggered by such panics can demonize users

---

[20] Acker, C. J. (1993). Stigma or legitimation? A historical examination of the social potentials of addiction disease models. *Journal of Psychoactive Drugs, 25*(3), 193-205. Husak, D. N. (2004). The moral relevance of addiction. *Substance Use and Misuse, 39*(3), 399-436.

[21] Corrigan, P. W., Kuwabara, S. A., & O'Shaughnessy, J. (2009). The public stigma of mental illness and drug addiction: Findings from a stratified random sample. *Journal of Social Work, 9*(2), 139-147.

[22] Husak, D. N. (2004). The moral relevance of addiction. *Substance Use and Misuse, 39*(3), 399-436.

[23] Woods, J. (2009). Personal communication, July 27, 2009.

[24] Capitanio, J. P., & Herek, G. M. (1999). AIDS-related stigma and attitudes toward injecting drug users among Black and White Americans. *American Behavioral Scientist, 42*(7), 1144-1157. Jones, E. E., Farina, A., Hastorf, A. H., Markus, H., Miller, D. T., Scott, R. A., et al. (1984). *Social stigma: The psychology of marked relationships*. New York: W.H. Freedman. Surlis, S., & Hyde, A. (2001). HIV-

and suppress treatment seeking is well-illustrated by the "moral panic" linked to crack cocaine in the 1980s and the more recent panic related to surges in methamphetamine use.[25] The attribution of "badness" (social stigma) has for most of the past century been most intense for those persons who regularly self-inject heroin.[26]

By extension, greater addiction-related stigma is extended to people in opioid treatment modalities. This stigma is particularly severe for persons whose treatment and recovery is supported by methadone, in spite of the well-established scientific legitimacy and effectiveness of methadone treatment.[27] In one of the most recent studies of methadone-related stigma, 98% of MAT patients surveyed reported that "stigma is an essential feature of methadone maintenance treatment."[28] For many opiate addicts, the stigma attached to medication-assisted treatment (MAT) is internalized from the culture at large and from illicit opioid street cultures long before treatment becomes a possibility or a necessity. Members of the illicit opioid street culture are also aware of methadone-related stigma and discrimination—spanning employment, child custody, access to other forms of addiction treatment, and even denial of certain privileges within the recovery community, e.g., right to speak at a recovery fellowship meeting, chair a meeting, head a service committee or be credited with "clean time" while taking methadone.[29]

Multidimensional Stigma: The weight of addiction-related social stigma is not equally applied. Its burdens fall heaviest on those with the least resources to resist it, e.g., those for whom stigma is layered across multiple conditions (addiction, mental illness, HIV/AIDS, incarceration, minority status, poverty, homelessness, aging) and when these conditions are perceived as conflicting with gender-linked role responsibilities, e.g., addicted pregnant women/mothers.[30] Persons experiencing such

---

positive patients' experiences of stigma during hospitalization. *Journal of the Association of Nurses in AIDS Care*, *12*, 68-77.

[25] Semple, S. J., Grant, L., & Patterson, T. L. (2005). Utilization of drug treatment programs by methamphetamine users: The role of social stigma. *The American Journal of Addictions*, *14*, 367-380. Humphries, D. (1999). *Crack mothers: Pregnancy, drug and the media*. Columbus: Ohio University Press.

[26] Surlis, S., & Hyde, A. (2001). HIV-positive patients' experiences of stigma during hospitalization. *Journal of the Association of Nurses in AIDS Care*, *12*, 68-77.

[27] Joseph, H. (1995). *Medical methadone maintenance: The further concealment of a stigmatized condition.* Unpublished doctoral dissertation, City University of New York. Murphy, S., & Irwin, J. (1992). "Living with the dirty secret": Problems of disclosure for methadone maintenance clients. *Journal of Psychoactive Drugs, 24*(3), 257-264. Woods, J. (2001). Methadone advocacy: The voice of the patient. *The Mount Sinai Journal of Medicine*, *68*, 75-78.

[28] Vigilant, L.G. (2004). The stigma paradox in methadone maintenance: Naïve and positive consequences of a "treatment punishment" approach to opiate addiction. *Humanity and Society*, *28*(4), 403-418.

[29] Hettema, J., & Sorenson, J.L. (2009). Access to care for methadone maintenance patients in the United States. *International Journal of Mental Health and Addiction*. Online publication ahead of print. Retrieved from http://www.springerlink.com/content/c5v56125880u2p64/. Joseph, H., Stancliff, S., & Langrod, J. (2000). Methadone maintenance treatment: A review of historical and clinical issues. *Mount Sinai Journal of Medicine*, *67*, 347-364.

[30] Anderson, T. L., & Levy, J. A. (2003). Marginality among older injectors in today's illicit drug culture: Assessing the impact of ageing. *Addiction*, *98*, 761-770. Capitanio, J. P., & Herek, G. M. (1999). AIDS-related stigma and attitudes toward injecting drug users among Black and White Americans. *American Behavioral Scientist*, *42*(7), 1144-1157. Conner, K. O., & Rosen, D. (2008). "You're nothing but a junkie": Multiple experiences of stigma in an aging methadone maintenance population. *Journal of Social Work Practice in the Addictions*, *8*(2), 244-264. Minior, T., Galea, S., Stuber, J., Ahern, J., & Ompad, D. (2003). For the patient. Does discrimination affect the mental health of substance abusers?

layered, multidimensional stigma are less likely to seek addiction treatment than persons experiencing a single discredited condition.[31] The social stigma attached to addiction begins primarily at the point of admission to treatment (a social signal of problem severity) and intensifies with multiple treatment episodes (a social signal of treatment failure).[32] One MAT patient distinguished the "inner shame" experienced during active addiction from the "public shame when you're in the clinic."[33]

Stigma in the Professional Context: The majority of health care professionals hold negative, stereotyped views of illicit drug users. These views are shaped for the most part not by their professional training, but by each professional's past experimentation with or lack of experimentation with illicit drugs.[34]

Stigma, Treatment-Seeking, and Long-Term Health: Stigma can elicit social isolation, reduce help-seeking, and compromise long-term physical and mental health status.[35] Social stigma is a major factor in preventing individuals from seeking and completing addiction treatment[36] and from utilizing harm reduction services such as needle exchange programs.[37] Social stigma increases the service needs of persons with substance use disorders, but by fostering social rejection and discrimination, that same stigma decreases access to such services.[38] Treatment seeking is also reduced by the perception that drug treatment program staff will "treat you like a little, nasty dope fiend."[39]

Ethnicity and Disease, 13(4), 549-550. Yannessa, J. F., Reece, M., & Basta, T. B. (2008). HIV provider perspectives: The impact of stigma on substance abusers living with HIV in a rural area of the United States. *AIDS Patient Care, 22*(8), 669-675.

[31] Conner, K. O., & Rosen, D. (2008). "You're nothing but a junkie": Multiple experiences of stigma in an aging methadone maintenance population. *Journal of Social Work Practice in the Addictions, 8*(2), 244-264.

[32] Luoma, J. B., Twohig, M. P., Waltz, T., Hayes, S. C., Roget, N., Padilla, M., et al. (2007). An investigation of stigma in individuals receiving treatment for substance abuse. *Addictive Behaviors, 32*(7), 1331-1346.

[33] Vigilant, L.G. (2004). The stigma paradox in methadone maintenance: Naïve and positive consequences of a "treatment punishment" approach to opiate addiction. *Humanity and Society, 28*(4), 403-418.

[34] McLaughlin, D., & Long, A. (1996). An extended literature review of health professionals' perceptions of illicit drugs and their clients who use them. *Journal of Psychiatric and Mental Health Nursing, 3*(5), 283-288.

[35] Ahern, J., Stuber, J., & Galea, S. (2007). Stigma, discrimination and the health of illicit drug users. *Drug and Alcohol Dependence, 88*(2-3), 188-196. Link, B. G., Struening, E. L., Rahav, M., Phelan, J. C., & Nuttbrock, L. (1997). On stigma and its consequences: Evidence from a longitudinal study of men with dual diagnosis of mental illness and substance abuse. *Journal of Health and Social Behavior*, *38*, 177-190. Minior, T., Galea, S., Stuber, J., Ahern, J., & Ompad, D. (2003). For the patient. Does discrimination affect the mental health of substance abusers? *Ethnicity and Disease, 13*(4), 549-550.

[36] Luoma, J. B., Twohig, M. P., Waltz, T., Hayes, S. C., Roget, N., Padilla, M., et al. (2007). An investigation of stigma in individuals receiving treatment for substance abuse. *Addictive Behaviors, 32*(7), 1331-1346. Thom, B. (1986). Sex differences in help-seeking for alcohol problems—I. The barriers to help-seeking. *The British Journal of Addictions*, *81*, 777-788.

[37] Simmonds, L., & Coomber, R. (2009). Injecting drug users: A stigmatized and stigmatizing population. *International Journal of Drug Policy*, *20*(2), 121-130.

[38] van Olphen, J., Eliason, M.J., Freudenberg, N., & Barnes, M. (2009). Nowhere to go: How stigma limits the options of female drug users after release from jail. *Substance Abuse Treatment Prevention and Policy, 4*. Retrieved from http://www.substanceabusepolicy.com/content/pdf/1747-597X-4-10.pdf.

[39] Beschner, G. M. & Walters, J. M. (1985). Just another habit? The heroin users' perspective on treatment. In B. Hanson, G. Beschner, J. M. Walters, & E. Bovelle (Eds.), *Life with heroin: Voices from the inner city.* Lexington, MA: Lexington Books.

Chronic Illness, Stigma, and Methadone Maintenance: Acute illness is something you have ("I have a cold"); chronic illness is something you are ("I am a diabetic"). With acute illnesses, one experiences the onset of the illness, one is professionally treated or self-treated, and one recovers without a lasting imprint on personal or social identity. Chronic illness bears a greater stigma burden, in part, because of the uncertainty with which the concept of recovery is applicable to a condition that is prolonged, is not in a technical sense "cured," and will require sustained self-management and in many cases, periodic professional treatment. Chronic illness can inflict social death, a loss of self, and a struggle to define a "time horizon" for recovery.[40]

Vigilant[41] attributes the stigma attached to methadone maintenance to the imperfect medicalization of chronic opioid addiction and its treatment. By imperfect, Vigilant means that: 1) heroin addiction and its treatment have been trapped between medical and moral/criminal models of problem definition and resolution, 2) methadone maintenance has never achieved full legitimacy as a medical treatment by the public, health care professionals, and the recovery community in spite of the scientific studies supporting it, 3) the person enrolled in methadone maintenance has never received full status as a "patient," and 4) the methadone clinic has yet to be viewed as a place of healing on par with hospitals or outpatient medical clinics.

Vigilant further argues that heroin addicts entering methadone treatment are christened "patients" but the treatment protocol—required daily clinic visits, forced sequestration of addicts together in a closed group regardless of recovery motivation and status, restrictive and inflexible medication pickup schedules, public exposure while standing in line for medication, observed urination for drug testing, mandatory counseling, sanctions for violations of treatment rules—is more akin to the status of "inmates" of "total institutions" than protocol befitting a medical patient.[42] Methadone clinics have not achieved the social status of a medical clinic because they have not been allowed to operate like a medical clinic. Methadone patients have not achieved their full status as "patients" because they have not been treated as patients.

The "Catch-22" in which the methadone patient, methadone treatment staff, and methadone clinic as an institution are trapped grew out of the conflicting interests that emerged as methadone maintenance was mainstreamed as a treatment modality. On the one hand, there were the needs of the methadone patient and the need for a long-term service relationship based on empathy, trust, and respect. On the other hand, there were concerns about public safety via the potential for methadone diversion. This tension between a milieu of engagement and empowerment versus a milieu of distrust and control left those being served caught between the status of a patient and the status of a prisoner/probationer and left the physician/nurse/counselor caught between their

---

[40] Vigilant, L. G. (2001). "Liquid handcuffs": The phenomenology of recovering on methadone maintenance. *Boston College Dissertations and Theses.* Vigilant, L. G. (2008). "I am still suffering:" The dilemma of multiple recoveries in the lives of methadone patients. *Sociological Spectrum, 28*, 278-298. Vigilant, L. G. (2005). "I don't have another run left with it": Ontological security in illness narratives of recovery on methadone maintenance. *Deviant Behavior, 26*(5), 399-416.

[41] Vigilant, L. G. (2001). "Liquid handcuffs": The phenomenology of recovering on methadone maintenance. *Boston College Dissertations and Theses.*

[42] Vigilant, L. G. (2001). "Liquid handcuffs": The phenomenology of recovering on methadone maintenance. *Boston College Dissertations and Theses.*

aspirations to serve as healers and onerous, regulatory-imposed policing functions.[43] The result is a demedicalized system of methadone maintenance in which people entering methadone maintenance are treated more like criminals (or recalcitrant children) than patients within a relational world more dominated by surveillance and control than compassion and choice.[44]

> *…clients often felt that the relationship between themselves and their counselors was less focused on therapy than power; less about psychological growth, getting help, and a sense of well-being than about social control, conforming to rules and regulations, and punishment.*[45]

Such focus on control versus care may be even more exaggerated for female patients, leaving unattended many obstacles to participation and recovery, e.g., child care, transportation, caretaking responsibilities, sabotage from addicted partners, threats of partner violence, and difficulties paying for treatment.[46]

The professional status of methadone treatment has suffered from the absence of theoretical models of addiction treatment and recovery that integrate the prevailing pre-occupation with the mechanics of the medicine (e.g., concern with dosages, pick-up schedules, drug testing, take-home privileges, tapering procedures) and control of the milieu (e.g., concern with loitering) with a focus on the broader physical, cognitive, emotional, relational, occupational, and spiritual aspects of long-term recovery.[47] The lack of such theoretical models and the performance expectations emanating from such models breeds clinics in which patients' contact with their counselor is rare, brief, and superficial and in which other ancillary services are minimal. As a result, methadone patients are all too often rendered and perceived as "passive figures onto which a treatment modality [methadone] is applied."[48] Missing is the image of the methadone patient as his or her own engineer of an enduring process of global (whole life) recovery.

Types of Stigma Attached to Methadone Maintenance: Vigilant's[49] study of the phenomenology of methadone-assisted recovery revealed five types of stigma unique to methadone treatment:

---

[43] Best, D. (2009). Personal communication.

[44] Fraser, S., & Valentine, K. (2008). *Substance and substitution: Methadone subjects in liberal societies.* New York: Macmillan. Rosenbaum, M. (1995). The demedicalization of methadone maintenance. *Journal of Psychoactive Drugs*, *27*, 145-149.

[45] Hunt, G., & Rosenbaum, M. (1998). 'Hustling' within the clinic: Consumer perspectives on methadone maintenance treatment. In J. A. Inciardi, & L. D. Harrison (Eds.), *Heroin in the age of crack-cocaine*. Thousand Oaks, CA: Sage.

[46] Fraser, J. (1997). Methadone clinic culture: The everyday realities of female methadone clients. *Qualitative Health Research*, *7*(1), 121-139.

[47] Hagman, G. (1995). A psychoanalyst in methadonia. *Journal of Substance Abuse Treatment, 12*(3), 167-179.

[48] Hunt, G., & Rosenbaum, M. (1998). 'Hustling' within the clinic: Consumer perspectives on methadone maintenance treatment. In J. A. Inciardi, & L. D. Harrison (Eds.), *Heroin in the age of crack-cocaine*. Thousand Oaks, CA: Sage.

[49] Vigilant, L. G. (2001). "Liquid handcuffs": The phenomenology of recovering on methadone maintenance. *Boston College Dissertations and Theses.*

1. *Methadone treatment stigma*: the stigma attached to treatment for opiate addiction; methadone treatment as a social signal of problem severity; stigma attached to methadone as a treatment modality by the culture at large and by major segments of the professional and recovery communities. (Methadone-related stigma is far greater for women than men, due to the perceived connection between heroin addiction and prostitution).
2. *Dose stigma*: the stigma attached within the clinic culture to those on high doses of methadone—a status often interpreted by other patients as indicating a lack of interest in recovery.
3. *Stigma of personal regret*: shame of looking back on the devastation to self, family, and community caused by heroin addiction.
4. *Stigma-related loss of associational ties*: shrinking of social network to the recovery/clinic community in order to avoid the social stigma attached to addiction and methadone treatment.
5. *Loss of control stigma*: shame related to the excessive demands of the clinic, its domination of one's life and forced participation in shaming rituals (e.g., observed urination to confirm that urine for drug testing is "fresh" and not being surreptitiously substituted).

Dr. Robert Newman[50] places Viglant's work within an important historical perspective. Newman argues that the original model of methadone maintenance was corrupted as it was mainstreamed.[51] Methadone treatment during this transition phase shifted to lower methadone doses, shorter lengths of methadone treatment participation, and decreased emphasis on services for collateral problems (e.g., counseling, employment, housing) that are critical to recovery stabilization and maintenance. These changes violated the original theoretical framework of methadone maintenance to the extent that Newman drew the following provocative conclusion:

> *Methadone maintenance treatment, with its unique, proven record of both effectiveness and safety, no longer exists. One can only hope that it is not too late to reassess that which has been cast aside, and to resurrect a form of treatment which has helped so many, and which could help many more.*[52]

Payte[53] suggests that the history of methadone maintenance treatment stands as an argument for professional activism:

---

[50] Newman, R.G. (1976). Methadone maintenance: It ain't what it used to be. *British Journal of Addiction, 71*, 183-186. See also: Des Jarlais, D.C., Paone, D., Friedman, S.R., Peyset, N. & Newman, R.G. (1995). Regulating controversial programs for unpopular people: Methadone maintenance and syringe exchange programs. American Journal of Public Health, 85(11), 1577-84.

[51] See Payte, J. T. (1991). A brief history of methadone in the treatment of opiate dependence: A personal perspective. *Journal of Psychoactive Drugs, 23*(2), 103-107.

[52] Newman, R.G. (1976). Methadone maintenance: It ain't what it used to be. *British Journal of Addiction, 71*, 183-186.

[53] Payte, J. T. (1991). A brief history of methadone in the treatment of opiate dependence: A personal perspective. *Journal of Psychoactive Drugs, 23*(2), 103-107.

It is no longer sufficient to take care of patients. Treatment providers must also become teachers, public relations workers, politicians, and advocates for all patients who want and need treatment.[54]

Personal Responses to Stigma: There is a high degree of variability in how persons in methadone maintenance respond to stigma. Users with more positive self-concepts and more social resources are better able to counter stigma and assert the positive benefits of MAT. Those with lower self-esteem and fewer social resources are less capable of resisting stigma and tend to self-define methadone treatment as another addiction (internalized stigma).[55] Personal strategies to deal with stigma include:

- Secrecy/concealment (e.g., concealing one's status of taking methadone at AA and NA meetings)
- Social withdrawal (e.g., avoiding new friendships; avoidance of recovery support meetings)
- Preventative disclosure (selective disclosure to test acceptability)
- Compensation (using personal strengths in another area to counter the imposed stigma)
- Strategic interpretation (comparing oneself to others within the stigmatized group rather than to those in the larger community)
- Political activism.[56]

People with diminished internal assets and diminished social capital experience difficulty resisting a stigmatizing label and challenging the personal/organizational entities that are applying the label.[57]

Stigma and Cultures of Addiction: Social stigma contributes to the propensity of persons with drug dependencies to become enmeshed in illicit drug subcultures.[58] Individuals who share the "spoiled identity" of addiction have historically organized their

---

[54] Payte, J. T. (1991). A brief history of methadone in the treatment of opiate dependence: A personal perspective. *Journal of Psychoactive Drugs, 23*(2), 103-107. See also Newman,, R. G., & Peyser, N. (1991). Methadone treatment: Experiment and experience. *Journal of Psychoactive Drugs, 23*(2), 115-121.

[55] Gourlay, J., Ricciardelli, L., & Ridge, D. (2005). Users' experiences of heroin and methadone treatment. *Substance Use and Misuse, 40*(12), 1875-1882.

[56] Herman, N. (1993). Return to sender: Reintegrative stigma-management strategies for ex-psychiatric patients. *Journal of Contemporary Ethnography, 22*(3), 302-321. Link, B. G., Struening, E. L., Rahav, M., Phelan, J. C., & Nuttbrock, L. (1997). On stigma and its consequences: Evidence from a longitudinal study of men with dual diagnosis of mental illness and substance abuse. *Journal of Health and Social Behavior, 38*, 177-190. Shih, M. (2004). Positive stigma: Examining resilience and empowerment in overcoming stigma. *Annals of the American Academy of Political and Social Science, 591*, 175-185. Vigilant, L.G. (2004). The stigma paradox in methadone maintenance: Naïve and positive consequences of a "treatment punishment" approach to opiate addiction. *Humanity and Society, 28*(4), 403-418.

[57] Schur, E. M. (1971). *Labeling deviant behavior: Its sociological implications.* New York: Harper & Row Publications.

[58] Anderson, T. L. (1993). Types of identity transformation in drug using and recovery careers. *Sociological Focus, 26*(2), 133-145. White, W. (1996). *Pathways from the culture of addiction to the culture of recovery*. Center City: Hazelden. Anderson, T. L., & Ripullo, F. (1996). Social setting, stigma management, and recovering drug addicts. *Humanity and Society, 20*, 25-43.

own countercultures marked by distinct language, values, roles, rules (behavioral codes), relationships, and rituals.[59] These subcultures provide shelter from stigma; access to drug supplies; social support for sustained drug use; meaningful roles, activities, and relationships; and mutual protection.

Within these cultures, drug users protect their own identities by stigmatizing other drug users viewed as less in control of their drug use.[60] Such attitudes can get played out within the social pecking order of drug treatment milieus. "Street cultures" are also imbedded with myths designed to inhibit treatment-seeking, contribute to ambivalence about treatment, and increase the likelihood of treatment disengagement, e.g., street myths about methadone—"it rots your teeth and bones," etc.[61]

Many individuals enmeshed in such cultures progressively diminish their contact with the mainstream culture and become as dependent on the culture of addiction as the drugs in their lives. As drug-related personal impairment escalates, individuals may experience rejection and isolation from both the mainstream society and from the illicit drug cultures that have sheltered them.[62] Addiction treatment, recovery mutual aid societies, and other helping structures must facilitate a journey from the culture of addiction, or from this marginalized isolation, to a culture of recovery if recovery and community reintegration are to be achieved and sustained. Stigma is a major obstacle to successfully traversing the physical, psychological, and social space between these two worlds.[63] Methadone advocate Walter Ginter recently reflected on this journey:

> *Methadone patients are caught between these two cultures. Even if recovery is their goal, they must stand in line at the clinic each day with people who are as interested in the best crack spot as they are about recovery. Under such a handicap, it is amazing that many patients find their way to medication-assisted recovery. When they do, it is more likely to be in spite of the treatment system than because of it. We have to find a way to separate the culture of addiction from the culture of recovery in our OTP's* [opioid treatment programs]. *It is unreasonable to expect patients to find recovery until we do*.[64]

---

[59] Agar, M. (1977). *Ripping and running: A formal ethnography of urban heroin addicts.* New York: Seminar Press, Inc. Biernacki, P. (1979). Junkiework, hustles, and social status among heroin addicts. *Journal of Drug Issues*, *9*, 535-551. Finestone, H. (1969). Cats, kicks and color. In H. Becker (Ed.), *The other side* (pp. 281-297). New York: Free Press. Waldorf, D. (1973). *Careers in dope.* Englewood Cliffs, NJ: Prentice-Hall, Inc. White, W. (1996). *Pathways from the culture of addiction to the culture of recovery*. Center City: Hazelden.

[60] Boeri, M.W. (2004). "Hell, I'm an addict but I ain't no junkie": An ethnographic analysis of aging heroin users. *Human Organization*, *63*, 236-245. Simmonds, L., & Coomber, R. (2009). Injecting drug users: A stigmatized and stigmatizing population. *International Journal of Drug Policy*, *20*(2), 121-130. Sutter, A.G. (1966). The world of the righteous dope fiend. *Issues in criminology*, *2*, 177-222. Zinberg, N.E. (1984). *Drug, set, and setting: The basis for controlled intoxicant use*. New Haven: Yale University.

[61] Rosenblum, A., Magura, S., & Joseph, H. (1991). Ambivalence toward methadone treatment among intravenous drug users. *Journal of Psychoactive Drugs*, *23*(1), 21-27.

[62] Anderson, T. L., & Levy, J. A. (2003). Marginality among older injectors in today's illicit drug culture: Assessing the impact of ageing. *Addiction*, *98*, 761-770.

[63] White, W. (1996). *Pathways from the culture of addiction to the culture of recovery*. Center City: Hazelden.

[64] Ginter, W. (2009). Personal Communication (Interview), June 22, 2009.

Ginter's observation elicits the image of "life in the queue"—the social influences that pervade interactions in the dosing line of the methadone clinic. The long-term addiction/recovery scales may well be tipped as much by the milieu as by methadone as a medication in the treatment of addiction.[65]

Strategies to Address Social Stigma: Three broad social strategies have been used to address stigma related to behavioral health disorders: 1) protest, 2) education, and 3) contact.[66] One major strategy, seeking to inculcate the belief that alcohol and drug addiction is a disease, may help alleviate personal shame,[67] but has not been consistently shown to produce sympathetic attitudes toward those with severe alcohol and other drug problems.[68] Public surveys reveal that those who agree that alcohol and drug addiction is a disease are more likely to see these problems as severe and intractable and to doubt reports of successful recovery.[69]

One of the most effective strategies to reduce social stigma is to increase interpersonal contact between mainstream citizens and members of the stigmatized group.[70] Contact between stigmatized and non-stigmatized groups as a vehicle of stigma reduction is most effective when the contact is between people of equal status (mutual identification); is personal, voluntary, and cooperative; and mutually judged to be a positive experience.[71] Encounters marked by such characteristics break down in-group/out-group boundaries of "us" and "them."

Social stigma is influenced by social proximity and distance. For example, community attitudes toward Oxford Houses are most positive among neighbors who live closest to these houses.[72] Reducing social distance and increasing interpersonal contact are important goals of any anti-stigma campaign. Individuals can express negative

---

[65] Fraser, S., & Valentine, K. (2008). *Substance and substitution: Methadone subjects in liberal societies.* New York: Macmillan.

[66] Corrigan, P. W., & Penn, D. L. (1999). Lessons from social psychology on discrediting psychiatric stigma. *American Psychologist, 54*, 765-776.

[67] White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America.* Bloomington, IL: Chestnut Health Systems.

[68] Crawford, J. R., Thomson, N. A., Gullion, F. E., & Garthwaute, P. (1989). Does endorsement of the disease concept of alcoholism predict humanitarian attitudes to alcoholics? *The International Journal of the Addictions, 24*, 71-77. Cunningham, J. A., Sobell, L. C., & Chow, V. M. (1993). What's in a label? The effects of substance types and labels on treatment considerations and stigma. *Journal of Studies on Alcohol, 54*(6), 693-699.

[69] Cunningham, J. A., Sobell, L. C., & Sobell, M. B. (1996). Are disease and other conceptions of alcohol abuse related to beliefs about outcome and recovery? *Journal of Applied Social Psychology, 26*(9), 773-780.

[70] Corrigan, P. W. (2002). Testing social cognitive models of mental illness stigma: The prairie state stigma studies. *Psychiatric Rehabilitation Skills, 6*, 232-254. Corrigan, P. W., River, L. P., Lundin, R. K., Penn, D. L., Uphoff-Wasowski, K., Campion, J., et al. (2001). Three strategies for changing attributions about severe mental illness. *Schizophrenia Bulletin, 27*, 187-195. Corrigan, P. W., & Wassel, A. (2008). Understanding and influencing the stigma of mental illness. *Journal of Psychosocial Nursing and Mental Health Services, 27*, 187-195. Couture, S. M., & Penn, D. L. (2003). Interpersonal contact and the stigma of mental illness: A review of the literature. *Journal of Mental Health, 12*, 291-305.

[71] Couture, S. M., & Penn, D. L. (2003). Interpersonal contact and the stigma of mental illness: A review of the literature. *Journal of Mental Health, 12*, 291-305.

[72] Jason, L. A., Roberts, K., & Olson, B. D. (2005). Attitudes towards recovery homes and residents: Does proximity make a difference? *Journal of Community Psychology, 33*(5), 529-535.

feelings toward a particular group while simultaneously having positive regard for individuals of that group. As such relationships increase, the sentiment towards the group weakens and dissipates. Strategies that focus on increasing public awareness of multiple pathways of long-term recovery and exposing people to others who have resolved these problems may be more effective in countering social stigma than promoting a particular conceptualization of the nature of addiction.[73]

Historical/Sociological Perspectives

The social stigma attached to certain patterns of psychoactive drug use has a long history in the United States and is inseparable from cultural strain related to such issues as race, religion, social class, gender roles, and intergenerational conflict. The social reform campaigns that have demonized certain drugs and classes of drug users shared common conceptual themes:

1. The drug is associated with a hated subgroup of the society or a foreign enemy.
2. The drug is identified as solely responsible for many problems in the culture, i.e., crime, violence, insanity.
3. The survival of the culture is pictured as being dependent on the prohibition of the drug.
4. The concept of "controlled" usage is destroyed and replaced by a "domino theory" of chemical progression.
5. The drug is associated with corruption of young children, particularly their sexual corruption.
6. Both the user and supplier of the drug are defined as fiends, always in search of new victims; usage of the drug is considered "contagious."
7. Policy options are presented as total prohibition or total access.
8. Anyone questioning any of the above assumptions is bitterly attacked and characterized as part of the problem that needs to be eliminated.[74]

These themes shape what Lindesmith[75] referred to as "dope fiend mythology"—a "body of superstition, half-truths and misinformation" that claims narcotic drug use causes moral degeneracy and violent crime (rape and murder) and that drug "pushers" and drug users have a voracious appetite for infecting non-users.[76] Modern studies of the historical origin of these myths have placed their beginnings within the Federal Bureau of

[73] Corrigan, P. W. (2002). Testing social cognitive models of mental illness stigma: The prairie state stigma studies. *Psychiatric Rehabilitation Skills*, *6*, 232-254. Cunningham, J. A., Sobell, L. C., & Sobell, M. B. (1996). Are disease and other conceptions of alcohol abuse related to beliefs about outcome and recovery? *Journal of Applied Social Psychology*, *26*(9), 773-780.

[74] White, W. (1979). Themes in chemical prohibition. In *Drugs in perspective*. Rockville, MD: National Drug Abuse Center/National Institute on Drug Abuse.

[75] Lindesmith, A. R. (1940). Dope fiend mythology. *Journal of Criminal Law, Criminology and Police Science*, *31*, 199-208.

[76] It was Lindesmith's position that moral degeneracy was a consequence of drug policy rather than drug pharmacology: "If our addicts appear to be moral degenerates and thieves it is we who have made them that by the methods we have chosen to apply to their problems." Lindesmith, A. R. (1940). Dope fiend mythology. *Journal of Criminal Law, Criminology and Police Science*, *31*, 199-208.

Narcotics' early and mid-twentieth century anti-drug campaigns,[77] but similar myths were also promulgated by the leaders of nineteenth century anti-alcohol, anti-tobacco, anti-opium, and anti-cocaine campaigns.[78] These myths about the nature of various drugs and the nature of the drug user constitute the conceptual foundation of addiction-related stigma.

The social stigma attached to methadone is rooted in a larger anti-medication bias within the history of addiction treatment. That bias is rooted in new drugs announced as breakthroughs in the treatment of alcohol and other addiction that were later found to create problems in their own right. Alcohol, opium, morphine, cocaine, cannabis, barbiturate and non-barbiturate sedatives, amphetamines and other psychostimulants, LSD, and the so-called "minor" tranquilizers have all been claimed to have curative properties in the treatment of addiction.[79] The history of such iatrogenic insults bodes caution and close scientific scrutiny of any new drug claimed as a treatment for drug addiction.[80] But that same history also suggests that new drugs of unsurpassed effectiveness could be developed that could be socially and professionally rejected because of this traditional anti-medication bias.

Social stigma toward alcohol and other drug (AOD) addiction may be defined as an obstacle to problem resolution or as a strategy of problem resolution. The stigmatization and criminalization of alcohol and other drug problems in the United States has grown over more than two centuries as an outcome of a series of "drug panics" and resulting social reform campaigns.[81] These campaigns have generated policies of isolation, control, and punishment of drug users.[82] Stigmatization is not an accidental by-product of these campaigns. It is a reflection of policies that "unashamedly aim to make the predicament of the addict as dreadful as possible in order to discourage others from engaging in drug experimentation."[83] An outcome of this complex social history is that many addiction professionals and recovery advocates see the stigma produced by "zero tolerance" policies as a problem to be alleviated, whereas preventionists see the stigma produced by such policies as a valuable community asset.[84] A key question thus remains,

---

[77] Reasons, C. E. (1972). *Dope, fiends and myths*. Paper presented at American Sociological Association's Annual Meeting (New Orleans, LA, August). Reasons, C.E. (1976). Images of crime and the criminal: The dope fiend mythology. *Journal of Research in Crime and Delinquency, 13*(2), 133-144.

[78] White, W. (1979). Themes in chemical prohibition. In *Drugs in perspective*. Rockville, MD: National Drug Abuse Center/National Institute on Drug Abuse.

[79] White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

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

[81] Jonnes, J. (1996). *Hep-cats, narcs, and pipe dreams*. New York: Scribner. Musto, D. (1973). *The American disease: Origins of narcotic controls*, New Haven: Yale University Press.

[82] White, W. (1979). Themes in chemical prohibition. In *Drugs in perspective*. Rockville, MD: National Drug Abuse Center/National Institute on Drug Abuse.

[83] Husak, D.N. (2004). The moral relevance of addiction. *Substance Use and Misuse, 39*(3), 399-436.

[84] There are those who take an extreme position on this, arguing that addiction is a moral problem, addicts are "bad people," stigma attached to addiction is good and should be increased, the internalized stigma attached to addiction directs most addict violence within the drug culture, and that any lowering of that stigma might create a re-direction of that violence outward toward normal citizens. Dalrymple, T. (2007). *Junk Medicine: Doctors, lies and the addiction bureaucracy*. Great Britain: Harriman House, Ltd.

"How do addiction treatment professionals, recovery advocates, and preventionists avoid working at cross-purposes in their educational efforts in local communities?" Efforts to reduce addiction-related stigma must engage multiple community groups in ways that alter community perception of the sources and solutions to alcohol and other drug problems.

Efforts to increase or reduce stigma attached to illicit drug use may have intended or unintended side-effects.[85] Two examples illustrate this point. First, efforts to decrease illicit drug use by portraying the drug user as physically diseased, morally depraved, and criminally dangerous may inadvertently decrease help-seeking behavior by creating caricatured images of addiction with which few people experiencing AOD problems identify. Such efforts may also promote patterns of social exclusion and discrimination within local communities that block the ability of drug-dependent individuals to re-enter mainstream community life. Second, community education efforts aimed at reducing stigma could increase drug use.[86] This could occur if these campaigns inadvertently normalized illicit drug use, increased non-user curiosity about drug effects, conveyed the impressions that addiction treatment is an assured safety net (available and affordable) or that recovery is easily attainable, or glamorized the recovering addict as a heroic figure within cultural contexts in which few heroic models are available.

Any campaign to counter addiction/treatment/recovery-related stigma must ask two related questions: 1) "What is the source of stigma?" and "Who profits from stigma?"[87] Efforts by one group to define another group as deviant can serve psychological, political, and economic interests. Put simply, stigmatizing others often serves to increase the self-esteem of the stigmatizer.[88] It elevates oneself as more worthy than the demeaned "other" and defines oneself as an upholder of community health and morality. Social scapegoating of others increases during periods in which personal esteem, security, safety, and social value are threatened. Participation in, or support of, a campaign that defines a particular group as "outsiders" serves to confirm one's own status as an "insider." Addiction professionals seeking to reduce social stigma attached to addiction/treatment/recovery must address such issues of esteem, security, safety, and social value.

Stigma has political utility. Anti-drug campaigns often mask and reflect deeper conflicts of gender, race, social class, and generational conflict. Such issues have long been manipulated for political gain. Stigma is often the delayed fruit of anti-drug campaigns waged for the benefit of those seeking to build or retain political power. Anti-stigma campaigns must address the question of how the community and its political leaders can benefit from changes in attitudes toward addiction/treatment/recovery.

Social stigma can be fed by individuals and institutions whose economic interests are served by such attitudes. Changes in attitudes can trigger shifts in cultural ownership of alcohol and other drug problems and in that process, shift millions of dollars in ways

---

[85] Room, R. (2005). Stigma, social inequality and alcohol and drug use. *Drug and Alcohol Review, 24*(2), 143-155.

[86] Gerber, J. (1973). Role of the ex-addict in drug abuse intervention. *Drug Forum*, *2*(2), 105-106.

[87] Weinstein, 2009, personal communication.

[88] Tajfel, H., & Turner, J. C. (1979). An integrative theory of intergroup conflict. In W. G. Austin, & S. Worchel (Eds.), *The social psychology of intergroup relations* (pp. 33-48). Monterey, CA: Brooks/Cole.

that affect the destinies of individuals, organizations, and whole communities. For example, changes in community attitudes have in the past shifted millions of dollars between community-based addiction treatment and the criminal justice system. Such shifts influence the fate of professional careers, organizations, and in some cases, entire community economies. Similarly, what may be viewed as a problem of "not in my back yard" (NIMBY) prejudice by citizens of a particular neighborhood may actually reflect opinion being manipulated by hidden financial interests, e.g., developers who would profit from gentrification of a neighborhood targeted for a new addiction treatment facility.[89]

Formal studies of public resistance to locating behavioral health (addiction or mental health) treatment clinics and recovery homes in a particular neighborhood have drawn several key conclusions. Facilities who notify neighbors before entrance into the community experience great initial resistance than those who do not, but achieve better long-term relationships with the local community—particularly when the facility has an active strategy of neighborhood relations, e.g., open houses and community service.[90] Many facilities are well-accepted in their communities, and acceptance is associated with public concepts of "social responsibility and collective care."[91] Acceptance is highest among community residents who are younger, more economically and educationally advantaged, personally know someone in recovery, rely on education/experience rather than the media as the most important source of information, see facility residents as similar to other people, and believe local residents encountering behavioral health problems should have access to local, community-based services.[92] By enhancing positive recovery outcomes, larger facilities (eight or more residents) generate fewer neighborhood complaints related to criminal or aggressive behavior.[93]

Local opposition to the opening of a new methadone clinic has been linked to fear of increased drug use and crime, fear of effects on property values, objections to the profits made by private methadone clinics, and philosophical opposition to methadone as a treatment and as a perceived method of social control of communities of color.[94] This opposition can be reduced by involvement of neighborhood leaders in site planning, placement of clinics in low-traffic areas, minimization of patient visibility (e.g., providing space for socializing to avoid loitering outside the clinic, encouraging early

---

[89] Joseph, H. (2009). Personal Communication (Interview), June 5, 2009.

[90] Zippay AL. (2007). Psychiatric Residences: Notification, NIMBY, and Neighborhood Relations. *Psychiatric Services* 58, 109–113. http://www.psychservices.psychiatryonline.org/

[91] Zippay, A. & Lee, S.K. (2008) Neighbors' perceptions of community-based psychiatric housing. *Social Service Review* 82(3), 395-417.

[92] Iutcovich, M., Iutcovich, J., & Strikland, W .J. (1996). Group homes for the mentally ill? NIMBY! *Social Insight*, 11-15. Repper, J., & Brooker, C. (1996). Public attitudes towards mental health facilities in the community. *Health and Social Care in the Community*, *4*(5), 290-299.

[93] Jason, L.A., Groh, D.R., Durocher, M., Alvarez, J., Aase, D.M., & Ferrari, J.R. (2008). Counteracting "Not in My Backyard": The positive effects of greater occupancy within mutual-help recovery homes. *Journal of Community Psychology, 36*, 947-958.

[94] Genevie, L., Struening, E. L., KAllos, J. E., Gelier, I., Muhlin, G. L. & Kaplan, S. (1988). Urban community reaction to health facilities in residential areas: Lessons from the placement of methadone facilities in New York City. *The International Journal of the Addictions*, *23*(6), 603-616.

morning pickups), and demonstration that methadone clinic patients can make a positive contribution to the community (e.g., community service programs).[95]

There has been considerable rethinking of the NIMBY issue. First, NIMBY may represent, not local prejudice, but a local manifestation of a belief system that is deeply ingrained within the national culture—suggesting the need for national as well as local anti-stigma strategies.[96]

> *It is essential that attempts are made to improve tolerance not only within local populations but also within the total population. This might be achieved through a broad based educational and awareness raising strategy which is properly funded by purchasers of health and social care*.[97]

Second, as a local issue, NIMBY is being viewed as more than a manifestation of misinformation and prejudice.

> *Siting conflicts should not be seen as resulting from the unreasonable and selfish attitudes of the local population, but as a real reflection of concerns about health, safety, quality of life, political interests, rights and moral issues…There is a need to break out of adversarial approaches towards cooperation.*[98]

Siting conflicts may be minimized if preceded by efforts to promote community consensus on such key propositions as the following:

- Each family/neighborhood has a responsibility to take care of its own.
- Each neighborhood/community has the responsibility of developing a level of prevention, early intervention, treatment, and recovery support services commensurate with the vulnerability for AOD problems in that neighborhood.
- Neighborhoods/communities may band together to create a full continuum of prevention, early intervention, treatment, and recovery support services available to all of their members, with all neighborhoods/communities having a voice through their elected representatives as to where such resources are located.
- Neighborhoods/communities have a right to be involved in planning decisions related to the siting of new addiction treatment and recovery support resources.
- Neighborhoods/communities have a right to know the extent to which individuals served by a treatment or recovery support facility come from within or outside the neighborhood/community.

---

[95] Genevie, L., Struening, E. L., KAllos, J. E., Gelier, I., Muhlin, G. L. & Kaplan, S. (1988). Urban community reaction to health facilities in residential areas: Lessons from the placement of methadone facilities in New York City. *The International Journal of the Addictions, 23*(6), 603-616.

[96] Tempalski, B., Friedman, R., Keem, , M., Coopoer, H. & Friedman, S.R. (2007). NIMBY localism and national inequitable exclusion alliances: The case of syringe exchange programs in the United States, Geoforum, 38(6), 1250-1263.

[97] Repper, J., & Brooker, C. (1996). Public attitudes towards mental health facilities in the community. *Health and Social Care in the Community*, *4*(5), 290-299.

[98] Repper, J., & Brooker, C. (1996). Public attitudes towards mental health facilities in the community. *Health and Social Care in the Community*, *4*(5), 290-299.

- Neighborhoods/communities have a right to know about potential problems that may arise within treatment and recovery support facilities and how such problems will be managed.
- Organizations seeking to open a new treatment or recovery support facility have a right to a fair hearing in which they can present how that facility meets current legal/regulatory requirements and how the facility will benefit the community via services, jobs, and economic resources.[99]

The stigma attached to methadone treatment for opioid addiction is rooted in the unique history of this drug and its close association with heroin addiction. Methadone maintenance as a treatment for heroin addiction has grown from a handful of patients in the mid-1960s to more than 260,000 patients in 2008 (plus an additional 140,000 opioid-dependent patients being treated with buprenorphine).[100] Early attacks on methadone in the late 1960s and 1970s focused on what was perceived as "drug substitution" and concerns about methadone diversion and methadone-related deaths.[101] Since that time, attitudes toward methadone are due in great part to the fact that the least stabilized medication-assisted treatment (MAT) patients and the worst MAT programs (e.g., poorest clinical, administrative, and fiscal practices) garner nearly all of the attention the media gives to the subject of methadone treatment.

Widely disseminated myths and misconceptions about the drug methadone and methadone maintenance as an addiction treatment have flourished since its introduction and continue to affect discussions about methadone at personal, professional, public, and policy levels. In spite of the established scientific legitimacy and effectiveness of methadone maintenance treatment (see later citations), methadone patients are forced to hide their "dirty little secret" for fear of social rejection and discrimination.[102]

Attitudes toward methadone as a mechanism of recovery support are unique in the broad arena of addiction treatment. For other areas of recovery support (e.g., participation in professional continuing care groups, peer-based recovery support meetings, daily recovery support rituals not involving medication), there is consistent praise for continuing or increasing these activities over time. But for the person whose recovery is supported by methadone, there is encouragement to taper off methadone and congratulations when such tapering is complete, in spite of research finding high relapse rates following such tapering and little expectation among patients or staff that tapering will be successful.[103] Professional congratulations to the person who similarly reduced

[99] White, 2009 Personal Communication to Dr. Arhur Evans

[100] Kleber, H. (2008). Methadone maintenance 4 decades later: Thousands of lives saved but still controversial. *Journal of the American Medical Association*, *300*(9), 2303-2305.

[101] Kleber, H. (2008). Methadone maintenance 4 decades later: Thousands of lives saved but still controversial. *Journal of the American Medical Association*, *300*(9), 2303-2305.

[102] Gryczynski, J. (2005). *Patient views on methadone treatment as conveyed in an online support group*. Presented at the annual meeting of the American Sociological Association, Philadelphia, PA. Murphy, S., & Irwin, J. (1992). "Living with the dirty secret": Problems of disclosure for methadone maintenance clients. *Journal of Psychoactive Drugs, 24*(3), 257-264.

[103] Gold, M. L., Sorenson, J. L., McCanlies, N., Trier, M., & Dlugosch, G. (1988). Tapering from methadone maintenance: Attitudes of clients and staff. *Journal of Substance Abuse Treatment*, *5*, 37-44.

and ended his or her recovery support meeting participation would be currently unthinkable.[104]

The stigma attached to methadone is also shaped by the expectations of methadone treatment as a system of care. Methadone advocate Walter Ginter comments on such expectations:

> *Patients, former patients, staff, policy makers, and the public expect the methadone treatment program to treat addiction. While that is a reasonable expectation, it is not what Opioid Treatment Programs (OTPs) do. OTPs treat opiate dependence, and they do it very well. Most patients on an adequate dose of methadone do not continue to use opiates. However, opiate addiction is more than dependence on opiates; it is dependence combined with a series of behaviors. OTPs (with a few exceptions) do not treat the behavioral aspects of addiction. The behavioral aspects are not treated by a medication but rather by counseling, therapy, peer recovery supports, and 12-step groups. As long as well-intentioned people go around saying that "methadone is recovery," it is going to continue to be misunderstood. Methadone is a medication, a tool, even a pathway, but it is not recovery. Recovery is a way of living one's life. It doesn't come in a bottle.*[105]

Modern OTPs, under the influence of the American Association for the Treatment of Opioid Dependence, are making significant strides in moving from this narrow focus on metabolic stabilization to the broader processes involved in addiction treatment and long-term addiction recovery.[106]

Patients entering methadone treatment are as likely to be seeking respite as recovery.[107] Entrance into addiction treatment can be a milestone in one's addiction career as well as a potential milestone of recovery.[108] It is the milieu of the clinic, the service relationships, and the broader menu of services in which methadone is nested that can tip the scales from the former to the latter. The social and professional perception of methadone treatment as consisting almost exclusively of the medication itself has contributed to the stigma attached to methadone and methadone maintenance treatment.

Conceptual Underpinnings of MAT-Linked Stigma

Social and professional stigma, particularly stigma associated with methadone treatment, is buttressed by a set of core assumptions or beliefs. Table 1 outlines some of these key assumptions and beliefs and their current scientific status.

---

[104] Woods, J. (2009). Personal communication, July 27, 2009.

[105] Ginter, W. (2009). Personal Communication (Interview), June 22, 2009.

[106] Kaltenbach, K. (2009). Personal Communication, October 12, 2009.

[107] Faulpel. C. (1999). *Shooting dope*. Gainesville, FL: University of Florida Press. Johnson, P. D., & Friedman, J. (1993) Social versus physiological motives in the drug careers of methadone clinic clients. *Deviant Behavior: An Interdisciplinary Journal*, *14*, 23-42.

[108] White, W. (1996). *Pathways from the culture of addiction to the culture of recovery*. Center City: Hazelden.

Table 1: Stigma-Linked Beliefs and Their Scientific Status

Stigma-Linked Beliefs	The Science
1. Compulsive drug use is a choice, and such voluntary choices and their consequences should not be masked within a disease rhetoric that fails to hold people accountable for their decisions and actions.	1. Volitional control over whether to use or not use a drug and how much and for how long to use once use begins progressively diminishes in vulnerable populations as the brain is "hijacked" via the dysregulation of normal brain functioning produced by sustained drug exposure.[109]
2. Methadone is a "crutch": it provides symptomatic treatment but fails to treat the deeper emotional and relational disturbances that led to the initiation and maintenance of heroin addiction.[110]	2. Opioid addiction is at its core more a physiological than psychological disorder,[111] but recovery rates in MAT can be compromised by high rates of co-occurring medical and psychiatric disorders.[112] MAT outcomes are enhanced when methadone is wrapped in a broader menu of medical, psychiatric, and social services.[113] The primary rationale for MAT is the following: the physiological core of opioid dependence requires a core treatment of physiological stabilization; abstinence-based treatment of opioid dependence is limited in terms of attraction, retention, and post-treatment outcomes because it lacks this core physiological treatment.
3. Methadone simply replaces one drug/addiction for another, i.e., "methadone is like the alcoholic replacing Bourbon with Scotch."[114]	3. Injected heroin produces intense euphoria, whereas oral consumption of appropriate doses of methadone in an opioid-tolerant patient produces a

[109] Dackis, C., & O'Brien, C. (2005). Neurobiology of addiction: Treatment and public policy ramifications. *Nature Neuroscience*, *8*(11), 1431-1436. Shaham, Y., & Hope, B. T. (2005). The role of neuroadaptations in relapse to drug seeking. *Nature Neuroscience*, *8*(11), 1437-1439.

[110] Beschner, G. M., & Walters, J. M. (1985). Just another habit? The heroin users' perspective on treatment. In B. Hanson, G. Beschner, J. M. Walters, & E. Bovelle (Eds.), *Life with heroin: Voices from the inner city.* Lexington, MA: Lexington Books.

[111] Kreek, M. J., & Reisinger, M. (1997). In J. Lowinson, P. Ruiz, R. B. Millman, & J. G. Langrod (Eds.), *Substance abuse: A comprehensive text* (pp. 822-853). Baltimore, MD: Williams and Wilkins.

[112] Cacciola, J. S., Alterman, A. I., Rutherford, M. J., McKay, J. R., & Milvaney, F. D. (2001). *Drug and Alcohol Dependence*, *61*, 271-280.

[113] Abbot, P. J., Moore, B., Delaney, H., & Weller, S. (1999). Retrospective analyses of additional services for methadone maintenance patients. *Journal of Substance Abuse Treatment*, *17*(1-2), 129-137. Hesse, M., & Pedersen, M.U. (2008). Easy-access services in low-threshold opiate agonist maintenance. *International Journal of Mental Health and Addiction*, *6*(3), 316-324. McLellan, A. T., Arndt, I. O., Metzger, D. S., Woody, G. E., & O'Brien, C. P. (1993). The effects of psychosocial services in substance abuse treatment. *Journal of the American Medical Association*, *269*, 1953-1959.

[114] Marion, I.J. (2009). Personal communication with author, June 24, 2009.

	normalizing rather than euphoric effect.[115] Because of this, most patients on methadone view methadone as a "medication" rather than a "drug."[116] Methadone and buprenorphine are best thought of as addiction-ameliorating medications rather than addiction-inducing drugs.[117] Methadone, like other legal medication, is subjected to quality controls (assurance of proper and consistent dosage and purity) not available with illicit opioids. Self-reports of MMT patients switching from being a "slave to heroin" to a "slave to methadone"[118] have more to do with the rigorous demands of the MMT clinic structure than the pharmacological equivalency of heroin and methadone.
4. Methadone maintenance diminishes one's capacity to eventually achieve long-term abstinence from opiates.	4. The effect of methadone on the duration of addiction careers is unclear. Maddux and Desmond[119] found rates of long-term abstinence (defined in this study as abstinence from all opiates <u>including</u> methadone) of persons following MMT (9-21%) similar to those for persons treated in drug-free treatment (10-19%). The data "do not suggest that methadone impedes eventual recovery."[120] In a study published this same year, Maddux and Desmond conducted a 10-year follow-up comparison of patients with less than one year and more than one year on methadone maintenance and concluded: "methadone maintenance for 1 year or longer impedes eventual recovery from opioid dependence." They went on to say that

[115] Zweben, J. (1991). Counseling issues in methadone treatment. *Journal of Psychoactive Drugs*, *23*(2), 177-190.

[116] McGonagle, D. (1994). Methadone Anonymous: A 12-Step program. *Journal of Psychosocial Nursing*, *32*(10), 5-12.

[117] Maremmani, I., & Pacini, M. (2006). Combating the stigma: Discarding the label "substitution treatment" in favour of "behavior-normalization treatment." *Heroin Addiction and Related Clinical Problems*, *8*(4), 5-8.

[118] Baldino, R.G. (2000). *Welcome to Methadonia: A social worker's candid account of life in a methadone clinic*. Harrisburg, PA: White Hat Communications.

[119] Maddux, J. F., & Desmond, D. P. (1992). Methadone maintenance and recovery from opioid dependence. *American Journal of Drug and Alcohol Abuse*, *18*(1), 63-74.

[120] Maddux, J. F., & Desmond, D. P. (1992). Methadone maintenance and recovery from opioid dependence. *American Journal of Drug and Alcohol Abuse*, *18*(1), 63-74.

	"For many patients, however, the benefits of prolonged methadone maintenance could outweigh the possible cost of diminished likelihood of eventual recovery."[121] A definitive answer to the effects of methadone maintenance on long-term addiction and recovery careers remains unclear. Future studies must include those in stable medication-assisted treatment without secondary drug use, with indicators of progress towards global health and community integration within the definition of recovery.[122]
5. Low doses and short periods of methadone maintenance result in better rates of long-term recovery.	5. There is a significant relationship between methadone dosage and the odds of continued heroin use during MAT.[123] Two-thirds of methadone treatment patients receive inadequate daily dosages of methadone—dosages below 80 mg/day[124]—in spite of growing evidence that higher dosages are linked to greater reductions in the use of other opiates, greater reductions in secondary drug use (e.g. cocaine, benzodiazepines), and enhancements in global recovery outcomes.[125] The effective duration of methadone maintenance associated with the best long-term recovery outcomes is at least one year of participation.[126] In 2002, the average length of time from admission

[121] Maddux, J. F. & Desmond, D. P. (1992) Ten-year follow-up after admission to methadone maintenance. *American Journal of Drug and Alcohol Abuse*, *18*(3), 289-303.

[122] Betty Ford Institute Consensus Panel. (2007). What is recovery? A working definition from the Betty Ford Institute. *Journal of Substance Abuse Treatment, 33,* 221-228. White, W. (2007) Addiction recovery: Its definition and conceptual boundaries. *Journal of Substance Abuse Treatment, 33*, 229-241.

[123] Caplehorn, J. R. M., Bell, J., Kleinbaum, D. G., & Gebski, V. J. (1993). Methadone dose and heroin use during maintenance treatment. *Addiction, 88*, 119-124. Gossop, M., Marsden, J., Stewart, D., & Treacy, S. (2001). Outcomes after methadone maintenance and methadone reduction treatments: Two-year follow-up results from the National Treatment Outcome Research Study. *Drug and Alcohol Dependence, 62*(3), 255-264.

[124] D'Aunno, T. (2006). The role of organization and management in substance abuse treatment: Review and roadmap. *Journal of Substance Abuse Treatment, 31*, 221-233.

[125] Gerra, G., Ferri, M., Polidori, E., Santoro, G., Zaimovic, A., & Sternieri, E. (2003). Long-term methadone maintenance effectiveness: Psychosocial and pharmacological variables. *Journal of Substance Abuse Treatment, 25*, 1-8.

[126] Simpson, D. D., & Joe, G. W. (2004). A longitudinal evaluation of treatment engagement and recovery stages. *Journal of Substance Abuse Treatment, 27*, 99-121.

	to discharge in outpatient methadone maintenance was 175 days.[127]
6. MAT patients should be encouraged to end MAT as soon as possible.	6. The majority of opioid dependent persons leaving MAT, like their opioid-dependent counterparts leaving drug-free treatment, quickly relapse, and up to two-thirds later return to treatment—often for repeated episodes of treatment.[128] The choice to end MAT is a decision to be made by the patient in consultation with his or her physician, but is best attempted after a substantial period of stability in MAT and with increased support during and following the tapering and cessation periods. The inability of some people to successfully taper from methadone may result more from physiological differences than from inadequate levels of personal motivation or family/social support.

Semantic and Visual Images Underpinning MAT-Related Stigma

Social and professional stigma attached to opiate addiction and medication-assisted treatment (MAT) is buttressed by language. It is manifested in language that demedicalizes the status of addiction and depersonalizes and demonizes those with the disorder. Words and phrases such as *drug habit*, *drug abuse*, *dope fiend*, *junkie*, *smackhead*, *addict*, *dirty* (versus *clean*), *user*, *client* (rather than *patient*), and *substitution* all reflect such demedicalized and objectifying language.[129]

> …*these terms* [substitution therapy, replacement therapy] *do not confer legitimacy or status on treatment…, indeed the opposite is the case. All are associated with a culture of inauthenticity, and as a result, their value is permanently in question.*

---

[127] Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2005). *Treatment Episode Data Set (TEDS): 2002. Discharges from Substance Abuse Treatment Services* (DASIS Series: S-25, DHHS Publication No. (SMA) 04-3967). Rockville, MD. Retrieved from http://wwwdasis.samhsa.gov/teds02/2002_teds_rpt_d.pdf.

[128] Ball, J. C., & Ross, A. (1991). *The effectiveness of methadone maintenance treatment: Patients, programs, services and outcomes*. New York: Springer Verlag. Bell, J., Burrell, T., Indig, D., & Gilmour, S. (2006). Cycling in and out of treatment; participation in methadone treatment in NSW, 1990-2002. *Drug and Alcohol Dependence, 81*, 55-61.

[129] White, W. (2001). *The rhetoric of recovery advocacy.* Retrieved from www.facesandvoicesofrecovery.org. NAMA (1994). Client vs. patient. National Alliance of Methadone Advocates, inc, Policy Statement # 4, May, 1994. Retrieved July 28, 2009 from http://www.methadone.org/namadocuments/ps04client_v_patient.html.

It might be that, endemic as this language of substitution has become, new terms should be found.[130]

The stigma attached to heroin addiction has been extended to methadone treatment and intensified through such language as *methodonia*, *methodonian,* and *deathadone*. Books with titles like *Methadone: A Technological Fix,*[131] are popular and the titles of professional articles proclaim "Stoned on Methadone," "Hooked: The Madness in Methadone Treatment," "Methadone: The Forlorn Hope," and "The Methdonians." Film "documentaries" are promoted through such titles as "Methadonia," and "Methadone: An American Way of Dealing,"[132] and methadone treatment is commonly portrayed as ineffective through such popular films as "Sid and Nancy," "Trainspotting," and "Permanent Midnight."[133] The language of methadone maintenance (e.g., its designation as a "substitution therapy" or "replacement therapy") has contributed to the stigma attached to MAT by reinforcing the proposition that MAT is nothing more than the replacement of an illegal high with a legal high.[134]

As noted earlier, the social stigma attached to narcotic addiction has been internalized within American drug cultures. The pecking orders within these cultures are reinforced by one's status as a *righteous dope fiend, hope-to-die dope fiend* or *gutter hype*. Such pecking orders can be acted out within the addiction treatment milieu as well as within local drug cultures.

Street Myths and Stigma

Stigma attached to methadone has also been infused within the illicit drug culture of the United States.[135] Table 2 illustrates some of the methadone-related myths that pervade the American drug culture and that serve to inhibit treatment seeking behavior and contribute to early treatment termination.

The Myth	**The Facts**
1. The name Dolophine (a pharmaceutical brand of methadone marketed by Eli Lilly) was named for Adolf Hitler.	1. The "dolo" in Dolophine comes from the Latin *dolor*, meaning "pain," and the "phine" likely comes from morphine or is derived from "fin," meaning "end"; the

[130] Fraser, S., & Valentine, K. (2008). *Substance and substitution: Methadone subjects in liberal societies.* New York: Macmillan.
[131] Nelkin, D. (1973). *Methadone maintenance: A technological fix*. New York: George Braziller.
[132] Joseph, H. (1995). *Medical methadone maintenance: The further concealment of a stigmatized condition*. Unpublished doctoral dissertation, City University of New York.
[133] Cape, G. S. (2003). Addiction, stigma, and movies. *Acta Psychiatrica Scandinavica, 107*(3), 163-169.
[134] Maremmani, I., & Pacini, M. (2006). Combating the stigma: Discarding the label "substitution treatment" in favour of "behavior-normalization treatment." *Heroin Addiction and Related Clinical Problems, 8*(4), 5-8.
[135] Beschner, G. M., & Walters, J. M. (1985). Just another habit? The heroin users' perspective on treatment. In B. Hanson, G. Beschner, J. M. Walters, & E. Bovelle (Eds.), *Life with heroin: Voices from the inner city.* Lexington, MA: Lexington Books.

	name reflects the search for an alternative for morphine in the treatment of pain.[136]
2. Methadone is addicting.	2. Prolonged use of methadone, like any opioid, induces physical dependence, but there is no evidence that it induces addiction. The definitional determinants of addiction have historically included three components: 1) tolerance, 2) withdrawal, and 3) compulsive use in spite of adverse consequences. Methadone meets the first two criteria, but not the third. Since its widespread introduction, there has not been a significant population of people who compulsively pursue methadone as a primary drug choice, although the potential for emergence of such a population continues to be monitored.[137] People maintained on methadone for prolonged periods may be physically dependent upon methadone, but their addiction is to heroin or other short-acting narcotics, not methadone.
3. Methadone is harder to "kick" than heroin.	3. Acute withdrawal from methadone takes longer than withdrawal from heroin.
4. Methadone is nothing more than a cheap, legal high for people who cannot obtain heroin.	4. Methadone at optimal doses does not produce intoxication; it produces physiological stabilization without heroin's brief cycles of withdrawal distress and impairment related to acute intoxication.
5. Once on methadone, you can never get off of it.	5. Relapse rates are high following cessation of both heroin and methadone. Some individuals do initiate and maintain recovery with the aid of methadone and then later stop using methadone as a recovery adjunct while maintaining successful long-term recovery.
6. Methadone maintenance extends the total length of addiction careers.	6. There is no scientific evidence that MAT lengthens addiction careers; addiction careers are instead influenced by factors such as age of onset of use, degree of problem severity/complexity, and the level of personal recovery capital (internal and

[136] Payte, J. T. (1991). A brief history of methadone in the treatment of opiate dependence: A personal perspective. *Journal of Psychoactive Drugs*, *23*(2), 103-107.

[137] A few commentators suggested that this has recently begun to change and that trends in this area should be closely monitored.

	external resources that can be mobilized to initiate and sustain recovery).
7. Methadone hurts your health, e.g., rots your bones and teeth.[138]	7. The safety of methadone, including its safety for pregnant women and the infants they deliver, has been established in innumerable scientific studies.[139] Most side-effects reported by MAT patients are not a function of methadone per se, but are due to "inadequate dosages which precipitate withdrawal symptoms, excessive amounts of methadone, undiagnosed medical problems, or the interaction of methadone with other drugs and/or alcohol."[140] Long-term health problems, specifically dental disease, result from years of avoiding medical/dental care and are often first identified when the person enters MAT.
8. Methadone makes you fat.	8. Weight gain is common among MAT patients and is a product of increased food intake and improvement in overall health. Weight stabilizes with improved nutrition and exercise.[141]
9. MAT patients are at increased risk of developing alcohol problems.	9. Problems of secondary drug dependence are a risk factor for all persons in recovery from opioid addiction, but this risk is similar across modalities of treatment. These problems are elevated in MAT programs that use sub-optimal doses of methadone and do not clinically address the problem of co-occurring psychiatric illness and secondary drug use—particularly the "pill culture" (e.g.,

[138] Beschner, G. M., & Walters, J. M. (1985). Just another habit? The heroin users' perspective on treatment. In B. Hanson, G. Beschner, J. M. Walters, & E. Bovelle (Eds.), *Life with heroin: Voices from the inner city.* Lexington, MA: Lexington Books.

[139] Kreek, M. J. (1983). Health consequences associated with the use of methadone. In J. R. Cooper, F. Altman, B. S. Brown, & D. Czechowicz (Eds.), *Research on the treatment of narcotic addiction: State of the art* (NIDA Research Monograph Series; DHHS Publication No. (ADM) 83-1281; pp. 456-482). Rockville, MD: National Institute on Drug Abuse. Kreek, M. J., & Vocci, F. (2002). History and current status of opioid maintenance treatments. *Journal of Substance Abuse Treatment, 23*(2), 93-105. Center for Substance Abuse Treatment. (2005). *Medication-assisted treatment for opioid addiction in opioid treatment programs* (Treatment Improvement Protocol (TIP) Series 43. DHHS Publication No. (SMA) 05-4048). Rockville, MD: Substance Abuse and Mental Health Services Administration.

[140] Goldsmith, D. S., Hunt, D. E., Litpon, D. S., & Strug, D. L. (1984). Methadone folklore: Beliefs about side effects and their impact on treatment. *Human Organization, 43*(4), 330-340.

[141] Marion, I.J. (2009). Methadone: Myths and Facts (Presentation slides).

	benzodiazepines) that permeates many methadone clinics. The lack of meaningful activities may also contribute to such secondary drug use among MAT patients.[142]
10. Methadone blunts the emotions, e.g., references to "methadone mummies."	10. MAT patients actually report increased capacity to acknowledge and express emotion.[143] The blunting of emotion could result from excessive methadone doses or secondary use of other drugs, e.g., benzodiazepines.
11. Methadone maintenance is for "losers." It is for people who can no longer "take care of business" on the streets.[144]	11. "This image of the methadone client as a 'loser,' without 'heart,' and unable to 'make it on the streets anymore,' is reinforced by the low visibility of methadone clients who are working regularly and/or have what both clients and users not in treatment describe as a 'steady hustle,' that is, regular, income-generating employment, either legal or illegal."[145]
12. Methadone is a tool of political pacification of poor communities of color.	12. Methadone makes a positive contribution to poor communities of color via reduced heroin-related deaths, reduced transmission of HIV and other diseases, reduced crime, and the social and economic assets stable MAT patients add to their communities. Anti-methadone attitudes within the African American community must be viewed within the context of a long history of this community being victimized by scientific and medical enterprises, e.g., withholding medical treatment from 399 African American

[142] Best, D. (2009). Personal communication.

[143] Flynn, P. M., Joe, G. W., Broome, K. M. Simpson, D. D., & Brown, B. S. (2003). Recovery from opioid addiction in DATOS. *Journal of Substance Abuse Treatment*, *25*(3), 177-186.

[144] Preble, E., & Casey, J. (1969). Taking care of business - The heroin user's life on the street. *The International Journal of the Addictions*, *6*(1), 1-24. Preble, E., & Miller. T. (1977). Methadone, wine and welfare. In R. S. Weppner (Ed.), *Street ethnography* (pp. 229-248). Beverly Hills: Sage Publications.

[145] Hunt, D. E., Litpon, D. S., Goldsmith, D. S., Strug, D. L., & Spunt, B. (1985). "It takes your heart": The image of methadone maintenance in the addict world and the effect on recruitment into treatment. *International Journal of the Addictions*, *20*(11-12), 1751-1171.

	sharecroppers in the Tuskegee Syphilis Study.[146]

Sources: Hunt, D. E., Litpon, D. S., Goldsmith, D. S., Strug, D. L., & Spunt, B. (1985). "It takes your heart": The image of methadone maintenance in the addict world and the effect on recruitment into treatment. *International Journal of the Addictions*, *20*(11-12), 1751-1171.; Velton, E. (1992). *Myths about methadone*. National Alliance of Methadone Advocates, Education Series Number 3; Joseph, H., Stancliff, S. & Langrod, J. (2000). Methadone maintenance treatment: A review of historical and clinical issues. *Mount Sinai Journal of Medicine*, 67, 347-364.

Again, these myths inhibit help-seeking, contribute to ambivalence about treatment, and increase the likelihood of treatment disengagement of MAT patients.[147]

Examples of Addiction/Treatment/Recovery-Related Stigma/Discrimination

Addiction-related stigma is manifested in a broad range of attitudes, behaviors, and policies. These general effects include:

- Social shunning/distancing
- Expression of disregard and contempt
- Denial of needed medication for pain (interpreting expressions of pain as drug-seeking behavior)
- Disrespect from primary health care providers and social service personnel
- Denial of basic medical services
- Denial of liver transplantation
- Discrimination via denial of governmental benefits for people with drug-related felonies, e.g., student loans, public housing, small business loans
- Denial of training/employment opportunities
- Denial of housing and homelessness services

Other effects of such stigma are reserved specifically for those persons whose treatment and recovery is supported by methadone. These more specific effects include:

- Denial of methadone support or medically-supervised withdrawal during incarceration
- Denial of access to other addiction treatment modalities and recovery support services, e.g., denial of access to many residential treatment facilities and

---

[146] White, W., & Sanders, M. (2008). Recovery management and people of color: Redesigning addiction treatment for historically disempowered communities. *Alcoholism Treatment Quarterly*, *26*(3), 365-395.

[147] Hunt, D. E., Litpon, D. S., Goldsmith, D. S., Strug, D. L., & Spunt, B. (1985). "It takes your heart": The image of methadone maintenance in the addict world and the effect on recruitment into treatment. *International Journal of the Addictions*, *20*(11-12), 1751-1171. Rosenblum, A., Magura, S., & Joseph, H. (1991). Ambivalence toward methadone treatment among intravenous drug users. *Journal of Psychoactive Drugs*, *23*(1), 21-27.

recovery homes in spite of evidence that persons on methadone can benefit on par with non-medicated patients from such services[148]
- Denial of medication for pain on the false assumption that pain is relieved by the existing methadone dose
- Exposure to punitive, as opposed to supportive, styles of counseling
- Denial of the right to speak and assume leadership roles in local AA/NA meetings
- Denial of detoxification services in acute medical facilities for other addictive substances (e.g., medical management of alcohol withdrawal) while being maintained on one's prescribed and stabilized dose of methadone[149]
- Loss of child custody due to participation in MAT.

The stigma attached to addiction, and to the use of methadone as a medication in particular, has influenced key clinical practices within methadone treatment since its inception in the mid-1960s. Such practices, often "legislated" by oversight bodies, further contributed to the stigma associated with methadone treatment.[150] These practices, some of which have declined due to changes in regulatory guidelines, include:

- Resistance to hiring methadone patients as counselors (e.g., requirement that they first be tapered)
- Being required to stand in line in a publicly visible area (e.g., public sidewalk) to receive methadone
- Separate bathrooms for staff and patients (required by regulation in most states)
- Refusing to admit people on the grounds of insufficient motivation
- Informal use of pejorative labels to designate readmitted patients (e.g., *frequent flyers*, *retreads*)
- Lowered "horizons of possibilities" (expectations) communicated to patients
- Suboptimal methadone doses
- Lowering methadone dose or disciplinary discharge as a punishment for clinic rule violations
- Discharging patients for drug use[151]

---

[148] De Leon, G., Stains, G. L., Perlis, T. E., Sacks, S., McKendrick, K., Hilton, R., & Brady, R. (1995). Therapeutic community methods in methadone maintenance (Passages): An open clinical trial. *Drug and Alcohol Dependence, 37*, 45-57. Sorensen, J. L., Andrews, S., Delucchi, K. L., Greenberg, B., Guydish, J., Masson, C. L., et al. (2008). Methadone patients in the therapeutic community: A test of equivalency. *Drug and Alcohol Dependence*, *100*(1), 100-109.

[149] Hettema, J., & Sorenson, J. L. (2009). Access to care for methadone maintenance patients in the United States. *International Journal of Mental Health and Addiction*. Online publication ahead of print. Retrieved from http://www.springerlink.com/content/c5v56125880u2p64/. Joe, G. W., Simpson, D. D, & Rowan-Szal, G. A. (2009). Interaction of counseling rapport and topics discussed in sessions with methadone treatment clients. *Substance Use and Misuse, 44*, 3-17. Joseph, H., Stancliff, S., & Langrod, J. (2000). Methadone maintenance treatment: A review of historical and clinical issues. *Mount Sinai Journal of Medicine, 67*, 347-364.

[150] Anstice, S., Strike, C. J., & Brands, B. (2009). Supervised methadone consumption: Client issues and stigma. *Substance Use and Misuse, 44*(6), 794-808. O'Brien, C. P. (2008). A 50 year old woman addicted to heron: Review of treatment for heroin addiction. *Journal of the American Medical Association, 300*, 414-321.

[151] NAMA (1994) Discharge from treatment for drug use. Policy statement # 3. Retrieved May 25, 2009 from http://www.methadone.org/namadocuments/ps03discharge_from.html.

- "Blind dosing" without patient's involvement and consent
- Stigma attached to having a high dose of methadone within the MAT subculture
- Staff pressure on patients to taper (medically withdraw) from methadone in settings with an abstinence orientation toward MAT
- Staff discouragement of tapering for all patients out of fear "they won't make it" in settings with a harm reduction orientation toward MAT
- Onerous pickup schedules and restricted dispensing hours that interfere with pro-social roles, e.g., education, employment, parenting
- Supervised consumption of methadone and frontally observed urine drops (required by regulation)
- Arbitrary limits on the duration of methadone maintenance
- Discouragement/prohibition of fraternization among MAT patients
- Inadequate funding/reimbursement for ancillary health and social services, inadequate education and training of staff, and inadequate clinical supervision
- Elaborate and medically unprecedented regulatory requirements governing the use of methadone as a medication in addiction treatment.[152]

In the MAT context, these practices are often experienced by patients as a demonstration of the power held over them by professional staff. There are evidence-based training strategies and techniques that can lower stigma and its behavioral manifestations displayed by frontline addiction treatment service providers.[153]

Methadone-specific stigma can also affect methadone treatment organizations and their staff. Organizational effects can include community resistance to opening of a new methadone treatment site, resistance to relocation of an existing program, or political pressure to close an existing MAT site.

Conceptual Underpinnings of a Campaign to Eliminate Stigma Related to Methadone

Anti-stigma campaigns in the addictions arena have historically focused on a core set of ideas.[154] These simply stated propositions serve as the skeletal foundation of professional and public education efforts and policy advocacy efforts. For example, the "modern alcoholism movement" launched in the 1940s laid the foundation for the rise of modern addiction treatment. This movement was built on the five "kinetic" ideas:

---

[152] Järvinen, M., & Andersen, D. (2009). The making of the chronic addict. *Substance Use and Misuse, 44*, 865-885. Rosenbaum, M. (1995). The demedicalization of methadone maintenance. *Journal of Psychoactive Drugs, 27*, 145-149.

[153] Andrews, S. B., Sorenson, J. L., & Delucchi, K. (2004). *Methadone stigma and the potential effect of sensitivity training for drug treatment staff.* Presented at the annual meeting of the American Public Health Association, November 6-10, Washington, DC. Hayes, S. C., Bissett, R., Roget, N., Padilla, M., Kohlenberg, B. S., Fisher, G., et al. (2004). The impact of acceptance and commitment training and multicultural training on the stigmatizing attitudes and professional burnout of substance abuse counselors. *Behavior Therapy, 35*(4), 821-835.

[154] Johnson, B. (1973). *The alcoholism movement in America: A study in cultural innovation.* Unpublished doctoral dissertation, University of Illinois, Urbana, Illinois.

Modern Alcoholism Movement Kinetic Ideas
1. Alcoholism is a disease. 2. The alcoholic, therefore, is a sick person. 3. The alcoholic can be helped. 4. The alcoholic is worth helping. 5. Alcoholism is our No. 4 public health problem, and our public responsibility.[155]

The "new addiction recovery advocacy movement" is similarly based on a set of core ideas:

New Recovery Advocacy Movement Core Ideas
1. Addiction recovery is a reality in the lives of hundreds of thousands of individuals and families throughout the United States. 2. There are many paths to recovery, and all are cause for celebration. 3. Recovering and recovered people are part of the solution to alcohol and other drug problems. 4. Recovery flourishes in supportive communities. 5. Recovery is voluntary. 6. Recovery gives back what addiction has taken from individuals, families, neighborhoods, and communities.[156]

Any movement to destigmatize methadone treatment and the broader arena of medication-assisted recovery will need its own set of core ideas. The propositions listed below constitute a menu of propositions from which such a set of ideas could be formulated and condensed to form operational slogans.

The Nature of Addictive Disorders

- The decision to initially consume or not consume alcohol, tobacco, and other drugs is, in most but not all circumstances, a voluntary choice.[157]

[155] Anderson, D. (1942). Alcohol and public opinion. *Quarterly Journal of Studies on Alcohol, 3*(3), 376-392. Mann, M. (1944). Formation of a National Committee for Education on Alcoholism. *Quarterly Journal of Studies on Alcohol, 5*(2), 354-358.

[156] White, W. (2006). *Let's go make some history: Chronicles of the new addiction recovery advocacy movement*. Washington, D.C.: Johnson Institute and Faces and Voices of Recovery.

- This initial choice may be consciously influenced by moral or religious values,[158] but more often reflects behavior directed at normal needs and experiences, e.g., pleasure seeking, social inclusion, personal identity, relief of physical/emotional discomfort or family distress.
- The long-term consequences flowing from continued drug exposure have more to do with factors of personal and environmental vulnerability than personal morality or strength of character.
- Addiction is a brain disease that manifests itself in the loss of volitional control over drug-seeking, drug use, and its consequences.
- This loss of volitional control is related to neurobiological changes in the brain that place the need for the drug above other physical needs and social responsibilities.
- Addiction is not a problem easily resolved through "willpower"; addiction is, by definition, a failure of such power.
- Nearly two-thirds of American families have direct experience with alcohol or drug addiction.[159]

Nature of Addiction Recovery

- Recovery from alcohol and drug addiction requires personal persistence and sustained family and social support; recovery flourishes in supportive communities.
- Recovery-supportive communities are good for everyone; all citizens reap dividends from successful long-term recovery.
- Long-term addiction recovery is a living reality for hundreds of thousands of individuals and families.
- Recovery from alcohol and drug addiction requires personal persistence and sustained family and social support; recovery flourishes in supportive communities.
- There are multiple pathways of long-term recovery, and all are cause for celebration.
- Providing addiction treatment and sustained recovery support services is more effective and a more prudent use of community resources than the strategy of mass incarceration.

Medication and Recovery

---

[157] Dr. Karol Kaltenbach and others point out that multiple factors compromise the volitional intent involved in initial drug consumption: early age of onset, introduction of drug use by an older authority figure, coerced use as a dimension of sexual victimization, and drug-saturated peer environments can all compromise the voluntary quality of such choices.

[158] Husak, D. N. (2004). The moral relevance of addiction. *Substance Use and Misuse, 39*(3), 399-436.

[159] Peter D. Hart Research Associates/Coldwater Corporation (2004). *2004 Peter D. Hart Research Associates/Coldwater Corporation, Faces and Voices of Recovery public survey.* Washington, DC: Faces and Voices of Recovery.

- Some opioid-dependent individuals with sustained abstinence from short-acting opioids and social support may achieve long-term recovery (brain recovery and psychosocial recovery) without the aid of medications, while other drug-dependent individuals will require prolonged, if not lifelong, use of medications that reduce drug craving and facilitate full biopsychosocial/spiritual functioning.
- There are stabilizing medications available for the treatment of severe opioid addiction, and even more effective medications may become available in the future.
- Opiate addiction is a "brain-related medical disorder" that is treatable with effective medications; other professionally-directed medical, psychological, and social services; and peer-based recovery support services.[160]
- Appropriate daily dosages of methadone suppress cellular craving for narcotics, prevent withdrawal symptoms (the opioid abstinence syndrome), block the effects of heroin use, and provide a platform or metabolic stability upon which full physical, emotional, and cognitive recovery can be achieved.[161]
- The dosages required to achieve these effects vary from individual to individual.[162]
- Appropriate oral doses of methadone do not produce an experience of sedation or euphoria in individuals who are opiate-tolerant;[163] stabilized patients not using other substances are capable of experiencing the full range of emotional and physical pain.[164]
- Methadone maintenance combined with needed ancillary medical, psychological, and social services is the most effective method of treating chronic heroin addiction.[165]
- The effectiveness of methadone maintenance treatment has been reviewed and affirmed by major health research and policy bodies, including the National Institute on Drug Abuse, the American Medical Association, the American Society of Addiction Medicine, the Institute of Medicine, the National Academy of Sciences, the National Institute on Health Consensus Panel, and the Office of

---

[160] Joseph, H., Stancliff, S., & Langrod, J. (2000). Methadone maintenance treatment: A review of historical and clinical issues. *Mount Sinai Journal of Medicine, 67,* 347-364. White, W. (2009). The mobilization of community resources to support long-term addiction recovery. *Journal of Substance Abuse Treatment, 36,* 146-158.

[161] Joseph, H., Stancliff, S., & Langrod, J. (2000). Methadone maintenance treatment: A review of historical and clinical issues. *Mount Sinai Journal of Medicine, 67,* 347-364.

[162] Joseph, H., Stancliff, S., & Langrod, J. (2000). Methadone maintenance treatment: A review of historical and clinical issues. *Mount Sinai Journal of Medicine, 67,* 347-364.

[163] Marion, I.J. (2009). Methadone: Myths and Facts (Presentation slides); Murray, J. B. (1998). Effectiveness of methadone maintenance for heroin addiction. *Psychological Reports, 83,* 295-302. Zweben, J. (1991). Counseling issues in methadone treatment. *Journal of Psychoactive Drugs, 23*(2), 177-190.

[164] Joseph, H., Stancliff, S., & Langrod, J. (2000). Methadone maintenance treatment: A review of historical and clinical issues. *Mount Sinai Journal of Medicine, 67,* 347-364.

[165] Rettig, R. A., & Yarmolinsky, A. (1995). *Federal regulation of methadone treatment.* Washington D.C.: National Academy Press. National Consensus Development Panel on Effective Medical Treatment of Opiate Addiction. (1998). Effective medical treatment of opiate addiction. *Journal of the American Medical Association, 280*(22), 1936-1943.

National Drug Control Policy,[166] as well as the World Health Organization and other governmental health policy groups around the world.

- These collective reviews conclude that orally administered methadone can be provided for a prolonged period at stable dosages with a high degree of safety and without significant effects on psychomotor or cognitive functioning.[167]
- Methadone is the safest medication available to treat heroin addiction in pregnant women.[168]
- These reviews also confirm that MAT delivered at optimal dosages by competent practitioners: 1) decreases the death rate of opiate-dependent individuals by as much as 50%, 2) reduces transmission of HIV (4-6 fold reductions), hepatitis B and C, and other infections, 3) eliminates or reduces illicit opiate use (by minimizing narcotic craving and blocking the euphoric effects of other narcotics), 4) reduces criminal activity, 5) enhances productive behavior via employment and academic/vocational functioning, 6) improves global health and social functioning, and 7) is cost-effective.[169]
- Methadone-related deaths are related primarily to the diversion of methadone prescriptions for pain rather than from methadone used as a treatment for addiction or illegally diverted from methadone clinics/patients.[170]
- Methadone as a pharmacological adjunct in the treatment of opioid addiction, like insulin in the treatment of diabetes, is a corrective therapy, not a curative therapy. It is only effective when consumed on a sustained daily basis. Relapse rates are high following cessation of methadone maintenance, and mortality rates rise following medical withdrawal.[171] People should not be precipitously encouraged

---

[166] White, W., & Coon, B. (2003). Methadone and the anti-medication bias in addiction treatment. *Counselor, 4*(5), 58-63.

[167] Kreek, M. J., & Vocci, F. (2002). History and current status of opioid maintenance treatments. *Journal of Substance Abuse Treatment, 23*(2), 93-105. National Consensus Development Panel on Effective Medical Treatment of Opiate Addiction. (1998). Effective medical treatment of opiate addiction. *Journal of the American Medical Association, 280*(22), 1936-1943.

[168] Joseph, H., Stancliff, S., & Langrod, J. (2000). Methadone maintenance treatment: A review of historical and clinical issues. *Mount Sinai Journal of Medicine, 67*, 347-364. Kreek, M. J., & Vocci, F. (2002). History and current status of opioid maintenance treatments. *Journal of Substance Abuse Treatment, 23*(2), 93-105.

[169] Clausen, T., Ancherson, K., & Waal, H. (2008). Mortality prior to, during and after opioid maintenance treatment (OMT): A national prospective study. *Drug and Alcohol Dependence, 94*, 151-157. Corsi, K. F., Lehman, W. K. & Booth, R. E. (2009). The effect of methadone maintenance on positive outcomes for opiate injection drug users. *Journal of Substance Abuse Treatment, 37*, 120-126. Kreek, M. J., & Vocci, F. (2002). History and current status of opioid maintenance treatments. *Journal of Substance Abuse Treatment, 23*(2), 93-105. National Consensus Development Panel on Effective Medical Treatment of Opiate Addiction. (1998). Effective medical treatment of opiate addiction. *Journal of the American Medical Association, 280*(22), 1936-1943.

[170] Paulozzi, L. J., Budnitz, D. S., & Xi, Y. (2006). Increasing deaths from opioid analgesics in the United States. *Pharmacoepidemiology and Drug Safety, 15*(9), 618-27. Sims, S. A., Snow, L. A., & Porucznik, C. A. (2006). Surveillance of methadone-related adverse drug events using multiple public health data sources. *Journal of Biomedical Information, 40*(4), 382-389. Webster, L. R. (2005). Methadone-related deaths. *Journal of Opioid Management, 1*, 211- 217.

[171] Davoli, M., Bargagli. A. M., Perucci C. A. Schifano. P., Belleudi, V. Hickman, M., et al. (2007). Risk of fatal overdose during and after specialist drug treatment: The VEdeTTE study: A national multi-site prospective cohort study. *Addiction, 102*, 1954-1959. Joseph, H., Stancliff, S., & Langrod, J.

to end such treatment.[172] Patients choosing to taper (end methadone maintenance) should receive increased program support, including educational guidance on the tapering decision, relapse prevention, and recovery strengthening techniques; support for changes in diet and exercise; continued professional and peer-based support; close post-tapering monitoring; and if and when needed, early re-intervention and re-initiation of methadone maintenance.[173]

- After more than 40 years experience with methadone maintenance, primary addiction to methadone within the illicit drug culture occurs but still constitutes a rare phenomenon. Methadone has value in the illicit drug culture primarily to self-medicate opiate-dependent individuals who cannot procure heroin or other short-acting opioids or to self-medicate individuals who cannot get into a methadone maintenance program.[174]

Stigma as a Barrier to Recovery

- The stigma attached to addiction, treatment, and recovery injures those—the patient and family—directly affected by these experiences as well as the larger community.[175]
- The stigma attached to addiction perpetuates the very problem it is intended to discourage.
- There is substantial shame imbedded in the experience of addiction; people in need of addiction treatment should not be shamed for seeking the very resources that may be critical to their long-term recovery. Yet entry into methadone maintenance, because of the attached stigma, is often experienced as failure as a person—and even failure as an addict.[176]

An Addiction/Treatment/Recovery Campaign

The stigma attached specifically to methadone maintenance is imbedded at the community level within a larger body of negative attitudes toward illicit drug use, drug

---

(2000). Methadone maintenance treatment: A review of historical and clinical issues. *Mount Sinai Journal of Medicine*, *67*, 347-364.

[172] Cooper, J. R. (1992). Ineffective use of psychoactive drugs: Methadone is no exception. *Journal of the American Medical Association*, *267*(2), 281-282.

[173] Gold, M. L., Sorenson, J. L., McCanlies, N., Trier, M., & Dlugosch, G. (1988). Tapering from methadone maintenance: Attitudes of clients and staff. *Journal of Substance Abuse Treatment*, *5*, 37-44. Joseph, H., Stancliff, S., & Langrod, J. (2000). Methadone maintenance treatment: A review of historical and clinical issues. *Mount Sinai Journal of Medicine*, *67*, 347-364.

[174] Hunt, D. E., Litpon, D. S., Goldsmith, D. S., Strug, D. L., & Spunt, B. (1985). "It takes your heart": the image of methadone maintenance in the addict world and the effect on recruitment into treatment. *International Journal of the Addictions*, *20*(11-12), 1751-1171. Joseph, H., Stancliff, S., & Langrod, J. (2000). Methadone maintenance treatment: A review of historical and clinical issues. *Mount Sinai Journal of Medicine*, *67*, 347-364.

[175] Lavack, A. (2007). Using social marketing to de-stigmatize addictions: A review. *Addiction Research and Theory*, *15*(5), 479-492.

[176] Hunt, D. E., Litpon, D. S., Goldsmith, D. S., Strug, D. L., & Spunt, B. (1985). "It takes your heart": the image of methadone maintenance in the addict world and the effect on recruitment into treatment. *International Journal of the Addictions*, *20*(11-12), 1751-1171.

addiction, addiction treatment, and addiction recovery. The best stigma reduction campaign would aim at general attitudes toward addiction, treatment, and recovery, with a sub-campaign that specifically addresses stigma related to methadone and other medications.

Guiding Vision: Create a city and a world in which "people with a history of alcohol or drug problems, people in recovery, and people at risk for these problems are valued and treated with dignity, and where stigma, accompanying attitudes, discrimination, and other barriers to recovery are eliminated."[177]

Campaign Goals: To:

- Change public and professional views on methadone maintenance treatment from a practice that just "substitutes one drug/addiction for another" to a scientifically validated medical practice capable of saving and transforming lives and enhancing the quality of community life.[178]
- Change the view of methadone maintenance within the heroin using community from that of a passive process of "giving up" to an assertive lifestyle of active recovery.[179]
- Put a face and voice on medication-assisted recovery by conveying the stories of individuals and families in long-term addiction recovery and explaining the role MAT programs are playing in enhancing the health and safety of particular neighborhoods.
- Portray the contributions of people in medication-assisted recovery to their communities through their family support, educational, occupational, and community service activities.
- Encourage participation of MAT providers in local community activities to improve the public image of the methadone clinic/patient.

A Menu of Potential Strategies: Listed below is a menu of potential strategies that could be refined and implemented to achieve the goals outlined above. These potential strategies are offered as a starting point for local discussion.

Recovery Representation and Community Mobilization

1. Assure broad representation of people in medication-assisted recovery and professional representation from medication-assisted treatment providers within DBH/MRS policy advisory groups and technical work groups.

[177] Substance Abuse and Mental Health Services Administration (SAMHSA). (2002). *National Recovery Month helps reduce stigma*. Substance Abuse and Mental Health Services Administration. Retrieved June 17, 2009 from http://www.hazelden.org/web/public/ade20909.page.

[178] Joseph, H. (1995). *Medical methadone maintenance: The further concealment of a stigmatized condition*. Unpublished doctoral dissertation, City University of New York.

[179] Hunt, D. E., Litpon, D. S., Goldsmith, D. S., Strug, D. L., & Spunt, B. (1985). "It takes your heart": the image of methadone maintenance in the addict world and the effect on recruitment into treatment. *International Journal of the Addictions, 20*(11-12), 1751-1171.

2. Create an organizational structure to lead a campaign to define and promote methadone-assisted recovery initiation and recovery maintenance (sobriety, global health, and citizenship) as a morally honorable pathway of long-term recovery. Try to elevate the legitimacy and visibility of the campaign via local political sponsorship, e.g., a mayoral commission.

3. Encourage the inclusion of people in medication-assisted recovery in existing recovery support fellowships and develop/support recovery fellowships specifically for people in medication-assisted recovery, e.g., Methadone Anonymous.[180] (The encouragement and use of recovery support groups has significantly increased in MAT clinics in the United States, and the M.A.R.S. Project in New York City is receiving many requests for information about such support groups).[181]

4. Encourage the development of venues through which people in recovery (particularly current or former MAT patients) can perform acts of service to those seeking recovery as well as broader acts of community service.

5. Create a Mayor's Task Force to assist in the planned relocation of an existing treatment program or site location for new programs—proactive management of "Not in my backyard" (NIMBY) resistance by establishing principles on locating addiction treatment and recovery support resources. (This may be best addressed within a Task Force that explores siting issues for all health and social service programs.) Those principles identified earlier in this paper could serve as beginning points for discussion.

6. Explore ways to use patient writing, art, drama, music, dance, and videography as vehicles of education on medication-assisted treatment and recovery.

Community Education

1. Design, implement, and evaluate a public education campaign (similar to the drunk driving media campaigns of the 1980s and California's Methadone Saves Lives campaign) through a Mayor's task force that would include representatives from all major Philadelphia media outlets.

    --Put mainstream faces and voices on addiction, treatment, and recovery.
    --Include the faces of family members whose lives have been influenced by addiction treatment and recovery.

[180] Gilman, S. M., Galanter, M., & Dermatis, H. (2001). Methadone Anonymous: A 12-step program for methadone maintained heroin addicts. *Substance Abuse*, *22*(4), 247-256. Glickman, L. Galanter, M., Dermatis, H., & Dingle, S. (2006). Recovery and spiritual transformation among peer leaders of a modified Methadone Anonymous group. *Journal of Psychoactive Drugs*, *38*(4), 531-533. Obuchowsky, M., & Zweben, J.E. (1987). Bridging the gap: The methadone client in 12-Step programs. *Journal of Psychoactive Drugs*, *19*(3), 301-302.

[181] Ginter, W. (2009). Personal Communication (Interview), June 22, 2009.

--Imbed information on opioid addiction and medication-assisted recovery in mainstream healthcare outlets, e.g., medical clinics, pharmacies, health fairs, etc.

--Target those zip codes in the city of Philadelphia experiencing the most severe opioid dependence problems.

2. Establish interdisciplinary work groups who, as part of the Mayor's task force, will be charged with: developing/disseminating articles, pamphlets, and training materials on medication-assisted recovery aimed at reaching local lay and professional audiences; placing articles in media outlets; and immediately responding to inaccurate portrayals of medication-assisted treatment/recovery by the media.[182]

3. Develop and support a corps of people who, through interviews and speeches, can put a positive face and voice on medication-assisted recovery; recruit people in medication-assisted recovery for participation in Storytelling Training;[183] organize speaking teams of professionals and recovery advocates who can speak to local groups; and develop information packets to support the work of these teams.

4. Develop brief information packets and oral presentations that could be used by outreach workers to challenge "street mythologies" on methadone and other medications used in the treatment of addiction.

Professional Education

1. Create opportunities for people throughout the DBH/MRS system to be exposed to the faces and voices of people in long-term medication-assisted recovery.

2. Assure that all staff and volunteers working within addiction treatment are educated about the effectiveness of medication-assisted treatment, myths versus scientific findings on methadone maintenance, the importance of proper dosing in medication-assisted treatment, comparative outcomes of medication-assisted and drug-free treatment, and post-treatment outcomes for both medication-assisted and drug-free treatment.[184] Provide a centralized orientation on a monthly basis

[182] Jones, D. J. (2002). Methadone patient advocacy—letters to the media helps change attitudes. *Methadone Today*, *6*(9), 4. Joseph, H. (1995). *Medical methadone maintenance: The further concealment of a stigmatized condition*. Unpublished doctoral dissertation, City University of New York.

[183] Storytelling Training is a skills-based training for persons in recovery to assist them in developing their recovery stories and gaining confidence in refining and presenting those stories in public and professional forums.

[184] Kang, S-Y, Magura, S., Nwakese, P., & Demsky, S. (1997). Counselor attitudes in methadone maintenance. *Journal of Maintenance in the Addictions*, *1*(2), 41-58.

for all new staff entering the Philadelphia treatment system that includes the above information.[185]

3. Provide structured opportunities for staff exchanges between medication-assisted and drug-free treatment programs that include opportunities for formal and informal interactions with staff and patients. Assure admission policies/practices that allow people in medication-assisted treatment to receive collateral treatment and recovery support services from other addiction treatment and recovery support organizations, e.g. the integrated treatment of methadone patients for co-occurring alcohol dependence within alcoholism treatment programs.[186]

4. Assure that scientifically-grounded information on medication-assisted recovery is included in local addiction studies programs and within the in-service training programs of all funded addiction treatment programs.

5. Integrate information on medication-assisted addiction treatment into the curricula of Philadelphia-area medical schools and host an annual training for local physicians and psychiatrists on the use of medications in the treatment of addiction and best practices for pain management in patients being treated for addiction with methadone or buprenorphine. Provide information and resources of persons in medication-assisted recovery for use in psychology, social work, and allied health professional training programs.

6. Ensure that all managed care behavioral health organizations (MCBHOs) include an adequate number of panel providers with experience or training in the area of medication-assisted opioid treatment and pain management.

7. Host a training on medication-assisted treatment for key criminal justice personnel to police (via police academy), jail staff, attorneys, and judges—particularly criminal court, drug court, and family court judges. This is of paramount importance for pregnant and parenting women.[187]

8. Provide orientation to treatment and medication-assisted treatment to key city officials—both political leaders and department heads and supervisors.

Non-Stigmatizing, Recovery-Focused Language

---

[185] Recent studies--Abraham, A.J., Ducharme, L. & Roman, P. (2009). Counselor attitudes toward pharmacotherapies for alcohol dependence, *Journal of Studies of Alcohol and Drugs*, *70*, 628-635—suggest that counselors are quite receptive to pharmacological adjuncts in the treatment of alcohol dependence when give proper training on the use of such adjuncts. The extent to which these findings would extend to receptiveness to methadone with similar training is unclear.

[186] Kipnis, S. S., Herron, A., Perez, J., & Joseph, H. (2001). Integrating the methadone patient in the traditional addiction inpatient rehabilitation program—problems and solutions. *The Mount Sinai Journal of Medicine*, *68*(1), 28-32.

[187] Dr. Karol Kaltenbach, 2009, personal communication

1. Conduct an audit of the core concepts and language of addiction treatment and recovery, purging language that perpetuates myths, misunderstandings, and stigma and replacing that language with words and phrases that convey respect and hope for multiple pathways of long-term recovery.

2. Purge language that grew out of moral models of addiction, e.g., *dirty/clean*. Clarify the meaning of *drug free*, *abstinence*, *sobriety*, and *recovery*. Promote the Betty Ford Institute's (BFI) three component consensus definition of recovery: sobriety, global health, and citizenship, in which "formerly opioid-dependent individuals who take naltrexone, buprenorphine, or methadone as prescribed and are abstinent from alcohol and all other nonprescribed drugs would meet this definition of sobriety."[188]

3. Use the BFI recovery definition in order to achieve conceptual clarity and expose the abstinence versus methadone debate as a false dichotomy. The issue is not one of method but of mission: full recovery and a meaningful life in the community—by any means necessary. Using the BFI definition of recovery, there are individuals who are abstinent from all psychoactive drugs who do not meet the criteria for recovery and individuals maintained on methadone who do meet that criteria. Recovery is more than the elimination of alcohol and drugs from an otherwise unchanged life, and recovery is more than medication-facilitated metabolic stabilization. The BFI definition of recovery may help address stigma and discrimination at both professional and public levels.

4. Encourage members of Methadone Anonymous to advocate for a change in the name of the fellowship to something that does not equate methadone with heroin (e.g., Medication-Assisted Recovery Anonymous). Many other anonymous fellowships include in their name the drug or activity to be given up, e.g., Narcotics Anonymous, Cocaine Anonymous, Crystal Meth Anonymous, Gamblers Anonymous. This is not the explicit intent of Methadone Anonymous, but that is what is currently being conveyed via its name.[189]

5. Develop a policy statement on language and stigma for dissemination to all DBH/MRS-funded treatment programs.

6. Cease describing methadone maintenance in terms that suggest the equivalency of heroin and methadone, such as *substitution therapy* or *replacement therapy*, and use of the term *detoxification* to describe tapering (methadone is a medication, not a toxic substance). Replace such language with words and phrases that convey

[188] Betty Ford Institute Consensus Panel. (2007). What is recovery? A working definition from the Betty Ford Institute. *Journal of Substance Abuse Treatment, 33,* 221-228.

[189] NAMA (1995). On the name of Methadone Anonymous. National Alliance of Methadone Advocates, inc, Policy Statement # 6, May, 1994. Retrieved July 28, 2009 from http://www.methadone.org/namadocuments/ps06ma_name.html.

the link between methadone and long-term recovery, e.g., *medication-assisted treatment* and *medication-assisted recovery*.[190]

> *Dole and Nyswander would never prescribe a "substitute" for heroin. When Dole used the term "replacement therapy," he meant it in a physiological sense—that there were impairments in the central nervous system caused by the continuous use of opiates and that methadone could correct but not cure these impairments. He did not mean that methadone replaces heroin as a legal intoxicant. Methadone is a corrective medication, not a substitute for heroin*.[191]

Treatment Practices

1. Change institutional identities of medication-assisted treatment providers from "methadone clinics" to "addiction recovery centers"—as is currently being attempted in the State of New York. This would signal the institutional mission of recovery and relegate medication as one of many tools that can help achieve that goal. (Encourage patients to participate in a broad menu of professionally-directed and peer-based recovery support activities at the clinic or at a closely located recovery support center. Build strong cultures of recovery—a recovery haven, refuge, sanctuary—within or in proximity to existing clinics; expose the least stabilized patients to role models who have achieved successful stabilization and long-term recovery.)[192]

2. Explore regulatory and funding policy changes that would allow addiction treatment and recovery support services to be provided in less stigmatized sites, e.g., mainstream health delivery institutions, schools, churches, neighborhood centers, and other community service organizations.[193] Expand medical methadone maintenance—methadone provided to the most stabilized patients via a monthly visit to a private health practitioner.[194]

---

[190] Maremmani, I., & Pacini, M. (2006). Combating the stigma: Discarding the label "substitution treatment" in favour of "behavior-normalization treatment." *Heroin Addiction and Related Clinical Problems, 8*(4), 5-8. Joseph, H. (2009). Personal Communication (Interview), June 5, 2009. Ginter, W. (2009). Personal Communication (Interview), June 22, 2009.

[191] Joseph, H. (2009). Personal Communication (Interview), June 5, 2009.

[192] Until opioid treatment programs as a whole develop such vibrant cultures of recovery, they will be vulnerable to collective charge that they have done little more than transition their patients from an active life of hustling and getting high to a life of "methadone, wine and welfare". Prebble, E., & Miller. T. (1977). Methadone, wine and welfare. In R. S. Weppner (Ed.), *Street ethnography* (pp. 229-248), Beverly Hills: Sage Publications.

[193] Radcliffe, P., & Stevens, A. (2008). Are drug treatment services only for 'thieving junkie scumbags'? Drug users and the management of stigmatized identities. *Social Science and Medicine, 67*(7), 1065-1073.

[194] King, V. L., Burke, C., Stoller, K. B., Neufeld, K. J., Peirce, J., Kolodner, K., et al. (2008). Implementing methadone medical maintenance in community-based clinics: Disseminating evidence-based treatment. *Journal of Substance Abuse Treatment, 35*, 312-321. Marion, I.J. (2009). Personal communication with author, June 24, 2009

3. Prohibit the exclusion of persons on methadone or buprenorphine by any organization receiving DBH/MRS funding. This would add DBH/MRS authority to existing regulations prohibiting organizations receiving city/state/federal dollars to discriminate against MAT recipients. Any communication from DBH/MRS regarding such prohibition should also include the reminder that MAT recipients are protected under the American Disabilities Act.

4. Improve the public image of methadone clinics by upgrading the exterior and maintenance of the physical plant; improve the quality of the clinic visit experience by upgrading the quality and maintenance of the interior physical plant of methadone clinics. Increase use of "warm welcome" procedures, including casual dress by security personnel.

5. Facilitate (by DBH/MRS) greater integration between harm reduction (HR) projects (needle exchange programs), medication-assisted treatment, and medication-focused recovery advocacy, e.g., pilot programs that infuse clearer recovery options into HR, such as recovery-focused outreach workers available at needle exchange sites.

Local, State, and Federal Policy Advocacy

1. Encourage the development of medication-assisted recovery advocacy groups, e.g., local chapters of the National Alliance for Medication-Assisted Recovery (NAMA Recovery) and/or inclusion of people in medication-assisted recovery within existing or emerging recovery advocacy organizations.

2. Encourage (DBH/MRS) medication-assisted treatment providers to continue their advocacy activities through the Pennsylvania Association for the Treatment of Opioid Dependence (PATOD) and the American Association for the Treatment of Opioid Attendance (AATOD) related to federal, state, and local policy/regulatory/funding/research issues.

3. Seek alignment of policies, funding guidelines, and mechanism and regulatory guidelines to support recovery-focused treatment of chronic opioid dependence.

4. Encourage individuals and organizations to seek full legal redress in response to acts of discrimination related to medication-assisted treatment and recovery.

Evaluation

1. Establish a baseline of community attitudes and practices—among citizens, addiction treatment providers, allied health and human service providers, criminal justice personnel, child protection personnel, and members of recovery support fellowships—for use in evaluating this overall plan over time.

The implementation of some of these strategies will require a vanguard of people in methadone-assisted recovery to involve themselves in a larger recovery advocacy movement. Efforts must be made to encourage and support that vanguard.

Summary

The social stigma attached to addiction, addiction treatment, and addiction recovery exists at cultural, institutional, interpersonal, and intrapersonal levels.[195] This stigma is particularly intense for those with histories of heroin self-injection and who are in medication-assisted treatment. Efforts to lower stigma and discrimination for those in addiction treatment and recovery, particularly those in MAT, will need to operate at these same multiple levels. DBH/MRS is committed to mobilizing the citizens of Philadelphia to support policies and programs that support long-term personal and family recovery from alcohol and other drug problems and to provide services to youth aimed at breaking intergenerational cycles of alcohol and other drug problem transmission in individuals, families, and neighborhoods. Toward that end, DBH/MRS will engage multiple stakeholders in formulating strategies to reduce social stigma related to addiction treatment and recovery and to take special action to reduce the stigma related to medication-assisted treatment and recovery. Through this process, we will use one guiding principle: *There are multiple pathways of long-term addiction recovery, and all are cause for celebration.*

Acknowledgements: The author would like to acknowledge the contributions of Herman Joseph, PhD, for his landmark dissertation on methadone-related stigma and for the insights he provided in interviews with the author. Discussions with Walter Ginter, Roland Lamb, Dr. J. Bryce McLaulin, Dr. Charles Morgan, Lisa Torres, Joycelyn Woods, and the Philadelphia Medication Assisted Treatment Providers also contributed to the development of this document. The following individuals provided helpful feedback and suggestions on an early draft of this paper: Dr. David Best, Sadé Ali, John T. Carroll, Dr. Arthur Evans. Jr., Walter Ginter, Mike Flaherty, Tyrone Frazier, Robert Holmes, Dr. Karol Kaltenbach, Gregg Kelinson, Roland Lamb, Marvin Levine, Ira Marion, Denise McCulley, Terence McSherry, Paul Poplawski, Dr. Steve Weinstein, Pam Woll, and Joycelyn Woods. A portion of the literature review presented in this document was published as: White, W., Evans, A., & Lamb, R. (in press). Stigma: The addictions professional as activist. *Counselor*.

[195] Woll, P. (2005*). Healing the stigma of addiction: A guide for treatment professionals.* Chicago, IL: Great Lakes Addiction Technology Transfer Center.