Naturally Non-Compliant:

Mandatory Counseling for Methadone Clients in Arizona, 2021[1]

by

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[1] The term Naturally Non-compliant was developed by the North Carolina Survivor's Union (NCSU) Methadone Reform Team https://ncurbansurvivorunion.org

ABSTRACT

The US is unique in dispensing methadone for opioid dependent people only via opioid treatment programs (OTP), or “methadone clinics”. These OTP are governed by federal regulations which outline rules, such as mandatory counseling. Mandatory counseling in this context is a tool to determine which individuals may gain access to a sanctuary for safer drug use and who may not.

This dissertation is an analysis of data previously collected from a larger parent study, but which had remained unexamined until now. Utilizing a qualitative thematic approach to data analysis, this study seeks to answer two central research objectives. Firstly, what does the mandatory counseling consist of and what is the professional background of the counselors. When participant responses were analyzed, it was found that clients at OTP were provided scarce details regarding the professional background of their counselors and which, if any, therapeutic modality is offered. Clients have very little control over their treatment plans or counseling, and the role of the counselor is focused more directly on surveillance than therapeutic goals.

Secondly, this analysis explores client beliefs about mandatory counseling. While most participants generally held positive views about counseling independent of the mandate, responses bifurcated into two distinct groups. Participants were very supportive of the mandatory counseling, or they expressed a desire for more autonomy and freedom of choice regarding counseling. The findings of this dissertation indicate the need for comprehensive reform of methadone dispensation in the United States.

key terms: methadone, drug treatment, counseling, ableism, health equity, health care, gender, racial bias

DEDICATION

This dissertation is dedicated to illicit drug users and all the clients at methadone clinics who manage to survive and thrive despite the efforts of prohibition and these carceral opioid treatment programs to minimize our humanity and deny our bodily autonomy. May we see a day where we can all access the resources we need to succeed and live in the way we choose and work towards a future with more grace and compassion and less suffering and punishment.

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CHAPTER ONE

IT'S SUPPOSED TO HURT:

METHADONE CLINICS AND CONDITIONAL SAFETY

> Those who do not recover are people who cannot or will not completely give themselves to this simple program, usually men and women who are constitutionally incapable of being honest with themselves. There are such unfortunates. (Wilson, 1939, p. 58)

Make Live and Let Die: This is a matter of life and death

For years, drug overdose has been painted as a white people problem (Friedman & Hansen, p. 66). But drug poisonings and overdose are not only a "white problem", nor is it limited to any single community. Overdose and issues associated with illicit drug use impact every community, however the impacts are not felt the same by everyone. Illicit drug use and overdose have been concentrated predominantly in communities of Color that are suffering from high unemployment, poverty, and lack of housing (Dasgupta & Beletsky, 2018). Access to support for individuals who are struggling with their relationship to drugs is not equally accessible in the United States. Resources such as low-barrier drug treatments, like suboxone, have been concentrated in white communities, while highly regulated treatments like methadone are concentrated in poor urban communities (Netherland & Hansen, 2017). The overdose crisis is a racial justice issue that intersects with gender and economic inequalities. If we care about justice, we should care about keeping people who use drugs alive.

Everyday 130 people across the United States, including five people in Arizona, die from drug poisoning (*Opioid Epidemic | Maricopa County Attorney's Office, AZ*,

n.d.). In 2020, older Black men died from drug poisoning at a rate nearly seven times higher than older white men, and "Black individuals had the largest percentage increase in overdose mortality (48.8%) compared with white individuals (26.3%)" (Friedman & Hansen, 2022). This is a reversal from trends seen a decade ago in 2010, when overdose rates for white people was double that of Black people. Since 2020, Native Americans have had the highest rate of deadly overdose of any racial and ethnic group, with the rate of overdose mortality 30.8% higher than for white individuals (Friedman & Hansen, 2022). Communities of Color have seen an unprecedented and devastating rise in deadly drug poisoning in a very short period.

In addition to the risk of mortality posed by drug poisoning, people who inject drugs have mortality rates 13 times higher than other drug users (Degenhardt, 2006). People who use drugs are experiencing a lot of death. Access to methadone is one of the best tools available right now to decrease all-cause mortality for opioid dependent people (Sordo et al., 2017). In addition to all the reasons people deserve to be treated with respect and in a way that retains their dignity and agency, people deserve to remain alive. Improving access to evidence-based resources like methadone, and helping individuals maintain that access, is necessary to keep people alive.

The Pain is Part of the Treatment: Punishment and Drug Treatment

Sleeping outside is not fun. It is uncomfortable, scary, and when it comes to sleeping, we are not likely to get much rest nor sleep. Though I spent time without a home, sleeping in cars and sometimes women and children's shelters with my mom as a kid (which were much worse places to try to sleep than parking lots or cars), it's not something I've had to do much as an adult. The last time I had to sleep outside, it must

have been sometime around 2007, or was it 2008? I'm not certain, time is a slippery thing, and it does what it does: pass. One thing I do remember clearly about this last time I slept outside was how cold it was that night, so I can confirm that this night was during a winter month here in Phoenix, Arizona. Winter in a place like Phoenix isn't considered harsh by the standards of people from many other places in the world. But for me, I had large open wounds on both legs – I still do – and they really hurt when I get chilled or cold. When my legs get cold, the areas that don't have skin anymore feel like they get goosebumps even though this isn't possible since there is no tissue or skin there to get goosebumps. It feels as if all the nerves in my open wounds become activated in the cold.

My leg pain is something that is always with me now. It is like an annoying white noise that I can tune out better on some days than others. It feels like the missing parts of my legs still exist somewhere, maybe in a parallel universe, where they are still subject to getting goosebumps and feeling pain. The feeling reminds me of when you've accidentally touched something burning hot and your instinct is to recoil away from the thing that is burning you as fast as possible. Only in my case, I can't pull away from pain; it is just something I must accept. There have been several times over the past fifteen-plus years when I have reached out for help. Not just for my leg wounds, but I'm also dependent on opioids, which is how I ended up sleeping outside.

I slept in the parking lot of a methadone clinic[2] because I wanted to be one of the first people in line when the clinic opened at 4:00 am. Being one of the first in line when the doors open was supposed to increase my chance to be one of the few people admitted

[2] Methadone clinics are also referred to as Opioid Treatment Programs (OTP). These terms will be used interchangeably throughout this paper.

into one of the rare methadone clinics that accepted direct payment at the time. I had health insurance, but I was concerned about the possibility of my employer finding out I was on methadone and learning about my heroin use. I also had no idea if my insurance would even be accepted, or if my insurance would approve methadone treatment. So, I deliberately sought out a clinic that I could pay the $65 per week out of my own pocket and avoid all the concern and shame I had about needing to get on methadone in the first place.

The way things worked back then, methadone clinics would only do intake, meaning they would only accept new clients, on one or two days a week. To potentially be one of these newly admitted clients, you had to be there, at the clinic when the doors opened at 4:00 am. I wasn't the only one sleeping outside that night, and one of the other women sleeping outside in the clinic parking lot told me, "We better hope no pregnant women show up, because if they do, there's usually only 1-3 open spots every week for admission, and they always privilege pregnant women. They get first dibs at any spots in treatment!" I'm not sure if what she told me was completely accurate, but I remember feeling guilty at how relieved I was later that night when the only other person waiting for intake was a man who showed up in the parking lot around 2:00 am.

Clinic staff started arriving for their shift at around 3:30 am. By that time, there was a total of three of us who had spent the night there. One woman had brought a blanket, so she was nice enough to let me squeeze in under her smelly blanket, waiting up together against the wall, away from the wind. The first clinic staff to arrive was a young white woman, who looked over at us as she got out of her car and rushed towards the clinic building – looking back at us repeatedly, as if she feared us. As staff arrived and

passed us to get into the building, no one spoke to us. Along with the sense of their fear of us, as they rushed in and we could hear the door lock behind them, I got the feeling they resented our presence there. By 4:00 am, other people who were current methadone clients had started to form a line behind us, up against the clinic wall as we waited.

As it got closer to the time for the clinic to open, an older guy in line complained, "They better open on time this morning. I got to be at work by 5:00 am today!" The female staff member who had arrived before everyone else showed up at around 4:10 am. She unlocked the door and we all filed in. I told the lady at the front desk I was there for intake, and I was silently provided a clip board with what appeared to be almost 30 pages to fill out. Although I had brought friends to methadone clinics and waited outside for them, I had never been inside one before. I watched as the other people in line were slowly called up to the counter to take their methadone in front of the person behind the plexiglass as she shoved little cups of red liquid at them. I started filling out the paperwork as people filed past me on their way up to the counter to get their little red cup. One of the clinic staff, maybe a nurse (there was no way to tell who or what function any of the staff had), came to the waiting room, told me I was taking too long to fill out the paperwork, and asked me if I had any other health issues other than opioid dependency. I had been struggling with my leg wounds for about a year at that time, and I naively thought that this is a place that helps people who inject drugs, maybe if I am open and honest with them about some of the health issues I am struggling with, they may even be able to help me with my leg wounds. So, I told her about my wounds and that I was worried how they just didn't seem to be healing at all.

The woman asked me to show her my legs. I felt kind of embarrassed to show them to her, especially in the waiting room where everyone, even the people who I'd been in line with all night could see. But I really wanted help, so I pulled up my pant legs and showed her my wounds. Immediately, she backed up, her eyes wide with obvious disgust. She didn't say anything as she backed away, out of the waiting room. The lady I had spent the night under the blanket with told me how "She had a cousin who had a leg like that, and they cut it right off. He is in a wheelchair now."

After waiting for about two hours, someone called my name and said it was my turn to see the doctor. I went back into a room with two chairs; it didn't look like any medical exam room I had ever been in before. I waited in the room for another thirty minutes or so, my anxiety getting higher as I waited. Finally, a doctor walked in. He didn't introduce himself at all, nor did he sit down. He leaned against the wall on the opposite side of the room from me and said he heard I had some leg wounds and told me to show him "how much damage I'd done to myself." Again, I rolled up my pant legs and reveal the wounds. His reaction was less dramatic than the other staff woman. He wrote some comments on a clip board and walked out without saying anything.

After sitting alone in that room for another hour, the door opened, and another staff member asked me to follow her. She brought me to what appeared to be the doctor's personal office. His degrees hung on the wall behind him, and he was sitting behind a large, imposing desk, in an ugly fake leather chair. I sat down on the small plastic chair in front of his desk. He immediately tells me that my wounds are going to kill me, and that I am going to die if I don't seek help. He says that in addition to helping reduce opioid detox symptoms, methadone helps relieve physical pain, but, because of my leg wounds,

he says, "You *need* to be in pain so that you will seek help. You need to be in pain so that you will humble yourself, come to terms with your own bad decisions, and ask for help." I was really confused because I thought that the methadone clinic was a place that offered help to people like me, people who were struggling with their opioid dependency. If sleeping outside in their cold parking lot all night, filling out pages of paperwork that asked intrusive questions, showing them (and every client in the waiting room) my leg wounds, the most painful thing in my life, and waiting for hours in their crowded clinic was not considered "asking for help," then I didn't know what was.

I could feel my blood pressure rise. My leg wounds often bleed when I get upset, and I could feel blood starting to ooze from my right leg into my shoe. I wanted to tell him that I deserved to be helped as much as anyone else there that day, and that I was already in so much pain. I didn't understand how much more pain I could be in, and I wanted to demand an explanation from him about what "help" he thought I hadn't sought. I had been trying to get wound care, but this was before Obamacare[3] and even since this healthcare reform was enacted, accessing medical care in the U.S. still isn't exactly as easy as going to your local Wal-Mart. I wish this doctor knew how I had recently sought help at the emergency room because my feet had swelled so much that I could not put my steel toed boots on to go to my twelve-hour shift at work. But I was told that because I did not have any infection in my blood, I was not in mortal danger and my

[3] The Patient Protection and Affordable Care Act, or Affordable Care Act (ACA), is a healthcare reform law enacted in March 2010. This legislation changed several facets of healthcare in the United States, but what I am primarily referencing here is that the ACA removed the restrictions around pre-existing conditions. Prior to the passage of the ACA, insurers could deny you coverage for health conditions you had previously before getting newer coverage.

chronic health issues should be taken care of outside the emergency department.[4] I wanted to explain to him what wet-to-dry wound dressings[5] are and how many times I had let nurses rip dry dressings off my wounds like a waxing from hell. Instead, I thanked him for his time and hobbled out of his office. As I limped my way out of the waiting room, I could see the employee who had looked so scared of us that morning, sitting behind the front desk staring at me. As I opened the door to leave the clinic, the tears I had been holding back were ready to start flowing, and I hear the front desk lady say to my back, "You'll be back when you're ready…when you are ready to make good decisions and to change your life around."

After that awful first experience trying to get on methadone, I'm not even sure where I found the motivation and strength to try again, but despite similar messages I was receiving from nearly every contact I had with medical staff of any kind, that I was not deserving of any care or support, I still believed that I was deserving and that I should try again. I like to think of myself as a fast learner. My next attempt getting into a methadone clinic, I lied on the forms, and when asked about any pre-existing health issues, I told clinic staff I was fine physically. I was just opioid dependent and wanted to be on methadone. Lying worked. This was my first lesson in the culture of cruelty at the methadone clinics. As a client, we must hide any physical or mental weakness. I learned

[4] The Emergency Treatment and Labor Act, passed in 1986 guarantees that hospitals and emergency departments that are equipped to handle emergent medical needs must provide emergency care that stabilizes an individual regardless of a patient's ability to pay for it (*Emergency Medical Treatment & Labor Act (EMTALA)* | CMS, 2022). However, if you do not have a life-threatening condition, such as my chronic condition with my leg wounds, emergency rooms are not legally required to provide medical care.
[5] Wet to dry wound dressings are utilized by applying wet bandages that have been soaked in water or a cleansing solution such as saline to a wound or wounds, they are allowed to dry, the damaged and dead tissue will stick to the bandages and will be ripped off when the bandages are removed.

that the clinic is a predatory space, and any vulnerability would leave me open to harm and exploitation by clinic staff.

Regardless of the very low quality of care I received at the clinic where I was finally admitted into a methadone program, the one positive thing they did accomplish was they raised my dose rather quickly. The Substance Abuse and Mental Health Services Administration requires clinics to start clients at methadone dosages of no higher than 30 mg for their first day (Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Use Disorder, 2009). After that, my clinic raised my dose 10 mg every week until I reached a high enough dose (256 mg/per day) that I was able to completely switch from heroin to methadone without any detox or withdrawal symptoms. Simply put, having a safe, legal, and affordable supply of accessible opioids changed my life in many positive ways. Even though daily attendance at the clinic was incredibly burdensome, I was no longer at risk of being arrested for my drug use and having transparency into the quality and concentration of the drugs I was using allowed me to lead a much more stable life.

When we buy heroin from illicit markets, there is no transparency into the quality or how strong the drugs are.[6] This makes it incredibly challenging to ensure an ideal dosage for avoiding being sick and in withdrawal, and yet not be completely incapacitated and intoxicated. The potency of heroin bought on the street can vary dramatically, and even if when using the same amount by weight, it could be so weak that

[6] In Arizona, it is a felony to even attempt to characterize or test drugs like heroin to ascertain they are the drugs you intend to use (and not potentially poisoned or contaminated with synthetic opioids like nitazenes or fentanyl analogs), or to understand the concentration to more appropriately dose the amounts you will use every day (*13-3415 - Possession, Manufacture, Delivery and Advertisement of Drug Paraphernalia; Classification; Civil Forfeiture; Factors; Definitions*, n.d.).

you could be sick within hours after use, or it could be so potent that you could overdose and die. Without insight into the quality and concentration of the drugs you buy, it is also nearly impossible to control and taper the amount of heroin you use if you desire to control or even choose to reduce your heroin use. Methadone provided at the methadone clinic allows you to have strict control over exactly how much opioids you are using every day and to taper the amount slowly over time. Especially with the ongoing drug contamination issues permeating illicit markets right now, with illicitly manufactured fentanyl, xylazine,[7] and other synthetic opioids, access to a safer supply of drugs can greatly reduce risk of overdose. These are just a few examples of how legal drugs are made much safer merely by virtue of their legality, and how illegal drugs are deliberately made more dangerous because they are illegal.

Despite the intrusive and demanding rules of the clinic, such as daily observed dosing,[8] methadone also provided a reprieve from the risk of criminalization and the financial demands of an illicit opioid habit. A heroin habit was costing me between $60-120 every day, whereas the clinic was charging me only $65 per week. So financially, it seemed like a good trade off. But being a client at a methadone clinic wasn't exactly easy. Because I worked an adjusted graveyard shift full-time, my work schedule was 3:00 am to 3:00 pm and this made daily attendance very challenging for me. The clinic opened at 4:00 am and closed at 11:30 am. So, I would drive across town from my workplace to

[7] Xylazine (also known as Tranq) is a central nervous system depressant often used in veterinary procedures as a tranquilizer. It causes sleepiness, slow heart rate and breathing, and has been associated with higher prevalence of skin and soft tissue infections in injection drug users (IDU).
[8] Daily observed dosing means that a client at a methadone clinic must come in every single day to take their methadone in front of a clinic staff member, usually a nurse.

the clinic on my lunch hour, sometimes hitting upwards of 80 mph on the city streets to make it back in time from my one-hour lunch break.

Additionally, I could never be certain when the clinic would decide to keep me there for extra time for random demands such as counseling or group therapy. The counseling consisted of being pulled into the accountant's office, where she would check my account at the clinic to ensure that I was paid in full for all my charges. Even though I only spent about five minutes in the accountant's office for my counseling, this would generally add an additional hour onto my time spent at the clinic, just because of the amount of time I had to spend waiting to be called back into her office. I was told that the reason my counselor was the accountant was because I paid cash, out of pocket for my methadone. During the only group counseling session I attended, they made us glue popsicle sticks together to create little boxes or popsicle stick people.

Fortunately, I somehow managed to slip through the cracks of the clinic's demand for me to participate in group counseling. I believe the reason I was not forced to attend more of the counseling interactions is because I had no positive urine drug screens (UDS) after the first year. Regardless, they stopped demanding I participate in some of the more performative aspects of their "treatment" program after the first year. Aside from the methadone itself, it would feel disingenuous for me to refer to what I have received over the years from the clinic as "treatment" at all. None of the services I have ever received, such as building poopsicle stick people or meeting with the accountant, were appropriately medical or evidence-based for me to be able to honestly refer to them as treatment. Therefore, I refer to myself and others on methadone as clients. Based on my

experience, this term is more appropriate to describe the relationship between people on methadone and the methadone clinic.

In the roughly fifteen years since I've been on methadone, I've learned that my own disappointing experience is not unique. I've learned from and with other drug user activists, including the Phoenix drug user union, referred to as the Community Health Advisory Committee (CHAC), and engaged with the North Carolina Survivor's Union Methadone Reform Team (NCSU). The NCSU collectively authored one of the largest autoethnographic studies on methadone, *The Methadone Manifesto*, a living document and a call to action, demanding reforms to the U.S.-based opioid treatment program (OTP) system (Simon et. al., 2022). This manifesto is bolstered by numerous personal narratives, many of which mirror my own experiences of medical abuse, neglect, and exclusion from accessing methadone. This is unfortunate since methadone is one of the safest and most efficacious treatment modalities for reducing all-cause mortality for people who are using illicit opioids (Gibson et al., 2008; Sordo et al., 2016; Ma et al. 2019). Despite the proven efficacy of methadone, the issues outlined in *The Manifesto* prevent many people who are struggling with their use of illicit opioids from accessing this lifesaving drug.

The multitude of barriers that exist for people who could potentially benefit from access to methadone are well documented, even beyond those outlined in *The Methadone Manifesto* (Stroud, Norris, & Bain, 2022; Gaeta et al., 2022). In the U.S., methadone is heavily regulated by the federal government and many states impose additional burdens

on methadone provision.[9] These regulations decrease accessibility and reduce efficacy (Jaffe and O'Keefe 2003). The opioid treatment program (OTP) system was not established based on best practices or evidence that this clinical setting, with its ever-proliferating rules and regulations benefit clients nor increase community safety. Instead, the OTP system was developed in the 1970s to decrease crime in New York City that was perceived as a product of urban Black and Latino men who were dependent on heroin (Roberts, 2023). The regulations regarding OTP have not changed since this system was established in the 1970s, and much of the requirements remain vague. There has been very little research into how some of the federal mandates are implemented, especially the mandatory counseling required for anyone who receives methadone from an OTP (Strashny, 2014; HHS Office of the Assistant Secretary for Planning and Evaluation 2019).

Despite the lack of clarity into the quality and character of counseling provided in OTP, it remains mandatory that methadone clients receive it. As outlined by the Federal Guidelines for Opioid Treatment Programs, opioid treatment programs "must provide adequate substance abuse counseling to each patient as clinically necessary. This counseling shall be provided by a program counselor, qualified by education, training, or experience to assess the psychological and sociological background of patients, to contribute to the appropriate treatment plan for the patient and to monitor patient progress" (Substance Abuse and Mental Health Services Administration, 2015). This mandatory counseling, however, has been identified by *The Methadone Manifesto* as one

[9] Pew Charitable Trusts created a map showing a state-by-state overview of methadone regulations that exist in addition to federal regulations. https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2022/09/overview-of-opioid-treatment-program-regulations-by-state

of the key barriers that make it difficult for methadone clients to receive patient-centered care that respects the individual agency of people on methadone (Simon et al., 2022). The mandatory nature of the counseling is identified by *The Methadone Manifesto* as one of the issues in their call to action for methadone reform. In addition to answering this call to action, to support methadone reform, this dissertation seeks to fill in the research gaps around counseling in OTP settings as identified by a systematic review by Dugosh et al., and the 2019 U.S. Department of Health and Human Services report on the utilization of psychosocial services in OTP (Dugosh et al., 2016; HHS Office of the Assistant Secretary for Planning and Evaluation, 2019). This dissertation seeks to understand the experiences, beliefs, and opinions of Arizona methadone clients regarding the mandatory counseling in OTP.

Background

The small glimpse into my own personal experience with mandated counseling, as outlined above, emphasizes only one of many underexamined issues attendant to accessing methadone for people who are dependent on illicit opioids in the United States.[10] The questions regarding counseling characterization and client beliefs and opinions were added to the primary parent study (hereafter referred to as the MOUD Study) at the request of co-investigator D. M. Russell, with the knowledge that they could

[10] I am emphasizing that my personal experience is merely a glimpse into the many underexamined issues people dependent on illicit opioids encounter accessing methadone in the United States because the opioid treatment (OTP) system is singularly targeted towards people who are diagnosed with opioid dependency disorder (OUD) (Schwartz et. al., 2012). People who need/want and are prescribed methadone for any reason other than "OUD" may access it through office-based settings, via regular medical doctors, and pick their methadone up at a pharmacy, as they would with any other medication. The OTP system is reserved singularly for people with OUD to access methadone. This paper will not refer to people who are dependent on opioids as people with "OUD" because the term "disordered", when applied to individuals who are opioid dependent or using opioids, is stigmatizing and unnecessary for the purposes of this dissertation.

be examined later for this dissertation.[11] This dissertation is the first time the questions about counseling from the MOUD Study have been analyzed. Because of my own lived experience as a person who has been forced to participate in the mandatory counseling at OTP, I am aware of how useless and time consuming it is. None of the clinic staff who I engaged with (who were referred to as counselors) had any professional training or background in counseling. Additionally, through my engagement with drug user organizing, mutual aid, and the North Carolina Survivors' Union Methadone Reform Team, I knew that insight into the mandatory counseling has been desired by many people within the drug using community. These insights informed my decision to request questions about counseling in the interview instrument be included in the initial MOUD Study.

In addition to *The Methadone Manifesto* having identified the mandatory counseling as one of the key barriers to equitable access to methadone, as someone who has almost two decades of personal lived experience as a client at methadone clinics, I am keenly aware of the burden and barriers associated with the mandatory counseling in the OTP setting. As the subsequent chapters reveal in greater details, the counselors in OTP have a lot of power over the lives of clients at methadone clinics. Counselors make determinations on which clients are designated as compliant or non-compliant. These designations impact whether an individual will be able to access take-home doses of methadone, and thus be able to avoid the inconvenience and intrusion of daily observed dosing, or whether they will be able to maintain access to methadone at all.[12] *The*

[11] The acronym MOUD refers to Medications for Opioid Use Disorder.
[12] In addition to daily, observed dosing at the clinic being uncomfortable and invasive, it is also financially costly. The cost of gas, bus, or rideshare fare is expensive when you consider that this is something a

Methadone Manifesto has identified the "Useless, time-consuming, mandated counseling" as one of the central barriers to equitable methadone access. Following *The Manifesto's* call to action to end "the deadly culture of cruelty" embedded in the OTP system, this dissertation interrogates the mandatory counseling in methadone clinics (Simon et al., 2022, p. 4). People on methadone are subjected to many intrusive and infantilizing rules and regulations within the clinical setting and the mandatory counseling is a key feature of this.

To shift the culture of cruelty present in the OTP system, so poignantly exposed by the personal narratives included in *The Methadone Manifesto*, people on methadone need to be liberated from the surveillance posing as therapeutic support, which is exemplified by the federal counseling mandate for OTP. This could be done through legislative changes, but the federal regulations governing methadone provision through OTP have not substantially changed or been reformed since the 1970s. For the first time in decades though, legislation has been introduced to modernize access to methadone. Congressman Donald Norcross (NJ) has proposed the Opioid Treatment Access Act, which would make it so that methadone could be prescribed by medical professionals outside of OTP (*Rep. Norcross Announces Bill to Increase Access to and Modernize Opioid Use Disorder Treatment*, 2021). Another bill proposed last year by Senators Rand Paul (KY) and Edward J. Markey (MA), would allow methadone to be dispensed to individuals diagnosed with OUD at a pharmacy like any other medication (*Senators*

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methadone client must do every single day. The indignity of having to drink a medication and then open your mouth afterwards for someone to verify you have swallowed your medication, is infantilizing. Individuals who have other responsibilities and needs such as family, jobs, or even just the desire to sleep in, will not have these needs accommodated because daily clinic attendance interrupts all other life commitments.

Markey and Paul Introduce Bipartisan Legislation to Modernize, Improve Methadone Treatment amid Skyrocketing Opioid Overdoses and Deaths | U.S. Senator Ed Markey of Massachusetts, n.d.). These bills would go a long way towards normalizing access to methadone and eliminate the barriers posed by having this medication siloed in OTP settings.

It shouldn't be any surprise that many of those who profit from the OTP system, most especially methadone providers who own or work in OTP, have come out in opposition to these recent legislative initiatives. The American Association for the Treatment of Opioid Dependence (AATOD), an organization whose board consists of several of the largest OTP owners in the United States, has produced some of the most vocal opponents to methadone reform.[13] Mark Parrino, AATOD's founder, CEO, and director of Gramercy Park Medical Group (a for-profit methadone clinic), has been cited voicing his opposition to these two methadone reform bills. Parrino has stated that clients at methadone clinics would lose access to the specialized care provided by "highly trained specialists" if access to methadone is not restricted to OTP (Facher, 2022). Statements like these, from opponents of methadone reform, asserting that clients at methadone clinics are being provided highly trained and specialized care, inform the objectives of this dissertation.

Powerful special interest groups and crisis profiteers like AATOD are lobbying against methadone reform bills under the pretense that OTP offer specialized care, without which, methadone clients would be bereft. The findings of this dissertation are

[13] Current AATOD board members as of 2023 include Nick Stavros of Community Medical Services and Jason Kletter of Baymark Health Services, two of the largest methadone clinic operators in the United States. https://www.aatod.org/about-us/our-board-of-directors/

important in this context, because none of the participants who were interviewed described receiving specialized care from highly trained professionals. The current lack of research into the counseling provided by OTP has emboldened opponents of methadone reform to make broad, general statements about the quality of services provided to methadone clients. The findings of this dissertation do not support the claims made regarding the highly trained professional care provided in OTP, and as such, may hopefully be a tool for advocates of methadone reform to counter such claims.

Methodology

1. Research Questions and the MOUD Study

During the COVID-19 global pandemic, U.S. federal regulations outlining access to medications for opioid dependency[14] shifted to accommodate the needs of people on opioid replacement therapy (ORT) (*FAQs: Provision of Methadone and Buprenorphine for the Treatment of opioid Use Disorder in the COVID-19 Emergency*, n. d.). A study by a research team[15] led by principal investigator, Beth Meyerson from the University of Arizona, was conducted to examine the impact of these federal regulatory shifts on people on ORT in Arizona. Additional questions about issues of interest were added to the interview instrument at the request of co-investigator D. M. Russell. This included questions about client experiences around counseling, which until this dissertation, had not yet been examined or analyzed. This dissertation is a secondary analysis of the items

[14] These medications are primarily methadone and buprenorphine. Many acronyms are used interchangeably to describe the use of these medications, some of the more popular terms include medications for opioid use disorder (MOUD), opioid replacement therapy (ORT), opioid agonist therapy (OAT), and medication-assisted treatment (MAT).

[15] The research team for the parent study included the author of this dissertation research, D. M. Russell as a co-investigator.

regarding counseling from the parent study, which had been unexamined until now. This dissertation utilized a qualitative thematic approach to data analysis, with qualitative data analyzed and themes reported to provide context and quantitated where appropriate. Transcripts and qualitative data were managed and analyzed using NVivo software (QSR International, version 1.6.2). As noted, my dissertation broadly encompasses the following questions:

1. What do clients at methadone clinics experience as counseling?
2. What are client views and beliefs surrounding the mandatory counseling?

There are two central objectives of this study: first, to characterize what the psychosocial or other resources methadone clinic recipients are required to participate in as part of the counseling mandate in the U.S. for opioid treatment programs, and second, to examine client beliefs and opinions regarding the counseling they are required to receive. It is a natural extension of the MOUD Study, directed by Dr. Beth Meyerson of the College of Medicine, within the University of Arizona, and in which I was a Co-investigator.

Insight into these questions is important because there is a deficit of research into the counseling experiences of methadone clients generally, but most especially from the perspective of the clients themselves. Forcing individuals to engage in something as personal as counseling to access resources they need to improve quality of life and their chances of survival, should not be undertaken without careful consideration of the risks and benefits of this intrusion on individual liberty. As this dissertation will delineate, there is currently no evidence base to support imposing mandatory counseling on methadone clients. Additionally, opponents of legislative and policy changes regarding methadone have cited the specialized and superior services, such as mandatory

counseling, as rationale for not extending access to methadone outside of OTP. If we are to advocate for increased accessibility to methadone, we need to at least understand what existing services are like. These research objectives will help to establish that baseline.

I supported the MOUD study from its genesis, including budget planning, development of the interview instrument, hiring field investigators (who conducted interviews), training field investigators, and data analysis. Its central purpose was to examine the impact of federal regulatory changes during COVID on access to methadone and buprenorphine treatment (Meyerson et al., 2022). I collaborated with Dr. Meyerson on study initiation, budget development, coalition recruitment, and all aspects of research implementation. Along with me, several co-investigators on the MOUD Study, Christopher Abert of Southwest Recovery Alliance (SRA), and Nick Voyles of Indiana Recovery Alliance (IRA) identify as people with living experience of illicit drug use. Because the MOUD Study was oriented towards community-based participatory action research (CBPAR), coalition recruitment targeted and hired community members who had lived or living experience with illicit drug use and/or opioid replacement treatment (ORT). Research was conducted in collaboration with a community coalition comprised of people with lived and living experience and methadone clinic staff. The coalition, the Drug Policy Research and Advocacy Board (DPRAB) shared decisions about research methods and design, as well as data collection and analysis.

This background information about the MOUD Study is included because it impacts the quality of the data utilized for this dissertation. Beyond the ethical considerations of ensuring research is collaborative and meaningful to the community from which data is gathered, the community-based orientation of the MOUD Study

ensured that people who could be directly impacted by study findings had power over the study process. Having people with lived and living experience originate the central research objectives shifts power from the academy to community. The DPRAB, a board with OTP clinicians and clients who shared power over research decisions, ensured the development of the interview instrument and research objectives was democratic and retained utility for directly impacted people.

Study participants were at least 18 years old, living in Arizona, and had been clients receiving buprenorphine or methadone at some between January 1, 2022, and March 31, 2021, during the COVID-19 global pandemic. Seventeen people with lived and living experience of illicit drug use were hired and then trained as field researchers to conduct interviews within their social networks; a total of 131 interviews were conducted.[16] The study locations included both urban and rural locations in Arizona. The inclusion of rural and urban locations is important to note because access to OTP has been shown to vary depending on where an individual lives. People living in rural areas must travel greater distances to access medications for opioid replacement (Joudrey, 2020). There are also racial disparities in treatment accessibility which are visible in who has access to medications like methadone (Netherland & Hansen, 2017). It is a strength of this study that the experiences of both urban and rural methadone clients have been captured.

Approximately 32.3% of Arizonans self-identified as Hispanic or Latino (*U.S. Census Bureau QuickFacts: Arizona*, 2022). Spanish is a language used by a large

[16] This is a large sample size for a qualitative study. However, the MOUD Study was conducted across the state of Arizona in urban and rural locations. The large sample size allowed for us to gather data from populations which would have been potentially excluded with a smaller sample size.

population across the state. To accommodate this reality, interviews were conducted in the preferred and/or primary language of the person being interviewed, which was English or Spanish. Interviews that were conducted in Spanish were transcribed into both English and Spanish to preserve the original statements made by the participants. This helped to ensure that participation in the MOUD Study was not limited only to English speakers.

Data collection occurred between August through October 2021. The initial question, which was brought to Dr. Meyerson by community members,[17] and informed the MOUD Study, was, "What happened to people on methadone during COVID?" People within the drug user activist community were aware that federal regulations around the provision of methadone and buprenorphine had changed due to the pandemic. However, there was very little research or conclusive information available to explain exactly what had happened and how these regulatory changes impacted people on methadone or buprenorphine at that time. To help the community with this research need, Dr. Meyerson worked to gain funding to support the research efforts for the MOUD Study.

A 27-question instrument was co-created by the research team. This instrument focused on measuring aspects of accessibility to methadone and buprenorphine during COVID, including measuring the subjective experience of the federal regulatory changes, risk for severe COVID outcomes (per CDC definition), and other issues related to drug

[17] Chris Abert, Executive Director (at the time) of Southwest Recovery Alliance and Nick Voyles of Indiana Recovery Alliance approached Dr. Meyerson with this question because they had previous experience working with her on other community-based research efforts. She was known in the community of people who use drugs as someone they could go to for support with research questions and needs.

user health such as recommendations for improvement to treatment options (Meyerson et al., 2022). I requested two additional questions with prompts regarding counseling be added to the interview instrument, knowing they could be available for future analysis. Interviews lasted approximately one hour and were audio-recorded. Each of the 27 items contained follow-up probes and prompts to help with clarity. The research team, including the Interviewers, met several times over the course of the study period to help improve the prompts to the questions. Meetings with the DPRAB occurred regularly to monitor and discuss the research as it progressed.

So far, the original parent study has resulted in two published papers, "*Nothing Really Changed: Arizona patient experience of methadone and buprenorphine access during COVID*" (Meyerson et al., 2022) and "*Opportunities and Challenges: Hepatitis C testing and treatment access experiences among people in methadone and buprenorphine treatment during COVID, Arizona, 2021*" (Meyerson, et. al 2022). A third paper related to this parent study, examining provider experiences during COVID, is currently under review. The DPRAB has also contributed to an initiative to study patient-centered and trauma informed methadone treatment, which is currently in development. This dissertation studies previously unanalyzed data drawn from the counseling questions.

2. Orientation: Centering Community in the Research Process

The MOUD study utilized a community based participatory action research (CBPAR) orientation, which has been deliberately chosen because action research is "inquiry that is done *by* or *with* insiders to an organization or community, but never *to* or *on* them" (Herr & Anderson, 2005, p. 19). People who have lived experience with illicit drug use (PWLE) are heavily stigmatized (Simmonds & Coomber, 2009; Lloyd, 2010). This

stigma partly derives from historic and structural conditions of marginalization, racism, and ableism. The deeply ingrained negative stereotypes and pathologizing of people who use illicit drugs has resulted in this community frequently being viewed by professional academics as suitable objects of study, but rarely as researchers and collaborators in our own right (Salazar, 2021; Simon et. al., 2022).

As Caty Simon, a member of the NC Survivor's Union[18] explains, "Although our lives are shaped by subjects of interest to many researchers, including stigma, infection risk, incarceration, and overdose, we struggle to share our experiential knowledge on these topics in a way that benefits us" (Simon et al., 2022). People who use drugs are frequently researched but are frequently excluded from shaping and even accessing the research they contribute to. Extending the CBPAR orientation to this dissertation helps disrupt the extractive nature that has characterized traditional research done *on* people who use illicit drugs and allow this study to be done collaboratively by those of us who are directly impacted by the issues being examined by this study.

Stigmatized assumptions about people who are addicted to drugs posit that they are incompetent and incapable, always in need of direction, and certainly not directing anything of importance. It is critical to disrupt the extractive nature of research that has historically targeted people who use drugs (Salazar, 2021). One way to start disrupting this extractive relationship, is to ensure that the agency and autonomy of people with

[18] Caty Simon is a founder, co-organizer, and co-executive director of Whose Corner Is It Anyway; She is an author, researcher, and activist who has 20 years of experience advocating within the drug user union, sex worker and psychiatric survivor's rights movement. Whose Corner Is It Anyway is a "Western Massachusetts-based mutual aid, harm reduction, political education, and organizing group led by stimulant and opioid-using low-income, survival, or street-based sex workers". https://oldprosonline.org/whose-corner-is-it-anyway/

lived and living experience is respected. This means that rather than only include as objects of research, people who use drugs need to be involved as co-collaborators throughout the research process. It also means that attention must be paid to reimbursing participants and collaborators[19] fairly for their expertise and contributions to the research process. Funding is one way that traditional researchers either choose to retain or share power with research participants or collaborators.[20] Reimbursement for study participation is one way in which power can be shared on a research project, collaborating with multiple partners to ensure research funding is fairly distributed during budget planning at the study's genesis is also helpful.

Historically, people who have lived and living experience with illicit drug use and addiction are only engaged as research subjects who have little or no influence on research design or outcomes (Salazar et. al, 2021; Simon et al., 2022). The impact of this traditional, extractive research orientation is frequently evident in the research produced and published about people who use drugs. Two recent articles helpfully provide some examples of how research on drug users position the individual as the source of pathology, or as in need of intervention, as opposed to interrogating what might be wrong with society or the treatments themselves (Santo et al., 2023; Rasmussen et al., 2018).[21]

[19] Here collaborators could refer to research consultants, field investigators, or any person with lived or living experience of illicit drug use who contributes to the study.

[20] Regardless of the research entity that is conducting research, whether it is a nonprofit, health department, or an academic institution, it is highly unlikely that the individuals directing the research or controlling the grant money funding the work is contributing their labor for free. The fact that this individual (potentially known as the PI (Principal Investigator) might expect others on the project to donate their time for free, while they are building a career and supporting themselves with this work, exposes the power imbalance at play in these relationships between researcher and researched. If an individual is being sought after to contribute to a research project as a participant, clearly, they have valuable experiential or professional knowledge. This knowledge is valuable and should be treated as such with appropriate reimbursement.

[21] I chose these two articles because they exemplify the trend of research on drug users that I encounter as someone who follows research on the topics of illicit drug use and drug treatment. They are not outliers, but are exemplary of the kind of articles I see occur quite regularly.

The study by Rasmussen et al. investigated differences in self-reported PTSD, general psychological distress, and childhood trauma between 112 individuals with substance use disorder (SUD) and 112 individuals with mild to moderate mental health disorders. This study found more childhood trauma in the individuals with SUD, with a particularly strong association for female drug users (Rasmussen et. al., 2018). This is an example of research which frames drug use as a behavior engaged in by individuals who have something inherently wrong with them, such framings work to obscure the role of the state as an architect of harm.

This exemplifies this tendency of research to individualize social problems as something which can be traced back to defects in individuals. Focusing on how traumatized individuals respond differently to treatment, Santo et. al. found that those who had been labeled with anti-social personality disorder and who had extensive childhood trauma were more likely to delay and resist drug treatment (Santo et. al. 2018). Both articles mentioned here sought to understand the underlying causes of drug use as if the answer resides in the defective individual and not elsewhere. These tendencies in drug research narrow focus on individuals, as if people are defective instead of focusing on systemic factors contributing to harms related to drug use. This is important because instead of focusing on changing the structures which impose harms on people and traumatize them, interventions are instead focused on treating individuals.

I would like to point out how absurd it would be for me to write and expect to publish a paper entitled, *Adverse shopping outcomes: Walmart found that people who don't buy their products are suffering from mental illness*. The example of the Santo et. al. article, exemplified this kind of attitude by researchers. Authors focused on what

could be wrong with individuals that they are delaying or refusing to utilize treatment options. Instead of asking what is wrong with drug treatment, prisons, or society, research like these articles are constantly seeking to inspect or assess the presumed wrongness of the individual who uses drugs.[22] This is intended to emphasize the fact that instead of being oriented towards studying communities that are facing issues, researchers such as those who produced the articles by Santo et. al. and Rasmussen et. al., approach people who use drugs as the issue. The result is research that furthers the narrative of people who use drugs as a uniquely pathological phenomenon, with very little or no acknowledgment of the historical or sociostructural influences that have targeted certain drugs and the people who use them.

An additional burden that prevents research from being more democratic is the fact that most journals have costly open access fees and are not generally accessible to the public, including people who use drugs (Albert, 2006; Saqr et. al, 2020). Because of this, people who use drugs frequently have no access to the research that is done on them or the issues that touch their lives. Many studies into the impact of open access research focus on how researchers and scholars are impacted by limited access to research (ElSabry, 2017). But less is known about how increased access to scholarly research would impact the knowledge and interests of non-researchers (ElSabry, 2017).

The lack of access to scholarly research by non-researchers may be one reason that some research participants have reported feeling alienated from the research process. Women who use drugs who participated in research mentioned feeling like researchers

[22] Research around drug use often focuses intently on building extensive drug use histories. This is because the research itself is oriented towards the individual as flawed, so the individual must first be objectified and constructed as wrong.

asked questions in ways that were repetitive, and which were transparently slanted "to prove whatever assumptions the researcher already had about drug users" (Bell & Salmon, 2022, p. 88). In my own experience as a research participant, researchers never made any efforts to share or communicate their findings with me as a study participant.[23] The example of my own experience is anecdotal, but this limited glimpse into how I have been treated as a research participant exemplifies how the research being done was oriented towards extracting information from me, and I was positioned merely as an object of study.

While I cannot say with certainty how frequently researchers make efforts to communicate data and findings with participants, the fact that it occurs at all is indicative that the research being done isn't viewed by researchers as having enough of an impact on the people and communities being studied to warrant being shared with them. This brings us in confrontation with the very nature of research itself and understandings about the purpose of research. If the research is not meaningful enough to warrant the findings being shared with the people and communities who are being studied, then what is the purpose of the research and who is it supposed to benefit? This phenomenon exposes how people who use drugs are viewed by traditional researchers. They are conceptualized not as a community, or even as autonomous individuals, but as a problem or an issue that needs to be solved.

[23] Over the past two decades, as a person who has living experience with injection drug use, I have participated in both online and in-person surveys and interviews with researchers from various institutional backgrounds. This includes surveys and interviews with health departments, nonprofits, syringe service providers, community organizations, and university researchers.

Despite being unable to access most of the research done *on* them, many people who use drugs will experience the impact of the research – whether through its power to influence theories about drug use and addiction and how it should be treated, or the way views about drug users are shaped. Research has power to shape the conversation around drugs and the people who use them. That is partly why it is so critically important to bring the community of directly impacted people into the research process, to be a part of deciding research agendas. People who are going to be directly impacted by research should have a central part in collaborating in the research process. Research is not only conducted by university researchers. Much of the research done on people who use drugs is conducted by other research entities such as non-profits, health departments, and government agencies. Regardless of the identity of the research entity, at minimum, researchers have a responsibility to communicate their findings to the communities they are studying.

In a deliberate effort to interrupt the problematic history of research conducted on people who use drugs, the MOUD Study and this dissertation have sought to adhere to a community-based orientation throughout the research process. The initial questions, which drove the study, emerged in the community with several community organizations, which included PWLE. These individuals, who are members of drug user activism communities, had been working with individuals who were on methadone and buprenorphine during COVID and wanted to know more about what the impact of federal regulatory changes during COVID were really like. They were aware of the shift in federal policies regarding ORT and knew that many people were experiencing these changes differently. A deeper insight into what was really happening was necessary. This

insight is especially important to people who want to advocate for more equitable access and a more client-centered approach to methadone treatment. Because of their previous relationship working with Dr. Beth Meyerson, she was approached with the initial research questions. This led to the establishment of a research team, which includes a community research board, the Drug Policy Research and Advocacy Board (DPRAB). This board is comprised of PWLE, methadone providers, harm reduction[24] organizations and university researchers.

I plan to share the findings from this dissertation with the DPRAB.[25] The input and feedback of this community-based organization will inform and determine any action and advocacy that results from the findings of this research. The MOUD Study and this dissertation, have intentionally sought to include community in every step of the research process. In contrast to traditional extractive research done *on* people who use drugs, PWLE have been part of every step of project development, from inception through data dissemination for this project.

I am currently a person on methadone, and the findings of this research could have a direct impact on my quality of life. Rather than view the supposed non-objectivity posed by my lived experience as a potential weakness, my experience is beneficial. This is because research seeks to ask questions about how to improve something, and this is a question laden with value judgments about what will be improved and for whom.

[24] In this dissertation I have intentionally decentered this harm reduction discourse. It has limitations as an approach because it is increasingly coopted by rehabilitative and recovery discourses. Harm reduction is a strategy deployed by oppressed individuals to mitigate sociostructural violence to survive, and it is neither radical nor transformative.

[25] The DPRAB is a community advocacy board in Arizona, whose membership consists of both people with lived experience with illicit substance use and/or ORT, as well as individuals who work within the ORT clinical setting.

Because of my close association to this study as someone with living experience with illicit substance use and opioid replacement treatment (ORT), the research questions and outcomes could impact my daily life. Additionally, the collaboration with other people with lived experience via the DPRAB, will help ensure a democratic outcome and ultimately that any outcome or improvements from this study will be led by those who are directly impacted.

This study was limited by not asking follow-up questions in the interview instrument about why individuals held the opinions they expressed about the counseling. Because a community-based participatory action research orientation was used for this study, several field investigators with lived and living experience of illicit drug use were hired to conduct interviews. Overall, this is a key strength of this study because directly impacted people collaborated in every facet of the research process, which ensures ethical, quality research. However, with so many people working together to conduct interviews, it does slow down the process if we were to choose to add additional questions to the interview instrument. While we did adjust the interview instrument after deliberation and feedback from the research team, including field investigators, given the limited time, inserting additional follow-up questions about the counseling opinions was not feasible. Future studies examining why some people on methadone embrace the discipline and punishment role of counselors instead of the supportive role of case management or psychotherapy conducted with a focus on establishing a healthy therapeutic alliance would be beneficial and have the potential to improve treatment experiences.

3. Data Collection

As noted, the original sample included 131 people. Participants were recruited across urban and rural locations in Mohave, Yavapai, Maricopa, Yuma, and Pima Counties. Because this research is informed by a community-based participatory action research (CBPAR) orientation, a coalition of community members was convened to develop the study, including the methods, data analysis, and to disseminate findings. This community coalition, known as the Drug Policy Research and Advocacy Board (DPRAB) is comprised of people with lived and living experience of illicit drug use, clinicians, opioid treatment program (OTP) staff, and researchers from the University of Arizona and Arizona State University.

A total of seventeen interviewers with lived and living experience were recruited and trained in a 2-hour online Zoom training session to conduct qualitative interviews.[26] Interviewers were paid for the training session, conducting the 60-minute recorded interviews, and for uploading the recordings to a HIPAA compliant portal for transcription. Field investigators for this study have unique and valuable lived and living experience with illicit drug use. Ensuring they are paid fairly for their contributions and expertise is a critical part of ensuring the research is oriented towards building community capacity and treating the people from the community which is being researched with respect. A scoping review to identify ethical issues in research conducted with drug users found that participant compensation garnered the most attention in the literature review (Souleymanov et. al. 2016). By showing that the MOUD Study was conducted in an ethical manner, which respected the autonomy and lived experience of

[26] Primary-investigator Beth Meyerson, and co-investigators D. M. Russell and Missy Downer co-developed the training for field investigators.

field investigators and participants, this is intended to demonstrate the quality of data utilized for this dissertation.

Participants were socially recruited through convenience sampling conducted by the interviewers, with interviews conducted between August-October 2021. Interviewers could attend weekly drop-in sessions held by Dr. Meyerson, D. M. Russell, and Missy Downer. These weekly drop-in sessions allowed for interviewers to be supported as they navigated the data collection process.[27] This format also allowed for us to update the interview instrument and make clarifications and follow-ups to the questions and prompts as the study progressed.

It is important to note that the interviewers all had lived or living experience with illicit drug use and methadone or buprenorphine. This is a deviation from traditional research, which primarily utilizes academics[28] to conduct interviews and to make meaning about the data and findings. Interviewers for this project shared the positionality of the individuals being interviewed, collaborated in developing the interview instrument, and data analysis. These details about the primary MOUD Study are included because many of these accommodations are intentional to ensure field investigators and participants were treated as equal collaborators in the study. Details about interviewer characteristics can be viewed in Table 1.

[27] Because field investigators shared the positionality and some of the experiences of the participants they were interviewing, there was potential for the interviews to bring up emotional experiences in both interviewer and interviewee. For example, one field investigator shared their personal experience of self-harm during an interview. The weekly drop-ins allowed Co-Investigators to provide emotional support to field investigators and to check in with them throughout the data gathering process.

[28] In my experience participating in several studies and as a frequent reader of qualitative research on drug users, interviews are often conducted by professors or graduate students who are not open about their positionality, if they have any lived or living experience connected to the study at all.

Table 1

Interviewer Characteristics

Table 1. Interviewer Characteristics				
Name	County	Gender	Interviews Conducted	Notes
Amirah	Yavapai	Female	8	Currently on buprenorphine
Arlene	Maricopa	Female	4	Queer, Sex worker
Becky	Maricopa	Female	9	Works as peer support
Charisse	Pima	Female	12	Currently on Buprenorphine
Chelsy	Maricopa	Female	4	
Elle	Maricopa	Female	4	
Greg	Maricopa	Male	16	Currently on methadone
Irene	Maricopa	Female	4	Currently on methadone
Jeanell	Maricopa	Female	8	
John	Pima	Male	18	Works as manager at sober living home.
Julie	Mohave	Female	6	
Lisa	Mohave	Female	4	
Moises	Yuma	Male	12	Bilingual (English/Spanish), Currently on methadone
Roberto	Yuma	Male	6	Bilingual (English/Spanish)
Sarah	Yavapai	Female	1	
Savannah	Pima	Female	12	Works as peer support
Tawni	Pima	Female	4	

Because the focus of this dissertation is mandatory counseling for individuals who are clients receiving methadone at opioid treatment programs (OTP), interviews were assessed to determine which qualified for inclusion based on whether they had been on methadone or not. Participants who had treatment experience with methadone-only and individuals who had treatment experience with both methadone and buprenorphine were included. Currently, only methadone is subject to the federal mandate to require counseling. In the United States, methadone can only be dispensed by federally sanctioned opioid treatment programs (OTP) to individuals who have been diagnosed with an opioid use disorder. These OTP are governed by both state and federal legislation, with federal laws and regulations designated by executive departments and agencies laid out in the Code of Federal Regulations (CFR). Opioid treatment programs are governed by 42 CFR section 8.12. These federal regulations governing OTP outline counseling requirements applicable to all methadone clinics,

> …(OTP) must provide adequate substance abuse counseling to each patient as clinically necessary. This counseling shall be provided by a program counselor, qualified by education, training, or experience to assess the psychological and sociological background of patients, to contribute to the appropriate treatment plan for the patient and to monitor patient progress. (Substance Abuse and Mental Health Administration, 2015)

These strict rules for counseling exist for methadone but there is no federal counseling mandate for buprenorphine. For this reason, any interview participants who only had experience on buprenorphine were excluded from this dissertation. This resulted in 33 interviews being excluded from analysis because they only had prior experience with

accessing buprenorphine-based treatment and would not have been exposed to the mandatory counseling outlined by the Code of Federal Regulations. The remaining 98 interviews were comprised of the two sub-groups, individuals who accessed methadone-only (n=96) and individuals who accessed both buprenorphine and methadone (n=2). The two individuals who self-identified as having been on both medications indicated that they had switched from methadone to buprenorphine or from buprenorphine to methadone at some point over the duration of their treatment.

Interviewers were recruited across the state of Arizona and interviewed and screened to ensure that individuals with lived or living experience with illicit drug use were hired. In addition to having lived and living experience with illicit drug use, "interviewers represented the diversity of Arizona, including bilingual (English/Spanish) language and geographic location (county and rurality)" (Meyerson et al., 2022). The table below provides information about how many interviews each interviewer conducted, what county they were in, and personal identities interviewers believed were important enough to share with the research group.

Interviews were conducted in English and Spanish through 60-minute, recorded, in-person interviews between August-October 2021. Participants answered the 27-question, audio recorded interview, which covered a range of issues pertaining to drug user health and their experience accessing methadone during the start of the COVID epidemic. Table 2 details the questions of interest for this dissertation regarding counseling. Interviews were conducted in several counties across Arizona: Yuma (17.7%), Yavapai (5.2%), Pima (28.1%), Mohave (7.3%), and Maricopa counties (41.7%). Participants and audio recordings were anonymous and after audio files were

uploaded to the HIPAA-compliant database, interviewers were instructed to delete the recordings from their recording device.

Table 2

Counseling Questions and Probes

ENGLISH
What kind of counseling were you required to have in order to get bupe or methadone during COVID? Probe: Please explain what the counseling involved specifically...what happens when you get counseling through your MAT provider? (We are not looking to hear about your personal stuff. We know that "counseling" is different wherever people go for MAT). Probe: Who did you meet with for counseling—what kind of staff member? (a 'counselor' a 'staff member' who asked you to talk with them? A "nurse" or a "trained therapist", or someone in a certain color scrubs?) Probe: How was this counseling requirement different before COVID?
What is your opinion about whether people need counseling in order to get bupe or methadone?
SPANISH
¿Qué tipo de consejería se le exigió para obtener buprenorfina o metadona durante la COVID? 1. Averigüe: Explique en qué consiste específicamente la consejería... ¿Qué sucede cuando recibe asesoría a través de su proveedor de MAT? (No queremos oír hablar de sus asuntos personales. Sabemos que la "consejería" es diferente dondequiera que la gente acuda a MAT). 2. Averigüe: ¿Con quién se reunió para recibir la consejería, qué tipo de miembro del personal? (¿Un "consejero", un "miembro del personal" que le pidió que hablara conellos? ¿Una "enfermera" o un "terapeuta capacitado", o alguien con un uniforme de cierto color?) 3. Averigüe: ¿En qué se diferenciaba este requisito de la asesoría antes de la COVID?
¿Cuál es su opinión sobre si la gente necesita asesoría para recibir buprenorfina o metadona?

All interviewers attended a 2-hour online training session on Zoom, where they were taught by Dr. Meyerson, D. M. Russell, and Missy Downer, regarding how to

conduct qualitative interviews and ethical research, including basic principles of informed consent. As recordings were uploaded to the database by interviewers, the interviews were reviewed for quality and completeness. Weekly drop-in meetings with the interviewers were held by Dr. Meyerson, D. M. Russell, and occasionally, other members of the research team. These drop-in meetings facilitated answering any questions interviewers had that came up during the study, as well as collaboration on adjustments to the interview instrument. Because the interviews were also discussing issues of a personal nature, and the interviewers share the positionality of the individuals being interviewed, these weekly meetings were also a space to debrief and offer emotional support to interviewers throughout the interview process.

4. Ethical Approval

The University of Arizona Institutional Review Board of the Human Subjects Protection Program provided ethical oversight for the parent study. The Arizona State University Institutional Review Board of the Human Subjects Protection Program provided ethical oversight and approval for this secondary analysis and study. In-person interviews were conducted and recorded using a hand-held audio recorder. Interview participants were provided a $30 Visa gift card for their participation. The field researchers who conducted the interviews were paid $200 for attending the 2-hour online training and $40 for each completed interview.[29]

These details regarding payments to field investigators and participants in the MOUD Study are detailed in this dissertation because payment is a key site of power and control

[29] Field investigators were also reimbursed for travel expenses if they had to travel to conduct the interviews. This included gas and/or bus fare.

in the research relationship. How collaborators are reimbursed (or not) for contributing to the research project is critical to demonstrate that the relationship is not based purely on extraction and exploitation. The debate about payment to people who use illicit drugs frequently is focused on the assumption that they will use this money to buy drugs (Anderson, 2018). In my own experience as a research participant, often the researcher will refuse to pay participants in cash and instead will only pay in gift cards. The gift cards I have received from research participation always include a statement that prohibits me from using or selling the gift card to "buy alcohol, tobacco, or firearms" (See Figure 1). Further, the researcher has required me to sign a document stating that I will not sell the gift card for money to spend on drugs or alcohol.

Figure 1. Gift card received for participation in research. Received by DM Russell, March 2022.[30]

Interviewers were trained to provide study participants with written study information on a sheet that participants could keep and to participate in an oral informed consent process. Once a participant gave an interviewer consent to be part of the study, the interviewer would ask again at the start of the interview after the recorder was turned on.

[30] Figure 1 is a photo taken by Danielle Russell of a gift card she received for taking a survey administered by the Arizona Department of Public Health in March 2022.

This consent was transcribed along with the rest of the audio recording of the interview and kept as a record of consent.

The specific questions asked in the interview regarding counseling can be seen in Table 2. These questions were asked in both English and Spanish, depending on the preferred and/or primary language of the interviewer and participant. Interviews that were conducted in Spanish were transcribed in both English and Spanish to preserve the original language in which the interview was conducted. The counseling questions were added to the parent study at the request of co-investigator D. M. Russell, with the knowledge that they could be available for analysis later for this dissertation.

5. Data Analysis

Qualitative data analysis included thematic analysis with a combination of inductive and deductive coding. As a first step, collected data were assessed for quality and missingness and completeness of qualitative interview responses to selected questions related to counseling. Files were coded for three different cases: buprenorphine (n=28), methadone (n=86), and both methadone and buprenorphine (n=10). A total of 96 files were identified for interviews with individuals who were either on methadone (n=86) or both (n=10), with 28 files containing interviews that were buprenorphine only. These 28 files were discarded from analysis because buprenorphine is not subject to the same rules governing methadone, and so they are beyond the purview of this specific study. Deductive codes intended to establish a baseline of client opinion about the counseling mandate by coding "Counseling Yes" or "Counseling No" for responses to questions about whether counseling should be mandatory or not. Other themes for deductive codes included characterizing what the counseling consisted of for individuals. This included codes like

"frequency, identity, requirements, description, and unclear." When attempting to establish the identity of counselors, these codes were important because most responses to the probe, "Who did you meet with?" were met with responses that included either the frequency or times the participant had to meet with counselors (frequency), a clear description of who they met with and their role in the clinic (identity), things that were required of them around counseling (requirements), a description of what the counselor did or looked like (description), and some participants were not sure who their counselor was, or that they received counseling at all (unclear).

Inductive codes that were added as coding progressed included examples such as "value judgment, age, stigma – self and others." These codes were helpful in making sense of responses to the second question about counseling, "What is your opinion about whether people need counseling to get either methadone or buprenorphine?" Coding for reactions that signaled the participant was making a value judgment about the counseling itself (value judgment) was useful to clarify the response about if counseling is necessary. The code for age was added because several times, the age of the Participant or counselor was mentioned in response to either of the counseling questions or prompts. The codes for stigma consisted of one larger code to capture any stigma, followed by smaller sub-codes for self-stigma and stigma towards others. These codes helped to interrogate the responses, especially the second question about whether counseling should be required. Stigma seemed central to many of the participant beliefs about the utility of counseling and the coercive nature of counseling in the context of methadone.

Stigma has been identified as a major contributor to negative outcomes for people who use drugs (Francia et. al., 2023; Muncan et. al., 2020; Pacquette et. al., 2018).

Coding with a focus on participant experiences of stigma assisted in gaining a deeper understanding of participant beliefs and opinions about counseling and why they may hold these views. Erving Goffman defines stigma as an attribute that is viewed negatively (by self or others) and discredits an individual or community which shares these stigmatized attributes (Goffman, 1963, p. 3). As will be discussed more in Chapters 3 and 4, many participants expressed views that considered counseling to be synonymous with punishment. This is distinct from how counseling is generally conceptualized by clinicians as a psychosocial support meant to assist individuals in improved well-being and decreased emotional distress (Bower et. al., 2011). In this context, the coding for stigma helps to understand why some participants may express opinions which devalue their own worthiness to be supported through emotional distress and to be offered punishment instead.

Intersectionality was a term initially outlined by Kimberlé Crenshaw to help illuminate the multidimensionality of Black women's experience (Crenshaw, 1989). Crenshaw explained how Black women's experiences are erased when inquiry is limited to a single-axis framework such as *only* Black or *only* woman. Many people occupy multiply marginalized positionalities all at the same time. An intersectional framework can helpfully be understood as examining the "interconnected nature of social categories like race, class, and gender" (Logie et. al., 2011). For the purposes of this dissertation, an intersectional analysis is useful to help understand how drug use and different positionalities overlap to contribute to increased marginalization or disadvantage. The way that overlapping identities impacts individuals who use drugs is exposed in many ways, most notably in how Black people's drug use is criminalized and white people's

drug use is medicalized (Netherland & Hansen, 2017). This is further exemplified by disparate targeting by state child protective services of Black and Indigenous women who use drugs (Font et. al., 2013). Individuals are not either or only women, mothers, Black, drug users, or Indigenous; some may occupy several or all of these positions at once. Chapters 2 and 3 will discuss the history of gender, race, and drug policy in the United States in greater detail.

The sample included 98 people who were on methadone at some point during COVID. The racial and ethnic diversity of the sample cohort for this dissertation, self-identified as 15.3% Hispanic, 1% Black (African American), 1% Native American, 3.1% Asian, and 70.4% white. Many of those interviewed experienced housing instability (40.8%) during COVID, with 15.3% experiencing homelessness. Individuals self-identified their gender identity in interviews as cismale (62.2%), cisfemale (36.7%), and nonbinary (1.0%). See Table 3 for more detailed characteristics of the complete sample cohort.

Table 3

Characteristics of People on MOUD during COVID, Arizona (N=98)

Demographics	
Age	Mean=38.0 years (r:19-65, SD: 11.6)
Race and Ethnicity	
White	69 (70.4%)
Hispanic	15 (15.3%)
Black	1 (1.0%)
Native American	1 (1.0%)
Asian	3 (3.1%)
Gender Identity	
Cismale	61 (62.2%)
Cisfemale	36 (36.7%)
Nonbinary	1 (1.0%)
Sexual Orientation	
Heterosexual	84 (85.7%)
Bisexual	10 (10.2%)
Lesbian or Gay	3 (3.1%)
Queer	1 (1.0%)
Housing	
Housing was affected by COVID	40 (40.8%)
Unhoused at some point during COVID	15 (15.3%)
Rurality (Towns listed in population order by rurality)*	
Rural	18 (18.4%)
Cordes Lakes (2,684 pop)	1 (1.0%)
Dewey-Humbolt (4,326 pop)	1 (1.0%)
Somerton (14,197 pop)	3 (3.1%)
Kingman (32,689 pop)	9 (9.2%)
San Luis (35,257 pop)	1 (1.0%)
Prescott (45,827 pop)	3 (3.1%)
Rural/Urban Mix	11 (11.2%)
Tempe (180,587 pop)	1 (1.0%)
Yuma (203,881 pop)	10 (10.2%)
Urban	68 (69.4%)
Scottsdale (241,361 pop)	1 (1.0%)
Mesa (504,258 pop)	10 (10.2%)
Tucson (542,629 pop)	32 (32.7%)
Phoenix (1,608,139 pop)	26 (26.5%)
Methadone Access During COVID	
Methadone only	96 (98.0%)
Methadone and Buprenorphine	2 (2.0%)

Had to go to the clinic daily to get medication	54 (55.1%)
Total time on methadone (in months), predates COVID	Mean=32.8 (r:1-240, SD:40.8)
Distance from MOUD Provider	
Miles from provider	Mean=2.6 (r:1-25, SD:4.6)
Commute time to provider (in minutes *one way*)	Mean=5.9 (r:5-60, SD:12.6)

*U.S. Decennial Census 2020 (www.census.gov)

Coding is a decision-making process engaged in by qualitative researchers in line with their research questions and the practicalities of their studies (Elliott, 2018). The process of coding is intended to make sense of data in relation to our research questions. Victoria Elliott asserts that coding works best when it is responsive to the needs of each individual study and does not adhere to a strict guideline rigidly applied across every project (Elliott, 2018). This dissertation utilized qualitative research methods outlined by Elliott and qualitative researcher Heather Stuckey. Stuckey outlines three steps to be taken in every coding process for qualitative research data. The first step is to read through the data and create a story line, the second is to organize the storyline into codes, and thirdly to create memos which will assist in interpretation and clarification (Stuckey 2015).

Following the steps outlined by Stuckey, an *a priori* coding approach was initially used because this study seeks to characterize participant perception of counseling within the OTP setting, and to understand client perceptions and beliefs regarding the mandatory counseling. The *a priori* coding approach allowed to develop codes targeted at understanding these key issues. These codes include value, requirements, and impact of counseling, counseling function, as well as type of counseling and who provides it.

This allowed for coding to focus on understanding the identity of the counselor and Participant understandings about the purpose of counseling. Additionally, to assess

beliefs more closely about counseling, this dissertation coded for ableism, stigma, and curative violence. These codes were important because we are drawing from a critical disability and drug studies methodology. Critical drug studies researcher Nancy D. Campbell explains how to apply an intersectional analysis to the transdisciplinary knowledge project of drug studies (Campbell, 2022). This is important because we cannot begin to understand how drugs have become to be utilized as a tool for social control if we do not consider the role that race, gender, class, and ableism all play in constructing the drug "addict".

Drawing from critical disability studies, which "centers the understanding of disability as a political, cultural, and historical experience" we can better understand how intersecting conditions of oppression construct some people as disabled, different, or other (*FAQs | Critical Disability Studies Collective, n.d.*). This understanding allows us to shift our orientation from considering people who use drugs as uniquely pathological individuals towards understanding the socio-structural conditions that impose harms on drug users. As Julie Minich explains, "the methodology of disability studies as I would define it, then, involves scrutinizing not bodily or mental impairments but the social norms that define particular attributes as impairments, as well as the social conditions that concentrate stigmatized attributes in particular populations" (Minich, 2016, para. 6). In addition to critical disability and drug studies methodology, we are utilizing a Foucauldian theoretical analysis.

Foucault's theory of biopolitics outlines how life is administered through population management (Foucault, 1976). Drug users are a specific population who are designated as available for state violence. Using Foucault's understanding of biopower,

we can more fully grasp how the administration and regulation of populations is exerted through the creation of certain categories which allow state violence to be enacted upon them (Foucault, 1979). Because data analysis is paying attention to these concepts outlined by Foucault, transcripts were also coded for themes related to gaze, observation, and power-knowledge. These codes are all related to key concepts defined by Michel Foucault, which inform our understanding of how biopolitics operates. His ideas about biopolitics, power-knowledge, and the history of the clinic will all be applied to discussion and analysis in later chapters.

An intersectional analysis is especially important to put in conversation with Foucault's theory of biopolitics and population management. Especially in the context of the methadone clinic, this is important to understand the purpose and intent behind the counseling mandate, as well as understanding participant beliefs and opinions about mandatory counseling. According to Foucault, the state utilizes categories of humanity, such as race, gender, class, and health to designate some populations as abnormal and disposable (Foucault, 1976). I hypothesize that the methadone clinic operates to categorize a highly stigmatized population (people who are opioid dependent, or addicts) into further categories of compliance (not-yet disposable) and non-compliance (disposable). The methadone clinic operates to determine and designate which individuals have potential to return to normal (recover), and those who do not and are disposable. The counselor acts as a key tool in this process of categorizing some individuals as recoverable (non-disposable/compliant) and others as irrecoverable (disposable/non-compliant). These are the theories and hypothesis that will inform the qualitative analysis of the data and the discussion in this study in the following chapters.

Chapter Outline

Chapter 2 of this dissertation provides a brief historical background into how some drugs used for intoxication ended up currently being constructed as a personal pathology which must be treated and punished. The historical context is necessary to contextualize modern drug treatment within the legacy of medico-criminalization, and especially to illuminate the intersecting lines between punishment, discipline, and cure in the United States-based OTP setting.

The data regarding counseling characterization, along with client beliefs and opinions regarding the mandatory counseling are presented in Chapter 3. This includes an analysis of who counselors are from the perspective of methadone clients. While many clients could clearly explain the frequency with which they had to interact or attend something that may have been referred to as counseling, many did not offer rich descriptions of who the counselor is, nor what the counseling consisted of. Instead, many stated directly that they were uncertain about the professional background of their counselor. Chapter 4 outlines the responses to the interview questions regarding counselor identity, what the counseling consisted of, and participant's beliefs and opinions about the mandatory counseling. This chapter provides an in-depth discussion and theoretical analysis of the study findings and data presented in Chapter 3. Study participants offered a broad range of beliefs and opinions about the role and utility of counseling in the OTP setting. Participant responses outlining their opinions about the mandatory counseling diverged into two distinct groups, those who believed counseling should be imposed even on unwilling clients and those who desired more autonomy over their treatment plans. The role of mandatory counseling in OTP as a tool to make

determinations regarding worthiness or unworthiness informed participant's opinions about the counseling. Chapter 4 explores how compliance and carcerality are insidious in the way that counseling is socially constructed for people on methadone. The counseling provided does not allow methadone clients to direct their own treatment and instead the counselors' role was primarily directed towards punishing clients who failed to comply with clinic rules. As observed in Chapter 3, this disciplinary role of counselors was clearly understood by clients. This function was not a hidden and unfortunate side-effect of counseling in OTP but was instead understood as its primary purpose.

To conclude this dissertation, Chapter 5 assesses the implications of the study data and findings. Building on the work of community-led organizations such as the Urban Survivor's Union, this chapter emphasizes the urgent need for socio-structural changes – not just in how methadone is accessed but demanding that the human rights and the dignity of people who use and/or are dependent on illicit drugs are treated. Mandating that individuals must be counseled to access potentially life-saving drugs is disrespectful to the right to personal agency and bodily autonomy. Building the scaffolding for social change, to build a future where methadone clinics and the OTP system no longer exist, will require a fundamental reordering of society that no longer seeks to regulate, treat, or eradicate human difference. This includes expanding not just our views of drug treatment, but of how humans treat one another generally, with respect for those core human rights of agency and bodily autonomy.

My living experience as someone who has struggled to access and maintain my access to methadone informs these research objectives. I know firsthand what it is like to have punishment by clinic staff mischaracterized as counseling and to struggle with the

intrusive demands of the clinic to maintain my status as a compliant methadone client. As explored in the subsequent chapters, the shifting orientation of opioid maintenance treatment towards surveillance and identifying compliant and non-compliant clients is a relatively new development. Unlike morphine maintenance, modern methadone maintenance is deliberately creating contingent spaces for safer drug use for some clients who are designated as compliant, and restricting access to clients who are designated as non-compliant. The counselor plays a key role in identifying who is going to be allowed access to these safer spaces of legal opioid use and who will be relegated to spaces of criminalized drug use. The following chapter will provide brief historical context to understand this biopolitical shift towards surveillance through the establishment of opioid treatment programs.

CHAPTER TWO

PLEASURE, PAIN, THERAPY, AFFLICTION

A Brief History of Opioids

Before we can fully understand methadone clinics, we must first understand how they have come to exist at all. History is important not just because it provides us lessons, which we can apply in the present, but also because it helps contextualize our modern experience within a broader timeframe. History helps us orient ourselves more fully within the scope of human experience. In the context of methadone clinics, it will be useful to understand how some drugs have become used as state tools for social control and other have not. By examining the concept of drugs through time, we can grasp why we have methadone clinics, but we do not have alcohol or coffee clinics.

Drugs have been used throughout human history for healing, performance enhancement, intoxication, and to connect with the spiritual realm. They can potentially shift how an individual experiences and perceives their purpose in the world. Sometimes all these utilities and effects of drugs intersect with one another. Opium was one of the first drugs identified by humans to sit within the intersection of pleasure and therapy. It was noticed that in addition to its intoxicating and analgesic effects, prolonged use of the drug could result in an individual needing increased doses to achieve the same intoxicating or therapeutic effect. This is what we would now refer to as building drug tolerance.

The early Greeks provided some of the earliest documentation of opium tolerance or addiction. Though unlike our modern era, which views this as an affliction, they recognized the phenomenon less as the “tracks of an undesirable habit but as a

mechanism of autoimmunization" (Escohotado, 1999, p. 13). John M. Riddle, professor emeritus of history at North Carolina State University has, "noted that curiously, people in antiquity the Middle Ages and even the early modern period did not have a concept equivalent to our opioid use disorder" (Lanzillotta, 2023). Early philosophers and doctors were very aware of opium's properties and yet they did not report addiction as a problem. Instead, most warnings about opium include warnings about using too much and causing death (Lanzillotta, 2023). This indicates that the construction of drug dependency as a medico-moral issue is a uniquely modern one. Even what constitutes a "drug" is subject to change over time and not without contestation (Goodman, Sherratt, & Lovejoy, 2014). Today, what we consider as drugs or medicine are strongly derived from decades of Prohibition.

Since the Middle Ages, opium has evolved into a plethora of various natural and synthetic variations and chemical analogs which are known to cause both tolerance and dependency. Opioid dependency is characterized by tolerance to opioids[31] and "an altered physiological state that is revealed by an opioid withdrawal syndrome involving autonomic and somatic hyperactivity" (Benyamin et al., 2008, p. 106). This capacity of opioids to cause strong emotional, behavioral, and physiological changes can result in some challenges for those who use them over an extended period and decide to try to stop using them or are involuntarily cut off from a steady supply of opioids.

Opioid detox symptoms feel like food poisoning combined with the flu, accompanied simultaneously by intense mental suffering and anguish. The psychological

[31] Tolerance occurs when, after prolonged exposure to opioids, an individual needs more of the same substance to achieve the desired effects which were previously achieved with a lower dosage.

suffering seems to last much longer than the initial physical symptoms of withdrawal. Opioid withdrawal has been described as, "a point of total, extreme pain - not only physically but mentally also. And this pain is unbearable…if anyone who has ever done drugs had one hour of dope sickness, I guarantee you they'd never want that feeling again in their entire life. Ever" (Omand, 2016). Though drug use that is repeated despite negative consequences such as criminalization, social marginalization, or risk of death may appear irrational, avoiding pain and suffering is generally a natural human response.

In fact, the drug seeking response to withdrawal, so frequently characterized as irrational and pathological behavior of the "addict", could be understood as a health seeking behavior. Health seeking behavior "has been defined as any action undertaken by individuals who perceive themselves to have a health problem or to be ill for the purpose of finding an appropriate remedy" (Olenja, 2003, p. 61). This understanding counters popular narratives of opioid dependent individuals as demon possessed, or more recently, as having "highjacked brains."[32] Far from being the irrational response of a mentally depraved individual, opioid dependent people who seek to mitigate withdrawal symptoms are engaging in thoughtful risk analysis and health seeking behavior. Additionally, these withdrawal symptoms, and the trauma they impose on opioid dependent people are often minimized by health care professionals, who frequently describe them as merely "flu like symptoms" (Farrell, 1994, p. 1471). This dismissive attitude displayed by researchers and health care professionals towards pain associated with opioid withdrawal is meant to

[32] The "highjacked brains" trope has been popularized by researchers at the National Institutes on Drug Abuse. The term sounds less unscientific than describing drug dependent people as "possessed," and manages to seem authoritative by gesturing to the brain, the seat of rational thought. https://www.science.org/content/article/chemists-seek-antiaddiction-drugs-save-hijacked-brains

legitimize leaving individuals in pain. The pain of withdrawal can sometimes feel like an individual is in a life-or-death situation. Yet they will not be treated as if their pain or needs are valid if they seek help from medical professionals.

For individuals who are dependent on opioids, wellness can feel very much beyond one's grasp without sustained access to these drugs. Opioids are drugs which impact the central nervous system, and result in physical and mental dependency, also sometimes referred to as addiction.[33] It is estimated that there are approximately 15.5 million people who are dependent on opioids worldwide (Sordo et al., 2017, p. 357). The National Institute of Health estimates that almost 10% of people in the U.S. would meet the criteria to be diagnosed with a substance use disorder at some point in their lives (National Institute of Health, 2015). Far from a niche issue, opioid dependency impacts a broad and diverse cross section of people on this planet.

Beyond just the addictive properties that have helped it gain so much widespread notoriety, opium has been used for healing and pleasure since ancient times. Since ancient times, drugs like opium have been used to feel good, heal, improve performance, and to connect with the spiritual realm (Escohotado, 1999, p. 3). But today, which substances are appropriate to be used by whom, when, where, and for what purpose, is regulated by law. Using opioids outside of official state-sanctioned medicalized surveillance is criminalized and can result in intensive social marginalization even for

[33] Opiate withdrawal syndrome can be experienced as various signs and symptoms, including nausea, vomiting, psychosis, muscle and bone pain, emotional distress, sweating, pulse and blood pressure changes, anxiety, abdominal pain, etc. While clinical tools such as the clinical opioid withdrawal scale (COWS) have been developed in attempts to assess and quantify opiate withdrawal, pain and withdrawal experience is subjective and the utility of these assessment tools are only recently gaining more interest as drugs like buprenorphine are known to cause precipitated withdrawal.
https://www.ncbi.nlm.nih.gov/books/NBK526012/

individuals who have never been incarcerated. In modern times, opioids are no longer widely viewed as a tool for healing and connection with the spiritual realm through intoxication. In fact, opioid use is considered so dangerous, its sale and use must be tightly controlled and placed under surveillance of designated professionals. While it is still recognized and medically used as an analgesic, in the United States, only state-sanctioned military and medical professionals are legally allowed to make determinations on who can access and use opioids legally.

The modern era has experienced a biopolitical shift, under which drugs are used to discipline, control, and regulate populations. Drugs of all kinds, whether psychoactive, intoxicating, or even substances that have no intoxicating capacity at all, are now utilized as part of the drug disciplinary regime, which operates "to make live and to let die" (Foucault 2003, p. 240). The medicalized or criminalized context and discursive practices around which drugs are used, by whom, and for what, greatly influences impact - drugs can help to make one live, or to let one die. For someone who is experiencing chronic pain and/or who is physically dependent on opioids, access to these drugs may increase quality of life and longevity (Dole 1973). The state now controls and regulates access to professionalized medicine, controlling who may or may not access both medical care and drugs.

Opioids are just one class of drugs where the drug disciplinary regime and biopolitics intersect on the bodies of people who use drugs. After the advent of morphine in the 19th century, doctors in the United States became the primary source for individuals to obtain opiates (Davenport-Hines, 2001, p. 61). In the late 1800s and early 1900s, doctors supplied and maintained people who became dependent on opioids by prescribing

them morphine. This process of sustaining opioid dependent individuals on morphine was known as morphine maintenance, and a broad range of people with diverse backgrounds had their opioid dependencies maintained by doctors in this way. In 1914-15, however, The Harrison Narcotics Tax Act (commonly referred to as The Harrison Act) enacted strict regulation and taxation on the production and importation of coca and opium products in the United States. These taxes and regulations resulted in making morphine maintenance illegal. It was not until the 1970s that the federal government would again similarly allow medical opioid maintenance, but this time with another synthetic opioid: methadone (Andraka-Christou, 2020, p. 21). Instead of the long-gone morphine maintenance, people dependent on opioids began to be shifted into highly regulated methadone maintenance programs.

Methadone is now the primary treatment for opioid dependency. Approved for this use by the Food and Drug Administration (FDA) in 1972, methadone is a "weak-acting opioid agonist (that is, it imitates the action of an opiate, such as heroin) that does not generate the euphoria of an opiate but does reduce symptoms of opiate withdrawal" (Institute of Medicine (US) Committee on Federal Regulation of Methadone Treatment, Rettig, & Yarmolinsky, 1995, p. 1). Instead of being maintained by a doctor within private practice (as people who were opioid dependent were with morphine prior to the passage of the Harrison Act), methadone maintenance was siloed into specific clinical settings referred to as opioid treatment programs (OTP). In contrast to morphine maintenance programs, modern methadone maintenance programs help to extend the reach of the drug disciplinary regime further into the lives of people who are dependent

on opioids by merging carceral and ostensibly therapeutic practices into the clinical OTP setting.

Morphine maintenance was provided to individuals by doctors in private practice, outside of clinical settings. This allowed people who were in morphine maintenance to essentially maintain their opioid dependency privately, much like they would any other chronic health issue requiring daily medication. Since 1972, however, methadone maintenance has been offered only in clinical OTP settings, under conditions of intensive surveillance and monitoring regulated by the federal government (Institute of Medicine (US) Committee on Federal Regulation of Methadone Treatment, 1995). Methadone is regulated even more intensely by some individual state laws (*Overview of Opioid Treatment Program Regulations by State, n.d.*). This shift from morphine maintenance, which was provided by doctors in office-based settings, to only providing methadone administered through clinics, or OTP, signals the biopolitical shift and the establishment of an intensive drug disciplinary regime working through these OTP to discipline and punish people who are dependent on opioids and other illicit drugs. Morphine maintenance was a medical intervention, while the goal of the methadone clinic is population management.[34]

[34] Morphine maintenance allowed individuals who were dependent on opioids to maintain their drug use in the privacy of their own home, under the treatment of a personal doctor. The establishment of OTP shifted the maintenance of opioid dependent people into spaces where clinicians and counselors make decisions about who may or may not access methadone (and the space of safer, legal drug use this provides). This is how the OTP operates as population management, by providing only those individuals who can maintain their status as a compliant methadone client access to the legal sanctuary provided by methadone.

Coercing Compliance

Shifting away from the role of morphine or methadone as maintenance, which was focused on supporting opioid dependent individuals and reducing social harms related to illicit opioid use, methadone treatment embraced values from the recovery movement (Frank 2018). In 1972, federal opioid treatment standards were published outlining the rules and regulations opioid treatment programs that dispense methadone must follow and they have not changed or been broadly amended since (Substance Abuse and Mental Health Services Administration 2015). These federal treatment regulations require methadone only be prescribed for maintenance of opiate dependent individuals within a tightly controlled clinical system, today referred to as methadone clinics or opioid treatment programs (OTP). For guidance on accreditation clinics rely on the Substance Abuse and Mental Health Services Administration (SAMHSA), an agency within the Department of Health and Human Services. The regulations outline strict surveillance and control protocol over clinic staff, methadone itself, and most especially, over the clients who navigate these spaces.

This move from private doctors prescribing morphine to opioid dependent patients, to legally silo opioid dependency maintenance into the clinical setting is part of the biopolitical shift described by Foucault. The bodies of opioid dependent people are now "in the grip of very strict powers, which imposed on it constraints, prohibitions, or obligations" (Foucault & Rabinow, 1984, p. 180). This is part of the process of creating docile bodies, individuals will either be made to live by being transformed and recovered, or they will be allowed to die if they are unable to or refuse to be recovered. This shift towards viewing addiction as disease or individual pathology is politically expedient, it

elides the role of structural forces, such as prohibition, in imposing harms on the bodies of people who use illicit drugs.

During these past 50 years since methadone has been utilized as a maintenance drug, hundreds of thousands of opiate dependent individuals in the U.S., including myself, have accessed methadone via these clinical networks (General Accounting Office, 1989; NIDA, 1990). Most of us are forced to attend the clinic daily to receive our daily dosage of methadone. There are very few holidays from this intrusive and burdensome routine. For the last several years, I have spent every Christmas morning at the methadone clinic, waking up at 4:00 am to drive across town to go get my methadone. Methadone clinic clients are offered few days off or any reprieve from attending the clinic without jumping through a lot of hoops to get additional take-home doses of medication. Clients are subjected to intensive, intrusive monitoring by these methadone clinics. It is not uncommon for clients at OTP to end up having to spend hours every single day traveling to or at the clinic, merely to access medication that helps them to stay alive and healthy (Joudrey et al., 2020). This is a routine that is quite disruptive to living a normal life. The desire of people on methadone to both maintain access to a drug which allows them to live a life free from the pain of opioid detox and withdrawal, as well as the potential to be able to get take home doses, which would allow them to escape this burdensome daily attendance, is exploited by staff to coerce compliant behavior from clients. They do this by promising decreased abuse for compliance with clinic rules.

There is very little transparency for clients regarding compliance standards at the clinic. However, it is made abundantly clear that missing days, showing up late, refusing

to submit to urine drug screens (UDS)[35] or counseling, or any disagreements with staff can result in being labeled non-compliant. If a client is deemed to be non-compliant by clinic staff, they could be subjected to a variety of consequences. Consequences for non-compliance could include being forced to participate in even more burdensome (and billable)[36] clinic meetings such as counseling, additional drug screening, rapid detox and taper of methadone, or a client may be expelled from the clinic altogether.[37]

While state regulations and how each clinic interprets them vary, U.S. federal regulations dictate that methadone clients must submit to random and frequent drug testing,[38] daily attendance, observed dosing,[39] physical examinations, and attend mandatory counseling. If a client does not adhere and submit to any of the clinic requirements, they are deemed non-compliant and will be subjected to disciplinary procedures. In addition to the potential to gain take home doses of methadone, efforts to coerce compliance and to discipline and control clients' behavior[40] sometimes include withholding or reducing the amount of methadone an individual takes every day

[35] Urine drug screens may be monitored by clinic staff. This can include cameras and mirrors in toilets, which have the potential to zoom in on clients' genitals when urinating or having staff of the opposite sex physically watch clients urinate.
[36] The more services a client receives, either by coercion or by choice, the more the clinic can bill the insurance for these services. This demonstrates a clear profit motive.
[37] For rural methadone clients, the impact of being expelled from a clinic could be devastating. In addition to the risk posed by the disruption of their access to methadone, which urban clients also experience, rural clients may not have multiple different clinic options available to them.
[38] Drug testing is usually done through urine drug screening (UDS), but clinics also utilize saliva and blood tests to conduct surveillance over client use of intoxicants.
[39] Clinic staff supervise clients as they swallow the methadone, with many clinics requiring clients to open their mouth or speak to the employee who provided the dose before they can leave the dosing window.
[40] The behavior for which a client may be punished includes the failure to pay the clinic. Failure to pay the weekly fee or slipping too far behind in payment to the clinic will result in a rapid detox (colloquially referred to as the "feetox") and they will have their dosage rapidly reduced until they either pay the balance due or they are expelled from the clinic.

(Bigelow, 1976). The clinics control access to methadone, a resource which helps opioid dependent individuals maintain their comfort, stability, and quality of life.

This control over resource provision is utilized both to coerce and to maintain compliance from clients. A central and ever-present facet of any methadone program is frequent drug testing, usually conducted through urine drug screenings (UDS).[41] In 2022, while we were experiencing a global pandemic and many people were under lockdown and quarantine protocol, I personally was required to submit to a urine drug screening at the clinic at least once every week for the entire year. Some clinics even have mirrors and cameras placed in the bathrooms to view and record the genitals of clients as they urinate. Supposedly this is to ensure no one tries to submit a urine sample that is not theirs or that has been tampered with. But some clients at methadone clinics suspect that the degradation is the intended function of these "pecker cameras" as they are colloquially referred to by methadone clients. At meetings with the Urban Survivor's Union, members who are transgender have shared their experience being laughed at by clinic staff who observe their UDS, and having their genitals mockingly described to other staff or clients.

The stated primary objective behind these regulations and the hyper-focus on compliance is to deter diversion of methadone to the illicit market.[42] One of the current requirements outlined in this code of federal regulations (CFR) is that "substance abuse counseling" is mandatory for all clients who receive methadone at an OTP:

[41] Drug Screens may also include saliva swab testing, or breath testing.
[42] In the case of the "pecker cameras", the premise behind the supposed need for such indignities are to prevent any clients who do not have the requisite methadone-only urine drug screens (UDS) to qualify for additional take home doses of medication or travel "privileges" as they are called. Take home doses and travel doses at the methadone clinic are referred to by staff as "privileges." It is notable that access to a medication that some individuals need to function and retain a healthy, stable life, is referred to as a privilege.

> OTPs must provide adequate substance abuse counseling to each patient as clinically necessary. This counseling shall be provided by a program counselor, qualified by education, training, or experience to assess the psychological and sociological background of patients, to contribute to the appropriate treatment plan for the patient and to monitor patient progress. (Federal Guidelines for Opioid Treatment Programs 42 C.F.R. § 8.12(f)(5))

There is a lack of clarity around what type of counseling is "clinically necessary," who is "qualified" to offer it, how frequent it must be, and what "substance abuse counseling" is. My research aims to characterize counseling in opiate treatment program (OTP) settings in Arizona and to interrogate it using a Foucauldian lens. I theorize that any pretense at a therapeutic alliance is broken when counseling is mandatory, and the way it is implemented in the clinical setting is often punitive, and coercive – conditions that are not appropriate for building trust, a central component of the therapeutic alliance (Reyre et al., 2017). Counseling is utilized in methadone clinics similarly to how sex offenders receive counseling and therapy, with disciplinary measures being decided on by counselors and functioning more for surveillance than to support any treatment goals the client may have (Simon et al., 2022, p. 4). The carceral surveillance aspect of the OTP system is hidden behind a flimsy therapeutic façade that purports to monitor and control individuals for their own benefit and protection. The underlying rationale motivating this is that opiate dependent individuals are a danger to themselves, so must be monitored to be protected from their own behavior. A Foucauldian analysis of the mandatory counseling in OTP settings is used to understand how discipline and punishment is embedded within this smokescreen of care and to outline how docile bodies are created.

Analyzing the opinions of methadone clients about the mandatory counseling will help to illuminate the impact this has on the people being subjected to it.

A Brief History of Methadone

Methadone Policy Review

Methadone is currently available as a treatment for opioid dependence in 65 countries (Schwartz et al., 2012). Since 1972, the United States adopted the regulations in 42 CFR requiring some type of psychosocial treatment to accompany methadone provision, "These psychosocial services are not required to accompany methadone delivery in 13 countries in the European Union and Australia and are not required for buprenorphine treatment in the U.S." (Schwartz et al., 2012, p. 943). The lack of availability of these psychosocial treatments (e.g., counseling) has inhibited the ability to offer methadone outside of urban centers in the U.S, leaving individuals in rural areas particularly underserved due to the increased distances individuals must travel to the closest clinic (Kiang et al., 2021). Most of the research into the efficacy and utility of these psychosocial interventions, or counseling as I will refer to them for the purposes of this study, have focused on assessing whether the counseling requirement is necessary to expand access more rapidly to methadone. But it has not examined client beliefs or experience of the counseling mandates, nor whether clients desire or value the counseling.

Notably, many claims have been made about the presumed value and important role that counseling plays in methadone provision even though no researchers have ever managed to definitively demonstrate positive impact of counseling on treatment outcomes in the context of methadone provision for opioid dependency (Bigelow 1976,

Yale University 2006, Dugosh et al. 2016). The American Handbook of Psychiatry even states, “Although the provision of counseling and auxiliary social services in methadone maintenance has not yet conclusively proven to influence treatment outcome, few serious observers doubt that such services play a vital role” (Senay, 1975, p. 839). Yet there is not much evidence for said “serious observers” to make a basis for such an opinion. In the literature, it is not the lack of evidence that is cited, but instead it is the cost of offering these services which is identified as prohibitive for increasing access to methadone, and it is cited as a “limiting step in providing treatment” (Schwartz et al., 2012). Despite the lack of evidence demonstrating utility or benefit, as well as the prohibitive cost and decreased accessibility caused by the counseling requirements, the positive regard towards counseling remains pervasive among researchers (Schwartz et al., 2012). There is a positive bias towards counseling in methadone treatment settings by researchers despite their inability to produce substantive evidence demonstrating efficacy or positive impact of counseling.

Two of the doctors who conducted some of the earliest research demonstrating the efficacy of methadone at decreasing negative outcomes associated with opioid dependency, Dr. Vincent Dole and Dr. Marie Nyswander, explained “there has been very little need for psychotherapy, and no indication that structured group therapy would contribute to rehabilitation…the lack of formal psychotherapy in the treatment program thus reflected the experience of the professional staff that routine psychotherapy was not needed for rehabilitation of the patients we had stabilized on methadone” (Dole and Nyswander, 1967, p. 19-20). This indicates that even at the genesis of treatment programs utilizing methadone as an opioid replacement, it was understood that psychosocial

interventions such as group therapy and counseling were not a critical aspect of the treatment.

Concern over the lack of research published regarding supportive therapies like counseling in methadone programs has been voiced as early as 1972, when comments were made at the Fourth National Conference on Methadone regarding the vacuum of reports coming out of methadone programs regarding what supports were being offered (Lowen, 1972). Even today, decades later, it remains unclear what other than methadone is being offered, and there is still a lack of transparency around what kind of counseling is being provided to clients at these opioid treatment programs (OTP). Researchers and clinicians prescribing methadone have vocalized their belief that "methadone is a drug, not a treatment" (Kleber, 1977; Isikoff, 1989) and "despite the real and symbolic importance of methadone to the addict [sic], the counseling relationship is still central to the rehabilitative process" (Weiner and Schut, 1975, p. 292). Despite the persistently vocal beliefs of clinicians and researchers that counseling has value, none of them seem to be able to demonstrate this in their research. From the statements by Weiner and Schut, it seems that there is an emotional bias on their part to denigrate the importance of the methadone as viewed by methadone clients, and to instead privilege their own role in rendering other services as central to methadone provision and the positive results it engenders.

The desire of clinicians and researchers to believe in the efficacy of counseling and therapeutic interventions, or "methadone is a drug, not a treatment" as Kleber stated, might be because if the positive outcomes associated with methadone are the result of a drug, and not these interventions, then human contributions are downplayed. Especially

downplayed are the contributions of educated professionals like the researchers and doctors who remain convinced of the value of their effort as manifested in the counseling. If we accept that methadone is just a drug, effective at decreasing negative outcomes regardless of additional interventions like counseling, this will mean that their own contributions as clinicians and experts are downplayed and less valuable than they may hope to believe. Also, if exchanging an illegal drug with a legal drug is enough to facilitate positive outcomes for the patient and dramatically reduce all-cause mortality, then perhaps many of the harms previously attributed to the personal pathology of "addiction" are the result of socially constructed harms related to the illegality itself – prohibition and criminalization. Accepting that methadone is replacing one drug with another, and that itself is the function which reduces harm, would instead emphasize the role that socio-structural harms like criminalization play in increasing negative outcomes experienced by people who use illegal drugs. Viewing methadone use by people who are dependent on illicit opioids as replacing one drug with another also deemphasizes the role of "recovery" in methadone provision.

As methadone researcher David Frank[43] points out, the U.S. has been experiencing a "cultural and epistemological shift away from an approach that emphasized client stabilization and a reduction in social harms towards one grounded in the values of the recovery movement" (Frank 2018). The recovery movement centers the disease model of addiction and abstinence from all intoxicants, with psychosocial services like counseling emphasized as central to the normative recovery process. The

[43] Dr. David Frank is a researcher at New York University who is also open to the public about his status as someone on methadone. He is also a member of the NC Survivor's Union.

way that recovery is being conceptualized regarding methadone provision depoliticizes individual choices to take methadone by decontextualizing from the fact that by switching from an illegal drug to a legal drug, individuals are being sheltered from the central social harm of criminalization. The work that this focus on individual recovery does is that it allows the status quo of criminalization as the central harm experienced by people who use illicit drugs to go unchallenged and for the narrative of individual pathology and medicalization to elide the socio-structural drivers of harm and death.

There has been a clear gap in the evidence-base, with very little research examining client views and beliefs about the counseling they are forced to receive while they are on methadone. To my knowledge, this is the first study to examine client views and beliefs about the counseling mandate for individuals receiving methadone for opioid dependency. Similarly, the literature on differences in gender in methadone treatment has been limited (Rowan-Szal, Chatham, Joe, & Simpson, 2000, p. 7). Methadone is offered through OTP in a way that ignores the positionality of clients. Just as whiteness is the unstated norm around which treatment is centered, it is also unstated that access to methadone is centered around male clients.

Some methadone clinics do not allow children in the clinic at all. This exclusion of children from the clinic, combined with the demand for daily observed dosing, makes compliance for pregnant and parenting clients very challenging. The clinic rules and designations for compliant or non-compliance revolve around the needs and schedule of an individual who does not have any responsibility to care for children. This disproportionately impacts women, who share much of the burden for children and caretaking. Many clinics have operating hours that are very early in the morning, opening

at 4:00 am and closing by 11:00 am. For anyone with the responsibility of waking children, feeding them, and taking them to school, the additional burden of stopping by a clinic every day to get their medication, is extremely disruptive. This leaves women who are clients at methadone clinics more likely to miss days of attendance at the clinic, which will place them at risk for being deemed non-compliant and potentially expelled from the clinic.

Another key gender difference experienced by OTP clients is that women have less arrests than men and counselors report providing more medical referrals to women clients (Rowan-Szal, Chatham, Joe, & Simpson, 2000, p. 7). This is likely because women who access methadone through methadone clinics generally enter at a much later age than men (Rizal, Khan, Harun, & Saleh, 2020, p. 657). Women who use drugs risk losing custody of their children if they are exposed as drug users. There is additional stigma attached to drug use for women, who are viewed not just as deviant drug users, but as deviant against their gender roles. Women are supposed to be chaste not only sexually, but chaste with their use of intoxicants as well.

Any illicit drug use at all, even drug use that is not viewed as problematic by the woman using drugs, is frequently conflated with child abuse. Many states designate counselors as mandatory reporters if they find out that a client who is a parent is using illicit drugs (*Substance Use and Pregnancy—Part 1 Current State Policies on Mandatory Reporting of Substance Use during Pregnancy, and Their Implications*, n.d.). This means that many counselors at methadone clinics may report mothers who enter treatment. For these reasons, women generally tend to access methadone at a much later age than men. Women are afraid to be exposed as drug users and risk separation from their children.

Because of this delay in seeking support for their opioid dependency, women often have greater unaddressed medical needs when they enter a methadone program.

Leaving gender unaddressed, similarly to the color-blind approach deployed by methadone clinics, fails to support the unique needs of women who are opioid dependent. Clinic rules such as observed urine drug screens (UDS), which are often conducted by male clinic staff, ignore the fact that many women who use drugs have experienced sexual abuse. Even women who have never been labeled with a substance use disorder diagnosis have been found to increase their use of drugs and alcohol after an abusive event (Kilpatrick, Acierno, Resnick, Saunders, & Best, 1997, p. 834). By ignoring gender completely, and subjecting female clients to the indignity of having to urinate in front of male staff, methadone clinics are imposing more trauma on female clients. This can be even more traumatizing when female clients must use toilets with mirrors and cameras placed inside, with the capability of zooming in on your private areas as you urinate. The additional indignity of being forced to do this while menstruating must also be stressed. Even at clinics that do not have observed UDS, mirrors or cameras in the toilet, I can personally attest to the fact that carrying a cup of bloody urine around a waiting room can be quite uncomfortable.

Mandating Counseling

There is little transparency into the character of counseling resources offered within the OTP setting and research has been limited. However, the Substance Abuse and Mental Health Services Administration, the federal agency responsible for supporting methadone clinics, has published recommendations for methadone providers. For SAMHSA-approved best practices, clinicians who prescribe methadone are directed to the

Treatment Improvement Protocol 43 (TIP 43): Medication-assisted Treatment for Opioid Addiction in Opioid Treatment Programs (*A Treatment Improvement Protocol 43 Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs TIP*, n.d.). Regarding counseling, SAMSHA references the federal regulatory mandate and adds that this "may include different forms of behavioral therapy" (Substance Abuse and Mental Health Administration, n.d.; Center for Substance Abuse Treatment, 2005). The language of the regulations and the accompanying guidance leaves what counseling might entail open to interpretation, and unless otherwise directly specified by state law, interpretation is left to the determination of each individual clinic. In practice, this means that clinicians have a lot of power to decide how intrusive – or not – the counseling requirements at their individual clinics will be.

Access to both vocational and educational counseling is stipulated as a requisite offering alongside any behavioral therapy. The American Psychological Association defines therapy and counseling as,

> A collaborative treatment based on the relationship between an individual and a psychologist. A psychologist provides a supportive environment that allows patients to talk openly with someone who is objective, neutral, and non-judgmental (*Therapy*, 2021).

However, it is unclear if clients at methadone clinics receive, or are even able to receive counseling that meets this standard outlined by the American Psychological Association. A 2019 Report from the U.S. Department of Health and Human Services conducted site visits and interviews with key informants at methadone clinics across the U.S. and found that there is no standard of counseling, and the quality of care or "treatment" varies

dramatically from clinic to clinic (HHS Office of the Assistant Secretary for Planning and Evaluation 2019). This lack of clarity emphasizes the need for this research, which will characterize the counseling OTP clients in Arizona are mandated to comply with. A recent study of drug treatment in Arizona found that less than 30% of drug treatment providers could answer questions about what the treatment would entail when they were called by secret shoppers on the phone (Meyerson et al., 2022). When it comes to understanding what is happening inside of these methadone clinics for counseling, there is very little communication, even between prospective/existing clients and the clinicians who supposedly provide these services.

Despite this lack of clarity around what counseling is, any refusal or inability to participate in whatever arrangement a clinic designates to be counseling could result in rapid administrative detox. Methadone is dependency-forming, so rapid detox is not only painful, but it also increases risk for deadly overdose events, and other negative health outcomes. For clinic clients who are already required to come into the clinic daily for observed dosing, the additional burden of attending mandatory counseling sessions may be a barrier to maintaining access to their medication. Attempting to maintain obligations for family, work, and health while also being required to travel across town to pick up medication daily is challenging enough, but with the addition of onerous time-consuming requirements like attending counseling, this challenge can become insurmountable. For individuals who do not own a vehicle, the requirement to make additional trips to the clinic are even more challenging and disruptive to their daily lives. Some clients may also not want to participate in counseling, especially within a space that they are subjected to

indignities by staff in whom they have very little trust, whose central role is frequently focused on discipline and surveillance.

Methadone clinics are spaces with extreme power imbalances between staff and clients. This power imbalance is evident in the client-counselor relationship as well. In addition to potentially having access to personal information about clients which may make them vulnerable to abuse or exploitation, counselors are allowed to make decisions about who is compliant or non-compliant, designations that determine whether a client will be able to have access to safe and legal opioids. The counseling mandate was implemented despite the lack of evidence that it improves positive outcomes for clients and may increase negative outcomes by creating barriers to accessing medication for those who are non-compliant (Schwartz et al., 2012; Simon et al., 2022). Considering the burden and potential barrier to care and accessibility this mandate creates, it is important to interrogate why this is required. Additionally, anyone who cares about health equity for people who use drugs should be concerned with understanding what exactly is being demanded of methadone clients and what counseling in these spaces consists of. If an individual is going to be required to provide potentially private personal information, which could make them vulnerable, it would seem there should be some minimum standard of quality or guarantee of professional conduct for clinic staff designated as counselors.

The largest autoethnographic study written by people who are on methadone, *The Methadone Manifesto*, outlines how much control counselors have over clients, and the impact counseling sessions can have on client treatment plans in OTP (Simon et al., 2022). Counselors have power to influence client treatment plan goals, including dosage,

take-home allowances, and promote abstinence-only goals even when these goals are counter to those goals directly expressed by clients. Because of the federal mandate to conduct drug testing, generally via urine drug screenings (UDS), and to use the toxicology results as a determination of compliance or non-compliance, individuals do not get to direct their own treatment goals in these programs. For example, an individual who is seeking support for their opioid dependency but has a positive result in their UDS for cannabis or alcohol (even though they do not view their use of these specific drugs as problematic) will still be deemed non-compliant. Many clinics allow counselors to reduce or withhold medications from clients they deem to be non-compliant. Counselors could also make the decision to expel a client from the OTP if they test positive for other drugs regardless of if they are legal or not.

Methadone clients can be discharged from treatment if they are designated to be non-compliant by counselors, which can include if they do not or refuse to attend counseling. Expulsion, treatment discontinuation, and rapid detox from methadone programs greatly increases all-cause mortality risks for people who are opioid dependent (Sordo et al., 2017). Creating additional challenges for individuals to remain in methadone programs not only causes suffering and pain for opioid dependent people who may be forced to experience withdrawal symptoms, but it also increases the likelihood that they might die. Additionally, clinics often are only open for minimal hours in the early morning of the weekday, making attending mandatory counseling sessions challenging for clients who are employed, lack transportation, stable housing, or have other comorbid health issues.

Barriers to accessing methadone, the most efficacious evidence-based resource available for opiate dependency, can have disastrous consequences. Since 2020, the United States has seen a dramatic increase in mortality from drug poisoning. This increase in drug poisoning deaths has disproportionately impacted Black and Native American communities, with drug poisoning rates for Black individuals exceeding that of white individuals by 20% and Native Americans experiencing the highest drug poisoning rates of any racial/ethnic group in the United States, at 30% higher than white individuals (Friedman and Hansen, 2022, p. 30). Methadone is one of the most efficacious resources to decrease mortality for people who are dependent on opioids, yet it remains disproportionately accessible to white men (Netherland & Hansen, 2017). Improving equitable accessibility to this resource, which at present is one of the only forms of full agonist safe supply legally available, is critically important at this moment. The counseling mandate is one of the bureaucratic hurdles identified by *The Methadone Manifesto* as a barrier to health equity for people who use illicit drugs.

Methadone and Biopolitics

> Some of us are granted personhood as our birthright, but others are required to prove and defend it every day. And when we fail this perverse test, we're in trouble. (Clare, 2017, p. 28)

Following Michel Foucault's theory of biopolitics (Foucault, 2008) and Eli Clare's critical disability studies critique of curative impulses (Clare, 2017), my research centers on the potential of community-based participatory action research (CBPAR) to build capacity among other people with lived experience with illicit substance use (PWLE) and to improve access to opioid agonist treatment (OAT), an important resource

in the community. Foucault's biopolitical theory describes how the state or other institutions govern through "biopower." This is relevant to how methadone is applied in the clinical setting because biopower refers to the "numerous and diverse techniques for achieving the subjugation of bodies and the control of populations" (Foucault, 2008, p. 140). It is necessary to understand how methadone, as a tool of the larger drug disciplinary regime, is being utilized in this context of biopower. The work of disability activists such as Eli Clare will also be useful to understand the relationship between the life-saving capacity of medical technology and resources (such as methadone), and the potential for curative violence. As Eli Clare explains, "The ableist invention of defectiveness functions as an indisputable justification not only for cure but also for many systems of oppression" (Clare, 2017, p. 23). The shift from morphine maintenance with private doctors to methadone provided only in clinical OTP settings has been part of the shift from viewing opioid dependency as something to be managed, to something that must be cured. The counseling mandate is part of targeted, curative violence directed at people who are opioid dependent.

Especially as this study seeks to characterize counseling and client beliefs and opinions about counseling, Foucault's theory of the gaze and how medical perception within the clinic setting creates knowledge about individuals who are on methadone is invaluable. As Foucault describes, "It is often thought that the clinic originated in that free garden where, by common consent, doctor and patient met, where observation took place, innocent of theories, by the unaided brightness of the gaze, where, from master to disciple, experience was transmitted beneath the level of words" (Foucault, 1973, p. 52). This understanding of the history of the clinic and its task, will help us to understand why

resources like counseling still hold such a position of prominence in the minds of doctors and patients – even though there is a vacuum of evidence that counseling holds much utility for increasing positive outcomes for people on methadone at OTP. While there is currently a lot of available documentation and publications outlining the generally positive sentiments of researchers and clinicians on the impact and utility of mandatory counseling in the clinical setting, this study seeks to understand and characterize the opinions people on methadone hold regarding this experience.

The dehumanization that occurs within the clinical setting also intersects with Eli Clare's theory of curative violence. Within the clinic, "the individual ceases to be an individual, the patient is the accident of his disease, the transitory object that it happens to have seized upon" (Foucault, 1973, p. 59). The social marginalization and isolation can be intense and result in a lot of suffering for people who use or are dependent on illicit drugs, especially when using highly stigmatized drugs like heroin and illicit fentanyl. For individuals who experience harms and suffering from their health issues that no amount of social justice or accommodation can eliminate, a potential path to cure, even if it is also violent, may seem worth striving towards. Eli Clare advocates for accepting body-mind differences and explains that the desire to normalize all human difference is rooted in ableism (Clare, 2017, p. 61). Diagnosis and treatment can be useful, but in the case of methadone clinics, it is unclear who is the true beneficiary of these treatment modalities.

Clare's theory of curative violence and a critical disability studies orientation will help to analyze the data about clinic client beliefs and opinions regarding the mandatory counseling. A critical disability studies exposes how the addicted body has become a symbol of sickness and how the restoration of health within the clinical setting equates to

elimination of the addict. But what if addiction could be conceptualized not just a symbol, but as a lived reality amidst injustice? The mandatory counseling within the clinical setting is oriented towards eradicating this pathology of addiction, “elimination of some kind – of a disease, of future existence, of present-day embodiments, of life itself – is essential to the work of cure. Sometimes these eradications result in benefit, but they can also cause individual death and the diminishment of whole groups of people. The violence that shadows these erasures could be framed as mere side-effect, or the unavoidable cost of saving lives and normalizing body-minds” (Clare, 2017, p. 28). These two theoretical frameworks will be utilized to understand and analyze what the counseling is in the clinical setting and client beliefs and opinions about the mandatory counseling. This will assist in understanding not just who the counselors are, regarding their professional backgrounds and identities, but to understand what their primary role in the clinic is. The next chapter will outline the functional role mandatory counseling fulfills in the OTP setting.

CHAPTER THREE

Counterfeit Counseling

"The counselors are not like counselors. They're not." (Participant 49)

Methadone clinics are highly regulated spaces where both clients and staff are under strict surveillance. This surveillance is internal, between staff and clients, and external, with clinics and staff subject to all applicable federal and state laws, and the Code of Federal Regulations that govern methadone provision in opioid treatment program settings (OTP). Counseling is one of the resources that are necessitated by these Code of Federal Regulations. As discussed in previous chapters, methadone clinics are required by federal law to provide mandatory counseling to their clients.

This issue is much bigger than just counseling at OTP though and is a product of the discourse surrounding addiction and recovery. As we will see, the counseling at methadone clinics is about gatekeeping access to safety through the violent normalization of human difference. The counseling in these clinical spaces is not intended to support or collaborate with clients to meet patient-centered goals. The role of counseling at OTP is to conduct surveillance on clients to make determinations about whether an individual is compliant or non-compliant. These determinations have significant impact on the lives of methadone clients. Access to a non-criminalized, safer supply of opioids can be the difference between life and death in this moment where illicit drug markets are increasingly contaminated with synthetic opioids and tranquilizers. For some clients, maintaining access to methadone is the difference between being able to retain familial connections, employment, and stable housing. These are just a few examples of how being labeled compliant or non-compliant can destabilize an individual.

Studies examining psychosocial practices in methadone clinics are limited. In 2012, a survey by the Substance Abuse and Mental Health Services Administration (SAMHSA) found that OTP settings mandated most clients to attend individual counseling, and roughly one third of clients were mandated to attend group counseling as well (Strashny, 2014) (See Figure 2). A systematic review conducted by Dugosh et al. in 2016 found that most methadone clinics self-reported implementing some form of cognitive behavioral therapy through individual meetings with a counselor (Dugosh et. al., 2016). There is not much transparency into what exactly occurs in these individual counseling sessions regarding the quality or type of therapeutic support utilized. Additionally, there is a vacuum of evidence to indicate which, if any, psychosocial resources are beneficial to people on methadone (Dugosh et. al., 2016). This dissertation seeks to provide insight into what the mandatory counseling environment looks like from the perspective of methadone clients in Arizona, U.S.A in 2021.

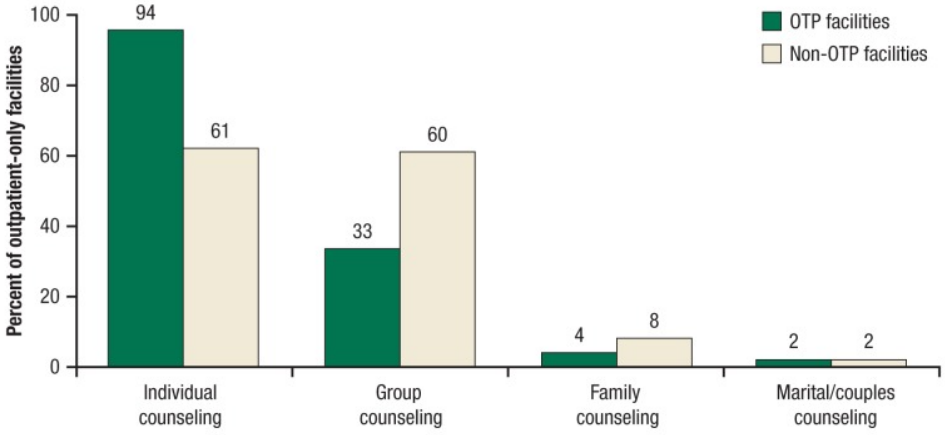
The 2016 systematic review of psychosocial supports in medication assisted treatment (MAT)[44] conducted by Dugosh et. al. emphasized significant gaps in the literature on this topic. Dugosh's findings expose that there is a "dearth of empirical research on the optimal psychosocial interventions to use with these medications…The review highlights significant gaps in the literature and provides areas for future research" (Strashny, 2014, p. 93). Until this dissertation, there had not been any previous research

[44] Medication assisted treatment (MAT) is another term used to refer to methadone, buprenorphine, and naloxone treatment. There are many terms used to describe these medications and treatment utilizing them. These terms can be used interchangeably with other descriptors such as opiate agonist treatment (OAT), opioid replacement treatment (ORT), methadone maintenance treatment (MMT), or medications for opioid use disorder (MOUD). Opioid treatment programs deliver MAT, ORT, OAT, etc. The decision behind which term to apply to this treatment modality may reflect underlying beliefs about addiction and the treatment itself.

attempting to identify and characterize the counseling services provided by Arizona OTP. This is the first study to examine the counseling practices and opinions of OTP clients in Arizona. Understandings of the counseling provided within OTP settings are murky, and recently the U.S. government has taken an increased interest in discovering what type of psychosocial supports are being offered to clients at methadone clinics.

Figure 2

Types of counseling received by more than three-quarters of clients in outpatient-only substance abuse treatment facilities by opioid treatment program (OTP) status (2012)



(SAMHSA National Survey of Substance Abuse Treatment Services (N-SSATS), 2012).[45]

In July 2019, the U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation (ASPE), conducted a literature review including site visits to interview key informants[46] and published a report outlining their

[45]https://www.samhsa.gov/data/sites/default/files/NSSATS%20_SR_162/NSSATS%20_SR_162/NSSATS-SR162-OpioidOOTx-2014.pdf

[46] The report identified stakeholders or what they later refer to as key informants, as clinic staff, researchers, healthcare providers., policymakers, and methadone clinic directors.

findings. The purpose of these site visits was to "gain a better understanding of the role and range of different models of psychosocial support in medication-assisted treatment for opioid use disorder" (Dugosh et al., 2016). Their findings showed that counseling services offered to clients in OTP covered a very broad range of potential services, from general addiction counseling, peer support, or computer and phone-based interventions.[47] The counseling services offered varied widely from clinic to clinic.

This lack of consistency emphasizes that there is no national standard of care or professionalized counseling support offered for people on methadone across the United States. The counseling resources provided to an individual at a clinic on one side of a city could be dramatically different than the counseling an individual with identical needs receives on the other side of the same city. Some of this disparity could be explained by a fact highlighted in the report, "current research is inadequate to provide clear guidance on the types or levels of psychosocial services that should be provided, or on how to adapt psychosocial supports across clinical settings or patient groups." The evidence-base is lacking information to provide clear guidance to methadone clinics on implementing appropriate psychosocial support. More research is needed to understand if counseling is even beneficial to clients on methadone, as well as what resources should be offered. A noticeable blind spot in the ASPE report is its failure to consider the coercion which underlies the provision of these services. The fact that counseling is mandatory for anyone who is receiving methadone at an OTP should be a central consideration regarding any assessment of these services.

[47] The computer and phone-based interventions included virtual meetings with clinic staff online and telephone calls from clinic staff to clients.

Additionally, the ASPE report found that staff working in OTP settings frequently hold stigmatizing views that inhibit the quality of counseling, and the services clients received varied drastically depending on the clinic which they attended. The report outlined that the quality of services offered, such as counseling, may be directly impacted by the stigmatizing views of clinic staff and even clients themselves. Clinic staff who perceive methadone clients as undeserving are unlikely to engage with them in a way that is productive to support individual client needs. Clients who have internalized stigma and view themselves as undeserving are also less likely to self-advocate or to request support that meets their needs.

In the absence of tangible psychosocial support provided by OTP, many individuals who are opioid dependent are referred to self-help groups like Narcotics or Heroin Anonymous. Self-help groups that adhere to an abstinence-based ideology are frequently stigmatizing to individuals who are on methadone, and this could increase internalized stigma which impacts the ability to remain in treatment. The report concluded by outlining the need that "More consistent and comprehensive data are needed to better describe the delivery of psychosocial supports in MAT for opioid use disorder (OUD) across the full range of settings that provide this type of care" (HHS Office of the Assistant Secretary for Planning and Evaluation, 2019). This dissertation steps into the knowledge gap outlined by the systematic review conducted by Dugosh et al. (2016) and the site visit findings of the U.S. Department of Health and Human Services (HHS Office of the Assistant Secretary for Planning and Evaluation, 2019). This is one of the first studies to characterize counseling and client opinions and beliefs about

the mandatory counseling required for methadone recipients through analysis of responses directly from methadone clients themselves.

The lack of clarity and understanding around what exactly counseling is within methadone clinics, is not limited to those outside the clinic walls. When asked what kind of counseling was required to get methadone, nearly all respondents in this study answered without much specificity outside of the frequency with which they were required to have an encounter described as counseling. Despite prompts following the initial question regarding counselor identity, most interview participants were unable to provide much detail aside from the fact that a clinic staff member was referred to as a counselor, and the requirements regarding the frequency with which they were directed to meet with them. Descriptions usually focused on the time they were required to spend with a staff member referred to as a counselor. Many participants said they were not certain exactly who their counselor is, or what credentials they had when interviewers followed up the initial question with prompts. A standard response looked like this:

> Interviewer: What kind of counseling were you required to have in order to get your methadone?
>
> Participant: I was required to see my counselor once a month, who maintained my drug tests…
>
> Interviewer: Who did you meet with? Was it a staff member? A counselor?
>
> Participant: A counselor (Participant 10)

Responses such as this indicate that the participant's interaction with the counselor impressed upon them that the role of the counselor is to maintain their urine drug screens (UDS). This demonstrates that the role of the counselor here is understood foremost as

one of surveillance. If we accept the definition of the American Psychological Association, which defines counseling as a neutral, collaborative relationship between the counselor and the client, maintaining urine drug screens shouldn't be the central role of the counselor. What is being described here is presented to clients as counseling, but it is not counseling, it is counterfeit counseling. If counselors are professionals who have expert training to provide counseling and therapy, perhaps we can presume that in addition to maintaining UDS they offer other therapeutic support. Who exactly are these counselors though?

When interviewers asked for more details about the identity of the counselor, participants would openly speculate, but seemed generally uncertain of who the counselor is.

> Interviewer: Who did you meet with for your counseling? What kind of staff members?
>
> Participant: The kind that worked there, I don't know.
>
> Interviewer: Were they a therapist or someone with certain color scrubs?
>
> Participant: A psychiatrist…I don't know a psychologist. Yeah, I guess a therapist, counselor, whatever you want to call them. (Participant 23).

There was a pervasive sense of uncertainty around the identity of the counselor in participant responses. This reveals that the clinic does not believe that clients need or could potentially benefit from knowing the professional background of the staff who they are engaging with. To build trust in any relationship, transparency about identity is usually the first step in an interaction upon meeting someone new. Introductions are a general baseline of engagement in both professional and personal settings. It seems quite

notable then that so many participants were uncertain of basic background information about the counselors with whom they engaged with. Some of the participants who indicated they were uncertain about the professional background of their counselor reported they had been a client at a methadone clinic for over a decade. This is important to emphasize because in all those years, clinic staff, including the counselors themselves did not view communicating details about their professional qualifications to their clients.

Participant responses helped illuminate some of the reasons for the lack of transparency into counselors' identity and professional backgrounds. Some participants expressed a sense that there was not any designated time for counseling and that they only talked to people when they first enter the program.

> Participant: The only counseling I had was on my initial arrival…They speak with you when you are there every day, but not at great length. It was mainly my initial appointment with the doctor. But for the most part, the people there don't go into great length because there's all kinds of people waiting in line. (Participant 26)

This was an exemplary response among many that outlined the sense among clients that conditions at the clinic were impersonal and rushed. Under these time constraints, there was very little time and opportunity for participants to discuss any issues of personal importance with counselors even if they desired to.

Another important aspect of this response is that it indicates that clients did not feel like they were empowered to seek meetings with their counselors, instead they were directed by clinic staff as to when they would meet with the counselor. This emphasizes the existing power imbalance between clinic staff and clients. Clients do not direct when and how they will receive these services, the clinic rules and need for compliance with

federal mandates dictate access. If the purpose of the counseling were to support methadone clients, one would assume that clients dictate when they meet with counselors and would see them at their own request. Instead, the needs of the clinic and the federal mandate dictate when clients will be subjected to counseling. This is yet another facet of counterfeit counseling – instead of client-centered care, care is centered on the business model and legal needs of the clinic.

The impression that the counseling resources were provided to individuals as if they were on a factory assembly line was pervasive. It became clear during data analysis that there was an understanding among some participants that the services they were receiving were inferior or that they were not accurately described. Participants indicated that they were aware that the counseling was not a resource that existed for their support and benefit.

> Interviewer: If you wanted to get counseling, could you meet with the counselor, do you know?
>
> Participant: Yeah. But I wouldn't. I wouldn't do that. The counselors are not like counselors. They're not. (Participant 49).

If not counselors, then what are they? For several participants, responses like this indicate that they know that the counselors aren't an accessible resource for them to utilize for support but instead existed for some other purpose. Again, emphasizing the extreme and ever-present power imbalance, the counseling is not something to seek out, rather, it is an intrusion that is imposed upon clients. This participant clearly indicated that they would never seek out the counselors on their own. When asked if they could meet with their counselor if they wanted to, the participant scoffed at the prospect, explaining that the

counselors are not truly counselors. Participants consistently indicated that they know the counselors' role is not to provide counseling. The role of the counselors at OTP are to maintain drug screens, and as we will see, to discipline clients who are judged to be non-compliant.

Because of the community-based orientation of the study, the interviewers were also people with lived/living experience of illicit drug use, including methadone. This resulted in conversations between interviewer and participants, with the interviewers also occasionally answering some of the questions as they asked them:

> Interviewer: Do you know about their credentials, or you think they are good?
>
> Participant: Actually, yeah, I don't know anything about….
>
> Interviewer: Because I don't. I don't even know about my counselors. Yeah. They could be some guy off the street. I have no idea. (Participant 36).

Interactions like this, with Participant 36, expose how field researchers who were asking the questions experienced counseling. Listening to the audio recording of this conversation, the frustration with not knowing who their counselor is, or if they have any training or professional background whatsoever was palpable. There is a lot of frustration over not having even basic information about their counselor, or the quality of the services they are supposedly providing. As we see in the response of the participant, he also admits he doesn't know anything about his counselor. This lack of communication from the counselor to their clients indicates that the counselor does not view it as important that their clients know who they are or whether they are trusted. Knowing the identity of another individual is a standard baseline for meeting someone new and building trust. The combination of the lack of trust and the evidence that counselors do

not view trust as important to build between themselves and clients, exposes that counseling is not the purpose of these relationships or interactions at all.[48]

In addition to frustration, some participants seemed jaded about the quality of the counseling they received, and when asked about the identity and credentials of their counselor responded with cynicism and frustration:

> Participant: She's a girl my age. She's literally my age. She's the front desk lady. She's a no one. (Participant 40).

This interaction demonstrates that this participant was aware that the individual described by the clinic as a counselor was not in actuality a counselor. As Participant 40 explains, the person assigned as their counselor did not have any professional training to provide therapeutic support, and she also fulfilled other roles at the clinic in addition to providing the counseling. In all these responses so far, we see the common theme that counselors are not professionally trained or licensed to provide counseling, it is unclear what their background is at all, and while they are described by the clinic as "counselors", none of them seem to be licensed counselors. Considering these responses, we can conclude that therapeutic or psychosocial support is not the intended purpose of counseling. Instead, we can understand that the role of the counselors can be fulfilled without any trust between clients and without any specialized training or qualifications.

Despite expressing mistrust and frustration, most participants did not complain about the counseling they received, even when they mentioned being dissatisfied or let

[48] I refer to this as an interaction instead of a relationship because to build any relationship, whether personal, professional, or romantic, establishing a baseline of introduction.

down by the counselor or quality of counseling available. However, a few did express exasperation with the counseling process and its lack of utility.

> Interviewer: What is your opinion about whether people need counseling in order to get methadone or suboxone?
>
> Participant: You know what? To me it sucks, if you ask me. The case managers don't do nothing for me. It's an in and out kind of thing. Ask me the same questions all the time. Anytime I've ever had a problem, I've always done it myself. I've dealt with it myself. I'm taking myself down right now (referring to decreasing/tapering dosage of methadone). The last time I asked the counselor about it, I said, "What do you think about me going down on my methadone?" "Oh well. Do you think that's a good idea? I don't think it's a good idea." They wanted me to go up. (Participant 19).

Interview responses like this reiterated the sense among participants that services within the clinic operated like a factory assembly line and emphasized the lack of trust or support from counselors they frequently experienced. Even when participants referenced asking counselors or other clinic staff direct and technical questions related to the medication itself, such as increasing or decreasing dosages, side-effects, or tapering off the methadone, many reported being unable to get clear answers to their inquiries from clinic staff, including counselors. Participants indicated the counseling lacked any utility as far as providing support to them with issues related to the methadone itself. This seems to be a rather large and important oversight. Counselors are unable to provide even basic support regarding the medication that their clients are taking. So far, we know that counselors at methadone clinics are not professionally trained, they maintain drug test

information, they do not provide counseling, and they do not offer support for adjusting medication dosages. The only clear role counselors seem to have for clients is to maintain information about their urine drug screens.

What did clients want from their counselors though? Many participants expressed that they needed and wanted more support from counselors.

> "I think it's important, I do. I think it's like having a safety net, some support." (Participant 55).

This participant indicated that they viewed the role of the counselor as one of offering support. Or at least regardless of whether the counselor provides support or not, the participant believed that the counseling should operate as a safety net. Despite some participants' directly expressed desire for more support, none of the descriptions provided described interactions with counselors that exemplified support. Instead, descriptions were of discipline and surveillance posing as counseling.

When asked what kind of counseling they were required to have, some participants answered that they did not have to do any counseling, but that they did meet with someone who asked them if they want to go up or down on their dose, speculating that this staff member might be their counselor. Many participants stated that they would be asked how they are generally by other staff at the clinic, and they believed that interaction, consisting of a general "checking-in", counted as their mandatory counseling session. These interactions were described as frequently occurring between the front desk lady, peer outreach workers, or other administrative clinic staff. There was not any transparency or clear communication from the clinic indicated by participants as to what

their counselor was supposed to do, or what purpose existed behind the counseling, other than a frequency with which they had to meet with someone.

> Interviewer: What kind of counseling were you required to have in order to get your methadone?
>
> Participant: I don't know if it would be counseling, but they were just basically asking me the typical question, and just trying to get basic knowledge of who I am and what I've been going through, and why I need methadone or whatnot. So just the typical. (Participant 24).

In this interview, the participant explains that the counselor is the individual who decides on whether and why they want to access methadone. This role as gatekeeper over methadone accessibility is consistent in nearly all the participant's descriptions of the role of counseling. Counselors maintain drug tests, but they also examine clients' intentions to determine who should access or sustain access to methadone and the legal sanctuary for safer opioid use it provides.

Many participants seemed uncertain of which interaction was designated as counseling by clinic staff, and the understanding seemed to be that counseling is a general checking in with individuals and asking how their day is going. The consensus among interview participants appeared to be that counseling consists of being compelled to update a clinic staff member on how they are doing generally, and the counselor makes decisions that impact their ability to remain on methadone at all. Responses often indicated that participants did not feel like they had any choice or freedom to make decisions around their counseling. Counseling is just another item on a list of things they are required to do to get access to the medication.

Interviewer: What kind of counseling were you required to have?

Participant: Oh, just therapy, just regular counseling, just talking about, how I am feeling and just the typical whatever…whatever they make you do basically. (Participant 27).

This response exemplifies the general tone of participant responses that viewed counseling as just one more thing that the clinic uses its power to make them do. Referring to the counseling as "whatever they make you do basically" emphasizes the lack of agency and control over interactions with counselors. The counseling in the OTP is not a resource for clients to access for support as needed, or to collaboratively establish treatment plans, it is just another thing that clients are forced to endure to maintain safety and access to methadone. The picture of counseling that is being painted by participants is one of coercion, surveillance, control, and discipline. All responsibilities of the counselor revolve around watching and examining the behavior of their clients. Some participants did mention setting goals or treatment plans with their counselors. But the majority did not participate with counselors at all in establishing treatment plans and instead described the process as a general checking in on them.

Interviewer: What happens when you see a counselor? Don't get into specifics, but do you work on treatment plans, prevention?

Participant: No, I basically complain about what's going on in my life and she basically says, oh, that sucks. (Participant 40)

Counselors power was clearly limited to implementing punitive clinic rules and policies, yet they did not have any power to assist or support participants with personal issues or struggles. None of the participants described counseling as consisting of any clear

therapeutic treatment or goal setting and many expressed frustrations that there was no clarity around what the purpose was supposed to be. This lack of clarity, combined with no transparency into the identity, credentials, or background of the counselor, increased mistrust of the clinic and clinic staff among participants.

The interviews were conducted at the start of the COVID pandemic and focused on what counseling looked like during this time for individuals who were receiving methadone. Some participants indicated that they had to meet with counselors even less than usual during COVID, but no one indicated that they were able to self-direct or influence the frequency with which they met with counselors.

> Interviewer: What kind of counseling were you required to have during COVID?
>
> Participant: They were supposed to meet with me once a month. My counselor, she would call me here and there. But I barely met with her in person while COVID has been going on. (Participant13).

This emphasizes the lack of agency and empowerment experienced by participants. Regardless of whether they wanted to meet with counselors, or not at all, they were not able to play an active role in the decision-making process around any of their treatment plans or interactions at the clinic. It is clear and evident that the needs and desires of the individuals who were interviewed were not centered at all in the clinical setting. Instead, the emphasis on the frequency of meetings with counselors indicates that clinic rules and protocol regarding counseling were privileged over client need. So instead of existing to support the individual needs of clients, the counseling exists for something else. The role counseling appears to consistently fill is surveillance and discipline. Counselors work to organize clients into a hierarchy of complaint or non-compliant by maintaining drug tests

and examining client behavior. The services provided by OTP are described as counseling, but what clients receive is counterfeit counseling – it is intended to look legitimate enough on the surface that an observer might assume it is counseling. But as we see here, upon interrogation, this is not counseling.

In addition to checking in with participants, the counselors were also reported to have acted as administrative staff or clinic security officers and had the role of enforcing clinic rules. This was especially true for counselors enforcing the COVID safety measures like wearing a mask and social distancing while in line and in the waiting room. When asked by an interviewer how did the methadone provider keep them safe from being infected with COVID, one participant responded, "I think it was the other way around. They wanted to reduce their contact with us" (Participant 2). Retention in treatment for people on methadone has been shown to increase positive outcomes including reduced risk for all-cause mortality (Gossop, Marsden, Stewart, &Treacy, 2001). This means that methadone clients who suddenly quit treatment are at increased risk for experiencing harm, including death. Methadone clients have reported that negative experiences at the clinic, including confrontation with counselors, have impacted their decision to leave treatment before they felt ready to (Reisinger et al. 2009). Counselors that make clients feel devalued and unwelcome can increase the risk for early treatment cessation.

In addition to maintaining drug tests, counselors were also reported by participants to be the clinic staff that are primarily responsible for communicating urine drug screen (UDS) results to participants. This is yet another task that positions counselors to act more as disciplinarians, whose job is to punish clients rather than to

support them, which contributes to decreased trust between counselors and clients. Some researchers assert that trust is an integral and necessary component for building a therapeutic alliance, which is a necessary component for effective counseling (Schwartz et al. 2017, Reyre et al., 2017). Results that are negative for illicit drugs or alcohol are not communicated, but any UDS results that are positive are conveyed to clients, who are designated as non-compliant and either immediately discharged or put on behavioral contracts.[49] One interview exemplified how counseling was used as punishment when they were put on behavioral contracts which can lead to involuntary detox:

> Interviewer: So when you were on methadone you said you still talked to your counselor. How often was that?
>
> Participant: Monthly…when I was on contract, it was weekly. I had to do counseling weekly. (Participant 1)

Counselors were also cited by participants as being the member of clinic staff who kick you out of the program for noncompliance.

> Participant: Yeah. Everybody pretty much says, "What can we do to help? If you don't test negative (for illicit drugs) by this time, we are kicking you off methadone." (Participant 3)

Both participants explain the disciplinary role of counselors. Drug screens that are positive for any substance banned by the clinic will result in increased contact with a

[49] Behavioral contracts at OTP are basically warnings that clients who have violated a clinic rule (such as having a positive drug screen result) are required to sign to maintain access to methadone. Refusal to sign a behavioral contract will result in rapid involuntary detox. These contracts often demand clients who are on them participate in additional conditions such as extra group meetings, counseling sessions, or peer support, to retain access to methadone (these conditions are usually billable for the clinic as well, so there is a financial incentive present for the clinic to implement these behavioral contracts).

counselor. Participants made it abundantly clear that abstinence from all substances banned by the clinic is the singular goal projected on every client. Failure to conform to that clinic-mandated goal will result in more frequent contact with counselors, whose job is to exert pressure on clients to meet these clinic goals. These responses highlight how antithetical it is to expect clients to build trust with counselors, the same individuals who are responsible for punishing them. Participant responses again indicate that the role of counselors in the OTP is not to provide the kind of counseling described by the American Psychological Association. The counselors' role is to discipline and enforce clinic rules and policies.

This disciplinary role was further emphasized by participants who explained how their access to methadone was weaponized by counselors to coerce their compliance with clinic rules.

> Participant: And so they wouldn't increase me and stuff (referring to raising their daily dosage of methadone). And so it was just, I would also have to wait outside the clinic and wait for them to drug test me, and this was a swab…and that would sometimes determine if I even got the dose. (Participant 3).

The results of drug screens that were positive for substances banned by the clinic were described as central in communications with counselors. As we see with Participant 3, they would not even be allowed to enter the clinic to get their methadone until they submitted to a saliva drug test, also referred to as a "swab".[50] Decisions and requests for

[50] Saliva drug tests are frequently administered in the waiting room (or as described by Participant 3, outside in the parking lot) in front of other clients and staff. There is no privacy for individuals who have to place what some describe as a "cotton tampon" into their mouth for several minutes, until a clinic staff member comes to collect the swab from the client's mouth.

dosage increases (or even decreases/tapers) are frequently refused for individuals who are not submitting drug tests that are indicative of methadone positivity-only. For clients who wish to increase the amount of methadone they take every day, clinic staff, including counselors, frequently make decisions without client input. For example, as Participant 3 indicated, they were not allowed to increase their daily dosage of methadone because of their positive drug screens.

This is counterintuitive though, because if someone is still using opioids, it could be indicative that they are not getting enough methadone to prevent them from experiencing detox and withdrawal symptoms. Conversely, other clients at methadone clinics describe being pushed by counselors to increase their dose when they have produced positive drug screens. Some people use methadone to supplement their opioid use rather than to achieve opioid abstinence, and still desire to continue using illicit opioids, albeit in a much more moderated way. This is referred to as “chipping”. If counselors suspect you are chipping, they often force clients to increase their methadone dose because they know this will make it so the individual will not be able to experience the euphoria from illicit opioids. Once a methadone dose is high enough, it makes it challenging to get any effects from other opioids. For this reason, people who are chipping will often attempt to keep their methadone dosage high enough to not get sick from detox and withdrawal, but low enough that they can still enjoy a heroin high when they choose to use it. This inconsistency with dosing by methadone clinics exemplifies the overall lack of agency and autonomy over their treatment experienced by clients.

Regardless of whether participants described being pushed by counselors to increase their dosage, or whether they were refused an increase in their dosage, the role

of counselor was consistently focused on monitoring them. Surveillance is not support. For participants who perceived interaction with their counselor as functioning mainly as a surveillance mechanism for the clinic, the relationship was described as much more adversarial than for those who reported engaging with counselors for other reasons than just positive drug screens. Individuals who reported their experience of counseling to be oriented overtly towards surveillance, their perception seemingly destroyed the thin veneer of medicalization that counseling at the methadone clinic existed as some form of support for them. Some participants who described this experience reported dropping out from treatment altogether and had negative views about the efficacy of methadone as a treatment generally. The power imbalance between counselors and methadone recipients was evidenced throughout interview responses indicating that counselors held power over the amount of methadone they are taking every day, and even the participant's ability to stay in the methadone program at all.

While every person interviewed described engaging in some form of individual contact with a member of clinic staff which was described as counseling, 8.3%[51] of participants in this study mentioned being required to attend group counseling sessions in addition to individual counseling sessions with a counselor. The amount of group counseling reported among this small cohort varied greatly. The other 88 participants did not report any group counseling being required or available. However, for individuals who reported having to attend group counseling sessions in addition to individual sessions, the amount of time being spent in person, at the clinic seemed excessive and onerous. One participant reported being required to attend 2-hour group sessions up to 3

[51] 8 out of 96 participants reported going to some form of group meeting or group therapy session.

times per week, resulting in a total of 6 hours of group counseling sessions they were required to attend every week. When put in context with the other time demands of clinic attendance, such as daily observed dosing, drive time to and from the clinic, and any other additional appointments demanded by clinic staff, the amount of time an individual on methadone must spend to remain in compliance with clinic rules and demands is incredibly disruptive to living a normal life. At a minimum, participants who do not have additional take home doses must travel to and from the clinic every day to take an observed daily dose. The requirements to additionally attend mandatory individual and group counseling sessions increases this time commitment burden.

As discussed in Chapters 1and 2, counseling as defined by the American Psychological Association is a collaborative relationship between the patient and counselor, neutral, and free of judgment. What is being described by participants in this dissertation is not a collaborative, neutral relationship. Counseling in the context of the methadone clinic is an imitation of this relationship, this is counterfeit counseling. Instead of collaboration and neutrality, participants describe being judged, assessed, and pressured towards abstinence. Some participants described feeling like they had no support to decrease or taper their dosage of methadone and feeling more trapped at the clinic than they did when they were using illicit drugs. Counselors and clinic staff ultimately control all decisions about dosage increases or decreases.

These are all features described by Foucault as the instruments of disciplinary power, “The success of disciplinary power derives no doubt from the use of simple instruments; hierarchical observation, normalizing judgment and their combination in a procedure that is specific to it, the examination” (Foucault, 1975, p. 170). Counselors’

role here is to submit clients to examination and sort individuals into categories of deserving and undeserving based on their ability to demonstrate compliance or conversely, their non-compliance – this is the hierarchical observation described by Foucault. Counseling in the clinical setting operates as a disciplinary apparatus to "hierarchize the "good" and the "bad" subjects in relation to one another" (Foucault, 1975, p. 181). This normalizing judgment is utilized not only to punish non-compliant clients who are unable to conform to standards of normative behavior outlined by clinic rules, but also to reward clients who are deemed compliant and capable of conforming to clinic rules.

Decisions about who is compliant or not have potentially life-changing consequences for individual methadone clients.[52] But this issue extends beyond the methadone clinic, these ideas about the normative capacity of people who use drugs inform drug and recovery discourses which permeate spaces well beyond the methadone clinic. Public health and criminal approaches to illicit drug use are really two sides of the same coin – both are tools to normalize individuals who are considered different and unable or unwilling to conform to normative drug use.

The impulse of institutions to violently normalize individuals is insidious. This normative impulse works to reinforce racial, class, and gender hierarchies. The methadone clinic operates to reclaim and offer contingent space for safer opioid use to those individuals who can demonstrate their ability and willingness to conform.

[52] As is discussed in more depth in other chapters, losing access to or being denied access to methadone (the only full agonist ORT currently available in the US) increases risk for all-cause mortality for opioid dependent people. Involuntary treatment cessation is also associated with increased risk of an individual experiencing an overdose.

However, those individuals who are judged to be non-compliant are relegated to accessing opioids via illicit markets where their drug use will remain criminalized and pathologized. Race, class, and gender are never explicitly mentioned in methadone clinic rules, yet the impact of these rules have differential impact on individuals depending on their positionality.

This differential impact is especially notable in disparate treatment outcomes for Black and Hispanic people who access medication assisted treatments (Parlier-Ahmed et al., 2021; Kelly et al., 2011).[53] Black and Hispanic people are less likely to remain in medication assisted treatment for longer than one year (Weinstein et al., 2017). This is important to note because longer retention in methadone treatment (≥ 1 year) is associated with increased positive outcomes compared to shorter duration of treatment (Kelly et al., 2011). Additionally, women also experience issues retaining access to treatment due to family responsibilities, use severity, and mental health (Marsh et al., 2021). Race, gender, and class all impact an individual's ability to maintain access to methadone and the contingent safety it provides. Another factor that is important to consider is the impact stigma against methadone has on experiences of racial discrimination in healthcare settings outside of the methadone clinic. One recent study found that Native Americans who were on methadone reported experiencing racial discrimination in healthcare settings at a rate 30 times the odds of their non-methadone utilizing counterparts (Pro & Zaller, 2020). These examples emphasize how an

[53] I refer to medication assisted treatment here because this statement is true for both methadone and buprenorphine.

individual's positionality greatly impacts their health and whether methadone is even accessible at all.

No one is either only Black or only female, individuals frequently occupy multiply marginalized positions simultaneously. This kind of intersectional subordination has been described by legal scholar Kimberlé Crenshaw, who points out that "intersectional subordination need not be intentionally reproduced; in fact, it is frequently the consequence of the imposition of one burden that interacts with preexisting vulnerabilities to create yet another dimension of disempowerment" (Crenshaw, 1991, 1249). This is precisely the phenomenon demonstrated by the exemplars previously noted, such as Native American women, who will have an increased likelihood of experiencing barriers to accessing methadone, while simultaneously experiencing prejudice and racial discrimination in other healthcare settings for utilizing methadone as a resource at all.

It is also important to note that a recent (2021) systematic review of retention in medication assisted treatment programs found that methadone programs that required additional psychosocial counseling had significantly lower treatment retention than programs that utilized medication alone (Hochheimer & Unick, 2021). This indicates that increased contact with counselors resulted in both voluntary and involuntary discontinuation of treatment. If we are to gain a better understanding of how additional counseling results in decreased retention in methadone programs, we must ask people on methadone what they think of the counseling they are subjected to. In the next section, we will examine client beliefs and opinions about the mandatory counseling.

A Hammer to the Head: Beliefs and Opinions About Counseling

To assess individuals' beliefs about the mandatory counseling and counseling generally, I coded transcripts with a focus on participant expressions of opinion and value judgments. While the sparse research into counseling offered at OTP has indicated the need to determine what services are optimal for people on methadone, none of them directly gestured to seeking these answers from individuals who are already on methadone. If the goal is truly to optimize treatment experiences, asking individuals who are directly impacted and who are already on methadone should be a critical step in making this determination. Both the ASPE report and the Dugosh et al. review accepted that the counseling in OTP settings has inherent value to clients at OTP. I chose to focus on client beliefs and opinions about the mandatory counseling because I theorize that counseling which is coercive has limited utility to clients at methadone clinics.

The main codes utilized to assess participant beliefs and opinions about counseling were opinions, Counseling No, Stigma, Paternalism, Needs Met, Preferences and Value. Value had several sub-codes that are relevant to participant beliefs regarding counseling. These participant value judgments about counseling were sub-coded as Yes Mandate, No Mandate, Neutral Counsel, Positive Counsel, and Negative Counsel. These sub-codes are intended to assess participant beliefs along a spectrum of negative, neutral, and positive. Additionally, the Yes and No Mandate quantified the responses that had clear answers regarding if the participant believed that counseling should be mandatory or not. It is my belief that people who are directly impacted by an issue and closest to the problem, are also closest to the solution. Individuals know their own body-minds and needs better than anyone else. Therefore, I decided to ask people directly about their

opinions and beliefs regarding the mandatory counseling and to code with a focus on these responses.

The answers to Yes and No Mandate were nearly equal, with n=31 (32%) participant responses coded as Yes Mandate and n=33 (34%) participant responses coded as No Mandate. Those that were not coded as either Yes or No did not answer directly when asked this question or they were not asked the question in a way that resulted in a direct, yes or no answer. Participants that were coded as No Mandate often had very practical reasons for not wanting the counseling to be required. Responses would mention how time consuming the counseling requirements were or how the clinic requirements interfered with normal life responsibilities.

Interviewer: What's your opinion about people needing counseling when they get on methadone? Should they be required to see a counselor?

Participant: I don't think you should be required because people have jobs. Some people need to get their methadone and go. I think it should be offered if you want to do counseling, but it shouldn't be required. (Participant 40)

Methadone clinics generally have very limited hours of operation. Some methadone clinics in Arizona open at 4:00 am and close at 11:00 am. These limited hours can be quite a challenge for individuals who have other life responsibilities such as familial duties, work, probation, or mental health issues that make keeping track of dates and times difficult. Participant 40 explains how the additional burden of attending counseling appointments, on top of daily observed dosing, can be intrusive for clients who have jobs. Especially when the main function of the counselor is to examine your drug tests, having

to spend more time at the clinic to be chastised about one's behavior is likely to feel like a waste of time.

In addition to the frustration over the extra time counseling consumed, there were also sentiments shared that expressed resentment over the counseling being forced on people.

> Participant: Then COVID happened, and then all of a sudden my counselor is made apparent to me…and then it was shoved down my throat. (Participant 44)

For clients who feel like the counseling is shoved down their throat, it seems clear that this is not the collaborative, therapeutic alliance that is necessary to provide counseling. Even when participants indicated they were in support of the mandatory counseling, and the forced aspect was a facet they appreciated, what was described was not counseling. Clients at methadone clinics are being forced to engage with people who are referred to as counselors, but it would be incredibly disingenuous for any serious observer to refer to what participants have described throughout this dissertation as counseling.

In addition to the dubious therapeutic utility of counseling, there was no consistency in counseling requirements described by participants. While some participants described what they felt was an excessive and life disruptive amount of counseling, others mentioned not doing any counseling at all.

> Interviewer: What kind of counseling were you required to have in order to get methadone?
>
> Participant: That's hysterical. Zero. In theory, you're supposed to, but no. I mean, they've got so many clients, and they've got one counselor to see a thousand clients. It's ridiculous. (Participant 49)

Again, we see the repetitive theme arise of the counseling experience described as resembling an assembly line, in which no counselor has time to speak to clients. This participant expressed frustration over the "ridiculous" nature of the counseling – or rather the lack thereof. Because we are characterizing counseling by asking individuals who are receiving methadone from an OTP what their counseling consisted of, it wasn't clear whether participants who responded they got zero counseling just didn't recognize any interactions with clinic staff as counseling because it didn't meet their standards or expectation they had for it, or if the clinic might be considering some interaction between client and staff as counseling. I have personally been informed by clinic management that any interaction at my methadone clinic with staff who are in scrubs, including greetings of "hello", is charged in 15-minute increments as counseling or peer support. It is likely that staff and client perceptions about counseling are not in agreement. Federal regulations require clients at methadone clinics must engage in counseling. Either these clinics where participants indicated they did not receive any counseling are out of compliance with federal regulations, they counted something completely unrecognizable to the client as counseling, or the clinics are reporting they provided counseling when they did not.

Quite a few participants expressed support for mandatory counseling because they believed that counseling has the power to discover innate truths about individuals. Gaze, observation, and power-knowledge were used as codes when the counseling was viewed as surveillance or that the role of the counselor is to extrapolate some core, hidden "truth" about the client or "addicts." Beliefs about counseling existing as a disciplinary tool that could potentially reveal some central truth about an individual were expressed by

multiple participants. These participants frequently mentioned counseling immediately after referencing physical violence. This was clearly exemplified when one interviewer asked what emotional support would look like after an overdose.

> Interviewer: What would support look like after an experience like an overdose?
>
> Participant: You should have your ass beat.
>
> Interviewer: That's what we get every time, right?
>
> Participant: I think groups. I used to go to these groups that were…I had the groups in the methadone clinic, but those always just turned out everybody talking and that because everybody's crazy heroin addicts…What bothers me is certain people that won't let it take. People who go in and just talk over the facilitator about stupid shit about their self all the time…and won't get serious and won't pay attention to what they have to say to you and take it to heart. (Participant 1)

This opinion that the group counseling is ruined by people "just talking" was a theme that came up frequently. It seems that the counseling is viewed less as a time for individuals to actively engage in discussion, or work through trauma, and instead to passively be told what they should do, or to be reformed, otherwise the counseling might not "take". It is understandable that many participants understood counseling to be a disciplinary tool, because that is precisely how counseling has been deployed by OTP. When pressed to consider that other individuals may have different needs, Participant 1 again bracketed their understanding of counseling with references to physical violence.

Interviewer: Maybe they are just not ready (referring to people the participant believes waste time by talking during group counseling). For people like that, do you think they should still be required to do counseling?

Participant: I think they need a hammer to their head or something.

Interviewer: Maybe one-on-one counseling?

Participant: A brain transplant.

Interviewer: If only right? I'm sure methadone clinics have gotten together saying how can we give a brain transplant to each of these clients?

Participant: Yeah. That's what I hear. Yeah. (Participant 1)

This conversation between the interviewer and participant reveals how effective counseling is conceptualized here as being capable of fundamentally changing who a person is. Not only is the inherent violence of such a project of self-erasure acceptable to the participant in this example, but it is even viewed as a desirable outcome of therapeutic intervention for someone who is struggling with their relationship to intoxicants. In this interview, we observe the interviewer's discomfort with the participant's response. The interviewer attempts to gently indicate that maybe everyone responds to trauma differently. Despite this, Participant 1 continues to push for violent erasure of individuals who "refuse to let the counseling take". Considering what it means for "certain people that won't let it take… (and just talk) stupid shit about their self all the time", we can helpfully understand this as internalized ableism. Participant 1 is speaking negatively about those who resist normative violence, and we could understand that this participant views themselves as having accepted a "brain transplant" if that is how they

conceptualize successful counseling. This response is best understood as internalized ableism.

Liat Ben-Moshe defines ableism as, "oppression faced due to disability/impairment (perceived or lived), which not only signals disability as a form of difference but constructs it as inferior…carceral ableism is the praxis and belief that people with disabilities need special or extra protections, in ways that often expand and legitimate their further marginalization and incarceration" (Ben-Moshe 2020, p.16). This example of ableism and carceral ableism is relevant to how counseling is experienced in the clinical setting for people who are on methadone. In the context of methadone, those who are resistant to counseling were viewed by their peers[54] as in need of more intensive or even physically violent discipline. This was exemplified by the responses from Participant 1. For people who are on methadone, their difference as someone who is dependent on opioids[55] is constructed as inferior and rather than legitimizing protection, this belief legitimizes their disposability and necessitates erasure.

Biopolitics as defined by Foucault is the power over life by managing and disciplining populations not just through surveillance, but by managing all aspects of health and life (Foucault 1976). Population management is linked to eugenics, a form of ableism that seeks to eradicate difference and which views abnormalities as a quality that makes individuals disposable. Foucault described how the state used differences like race, class, and health to filter and differentiate which bodies are worthy of being made to live, and which are disposable (Foucault 1976). For individuals on methadone, those who

[54] Here, the term "peer" is used to refer to other people on methadone.
[55] Many people on methadone might use or be dependent on other licit and illicit drugs as well.

are compliant are deemed worthy of being made to live, while those who are non-compliant are disposable and not worthy to access the safety and sanctuary of a legal, safe supply of opioids from which to maintain their dependency safely. Those who are deemed non-compliant are exposed to the conditions which can result in their harm or earlier death.[56]

Counseling: Coerced Monitoring Billed as Therapy

Many researchers that have written about counseling in the context of methadone provision for opioid dependency expressed their belief that counseling is a positive thing to include for methadone recipients (Desmond, 1979; Dole, 1973; MacNeill, et al., 2021). Vincent Dole, who was one of the first clinicians to publish studies with Marie Nyswander on the efficacy of replacing illicit diacetylmorphine (heroin) with methadone, also extolled the presumptive positive benefits of counseling for methadone recipients (Dole and Nyswander 1965). Dole even established a methadone clinic that provided minimal services, with the intent to compare results to his clinics where more intensive counseling resources were provided. Reportedly, Dole had intended to publish his findings from a comparative analysis between the full-service OTP (offering more intensive psychosocial services such as counseling) and the minimal service OTP that were run more like methadone dispensaries (Brecher, 1972). Notably, despite his

[56] Opioid dependent individuals who access drugs through illicit markets are subject to criminalization, which poses a multitude of health and safety risks. Additionally, individuals who are unable to access a safer, legal supply of opioids (such as methadone) are exposed to the risks of the illicit market, which now is experiencing an unprecedented poisoning and contamination crisis. Potent synthetic opioids like fentanyl and tranquilizers like xylazine are increasingly contaminating illicit drug supply chains. In many states, including Arizona, it remains a felony to attempt to characterize and analyze drugs procured on the illicit market. This means that even attempts at limiting risk of bodily harm and drug poisoning by testing drugs purchased on the illicit market are criminalized. The risks posed by the illicit drug market are often created and amplified by prohibitionary drug laws.

expressed intent to do so, with his stated purpose to prove the importance of psychosocial interventions like counseling, results were never published. We are left to speculate why Dole never published any of his findings from his differential treatment approaches.

Similarly, to so many researchers, more than half of the interview participants in this study held positive opinions about counseling 66% (n=63) and about 32% (n=31) believed that mandatory counseling should be enforced as a requirement for anyone to be able to get methadone. Counseling retains this support and positive regard even though the quality of the counseling that participants described receiving did not seem adequate nor to hold much therapeutic value. The way that some participants conceptualized the utility of counseling was to view it as a tool for both punishment and disciplining unruly, non-compliant clients. Participant 1 provides such a strong example of this.

> Interviewer: What's your opinion about whether people need counseling to get methadone or suboxone? Do you think it should be a requirement?
>
> Participant: Yeah. I think it's real important. What bothers me is certain people won't let it take…
>
> Interviewer: Because maybe they're just not ready. So what about people like that? Do you think- For people like that, do you think they should still be required to do counseling?
>
> Participant: I think they need a hammer to their head or something.
>
> Interviewer: Maybe one-on-one counseling?
>
> Participant: A brain transplant.
>
> Interviewer: If only, right? I'm sure the methadone clinics have gotten together saying how can we give a brain transplant to each of these clients?

Participant: Yeah. That's what I hear. Yeah. (Participant 1)

As we revisit this conversation, it indicates that the utility of the mandatory counseling is for it to stand in place of physical violence such as a hammer to the head or a brain transplant. The participant mentions being bothered by people who "won't let the counseling take." This signals an understanding of power-knowledge through observation or gaze – some individuals are not revealing themselves fully to the gaze of the counselor to be fully disciplined and corrected. Many participants recognized this function of counseling and expressed irritation with other clients who refused to submit themselves to the gaze of the counselor appropriately.

The gaze of the counselor has the power to examine and determine who is compliant and who is non-compliant. The benefits and consequences behind this determination can have serious impacts on the lives of individuals who are on methadone. For those who have been dependent on illicit drugs like heroin, the respite provided by access to the safety and legal sanctuary provided by methadone can be life changing – and for some individuals like myself, I would assert it can be lifesaving. If a counselor makes the determination that a client is non-compliant, the worst consequence they could face is potentially losing access to methadone completely. Other consequences, as exemplified by the quotes from interview participants in this study, could include being forced to do more counseling, more urine drug screens, or having the dosage amount of methadone reduced.

For individuals who are clients at OTP, access to methadone hinges on counselor perception of whether they are compliant or not. This constant state of precarity is stressful by design and works to remind clients that they could always lose access to

methadone, a resource which helps them maintain stability and normalcy in their daily lives. It pushes clients to internalize the desire for conformity and compliance. Afterall, non-compliance results in even more surveillance and punishment. Even when the counselor is not watching, they could always request an individual submit to examination.

To move towards client-centered methadone access, we must shift the treatment orientation away from this hyper focus on counseling, coercion, surveillance, and enforcement. Instead of ignoring and attempting to violently normalize human difference, difference must be recognized and accommodated. For individuals who are struggling with their relationship to, or who are dependent on opioids, methadone is one of the few and most efficacious evidence-based resources available (Ali, Tahir, Jabeen, & Malik, 2017). Improving accessibility to opioid replacement therapy (ORT) at this moment, when we are experiencing an unprecedented drug contamination and poisoning crisis in the U.S., is of critical importance. People who occupy multiple intersecting, multiply marginalized positionalities all have unique needs. Those needs cannot be addressed and supported if they are not acknowledged. In the next chapter, this study concludes by reviewing what a future where the health and lives of people who are opioid dependent are equally valued and support is divorced from criminalization and punishment could potentially look like. There are changes that could be implemented to ensure equitable access to life-saving resources such as methadone.

CHAPTER FOUR

COMPLY OR DIE: RECOVERING THE WORTHY

> "Well, I hate daily dosing, so I would like if they weren't so strict…But if you doing it, going and dosing every day, because I go dose every two days, that's a negative towards me. So, I can't even earn more take homes because of that, because I'm not showing compliant, because I'm not daily dosing, because I'm listening to my body, and I can't handle it right now." (Participant 91)

Compliance and Carcerality

Counselors at methadone clinics have broad powers over their client's lives, with their role frequently focused towards serving as disciplinarians for non-compliance with clinic rules (Mitchell et al, 2018). Despite this, clients are expected to build trust and form a therapeutic relationship with the counselor, who is also the individual who enforces clinic policies for non-compliance such as administrative discharge, feetox,[57] punishments for positive urine drug screens (UDS) or refusing to attend the mandatory counseling appointments. It is counterintuitive to expect individuals to rely on and utilize counselors for therapeutic support when their role at the clinic is so deeply imbricated with surveillance and punishment of the same individuals that they are supposedly purported to be building a trusting relationship with.

Someone who is struggling with their relationship to intoxicants may genuinely desire counseling, whether this is represented merely by someone to talk to, or by a licensed professional therapist. However, if an individual at an OTP is struggling and

[57] The "feetox" is how methadone clinic staff and clients refer to an administrative discharge that occurs because a client was unable to pay the fee for their treatment.

desires to speak with someone, the counselor at the clinic could decide they will be subjected to punishments based on the information that is shared with them. Afterall, the counselor is responsible for enforcing clinic policies for non-compliance. These punishments have consequences for clients, who could have their daily life impacted if they lose access to take home doses or are subjected to additional disciplinary and surveillance measures. This results in a situation where individuals on methadone are unable to ask for help for the issue which they have ostensibly sought methadone for in the first place. For someone who feels that they need, or who wants counseling, this situation is akin to locking someone in a pantry full of food, but all the shelves are out of their reach. Then, when they are starving, acting as if they are responsible for not helping themselves to the food with which they are surrounded. It is important to acknowledge that when the clinic offers counseling in this way, embedding punishment into what is supposed to be a therapeutic resource, this is a cruel and hurtful policy to clients who desire support.

We see the impact of these cruel and hurtful policies expressed in very low clinic retention rates. The punitive clinic policies that the counselors are responsible for enforcing have a negative impact on clients and have been shown to increase dropout rates and treatment cessation (Reisinger et al, 2009). However, when people on methadone report greater satisfaction with their counselor, it has been shown to increase positive treatment outcomes (O'Grady, Brown, Mitchell & Schwartz, 2010; Magura, Nwakeze, & Demsky, 2010). Especially considering the high rates of all-cause mortality for individuals who are dependent on illicit opioids (Bech, Clausen, Waal, Benth, & Skeie, 2019; Nogrady, 2017), it is critically important to address these issues faced by

individuals who are accessing methadone because maintaining access to methadone makes them less likely to die (Biondi, Vander Wyk, Schlossberg, Shaw, & Springer, 2022). A shift in clinic culture that centers and is responsive to the needs of clients and ceases to focus on surveillance and discipline of non-compliant clients could have a dramatically positive impact on the lives of people who access methadone. In addition to improving outcomes for the individuals who would not be expelled from treatment for non-compliance, this shift in clinic staff behavior could also increase accessibility and positive outcomes for those who do not seek or voluntarily drop out of treatment due to the carceral environment within the clinic.

While it is hard to quantify exactly how many opioid dependent people do not seek methadone as a resource because they are aware of the punishing, carceral nature of the clinic, some estimate that up to 90% of people who would qualify as having an opioid use disorder (OUD) do not receive evidence-based treatment (Krawczyk et al 2019). This number needs to be put into the context of the ongoing opioid overdose crisis. Over 100,000 people in the U.S. died over twelve months during 2021, with "overdose mortality per capita among non-Hispanic Black individuals more than tripling between 2010-2019" (Friedman, Beletsky, & Jordan, 2022). We are seeing these prolific increases in overdose rates because the drug supply has shifted from opioids like heroin, to increasingly potent synthetic opioids such as fentanyl.

Heroin is generally dosed in tenths of a gram, while fentanyl, on the other hand, is dosed in micrograms. This means that if dosed incorrectly, it is much easier to experience an accidental drug poisoning or overdose. Most people who purchase drugs on the illicit market do not have access to information about the dosage or any characterization of

their drugs at all beyond what they are told directly by the seller. Due to the pressure of criminalization, the illicit drug supply chain is deliberately vague about provenance and detailed information about the drugs being transferred and sold.

As drugs get furthest from their point of origin, at the level of peer-to-peer sales, there may be little transparency into the drugs being sold, and people go based on word of mouth to make determinations into quality and likely dosing amounts needed. While this lack of transparency into the quality of drugs being sold was dangerous for heroin, it has been demonstrably even more deadly for fentanyl since small discrepancies in dosing can be the difference between life and death. The impact on drug using communities has been devastating and supporting access to evidence-based interventions, such as methadone, are proven to reduce all-cause mortality (Sordo et al, 2017). Transforming accessibility to methadone has implications for saving lives as well as improving the quality of life for opioid dependent people.

Practical changes in clinical practice, such as a cultural shift away from punitive surveillance towards building a client-centered culture of responsiveness and care, should be seriously considered as an urgent advocacy issue for allies of people who use drugs as well as individuals committed to prison abolition. These changes are what scholars like Ruth Wilson Gilmore, Liat Ben-Moshe, and others have referred to as non-reformist reforms (Gilmore, 2007; Ben-Moshe, 2020). Liat Ben-Moshe describes this concept,

> Reformist reforms are situated in the status quo, so that any changes are made within or against this existing framework. Non-reformist reforms imagine a different horizon and are not limited by a discussion of what is possible at present. (Ben-Moshe, 2020).

To delineate between reformist and non-reformist reforms is important because it will prevent advocacy and activism that risks expanding the power of carceral networks – which are originators of harm. Advocating for a change in clinic practice and culture towards a more client-centered role would increase accessibility to this treatment modality and it would also improve the lives of people who are on methadone by respecting their autonomy and individual agency to direct their own treatment goals.

There is some risk that changes in methadone clinic culture could strengthen the clinic itself by improving business and increasing profit, which would inevitably increase the power of an institution of carceral control. As Liat Ben-Moshe warned us, this should be considered and kept front and center in any attempt to improve conditions for people who are directly impacted by carceral networks. Thus, attempts at improving access to methadone should work hard to limit any benefits gained by the clinic itself. The benefit of increased access to methadone should be weighed against the potential harm of increasing the power and reach of methadone clinics. Increasing client-centered care in OTP would improve client autonomy and empower clients, which could potentially offset the risk of harm posed by the potential of strengthening the institution of the clinic.

Throughout the interviews for this study, individuals demonstrated a keen awareness of the lack of autonomy over their treatment and access to methadone. Rather than view the punitive role of counselors as an unfortunate aspect of drug treatment that has been overlooked, it should be viewed as one of the key components of the treatment. Much of the treatment protocol within methadone clinics is intentionally centered on discipline and punishment. This is not an oversight or accident on the part of the clinics, it is deliberately enforced. Opioid treatment programs (OTP) are playing their part within

the carceral system by instilling responsibility for socio-structural harms in individuals. Therefore, even though increasing client autonomy and satisfaction has been shown to increase program retention (Magura, Nwakeze, & Demsky, 1998), as we saw with many of the responses of individuals interviewed for this study, methadone clinics persist in utilizing staff, including counselors, as disciplinarians and not as therapeutic supports. This is because treatment within the OTP setting operates like a sieve, filtering out the worthy and the non-worthy by making determinations of who is compliant and who is non-compliant.

Because methadone offers legal sanctuary for opioid use, the implications of being deemed compliant are to be equated to being assessed as non-disposable. Those who are labeled by the clinic as compliant will be sheltered from the most overt hams of criminalized drug use. There are further implications for safety in today's contaminated illicit drug market, access to methadone provides a legal, safe supply of opioids.[58] Decisions about compliance or non-compliance have a direct impact on who has better chances of survival. At their core, these are decisions about who deserves to live and who deserves to die.

Access to methadone treatment, and the conditional safety for legal opioid use which OTP create, is limited to a small segment of individuals who can conform to the intrusive demands of the clinical setting. Structures of access to this precarious sanctuary

[58] Fentanyl is increasingly contaminating the illicit market and dominating former heroin markets. Because of the increased potency of fentanyl comparative to heroin, this poses greater risk for overdose. Illicit markets on the East Coast and in Canada are being contaminated by other tranquilizers and fentanyl analogs, which pose other yet uncertain risks to drug using communities. In this high-risk environment, where knowledge about the character and quality of the drugs purchased is deliberately hidden, and attempts at clarity are criminalized, access to a safe, legal supply of opioids is going to have direct impact on someone's life chances.

of legal opioid use are marked by privilege. Race, class, gender, and disability all intersect to inform who is even able to comply or not. Positionality influences not only how an individual's drug use is perceived and if it will be criminalized, medicalized, or both, it also greatly influences which drugs they will have access to at all. Throughout the 1960-70s, opioid use, particularly heroin, was widely viewed as an urban Black and Latinx issue (Mendoza, Rivera, & Hansen, 2019). This perception changed when OxyContin was introduced to the market in 1996. Fast-acting opioids with a high risk for dependency became available to predominantly white, rural, and suburban, middle-class communities in the U.S (Meier, 2018). These communities had been unimpacted by the previous decades of state violence from the War on Drugs that urban spaces have continuously been subjected to.[59] The response from policy makers, mainstream media, and other powerful actors to the changing face of opioid dependency has been markedly different.

As pain killers became more prevalent as a social issue during the late 1990s, white opioid users began to be presented in mainstream media as victims of predatory doctors, large pharmaceutical companies, and urban drug dealers (Tough, 2001; Ung, 2001). This narrative of white victimhood, particularly the idea that rural and suburban communities in the U.S. are under attack by hostile outside forces has continued to be fueled by medical doctors and researchers. However, Black and Latinx opioid users continue to be portrayed by policy makers and mainstream media as drug dealers and criminals who must be incarcerated before more urban problems could spread to

[59] Impoverished urban communities have been simultaneously subjected to the violence fueled by the War on Drugs such as overdose and transmissible disease and infection (HIV, HCV, syphilis, etc.), as well as the state-sanctioned violence of criminalization.

suburban and rural white communities (Agar & Reisinger, 2002). Medical doctors and researchers engage in a racial biopolitics that helps to carve out and maintain spaces of safer, decriminalized drug use for white people at the expense of communities of Color. They do this by not mentioning race at all.

Efforts by medical doctors to establish addiction as a biomedical or neurological disorder or "chronic relapsing brain disease"[60] (Volkow & Morales, 2015) operate under what Michelle Alexander names a "color blind ideology" which deliberately refuses to directly address race (Alexander, 2010). This is dangerous if we are seeking to build a more equitable future devoid of racial disparities that fuel social issues like the War on Drugs. Initiatives that purport to operate from a universal positionality that do not mention race, have historically resulted in social reforms that inadvertently intensified racial inequalities (Alexander, 2010). White supremacy and white privilege are "typically reproduced by eliminating racial references from seemingly universal policies and practice" (Netherland & Hansen, 2017). Racial hierarchies are maintained this way even without the implicit direction of individuals. To disrupt these racial hierarchies embedded in drug treatment settings, we must first acknowledge that they are there.

The U.S. War on Drugs continues to reinforce social hierarchies while not naming race explicitly. As Jules Netherland explains, "Racial projects are inherently implicated in medicine…race is reified in discourses of legitimacy, normativity, and technological precision" (Netherland & Hansen, 2017). Biomedical technologies like methadone have

[60] Nora Volkow, director of the National Institute on Drug Abuse (NIDA) at the National Institutes of Health (NIH), is one of the most prominent proponents of the chronic relapsing brain disease theory of addiction. This theory asserts that drug dependency or addiction is compulsive use of drugs characterized by changes in the brain's circuits involved in reward, stress, and self-control.

these elaborate structures for inclusion and exclusion to operate as a biopolitical tool to distinguish the worthy from the non-worthy drug user,[61] and to ensure that only those capable of compliance can access these spaces of safe legal drug use. Methadone is the only full agonist[62] opioid replacement legally available to opioid dependent people. Black Americans are less likely to use illicit drugs than white Americans, but they are almost 10 times more likely to be arrested and incarcerated for drug charges (Bigg, 2007). Since President Ronald Reagan declared a "War on Drugs" in 1986,[63] race has increasingly been deployed as a tool for constructing some drug users (Black or Latino, poor, mentally ill, urban) as dangerous criminals, while other drug users (white, suburban, or rural, middle class, feminine) are constructed as unfortunate victims of nefarious circumstances beyond their control. This continues to be evident in the mainstream media response to the ongoing "opioid crisis" since the 1996 introduction of OxyContin.

Current media representations of drug use greatly inform public perceptions and frequently position drugs like heroin as an urban scourge, tragically seeping out and polluting suburban environments (Lassiter, 2015). In the 1990s, *Dateline* on NBC warned viewers that, "heroin, an inner-city drug, has jumped the tracks and has been killing kids in some of our most prosperous suburbs" (Lassiter, 2015). This exemplifies the

[61] The worthy and non-worthy drug user is identified in the clinical setting through establishing compliant (worthy) and non-compliant (unworthy) individuals and then affording differential treatment to each based on these labels. These labels are portrayed as neutral or color-blind, as if they are derived from individual behaviors or pathology, yet in reality they cannot be disentangled from positionality of the individuals to which these labels are applied.

[62] A full opioid agonist, such as methadone, activates the opioid receptors in the brain, providing the full effect of opioids. While a partial agonist, like buprenorphine, attach to opioid receptors in the brain, but do not activate them. https://www.ihs.gov/opioids/recovery/pharmatreatment/

[63] Ronald Reagan was a proponent of the Anti-drug Abuse Act, which was passed in 1986. After it was passed, he addressed the United States with his wife, Nancy Reagan, to declare a war on drugs.

persistently prevalent narrative in mainstream media that positions poor urban spaces, predominantly communities of Color, as the rightful place for problems related to the War on Drugs – overdose, violence, and problematic illicit drug use. While the "other side of the tracks," white suburban and rural communities are positioned as undeserving victims of problems that rightfully belong in poor neighborhoods.

These media representations also continue to fuel the pervasively present narrative of clean-cut, white, suburban youth as being targeted by Black and Brown "drug dealers." Media and politicians have a reciprocal relationship with one another, continuously scapegoating immigrants as the cause behind suburban drug use. This representation is perversely out of touch with the reality that white middle-class people in the U.S. drive illicit drug markets with their nearly insatiable demand for drugs, as they consume most of the drugs in this country (Rosenberg, Groves, & Blankenship, 2017). States such as Arizona provide an exemplar of how beliefs of immigrant-fueled drug crisis derive in racist fictions. Despite dramatic decreases in the number of undocumented immigrants[64] over the past twenty years (primarily due to decreased economic and employment opportunities), the rate of illicit drug use among the resident population in the state of Arizona has only continued to increase (Males & Macallair, 2010). Despite so much historical and current evidence to the contrary, representations of whiteness in mainstream media portray white individuals as innocent victims, who are under siege by hostile outside influences – immigrants. This is one of the signature moves of white innocence, to demand copious amounts of narcotics, but to position the white middle-

[64] Between 2007-2010, the number of undocumented immigrants in Arizona decreased by 40%. https://www.ojp.gov/ncjrs/virtual-library/abstracts/scapegoating-immigrants-arizonas-real-crisis-rooted-state-residents

class, with their nearly insatiable desire for drugs, as eternal victims, blaming everyone else involved in providing what they have been asking for.

This tendency within the U.S. to scapegoat immigrants has only intensified as the drug supply has shifted towards increasingly potent synthetic opioids like fentanyl. Creating moral panic around opioids and China has a lengthy history in the U.S., that continues today. Politicians, including President Donald Trump have repeatedly blamed China for the increasing rates of overdose that have occurred in the U.S. since 2017.[65] This could be described as the historical continuation of "Yellow Peril" which originated during the mid-19th century Opium Wars. This fear has been fueled by the ongoing anxiety that China is trying to destroy Euro-American society and it is not a new phenomenon (Blanchard, 2019). In the late 1800's, a Virginia newspaper published this warning to the U.S. public:

> The Chinese are sowing among us vices worse than those that caused the fall of ancient empires and the most terrible evils which Chinese immigrants are bringing to these coasts are not to the industries, but through opium. (Ahmad, 2014).

The persistence of this narrative of white innocence being attacked by hostile outside forces, intent on the destruction of Euro-American communities continues to pervade Drug War rhetoric. The fact that white middle-class communities are demanding and consuming most of the illicit drugs that come into the country is conveniently ignored.

[65] President Trump tweeted about fentanyl "pouring into the U.S. postal system from China…killing our children and destroying our country". https://twitter.com/realDonaldTrump/status/1031590431379865600

The demand for narcotics by U.S. residents is certainly nothing new. Neither is the scapegoating of immigrants by repeated proclamations of white innocence. Even if China were to impose a blanket ban on the production of all the materials used in the manufacture of fentanyl and fentanyl analogs, the insatiable and lucrative demand for opioids in the U.S. would likely drive production of these chemicals to another country. This phenomenon is known as the "balloon" effect, whereby when production and trafficking are driven from one area, but demand is not impacted, producers and traffickers merely move to another area where they can continue business operations (Laffiteau, 2011). This is a large part of why U.S. drug policy has been so ineffective. Money is poured into militarization of the police and borders, instead of options that would address the prolific demand for drugs,

Treatment for "Good" Drug Users & Prison for "Bad" Drug Users

The 'War on Drugs" has repeatedly utilized a narrative that constructs illicit drug use as a crisis originating in the cities and threatening the safety of suburban, middle-class youth (Lassiter, 2015; Netherland & Hansen, 2017). Not only do these narratives position predominately white, middle-class youth as needing to be protected from harms attendant to illicit drugs, they must also be sheltered and protected from criminal drug laws. The criminalization of illicit drug use is viewed as an appropriate and necessary response to urban drug use in poor communities that are consisting of mostly people of Color. Not only has the over half a century War on Drugs imprisoned millions of people of Color, especially targeting Black men, but urban neighborhoods have been devastated by abusive, militarized policing (Raphling, 2019). Impoverished, Black communities are

subjected to policing in its most intensive and violent forms. Poverty and race intersect,[66] with poverty being a "substantial factor in understanding interactions between civilians and law enforcement, predicting frequency of arrest, detentions and possibly uses of physical force" (Raphling, 2019). Being poor increases the likelihood that an individual will be exposed to carceral state violence in all its forms.

Women who use drugs are also disproportionately impacted by state violence and drug policy. Male drug users, by virtue of being male are automatically viewed as fully autonomous citizens. However, women's rights and their ability to be somewhat autonomous citizens is contingent on good behavior, "women must purchase their autonomy at the price of good behavior and social conformity" (Campbell 4, 2002). Using illicit drugs revokes women's social autonomy and historically, women were punished with social stigma and the threat of losing their children. It wasn't until the construction of the "crack epidemic" in the 1980s that women's drug use began to be criminalized more similarly to men. Enforcement of drug laws against women "increased the number of incarcerated women by almost 500% between 1980-1994" (Campbell 5, 2002). In this way, women were absorbed into the War on Drugs.

Most women incarcerated inside federal prisons are there on drug offenses. This targeted drug criminalization doesn't impact every woman equally. Black women and single mothers are disproportionately impacted by drug criminalization, with 70% of women in prison being single parents, and Black women being 7-times more likely to be incarcerated than white women (Campbell 5, 2002). The impact of the harms of drug

[66] Throughout the U.S., Black people have the second highest poverty rate, following Native Americans. https://www.povertyusa.org/facts

policy falls on everyone differently, and the degree of harmful impact is influenced by positionality such as race, gender, and class. The stories we tell about drugs and the people who use them, these addiction narratives,[67] work to elide other sociostructural drivers of the suffering and human distress observed and associated with illicit drug use. Addiction narratives are utilized to justify the targeted exclusion of people who use drugs, including criminalization and incarceration.

Much like the prison system in the U.S., the methadone clinic system is not broken, it is working exactly as intended (Feldman, 2019). The clinic originated in the prison and remains inherently carceral (Foucault, 1975). The methadone clinic continues to operate, following the carceral blueprints from which it originated. Staff within OTP do not need to be aware of their existence to enforce these carceral blueprints because they are the very basis of the structure of the clinic itself. The task of the clinic is distinct from that of the hospital.

> In the hospital, the patient is the subject of his disease, that is, he is a case; in the clinic, where one is dealing only in examples, the patient is the accident of his disease, the transitory object that it happens to have seized upon. (Foucault, 1975).

Unlike hospitals, where a patient is a person with a disease, within the clinical setting, patients are objectified as the disease itself. In line with clinical constructions of disease, traditional research helps support and shape this narrative around drug users constructed

[67] Addiction narratives such as the highjacked brain trope, demon possession, or diseased brains, serve to displace other reasons behind harms and human distress, such as social marginalization, poverty, or racism.

as the disease itself.[68] Once an individual is objectified like this, they are more easily sorted into categories of deserving and undeserving, which I would assert occurs in the context of the methadone clinic by sorting some individuals into categories of compliance or non-compliance.

As Foucault has outlined, historically, hospitals existed to warehouse the poor (Foucault, 2012). Historically, wealthy social elites financially supported and maintained hospitals mainly due to their fear of the power of the masses of poor in urban centers. Rich people wanted to virtue signal that they were invested in protecting the poor, while their actions would materially protect them from the poor. Essentially, they were able to donate money to hospitals under the guise of altruism, whilst they were acting out of self-interest. In the late 1700s, the clinic was established and bound up with the reorganization of the hospitals in France (Foucault, 1975). The clinic allowed for a space of social protection – poor people could maybe get assistance for a need, while medicine could still maintain the privilege of the gaze over the body of poor people. Rich people could still benefit from learning and making truth about the bodies of poor people, while no longer having to pay to warehouse the poor in hospitals.

The function of the clinic to operate as a space of learning and truth making continues to this current day. Foucault described the power of doctors and medical staff to create truth about a patient as the medical gaze (Foucault, 1975). Clinic staff look at, identify, classify, and pathologize the bodies and circumstances of the patients that they

[68] One way that researchers objectify people who use drugs is through construction of lengthy drug histories. This is necessary to create the subject/object relationship and establish the individual being researched as an object of study or *other*. In madness studies, this would be referred to as the construction of the mad object.

see in the clinical setting. The medical gaze was organized in the clinic in a new way, clinic staff are vested with institutional power as well as the power to intervene and make decisions regarding what is normal or not. The medical gaze is "always receptive to the deviant" (Foucault, 1975) and the gaze acquires power with this science of normalization, in which anything that doesn't fit is deviant. This is nearly the entire discourse of drug addiction.

Within the methadone clinic, the pervasive belief that drug use is a moral failing and drug dependency is a perversion of the free will, intersects with the liberal idea that addiction is a biomedical disease based in neurological changes in the brain. The understanding that addiction is a brain disease has helped provide scientific support for treating *some* drug dependency as a clinical disease in need of treatment and not merely punishment, but the clinical setting provides the opportunity to do both – to punish *and* treat individuals. The experiences of individuals expressed in interviews for this study emphasize these dichotomous features of the clinic, whereby the punishment *is* the treatment.

Throughout interview responses, counseling and case management appeared to be consistently conflated with one another in the descriptions provided by study participants. Case management is the operationalization of the medical gaze – it includes assessment, monitoring, and treatment planning and evaluation. Notably, in assessments of the efficacy of case management in drug treatment settings, and in efficacy of drug treatment programs generally, there is no universal agreement on what indicators of success in treatment even are. There is no presumption that individuals are the best to determine their own indicators of success. This dissertation is unique in that it is assessing client

beliefs and opinions about psychosocial supports in the drug treatment settings, specifically methadone clinics. Other studies researching the effectiveness of case management for drug treatment have examined indicators of success such as urine drug screen (UDS) results and retention in treatment programs, or employment, legal, and mental health indicators (Plater-Zyberk, Varenbut, Daiter, & Worster, 2012; Saleh et al, 2002). Yet little attention is paid to the beliefs and opinions of the clients or patients themselves. It appears that asking individuals who use these treatment services directly about their efficacy holds little value in their assessment. Without the historical context of the clinic outlined by Foucault, it would almost seem absurd that the beliefs and opinions of the individuals receiving a treatment for a condition would not be considered as integral to assessing outcomes and measuring success. However, in the clinical setting, it is only medical doctors and clinic staff who possess the power of the medical gaze to make these determinations around both treatment goals and what constitutes success or positive outcomes.

Expert Care: When Asking "How is Your Day?" Counts as Therapy

As touched on earlier, in the spring of 2020, in response to the COVID pandemic, the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), the agency within the U.S. Department of Health and Human Services which is responsible for advancing the behavioral health of the nation, issued blanket exceptions to all opioid treatment programs (OTP)[69] to increase accessibility to methadone during this

[69] "Methadone Take-Home Flexibilities Extension Guidance." *Substance Abuse and Mental Health Services Administration (SAMHSA)*, U.S. Department of Health and Human Services, 25 Jan. 2023, https://www.samhsa.gov/medications-substance-use-disorders/statutes-regulations-guidelines/methadone-guidance.

unprecedented double crisis.[70] These exceptions allowed methadone clinics to offer increased take homes to methadone clients.[71] Access to increased take home doses of methadone, which would allow methadone clients greater autonomy and freedom from daily clinic attendance and the indignity of daily observed dosing, is one of the accommodations in highest demand by people on methadone (Simon et al., 2022; Myerson et al., 2022). The lack of take-home doses and the life-disrupting demand of daily clinic attendance is one of the key barriers identified by *The Methadone Manifesto*[72] as restricting the efficacy of methadone as a treatment modality. In addition to the take-home restrictions, *The Methadone Manifesto* also identified the mandatory counseling as one of the other key barriers to equitable access to methadone (Simon et al., 2022). Unfortunately, despite the lack of evidence that mandatory counseling improves outcomes for methadone clients (e.g., Bigelow, 1976; Yale University, 2006), the federal regulatory changes did not dismiss the counseling mandate for OTP. The only aspect of counseling which was addressed by the COVID regulatory changes were related to allowing telehealth or telemedicine to be implemented (U.S. Department of Health and Human Services, 2020).

Despite the intent of these federal regulatory changes to increase accessibility to methadone and improve positive outcomes for methadone clients, a growing body of evidence indicates that many OTP did not implement changes in their clinic practice

[70] The double crisis meaning both the ongoing COVID pandemic as well as the ongoing unprecedented rise in drug poisoning/overdose epidemic within the United States.
[71] The increased take-home doses allowed by this federal exemption is 14 days of take homes allowed to unstable clients, and 28 days of take homes allowed to stable clients. This means that individuals on methadone are no longer federally required to attend the clinic daily for observed dosing at the clinic.
[72] *The Methadone Manifesto* is the largest autoethnographic studies conducted by directly impacted people. It is a living document, which is continuously being updated with new case studies and contributions by people who use illicit drugs.

(e.g., Meyerson et al., 2022; .Krawczyk, Fingerhood, & Agus, 2020; Brothers, Viera, & Heimer, 2021). This indicates that federal regulations and policy are not the only factor that influence clinic protocol and practices. Clinic culture centered around paternalistic and intrusive surveillance measures has had decades to ossify. Any attempt to fulfill the intent of the recent regulatory changes will need to either pursue options for methadone access outside of the OPT clinical setting or intentionally disrupt clinic culture with legislation or directives that mandate these changes as opposed to suggesting them as SAMHSA has done with the COVID accommodations.

The publicly stated rationale behind methadone being siloed into these OTP, was that clinic protocol, such as the mandatory observed daily dosing, reduced risks of diversion.[73] However, the COVID pandemic provided a unique opportunity to assess the validity of these claims that have been made over the last several decades. In the two years since these federal regulatory shifts, which allowed for more take homes and decreased surveillance by the clinics, there is no evidence that the mandatory observed daily dosing decreased client diversion of methadone, nor that increased take home doses increased overdose risk (Amram, Amiri, Panwala, Lutz, Joudrey, & Socias, 2021). At least with the limited data that we have seen so far, the fears about diversion and increased overdose from methadone appear unfounded.

For the first time in years, these federal regulatory changes have been accompanied by demands to integrate methadone into the healthcare system and outside of opioid treatment programs (Facher, 2022; Doyle & McGaffey, 2023). This could

[73] Diversion is the term used to describe when methadone clients share their medication with someone other than the person the methadone is prescribed for. For example, transferring or selling to another individual.

include expanding access to methadone into office-based treatment settings such as primary care practice and allowing methadone to be dispensed at local pharmacies.[74] This initiative to expand methadone accessibility beyond the clinical OTP silo has had some surprising proponents. Nora Volkow, the head of the National Institute for Drug Abuse (NIDA) has come out in strong vocal support of allowing any medical professional to prescribe methadone (Facher, 2022). This is a surprising stance for Volkow since she is one of the preeminent researchers who promote the chronic relapsing brain disease theory of addiction (Volkow & Koob, 2015). The brain disease theory of addiction mirrors earlier iterations of drug "addicts" as demonically possessed, or at the very least, lacking in agency, therefore it is surprising to see researchers like Volkow offering public support for methadone liberalization.

The neurobiological understanding of addiction promoted by researchers like Nora Volkow, with its emphasis on the brain as fundamentally changed by chronic drug dependency, asserts that the brains of people addicted to drugs have essentially been "highjacked" (Hammer et al., 2013). While the neurobiological disease theory of addiction may have the veneer of operating from a more objective standing, this idea of highjacked brains, running amuck, stolen from addicted individuals, is rooted in some of the same old mythologies about mentally ill, demon possessed, or mad people. Far from decreasing moral and medical stigma against people who use drugs, it may be harmful to portray addiction as a disease.

[74] Methadone is already currently dispensed at pharmacies for long-term opioid therapy (LTOT) or pain management. The federal regulations (42 CFR part 8) dictate that when methadone is dispensed for opioid use disorder, it can only be provided by accredited opioid treatment programs (OTP).

Conceptualizing people dependent on drugs as victims of highjacked brains isn't very different than viewing mentally ill or mad people as demon possessed. The tradition of labeling people who are mentally ill or those who deviate from normative expectations and standards of behavior as demon possessed can be traced back to The Bible. Early Christian authorities believed that madness was a manifestation of the Devil or possession by evil demons and spirits (Girgis, 2020). This understanding of mental illness as a fall from grace and reason parallels the neurobiological disease theory of addiction as deriving from highjacked brains, no longer capable of free will. Both theories embrace the idea of the effected individual as being incapable of rational thought and behavior and could be used to justify denying basic human rights to individuals believed to be suffering from either demonic possession or diseased brains.

The fascist impulse on the center-left,[75] which some may view as promoting an agenda of domination and conformity in society, often seems to express itself as interest in public health. In his text, Madness and Civilization, Michel Foucault historicizes western societies' treatment of individuals who were deemed mad and then later mentally ill (Foucault & Rabinow, 1984). For Foucault, more modern medicalized understandings of mental illness cannot be understood outside of the context in which these diagnoses are socially constructed. This is relevant to a critique of the neurobiological disease model of addiction because he even offers us a very relevant parallel historical analysis with the example of asylum reformers Samuel Tuke and Phillippe Pinel.

Foucault outlines how Tuke and Pinel set out in the 1800s to purportedly establish more humane conditions for people who were deemed mad or mentally ill. Some

[75] I am defining center-left as the political position generally of your average U.S.-based liberal.

historians assert that Tuke and Pinel were beneficent reformers who helped free people who were mentally ill from horribly cruel confinement in oppressive asylums, setting the ground for modern psychiatry (Charland, 2012). Foucault instead asserts that this shift in how people who were mentally ill were treated was not a liberation from oppression, it was merely a switch from direct incarceration towards a more indirect insidious form of control over this population.[76] Instead of incarceration and direct control over the bodies of the mentally ill, this new form of treatment sought to control the minds of individuals under their control. This was done by constant observation and criticism of a doctor who took on the paternal role of behavior correction. Once the patient internalizes the diagnosis and accepts the authority of the doctor, Foucault asserts that these individuals will be less liberated than the individuals of asylums in the past (Foucault & Rabinow, 1984).

This analysis is important here because it parallels current attempts to understand addiction and other mental illness as deriving in innate individual pathology within the brain. While the explanation differs slightly, the proposed changes and impact may be quite like the shift explained by Foucault that occurred during the 1800s with Pinel and Tuke. Like Pinel and Tuke, those who promote the modern brain disease theory assert that accepting this understanding of mental illness or addiction will result in a kinder, gentler approach to treatment. However, like Foucault's critique of Pinel and Tuke as failing to understand how difference or mental illness is relative and socially constructed, modern researchers have criticized the brain disease theory of addiction as "reductively inattentive to individual values and social context" (Courtwright, 2010). It is also worth

[76] The population targeted for incarceration in asylums was mostly poor people in Europe at that time.

noting that the current version of the DSM-5 still defines addiction not as biological characteristics in the brain, but as a presentation of behaviors (Grant & Chamberlain, 2016). As much as the neurobiological disease theory of addiction presents as a novel, modern understanding of an age-old problem, it appears to share many characteristics with much older historical understandings of addiction and mental illness more broadly.

Understandings of drug dependency or addiction as a brain disease helps buttress support for evidence-based treatment such as methadone. On one hand, this is positive because it has potential to help more people access a resource (methadone) which does help reduce their chances of encountering deadly harm. On the other hand, the diseased brain model also further entrenches the idea that people who use drugs do not have agency. This is harmful because it reinforces models of treatment such as the methadone clinic. Those who profit off methadone clinics[77] assert that the intensive surveillance is necessary because the clients they serve are unruly and in need of this intrusive paternalism. Afterall, because of their disease, drug users do not have agency or self-control, and therefore cannot be trusted to make decisions independently, without supervision.

Force-Feeding Care

"The most potent weapon in the hands of the oppressor are the minds of the oppressed." – Stephen Biko

While the recent regulatory changes around methadone provision introduced by the Substance Abuse and Mental Health Services Administration (SAMHSA) have

[77] Such as clinic owners, labs that do the UDS and other tests demanded by the clinic, and other treatment services that make money by intersecting their services with the methadone clinic.

garnered some surprising supporters, these accommodations have also encountered some very well-funded and vocal opponents. Central among these opponents are some of the largest companies operating highly profitable OTP in the United States who have come out strongly in public opposition to these changes. Underlying this opposition appears to be concern that liberalization of methadone policies and regulations could result in abolishing the Opioid Treatment Program (OTP) and clinical setting completely.

Mark Parrino, chief executive officer for Baymark Health Services, an OTP operating in five U.S. states and in Canada, expressed his sentiments that methadone clinics remain necessary because they provide "comprehensive care" and access to highly trained practitioners for people on methadone (Facher, 2022). Opponents of the recent attempts to liberalize and expand methadone access also argue that methadone clinics provide regular counseling and that this counseling is provided by highly trained professionals that only OTP are uniquely positioned to provide. It is striking that for-profit methadone clinics and clinic owners like Mark Parrino seem so convinced of the value and quality of the counseling services they provide. This belief is in stark contrast to the findings of this study, which indicate that what is being provided to clients at methadone clinics is being called counseling but is not in fact counseling at all. What is being provided could not honestly be referred to as counseling or psychosocial support of any kind. However, the clinics are adept at subjecting clients to punishment and discipline behind a flimsy therapeutic façade and greatly stretching the truth around what services can even be referred to as counseling.

Reflecting the findings of systemic reviews conducted by Dugosh et al. and the report published by the U.S. Department of Health and Human Services following their

site visits, the findings of this dissertation showed that most clients at methadone clinics received counseling in the form of an inconsistent assortment of services from a broad variety of clinic staff (Dugosh, et al., 2016; HHS Office of the Assistant Secretary for Planning and Evaluation, 2019). The format and quality of the counseling received by participants in this study mostly consisted of a general checking-in with clients. There was no indication in the responses in any of the interviews conducted for this study of these comprehensive services mentioned by opponents of the federal regulatory shifts. Counselor training and professional background also lacked transparency, with no clear consensus around who the counselor is. Most responses indicated that clients were uncertain who and what their counseling was.

> Interviewer: Who did you meet with for your counseling? What kind of staff members?
>
> Participant: The kind that work there, I don't know.
>
> Interviewer: Were they a therapist or someone with certain color scrubs?
>
> Participant: A psychiatrist, psychologist…yeah, I guess a therapist, counselor, whatever you want to call them. (Participant 23)

There is a clear disconnect between client experience, methadone clinic staff perceptions, and the acceptance and implementation of federal regulations. The responsibility to communicate and provide transparency regarding the format, service delivery, and professional background of counselors within the OTP setting resides with the clinic. It is evident that participants in this study were not being provided these details regarding the counseling services they received, which could be beneficial to them in determining

quality of care, which could also help them to make decisions about their own treatment plans.

Opinions and beliefs regarding the mandatory nature of the counseling was split into two distinct groups. Most respondents articulated an opinion that counseling was a form of accountability and helped to sort the deserving from the undeserving within the clinical setting. This understanding that the counseling was expected to operate to differentiate the worthiness of an individual to access methadone was also vocalized even among those participants who were adamantly opposed to mandatory counseling. Some of the responses in support of the mandatory counseling went even further and advocated for increasing the number of mandatory counseling and classes, as well as advocating for more strict enforcement of attendance. It is notable that regardless of client opinion on whether the counseling should be mandatory or not, there was general agreement about the purpose underlying the counseling. This purpose, if nothing else about the nature of the counseling, was made transparent to clients. The counselor plays a key role in making determinations about who is worthy or non-worthy, which would be articulated by counselors as compliant or non-compliant.

Participants who responded that they believed mandatory counseling is necessary frequently mentioned that other clients at the clinic need even more discipline and surveillance in addition to that which they are already subjected to. Respondents expressing these sentiments generally did not seem to view their own selves as in need of more intensive discipline and punishment but appeared eager to subject others to the mandatory counseling, and in some instances, indicated that they would like it to be even more exclusionary.

Interviewer: What is your opinion about whether people need counseling in order to get methadone?

Participant: You know, I think counseling is very beneficial…I think counseling should be mandatory for part of the recovery of addiction…I think a lot more people should get it…it should be mandatory like it's part of the recovery process… (Case 20)

Addiction and opioid dependency in the clinical setting is viewed as an individual pathology, one which must be addressed by individuals who must put in the work to recover. Here recovery is conceptualized as a process in which submission to outside disciplinary forces is necessary.

Within the smaller group of participants who indicated that they did not think mandatory counseling was a necessary or good protocol, they didn't indicate that they were hostile to counseling generally but expressed an understanding that everyone has different needs and that the kind of counseling being offered had very little value.

Interviewer: What is your opinion about whether people need counseling in order to get stuff or methadone?

Participant: I don't think it should be necessary to need counseling to get methadone or suboxone. In my opinion, I think it's kind of a nuisance. It's kind of a hassle. (Case 7)

Only a few people within this cohort were adamantly opposed to the counseling entirely. When participants did articulate that they were opposed to counseling entirely, it was clarified that they held this view based on their perception of the poor quality of the counseling available in the clinical setting.

It is important not to ignore the role of stigma and internalized stigma when considering the opinions and beliefs of people on methadone, "internalized oppression refers to a psychological phenomenon that occurs when a person comes to internalize oppressive prejudices and biases about the identity group(s) to which he or she belongs" (David, 2014). A higher prevalence of internalized stigma has been associated with individuals who have experienced a severe mental illness diagnosis such as opioid dependency or opioid use disorder (West, Yanos, Smith, Roe, & Lysaker, 2011). This means that participants in this dissertation could be presumed to have a high level of internalized stigma and emphasizes the importance of further study to assess the impact this context has on the capacity of methadone clients to self-advocate within such an oppressive setting. One study found that middle-aged individuals who were assessed using the Internalized Stigma of Mental Illness Scale had the highest elevated internalized stigma scores (West, Yanos, Smith, Roe, & Lysaker, 2011). It could be theorized that this elevated indication of internalized stigma among older individuals with serious mental health issues is a result, or at least exacerbated by increased long-term exposure to mental health systems such as methadone clinics. The intensely intrusive and paternalistic protocol of methadone clinics, such as mandatory daily observed dosing and the mandatory surveillance posing as counseling projects onto clients that they are not capable of agency and autonomy and that they need this hyper-surveillance over their medical services.[78]

[78] Medical services are frequently referred to as health care or medical care. However, after listening to and reading the responses from clients in the interviews for this study, it is my opinion that the word "care" belongs nowhere near the description of the services being offered to individuals in methadone clinic settings.

Internalized stigma and oppression can reduce a person's sense of agency and cause them to view themselves as damaged, deviant entities (Liebow, 2016). Framing any social issue as a problem with a few individuals, divorced from socio-structural factors such as poverty, racism, gender oppression, and prohibitionary criminal drug laws can be problematic. This is especially true for drug use and dependency which have been portrayed negatively throughout decades of drug war propaganda. Most responses in this study indicated that not only do they find the mandatory counseling acceptable, but they accept it *because* of its capacity to exclude and hurt others. This seems to indicate that when oppression is kept out of the conversation, it makes it seem like the problems and the blame for harms associated with illicit substance use all reside in the individual and other important socio-structural factors are ignored.

The narrative of individual pathology imposed on people who are dependent on opioids, when devoid of historical context, leaves individuals as the "problem" needing to be solved as opposed to addressing other socio-structural factors that cause harm and devastate communities. Addiction theories which assert that drug dependency is a health condition like any other chronic health need, such as diabetes, high blood pressure, or cancer, locate the problem quite literally in the body-mind of the individual who is struggling with their relationship to intoxicants (McLellan, Lewis, O'Brien, & Kleber, 2000). This directs most efforts to address drug related harms towards treating individuals with pseudo-medicalized treatment protocol such as what we see implemented at the methadone clinics. Drug treatment blends moral and medical approaches to understanding drug dependency so we see individuals being offered some evidence-based resources with a heaping side of moralistic discipline and punishment. In

the methadone clinic, the drug, methadone is the evidence-based resource, but the "treatment" is an inconsistent mix of pseudoscience and judgment. Unfortunately, despite the professed intentions of researchers and drug treatment professionals who adhere to this ideology, who often assert that viewing addiction as a chronic relapsing brain disease will help to destigmatize the phenomenon as a legitimate medical condition like any other, it instead prevents efforts to address other structural drivers of harm experienced by people who use illicit drugs.

To disrupt the shame and stigma that seems so pervasive among people on methadone, it may be beneficial to help provide some historical context of the war on drugs and prohibition. Facilitating an understanding of history can help to disrupt dominant narratives of marginalized groups and communities as inherently unworthy or shameful. History provides multiple views that can allow an individual to see an issue or issues from multiple perspectives aside from that accepted and promoted by the status quo. Illicit substance use exists along a continuum that can range from casual intermittent use and spontaneous cessation to chronic daily use that interrupts nearly all aspects of an individual's life and can result in high rates of mortality. Over the course of an individual's lifetime, their patterns of use can pass along this continuum differently at different points in their life. Instead of limiting our understanding of this phenomenon to one specific theory, it is best understood as a multi-faceted issue that is driven by a broad range of factors. If our understanding becomes too myopic and focused on addressing individuals, not even as an individual with a problem, but people who struggle with their substance use positioned as social problems, we will only further entrench stigma and prejudice against people who use drugs.

Keeping methadone provision for people who are opioid dependent siloed singularly within the OTP setting increases stigma towards people who use illicit drugs. By isolating resources for individuals who need a certain type of support within these separate systems, which are subject to intense regulation and surveillance, such as the methadone clinic, stigma is increased. This isolation and differential treatment make it seem as if the needs of people on methadone are so uniquely different than other health needs people experience, they must be sequestered in their own limited clinical setting. To normalize the needs of people who use methadone, we will need to abolish the OTP system, or at least offer options to access methadone outside of and beyond the methadone clinic. There is no reason medical professionals, many of whom already may prescribe methadone to individuals for pain, should not be able to prescribe methadone to individuals who have an opioid use disorder (OUD) diagnosis.[79]

[79] Current law, as outlined by 42 Code of Federal Regulations (CFR) only requires that methadone when prescribed to individuals with OUD, be prescribed by providers in specialized OTP. Methadone can be prescribed for pain or other issues to individuals without an OUD label by any medical professional who is licensed to prescribe narcotics.

CHAPTER FIVE

BEYOND THE CLINIC: SUPPORT INSTEAD OF PUNISHMENT

> "Everybody (counselors) pretty much just says…if you don't test negative by this certain time, we're kicking you off methadone." (Participant 3)

Therapy, Coercion, Enforcement

To better understand why United States federal regulations have sequestered methadone into opioid treatment programs and imposed mandatory counseling on methadone clients, Chapter 1 outlined the history of opioid treatment programs (OTP) in the United States. These specialized clinics were constructed to simultaneously provide contingent legal sanctuary to some opioid dependent people, and to exclude others. This is a much larger issue than just counseling though. As discussed in Chapters 1 and 4, OTP utilize counselors to designate some clients as compliant or non-compliant. Access to methadone and the legal sanctuary it provides is only granted to those individuals who can prove they are compliant. This legal sanctuary provides protection from many of the harms that are imposed on the bodies of drug users, especially the harms of criminalization. The ability to be designated complaint correlates to racial, gender, and economic privileges. More than just imposing the mandatory counseling, OTP help to reinforce existing racial and gender hierarchy.

The strategy of the clinic is to filter clients into categories of worthiness and unworthiness, while projecting an image of neutrality. Counselors in OTP help support this goal by sorting clients into categories of compliant or non-compliant. This gives the appearance that individual adherence to rules and responsiveness to discipline and surveillance determines who is labeled as compliant or not. The fact that an individual's

ability to adhere to the strict rules of the clinic are dependent on the positionality of the client is unacknowledged by the clinic. This elides how the OTP system facilitates safety for some clients and not others based on immutable characteristics such as race and gender. The appearance of "earning privileges" is carefully and deliberately constructed as a smokescreen to hide the clinic's role in enforcing patriarchy and white supremacy.[80] In Chapters 2 and 3, we outlined how this hierarchical observation is a key tool of disciplinary power as theorized by Michel Foucault. The clinic is a space of observation and examination, and this power of observation and normalizing judgment is used to create hierarchy. This is precisely what we observed with the counselor's role of labeling some clients as compliant or non-compliant.

The lack of transparency around clinic rules and policies became more apparent during data analysis. Throughout this study, clients at methadone clinics reported a very broad array of client-provider interactions that were presented by clinic staff as counseling. Yet what was described by participants throughout this dissertation was not counseling. What participants described was examination and surveillance, but deliberately presented to give the appearance of being counseling. Because of the lack of transparency and direct communication from clinic staff to clients, any number of interactions, from a casual greeting in the hallway, to a meeting with the clinic accountant could be designated as counseling.[81]

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[80] As discussed in earlier chapters, clinic staff describe take home doses of methadone as "privileges" and refer to clients as "earning" them. This is even though much of the capacity to comply with clinic rules depend on actual privileges, especially economic privilege. For example, owning or having access to a car will allow an individual to show up at the clinic every day for observed daily dosing.

[81] It is especially important to note that these interactions were also charged to clients and billed as counseling. Participants frequently mentioned the fact that clinics are profit-driven, and the business model was very clear to them as clients. The motivation towards profit, which some participants felt was made abundantly clear to them as methadone clients, increased their distrust of clinic

As mentioned in Chapter 2, the American Psychological Association defines therapy and counseling as, a collaborative relationship that requires trust and is absent of judgment (*Therapy*, 2021). None of the participants in this study described relationships or interactions with clinic staff that appeared neutral and free of judgement. Instead, counselors' role as disciplinarians and the extreme power differential between client and counselor, ensured that these relationships were rife with conflict and judgment. In fact, as many participants noted, punishment was a key feature of the position. This was exemplified by participant responses to the question regarding what type of counseling participants were required to have. A participant in Chapter 3 explained, "Counseling? They counseled me to make sure it's what I want to do…What I'm allowed to use and not use, and the consequences as far as if I do use drugs while I'm on methadone, I could potentially be kicked out of the program" (Participant 9). This exemplifies how the counseling focused on outlining rules and potential consequences for non-compliance with clinic rules.

Additionally, while a few participants mentioned the existence of treatment plans, there were no mentions of these being developed as a collaborative effort, and no one described the OTP clinical setting as a neutral environment free of judgment. In fact, the setting described was one that fostered conditions of mistrust, judgment, and precarity. Clients were aware that their behavior and bodily fluids were under a microscope, and staff disapproval and judgment could limit their access to methadone. Consequences to

staff, including counselors. More research into the profit-service provision relationship is needed to better understand the impact on treatment experience and outcomes.

the client if a counselor decided to designate them as non-compliant could be incredibly destabilizing.

Participants in this study reported that the oppressive protocols of methadone clinics create an environment of surveillance and punishment instead of support. It was understood that the counselor's role was centered around disciplining and pushing clients to not use drugs. Urine drug screens that were positive for illicit drugs would lead to increased contact with them.

> Especially because if you pop dirty, you should have someone to at least like…Not wag finger of shame or anything, but like figure what's going on. (Participant 11)

This quote helps illuminate the participant's understanding that the purpose of counseling is to conduct surveillance on client's drug using behavior. The counselors, who bear the responsibility of enforcing the clinic rules, are neither neutral nor objective and are thus an inappropriate source for counseling. Clients who are hoping to get help navigating their relationship to intoxicants cannot look for support from the counselors at the OTP where they have chosen to seek treatment. A client cannot even request support they feel is appropriate for their individual needs because all focus is singularly directed towards total abstinence. This predicament results in a one-size-fits-all approach to treatment for every client – total abstinence from intoxicants.

If a client is open about their illicit drug use or appears to be struggling to abstain from substances, they are likely to be reprimanded by counselors. This reprimand could include punishments such as rapid detox and involuntary discharge from the clinic. Not only is this painful and disruptive to an individual's life, but treatment cessation increases

risk of all-cause mortality (Sordo et al., 2017). Any pretense of building a therapeutic alliance is shattered under the conditions present in the opioid treatment program (OTP) setting. This lack of trust necessary for a therapeutic relationship was exemplified in the following interaction discussed in Chapter 4, when an interviewer asked a participant if they would seek out counseling if they were struggling with their drug use:

> Interviewer: If you wanted to get counseling, could you meet with the counselor, do you know?
>
> Participant: Yeah. But I wouldn't. I wouldn't do that. The counselors are not like counselors. They're not. (Participant 49)

As discussed in Chapter 4, participants expressed an awareness that the counselors were not truly a support system for them, nor were they there to provide therapy. Participants understood the role of the counselor as focused predominantly on surveillance and maintaining drug tests. The role of disciplinarian prevented clients from forming any therapeutic alliance with counselors.

The therapeutic alliance has been referred to by some researchers and psychologists as the fundamental element of psychotherapy (Stubbe, 2018). Without it, as noted by Participant 49, "the counselors are not like counselors. They're not." A therapeutic relationship can be defined by "the collaborative nature of the relationship, the affective bond between patient and therapist, and the patient and therapist's ability to agree on treatment goals and tasks" (Stubbe, 2018). None of the participants in this study indicated that they experienced their relationship with their counselors as collaborative nor could they play a key role in identifying or determination of treatment plans or goals. As noted earlier, but this cannot be emphasized enough, it is because there is only one

goal for every client – total abstinence. The power imbalance in the relationship is extremely one-sided, with the counselor having control over many facets of their client's lives and very little accountability to the client.

The clinic demands total abstinence from all illicit drugs and even some legal and prescription drugs as the blanket treatment goal, regardless of clients' own (often directly expressed) personal goals.[82] There is little or no space for clients to direct and pursue their own treatment goals, treatment goals are instead dictated and enforced upon them. Because of the extreme power imbalance between the clinic staff and clients, there is a lot of pressure on clients to conform or suffer the consequences. As such, instead of working to establish a therapeutic alliance with clients, methadone clinic rules and policies rely mainly on coercion to filter non-compliant clients out from being able to access methadone.

In the context of drug treatment, it is generally accepted that three factors play a role in both treatment engagement and client outcomes: coercion, motivation, and therapeutic alliance (Wolfe, Kay-Lambkin, Bowman, & Childs, 2013). Counselors in OTP settings are not offering counseling or psychotherapy, instead of relying on building a therapeutic alliance to support clients in reaching self-determined treatment goals, they are engaging in enforcement and coercion as their primary tactic for behavioral change. Even beyond the possibility for coercion to facilitate behavioral change, this tactic helps to sort clients into categories of compliant and non-compliant, or not-yet disposable and disposable respectively. Some clients embraced the coercive approach and expressed

[82] Methadone clinics routinely demand clients do not use any alcohol, cannabis, or several other prescription drugs.

positive sentiments about sorting out the disposable and not-yet disposable clients. These participants viewed the clinic constructed categories of compliance and non-compliance as a tool to sift the worthy from the non-worthy, and only worthy people, capable of recovering should be able to access the safety provided by methadone.

As discussed in Chapter 2, drawing on the fields of critical disability and madness studies, helps us to better analyze the beliefs and opinions about mandatory counseling expressed by participants. This methodology allows us to better understand some participant's expressed support for the coercion and their seemingly eager acceptance of the punishment imposed by clinic staff on clients. Through a madness and disability studies lens, this could be understood as one of the effects of internalizing curative violence, but also as an act of self-preservation. Resistance to oppression by marginalized groups, especially for women and people of Color, has historically been treated as pathology (Clare, 2017). Drug dependency, addiction, opioid/substance use disorder – whatever label we attach to it, human difference which falls outside of the socially accepted normative order and is judged to be defective is often used to justify violence. For individuals who occupy multiple marginalized positionalities, communicating eagerness to be changed or cured may work to protect them from being targeted by even more overtly violent methods of cure or criminal incarceration.

As disability activist Eli Clare reminds us, "At the center of cure lies eradication and the many kinds of violence that accompany it" (Clare, 2017, p. 24). Because of the strict rules in place, individuals who seek methadone treatment at OTPs, are not left with any options other than to seek cure. Because the clinic and counselors assign the

treatment goal of total abstinence from illicit drugs[83] to every client, there is no room for clients to articulate other needs or to be supported to pursue self-directed goals that deviate from those of the clinic. Even if our goal is merely to increase the odds of survival for drug users, outside of the more ambitious goal of drug user liberation, drug treatment goals must be expanded to support the needs and desires of people accessing treatment.

People who desire to utilize methadone as a resource may have any number of motivations or goals for entering treatment at methadone clinics outside of abstinence. Some people may want to access methadone as one of the only accessible options for safe supply[84] where they live, or they may want to continue to use other drugs, or to drink alcohol or use cannabis while moderating their use of illicit opioids – there are a multitude of other rationale and goals an individual could have for attending the methadone clinic. When methadone clinics enforce a one-size-fits-all approach to treatment plans, they are completely disengaging from communication and respect for client agency and their right to self-determination. This means that eradication of difference must be sought, and there is no middle ground here to allow space for other goals outside of it.

[83] Not only do methadone clinics demand total abstinence from illicit drugs, they also demand abstinence from legal drugs like alcohol, prescription pain pills and benzodiazepines.
[84] Safe supply in this context refers to the ability to access a safer, regulated supply of opioids. Prescription pharmaceutical drugs like methadone provide the individual using this medication to have transparency into the concentration and provenance of the drug they are using. This kind of clarity around dosage amounts, potency, and quality are very hard to gather in relation to drugs bought in illicit markets.

Other Than Cure

If drug treatment is not trying to cure people of their drug dependency, then what? People could have a plethora of motivations other than cure, which in this context, cure equates to total abstinence or remission of illicit drug use. Personal goals such as survival, securing joy, maintaining dignity, and safety are all perfectly valid reasons for an individual to seek treatment and outside support. Any reason an individual asks for support and the boundaries of the support requested should be viewed as valid. Considering the unprecedentedly high rates of mortality experienced by people who use illicit drugs, respecting the validity of any rationale for accessing methadone, a resource which greatly reduces mortality for opioid dependent individuals, should be an urgent priority.

Methadone clinics operate with the singular focus on curing or eradicating addiction, typically through requiring complete abstinence from all drugs, both licit and illicit.[85] Those who are not able to adhere to the clinic's treatment plan for abstinence will be punished and eventually barred from accessing methadone. This overly restrictive approach overlooks many of the socio-structural issues that can have a massive impact on a person's quality of life outside of drug use alone, such as poverty, housing, and education.[86] As shared by Participant 13, the desire to have meaningful counseling available was often connected to a need for support with practical survival issues related to being unhoused, experiencing interpersonal violence, or past trauma. Consequently, to

[85] Methadone clinics can refuse methadone to clients who test positive for legal drugs such as alcohol, cannabis, and prescription benzodiazepines.
[86] All these issues intersect with an individual's positionality and are informed by historical context.

provide more meaningful addiction treatment, the current focus for funding and institutional support[87] needs to be shifted, to address these wider needs more effectively. Shifting the myopic focus from singularly demanding abstinence, towards a client-centered approach that accommodates the wide variety of needs and social justice issues that impact people who use illicit drugs could greatly improve outcomes, not just for clients at methadone clinics, but the communities that people on methadone disproportionately come from as well.

It is not only clinic staff and counselors who hope for cure. Throughout many of the interviews, the desire to be "normal," to recover, to be cured was palpable. There must be a way to support healing and recovery that doesn't simultaneously advocate for the eradication of human difference. Accepting that what healing might look like for one person isn't going to look the same for another and perhaps might even be rejected and undesirable for some is a good start to making the world a little less awful for people who are different, people who might be struggling. Also, we need to make space for the fact that not everyone is going to heal and recover. An individual's unwillingness, lack of desire or inability to heal should not prevent them from accessing resources like methadone, which could greatly extend and improve their quality of life. Accommodations should be made to support people in all their multi-faceted complexities as we step away from coercing and enforcing people to contort into the closest version of "normal" they can – or to die trying.

[87] Institutional support such as non-profits, health departments, or federal and state administrative entities should shift away from the hyper focus on treatment, often expressed as a need for more treatment beds, and instead focus on addressing sociostructural issues like systemic racism, gender violence, lack of affordable housing, and equitable medical care access.

Even though people on methadone conceptualize their use of methadone in a multitude of ways, the abstinence-only recovery model remains the dominant treatment paradigm in the OTP setting. If you Google the word "recovery", the first two definitions are as follows:

1. A return to a normal state of health, mind, or strength.
2. The action or process of regaining possession or control of something stolen or lost.

Outside of the OTP clinical setting, treatment and recovery for other health issues frequently include restoring and managing symptoms to the greatest degree possible. Yet the blanket goal projected on all clients at methadone clinics is one of total remission or recovery – individuals in treatment must return to a fully normal state of mind and regain possession of the healthy body-mind that was stolen or lost. For many people, this may not be desirable nor possible as a treatment goal. The intensely punitive setting of the OTP ensures that for that large number of people who find this goal of recovery untenable, they are denied any of the benefit they could potentially garner from access to methadone at all. This emphasizes how disability in this context is viewed not just as difference but as deficiency.

Methadone clinics in the U.S. have lower retention rates than methadone programs in other countries that have less punitive treatment environments (Saloner & Karthikeyan, 2015). This indicates that the punitive environment cultured and enforced within the U.S.-based OTP system is itself a hindrance to improving accessibility to the most efficacious resource available to reduce all-cause mortality for people dependent on opioids. The hyper-focus on recovery may also decrease retention rates and discourage

some people from even attempting to access methadone as a treatment modality (Frank, 2018). There are a multitude of reasons outside of recovery that an individual might seek to utilize methadone. Foremost among these reasons to access methadone might be the desire to remain alive.

Chapter 1 explained that the U.S. is currently experiencing an unprecedented increase in overdose deaths (National Institute on Drug Abuse, 2023). If we are to have any hope of interrupting this devastating loss of life, addressing these issues, and expanding accessibility to resources like methadone should be an urgent priority. The recovery model embedded within OTP treatment models decreases accessibility. One way it does this was exemplified in Chapter 4 by Participant 3, who was kicked off methadone for non-compliance; methadone clinics will administratively discharge individuals who do not adhere to the mandate for total abstinence from illicit (and some licit) drugs. This is counterintuitive to deny support to those who are the most vulnerable and who are struggling with the exact thing for which they sought assistance from the clinic in the first place.

This recovery discourse that informs the treatment model deployed by OTP is a rather new development in drug treatment settings. The difference in the discourses underlying treatment is evident in the way methadone treatment is referred to. In Australia and the United Kingdom, methadone clinics refer to the treatment as methadone maintenance treatment (MMT) or opioid replacement treatment (ORT). This emphasizes the act of maintaining or replacing an illegal drug for a legal one. This does not center the need to change an individual or their behavior but centers the role of the methadone itself. In the United States, methadone treatment is generally referred to as medication assisted

treatment (MAT) or medication for opioid use disorder (MOUD). This places emphasis on the role of treatment and individual or behavioral change as central to treatment. It also helps clinic staff idealize their role as experts, central to positive outcomes experienced by clients, as opposed to viewing the function of drug legality (or the drug itself) as producing positive outcomes. As discussed in Chapter 1, if replacing an illegal drug with a legal drug is all that is necessary to produce the outcome referred to as recovery, which appears to be the reality based on the low quality or total absence of psychosocial support indicated by participants in this study, then the pathology was never located in the individual, but is instead embedded in how we treat people who use drugs.[88]

The Recovery discourse also helps to expand discipline and surveillance further into the lives of people on methadone. David Frank explains that:

> Despite the wide variety of treatment goals among people on MMT (methadone), the Recovery discourse positions and organizes treatment strictly as abstinence-based self-help…(it) also serves as the justification of the expansion of the clinics' ability to surveil and intervene in aspects of people's lives which had previously been seen as outside of MMT's purview, including nutrition, public service, and spirituality (Frank, 2019, p. 1)

Frank argues that the recovery discourse limits the ability of methadone provision to decrease drug related harms, and for clinics to adopt "a more open-ended, low-threshold approach to treatment" (Frank, 2019, p. 1). Methadone treatment in the United States has

[88] Decades of propaganda influence how society treats people who use drugs, but this also includes drug laws and even media portrayals of drug users or "addicts".

relatively low rates of uptake and high dropout rates compared to countries that do not utilize the recovery model or OTP system (Saloner & Karthikeyan, 2015). This indicates that dropping the recovery model from methadone treatment could increase positive outcomes by expanding access and accommodating the diverse reasons an individual may desire to use methadone. The illicit opioid market continues to shift towards increasingly potent synthetic opioids such as fentanyl, which has prolifically increased rates of overdose mortality. Expanding access to methadone, at this moment, when illicit markets and supply chains are undergoing an unprecedented shift towards increasingly potent drugs, should be an urgent priority.

Implications for Future Methadone Advocacy and Reform

> Just to give them an idea of what they are in for, negative and positive aspects of getting on this (methadone treatment). If I would've talked to somebody beforehand and been told…I would've gone a different route. (Participant 36)

Three central implications for improving accessibility to methadone arose throughout the course of this research. Firstly, many people indicated they need and want professional counseling and therapeutic services. Secondly, the OTP clinical setting, with its emphasis on punishment and surveillance is not an appropriate space to offer these resources. Therapeutic resources must be offered in a space where a therapeutic alliance can be developed and divorced from surveillance and coercion. Thirdly, until methadone clinics are no longer necessary, attention must be paid to advocating for reforms that do not strengthen the carceral logics of the clinic but help to improve the lives of people who need and could benefit from methadone. Reforms must develop and be implemented

while keeping in mind that a future without the clinic and the surveillance and punishment embedded in this setting, is also an urgent need.

Most participants interviewed for this study indicated that they would like more support. In Chapter 4, Participant 55 exemplified this, stating directly that counseling could operate like a safety net and support is important. For other participants, this support included more information from counselors about the invasiveness of the clinical setting itself, as well as potential side-effects of the methadone. Many indicated that they did not understand how intrusive and burdensome the OTP setting would be and that they felt more trapped by the clinic than they had when they were using illicit drugs. Some of the frustration participants expressed in the interviews regarding the interactions they had with counselors revolved around the fact that the counselors could not provide any tangible support for the issues they were struggling with. This emphasizes how problematic an understanding of opioid dependency which singularly focuses on addressing individual pathology is. Because it ignores other social determinants of health such as poverty, interpersonal violence, education, employment, and lack of stable affordable housing, resources are tone deaf to the needs of the clients OTP are supposed to be providing services to.

Contingency management is one psychosocial intervention which has been shown to increase positive outcomes for individuals who are in drug treatment that also simultaneously addresses some of the psychosocial determinants of health that participants indicated wanting assistance with (Petry, 2011; Brown & DeFulio, 2020). Contingency management is utilized as a behavioral therapy, wherein rewards are offered as positive reinforcement for certain behaviors and for reaching treatment goals (Petry,

2011). The rewards or incentives offered can include money or gift cards, which clients can use to support their individual needs. While this has been demonstrated to be a highly effective resource within drug treatment settings, the ethics of providing or withholding support from an individual in need based on whether they can achieve and maintain treatment goals is unethical.

The way contingency management is utilized in drug treatment settings exposes how sustained drug use remains viewed as a character failing. It would be interesting to see if this approach of offering financial rewards for treatment outcomes were offered for a less stigmatized need, for example, individuals undergoing treatment for cancer, if it would be considered an appropriate response. It is hard to imagine oncologists making the same value judgments around an individual's continued need for more treatment or ability to achieve treatment goals. To disrupt this innate value judgment in the way contingency management is currently implemented in drug treatment settings, support should be offered to all individuals in treatment regardless of whether they achieve or maintain any treatment goals at all.[89] This intervention could be greatly improved by divorcing it from the coercive element of rewarding compliance in drug treatment spaces.

The clinic originated in the prison, and it has not evolved beyond the carceral blueprint of its origins. The U.S. is unique among Western countries in isolating methadone within the opioid treatment program (OTP) clinical setting. Other countries

[89] This is especially true since in the context of OTP, the capacity to adhere to clinic rules and be judged compliant, are so strongly influenced by whether an individual has support. For example, the ability to show up to the clinic every day is dependent on economic stability and having resources like a car and money for gas or a bus pass. The clinics will not provide take home doses beyond a day or two to clients who do not have a stable home. Clients who do not have a home are non-compliant based on their status of not having a secure home to store their methadone.

like Australia and in Western Europe prescribe methadone through regular doctors or specialists and the methadone is picked up at a pharmacy like any other medication (Chaar, Hanrahan, & Day, 2011). Not only is picking up several doses of methadone at a time more convenient and less disruptive to an individual's life more ideal, but it also allows for clients to retain dignity and not be subjected to the mandatory daily observed dosing that U.S. methadone clients are subjected to. Ostensibly, Australian and UK pharmacy-based methadone implements observed dosing monitored by pharmacy staff. However, on multiple occasions when I have accompanied friends to pick up their methadone across multiple countries, I have never seen this observed dosing occur. Individuals pick up their methadone exactly as they would pick up any other medication at a pharmacy.

Aside from the issues deriving from the carceral logic of the clinical setting, other more practical issues also indicate the need for expanding access to methadone beyond OTP in the United States. For many people, OTP are physically inaccessible, and not every town in the U.S. has an OTP available. This is especially burdensome and creates additional barriers to accessing methadone for individuals who live in rural areas. One recent study of drive times for urban and rural methadone clients found that rural methadone clinic clients have a median drive time of 48.4 minutes each direction to the clinic, for a total of 96.8 minutes of drive time (Joudrey et al., 2020). The cost of gas and time to drive nearly an hour, every single day to attend mandatory observed daily dosing at a clinic is considerable and dramatically disruptive to the lives of methadone clients. This also exposes how access to methadone is greatly limited to individuals who have at least some economic stabilities, such as access to a car and money for gas. Access to

office-based methadone provision has also been shown to improve quality of life and treatment retention and satisfaction (McCarty et al., 2021). Keeping methadone siloed in the OTP setting greatly limits who can access this life-saving resource. This is not an unfortunate accident; it is the central underlying but unstated intention of the methadone clinic.

As outlined in Chapter 5, the methadone clinic offers legal sanctuary to individuals who are deemed compliant so that they can use opioids legally. This helps them avoid criminalization and much of the harms that are attendant to criminalization and prohibition, including premature death.[90] Those who are determined to be non-compliant however, are unable to access this shelter from the harms of illegal drug use. These decisions about compliance have a direct impact on who lives and who dies, and as discussed in Chapter 2, this is an aspect of population management as outlined by Foucault in his history of the clinic.

There are options that exist to provide methadone to opioid dependent people outside of the methadone clinic and OTP setting.[91] Several pilot studies evaluating the feasibility of pharmacy-based[92] methadone in the United States have produced positive findings (Brooner et al., 2022; Tuchman, Simson, & Drucker, 2006). A clinical trial of office-based methadone treatment in New Haven, Connecticut, did a comparative analysis of clients assigned to the OTP and those recruited into an office-based setting.

[90] One of the most devastating harms resulting from criminalization and prohibition includes drug poisoning from using contaminated drugs purchased in illicit markets. But these harms can also include incarceration, skin and soft tissue infections, infection with diseases like HIV, syphilis, or hepatitis C, and social marginalization.

[91] Individuals who utilize methadone for long-term opioid pain treatment receive their methadone prescription at the pharmacy.

[92] These clinical studies utilized either office-based settings with pharmacy provision of methadone, or they offered only office-based setting and provided take home doses of methadone at the doctor's office.

Rates of opioid positive urine drug screens (UDS) were similar for both groups, but there was a dramatic difference in how clients rated the care they received. Individuals who remained in the usual OTP setting and reported the care as excellent was 13%, while 73% of the individuals who were assigned to the office-based setting described the care they received as excellent (McCarty et al., 2021). This is quite a disparity in perceptions of the quality of care received by methadone clients. Clearly, expanding methadone access outside of the OTP setting is not only feasible, but also highly desirable to improve client satisfaction. Primary care doctors in office-based settings prescribe methadone for opioid dependency in Australia, Canada, and the United Kingdom. Since methadone is already provided in office-based settings and pharmacies in many other countries around the world (Joudrey, Edelman, & Wang, 2020), with the United States reliance on the OTP system existing as an outlier, it seems odd that such feasibility studies are even necessary. Feasibility is already indicated by the fact that so many other countries currently provide methadone without utilizing the OTP system being used in the United States. The decision to isolate methadone provision for opioid dependency into the OTP was not based on evidence this provided benefits to clients.

Shifting methadone provision outside of the clinical setting would also be beneficial because especially when providing a narcotic with dependency-forming potential, it is dangerous to allow power to concentrate into the hands of a very small group of people. This is perhaps one of the reasons that methadone clinics are so rife with abuse. Methadone clinics in the United States have demonstrated they are vulnerable to a range of issues resulting in abuses against clients including diluting the methadone (Daily Journal Online, 2023), or even weaponizing the addictive properties of methadone to

sexually abuse clients (Florin, 2015), or to coerce reproductive decisions. Keeping methadone siloed only within the clinical setting, forcing everyone with a specific, highly stigmatized medical need into separate and unequal space for their healthcare needs is also unethical. This spatial isolation only increases the stigma around methadone and the people who take it.

Pharmacies in the United States already currently dispense methadone to patients for pain management. They are legally unable to do so for people who have an opioid use disorder diagnosis. Federal Regulations (title 42 of the Code of Federal Regulations, part 8) specifically exclude individuals who have been diagnosed with opioid use disorder from being treated with methadone replacement outside of OTP. This limits access to this potentially life-saving medication even though it is already available and being dispensed at pharmacies for other, less stigmatized health needs.

Until the laws keeping methadone access for individuals with an opioid use disorder diagnosis are changed, opioid dependent people have limited options for evidence-based treatment. The OTP setting is a very flawed system, but until we can abolish the clinic, we would do well to ensure that we are mindful about implementing non-reformist reforms instead of reformist reforms. Disability, madness, and decarceration activist Liat Ben-Moshe works to expand how carceral locations are conceptualized. Ben-Moshe explains,

> Reformist reforms are situated in the status quo, so that any changes are made within or against this existing framework. Non-reformist reforms imagine a different horizon and are not limited by a discussion of what is possible at present. (Ben-Moshe, 2020, p. 16)

This is important because it is critical that we do not inadvertently make the clinic (and the prison system from which it derives) stronger with our advocacy and actions. For example, advocating for increased take home doses for methadone clients is a non-reformist reform. Increased take home doses of methadone could help to improve and even extend the lives of clients who experience this accommodation. However, advocating for increased take home doses for clients under the condition that they purchase electronic lockboxes with cameras and tracking devices, which will allow medical staff to conduct surveillance and monitoring inside of client's homes is a reformist reform that would help to further entrench the prison into daily life.

The difference between reformist and non-reformist reforms is also exemplified by the capacity of non-reformist reforms to work towards abolition and freedom. In the example of the non-reformist reform of increased take homes, this could also further systemic transformation for individuals on methadone because it would help to promote respect for individual agency, and it disrupts the paternalistic surveillance mechanism of the clinic. Dylan Rodríguez explains, "reform is best understood as a logic rather than an outcome: an approach to institutional change that sustains existing social, economic, political, and/or legal systems" (Rodríguez, 2020, p. 1). Reform in the context of the methadone clinic would involve adjustments to different aspects of OTPs that would have the effect of protecting this system from total collapse. The logic of reform also operates to convince people who have been harmed by the OTP system that the methadone clinic can be reformed and made to serve the needs of the same people it has historically surveilled, rejected, and harmed.

Surveillance technologies that expand carceral oppression into our daily lives such as digital medicine labels being marketed by Sonara Health (Knopf, 2022) or a medicine lockbox replete with GPS tracking and embedded cameras by Verinetics (Redmond, 2023), are the kind of adjustments or reformist reforms to be avoided at all costs. Sonara Health markets its digital medicine labels, stating, "the lack of trust between the (methadone) patient and the provider is one of the impediments to successful treatment" (Knopf, 2022). Notably, the way that trust is considered here is one-way, and perpetuates the narrative of people on methadone as infantile, dishonest, and in need of paternalistic observation and correction of medical providers. It is beneath mention or consideration that technologies like this would only increase mistrust of methadone clinic staff among clients.

Sonara Health's digital label has a QR code that is voided once scanned when the bottle is opened, clients must video record themselves on their phones swallowing the medication, and the video is automatically uploaded for clinic staff to inspect and review. Verinetics takes the surveillance a step further, the company manufactures lockable boxes with embedded 5G radio with real-time cameras, inventory tracking and analytic software (Redmond, 2023). Clinic staff can logon to the lockbox to view the medication and areas nearby in the client's home, disable access to medication, and track the location of the box through geofencing technology. The cost for these surveillance technologies is offloaded onto clients, who are charged an additional $70 per month for the opportunity to be observed remotely.[93]

[93] The language currently used by methadone clinics to refer to take home doses of methadone is literally "privileges." These technologies and take-home doses are being marketed to people on methadone as a privilege that may be available to them.

Reformist reforms in the context of medical technologies like the Orwellian medicine lockbox and digital labels, are an example of what James Kilgore has referred to as carceral humanism (Kilgore, 2014). Kilgore explains that marketing this kind of extension of oppression as a compassionate resource, which also normalizes and blurs the line between what is carceral and what is a social service, is a key facet of carceral humanism. Similarly, Dylan Rodríguez refers to this logic of reform, which posits that oppressed people should continue to tolerate the intolerable as a liberal-progressive counterinsurgency. These "reformist counterinsurgencies serve to undermine, discredit, or otherwise disrupt oppressed, freedom-seeking (Black, Indigenous, incarcerated, colonized) people's growing struggles for abolitionist, anti-colonial, decolonizing, and/or revolutionary transformations of existing social, political, and economic systems" (Rodríguez, 2020, p. 1). This is precisely what occurs in methadone clinics and drug treatment generally. Carceral violence is implemented in a way that positions itself as if victims should be grateful to be targeted.

The drift away from overt criminalization and towards carceral humanism has intensified in the United States over the past several years as people who often see themselves as advocates for people who use drugs have called for more treatment and less prisons. Attempts to impose involuntary treatment on individuals who are believed to be using illicit drugs have intensified, with 37 states currently having laws that allow for "concerned individuals" to petition courts for involuntary rehab (Health in Justice Action Lab, 2018). The state of Washington recently expanded their mental health statutes to

include involuntary treatment for individuals who use illicit drugs,[94] regardless of whether they have a substance use disorder diagnosis or pose a threat to themselves or others (Washington State Healthcare Authority, 2018). This mental health statute places property rights above individual human rights. The statute is written that if an individual poses a threat to property, they can be mandated involuntarily to drug treatment programs. Laws that impose involuntary treatment into what are referred to as secure withdrawal management and stabilization facilities operate under the pretense that this is a kinder response than sending people to jails or prisons. In stark contrast to the belief that involuntary withdrawal and stabilization is kinder than prison, medically managed withdrawal increases risk for an overdose event (Walley et al., 2020). Referring to this treatment as stabilization is a misnomer, as it has the potential to destabilize opioid dependent individuals and put them at increased risk for an overdose.

Further proof of how drug treatment exists as an extension of punitive carceral approaches to illicit substance are evidenced by the near vacuum of positive outcomes from these treatments. Involuntary treatment has not been demonstrated to increase positive outcomes for individuals who are mandated into treatment, nor to result in decreased illicit drug use or criminal involvement (Rafful et al., 2020; Werb et al., 2016). In a systematic review of involuntary drug treatment, five out of the nine studies included found no reduction in drug use or criminal recidivism, while two increased negative outcomes (Werb et al., 2016). Two studies in China and Taiwan, found that involuntary drug treatment increased negative outcomes, including increased criminal recidivism

[94] HB 1713 codifies the 2018 expansion of Washington state's civil commitment law includes involuntary commitment for individuals who are determined to pose a potential risk to property. This places the rights of individuals as lower than an item, which has more of a right to exist and be left alone than a human.

(Huang, Zhang, & Liu, 2011; Vaughn, Deng, & Lee, 2003). The belief that depriving an individual who is using illicit drugs of their freedom is necessary to protect them from their own destructive behavior can result in devastating outcomes.

Advocacy for involuntary treatment is often driven by concerned family or friends of individuals who use drugs. For Kelssie Green, a 24-year-old Alaskan woman, it was her parents who called Alaska State Troopers, begging them to arrest their daughter. They said that her drug use was excessive, and they could not control her. Within five days after her arrest for failing to complete community service after driving on a revoked driver's license, Kelssie was found dead in her jail cell. She died while going through opioid detox and withdrawal with no medical support while in the Anchorage Jail (Hollander, 2019). Even after their daughter's death in jail after begging for her arrest, Kelssie's parents remain convinced they just hadn't managed to find the right combination of enforcement and coercion to make treatment work. For Kelssie, instead of centering needs like safety and dignity, abstinence and cure were privileged over all other outcomes and resulted in Kelssie's death. Apparently, it is not even worth imagining what a reality would look like where people are not violently pushed towards total abstinence from drugs and instead supported to stay safe, healthy, and above all – alive. Depriving people of their basic human rights, including the right to freedom, shouldn't be taken lightly. Especially considering that involuntary treatment is so frequently ineffective at achieving the goals of the state, friends, or family, and in some cases may even exacerbate problems, this should not be pursued as a solution to illicit drug use. The fact that it is still pursued, despite the lack of demonstrably positive outcomes, exposes

how deeply cure and eradication are imbricated in the treatment of people who are dependent on illicit drugs.

Unfortunately, just as mandatory treatment and even incarceration in jails or prison may seem appealing to friends or family of people who use drugs, carceral humanism, in the form of the kind of surveillance technologies being adopted by some methadone clinics, may still appear attractive to some people – even those who are directly targeted. For someone who doesn't want to or cannot catch a bus to ride several hours to a clinic every day, bringing a medical lockbox with GPS and a camera into their home might seem like an acceptable compromise. Exchanging privacy for some limited freedom may initially appear to be an acceptable compromise to the horror and indignity of daily clinic attendance and observed dosing. But if we do not resist these ever-proliferating indignities and intrusions, they will only continue to increase and become more oppressive and ever-present in our daily lives. The line between the overtly carceral and social service is incredibly murky when it comes to methadone access and drug treatment in the United States.

To resist the continuous creep of surveillance technologies and the reach of carceral humanism, people must feel empowered to demand that they be treated with dignity and basic respect. In the context of drug treatment, such as that offered within OTP, this means that staff and clients within the clinical setting need to reject curative violence, which seeks to eradicate difference, and instead embrace the wide range of reasons an individual might seek treatment, including methadone. This should be expanded beyond the clinical setting to include anyone who struggles with their drug use, even outside of treatment and resource provision. When people are convinced that they

are defective, damaged, or evil, they are less likely to engage in self-advocacy and to feel disempowered (Volkow, 2020). Not only does this result in delay or avoidance in seeking any healthcare, but it also means that, as we observed in the responses in this study, individuals will accept sub-par and abusive healthcare interactions as not just acceptable, but even desirable. Afterall, they are junkies, and this is how junkies need to be treated.

Manifesting a Better Future

> All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood. (Article 1 of the Universal Declaration of Human Rights, 1948)

The mandatory counseling required in methadone clinics is not counseling. But many of the participants of this study indicated they wanted counseling. It is hard to say what resources people would want if they were not violently hounded to contort and conform to become as close to normal as they possibly can. Introduced in Chapter 1, *The Methadone Manifesto* is the largest autoethnographic study coauthored by people on methadone. It is a call to action to reform the OTP system in the United States. *The Methadone Manifesto* helpfully outlines seven broad categories for recommendations that would improve access to methadone (See Figure 3).[95] Building on a few of *The Methadone Manifesto's* recommendations, and based on the findings of this dissertation, I will offer a critique and three suggestions of my own.

[95] All of the authors of *The Manifesto* are individuals who are or have been on methadone or buprenorphine.

Figure 3

Methadone Manifesto Recommendations

Recommendations for Improving Access to Methadone Maintenance Treatment (MMT)

Problems during COVID-19	• SAMHSA COVID-19 MMT relaxations should be extended through the duration of the pandemic, implemented fully by all opioid treatment programs, and made permanent. • MMT programs should consistently implement use of social distancing and masks in clinics.
Take-home doses	• Federal policy should allow primary care and pharmacy-based prescribing to increase MMT geographic availability. • State and federal policies should not require negative drug tests for take-home dosing eligibility. • MMT programs should eliminate take-home bottle return requirements. • MMT programs should eliminate lock box requirements for take-home dosing. • MMT programs should provide morning, afternoon, evening, and weekend dosing hours to accommodate vulnerable patients, including disabled patients and sex workers. • MMT programs should consider transportation and disability issues when determining take-home eligibility.
Counseling and treatment plans	• Policies and MMT programs should provide voluntary instead of mandatory individual and group counseling • MMT programs should adhere to state minimum counseling requirements and not impose more burdensome standards. • MMT programs should provide funding and support for voluntary patient-only support groups, including parenting support groups and support groups exclusively designed for current or former sex workers. • MMT programs should allow members of the same households and carpools to attend the same counseling groups.
Costs	• Policies should prohibit accelerated tapering schedules and financial detox.
Parenting patients	• MMT staff should be trained on the limits of mandatory child protective service reporting requirements and the potential negative outcomes of reporting. • MMT programs should allow children into the building, provide free child care on site, and support voluntary parent/child integrated treatment programs.
Patients in the sex trades	• MMT engagement and retention of sex workers should be a research and policy priority.
Broader recommendations	• MMT regulations should be supported by current research. • Additional regulations beyond the federal level should not be allowed. • Policymakers and MMT programs should give methadone patients a decision-making role in policy and program practice. • MMT programs should fast track patients through intake processes, especially more vulnerable patients such as those who are elderly or disabled. • Policies should expand and improve transportation assistance. • Disabled patients should be consulted on new facility development, and MMT facilities should be disability accessible. • MMT programs should implement cultural competency training for all staff in areas including disability, sex worker rights and health issues, family separation, and antiracism. • MMT programs should support harm reduction treatment models as fully as abstinence-based models. • Programs should individualize treatment and implement patient-centered practices. • MMT programs should serve as drug user health hubs, integrating voluntary services such as hepatitis C virus treatment and safe consumption sites. Health hubs should offer health resources and referrals for vulnerable groups (e.g., preexposure and postexposure prophylaxis, hygiene items, obstetrical/gynecological care, and culturally competent mental health treatment).

Note. SAMHSA = Substance Abuse and Mental Health Services Administration.

(Simon et al., 2022)[96]

The Manifesto was important to include because personal narratives can be a powerful tool to advocate for policy change. The data for this dissertation originated from a study that has its genesis in the community of people who use drugs. It is appropriate that recommendations also originate in the community, informed by the perspectives of directly impacted individuals. As Nancy D. Campbell explains, "Ethnography potentially

[96] Simon, C., Vincent, L., Coulter, A., Salazar, Z., Voyles, N., Roberts, L., Frank, D., & Brothers, S. (2022). The Methadone Manifesto: Treatment Experiences and Policy Recommendations from Methadone Patient Activists. *American Journal of Public Health (1971)*, *112*(S2), S117–S122. https://doi.org/10.2105/AJPH.2021.306665

rearticulates knowledge claims in ways that are useful to a movement for socially just drug policy and a feminist movement for women's autonomy" (Campbell, 2002, p. 195). *The Manifesto* is a collaborative work that brings together perspectives and experiences from people on methadone across the United States. This dissertation worked to explain and draw on the community-based perspectives and recommendations provided by *The Manifesto*.

One section in *The Manifesto's* list of recommendations includes suggestions for the counseling and treatment plans administered by OTP. Ideally, the archaic OTP system would be abolished, and methadone should be prescribed by any office-based doctor and picked up at the pharmacy like any other medication. As noted previously, chronic pain patients currently get their prescription from an office-based medical provider and pick up their methadone from the pharmacy. But until office-based prescribing and pharmacy pick-up is a reality for opioid dependent people, these are some recommendations to start improving the lives of people on methadone without strengthening the carceral OTP system.

The first recommendation within *The Manifesto's* section on counseling and treatment plans is that counseling should be voluntary (Simon et al., 2022). If people want therapy, this should not be mandatory. To build a liberatory form of counseling, I would suggest that the counseling must be provided outside of the OTP. This means that there would be no counselors at the methadone clinic. Staff at the OTP cannot have access to therapy notes or any details from counseling sessions. Until methadone provision is divorced completely from surveillance and the carceral blueprints of the clinic, it is not safe for individuals to have this kind of information available to clinic

staff. If someone indicates that they are struggling with their illicit drug use, they could be kicked out. Also, under the current OTP system, if clients mention that they take more or less of their methadone than instructed, there are repercussions. Methadone is a narcotic with the potential to cause dependency. The fact that the drug is dependency-causing and someone taking it is incredibly vulnerable to exploitation or abuse, is important to consider. As participants explained, counselors frequently weaponize the addictive properties of methadone to coerce behavior. This was one of the central roles of counselors, to act as disciplinarians. This extensive control and power to gatekeep access to methadone, was described by participants as a key factor that increased the power imbalance between counselors and clients. The more power is spread out, beyond the clinic and clinic staff, the less likely the possibility will be for this type of abuse. Therefore, any counseling must be independent from the OTP setting and provision of methadone.

Participants clearly outlined how there was a lack of transparency into the credentials and background of the clinic staff who operate as counselors. When counseling or any psychosocial support is provided, there needs to be clear communication and transparency into the identity and role of the staff providing this support. As discussed in Chapters 3 and 4, trust is important for building a therapeutic relationship and alliance. To build a more liberatory form of counseling, clients need to be able to trust the individual who is providing them counseling. This would also include options for clients to choose and direct who their counselor is. Clients may feel safer and more trust towards individuals who share similar positionalities or backgrounds as themselves.

Options for different types of therapeutic support and any potential benefits need to be clearly communicated to clients. Clients who voluntarily request counseling should be able to access trained professionals like licensed professional counselors (LPC), licensed mental health counselors (LMHC), and licensed clinical professional counselors (LCPC). They should also be provided education and access to different types of actual therapy such as cognitive behavioral therapy (CBT), dialectical behavioral therapy, psychotherapy, and family or group therapy if they choose.

The second recommendation of *The Manifesto* that I would like to emphasize, urges clinics to fund and support voluntary client-only support groups, such as parenting, education, and sex worker support groups (Simon et al., 2022). This recommendation is important because it addresses the desire expressed by many in this study to have psychosocial services that meet their individual needs. Some participants also indicated that they needed support for issues that were not related to psychosocial counseling. These support groups must also be divorced from and independent of the OTP setting. One aspect of OTP is that they centralize all resources into the clinical setting. To decrease the methadone clinic's ability to cause harm, this power must be disrupted and rebalanced. Distributing responsibility and resource provision into other spaces outside the clinic will help reduce the power imbalance. For clients who feel isolated, being able to engage in group settings with other people who share similar positionality to themselves may be desirable. Client-only support groups could also offer the potential for coalition-building which has transformative potential and could provide the possibility of consciousness raising among clients at methadone clinics.

Finally, as discussed in Chapter 2, the unique needs of clients based on gender should not be ignored. Gender appropriate care would require that no one, but especially women and individuals[97] who have experienced sexual violence should not be subjected to observed urine drug screens. No one should be forced to discuss or identify themselves as a victim of sexual abuse and violence if they do not want to, so protocol should assume and treat every client as if they may have been a victim of sexual violence. This also means that intrusive monitoring such as toilet cameras and mirrors are inappropriate and should never be implemented at any time. It is also important to understand that women generally enter treatment much later than men and this often means that they have additional medical needs. This can include wound care, support for infectious diseases like HIV, TB, and hepatitis C. Accessible options for treatment should be provided to women who desire this support.

Additionally, clinic staff and anyone providing resources to people who use drugs should be trained on the limits of mandatory reporting to child protective services. This includes educating staff on the potential negative outcomes of reporting clients to child protective services. Women who use drugs, and especially mothers, are too often portrayed as inherently bad parents because of their drug use. In the U.S., Black mothers and their newborns are more likely to be drug tested in medical settings (Wakeman, Bryant, &Harrison, 2022). Methadone or buprenorphine are the accepted standard of care for pregnant people who are dependent on illicit opioids and have been shown to improve pregnancy outcomes. Unfortunately, access to this gold standard of care is still limited. Racial disparities impact accessibility to methadone, and this extends to access for

[97] This includes transgender or gender nonconforming individuals.

pregnant people who are Black or Latinx (Schiff et al., 2020). Being a drug user does not automatically make someone a bad parent nor does illicit drug use alone indicate that a child is being abused.

Mandatory reporting of parents who use illicit drugs in many states is a result of the federal Child Abuse Prevention and Treatment Act (CAPTA). The fear of mandatory reporting and the resulting child and family separation is one of the key drivers of treatment delay for women. CAPTA is a funding provision which requires states to enact and enforce policies for the safe care of infants who have been identified as affected by substance use. While this act does not require reporting to child welfare agencies, many states do require healthcare professionals to report all substance-exposed newborns to child welfare agencies for the purposes of investigation (Child Welfare Information Gateway, n.d.). Any woman who is identified as having used drugs while pregnant will risk being placed under investigation.

Connecticut Child Protective Services has developed a solution that has helped prevent the separation of families for parents who use drugs who do not pose any risk for abuse or neglect. They have created an anonymous database that fulfills the reporting requirements of CAPTA yet does not identify families who pose no risk for abuse or neglect to child protective services (National Center on Substance Abuse and Child Welfare, n.d.). If more states followed the example of Connecticut, funds that previously supported costly investigations and traumatic family separations among families that use drugs, yet pose no abuse risk, could instead go towards creating other resources. Ideally, resources that help support families in crisis and do not separate infants from parents who pose no risk to their wellbeing.

In a future devoid of clinics, methadone could be offered with an orientation towards safe supply alongside other medications or drugs utilized as a replacement for chemically similar or identical illicit drugs. This could also include a safe space to use and inject drugs. Sydney, Australia has a safe injection space, the Medically Supervised Injection Center (MSIC) (Day, Jauncey, Bartlett, & Roxburgh, 2022). The MSIC provides a space for individuals to bring their drugs to inject in a safe, clean area, with the support of trained medical professionals. In over 20 years, the MSIC has never had a single overdose death (Day, Jauncey, Bartlett, & Roxburgh, 2022). This shows how implementing evidence-based resources for people who use drugs can save lives.

In addition to providing a safe place to inject drugs with a greatly decreased risk for overdose death, people who come to the MSIC are connected to other resources such as HIV and HCV testing and treatment,[98] sterile syringes and injecting equipment,[99] they are also provided vein assessments, and training and assistance to inject drugs in a way that decreases damage and risk for chronic infection and wounds. While the MSIC provides referrals to individuals who request assistance to access opioid replacement treatments, they do not provide methadone or buprenorphine on site. This is ideal because it helps prevent too much of a power imbalance from developing. By keeping the provision of dependency-causing narcotics separate from other resource and support provision, the MSIC is preventing the inflation of a power imbalance between clients and

[98] Unlike the United States, where HIV and HCV testing is provided independently of treatment, individuals who test positive or have HIV or HCV are provided their treatment directly through the MSIC. This helps prevent anyone from falling through gaps in the continuum of care between testing and treatment referral.

[99] Sterile injecting equipment includes but is not limited to sterile syringes, sterile cookers, sterile water, sterile filters, and all manner of resources for injecting drugs more safely.

staff. While there could still be some imbalance between clients and staff in these spaces, by limiting the number of resources provided by any one institution or group, it at least reduces the amount of power collected in one place.

Even beyond the realm of the methadone clinic and addiction treatment, the entire field of psychiatry is oriented towards labeling much of human distress and emotional response to struggle as pathological. However, labeling and diagnosing emotional distress, as if people are defective for the way they respond to suffering, is not even helpful to the individuals who are in distress. Convincing people that if they are different or suffering that there is something deeply wrong with them, as if their very being is wrong, is ultimately hurtful. Understanding these labels operationally - who gets to create, define, apply, and ultimately, who gets to benefit and profit from them is helpful for understanding why some people and communities are pathologized and the work that treatment does.

Addiction treatment operates as a social panacea, pathologizing suffering that could otherwise inspire coalition-building and political action driven towards social reform. Instead of naming or diagnosing the conditions that cause harm and distress, mental health systems like the OTP diagnose and tunnel focus towards individuals. In this way, the methadone clinic itself exists as an ideological sedative much stronger than the methadone itself, paralyzing the impulse to collectively organize and work towards building communities and a future with less suffering.

Community resources like the MSIC are one way that people have collectively organized to resist oppression and to survive. Other drug user-led collectives, such as the

Drug User Liberation Front (DULF) in Vancouver, Canada[100] have started to engage in mutual aid in the form of compassion clubs. The illicit drug market has become increasingly contaminated in recent years, resulting in an unprecedented rise in deadly drug poisonings (Krausz et al., 2021; Sloss, 2023). There is very little transparency into the quality and provenance of drugs bought on illicit markets. In fact, because of criminalization and prohibition, a lot of effort goes into hiding where illicit drugs are coming from. Assumptions about the character and quality of drugs bought in illicit markets are mostly based on trust established through personal networks.

In many states, including Arizona, it remains illegal to conduct any analytical testing of illicit drugs for people who intend to use them (ARS 13-3415, n.d.). Drug users in Vancouver, British Columbia, Canada also experienced similar barriers to characterizing their drugs. Because of this, compassion clubs were established by DULF, and they distributed 3.5-gram boxes of heroin, cocaine, and methamphetamine that had been tested and analyzed in a laboratory (Figure 4). Figure 4 shows a box filled with the individually packaged 3.5-gram portions of laboratory-tested heroin and cocaine that was distributed by members of DULF.[101] The heroin and cocaine were purchased and then analyzed by a laboratory to ensure the quality and concentration of the drugs being distributed.

Distributing a safe, legal supply can help reduce overdose.[102] Reducing the risk of deadly overdose is critically important. Figure 5 explains the "5 W's" of their compassion

[100] https://opencollective.com/dulf
[101] These compassion clubs established by DULF are illegal, but members of the organization decided that they were going to establish this resource regardless of legality.
[102] Deaths from drugs procured on illicit markets are generally referred to as "overdoses." However, they are more appropriately characterized as drug poisonings. To overdose, individuals would need to have

club model of safe drug supply. DULF acknowledges the performative nature of their direct action and episodic compassion clubs. The population of people who use illicit drugs is much greater than what can be addressed by a single community-based organization like DULF. The fact that the illicit supply, which prevents individuals from having basic information about the quality and concentration of their drugs, increasing risk of death, is explained in Figure 5. The compassion club model emphasizes that drug user's lives matter. It is also important to signal to people who use drugs that their lives, pleasure, and safety matter. Because of the inherent risks of the current illicit market, especially the risk of fentanyl or other fentanyl analog contamination, many people who use illicit drugs have become accustomed to being treated like risk to their bodies and lives are completely acceptable. Initiatives like DULF's compassion clubs help to remind people that they matter, and their bodies are deserving of protection and safety.

information about what the drug is, quality and concentration. Most people who use illicit drugs are systematically and deliberately deprived of this information to protect their bodies from harm and death. They do not have enough information to overdose. They are being poisoned.

Figure 4

Pure Heroin, Cocaine, and Methamphetamine Distributed by DULF

Pure heroin and cocaine distributed by DULF (Medrano, 2022).[103]

[103] This image of the pure heroin and cocaine samples distributed by DULF are taken from a FILTER article by Kastalia Medrano, May 5, 2022.

Figure 5

DULF Compassion Club Model of Safe Supply Poster

Poster created by DULF to explain their compassion club model of safe supply. (Medrano, 2022).[104]

[104] This image of "The 5 W's of Episodic Compassion Clubs" is taken from a FILTER article by Kastalia Medrano, May 5, 2022.

Ultimately, we must work towards a future in which everyone is seen and treated as if they deserve protection and safety, where bodily autonomy and individual agency is respected. This means accepting that everyone has an innate human right to bodily autonomy and dignity. The current OTP system and the mandatory counseling operating within cause harm to individuals on methadone. Until we can abolish the clinic and the carceral logic that informs it, we must persist in advocating for non-reformist reforms that do not strengthen the systems that oppress us. Part of building the scaffolding for social change that will make the clinics no longer necessary is also to resist the urge to eradicate difference, whether that difference is with others or internal. People who use illicit drugs and have been criminalized have the right to exist and the right to be treated with dignity and respect.

Methadone clinics are an extension of the carceral state, and part of "the very logics of the overlapping criminal justice and policing regimes (which) systematically perpetuate racial, sexual, gender, colonial, and class violence through carceral power" (Rodríguez 1576, 2019). To create a future where the clinic is no longer implemented, we also need to work towards a future where funds are redirected from prisons and policing towards building social security. This future free of prisons and policing will not be accomplished by gradual change. As abolitionist Dylan Rodríguez reminds us, reformists essentially tell people who are experiencing oppression that they must wait for change and tolerate violence and suffering, "as they wait for the "fix" to take hold" (Rodríguez 2020). This kind of reformism often undermines more direct action that could lead to systemic change.

In the context of methadone clinics, avoiding this piecemeal reformism means organizing for collective wellness and liberation. This includes direct action such as establishing compassion clubs like the Drug User Liberation Front (DULF) has started in Vancouver. Access to safer drugs has the immediately tangible impact of extending the lives of drug users. Drug user unions are also a powerful way to build the capacity of people who use drugs to collectively support one another and strengthen community to circumvent the things that are trying to kill us, such as the methadone clinics. Finally, we must avoid this reformist impulse which seeks to merely soften the blow of carceral systems. This means doing the work every day of orienting ourselves towards an abolitionist mindset to build a future where people are no longer criminalized for choices they make regarding their own bodies.

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APPENDIX A

ARIZONA STATE UNIVERISTY IRB APPROVAL

EXEMPTION GRANTED

Helen Quan
CLAS-SS: Social Transformation, School of (SST)
480/727-8461
h.q@asu.edu

Dear Helen Quan:

On 11/23/2022 the ASU IRB reviewed the following protocol:

Type of Review:	Initial Study
Title:	Naturally Non-Compliant: Counseling Requirements in OAT Programs, Arizona 2021
Investigator:	Helen Quan
IRB ID:	STUDY00016762
Funding:	None
Grant Title:	None
Grant ID:	None
Documents Reviewed:	• Data Use Agreement Unnecessary, Category: Other; • Response to Reviewers, Category: Other; • Social Behavioral Protocol , Category: IRB Protocol; • U of A IRB Approval, Category: Off-site authorizations (school permission, other IRB approvals, Tribal permission etc);

The IRB determined that the protocol is considered exempt pursuant to Federal Regulations 45CFR46 (2)(ii) Tests, surveys, interviews, or observation (low risk) on 11/14/2022.

In conducting this protocol you are required to follow the requirements listed in the INVESTIGATOR MANUAL (HRP-103).

If any changes are made to the study, the IRB must be notified at research.integrity@asu.edu to determine if additional reviews/approvals are required.

APPENDIX B

UNIVERSITY OF ARIZONA CONSENT FORM

Consent to Participate in Research

Study Title: Evidence for Action: COVID as a window of opportunity to normalize MOUD Access

Principal Investigator: Dr. Beth Meyerson

Sponsors: Foundation for Opioid Response Efforts (FORE) and the Vitalyst Health Foundation

Study Information
You are being asked to participate in a study about MOUD/MAT services during COVID. The study will require no more than 60 minutes of your time, when you will complete an interview with me. Let me explain below.

The University of Arizona with support from Sonoran Prevention Works and Southwest Recovery Alliance is conducting 60 minute anonymous interviews to help improve buprenorphine and methadone services in Arizona. Interview questions were developed by a statewide advisory board of people with lived experience, MAT providers and harm reduction researchers.

Why is this study being done?
The purpose of the study is to learn about the experiences of people on methadone or buprenorphine "bup" or "subs" during COVID. Interview findings will inform policy makers, service providers, and others in the community about needed changes to the MAT system.

What will happen if I take part in this study?
I am a trained field interviewer with lived experience. I will read you the interview questions and record your answers using a digital recorder so that I can better listen to you. **This is an anonymous interview.** At no time do you need to give me your name or share it as part of the interview.

How long will I be in the study?
You only need to participate once. We will not ask anything else of you after the interview.

How many people will take part in this study?
We are conducting interviews with 200 people across Arizona over a several week period.

Can I stop being in the study?
Yes. Participation is voluntary. You can also stop the interview at any time. Your decision to participate in the interview will not affect your relationship with the University of Arizona, Sonoran Prevention Works or Southwest Recovery Alliance.

What risks or benefits can I expect from being in the study?
You might feel a little uncomfortable about some of the questions.

APPENDIX C

RECRUITMENT FLIER

Wanna improve methadone treatment?

MPACT

We will build & test a new methadone treatment approach over a 2-year period in two AZ clinics

We are hiring 20 People to help develop MPACT: a Patient-Empowered, Trauma-Informed methadone treatment approach.

We need YOU if you:

1. Have Arizona methadone treatment experience that is less than 5 years old (you can be a current patient)
2. Reside (pick one):
   - in Maricopa County but have not been/are not a patient at the 2 CMS clinics in Mesa (on Main or on Arbor)
   - in an Arizona rural community but not Sierra Vista and have not been/are not a patient at the CMS in Sierra Vista
3. Have access to the Internet, and have a phone, table or computer for communications

No other special knowledge is needed!

Requirement: 9 meetings over 2 years, paying $540 ($20/hr)
This consulting gig involves working on a team of people with methadone treatment experience from November 2023-Dec 2024. The group is convened by Southwest Recovery Alliance and will meet in Phoenix (urban group) or on zoom (rural group).

An initial 1 hr meeting will be held in February. You will be paid $20 for participating if you are hired.

Interested? **Go to https://tinyurl.com/t843w8tu**
Or scan this Code:

Questions? Email Arlene@Southwestrecoveryalliance.org or Bmeyerson@arizona.edu

SWRA Southwest Recovery Alliance

Harm Reduction Research Lab
THE UNIVERSITY OF ARIZONA COLLEGE OF MEDICINE TUCSON
Family & Community Medicine

APPENDIX D

INTERVIEW GUIDE

Interview Questions for People who were on Bup or Methadone during COVID

Eligibility

[Interviewer: After discussing the study information, please Confirm interview Eligibility (Yes to all is required)]:

- Are you 18 yrs of age or older?
- Did you live in Arizona during COVID? (between January 1, 2020 and March 31, 2021?
- Were you a patient at a clinic or provider who gave you methadone or buprenorphine ('bup' or 'subs') for opioid use disorder at some point between January 1, 2020 and March 31, 2021?

[if eligible]

OK, with your permission, I will start the recorder so that I can actively listen to you.
Do you give your permission to record this interview?

- If yes, turn on the recorder and say, *This is interview # with interviewer (your name).*
- (ask participant) *Do I have your permission to record the interview?*

[if yes] proceed with interview.

Go to next page