FROM THE FIELD

Healing the moral wounds: Distrust of medication in the recovery community

By William Stauffer

"The only totally safe drug is a new drug" — Anonymous Recovering Pharmacist

A few years back there was a flurry of excitement over the vast medical benefits of cannabis. In my home state of Pennsylvania, it included cannabis for opioid use disorder, which is now an allowable use across the commonwealth. I was reminded of that when I saw the recent article in *The Journal of the American Medical Association (*Therapeutic Use of Cannabis and Cannabinoids: A Review). The paper notes that "evidence is insufficient for the use of cannabis or cannabinoids for most medical indications," and that roughly one-third of persons who use the drug become addicted. Is there any doubt that harm is occurring? It is just the latest in a long trend of drugs in which profits are capitalized and consequences are quietly socialized. That dynamic of overpromised benefit and hidden harm is also probably the most significant reason that distrust for medications runs so deep in the recovery community. Yet it is easier to paint that reticence as ignorance, which remains the dominant narrative. Real progress would require an accounting for overhyped drugs, increased transparency, and a deep commitment to informed consent. Such a commitment would be a step toward reestablishing trust in our communities.

This is a topic I have written about before. Last year, in Once Bitten Twice Shy - the Recovery Community and the False Promise of Harmless Drugs, I noted how diazepam (Valium) was the miracle drug introduced in 1963. Initial reviews into the addictive potential of benzodiazepines quickly dismissed any concerns. Patients were irresponsibly prescribed higher doses for longer durations than necessary. By the 1990s, the scope of benzodiazepine addiction had been expanded by not only dosage escalation, but even by long-term low-level administration. Earlier in our history, cocaine was billed as a treatment for alcoholism and morphine addiction. Time and evidence now show us that while these drugs clearly have medicinal value in medical care, they also carry a great deal of risk. People got hurt, and some died.

In the U.S., drug marketing has long portrayed addictive and harmful drugs as harmless, nonaddictive and broadly beneficial. It is a core industry marketing strategy. Consider the tobacco industry executives testifying under oath in front of Congress in 1994 and lying through their teeth. They even marketed cigarettes as a safe health aid to reduce stress. Recreational and medicinal drugs are consistently marketed as beneficial and nonadditive in ways that are proven wrong over time. It has long been the case that the promises of a drugs' benefits fail to match the real-world experiences of persons at risk for addiction. Our systems then characterize recovering people as ignorant and misinformed, instead of openly acknowledging and addressing the harm that has occurred. It is a formidable barrier to forward progress.

Understanding these dynamics is critical for changing how the recovery community views medications that are safe and effective when taken as prescribed and combined with proper treatment and support. It is a subject that has received scant discussion at the policy level but should get significant focus.

The Example of Gabapentin

The drug that perhaps for me highlights this distrust most significantly in our era is gabapentin (Neurontin). It was approved by the FDA for use by Parke-Davis in 2000 as an adjunctive therapy for epileptic seizures. As highlighted in the *AMA Journal of Ethics*, Neurontin and Off-Label Marketing (2006), Parke-Davis illegally marketed it for more than a dozen off-label uses, including neuropathic pain. The company hired ghostwriters to talk about how effective it was to drum up sales. As this *STAT* news piece New on the streets: Gabapentin, a drug for nerve pain, and a new target of misuse (2017) notes, one of the claims was that it was nonaddictive. I suppose Parke-Davis made a lot of money, just as Purdue Pharma did with its extended-release oxycodone (OxyContin).

Over the summer, I ran across the *Pharmacy Times article* Gabapentin Use Linked to Increased Dementia Risk. It focused on long-term use of the drug in 52,000 patients with chronic back pain and found that those prescribed gabapentin six or more times had a 29% increased risk of dementia and an 85% increased risk of mild cognitive impairment compared with those who never received the drug. It found an even stronger association in patients ages 35 to 64, with more than double the risk of dementia and mild cognitive impairment. Among patients with 12 or more prescriptions, the dementia risk rose to 40% higher than those prescribed gabapentin three to 11 times.

I found it disturbing, as I recall that most of the patients I treated for substance use conditions starting in the mid-1990s were on this drug — easily more than half of our patients. We told them what we were told: It

Continues on page 6

Continued from page 5

was nonaddictive and safe to use. More than a few died. When I reflect across my career in the field of substance use treatment and recovery, that message about safety and harmlessness was often stated, but later found to be inaccurate. It is a huge reason why many people have deep distrust of pharmacological treatment. Medications for addictions have saved lives — broader acceptance of medication would almost certainly save more lives. But it is also true that if we want medications to be more widely embraced in the recovery community, we have to talk about the long-term dynamic of misrepresenting risks and adopt more nuanced and transparent processes that consider both risks and benefits in an individualized manner.

This misrepresentation of gabapentin, for which one company legally settled for $430 million and pled guilty to resolve civil and criminal charges, is burned into my memory. For me, it's an experience of moral wounding. We now know that gabapentin was being used recreationally on the street, and in this paper it was directly involved in the death of users in just under half of the cases reviewed. Gabapentin: Abuse, Dependence, and Withdrawal (2016) found addictive use of the drug, and all the cases of addiction were in patients who had a previous history of alcohol, cocaine, or opioid abuse, a group widely prescribed the drug. This is the marketing playbook for addictive drugs. We see it time and time again, yet we fail to address the problem in our systems through increased transparency, informed consent and open dialogue that includes positive regard for people who express valid concerns.

Do No Harm

The Hippocratic Oath asserts that we should do no harm. It is also true that there are no gold standard treatments with all upsides and no risks or downsides, just as the quote at the top of this article suggests. New medications have long been marketed in ways that hide or downplay their risks. Harm occurs and the communities end up distrusting drug interventions. To add insult to injury, the reasons behind the distrust for these interventions over the course of our history are not discussed, and the dominant narrative instead paints the community as ignorant. This is a rough equivalent to the old-school addiction counseling strategy of yelling at patients, telling them they are wrong, and ignoring their views while demanding compliance.

GLP-1 Drugs as an Emerging Tool to Support Addiction Recovery

GLP-1 drugs modulate compulsive behavior and can significantly decrease cravings and reduce relapse risks, which may help many people. Some addiction treatment programs are giving these drugs to nearly all of their patients. Are we considering all the risks? Appetite suppression is associated with these medications. Is there an increased risk for malnourishment and associated conditions for SUD patients on GLP-1 drugs? This may be particularly true for those with long-term alcohol dependence, but time will tell. As noted by Stanford researcher and author of *Dopamine Nation, Anna Lembke, MD,* "while GLP-1s may prove effective for some people, others may not respond at all. Some individuals will be able to stop the medication and continue their recovery, while others will relapse."

Even effective tools are not a panacea, but the truth of our history is that we often act like they are in gold rush fashion. A drug may be beneficial, but there are hosts of things, including trauma resolution and the development of recovery capital, you cannot get from a pill or a shot. We should be concerned about their indiscriminate use. We should do no harm. We stand to create additional distrust unless we move forward with transparency, open dialogue and caution.

Moving Forward

I suspect that in the coming decade, we will likely see the emergence of new medications that can be important lifesaving tools and benefit people in their recovery. They will be most effectively deployed if done with great forethought and efforts to repair the broken trust within the recovery community that has occurred over recent decades. This should include acknowledging historic harms, increased transparency, informed consent, and conversations grounded in positive regard — not derision — for people's concerns. It would support the fact that there is no single gold standard treatment, and that all approaches have risks/benefits.

There is a parallel here. In recent years, an emphasis has emerged on individualized care that moves beyond pathology, treats everyone with positive regard, and views all people as having inherent strengths. We should approach this issue from the very same mindset. Concern about drugs in the recovery community is often experientially informed by harms we have experienced historically. That is a truth that must be acknowledged and addressed to move forward. Starting there could very well lead to the repair of deep moral woundings across our communities. This would be a critical step forward to repair trust and set the stage for effective medications to gain broad acceptance in the recovery community.

Sources

- Approved "serious medical conditions" for Medical Marijuana. (2022). Pa.gov. https://www.pa.gov/agencies/health/programs/medical-marijuana/medical-marijuana-patients
- Big Tobacco and the Seven Dwarfs -- Swearing Under Oath to Lie. (2014, July). YouTube. https://youtu.be/MJBaBJawnSY
- Conley, M. (2025). Five things to know about GLP-1s and addiction. https://med.stanford.edu/news/insights/2025/04/ozempic-addiction-glp-1s-mounjaro-lembke.html
- Drug Industry Documents Library. (2024). Ucsf.edu. https://www.industrydocuments.ucsf.edu/drug/collections/neurontin-litigation-documents/
- Hsu M, Shah A, Jordan A, Gold MS, Hill KP. Therapeutic Use of Cannabis and Cannabinoids: A Review. JAMA. 2025 Nov 26. doi:

10.1001/jama.2025.19433. Epub ahead of print. PMID: 41296368. https://pubmed.ncbi.nlm.nih.gov/41296368/
- Krautkramer, C. J. (2006). Neurontin and Off-Label Marketing. AMA Journal of Ethics, 8(6), 397–402. https://doi.org/10.1001/virtualmentor.2006.8.6.hlaw1-0606.
- Lawrence, L. (2009, March 10). Cigarettes were once "physician" tested, approved. Www.healio.com. https://www.healio.com/news/hematology-oncology/20120325/cigarettes-were-once-physician-tested-approved
- Mersfelder TL, Nichols WH. Gabapentin: Abuse, Dependence, and Withdrawal. Ann Pharmacother. 2016 Mar;50(3):229-33. doi: 10.1177/1060028015620800. Epub 2015 Dec 31. PMID: 26721643. https://pubmed.ncbi.nlm.nih.gov/26721643/
- Rodriguez, C. H. (2017, July 6). New on the streets: Gabapentin, a drug for nerve pain, and a new target of misuse. Kaiser Health News STAT. https://www.statnews.com/2017/07/06/gabapentin-becomes-target-of-opioid-abuse/
- Stauffer, W. (2024, October 23). Once Bitten Twice Shy – the Recovery Community and the False Promise of Harmless Drugs. Recovery Review. https://recoveryreview.blog/2024/10/23/once-bitten-twice-shy-the-recovery-community-and-the-false-promise-of-harmless-drugs/
- Stauffer, W. (2021, May 27). Healing Moral Injury in our SUD Community & Care Service System. https://recoveryreview.blog/2021/05/27/healing-moral-injury-in-our-sud-community-care-service-system/
- Tharp AM, Hobron K, Wright T. (2019). Gabapentin-related Deaths: Patterns of Abuse and Postmortem Levels. J Forensic Sci. Jul;64(4):1105-1111. doi: 10.1111/1556-4029.14021. Epub 2019 Feb 7. PMID: 30731020. https://pubmed.ncbi.nlm.nih.gov/30731020/
- Valletti, D. (2025, July 17). Gabapentin Use Linked to Increased Dementia Risk in Patients With Chronic Back Pain. Pharmacy Times. https://www.pharmacytimes.com/view/gabapentin-use-linked-to-increased-dementia-risk-in-chronic-back-pain-patients
- White, W.L. & Webber, R. (2006). La Historia del Tratamiento Farmacológico para los Desórdenes del Uso de la Sustancia (The History of Pharmacological Treatment for Substance Use Disorders). In: F. López-Muñoz, F. & Alamo, C. (Eds.), La Historia de la Psicofarmacología, Madrid: Editorial Médica Panamericana, pp. 887-898. https://deriu82xba14l.cloudfront.net/file/54/2006-History-of-Pharmacological-Treatments.pdf

William (Bill) Stauffer is executive director of PRO-A in Harrisburg, Pennsylvania.

Methadone from page 1

incremental life-years, fatal overdose, and all-cause mortality. Buprenorphine's unfavorable results were slightly better when the researchers looked only at high-dose users of the drug.

British Columbia offers an ideal setting for a comparative study of the two medications because both treatments are available in office-based settings there. Study authors, led by Benjamin Enns, a health economist at the Centre for Advancing Health Outcomes in Vancouver, wrote: "While individual patients may have different likelihoods of benefiting from one treatment or another, individuals should ultimately be empowered to choose their treatment via shared decision-making with their clinician."

Details of study

The investigators conducted their analysis using data from the period between January 1, 2010 and March 17, 2020, employing a decision analytical model that accounts for the cumulative time individuals spent in and out of treatment, and also for changes in the risk of drug overdose events over time (such as a reduction in risk when take-home naloxone became more widely available in British Columbia as of 2016). Also as part of their analysis, the researchers estimated the prevalence of fentanyl in the community over the course of the study period.

The research team compared benefits and harms associated with buprenorphine/naloxone and methadone in the treatment of OUD. Treatment initiators could switch medications within episodes, although this occurred in less than 5% of cases.

The main outcomes the investigators examined were the cumulative difference in incremental life-years between buprenorphine and methadone treatment, as well as differences in fatal overdoses and all-cause deaths. A sensitivity analysis excluded those treatment episodes with suboptimal dosing, treatment switches or tapers. The researchers also looked at results separately for first-time treatment initiators and individuals who were experienced with medication treatment for OUD.

The study comprised just over 40,000 individuals with a median age of 33; two-thirds of the group were men. On average, time in treatment was considerably shorter for patients receiving exclusively buprenorphine/naloxone than for those receiving exclusively methadone.

The investigators estimated that over the 10-year period, a policy of exclusively buprenorphine/naloxone would have a difference of -1,602 life-years compared with methadone, with net health losses for buprenorphine in all of the analytical model's simulations. The investigators estimated an additional 221 fatal overdoses and 303 all-cause deaths with buprenorphine/naloxone compared with methadone.

"Our findings did not support recommendations of buprenorphine/naloxone as first-line treatment over methadone," the study's authors wrote. "In the most recent guideline update published in 2023, [British Columbia] removed 'first-line' terminology, although in the absence of patient preference or individual-level contraindicating factors, [British Columbia] suggested that buprenorphine/naloxone may be favored vs. other treatment options due to its safety profile."

Just over a year after officials had declared an overdose-driven public health emergency in British Columbia, clinical guidelines were written in 2017 to change the preferred first-line treatment for OUD from methadone to buprenorphine/naloxone. The 2023 update removed the first-line reference.

Continues on page 8