COUNSELORS' LIVED EXPERIENCE TREATING PATIENTS UTILIZING METHADONE: THE INTERSECTION OF CULTURE, POLICY, AND STIGMA

A Dissertation

Presented to the Faculty of

the Graduate School of Leadership & Change

Antioch University

In partial fulfillment for the degree of

DOCTOR OF PHILOSOPHY

by

Kathryn Floyd Eggert

ORCID Scholar No. 0000-0002-9859-0402

September 2023

COUNSELORS' LIVED EXPERIENCE TREATING PATIENTS UTILIZING METHADONE: THE INTERSECTION OF CULTURE, POLICY, AND STIGMA

This dissertation, by Kathryn Floyd Eggert, has
been approved by the committee members signed below
who recommend that it be accepted by the faculty of
Graduate School in Leadership & Change
Antioch University
in partial fulfillment of requirements for the degree of

DOCTOR OF PHILOSOPHY

Dissertation Committee:

J. Beth Mabry, PhD, Chairperson

Lemuel W. Watson, EdD

Declan T. Barry, PhD

ABSTRACT

COUNSELORS' LIVED EXPERIENCE TREATING PATIENTS UTILIZING METHADONE: THE INTERSECTION OF CULTURE, POLICY, AND STIGMA

Kathryn Floyd Eggert

Graduate School of Leadership and Change

Yellow Springs, OH

The United States continues to experience unprecedented deaths related to the opioid epidemic. Efforts to address the epidemic remain hampered by war-on-drugs policies that stigmatize people who use drugs and create barriers to accessing evidence-based treatments, particularly methadone maintenance treatments (MMT). Despite 50 years of research regarding MMT, it remains highly regulated, and arguably the most stigmatized treatment. The punitive regulatory structure of MMT remained unchanged until emergency waivers were initiated during the COVID-19 pandemic. The study used an exploratory, critical phenomenological approach to examine the intersection of culture and regulation on the lived experiences of 26 addiction counselors who provide treatment for opioid use disorder employing MMT. The phenomenon is examined through lenses of structural competency, cultural healthcare capital, structural racism, and self-determination theories. Using individual interviews, the study investigated whether counselors perceived, conveyed, or enacted stigma in treating those receiving MMT. The study explored whether the pandemic-era regulatory changes shifted counselors' perceptions of the treatment. Findings indicated that counselors enacted and mitigated stigma, two-thirds expressed moderate to high levels of stigma. Counselors perceived and enacted stigma by expressing frustrations regarding programs that embraced harm reduction strategies fearing approaches enabled symptomatic behaviors. They also expressed frustrations with patients' symptomatic behavior as reflected in paternalistic attitudes and feeling compelled to surveil patients' behaviors. A number of factors aligned with counselors' stigmatizing beliefs and attitudes: their pre-career negative experiences with methadone, personal abstinence-based recovery, recovery-oriented training, and/or their lack of exposure to information about the origins of the methadone regulatory structure. Stigmatization was enacted through labeling, discrimination, social exclusion, and the counselors' use of power. Counselors who mitigated the stigmatized identities of patients held whole-person views and were more likely to have personally utilized methadone. Counselors' reactions to the loosening of MMT regulations were mixed, most welcomed some level of change. Regulation changes, however, did not significantly impact counselors' attitudes. This finding, coupled with counselors' stigmatizing behaviors, appears grounded in the socio-historic, racially-biased cultural roots of MMT. Counselors' mitigation of stigma offers implications for future studies focused on abating ingrained cultural stigmatization of methadone and people who utilize it. This dissertation is available in open access at AURA (https://aura.antioch.edu/) and OhioLINK ETD Center, (https://etd.ohiolink.edu).

Keywords: methadone maintenance, addiction counselor, stigma, structural racism, opioid use disorders, leadership

Dedication

To the people called patients—thank you for teaching me, inspiring me, and challenging me to be the best I can be every day. Thank you.

Acknowledgements

A dissertation is a journey carried out by one person but supported by countless individuals. I could not have completed this work without the support of numerous mentors, colleagues, friends, and family. I am forever grateful for the incredible support, compassion, and mentorship that made this dissertation possible. I want to take a moment to acknowledge some of the people who are on this journey, however, please know here are many more beyond these few paragraphs.

First, to my committee, starting with my committee chair Beth Mabry, PhD, thank you for always being patient, giving me thoughtful and inspiring feedback, and forever being a coach and cheerleader. To Lemuel Watson, EdD, thank you for your willingness to jump onto my committee later in the process and offer your perspectives and insights. Your reflections and feedback helped to refine and improve my study. To Declan Barry, PhD, not only a committee member but a long-time colleague and mentor, thank you for your coaching and tremendous support on this journey. I appreciate the time you took to stop by my office and check on my progress and my well-being when the trip was challenging.

I am grateful to my fellow C-18 colleagues for all you shared with me along the way. Each of you has contributed to my growth as a person and scholar. Specifically, I want to thank Dr. Pam Viscione for being a part of my coding team and for challenging me to move forward when I hesitated with my study. Special recognition goes to Dr. Sharon Wamble-King, Dr. Heidi Sampson, and Dr. William Keating, who navigated this program from the early days of 2018 through each of our respective defenses in June 2023. I consider each of you part of my extended family.

My journey would not have been possible without my APT Foundation Community. There have been countless mentors who have shaped and molded my clinical and research practice. To Dr. Lynn Madden, for giving me the crazy idea of pursuing this degree, and for your direct support and mentorship as I progressed through the program. I owe a debt of gratitude to the APT Foundation board for their generosity in supporting my work, both by giving me funding to provide thank-you gifts to participants and the time of staff in directly completing internal participant recruitment and interviews. I am forever grateful to Ermonda Markaj, MA, APT Foundation research associate, for her time and commitment to my work. She not only recruited and interviewed counselors at the APT Foundation but went above and beyond with her enthusiasm for my project and her ongoing support.

To my friends and family, who have supported me not only on this journey but all the journeys before and after Antioch, without each of you, and your love, this degree would not have been possible. To my parents for always telling me I could. To my husband, Henry Eggert, who always told me *you will*—particularly when I did not think I could type another sentence; I am ever grateful for your love.

Table of Contents

List of Tables

List of Figures

CHAPTER I: INTRODUCTION

In the United States in 2021–2022, the news was wrought with sadness, violence, and death. Death from COVID-19, gun violence, police killings, climate change, and rising overdose deaths predominate the headlines in the news cycle. We are witnessing the convergence of multiple worldwide public health crises that have and will continue to have devastating impacts on health and well-being if there are no significant and sustained interventions. Between March 2020 and April 2021, the United States recorded over 100,000 deaths secondary to drug overdose (Centers for Disease Control, 2021). The current drug crisis in the United States represents a failure to implement evidence-based practices and establish policies that would drastically reduce lives lost and improve the quality of life for many people. Unfortunately, there is minimal political willpower to address the barriers blocking evidence-based practices to address these and many more public health issues.

At the center of these public health crises, longstanding culture wars have led research findings to be politically charged, thus imposing barriers to the implementation of evidence-based practices. In the battle against COVID-19, politics and culture tarnish the science supporting wearing masks and taking vaccines. The science behind substance use disorders (SUDs) and, more specifically, the treatment of opioid use disorder (OUD) continues to be hampered by cultural beliefs and ensuing policy over the knowledge of science, exacerbating our ongoing crisis.

U.S. policymakers fail to expand and enact measures demonstrated by research that reduce harm to people who use drugs PWUDs). Such failures include not passing legislation allowing the implementation and expansion of needle exchange programs, safe consumption sites, and the expansion of access to medications to treat opioid use disorder (MOUD), which stems from a cultural preference for abstinence-based measures. All these interventions effectively improve health and reduce morbidity (Kåberg et al., 2020; National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Health Sciences Policy; Committee on Medication-Assisted Treatment for Opioid Use Disorder, 2019; Ng et al., 2017). However, in the United States, they remain contested or poorly understood. Coon et al. (2020) declared, "The opioid crisis represents one of the largest failures of our current healthcare system as it continues to claim lives at an unprecedented rate and has caused a devastating range of preventable morbidity" (p. 1493). The World Health Organization recognizes opioid misuse as a global problem. Europe, by comparison to the United States and Canada, demonstrates substantially less mortality and morbidity associated with opioid misuse (Kennedy et al., 2020). This is in part due to their more progressive approach to harm reduction.

Understanding the historical socio-political context of the substance abuse treatment system in the United States and related drug policy helps make sense of the impact of those policies in the present climate of the opioid epidemic. The birth of the substance abuse treatment system policy in the United States began with the passage of Public Law 92-55, "An Act to Establish a Special Action Office of Drug Abuse Prevention and to concentrate the resources of the Nation against the problem of drug abuse," and is now cited as the "Drug Abuse Office and Treatment Act of 1972." President Richard Nixon signed this legislation and declared a war on drugs stating, "America's public enemy number one in the United States is drug abuse. To fight and defeat this enemy, it is necessary to wage a new, all-out offensive" (Nixon, 1971, para. 3).

The framing and subsequent enactment of legislation created the "war on drugs" and, also, a war on people who use drugs, marking them as enemies of the state (L. M. Madden, 2017). Marginalizing a person by labeling them deviant is at the core of the social construction

(Goffman, 1963; Schneider & Ingram, 1993). According to Schneider and Ingram (1993), poorly designed policies are iterative. In their critique of the power dynamics in U.S. policymaking, they state, “These policy design flaws perpetuate themselves by engendering a process that is sensitive to the interests of the advantaged and inattentive to the plight of the disadvantaged (p. 6). Additionally, they note, “designs are carefully crafted to distribute benefits and burdens in accord with social constructions. The result is that existing inequalities are exacerbated” (p. 193). For people with SUDs, in particular, opioid use disorders, who are labeled deviant by the government, as will be discussed, these inequalities are quite evident.

As noted by the World Health Organization, SUDs are the most stigmatized illness (Room et al., 2001). As defined by Goffman (1963), stigma is an attribute that an individual may possess that is considered a social aberration whereby the marked individual becomes, in more contemporary terminology, “othered.” Link and Phelan (2006) suggested that stigma is better understood as a socially constructed process whereby differences are labeled in negative ways differentiating between “us” and “them.” Power differentials and the exercising of power over the other is a crucial component of stigma.

Before Nixon's declaration of a war on drugs, there was intentional use of racial othering tied to the use of addictive substances. Attaching stigma to people who used substances began with California’s 1875 ban on opium dens (Morgan, 1978). The intention of this city ordinance was not to prohibit the use of opium but rather was fueled by racism to decrease the interaction between Chinese immigrants and White Americans (Rosino & Hughey, 2018). Wilkerson (2020) suggested that such policies serve an intentional ordering of people by the dominant class by “an artificial construction, a fixed and embedded ranking of human value” as a means of maintaining the established social order (p. 17).

The United States system of care portrays people who use drugs (PWUD) with considerable variation. This narrative contributes to a response whereby some substance users are criminalized while others are framed as victims of a public health crisis (Dollar, 2019; Lassiter, 2015; Netherland & Hansen, 2016). Since these initial drug policies, drug use and people who use drugs served as code for race, maintaining a social hierarchy privileging the dominant class of White, abled-bodied male Americans above all others (Hart, 2013; Wilkerson, 2020). The use of drug policy and who or what treatments are "privileged" through enacting these policies, poses implications for the current opioid crisis.

The current crisis of the opioid epidemic is leaving an indelible mark in the United States Over 100,000 individuals died of overdoses in the height of the COVID-19 pandemic, with fentanyl being a driving force (Centers for Disease Control, 2021). The number of lives lost represents a 28.5% increase in overdose deaths from the previous year. In addition to lives lost, between 2000 to 2013, according to the National Survey on Drug Use and Health, people having OUD rose from approximately 600,000 individuals to 2.4 million (Volkow et al., 2014). While politicians are racing to hold pharmaceutical companies and pharmacies liable for their role in the increase of opioid related deaths and illness, politicians themselves show little willpower to dismantle policy and policy structures that contribute to both stigmatization and profound loss of life.

OUD is considered a chronic relapsing condition that impacts the central nervous system and leads to structural and functional changes in the brain's reward, inhibitory, and emotional circuits (Volkow et al., 2014; Volkow & Morales, 2015). The disorder is associated with comorbid health issues, legal, interpersonal and employment problems (Bell & Strang, 2020).

OUD, as with other SUDs, using counseling, lifestyle changes, and medications is a treatable condition.

One of the primary recommendations to mitigate the crisis is to expand the use of MOUDs (Allen et al., 2019). Specifically, the agonist medications (ones that activate opioid receptos preventing withdrawal) methadone and buprenorphine are most effective in treating OUD (Kampman & Jarvis, 2015). Methadone and buprenorphine are long-acting opioid medications. When taken daily, MOUDs prevent individuals with OUD from experiencing withdrawal, reducing the use of heroin and other opioids (Fareed et al., 2009), reducing exposure to HIV and other illnesses (Corsi et al., 2009), reduce crime (Lind et al., 2005) and fatal overdose (Fugelstad et al., 2007).

Despite the effectiveness of MOUDs, these evidenced-based medications continue to be woefully underutilized in the United States. In 2012 the estimated treatment gap for those in need of MOUD was approximately 1.3 million (C. M. Jones et al., 2015). Additionally, a 2015 study showed that nearly 80% of individuals with OUD received no treatment (Saloner & Karthikeyan, 2015). Allen et al. (2019) asserted that there are no other conditions for which there are demonstrated treatments where those treatment options so underutilized. Stigma remains a persistent barrier to expanding the use of MOUDs, particularly methadone (Allen et al., 2020; Wakeman & Rich, 2018).

Both agonist medications—methadone and buprenorphine—allow individuals to re-engage in society and lead productive and meaningful lives, in addition to reducing their exposure to secondary illness. They, however, are poorly understood by the public, healthcare providers, and policymakers despite years of proven efficacy (Woods & Joseph, 2018). In 2017 this sentiment was exemplified by Tom Price, the former Secretary of Health and Human

Services charged with influencing and creating healthcare policy to address the current opioid crisis. He stated, “If we’re just substituting one opioid for another, we’re not moving the dial much” (as cited in Eyre, 2017, para. 13). The statement misconstrues physiological dependence on medication versus the symptoms of SUDs (Woods & Joseph, 2018). The sentiment is rooted in the United States cultural beliefs and cultural preference that abstinence is the preferred standard of care for people with SUDS (Dodes & Dodes, 2015). The resulting impact of this cultural preference is to marginalize and stigmatize the use of agonist MOUDs, particularly methadone creating significant barriers to their usage.

The above highlights the scope and magnitude of the opioid crisis. What follows is a discussion of my own path to working on the front lines of the opioid crisis and what compelled me to pursue this project.

Positionality

My lens as a substance use disorder expert and methadone provider. Thirty years ago, I began the journey that led me to this dissertation. My path started when I took what I anticipated would be a summer job as a research assistant. I began working for an organization invested in research and treatment for individuals with SUDs. My office was on the front end of a small campus with several other buildings occupied by the treatment programs. While chatting with my immediate supervisor, looking out the window, I noticed a line of people waiting to enter one of the treatment buildings. There was nothing remarkable about the line forming outside that somewhat run-down building, just people standing in a relatively orderly fashion, some conversing, others disengaged. I was aware the building housed one of our treatment centers but was not aware of the type of treatment offered. I was still learning about the range of services that the organization offered in addition to the array of research studies conducted. I began to ask my supervisor what was going on in that building when he noticed my gaze and curiosity. His usual jovial smile turned to a sneer as he commented, “Look at them, look at them over there lining up for their juice. They’re all useless junkies.” I stayed silent. I was new on the job, but I was witnessing my boss disparage a group of people who were using our services. I did not know what he meant about “drinking their juice,” and, at that time, I had no knowledge of methadone treatment. His disgust and contempt were stunning. I was shocked and confused by his remarks—but remained silent.

We were doing research meant to help people with SUDs. Some of the people who came in for research interviews had mentioned they went to “the program.” During my interviews with these folks, I met people who had experienced significant trauma and demonstrated remarkable resiliency. Not only were they resilient, but they also had unique stories and varied backgrounds. In fact, some of the people who came in, I crossed paths with either while in school, at social gatherings, or during my bar hopping days. I genuinely liked the people I was meeting and wanted to hear more about their experiences. I did not understand why my supervisor expressed such vitriol and contempt towards people under our care. Why was he so disgusted by these people? They were here to get help.

The people in that line were diagnosed with OUD, and the program they were waiting to enter was a methadone maintenance treatment program (MMT). Methadone, as noted, is a medication that manages the symptoms of OUD. It is considered the gold standard medication by which other MOUDs are compared (Bell & Strang, 2020).

The comments I heard that day represent the longstanding stigma towards people with opioid use disorders (OUDs). A supervisor was denigrating both our patients and the treatment they utilized. I learned that stigma against people with OUD is pervasive and is extended on multiple levels with profound effects on those individual'' lives. This stigma is evidenced in the public and throughout the healthcare industry, including among substance use treatment providers (Earnshaw et al., 2013). The stigma towards individuals with OUD extends beyond the person. It is echoed in every facet they touch, including the treatments utilized, where they receive services, and towards the people providing the services (Earnshaw et al., 2013; C. B. R. Smith, 2010).

I have been a treatment provider to individuals with substance use disorder for over thirty years. While on this journey, I have come to know thousands of individuals both directly and indirectly affected by SUDs. I have seen scores of individuals flourish and thrive and have lost more souls than I care to count. Most of my work has been at an organization in New Haven, Connecticut, called the APT Foundation. While the Foundation serves people with all SUDs, its efforts primarily focus on assisting individuals with OUDs using MOUDs. Having dedicated most of my adult life to working with individuals with OUD, I have witnessed firsthand the devastation, first of the HIV/AIDs epidemic, and now through the waves of the opioid crisis.

I can attest to the significance of the harmful impact of stigma on the lives of individuals with OUD and those who directly and indirectly associate and care for them. I can also attest to the adverse effects of the stigmatization and marginalization of methadone treatment. As a result of the policy structure and practices in substance abuse treatment programs, I watched the burden of daily visits to a clinic to receive methadone, watched someone denied medication because they arrived late secondary to a broken-down bus or other ordinary disruption in transportation, and I watched people make decisions to leave treatment and continue to use heroin because they could not get to their job on time. My experience is that the stigma associated with methadone treatment, like those with OUD, is all-encompassing. As a result of stigma, individuals leave methadone treatment prematurely (Proctor et al., 2015; Reisinger et al., 2009). Far too often, I learned that former patients became incarcerated or died secondary to overdose.

Approximately 12 years ago, our organization recruited a new CEO, Lynn Madden, who had been at the forefront of working with national groups invested in the transformation of the treatment of substance use disorders. Prior to her arrival, as an organization, we were struggling. We had significant waitlists for all our programs, struggled to retain our clients in care, and were financially struggling. Our program, till that point, had operated as any treatment program. We provided appointments to those who wanted care. We asked people seeking services to come on multiple occasions before receiving their first dose of medication, asked for a range of documentation to assist in verifying their appropriateness for care, and demonstrated their ability to pay for their services. These are all process issues that could be improved to eliminate wait time in to care (McCarty et al., 2007), which we accomplished under our new leadership.

Our innovations included providing treatment on demand for people appropriate for our range of services, including MOUDs and outpatient counseling, utilizing a harm reduction philosophy of care with a low barrier menu of services that patients could select from, and retaining people who continue to use substances. In addition to how care is organized for patients, we offer a true sliding scale including free care to people who do not have insurance or the ability to pay. These changes eliminated the waitlists for people entering treatment, with most beginning services the same day they sought care. Our admission rate increased dramatically, as did our retention to care. As a result of these changes, the organization became financially sound, dramatically increased our census, and allowed more ill people to enter care. We wrote up and submitted our findings to the peer-reviewed journal *Addictions*, which were accepted and published (L. M. Madden et al., 2018). Through Lynn Madden's vision and our successful implementation, our program remains a national model of care.

Though our work was on the cutting-edge incorporating strategies to reduce barriers to treatment, the organization was the target of significant stigma and outright hatred. We were at the center of a culture war in our city. While at community meetings, local officials targeted the APT Foundation for implementing the policies and practices recommended by industry leaders and disparaged our harm reduction approach. Additionally, when it suited their needs, other treatment programs would distance themselves from APT. I have been at more than one community meeting where a program manager or CEO stated, "We are not the APT Foundation."

The level of malcontent towards the APT Foundation is well documented in a series of articles by a local newspaper, The New Haven Independent, during the summer of 2018. A range of situations was occurring which inflamed the discontent. One problem, our Congress Avenue location grew rapidly. The opioid crisis was in full swing, and our philosophy was to get people the lifesaving treatment needed. We were working to open a clinic in a neighboring town; however, we ran into several roadblocks that delayed the clinic opening by over a year. Another critical event included a mass drug poisoning that resulted in 77 people being transported from the New Haven Green to our local hospitals. The substance ingested was a synthetic cannabinoid commonly called K-2. First responders believed that the batch of K-2 was laced with fentanyl, a potent opioid responsible for the surge of overdose deaths in the United States (Bass, 2018).

City officials suggested that the APT Foundation was partly to blame for the event asserting that our organization transported hundreds of people into the area every day. The other assertion is that those affected utilized our services (Appel, 2018). Comments in response to an article in the New Haven Independent newspaper are typified by the following:

> The APT foundation is the only clinic in the state that gives out methadone without drug testing. The result is addicts come from all over the state to get methadone in the morning and then camp out on the green all day until they get their nighttime dose. Then they head back home on the buses. The APT foundation is essentially dumping this problem on us. and so to answer @AverageTaxpayer's question of what is with the rampant selling of drugs on the green, the answer is the APT foundation is what's up with it (adelaide12, 2018).

Points raised in the article and emphasized by the comments about our services is inaccurate and represent a consistent narrative waged against our organization. The K-2 drug was not laced with fentanyl and, of the 77 people transported to the hospital, only five people utilized our services. Despite the reality that the APT Foundation was in no way responsible or contributing to the event, city alders convened a meeting with the primary agenda item, “What to do about the APT Foundation?”

Over 100 people attended the city council meeting, including townspeople, staff from the APT Foundation, and representatives from the Yale School of Public Health and Yale School of Medicine. The meeting was contentious. Public health researchers and medical professionals reinforced the model of care we provide. Many townspeople continued to make their displeasure with our services known. A few, including former clients, praised our treatment model. The result of the meeting concluded with the alders voting not to act on APT. The committee, in turn, voted to approve a resolution recognizing “addiction as a chronic medical condition” (Appel, 2018, para, 31), in essence recognizing what science demonstrated generations ago. The resolution was intended to charge the city to develop an action plan to deal with the crisis.

This event and corresponding articles with public comments exemplify the depths and problems associated with stigmas related to drugs, PWUDs, and associated treatments. In my opinion, it also highlights the ongoing culture war favoring abstinence-based treatments over the expansion of methadone and other MOUDs and placing the PWUDs and those who treat them as the deviant other. If it was not for the strong presence of the research community and other vocal advocates, I am uncertain what the city may have declared.

While the open-access treatment model established at the APT Foundation remains an international model of care and is lauded by the research community, we also remain encumbered by federal and state regulatory practices that maintain a culture that reinforces stigmatized identities for those we serve. Regulatory practices, including daily, observed dosing, are described to be more in line with the demands of a carceral system resembling the obligations of parole or probation rather than that of treatment for a healthcare disorder and serve to reinforce stigma (Bourgois, 2000; J. Harris & McElrath, 2012). In addition to the regulatory environment, some methadone programs may have additional program level policies and practices that exacerbate the already restrictive regulatory structure and lead to premature discharge from care (Deck & Carlson, 2005; Magura et al., 1998; Reisinger et al., 2009).

Stigma, as discussed above, is shown from the macro through the micro level of interaction. My experiences described above demonstrate some of the many complexities of stigma applied to PWUDs, providers giving care, and interventions offered. What follows is an outline of the area of interest for the current study, an examination of the intersection of micro and macro-level forces that fuel stigma on people with OUD and the services they use.

Problem Statement

Across MMTs nationwide, at the heart of each of these regulatory interactions are caring and passionate staff members who dedicate their efforts to care for those with OUD. Over my years, I have met staff that describe themselves as being in recovery- some of whom utilized MOUD and others that talk of family histories of SUDs, all now describing their work as a calling. I have met others who simply choose a path of service offering support for our patients.

Despite all their compassion and understanding for those affected by OUD, the staff- in particular, the counseling staff within the context of their clinical practice are charged to maintain the punitive regulatory structure of MMT that reinforces the stigmatized identities of people utilizing services.

At MMT clinics, counseling staff function in the role of disciplinarian, a position that puts them at odds with the therapeutic role (Schwartz et al., 2017). It is a position where, in my experience as a clinician, you are navigating the task of upholding a stigmatizing rule structure while still trying to communicate compassion and support. Qualitative studies from patient perspectives consistently evidence that healthcare workers, including addiction counselors, reinforce stigmatized identities (Ahern et al., 2007; Conner & Rosen, 2008; J. Harris & McElrath, 2012). One example of such an interaction that reinforces a stigmatized identity and discrimination towards a methadone patient follows.

MMT patients, like any other person, may need to travel unexpectedly to visit family or friends in crisis. Consider "Joe," who learns that his uncle, who lives in the rural part of any state in the union, is critically ill and in the hospital. Joe needs to travel to be with his uncle, likely for a final visit. There are no means or time to prepare for such a trip. Those of us with financial means simply get on the road, in the sky, or by rail to be with our family. Joe needs to stop at the program first to ensure he has enough methadone doses to correspond with his anticipated travel time. Joe's problem is that while he has not used heroin for over a year, he does periodically use cocaine. His cocaine use is reflected in his urine toxicology tests.

Due to the federal regulatory structure of methadone treatment filtered through additional state and clinic-level policies, Joe is not eligible for take-home medication even to visit a dying family member. In some states, he may be granted an emergency authorization by the State

Opioid Treatment Authority; however, the process is cumbersome and often takes several days. The other option is to assist Joe to “guest medicate” at a MMT clinic in the area he is traveling. Once again, paperwork must be filed, phone calls made, and treatment orders obtained all time-consuming processes. If Joe can utilize another clinic to guest medicate, there will be fees involved and daily travel to that clinic, which may be a distance from his family and will be time away from his uncle. Joe’s other option is to go without medication which will certainly result in his experiencing significant withdrawal. The other option is for Joe to turn to illegal sources to buy methadone or other illicit opioids.

Joe’s options are daunting. His choices relegate him to choose either not to see his beloved uncle or to travel to see his uncle after engaging in an illegal activity to prevent withdrawal. Now consider the conversation with the counselor at the clinic. The counselor faces a different dilemma. She must convey to Joe the options that are before him, including informing him that the clinic cannot provide take-home doses, counsel him regarding the very real risks of impulsive and illegal decisions, and still offer therapeutic support, including what may be a significant loss in Joe’s life. Understanding how and why counselors respond to their patients is the central question of this study. The counselor, shackled by regulation, will likely convey to Joe a message that reinforces a stigmatized identity. Her words and behavior at this moment, maybe the tipping point for Joe, and any patient utilizing methadone, which leads to the disengagement from an evidenced-base, live saving treatment.

This example is played out with varying themes routinely in MMT clinics. Consider the above example and add the emotions that could correspond to the conversation between clinician and patient. Joe’s anger, fear, frustration, or even desperation. The clinician’s frustrations and reactions to Joe’s emotions. The regulatory structure suggests Joe is not deserving or able to manage methadone despite not having used illicit opioids. It is a regulatory structure void of independent clinical consideration of a patient's strengths or protective factors for traveling with take-home medication. At the center of the interaction are two people, one in need and one communicating that the other's needs will not be met in any logical, straightforward, or dignified fashion. The impossible impasse created by a blind regulatory structure relegates Joe and every patient utilizing methadone as incapable or undeserving. The regulatory structure also codifies the addiction counselor as a punitive disciplinarian. The question that arises is, how does the addiction counselor in the MMT program communicate and counsel the patient? Does she navigate this interaction in a fashion that imparts compassion and support- or do her words and her own behavioral reaction encompassing the session further exacerbate the stigmatized identity of the patient receiving MMT?

The preceding section captures the essence of the interplay between policy structures and micro-level interactions between counselor and patient. The inherent power struggles enacting regulation contribute to a dehumanization of the patient and a demoralization of the counselor. However, as of March 2020, COVID-19 may provide a saving grace for people using MMTs.

Regulatory Change Secondary to COVID-19: An Opportunity to Reduce Stigma?

As warnings of COVID-19 sounded, there was significant concern among OUD treatment providers about the potential impact of COVID-19 within their facilities, given the rates of infection transmission. Secondary to the rigid rule structure for dispensing methadone, including the requirement for face-to-face counseling, opioid treatment programs (OTPs) faced the impossible challenge to improve social distancing. In March 2020, as a direct result of the escalation of COVID-19 infections, regulatory bodies relaxed and altered several provisions impacting the treatment of OUDs. Among the changes, the Substance Abuse and Mental Health

Authority (AAA), to enhance social distancing, issued guidance enabling OTPs to increase access to take-home medication and utilize telehealth when providing counseling (Knopf, 2021).

The relaxation of take-home medication guidelines for methadone treatment is an example of steps long called for by the research community to improve the methadone treatment system (Bao et al., 2020; Green et al., 2020; Krawczyk et al., 2020). Despite researchers asserting the need for structural changes to MMT, hesitancy remains (Treitler et al., 2022).

In my anecdotal experience, as the pandemic continued, mixed sentiments around the take-home waivers emerged. For example, at a state-level meeting of methadone providers, the Connecticut State Opioid Treatment Authority warned providers that methadone take-homes were a privilege and not a right and signaled that programs should anticipate a rescinding of the waivers in the coming months. Also, in conversations with other providers, I learned that agencies were reverting to more stringent practices reducing the use of extended take-home medication and reverting to daily dosing for patients new or less stable in treatment. During a recent accreditation review, in speaking with an auditor who provided services in another state, she expressed surprise that our agency was continuing the practice asserting concerns about the diversion of methadone.

A recent study examined the general attitudes of substance abuse professionals regarding take-home medication (E. F. Madden et al., 2021). The sample of professionals included individuals who worked within methadone treatment and abstinence-based programs. These professionals included administrators and providers who expressed varying attitudes regarding the relaxed regulations for take-home medication. The researchers note that one significant theme of the interviews around the loosening regulations centered on fear of patient behavior, including diversion of medication and overdose secondary to methadone misuse. Despite numerous calls by researchers to change the regulatory structure of methadone treatment, this reversion in practice by practitioners to a rigid and punitive system of care is alarming, given the well documented barriers imposed by stringent guidelines around take-home medication.

A notable consideration related to addiction counselors' interactions, knowledge, beliefs, and attitudes around patient care is how addiction counselors and practitioners, in general, are indoctrinated into the substance abuse treatment system. Despite our knowledge base around SUDs, including gains in knowledge of the physiological and psychological impact of SUDs and correlated mental health issues, as well as our understanding of the impact of structural forces, including structural and institutional racism that fuel stigmatized identities, training programs remain entrenched and influenced by the same "war on drugs" mentality as mainstream America. Medical and nursing schools only provide a few hours of training on SUDs. This training is not dissimilar for master or lesser trained counselors in mental health or substance abuse educational paths. The training emphasis is mainly on abstinence-based interventions and thus contributes to the limited understanding of the role of agonist treatments (Woods & Joseph, 2018). If education around agonist medication is part of the curriculum, there is no exposure to the origins of the regulatory structure. Additionally, MMTs typically utilize a recovery model of care that is oriented towards developing a positive and meaningful sense of identity apart from drug use (Delphon-Rittmon, 2015). The sentiment suggests that PWUDs do not, in the context of their substance use hold worthy identities.

Clinic reversion to rigid rule structure appears counter to both emerging research of outcomes related to the greater flexibility around take-home MMT as well as long-standing calls for structural changes. One recent study demonstrated no significant increase in overdose deaths associated with the increased availability of methadone in the state of Connecticut (Brothers et al., 2021). Additionally, another study noted that the increased take-home medication provides benefits to patients in the way of reduced travel to the clinic and providers and clinics by reducing patient volume and increasing capacity to manage more difficult patients (Heimer et al., 2020). These researchers also posit that the reduced patient traffic may also reduce community stigma toward methadone treatment programs (Heimer et al., 2020).

The ongoing fears such as medication diversion and community overdose events associated with patients engaged in methadone treatment, likely persist secondary to the longstanding cultural norms established through a racialized and criminalized system of care that defines MMT. Even within the context of the APT Foundation, a low-barrier MMT, I have sensed a hesitancy among counselors to continue implementing and expanding enhanced take-home medication. Amongst our own supervisory and counseling staff, there are different comfort levels with enacting and maintaining these enhanced take-home medication guidelines. The discomfort persists despite assurances from our medical director that she embraces access to take-home medication as a right versus common language in policies that it is a “privilege.” She continues to encourage staff to view the needs of the patients to best promote their well-being and engagement in establishing their lives away from the daily grind of methadone treatment.

In my own interactions with patients, the regulatory changes have allowed me to shift my own practice from navigating how to maintain a rule structure focusing on the needs of the patient. Returning to the example of a patient needing to travel, my focus under the current guidelines allows me to focus on the needs and welfare of the patient. For Joe, described above, the conversation shifts to one that affords partnership and real conversation about the risks of drug use and how to manage medication, utilize support, and cope while being away from the clinic. This described approach is called shared decision making (Godolphin, 2009) and is considered evidence-based support for people managing other chronic diseases. The use of shared decision making in an MMT was difficult, if not impossible, to practice until COVID.

Despite encouragement from our medical director and my own supervision of clinical staff, counselors appear to struggle to apply an approach that fosters patient autonomy and dignity, emphasizing the policing of patients' behavior instead. The attitudes of clinicians charged with assessing patient's need for and capacity to manage take-home medication may impact patient retention.

A loosening of regulations secondary to the pandemic afforded a unique natural experiment to examine the attitudes and beliefs of clinical staff in interacting with patients during a period of regulatory fluctuation. Implementation of these guidelines, albeit initiated to reduce the spread of COVID-19, has the potential of imparting the beginning of a cultural change in methadone treatment. A loosening of guidelines potentially shifts clinical practice from scrutinizing and criminalizing patients to supporting less stigmatized and more person-centered treatment. Under the current guidelines, addiction counselors can move out of the role of disciplinarian. This shift poses an opportunity for clinical staff to engage in more nuanced conversations regarding their needs versus being charged with enforcing a rule system. What remains unclear is whether clinicians' experiences of regulatory changes and subsequent narratives of interactions with patients demonstrate a change in their framing of patients.

In sum, addiction counselors providing care to people who are refutably among the most stigmatized group, secondary to the interaction of the inherent power structures by societal norms that discount the lifesaving medication of methadone and the people who use it. What follows is a review of the purpose and significance of the study.

Purpose and Significance of the Study

The purpose of the study was to explore addiction counselors' narratives or framing of their interactions with patients. This exploration of narratives offered the opportunity to examine the enactment of stigma by addiction counselors in the context of therapeutic interventions. The exploration additionally examined if narratives have evolved with a loosening of regulations. The evolving regulatory environment authorizing the loosening of take-home medication guidelines may afford counselors an opportunity to shift their practice and potentially decrease the conveyance stigma onto patients.

While the relaxation of guidelines for take-home medication represents a change long sought after by researchers and progressive practitioners, the cultural framing of methadone treatment and patients utilizing methadone remains unchanged. The uneven adoption of these guidelines (Brothers et al., 2021; Levander et al., 2021) suggests providers remain vigilant towards the suspected behavior of the methadone-maintained patient. Vigilance persists despite newly emerging data suggesting that the loosening of guidelines around take-home medication is not associated with diminished clinical outcome measures or emergency department visits (Amram et al., 2021; Brothers et al., 2021) and appears to benefit patients, clinic staff, and communities co-located with methadone programs (Brothers et al., 2021; Figgatt et al., 2021; Green et al., 2020). Additionally, fears of diversion of methadone and the potential of a rise in overdoses secondary to increased access to methadone have not been realized (Amram et al., 2021; Brothers et al., 2021; Figgatt et al., 2021).

The continued divergence between practice and research is highly concerning. As discussed in this chapter, the regulatory structure of MMT poses a barrier to the use of this life-saving treatment. Qualitative studies from patients' perspectives document those negative interactions with staff in MMT programs impose a significant barrier to retention (Carl et al., 2023).

E. F. Madden (2019) suggested that there may be inadequate communication between elite researchers and critical areas of health services, including curriculum committees in medical schools, advanced counseling degree programs, and community colleges that train many addictions counselor. Training programs do little to afford future practitioners an understanding of the structural stigma created and maintained through a punitive regulatory system and enacted by addiction counselors. An exploration of clinical narrative may assist in enhancing training practices.

Previous research on counselors providing substance use treatment has centered on training needs, implementation of non-medication evidenced-based practices, and factors contributing to turnover (Helseth et al., 2018; McNulty et al., 2007; Shoptaw et al., 2000). Few studies have focused on the lived experiences of substance abuse counselors (Mapp, 2008). No studies to date explore addiction counselors' narratives and meaning-making of interactions with patients in OTPs. By developing an understanding of their narrative or meaning-making of interactions offers opportunities to enhance training to reduce the enactment of stigma and discrimination in the context of clinical interactions.

Using the backdrop of an evolving regulatory framework of MMT, the current study addressed the following questions by use of a critical phenomenological methodology:

1. In what way do addiction counselors reflect the broader social stigmas around MMT and those who utilize it? And where do those views come from?
2. How does this show up in addiction counselors' everyday interactions with patients?

3. How did the COVID-19 waivers to MMTs change addiction counselors' views and practices (or not)?
4. How do addiction counselors' narratives of interactions with patients maintain the stigmatized identities of patients?

Study Delimitations

The current study utilized an exploratory, critical phenomenological methodology to understand clinicians working in MMT experiences both before and after dissemination of relaxed regulations afforded during the pandemic. The study was broad in nature to capture the range of experiences. Due to state variations in adoption of the pandemic emergency waivers, recruitment of addiction counselors only occurred in Connecticut. As part of the interview process descriptive information of the interviewee's education and background training as well as a description of their specific MMT (non-profit vs. for profit, low barrier vs. traditional MMT) was gathered.

Organization of Dissertation

This chapter provided an overview of the historical and socio-cultural framework that informs and guides the use of methadone treatment for individuals with OUD during the most significant "drug crisis" faced by the United States to date. Regulatory policies informing methadone treatment until the COVID-19 pandemic remained unchanged despite well-documented evidence of structural barriers limiting access and retention to people who would benefit from care. Chapter II provides a literature review of relevant constructs informing the theoretical framework of the proposed study including an historical review of the impact of drug policy on people who use drugs. The theoretical framework further examines the intersection of addiction counselor'' practice within an MMT and patients utilizing methadone treatment in the height of a humanitarian crisis of overdose deaths fueled by war on drug policies. Chapter III explores specific literature on stigma and mitigation of stigma. Chapter IV reviews the rationale and specific methodology by which data was data collected and analyzed. Data collection and analysis explored the clinical phenomena before and since regulations afforded during the COVID-19 pandemic. Chapter V presents the research findings and Chapter VI discusses implications of the data and suggests future studies.

CHAPTER II: LITERATURE REVIEW OF U.S. DRUG POLICY IMPACT ON PEOPLE WITH OPIOID USE DISORDER

The following literature review explored the intersection of policy, culture, and stigma within the context of the counseling relationship in methadone maintenance treatment. The study's central question centers on the impact of these forces on the lived experience and meaning-making of addiction counselors working with patients using methadone maintenance and their perceptions, attitudes, and beliefs of those they serve. Methadone maintenance treatment (MMT) is an evidence-based, gold standard of care for individuals with opioid use disorder (OUD). The use of methadone treatment remains grossly under-utilized secondary to the stigma created by and exacerbated by a punitive war on drugs policy structure. The review includes a deeper exploration of what is now a humanitarian crisis secondary to the evolving and expanding U.S. opioid epidemic and failed policy structures hampering the substance abuse treatment system. Essential to this dissertation is an understanding of power structures, the enactment and maintenance of stigma across micro and macro levels, and the impact of these forces on the counseling relationship in the setting of MMT. The literature review concludes with a specific examination of relevant research of the lived experiences of addiction counselors whose patients use methadone maintenance and the counselors' perceptions and experiences of their interactions with patients.

Opioid Epidemic: An Expanding Drug Crisis

The opioid epidemic has significantly impacted the United States In 2017 alone, there were nearly 48,000 overdose deaths (Scholl et al., 2019). In 2020, overdose deaths skyrocketed, with over 100,000 lives lost (Trecki, 2022). Overdose deaths are presently the leading cause of death for people under 50. Beginning in 2014, overdose deaths led to a decrease in overall life expectancy in the United States (Woolf & Schoomaker, 2019), with estimates that over 200 people are dying each day (S. Jaffe, 2023).

In 2022, the United States witnessed a fourth wave of overdose deaths. The death rate of each wave surpassed the previous. The first wave was associated with deaths from opioid pills beginning in 2000 and growing steadily through 2016. The second wave, associated with heroin usage, started increasing in 2007, surpassing the number of opioid pill deaths in 2015. The rise of fentanyl and its analogs in the drug supply chain rapidly growing after 2013 is responsible for the third wave of deaths (Ciccarone, 2019). Despite a decrease in death rates in 2018, since the onset of 2019, there has been a 6.6% spike in overdose deaths (Gold et al., 2020). In now the fourth wave of mortality, forty states across the United States reported a sharp increase in the rates of overdose deaths (Katz et al., 2020). Provisional data recorded over 100,000 deaths between March 2019 and April 2020 (Centers for Disease Control, 2021). Before the onset of COVID-19, the estimated cost of the opioid crisis in the United States was 500 billion dollars annually (Miclette et al., 2017). The price of the epidemic includes direct costs to the healthcare system, strain on personnel, judicial system costs– including increased incarcerations, lost employment, and productivity, and not least, emotional costs on families directly impacted (Scholl et al., 2019). These costs will undoubtedly rise.

While the costs of this epidemic continue to climb, so does the number of those affected. Between 2000 to 2013, those having OUD rose from approximately 600,000 individuals to 2.4 million (National Academies of Sciences, Engineering, & Medicine, 2019; Volkow & Thomas, 2016). As discussed, one leading recommendation to mitigate the impact of the opioid epidemic is to expand the availability of MOUDs (National Academies of Sciences, Engineering, & Medicine; Health and Medicine Division; Board on Health Sciences Policy; Committee on

Medication-Assisted Treatment for Opioid Use Disorder, 2019). Agonist MOUDs, including buprenorphine and methadone, are more effective than talk therapy interventions alone; however, they remain poorly utilized. In 2012 the estimated treatment gap for those in need of MOUD was approximately 1.3 million (C. M. Jones et al., 2015). Stigma is a crucial barrier to the use of agonist MOUDs, particularly methadone (National Academies of Sciences, Engineering, & Medicine Committee on Medication-Assisted Treatment for Opioid Use Disorder, 2019; Wakeman & Rich, 2018).

SUDs, particularly OUDs, are arguably among the most highly stigmatized disorders (Room et al., 2001; Yang et al., 2017). Stigma for those with OUD is an all-encompassing (Earnshaw et al., 2013), affecting every facet of a person's identity. Central to the process of stigma is the use of power by a dominant group that labels, stereotypes, and separates the other (Link & Phelan, 2001). For those with OUD, the process of stigmatization significantly diminishes the quality of life, if not extinguishing it. For example, people who are utilizing methadone may be pressured to prematurely taper off the medication by family members or the legal or child welfare system (Alex et al., 2017; Earnshaw et al., 2013), which can lead to overdose death (Sordo et al., 2017). Given the devastation associated with use as described above, it is essential to understand the power forces driving stigma, the cultural implications of stigma, and the subsequential impact on regulation and policy.

The costs encompassing the opioid crisis, as described above, are devastating. What follows is a conceptual review of stigma and the process of stigmatization. Central to these concepts is the application of power by people in the dominant class. As noted earlier, the White dominant class in the United States targeted minoritized population by linking them to substances of use. Marking them as other was not about the substance, but a vehicle to place them as the other.

Power Structures Impacting People with OUD and Treatment of OUD

The experience of stigma, socially constructed by culture and maintained through policy and carried out within the substance abuse treatment system, poses practice implications in the MOUD treatment systems. Central to this work are the concepts introduced by Goffman (1963), on “spoiled identity,” writings by Foucault on discipline and punishment (Foucault, 1977) and biopower (Foucault, 1978), Agamben’s (1998) conceptualization of “state of exception,” “qualified life” and “bare life,” and Galtung’s (1969) “structural violence” (p. 171) all elucidate the power structures hampering the substance abuse treatment system. These works provide a framework for understanding the interaction of micro and macro level forces on stigma in the context of OUD and related evidence-based treatments.

Stigma

Goffman (1963) conceptualized stigma as an attribute possessed by an individual that is considered a “social aberration.” His seminal work described different types of stigmas as “blemishes of individual character perceived as weak will, domineering, or unnatural passions” (Goffman, 1963, p. 4). These attributes, as he described, divide people into those the categories of “normal” or not, and as such is the “other” (Goffman, 1963, p. 6). This categorization of traits is the process whereby an individual comes to have a stigmatized or “spoiled identity” (Goffman, 1963). He further describes that people with spoiled identities need to navigate around “normal” to minimize their exposure and conceal their “spoiled identity” as “impression management” (Goffman, 1963).

Stigma is a socially constructed concept. The social construction of the ideal individual and those who are the not ideal “other” is at the root of stigma. According to Irigaray and Guynn (1995), Western culture holds that the “ideal” or dominant identity as male, White, and able-bodied. Individuals outside the dominant group become demarcated due to their inadequacies concerning the ideal, age, race, and culture (Irigaray & Guynn, 1995). Thus, as a function of being other than the ideal, they become stigmatized.

One criticism of the work of Goffman is the overemphasis on individual attributes (Link & Phelan, 2001). Link and Phelan (2001) added to the conceptualization of stigma by further defining it as “the co-occurrence of its components-labeling, stereotyping, separation, status loss, and discrimination” (p. 363). A central feature in the process of stigma is that power must be exercised. At the heart of the stigmatization process is human interaction. Blumer (1986) described human interaction as creating a “root images” (p. 6). Root images of those with SUDs are evident in media outlets. We see the images of individuals with SUD labeled as crazed and stereotyped as dirty and criminals, resulting in separation and status loss. The imagery used does not typically include White, able-bodied men who use substances at no lesser rate than people of color (James & Jordan, 2018).

The mechanisms of marking the other are described above. What follows is a description of the use of power and how power separates the other from the dominant class and, in so doing, diminishes their quality of life. These concepts will shed light on the structural issues that plague people with OUD in the context of MMT.

Disciplinary Power and Biopower

The work of Michel Foucault focuses on the nature of power relations within the context of micro and macro levels. His writings on discipline point to micro-level interactions of those in the dominant class whereby root images are conveyed and applied. He asserts that power is not privileged to this group but used strategically in all exchanges, including policy structures. The dominant culture asserts what Foucault called disciplinary power (1977) and biopower (1978).

Disciplinary power judges according to norms. The dominant group sculpts behavior through coercion to ensure individuals fully internalize their prevailing beliefs and values (Foucault, 1977). In the United States, as will be discussed further in this chapter, the dominant group asserts disciplinary power targeting specific types of substances and who is associated with the use of those substances. Biopower produces the mechanisms by which the dominant power regulates societal structures (Foucault, 1978). Discipline and punishment target control on the individual level (Foucault, 1977). These two sources of social control are evident in all aspects of our society and have significant relevance in treating people with OUD. As will be discussed further, people apply disciplinary power through institutions, including the criminal justice system, education systems, and psychiatric care, or in this case, the methadone maintenance treatment system. In MMT, counselors tasked with being disciplinarians enforce rules resulting in reducing take-home medication and up to discharge from care. Biopower is applied through the state and federal regulatory system (Taylor, 2014) and is the cornerstone failed regulatory structure of the MMT system.

Foucault's Concept of Bare Life

Agamben (1995) furthered the work of Foucault by introducing the impact of the state on individual rights and freedoms. Included are three key concepts: the state of exception, bare life, and qualified life (Agamben, 1995). He described the state of exception as arising during a time of crisis. The state extends the laws into spaces that were not traditionally political, creating "qualified life" versus "bare life." The state creates a social stratification where some individuals' rights and personhood are recognized or "qualified life" versus "bare life," in which the person is reduced to their bare physiological existence, in which the state can choose to end or preserve a person's life with impunity (Agamben, 1995). This state of exception disenfranchises some while honoring others, reducing them to their bare physiological existence. Agamben's work demonstrates the stratification of elevating some people while diminishing others through policy based on their proximity to the dominant class. Historically the dominant groups' use of power to create such policies is well evidenced. Furthermore, this use of power will be discussed, in the substance use treatment system of the United States, specifically as regulatory structures encompassing MOUD for different groupings of people along racial and class lines.

Structural Violence

Galtung (1969), like Foucault, explores power structures in society. The two differ in that Galtung's writings were on violence enacted in a society where Foucault sees power structures present in all interactions and not inherently wrong. In his exploration of peace and violence, Galtung (1969) noted that violence could be void of an actor and, as such, indirect. He referred to this as "structural violence" (p. 170), noting that this form of violence is "built into the structure and shows up as unequal life chances" (p. 171). Unequal life chances are, as Agamben (1995) described, the reducing of a person to subsistence mode or a bare life. Violence is enacted through the range of our social structures, including economic, political, legal, religious, and other cultural systems. Administrative violence translates into decreased access to education, good healthcare, poor living environments, and economic resources, to name a few. As will be discussed, the presence of structural and administrative violence in the methadone treatment system cannot be understated.

Administrative Violence

Like Galtung, Spade (2015) puts forth a theory he terms “administrative violence.” In his exploration of critical trans politics, he asserts that “life chances” are distributed through racialized-gendered systems of meaning and control, often in the form of programs that attest to be race and gender-neutral and merely administrative (Spade, 2015). He points to policies devised under the guise of the war on drugs, among other administrative procedures, leading to significant marginalization of individuals not in the dominant culture, such as people utilizing MMT.

Thus far, I have explored the use of power by the dominant class towards people marked as “other.” Power, applied against people who behave outside of the dominant structure, comes in the form of disciplinary power, such as the judicial system or biopower, structural, or regulatory and administrative structures that create unequal life chances for some. When considering PWUDs, one size does not fit all; however, there is further stratification or intersecting stigmas based on race, gender, substances of use, and so forth, as is discussed below.

Intersectionality

Utilizing an intersectional framework (Crenshaw, 1991), Spade (2015) developed the argument that for real change to occur, moving people who are in the margins means “facing multiple intersecting vulnerabilities” (p. 108). Concerning those with SUDs, intersectionality means accounting for and considering the multiple characteristics by which identity is constructed in the social world and reinforced by institutions—referred to as *structural intersectionality* (Crenshaw, 1991).

Understanding and addressing structural and administrative issues leading to decreased life chances for those with SUDs necessitates an understanding of the intersections of race, gender, and ableism in the context of healthcare and healthcare policy. Included in the following is a review of the impact of policy written targeting intersecting identities whereby some are granted “qualified” status versus “bare life.” Specifically, I will discuss the intersecting identities of peoples’ choice of drug use- which is solely based on financial resources and geographic location and the intersecting structural forces colliding with structural forces.

Impact of Power Structures on U.S. Treatment System

Structural violence and administrative violence are evident in the United States healthcare system. According to Shapiro (2018) these practices have become so normalized that “they are either willfully or naively overlooked” (p. 3). One of the root causes of this “desocialization” in medicine has been, is the search for the molecular basis of disease over other contributing factors, including environment, poverty, and education (Farmer et al., 2006). Shapiro (2018) expands on this, noting that the result of this biological focus is that physicians will not likely pay heed to the social determinants of health. This limiting perspective may lead to seeing the patient as irresponsible or not caring about their health and as moral failures.

Concerning persons with OUDs, this is particularly troublesome. As in the mainstream, OUD remains treated as a moral failing in healthcare systems. The continued use of substances despite negative consequences is thought to be volitional, negating the biological underpinnings of the disorder. Systems of care control the person with SUD and coerce them into productive society members through judicial and political discourse. As will be discussed later, society ignores the reality of their physiologic illness and continues to blame them for the symptoms of their condition that remain untreated. In addition to ignoring physiological illness, society exacerbates the illness further using the judicial system and regulatory systems by imposing barriers to housing, employment, and educational opportunities. For the person with OUD, these barriers can be insurmountable and, as such, perpetuate the symptoms of addiction.

Stigmatized conditions can be more challenging to treat. Conrad and Barker (2010) note that individuals with highly stigmatized diseases such as HIV may be less likely to seek help secondary to fear of judgment by disclosing their illness. Individuals who delay or do not seek help will likely experience increased disease symptomology and potentially experience premature death (Conrad & Barker, 2010). Delaying treatment is particularly true for individuals with SUDs who have upwards of a 13-year delay before seeking initial treatment (Wang et al., 2007). Studies examining other stigmatized populations, including those with mental health disorders, show stigma is associated with decreased life expectancy (Link & Phelan, 2006). Wilkerson's (2020) depiction of the United States creation and maintenance of a racial caste system to maintain power for the dominant culture notes that the further one is from the dominant culture, the more stigmatized and marginalized the other becomes. Put in the context of caste, policy in the substance use treatment system is closely tied to race and status, pending on who is associated with what drug crisis, whereby some receive medicalized care, and others receive criminalized care (Netherland & Hansen, 2016).

Despite the advancement of our understanding of the biological underpinnings of SUDs, the United States remains unable or unwilling to create appropriate policy changes to undo racially biased policies. The current definition of SUDs is that of chronic, relapsing disorders characterized by compulsive drug-seeking behaviors and use despite significant consequences (Leshner, 1997). Research continues to demonstrate that long-term drug use causes significant alterations in the brain's chemistry, disrupting behavior, regulation of emotions, and executive functioning (Leshner, 1997). For OUD, as stated earlier, MOUD is the gold standard of care.

While our biological, psychological, and sociological understanding of SUDs has evolved, our social ideology remains entrenched in the idea that SUDs represent moral failings of the individual and the person who fails to control their substance use is undeserving of care. The application of power on people who use drugs and those with SUDs is evident throughout the history of U.S. drug policy. What follows is a specific review of racially biased policies.

Overview: Drug Policy in the United States

Numerous scholars have noted that almost every drug prohibition or policy intended to regulate the use of substances has had some racial or political component (Alexander, 2020; Hari, 2015; Hart, 2013). Alexander (2020) and Hart (2013) both discuss that numerous drug control policies under the guise of protecting people from “the scourge” of drugs served as a mechanism for mass incarceration for Black, Indigenous, and People of Color (BIPOC) and impoverished communities. Drug policy in the United States is the modern manifestation of the racial caste system established in colonial America, creating, and maintaining a hierarchy of people by the color of their skin (Alexander, 2020, Hart, 2013, Wilkinson, 2020).

Alexander (2020) pointed to a recasting of Jim Crow era discrimination, including housing discrimination, denying the right to vote and educational opportunities. It is not legal to discriminate against race; however, once labeled a felon, an individual’s rights are considerably diminished. Hart (2013), a neuroscientist, demonstrated through his research that the rhetoric of the anti-drug movement is not scientifically based. The standard descriptions demonizing drug use and those who use drugs are, in fact, an “intentionally masked political agenda” (Hart, 2013, p. 18). The resulting impact of this new caste system has been to limit the life chances of all caught in its wake.

The 1875, city leaders' ban on opium dens in San Francisco provides an early example of racially motivated policies (Morgan, 1978). Behind the enactment of this city ordinance was just curtailing opium use; rather, it was fueled by racism, to decrease the interaction between Chinese immigrants and White, female, Americans (Fisher, 2014). Wilkerson (2020) suggested that racially based legislation of policy is an intentional ordering of people by the dominant class as "an artificial construction, a fixed and embedded ranking of human value" (p. 17) meant to maintain the established predominantly White-controlled social order.

Since these initial drug policies, drug use and people who use drugs have served as code for race, locking them into a social hierarchy privileging the dominant class of White, able-bodied male Americans above all others (Hart, 2013; Wilkerson, 2020). Drug policy has historically placed a higher value on individuals who are closer to the dominant class, as evidenced by the ongoing criminalization of individuals in the BIPOC community and the creation of loopholes or more medicalized approaches for young White individuals with resources (Hansen & Netherland, 2016; Hansen & Roberts, 2012; Murakawa, 2011). The use of race to maintain the social hierarchy is explicit in the Nixon administration's "Southern strategy" to win the South over for Republicans. The goal was to play on the fears and anger of White southern communities who felt threatened by the Civil Rights Movement. In an interview, John Ehrlichman, a top Nixon aide, stated the unequivocal purpose of the war on drugs:

> The Nixon campaign in 1968, and the Nixon White House after that, had two enemies: the antiwar left and Black people. You understand what I am saying. We knew we couldn't make it illegal to be either against the war or black, but by getting the public to associate the hippies with marijuana and blacks with heroin, and then criminalizing both heavily, we could disrupt those communities. We could arrest their leaders, raid their homes, break up their meetings, and vilify them night after night on the evening news. Did we know we were lying about the drugs? Of course we did. (as cited in Baum, 2016, para. 2)

Since Nixon, each president, Democrat, and Republican alike, has continued to enact drug policies that demonize both drugs and people who use them. The demonization of drug use and users continues to occur through racially charged media depicting images of the depraved that fuel support for harsh policies. Alexander (2020) noted that the Reagan administration used the emergence of crack cocaine in inner cities as an opportunity to gain support for the war on drugs.

In 1985, Robert Stutman served as director of the New York City office of the Drug Enforcement Agency (DEA). Through improving relations with the media, he sought to draw journalists' attention to the spread of crack cocaine in the inner city (Alexander, 2020). The strategy worked with news outlets declaring crack as the issue of the year, of epidemic proportions, and instantly addicting those who tried it (Alexander, 2020). Between October 1988 and October 1989, *The Washington Post* ran over 1,500 stories about the drug scourge (Alexander, 2020). The media became responsible for spreading a racially-loaded narrative depicting Black "crack whores," "crack babies," and "gangbangers," (Alexander, 2020, p. 66). Alexander (2020) and Hart (2013) each discuss this media frenzy reinforcing prevalent racial stereotypes, including Black men being referred to as "predators" and Black women being referred to as "welfare queens." This discourse was a lasting strategy for the Nixon and some subsequent administrations to assert their political agendas by promoting the war on drugs and a "get tough on crime" attitude.

Not only did law-and-order prevail healthcare as the focus of drug policy, beginning with the Nixon administration and in some subsequent administrations, resources were redirected from inner cities to the suburbs through block grants. This led to dismantling Model Cities Programs and instituting "benign neglect" (Corburn, 2007, p. 697) policies such as not responding to emergency alarms in poor minority neighborhoods. Specifically, New York City leaders created de facto policies of “planned shrinkage” (Wallace, 1990, p. 801), removing essential services such as libraries, fire protection, and public transportation from designated “sick” neighborhoods and reallocating them to healthier ones The reallocation of funding demonstrates an intentional willingness to remove access to healthy environments, decrease access to education, and simply gut neighborhoods. The policies of benign neglect are clear evidence of the casting of the BIPOC communities as harmful or spoiled and therefore reduced to bare life.

When President George H. W. Bush took office, the federal budget directed at the war on drugs escalated from five billion dollars per year to over 12 billion dollars. This escalation further locked the country into a punishment strategy and intolerance over treatment and caring for those who used drugs (Cowles & Singer, 2020). Under the G. H. W. Bush Administration, there was a movement toward mass incarceration. In 1989, then-U.S. Senator Joe Biden co-sponsored the Anti-Drug Abuse Act, which imposed mandatory minimum sentencing for drugs, including significantly harsher sentencing on crack cocaine versus powder cocaine (Cowles & Singer, 2020). In 1988, the first Bush Administration added civil penalties for people convicted of drug crimes, including the authority to evict tenants from public housing and eliminating many federal benefits, including student loans for a drug conviction (Alexander, 2020). These civil penalties forced those convicted to remain in the margins and receive unequal life chances, as described by Galtung (1969) and Spade (2015).

To illustrate, between 1985 and 2000 due to mass incarceration, more than half of young Black men in cities in the United States were under the control of the criminal justice system (Alexander, 2020). Black middle-aged men were more likely to have spent time in prison than in college or the military (Rich et al., 2011). Although Blacks are no more likely than Whites to use illicit substances, they are six to 10 times more likely to be incarcerated for drug offenses (Western, 2006). Blacks and Latinos account for 80% of prisoners serving time for federal drug offenses, with 60% in state prisons (Rosenberg et al., 2017). The impact of mass incarceration has a ripple effect across BIPOC communities leaving children fatherless and spouses without the social and economic support of their partners, along with lasting social and economic consequences. Additionally, mass incarceration leaves an entire group of people traumatized.

Segments of the media and politicians expressed concern that depictions of the crack epidemic unfairly targeted the Black community. In 1995, the United States Sentencing Commission reported that 90% of people sentenced for crack cocaine offenses were Black, even though most drug users were White (United States Sentencing Commission, 1995). They also recognized that powder and crack cocaine are the same drug (Yellen, 1995). The Commission recommended that sentencing be equalized for powder cocaine and crack cocaine arrests. Neither the Clinton administration nor the sitting Congress acted on this report resulting in more than a generation of mass incarceration of Black and Brown persons.

“Tough on drugs” related crime policies continued through subsequent administrations, focusing on allocating monies to punish and incarcerate PWUDs along racial and class lines. It was not until the Obama administration’s second term, in 2014, that an acknowledgment was made of this failed policy (Nadelmann & LaSalle, 2017). The administration pivoted from mass incarceration of citizens to eliminating sentencing disparities between those convicted of crack cocaine charges to those imprisoned for powder cocaine. The sentencing change was a significant step in the right direction. The Obama Administration granted clemency to over 2000 individuals previously convicted of drug-related crimes: however, his administration also advanced policies resulting in the deportation of Black and Brown immigrants (Alexander, 2020). This policy simply moved the war on drugs to focus on immigrants rather than black and brown citizens. The Obama administration was responsible for the deportation of over 3 million individuals- exponentially more than any other administration (Nowrasteh, 2014). After classifying individuals as criminals through any range of offenses, including minor possession of marijuana, a substance that is now legal for recreational use in 22 states and medicinal use in 39, the Obama Administration deported them (Alexander, 2020). The administration's attempt to address discrepancies secondary to mass incarceration for U.S. citizens convicted of drug crimes to criminalizing and deporting non-citizens for similarly low-level offenses is evidence of how ingrained the war on drugs messaging remains. We continue to criminalize persons who use substances that are both illicit but also more likely tied to urban/racialized or impoverished communities (Dollar, 2019; Lassiter, 2015; Netherland & Hansen, 2016).

In response to the opioid crisis, the Federal Government enacted several laws to address the opioid crisis: the Comprehensive Addiction and Recovery Act of 2016, the 21st Century Cures Act of 2016, and the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act of 2018 (Mutter & Duchovny 2022). Among the legislative goals was a decrease in the number of prescription opioids written (Cowles & Singer, 2020). For example, instead of receiving a 30-day supply of oxycodone for pain management of an acute injury, individuals would only receive a two-week supply. Additionally, the establishment of the prescription monitoring program, an interstate registry of controlled narcotics prescribed to individuals, monitored the type, dosage, and frequency of narcotic prescriptions given to a person. This was intended to reduce the volume of prescribed opioids in the community.

Between 2012 to 2017, prescribing rates fell to 58.5 from a previous high of 81.3 prescriptions per 100 persons, the lowest rate in decades (Kerr, 2019). However, the legislation had mixed consequences. Nearly 80% of people who came to use heroin had previously misused prescribed opioid medications (Cicero et al., 2014). Kerr (2019) noted that “the death rate attributable to opioids continues to rise, and prescription opioid misuse has remained fairly stable since 2010.While this result may seem unexpected, it is not entirely surprising given observed transitions from prescription opioid to heroin use (p. 377). The focus of monitoring and punishment moved from community members to the monitoring of physicians suspected of creating “pill mills.” There was a reduction in pill mills and pill mill doctors. However, pain management physicians concerned about an overzealous DEA, rapidly tapered individuals from their medications, pushing them to the street market and escalating heroin use (Mallatt, 2020). Physicians initiated tapers if patients used substances other than pain medication or were receiving unorthodox prescription regimens (Allen et al., 2020). Rapid tapers from pain management not only served to drive people to the street to alleviate physical pain and symptoms of withdrawal, but in so doing, put them at higher risk for exposure to illness, increased risk of incarceration, shame associated with being labeled an addict, and increased risk for overdose death (Mark & Parish, 2019).

While I served as the director of the admission unit for the APT Foundation, I watched the negative impact of this legislation. With the rise of the opioid epidemic, we initially saw the age of individuals seeking admission to service drop dramatically, with high numbers of people between 18 and 24 years of age seeking MOUDs presenting with severe histories of opioid and other substance use disorders. The decrease in age was a significant change from my earlier years in the field, where most people seeking methadone treatment were in their mid to late thirties. After the enactment of the Obama-era legislation and policies geared toward limiting the prescription of opioids, we saw a significantly older and more medically complex population of people seek our care. These individuals routinely reported being in pain management treatment with a physician who decided to rapidly taper them from what appeared to be a long-term stable medication regimen.

Additionally, I encountered providers and programs that use the prescription monitoring program as justification to taper people from MOUDs secondary to the person's use of other medications, such as benzodiazepines, or to bar the person from entry to care. It is reasonable to surmise that Obama-era drug legislation did not reduce the impact on lowering provider stigma. The unintended consequences of this set of legislation contributed to the second wave of the opioid crisis (Mallatt, 2020).

While the introduction of prescription drug monitoring programs exhibited unintended consequences, the Obama administration enacted significant legislation to advance the care for those with SUDs. In 2008, Congress passed the Mental Health Parity and Addiction Act, requiring insurance companies to cover mental health and addiction services equitably concerning other health conditions (Centers for Medicare and Medicaid Services, 2008). Subsequently, the Patient Protection and Affordable Care Act, passed in 2010, allowed states to expand Medicaid eligibility for adults or children whose incomes are less than 138% of the federal poverty level (Sommers & Rosenbaum, 2011). These legislative efforts have given more people the ability to access care not only through expanded insurance coverage but also regulatory insurance reforms mandating the inclusion of SUD treatments, including coverage for MOUD, enhanced parity, as well as opportunities to integrate SUD treatment within the mainstream healthcare (Abraham et al., 2017) most notably for White males (Novak et al., 2017).

The previous section focused on the broad impacts of drug policy in the United States and the consequences of those policies on PWUDs. These impacts affected minoritized populations with devastating consequences. What I describe next is how these policy mechanisms directly impact healthcare practices and, more specifically, treatment for PWUDs.

Drug Policy: Impact on the United States System of Care

Wilkerson's (2020) research on the origins of racism in the United States asserted that race is a socially constructed phenomenon. Colonial law used race to relegate "European workers and African workers into separate and unequal queues" (Wilkerson, 2020, p. 41) and set in motion the caste system that would become the cornerstone of America's social, political, and economic system. In *Caste, The Origins of Our Discontents*, Wilkerson noted that even within rungs on the ladder of the caste system, there are levels of superiority and degradation between groups. U.S. drug policy remains a cornerstone of this nation's racial caste system and evidences a ranking system based on substance of choice. Within the ranks of those with SUDs are unequal queues that severely hamper treatment.

The ranking of drugs and those who use them occurs through the social construction of beliefs and values through portrayals in the media, political processes, and a range of other social mechanisms (Hart, 2013). Drugs in and of themselves are neither good nor bad. The use of a substance can be beneficial or detrimental. For example, alcohol may enhance a meal; however, if used in excess can lead to significant and negative social and health consequences (Hart, 2013). Morphine and other opioids used in a medical setting are beneficial pain relievers. In a non-medical setting, opioids take on a negative and even demonic persona.

Research on the news media in the United States demonstrates that illicit substances such as heroin and cocaine receive more attention than tobacco or alcohol. Though alcohol and tobacco are the leading cause of death worldwide, the media frame illicit substances as more pressing (Fan, 1996; Gonzenbach, 1992). In 2015, the estimated disability-adjusted life years disease burden of illegal substances was estimated as tens of millions of dollars, while the comparable costs of alcohol use and tobacco smoking use were more than a quarter of a billion disability-adjusted life years worldwide (Peacock et al., 2018, pp. 4–5). The political framing of illicit substances, and the subsequent diminishment of those who use them, simply do not reflect the facts. Similarly, due to the same sociopolitical processes, PWUDs are cast as "good" or "bad" based on the individuals' demographic background or choice of substance. Depending on how far the substance user is from the ideal, discourse results in criminal characterization and the treatment they receive, as either criminalized or medicalized.

Dollar (2019), in her analysis of the social construction of the crack cocaine and methamphetamine crises, provided noteworthy examples of the hierarchical ordering of people based on proximity to the dominant class. The drug scares associated with these two substances occurred approximately a decade apart. During each scare, media sensationalism fueled political and public panic. These scares resulted in the criminalization of White, lower-class methamphetamine users, and urban, Black crack users. However, the narrative for each was vastly different. Methamphetamine use was characterized as a disruption of place (i.e., property), while cocaine was associated with violent threats against persons (Dollar, 2019). The media was more likely to portray White users as unproductive and descending to "White trash," while Black crack cocaine users were portrayed as violent criminals. White methamphetamine users though criminalized, were more likely to receive significantly less harsh sentencing than Blacks criminalized for crack (Taxy et al., 2015).

An Abstinence-Based System of Care

As there is an ordering of people, there is an ordering of treatment. The substance abuse treatment system prioritizes complete abstinence over measures viewed as harm reduction strategies, including MOUDs (Strike & Watson, 2019). The United States treatment system is primarily modeled after the principles of Alcoholics Anonymous (AA). AA is not a system of clinical intervention but a support fellowship for individuals living with SUDs (Dodes & Dodes, 2015). This self-help philosophy is abstinence-based and describes those with the illness as both powerless and moral failures. According to Dodes and Dodes (2015) that despite a dearth of supportive scientific evidence of effectiveness, AA is the recommended treatment of choice for alcohol use disorder. Ferri et al. (2006) completed a literature review ranging from 1965 to 2005 on AA's philosophy—the 12-step facilitation studies. They concluded that there was little evidence of the clinical utility in 12-step based treatment modalities.

The Betty Ford Center, the Caron Center' and the Hazelden Treatment Group are among the most revered treatment centers in the United States. These centers are deeply entrenched in AA's 12-step philosophy. Despite their esteem and being the standard bearers of care, these institutions have no demonstrated track record for success; however, they represent the model followed by most other rehabilitation centers (Dodes & Dodes, 2015). These "Cadillac" facilities can command upwards of $30,000 for a 30-day stay (Dodes & Dodes, 2015). These widely respected institutions underscore, without basing treatment on scientific evidence, how public and other treatment communities' standards align with what is in the best interest of the person with SUD. When an individual "fails" treatment, they are, in turn, blamed. The price tag associated with ineffective care in dollars is shocking in and of itself. The negative impact on individuals who continue to struggle with symptoms of SUDs during and after their course of care reverberates in cycles of stigma.

The United States system of care is both “punitive and coercive . . . [and] characterized by repetitive statements of personal powerlessness and moral failures” (L. M. Madden, 2017, p. i). Dodes and Dodes (2015) considered that the steps seem to exacerbate rather than relieve humiliating feelings associated with addiction. A sense of humiliation and shame can lead to further cycles of relapse to use and increase the severity of the illness (Matthews et al., 2017), resulting in further degradation and dehumanization.

Drug Policy: Medicalization vs. Criminalization

The narrative around PWUDs varies concerning race, age, class, and gender. These characteristics place persons in the caste system relative to the ideal identity as White, Western, rational male; therefore, they function as mechanisms of social control. This narrative contributes to a response in which some substance users are framed as criminals and others as victims of a public health crisis (Dollar, 2019; Lassiter, 2015; Netherland & Hansen, 2016).

Lassiter (2015), through an exploration of social movements and interest groups, found that since the 1950s, state institutions and political culture repeatedly constructed the war on drugs through a framework of suburban crisis, positioning White middle-class youth as victims who need shielding from the illegal drug markets. He pointed to community advocacy of drug reform and loopholes created by suburban interest groups secondary to “anxieties about the delinquency of affluent teenagers” (Lassiter, 2015, p. 3). Loopholes for middle and upper-class White youth included discretionary practices by the criminal justice system not to prosecute some first-time offenders. The political system used an over-hyped and inaccurate representation of marijuana as a gateway drug to heroin with demands for severe penalties to prevent "urban and foreign pushers" from corrupting White youth (Lassiter, 2015).

In the current opioid crisis, narratives differ vastly depending on a person's position in the caste system. Media coverage of heroin overdoses in wealthy White neighborhoods portrays young, White illegal drug consumers as "tragic victims" and as "clean-cut teenagers from affluent families with a bright future ahead of them" (Lassiter, 2015, p. 1). The descriptions contribute to policies with different outcomes based on race, gender, sexual orientation, and zip code. In response to a series of overdoses in an affluent Texas suburb, *Dateline NBC* warned, "heroin, the inner-city drug, has jumped the tracks and is killing kids" (as cited in Lassiter, 2015, p. 126). In the same news report, the police chief and U.S. district attorney blamed undocumented immigrants, and "pledged zero tolerance for the Mexican cartels 'preying on this community'" (as cited in Lassiter, 2015, p. 126).

The "White-washing" of the current opioid crisis has led to markedly different policies compared to other drug crises. Drug use under the current opioid crisis is "decriminalized" and treated primarily as a biomedical disease, where "White social privilege is preserved" (Netherland & Hansen, 2017, p. 217). The dominant narrative frames a young, White, able-bodied person who uses substances substantially different from other groups. It is a narrative that elicits empathy for the user who needs treatment rather than punishment (Dollar, 2019; Netherland & Hansen, 2016). White opioids, in the current crisis, remained associated with the tragic misuse of pain medications such as oxycontin and users are viewed as unfortunate victims. By contrast, Black and Brown people in a previous opioid crisis were associated with heroin use criminalized (Netherland & Hansen, 2017).

In 2021, there were over 100 thousand U.S. deaths from overdose, with 75% of those deaths involving opioids (Kaiser Family Foundation, 2021a). Whites who died from opioid-related overdoses made up 66% of this mortality, with only 18% being Black, 12% Hispanic, and 1.2% other (Kaiser Family Foundation, 2021b). Researchers have demonstrated that non-White persons are more likely to be undertreated in various medical settings and specifically in the treatment of pain. This discrimination initially served as a protective factor for non-Whites to OUD secondary to decreased access to pain medication (Santoro & Santoro, 2018). The over-prescribing of pain medication was a significant factor fueling the current opioid (DuPont, 2018).

By the late 1990s and early 2000s, White middle-class opioid use created a demand and need for treatment. Methadone, tightly associated with inner-city Black and Brown users, was viewed as too restrictive and stigmatized for the “new” cohort of opioid users (Hansen & Roberts, 2012). During this time, the National Institute of Drug Abuse (NIDA) focused its research agenda to examining the neurobiology of addiction, isolating the cause of addiction in the brain and biology of individuals (Campbell, 2010). McLellan and O’Brien (2001) declared “drug dependence as a chronic medical illness” (p. 409), asserting that addictions were comparable to diabetes, asthma, and hypertension. Additionally, they asserted that addictions could be treated as chronic diseases in general medicine with pharmaceutical interventions.

Advocates for substance use treatment used these research findings to campaign for moving treatment into the mainstream of medical care. The goal was “fully biomedicalizing addiction” (Hansen & Roberts, 2012, p. 94) and treating it in the same manner as other chronic diseases with medications to manage the symptoms. The belief is that moving substance use treatment back into mainstream medicine would destigmatize addiction and end decades of punitive treatment (Campbell, 2012). NIDA prioritized the development of pharmacological treatments for SUDs. Buprenorphine was the only new promising medication on the horizon for OUD. Methadone, though highly effective because of its stigmatized status, was not viewed as the singular solution to address the current opioid epidemic. There were no efforts to roll back regulations hampering methadone treatment. This policy inattention is a policy action (Link & Hatzenbuehler, 2016), reducing the life chances for individuals who benefit or could benefit from MMT.

Buprenorphine is a partial agonist opioid maintenance medication with unique pharmaceutical properties that help diminish the effects of physical dependency on opioids, such as withdrawal symptoms and cravings to use, increase safety in cases of overdose, and is believed to have a lower potential for misuse (Mauger et al., 2014). NIDA, the manufacturer of buprenorphine, and key legislators collaborated to pass the Drug Abuse Treatment Act permitting private, office-based physicians to prescribe opioid drugs that the DEA rates as having a low to moderate risk of creating dependence (Mauger et al., 2014) treatment opioid dependence (J. H. Jaffe & O'Keeffe, 2003).

A vital part of the lobbying for the Drug Addiction Treatment Act of 2000 involved distinguishing the market for buprenorphine as White, middle-class users deemed more trustworthy than non-White, low-income injectors of heroin who would need the more tightly regulated treatment of methadone (Hansen & Roberts, 2012). As with other drug policies, this argument came in the coded language of urban and suburban versus Black and White people. For example, Alan Leshner, the director of NIDA at that time, testified to Congress for the Drug Addiction Treatment Act (2000) and stated, “The current system, which tends to concentrate in urban areas, is a poor fit for the suburban spread of narcotic addiction” (Congressional Record as cited in Netherland & Hansen, 2017, p. 231). The pairing of the discourse of brain biology with the differentiation of the "new addict" elevated the White opioid user from Black/Brown opioid users of the previous generation.

Federal regulators additionally ensured that buprenorphine would be more accessible to White users by requiring prescribers of this medication to complete an eight-hour training course, qualifying them to apply for a special DEA waiver and associated prescription registration number. These requirements ensured that most prescribers would be private physicians with more resourced patients rather than overburdened public sector physicians who had little incentive to expand their client base (Hansen & Roberts, 2012).

Despite the federal government spending millions of dollars to support the expansion of buprenorphine, as of 2018, only 56,000 physicians are licensed to prescribe buprenorphine, and only 112,000 individuals received buprenorphine prescriptions that year (Vestal, 2018) comparatively to the estimates of almost 2 million who would benefit from MOUD (Saloner & Karthikeyan, 2015). Current demographic data support that buprenorphine is more likely prescribed to White, non-Hispanic, and likely younger (Rhee & Rosenheck, 2019). Studies demonstrated that over 90% are White and more likely to be college-educated and employed (Stanton et al., 2006) and are more likely to be treated by private physician offices (D. T. Barry et al., 2010; Fiellin, 2007). Buprenorphine patients are more likely to have financial resources to pay out of pocket for care (Stanton et al., 2006) or be privately insured (Andrews et al., 2013; Rhee & Rosenheck, 2019).

The demographic profile of buprenorphine patients exemplifies the racial ordering of individuals with OUD and sets a part in which treatment system is accessible to them. Legislation guiding methadone clinics and office-based buprenorphine served to create two different spaces for the treatment of OUD. One is held in public areas tightly controlled by many entities versus contrasting private and less regulated spaces for the White community (Hansen & Netherland, 2016). Given the presence of fentanyl in the drug supply chain, the lack of attention to improving access to methadone, a full agonist with better potential to address associated withdrawals and cravings, is a deadly mistake.

In the above section, I described the legislation that was initiated at the beginning of the current opioid crisis. In the late 1990s through the early 2000s, the opioid epidemic was disproportionally impacting people who were White and not living in the inner city. In fact, because of the range of inequities in healthcare, Black and Brown people were “protected” from the surge of oxycontin usage because they are often under-treated for pain (Netherland & Hansen, 2017). However, what follows is an overview of the historical roots of MMTs and the creation of a highly regulated, racialized, and stigmatized system of care.

Drug Policy: Methadone: A Stigmatized System of Care

Methadone maintenance treatment is a highly stigmatized system of care that benefits those with OUD while simultaneously representing the manifestation of social control that dehumanizes individuals receiving care. MMT has been described as “liquid handcuffs” (Frank et al., 2021, p. 1; Vigilant, 2016, p. 411). The use of methadone to treat heroin addiction began in the 1960s after undergoing successful trials with African Americans in the Harlem neighborhood of New York City (Dole & Nyswander, 1966). Regulatory policy surrounding the use of methadone changed rapidly between 1970 and 1975, ultimately leaving methadone the most highly regulated and policed treatment modality for any condition (Hansen & Roberts, 2012) despite being very efficacious (Calcaterra et al., 2019).

In 1972, under the Bureau of Narcotics and Dangerous Drugs authorization, the Food and Drug Administration (FDA) imposed a hybrid set of guidelines approving methadone for the treatment of OUD (Hansen & Roberts, 2012). Physicians could no longer prescribe methadone out of their offices to treat OUD. To this date, in the United States, only federally approved and licensed programs can provide methadone to treat OUD. These programs, and by default, their patients, are siloed from mainstream medicine, subject to constant scrutiny, and subject to unannounced inspections (Hansen & Roberts, 2012).

The road to approving methadone treatment was highly politicized and controversial. The controversy included—and continues to include—pushback from community-based groups endorsing drug-free approaches that rightfully recognized addictions as a complex social problem; it did not address the sociocultural issues, including poverty, unemployment, and housing. These groups and some political factions feared that the "methadone solution" reinforced the "illusion that a drug can be a fast, cheap, and magical answer to a complex human and social problem (Lennard et al., 1972, p. 882).

Another critique of methadone stemmed from the recognition that some of the most ardent supporters of its use were not physicians but conservative politicians who championed MMT more for its potential to reduce crime than for its therapeutic benefits (Hansen & Roberts, 2012). The stringent regulations of methadone treatment established a system of care based on a deviance model through scrutiny and monitoring of participants. Politicians encouraged by the success of MMT in New York City became increasingly concerned over crime in Washington D.C. that grew between 1966 through 1970. Dr. Stephen Brown, Superintendent of the United States Public Health Service and proponent of methadone, asserted,

> We must be honest with ourselves in facing the fact that certainly one of the major things that concerns us about opiate addiction is the crime which results from opiate addiction

> . . . It is precisely this criminal activity that will come to an end if heroin addicts . . . could obtain legal narcotics, such as methadone. (United States Senate Committee on the District of Columbia, 1969, pp. 25–26)

Despite many advocates of the time viewing methadone as a socially progressive alternative to punitive drug policies, its more widely accepted use was undoubtedly linked to the Nixon administration's war on drugs to not only control crime but as a form of social control for the BIPOC community (Dollar, 2019; Hansen & Roberts, 2012; Netherland & Hansen, 2016). Since its inception, the rigid structure of MMT has remained largely unaltered and serves to dehumanize and marginalize those that utilize or would benefit from using those services (Earnshaw, 2020; Byrne & Pearson, 2019).

As with other prescription drugs, both the FDA and the DEA regulate the use of methadone (Rettig & Yarmolinsky, 1995). However, unlike any other prescription medication, methadone, when used to treat opioid use disorder, is subjected to a third layer of federal regulation enforced by federal agents who govern in detail how physicians may or may not care for individuals with OUD (Rettig & Yarmolinsky, 1995). Additionally, there are adjunctive counseling requirements and provisions around how much take-home medication a person may receive, unlike other medicines afforded unencumbered prescriptions.

Language of the Comprehensive Drug Abuse Prevention and Control Act of 1970 pointed to the differentiation of types of "addicts" in the eyes of the state. As exemplified in the following regulatory language, the Secretary of Health and Human Services (HHS) is charged to "determine the appropriate methods of professional practice in the medical treatment of the narcotic addiction of various classes of narcotic addicts" (§ 4). Additionally, the Narcotic Addict Treatment Act (1974) requires practitioners who dispense methadone or provide detoxification treatment to obtain annual registration from the DEA. Registration additionally entailed a determination to be made by the DEA that the applicant would comply with the DEA's physical security and record-keeping requirements regarding the “quantities of narcotic drugs which may be provided for unsupervised use by individuals” (Narcotic Addict Treatment Act, 1974), which refers to take-home medication.

A key component of surveillance of individuals receiving methadone is observed dosing. What is clear is that this standard of care emphasizes more the potential harm the methadone-maintained person may cause to the community over the dignity and respect of the person in need of medical care, as illustrated in the following:

Observed dosing is the only way to ensure that a patient ingests a specific dose and to monitor patient response. In observed dosing, staff members who dispense medication first carefully identify patients by requiring them to remove hats or dark glasses, for example, and then provide the medication. To ensure that patients swallow oral doses of methadone, they should be required to speak before and after ingesting at least two ounces of liquid in which an appropriate dose of medication is dissolved (Center for Substance Abuse, 2005).

Another means of controlling individuals with OUD is the allowances for take-home medication. Methadone taken observed daily as described above continues until individuals meet the following guidelines for “unsupervised doses”:

Any OTP patient may receive a single take-home dose for a day when the OTP center is closed for business, including Sundays and state and federal holidays. Beyond this, decisions on dispensing take-home medication are determined by the medical director in accordance with eight criteria for take-home medication specified in federal regulations (42 CFR, Part 8 §12(i)):

1. Absence of recent drug and alcohol use.
2. Regular OTP attendance.
3. Absence of behavioral problems at the OTP.

4. Absence of recent criminal activity.
5. Stable home environment and social relationships.
6. Acceptable length of time in comprehensive maintenance treatment.
7. Determination the rehabilitative benefits of decreased OTP attendance outweigh the risk of diversion.

Once these clinical criteria are met, maximum take-home doses must be further restricted based on length of time in treatment as follows:

1. First 90 days (months 1 through 3): one take-home dose per week.
2. Second 90 days (months 4 through 6): two take-home doses per week.
3. Third 90 days (months 7 through 9): three take-home doses per week.
4. Fourth 90 days (months 10 through 12): 6-day supply of take-home doses per week.
5. After 1 year of continuous treatment: 2 weeks supply of take-home medication.
6. After 2 years of continuous treatment: 1 month supply of take-home medication, but monthly OTP visits are still required. (Center for Substance Abuse, 2005).

It is instructive to compare the experience of someone treated for another chronic condition like diabetes and what it would look like for that individual to receive doses of insulin under the same regulation as opioid users. This diabetic person could only receive insulin if they had not had any recent use of sugary foods, maintained regular attendance to their providers' location for monitoring of their blood sugar, an absence of vaguely defined behaviors, lack of criminal activity, stable relationships, and had been in care for two years before receiving a month's supply of medication. All of this sounds absurd as standards to obtain a life-saving, and daily access to insulin given it may impede access to work, maintain childcare, or impact family relations. However, for a person with OUD to receive the methadone, they must agree to abide by this rule structure.

The National Academy of Medicine (2022)—part of the National Academies of Sciences, Engineering, and Medicine—recently held a workshop discussing the regulatory structure of treatment with methadone. During the opening session, several individuals with lived experiences of methadone treatment discussed their journey. One woman who testified, a former addict and now activist, Abby Coulter, illustrated poignantly the impact of disciplinary actions administered by her clinic in response to a single positive opioid toxicology screen.

Abby entered treatment for OUD utilizing methadone approximately 20 years ago when she became pregnant. She reported that she was a model patient stabilizing quickly and benefitted from the medication and support of the clinic over the years without issue. She was gainfully employed, enjoyed her family, and by all standards, was a model for recovery. She had gained the maximum number of take-homes her clinic allowed with the increased flexibility secondary to the pandemic waivers and 28-day take-home doses. She was checking in with her clinician monthly for mandatory counseling sessions, the minimum allowed by regulations. By all societal standards, she presented as a well-adjusted woman.

In response to a single opioid positive toxicology screen and after years of demonstrated stability, this happened:

> Then, despite 20 years of being a successful, compliant methadone patient, she had a positive screen for an opioid and lost everything. Denied access to take-home medication, she was forced to go into the clinic for daily dosing and start inpatient counseling. “The idea that all of the work I had put in was stripped away in the blink of an eye, without a single thought of how that was going to affect everything I had worked for, was a terrible feeling” [Abby said]. (National Academy of Medicine. 2022, pp. 11–12).

Abby noted that because of medicating daily, she needed to change clinics. She recently moved out of the immediate area of the clinic that she attended for 20 years. If she only needed to travel every few weeks to pick up her medicine, she could continue at that location without issue; however, the daily travel was not sustainable. She described not only facing job loss but feeling shamed and demoralized by her former clinic. She reported that her new clinic is working with her differently, giving her some take-homes to allow her to work and care for her family more easily; however, the events have solidified her commitment to activism to change methadone regulations.

Abby's experience is in no way unique. It points to the disciplining and shaming of people with OUD in the context of methadone treatment. There are numerous other policies mandated in the structure of methadone programs, including diversion plans to mitigate patients from misusing or selling their medication, urine toxicology screening to monitor the use of a range of substances, and mandatory counseling. Regulators assert the described policies are essential aspects of care. However, secondary to the power differentials created between staff and patients the intersection of the regulatory structures and service structure fosters an atmosphere of mutual distrust, ultimately impeding the prospects of improved life chances for the patient.

While federal regulatory guidelines are prohibitive in and of themselves, state and agency interpretations of guidelines vary widely and are often more restrictive than the federal guidelines (Davis & Carr, 2019). Abby's case illustrates state differences among clinics. As an example, from my personal experience of collaborating with many methadone programs within the state of Connecticut and outside, the varied interpretation of these regulations can be exceedingly punitive. The action of discharging an individual from care is hazardous to that person and punitive. Clinics are known to discharge more complex and challenging clients from care, thus necessitating them to use services from other programs at greater distances. These varied interpretations and enactment of regulations are forms of administrative violence and structural stigma.

Structural stigma has been described to include institutional policies that intentionally restrict stigmatized individuals' opportunities or unintentionally yield consequences for them (Corrigan et al., 2004). Additionally, structural stigma includes "societal level conditions, cultural norms, and institutional policies that constrain the opportunities, resources, and well-being of the stigmatized" (Hatzenbuehler & Link, 2014, p. 2). MMT guidelines and added variations in administering guidelines at the program level limit opportunities for participants in their daily lives and lead to disenfranchisement and premature treatment dropout. The regulatory requirements do not allow the person with OUD to self-manage their illness, leading to an erosion of self-efficacy and reinforcing internalized feelings of shame.

Wilkerson (2020) described dehumanization as a primary component of the caste system. She asserted that by attaching stigma, "a taint of pollution to an entire group," dehumanizes the entire group (Wilkerson, 2020, p. 141). The dehumanization of a group operates to distance the out-group from the in-group and distance those in the in-group from their humanity. Dehumanization serves "to lock the marginalized outside of the norms of humanity so that any action against them is seen as reasonable" (Wilkerson, 2020, p. 141).

Through onerous and prescriptive legislation MMT remains siloed from the rest of the medical community into separate treatment spaces (Krawczyk et al., 2020), despite a decades-long evidence base and relatively low cost. The act of establishing MMT outside the traditional medical community labels the treatment as "the other." In so doing, both the treatment, the spaces they reside in, and those who utilize it are stigmatized. Methadone is "othered" despite being more cost-effective (Connock et al., 2007; Fairley et al., 2021) and demonstrates higher retention to care compared to buprenorphine (Farnum et al., 2021; Soyka et al., 2008).

E. F. Madden (2019) developed the concept of “intervention stigma.” (p. 324). He noted that, unlike “condition stigmas” that mark individuals due to diagnosis, intervention stigma keeps patients and health professionals associated with their involvement with medical treatment. Qualitative interviews demonstrated other healthcare professionals’ and abstinence-based treatment providers’ perceptions of discrimination toward methadone providers and patients (E. F. Madden, 2019). Frank (2011) also illustrated that secondary to the dominant discourse of the abstinence/morality model of care, the intervention of MMT itself is stigmatized. As a result of intervention stigma, patients utilizing MMT fear disclosure of treatment to medical providers and may, in fact, not seek treatment for medical conditions (Anstice et al., 2009; Carl et al., 2023; J. Harris & McElrath, 2012). Practitioners of methadone treatment may also feel compelled to hide their work from other professionals or the public (E. F. Madden, 2019; Oberleitner et al., 2019).

Intervention stigma is a tangible form of structural violence. It prevents some who do not wish to be labeled or identified from seeking treatment (Peterson et al., 2010). It contributes to others prematurely leaving treatment (Frank, 2011). Thus, it increases the risk of escalation of symptoms associated with OUD, other comorbid health issues, legal issues, and social consequences, including death (Hand, 2020).

The implication of intervention stigma is that individuals with OUD are subject to “unequal life chances,” as described by Galtung (1969, p. 171), resulting in the unequal ability to gain wellness compared to those with other health conditions and others with SUDs or others with OUD utilizing other treatment options. The continuation of a rigid rule structure creates a system of disciplinary power as described by Foucault (1977), resulting in, as Spade (2015) called it, “administrative violence” (Spade’s book title). As illustrated in Abby’s story, individuals who are deemed non-compliant with treatment rules are subject to the potential loss of take-home medication or rapidly tapered off methadone and discharged from care. Any disciplinary actions taken by a methadone program on a patient can result in loss of employment secondary to the difficulty of juggling clinic attendance and timeliness to the job site, disruption in family and social relationships, legal consequences secondary to relapse, reduced housing options, and health issues including death (J. Harris & McElrath, 2012; Knopf, 2016).

Methadone Beyond U.S. Borders: A Brief International Review

Internationally, policy approaches to substance use disorders fall along a continuum ranging from purely law enforcement and punishment to solely public health approaches. The law enforcement approach is generally attributed to the influence of the United States’ war on drug policies of the Nixon administration (Johnson et al., 2022) and, as such, may influence the stigmatization of the use of methadone.

Methadone, classified as a narcotic drug, is regulated by international drug treaties, specifically the Single Convention on Narcotic Drugs of 1961 (United Nations, n.d.) . The goal of the treaty is to ensure that controlled substances are available for medical and scientific uses and ensure that diversion from licit sources to illicit markets does not occur. Methadone is presently used in approximately 80 countries for the treatment of OUD (Larney, Peacock et al., 2017). Based on the philosophical drug policy orientation (public health orientation vs. law enforcement), the structure and acceptance of methadone vary.

In Spain, for example, up until the 1980s, the law reflected moralistic, restrictive views on the use of methadone. During this time, they had the highest rates of HIV infection with high levels of morbidity compared to other European countries. After changes in the regulatory structure of MMT, Spain reached 60% coverage of those needing MM, with 66% of the general population in favor of methadone (Torrens et al., 2013).

The United States can learn from other countries with less restrictive approaches to methadone, including Australia, Canada, and the U.K., which utilize pharmacy-based access to methadone for OUD (Calcaterra et al., 2019). Pharmacy-based methadone allows greater access to people in need of treatment in those countries permitting it. While allowing greater access, it is not clear if pharmacy-based methadone alone would impact the stigma associated with methadone in the United States; however, coupled with public health messaging, lessons learned from the experiences of Spain suggest so.

Chapter II Summary

The present chapter laid out the concept of stigma, how stigma is a process asserted through power by the dominant White, able-bodied class, and how stigma has been applied in a historical context. These foundational pillars detail the structures and cultural components by which groups of people are minoritized and marginalized based on race, class, gender, and substance of use. In the context of the substance of use, I have detailed the origins of methadone versus that of buprenorphine to outline how to use medications that treat the same illness. Despite years of research demonstrating both efficacy and debunking the mythology created by stigma, methadone remains vilified today.

What follows in Chapter III are the specific ways that stigma impacts people who use the medications, a review of strategies to mitigate stigma, concluding with the rationale for the current study.

CHAPTER III: LITERATURE REVIEW OF STIGMA'S IMPACT ON THE TREATMENT FOR PEOPLE UTILIZING METHADONE

The previous chapter provided a review of the intersection of policy and culture, which created and fueled the structural stigmatization of people with OUD. Structural stigma, as discussed, is present throughout the substance abuse treatment system however is hyperbolic in the context of treatment utilizing methadone. The literature review that follows will examine the specifics of how stigma decreases the life chances of those with OUD, with an emphasis on those utilizing methadone. The review includes the impacts associated with the legal system, access to housing, education, and healthcare. Also reviewed is research of the education system for counselors and efforts to decrease stigma. The chapter will conclude with a summary of the problem and rationale for the current study. The review begins with an overview of how people with OUD are publicly stigmatized and discriminated against, followed by a discussion on the impact of self-stigma.

Stigma and Persons with Opioid Use Disorders

Regardless of treatment choice, all individuals with OUD are highly stigmatized (National Academies of Sciences, Engineering, & Medicine, 2016). According to Link and Phelan (2001) "Stigma exists when elements of labeling, stereotyping, separation status loss, and discrimination occur together in a power situation that allows them" (p. 377), They described stigma as a process by which people "are labeled, set apart, and linked to undesirable characteristics thereby affecting their life prospects, including income, education, housing status, and well-being" (Link & Phelan, 2001, p. 371). This inevitably leads the stigmatized to experience status loss and discrimination.

People with OUDs experience numerous types of stigmas that are exogenous and endogenous and have significant deleterious effects (Earnshaw et al., 2013):

- *Public stigma* has been described as driven by stereotypes of the person with OUD (Acker, 1993; Corrigan et al., 2003), such as their perceived dangerousness or perceived moral failings (Janulis et al., 2013). This results in negative attitudes toward the person with OUD.
- *Anticipated stigma* occurs when people with stigmatized conditions or identities are aware of negative attitudes towards them and develop expectations that their stigmatized and potentially hidden identity will become known (Link, 1987).
- For those who do not hold the stigmatized identity, *perceived stigma* refers to the rejection of a stigmatized identity once it becomes known (Tsai et al., 2019).
- *Internalized stigma* occurs when the individual with a stigmatized identity accepts their devalued status as valid and adopts for themselves the dominant negative attitudes embedded in public stigma (Link et al., 1989).
- Discrimination and social distancing from individuals with stigmatized identities are forms of *enacted stigma* (Link et al., 1987).
- *Courtesy stigma* is the phenomenon by which family members, friends, and treatment providers, because of their proximity to the persons with OUD, experience all the described forms of stigma (Goffman, 1963) and may result in strain on or rejection of the relationship with the person with OUD.
- Finally, *structural stigma* entails the totality of ways societies constrain those with stigmatized identities through mutually reinforcing norms, policies, and resources (Corrigan et al., 2003; Hatzenbuehler, 2016; Pescosolido et al., 2008).

The National Academy of Sciences described the high level of stigma associated with individuals with OUD and MOUD as “persistent stigma” (National Academies of Sciences, Engineering, & Medicine Committee on Medication-Assisted Treatment for Opioid Use Disorder, 2019, para. 3). National public opinion data suggests negative attitudes towards people with prescription OUD exceed those reported for other medical conditions (C. L. Barry et al., 2014). Another national survey found respondents viewing individuals with OUD as to blame for their substance use with three-quarters of respondents stating that individuals with OUD lacked self-discipline (Kennedy-Hendricks et al., 2017). Two-thirds of respondents to this survey were unwilling to have a person with OUD marry into their family, and the majority endorsed discriminatory measures, including allowing an employer to deny employment to an individual with OUD Higher levels of stigma in the public were associated with greater support for more punitive policies through prosecution and arrests versus support for a public health-oriented policy response such as the expansion of Medicaid to cover MOUD.

Drug use is a way that stigmatized individuals cope with stress and negative emotions associated with discrimination (Pascoe & Smart Richman, 2009). People with OUD face stigma at every door they try to enter and even as they reflect in the mirror. Earnshaw et al. (2013) noted that individuals maintained on methadone, experience distress, including frustration, anger, and anxiety, because of experiencing stigma. The overall impact of stigma has profound effects on all facets of their lives, including interactions with the legal system, housing, employment, healthcare, social and family relationships, and their relationship to self.

Stigma: Persons with OUDs and the Legal System

The judicial system is responsible for almost half of the referrals to the substance use treatment system (DeFulio et al., 2013). In 2016, more than 20% of people with OUD were involved with the criminal justice system (Howell et al., 2021). Opioid overdose is the leading cause of death post-incarceration (Howell et al., 2021). The judicial system demonstrates a clear bias against evidence-based MOUDs, with only one in 20 referrals made to these specialty treatment programs (Krawczyk et al., 2017). Another study noted that court personnel in jails and probationary systems were hostile towards using MOUD (Andraka-Christou et al., 2019). The stigmatizing messaging and actions of the legal system on an individual with OUD and the gold standard treatments, MOUDs, pose significant risks.

MOUDs remain the gold standard of care for OUD, assisting with the cessation of opioid use, increasing integration into work, improving social relations, and preventing an escalation of health-related issues, including overdose (National Academies of Sciences, Engineering, & Medicine, 2019). If someone maintained on MOUD becomes incarcerated, most prison systems will not continue those individuals on their medication, a phenomenon that is highly problematic and potentially lethal (Hora, 2005). It cannot be overstated that there is no other health issue that requires the discontinuation of medications in the prison system (Cowles & Singer, 2020; Haas et al., 2021; Qi Gan et al., 2021).

Due to state-level policy, MOUDs are typically not permitted in correctional settings. As a result of incarceration, MOUDs are abruptly discontinued posing multiple consequences. Medication discontinuation inevitably puts a person into severe withdrawal from opioids. The experience of excruciating withdrawal coupled with the negative messaging of MOUDs reinforces to the person using methadone or buprenorphine that the medications are bad (Maradiaga et al., 2016).

The action of taking a person entering incarceration or into a drug court agreement off MOUD occurs by a policy of the state or by order of a judge, is not following best medical practice. Tapering a person from MOUD places the person with OUD at high risk for relapse and potentially a fatal overdose (Hora, 2005; Joseph et al., 2021). The state or judge executes this decision, again with no medical training having deemed MOUDs as ineffective or an unnecessary treatment in the legal attempts to rehabilitate the individual. The act of the state of removing an individual from a life-saving medication is a repudiation of scientific evidence of the benefits of MOUD. Additionally, it signals that a person maintained on MOUD is not in recovery (Maradiaga et al., 2016).

Individuals who are tapered off MOUD while incarcerated report experiencing severe and prolonged withdrawal symptoms (Maradiaga et al., 2016). The experience of withdrawal while incarcerated, coupled with the justice system's negative messaging regarding MOUD, deters persons who would benefit from MOUD from using them post-incarceration (Maradiaga et al., 2016). The fear of imprisonment thus prohibits the person with OUD from addressing their illness, exposing them not only to an escalation of symptoms but potentially death.

These legal practices have a more pronounced impact on Black and Brown persons than on other ethnicities. Although Black Americans are no more likely than Whites to use illicit drugs, they are six to 10 times more likely to become incarcerated for drug offenses (Netherland & Hansen, 2016). Coupled with the impact of rapid withdrawal from MOUDs, the elevated likelihood of incarceration may contribute to decreased engagement by Black and Brown persons with MOUDs, thus fueling health disparities among minoritized populations (James & Jordan, 2018). They fear withdrawal and additionally come to mistrust the treatment itself. Due to historical mistreatment and subsequent mistrust of the medical community and healthcare system (Cooper et al., 2006), second-hand experiences of BIPOC family members and BIPOC community members may further influence a reluctance to use of MOUDs. The above practices taken together are further examples of administrative violence decreasing life chances for the BIPOC individual with OUD (Hatcher et al., 2018).

Drug courts are specialized courts established to divert individuals who have committed a low-level, non-violent crime from incarceration. In such programs, judges work in tandem with a social worker and treatment programs to monitor a client's treatment progress. Individuals who test positive for substances or other treatment infractions receive sanctions. These sanctions may include a brief stay in jail up to their full original sentence. A recent survey within New York State explored the practices and policies of drug courts around the use of MOUDs (Csete & Catania, 2013). Results indicated that across this state, there was poor education surrounding the benefits and importance of the role of MOUD for individuals with OUD. The drug court system frequently denies individuals with OUD to participate or forces them to come off their medications before entering the program. Additionally, if individuals receive a sanction, they are often denied medication while incarcerated. The denial of medication puts the individual in withdrawal and increases the likelihood of relapse post-release from incarceration. In turn, relapse increases the likelihood of reincarceration or potential death (Alex et al., 2017; Hora, 2005).

In my work with the legal system or child welfare system, I have seen judges and child welfare workers recommending or even stipulating that patients utilizing methadone decrease or taper off these medications. As previously noted, premature tapering off methadone leaves people with OUD highly vulnerable to relapse, reincarceration, deterioration of family and social relationships, and potential overdose death. I have worked with individuals who felt compelled to rapidly taper off methadone secondary to judicial sanctions experiencing excruciating withdrawals with horrific consequences, including death.

One tragic but by no means unique example I encountered was a young woman who had established about a year of abstinence from illicit substances through methadone maintenance and supportive counseling. A child welfare worker pressured her to come off methadone. While tapering, she relapsed. The shame she felt led her into a cycle of further relapse. Her child was placed with a relative, and her use escalated. Ultimately, she lost her parental rights.

Stigma: Persons with OUDs and Housing

Access to safe housing is a well-recognized social determinant of health (World Health Organization, 2018). Having a substance use disorder is a significant risk factor to first-time homelessness (Thompson et al., 2013). Recovery residencies provide low-income housing and peer support for people entering and maintaining recovery.

Recovery housing can be an essential resource for individuals transitioning from inpatient programs back into the community or resources for relatively low-income, structured, supportive housing for those with SUDs. The National Alliance for Recovery Residencies (NARR) is one of the key organizations involved in certifying recovery residencies (Knopf, 2016). According to NARR, buprenorphine and methadone, which have been labeled “harm reduction strategies” to mitigate OUD, are not in line with their philosophy of recovery. Unless someone is working on tapering off maintenance medications, they are not eligible for their recovery houses.

Other recovery homes have varying rules regarding the admittance of individuals who utilize MOUDs. Oxford House is one such chain of homes. In Connecticut, in my experience as a practitioner making referrals to these houses, some allow individuals maintained with buprenorphine and not methadone. For example, one sober house in New Haven lists on its website that it will take only a limited number of persons prescribed buprenorphine, methadone, or benzodiazepines. Such language suggests that individuals utilizing medications are different and in need of additional oversight or management. Majer et al. (2018), in a review of Oxford House residents across the United States, found that most residents held negative attitudes regarding the use of MOUDs. Oxford House requires individuals to interview with house members before being invited into place. Oxford Houses are democratically-run houses where residents vote on the admittance of an applicant. In 2010, the Oxford House Organization adjusted their by-laws, allowing each house to admit individuals utilizing methadone or buprenorphine; however, due to negative attitudes and lack of education regarding MOUDs, people using these medications are often not accepted. Also, because of Oxford House's' historical refusal to admit individuals utilizing MOUDs, people who would benefit from sober living may not seek these support services (Majer et al., 2018).

Anecdotally, in my professional experience, the use or the dose of a medication may be a barrier to entry into a "sober home" (sometimes called a halfway house). It is not uncommon for house managers to dictate house expectations of upper limits of methadone dosing. As noted earlier in the context of the legal system, non-medical persons with no training feel compelled to make recommendations on medications, an illustration of the cultural and stigmatizing challenges that persons with OUD face in both the healthcare system and the community.

Stigma: Persons with OUD and Health Care

Stigma against people with OUD—and against the use of MOUDs—is rampant among healthcare providers across the healthcare spectrum, including primary care offices, hospital settings, emergency departments, counseling centers, and detention facilities (Earnshaw et al., 2013; Madras et al., 2020). Hospital systems and providers, for example, fail to address the specific treatment needs of people with OUDs providing sub-optimal (Frazier et al., 2017; Larochelle et al., 2018; Rosenthal et al., 2016) and improper care (Larochelle et al., 2016;

Naeger et al., 2016) during hospitalizations and post-discharge. Van Boekel et al.'s (2013) systematic review of attitudes toward those with SUDs, including physicians, nurses, and psychologists, showed that healthcare providers viewed patients with SUDs as violent, manipulative, and unmotivated for care. Another large-scale study assessing primary care physicians' views, indicated that the rates of stigma, including measures of blame for the condition and a desire for social distance, were as high or higher than that of the public (Kennedy-Hendricks et al., 2017).

Research exploring the attitudes and beliefs held by healthcare workers includes characterizations of PWUDs as non-compliant, out of control, and unwilling to change their risk behaviors (Beyrer et al., 2010). Another study found that nurses viewed PWUDs as violent, having weak characters, being unhygienic, and having contagious diseases (Ben Natan et al., 2009). Healthcare workers who are more prejudiced toward injection users are more likely to endorse drug use stereotypes and worry that injection drug users will behave poorly in treatment settings (Brener et al., 2010). Attitudes of healthcare workers may impact decisions about the care of PWUDs, including removal from organ transplant lists (Brener et al., 2010) and lack of access to HIV and HCV treatment (Kapadia et al., 2019; Kiriazova et al., 2017). Related to the power dynamics in the healthcare setting, individuals who experience negative stereotyping may not question or push back on an imposed stereotype (Matthews et al., 2017) and internalize stigma.

When people with OUD internalize or anticipate public stigma attached to their illness, maladaptive behaviors ensue (Tsai et al., 2019). These behaviors may be destructive, deterring the stigmatized person from seeking treatment for medical, psychiatric, or substance abuse treatment, leave treatments prematurely, leading to poorer health outcomes, sub-therapeutic dosing of methadone, and potentially death (Earnshaw et al., 2013; Matthews et al., 2017; Palis et al., 2016; Sanders et al., 2013; Tsai et al., 2019).

Addiction counselors do not prescribe medications for OUD; however, their discussions with patients regarding treatment options and treatment planning may heavily influence decisions about MOUDs, such as their initiation and duration (J. R. Gallagher & Bremer, 2018; Roberto et al., 2014; Yarborough et al., 2016). Counselor attitudes and beliefs can serve as barriers or facilitators to MOUDs (Magrath, 2016; Volkow et al., 2014; Yarborough et al., 2016). For example, Magrath (2016) found in Washington State that addiction counselors expressed more stigmatizing attitudes regarding the use of medications to treat OUD when compared to medical professionals who were using MOUDs. Counselors' education levels (Rieckmann et al., 2011) and recovery status (Abraham et al., 2011; Aletraris et al., 2016; Roberto et al., 2014) heavily influence their attitudes and beliefs around the use and perceived effectiveness of MOUDs. Stigmatizing attitudes of healthcare professionals also can have a significant impact on an individual's sense of well-being.

The Consequences of Internalized Stigma

A meta-analysis of mental health literature found that internalized stigma has a significant negative correlation with an individual's sense of hope, self-esteem, and self-efficacy (Livingston & Boyd, 2010). Bandura (2006) described self-efficacy as the "foundation of human agency" (p. 170). Suppose an individual does not believe that they can produce the desired effects by their actions. In that case, they have "little incentive to act or preserve in the face of difficulties" (Bandura, 2006, p. 170). Efficacy beliefs operate as the major cognitive motivators and regulators of human behavior, leading humans to be both "producers and products of their life conditions" (Bandura, 2006, p. 164). Perceived self-efficacy affects every phase of change in substance abuse, from initiation of change to relapse and long-term abstinence (Bandura, 1977). People with low-perceived self-efficacy are more likely not to enter treatment or prematurely leave it (DiClemente & Hughes, 1990). Individuals with higher self-efficacy benefit more from treatment as they can develop higher self-regulatory skills (Carey & Carey, 1993).

Earnshaw et al. (2013) discussed the implications of drug addiction stigma on individuals in methadone treatment. Individuals who use methadone as part of their recovery report feeling less than human, abnormal, or like criminals (O'Byrne & Jeske Pearson, 2019; J. Harris & McElrath, 2012; Murphy & Irwin, 1992; Woo et al., 2017). There is a common perception that MOUDs are bad and not truly in recovery compared to individuals in traditional abstinence-based treatments (Frank, 2011; Roose et al., 2012). Persons utilizing methadone often internalize this perception (Conner & Rosen, 2008; Murphy & Irwin, 1992).

Society bombards people with OUD with negative messaging, which becomes internalized. Media portrayals of individuals with OUD are highly damaging. For people engaged in methadone treatment, this is particularly true (McGinty et al., 2019). Media outlets have characterized people maintained on methadone as criminals, "walking zombies", and associated the clinics as affiliated with sex offenders (Bailey, 2011; Breen, 2019).

Excerpts of articles characterize people in facilities I work at in such light. The language used to describe individuals with SUDs contributes to exogenous and endogenous stigma (Wakeman, 2019). Stigmatizing language commonly associated with SUDs includes being "dirty or clean," "addict," and "junkie" (Botticelli & Koh, 2016) and serves to marginalize individuals with SUDs further. Robinson and Adinoff (2018) provided additional insights into the impact of language, which contributes to confusing and harmful messaging for people using MOUDs. They suggested, for example, that the terminology of "medication assisted" treatment is confusing to both the consumers and the public. The phrase “assisted treatment” indicates that the medication is an adjunctive status to the other resources provided in these treatment settings where the medicines are the primary treatment (Robinson & Adinoff, 2018). Minimizing the role of the medication may further stigmatize its utility as well as those who use it.

As a result of internalized stigma, people with OUD may form maladaptive behaviors that lead to poorer health outcomes (Crapanzano et al., 2019). It is important to note that individuals with additional stigmas such as race, gender, or status with the legal system, are more likely to identify stigma as a barrier to treatment (Conner & Rosen, 2008; Nyblade et al., 2019) and thus increase their overall vulnerability to the impacts of SUDs (McCabe et al., 2010).

Internalized and anticipated stigma is associated with poorer quality of life and psychological distress (Earnshaw et al., 2013) as well as continued substance use (Kulesza et al., 2017) and with reduced engagement with substance use treatment (Cunningham et al., 1993). In rural areas and small communities where treatment providers are more likely to encounter treatment participants outside of the clinical setting, the impact of internalized and anticipated stigma may be exacerbated, thus heightening concerns (Faulkner & Faulkner, 1997).

Bandura (1999) recognized SUDs as a social issue and suggests that policies be addressed to build what he describes as *collective efficacy*. Collective efficacy refers to creating “socially oriented models that provide the social and structural means for transforming drug-dependent lives into productive ones” and enhancing a group’s ability to improve their life circumstances (Bandura, 1999, p. 214).

To enhance the collective agency of those with SUDs and, most notably, those with OUDs in treatment with methadone, the policy issues contributing to structural stigma must be addressed. Individuals with OUD utilizing methadone are reduced to the lowest rungs of the caste system. This demarcation of persons, coupled with the impact of societal, institutional, and self-stigma in a hyper-regulated system of care in which people are denied the ability to self-manage their illness, may lower feelings of self-efficacy and, therefore, decrease their ability to manage their illness. Research examining other chronic diseases, including hypertension, diabetes, and asthma, demonstrated that higher levels of self-efficacy contributed to improved medication adherence (Náfrádi et al., 2017) and overall improvement in self-management of the disease (Breland et al., 2020).

Stigma: Education and Training of Healthcare Providers

The pervasive stigma against OUD impedes improving the treatment system for those with the disorder. Stigma obstructs providers' training and education on SUDs and resulted in the creation of silos that separate substance abuse treatment from other medical practices, limits access to MOUDs, and discourages access to care (Madras et al., 2020). Given the prevalence of SUDs and specifically the devastation of OUDs in the United States, this lack of adequate care exposes a failure of the medical education system to address the growing health crisis.

Medical students in the United States are woefully under-educated about the psychological, social, and economic implications of SUDs. A White House Leadership Conference on medical education in SUDs noted that dedicated training in SUDs is part of curriculums (Christie et al., 2017). In 2008, only 12 medical schools required participation in a SUD course, and another 45 offered this as an elective (Madras et al., 2020). While these numbers are improving, there remains a significant gap in the levels of training (Madras et al., 2020).

According to the 2015 National Survey on Drug Use and Health, more than 20 million Americans need treatment for SUDs, of which two million need treatment for OUDs (Substance

Abuse and Mental Health Services Administration, 2016). Despite these staggering numbers, only 2,000 physicians are trained in addiction psychiatry, while an additional 3,500 are trained in addiction medicine (Sokol & Kunz, 2017), representing only 0.2% of trained physicians to care for individuals with OUD. These numbers suggest a lack of emphasis on expanding the specialty of addiction medicine and attracting physicians to these training programs.

During the early part of the 20th century, due to a reluctance of medical and psychiatric professionals to treat individuals with SUDs, there was a rise in the use of untrained lay therapists to treat SUDs (W. L. White, 2014). Often the only credential for this professional role was their personal experience with the disorder (Dodes & Dodes, 2015; Stöffelmayr et al., 1999; W. L. White, 2014). Framed by the Temperance Movement, prohibition, and the Harrison Act of 1914, early training programs were grounded in a moralistic viewpoint. These programs created and maintained stereotypical ideas of substance use disorders (Chappel, 1973; W. L. White, 2014) and demonstrated the long-standing impact of the intersection of policy and cultural beliefs toward people with the disorder.

To this day, addiction counselors are not required to obtain the academic and clinical background required of other healthcare professionals (Keller & Dermatis, 1999; Richter et al., 2019). SUDs, despite the complexity of co-morbid physical and mental health conditions, are the only medical disorders for which the sole requirement to provide care is to potentially have experienced the disorder (Richter et al., 2019). There is no other illness for which there is such a dearth of professional training and education standards and demonstrates the degradation and disregard of people who use substances.

Even after the advancement of managed care requirements led to the development of SUD certification programs, training and education relied on a 12-step theoretical orientation

(Duryea & Calleja, 2013; Keller & Dermatis, 1999; Robinson & Adinoff, 2018) with care provided for by non-medically trained persons (Madras et al., 2020). The lack of adequate evidenced based training and elevation of groups of AA created a gap between empirical research of SUDs and SUD counseling practices restricting the dissemination and adoption of evidence-based practices (Duryea & Calleja, 2013; Keller & Dermatis, 1999; Robertson et al., 2015) including pharmacotherapies (Graves & Goodwin, 2008) such as MOUDs.

As stated, both recovery status and educational status affect the beliefs and attitudes of addiction counselors. One study found that 37% of addiction counselors in a community setting held a master's degree, 28 % obtained a bachelor's degree, and 35% held less than a bachelor's degree (B. D. Smith & Manfredo, 2011). More recently, Aletraris et al. (2015) found just over 47% of 731 counselors sampled held master's degrees, 26.5 % held a bachelor's degree, with the remainder holding less than a bachelor's degree. While having advanced educational degrees is associated with increased openness and implementation of evidence-based practices, including the use of MOUDs (Aarons, 2004; Rieckmann et al., 2011; J. S. Stanley, 2021), the United States educational and training system continues to lag in the necessary credentialing to support adequate care for the disorder.

Over the past two decades, researchers have been calling for national standardization of education, training, and licensure for the addiction counseling profession (Lawson et al., 2017). To date, this has not happened, thereby reinforcing the marginalization of the treatment system for those with SUDs (Roberto et al., 2014). A recent review of requirements for addiction counselor training across states showed an alarming variation in the needed credit hours to gain licensure or certification. Some states require as few as three credit hours to achieve certification, with the most being 120 credit hours, with the average being approximately 50 credit hours

(Chasek & Kawata, 2016). Varying levels of education translate into wide variation of beliefs and practices that hampers the acceptance and implementation of evidence-based approaches, including MOUDs. The research-to-practice gap in the education and training system across the healthcare spectrum is a marker of structural stigma and structural violence against those who would benefit from SUD treatment and, more specifically, treatment with MOUDs.

The relegation of treatment of SUDs to lesser trained, non-medical clinicians represents discrimination and marginalization of individuals with the disorders by separating them from mainstream medical care. Methadone treatment is furthermore separated and differentiated from medical and other substance use treatments by federal statutes that dictate its use to separate opioid treatment programs (Hansen & Roberts, 2012), codifying OUD as different from other medical disorders. Siloing treatment, layered with restrictive and inflexible regulations, poses significant challenges for people who would benefit from using services. Additionally, the structure of MMT poses challenges for healthcare providers in the administering of the treatment program.

Thus far specific issues with the overall educational and licensing requirements of counselors who work with people with SUDs have been discussed. Education specific to the use of MOUDs in curricula, if present at all, is a sidenote. This, again, demonstrates the long-standing cultural preference of abstinence-based approaches over MOUDs. What follows is a more specific review of the treatment culture in MMTs.

Methadone Treatment Culture

Addiction counselors typically approach counseling through the lens of the “Recovery Model” (Frank, 2020). This model views addiction as a disease state, with abstinence as the primary goal of treatment (Frank, 2020). While many people conceptualize substance use and treatment in this manner, those who use methadone may utilize treatment in more practical terms, including escaping from criminalization and increasing harm reduction (Frank, 2018; Mateu-Gelabert et al., 2010). In essence, the focus of MMT within the context of the Recovery Model can misconstrue the treatment goals of patients and, due to the regulatory structure, penalizes people who do not hold abstinence as their primary goal.

In Connecticut, for instance, the Department of Mental Health and Addiction Services (DMHAS) designs training programs to educate addiction counselors on the tenets of the recovery model. DMHAS has defined the recovery model as a system of care that embraces recovery as a "process of restoring or developing a positive and meaningful sense of identity apart from one's condition and then rebuilding one's life despite or within the limitations imposed by that condition" (Kirk, 2011, p. 213). This statement projects PWUDs as not having a meaningful identity outside of their substance use; their meaningful identity beyond that can only be restored by engaging in the recovery process.

DMHAS also encourages the use of "person-centered planning" as a mechanism to promote the recovery-oriented system of care. The language DMHAS utilizes strongly suggests that the ultimate goal of recovery is for individuals to move from active substance use to abstinence. The addiction counselor trained in the Recovery Model orientation views PWUDs as not having meaning or value in their life because of their substance use and, therefore, is required to help the "abject drug user" create a new identity through cessation of use (Kirk, 2011).

In the context of methadone treatment, the recovery model poses numerous dilemmas for counselors. It compels the counselor to guide patients forward in the recovery process. If patients do not move forward with goals, counselors are tasked with holding the patient accountable. The lens of the recovery model also reinforces the identity of PWUDs as either “bad” patients or “non-compliant,” further reinforcing a stigmatized identity.

Clinicians providing counseling within MMT based on the recovery model orientation are placed not in a therapeutic position but in policing patients in the context of a rule structure (Attewell & Gerstein, 1979; Frank, 2020; Mateu-Gelabert et al., 2010). Rule enforcement may include reducing patients’ number of take-home doses and discharging them from care (Frank, 2020; Schwartz et al., 2017). The recovery orientation thus places the addiction counselor in a superior role to the patient and potentially creates a hostile treatment culture resulting in patients prematurely leaving treatment, reinforcing stigmatized identities (Earnshaw et al., 2013; J. Harris & McElrath, 2012) and stigmatization of the use of methadone (E. F. Madden, 2019). Given the regulatory design, reinforced by training approaches and culture, the MMT environment often is one of policing patients rather than promoting health and wellness based on the patient’s goals and wishes.

Stigma associated with the use of MOUDs and people who use MOUDs is all encompassing and includes micro and macro level forces. These influences contribute to decreased life chances for PWUDs. However, there is a range of opportunities to consider that may mitigate stigma and, ultimately, improve care and outcomes for PWUDs.

Approaches to Reduce Stigma

There is a vast body of research examining stigma and stigma reduction interventions across an array of social identities and health conditions. There is a paucity of high-level, randomized trials examining best-practice initiatives (Dobson & Stuart, 2021; McGinty & Barry, 2020). However, some promising approaches include self-management and peer support strategies, education, contact-based education, protest, advocacy, and legislative reform (Dobson

& Stuart, 2021). Across these initiatives, one or more levels of stigma may be targeted (Dobson & Stuart, 2021), including internalized stigma, public stigma, and structural stigma.

Strategies to Manage Internalized Stigma

There is strong evidence substantiating that internalized stigma prevents people from seeking help for a range of health conditions, including mental health (Corrigan et al., 2016; Corrigan & Rao, 2012), obesity (Alimoradi et al., 2020), HIV (Pantelic et al., 2019), and substance use (Benz et al., 2021; Wakeman & Rich, 2018). Though the effects of self-stigma are well documented, most stigma-reduction research focuses on public or enacted stigma (Stangl et al., 2019).

Education

Two primary types of strategies to alleviate the effects of self-stigma include interventions to enhance coping skills to moderate stigmatizing experiences (Link et al., 2002) and reduce self-stigmatizing cognitions (Ross et al., 2007). Analysis of these interventions showed only a moderate to low effect (Krafft et al., 2018). Another approach, Acceptance and Commitment Therapy (ACT; Hayes et al., 2012), combats the negative impacts of stigmatizing thoughts or attitudes by teaching individuals to notice their thoughts mindfully without trying to change the content of those thoughts but to focus on behaviors aligned with valued ways of being (Hayes et al., 2012). ACT teaches psychological flexibility or diffusion of thoughts in acknowledging and being mindful of uncomfortable events while remaining engaged in positive or valued behaviors (Hayes et al., 2012). Meta-analysis of the use of ACT (Krafft et al., 2018) shows promising results in reducing stigma across populations (Berman et al., 2016; Clarke et al., 2015; Moitra et al., 2015). Research on ACT is a relatively new area of investigation but indicates potentially long-term reductions in stigma (Krafft et al., 2018).

Peer Support Services

The use of peer support may also reduce the impact of internalized stigma. Peer support is utilized across the healthcare system, including people being treated for epilepsy (Elafros et al., 2013), physical and intellectual disabilities (Griffin et al., 2016), severe mental illness (Wood et al., 2017), other mental health and SUDs (Anvari et al., 2022; Burke et al., 2019). In mental health and SUDs, peer support is championed by activists, service users, and researchers in part because it is believed to be in keeping with a recovery model orientation (Burke et al., 2019; Lyons et al., 2021).

Peer service providers are people with lived experiences who work as part of a healthcare team and foster the provision of non-judgmental, non-discriminatory services while openly identifying their own experiences (Corrigan & Phelan, 2004). Peer support is now a standard of policy guidance internationally (WHO, 2021; Wykes et al., 2021). Two recent meta-analyses reviewing the impact of peer support on mental health and substance use treatment revealed that one-to-one peer support services show a modest, positive effect on empowerment and self-reported recovery (Lyons et al., 2021; S. White et al., 2020). Additionally, peer support may impact the alliance between service users, professionals, and social network support. The reviews did not substantiate an effect on clinical outcomes such as reduced symptoms or number of hospitalizations (Lyons et al., 2021; S. White et al., 2020). Each of these meta-analyses noted there is a diversity in peer support interventions employed as studies emerge; meta-analysis should focus on specific types of interventions.

Of specific interest to the current research study is peer support's role in reducing the stigma associated with using MOUDs, particularly methadone. There is a substantial body of evidence that demonstrates that peers enact stigma towards people utilizing MOUDs (Allen &

Harocopos, 2016; Larney, Zador et al., 2017; Paquette et al., 2018; Zelenev et al., 2018). Peer support is often recommended as adjunctive services to SUD treatment, with Alcoholics Anonymous and other 12-step based groups being the most prevalent peer support services. Peers may frame people utilizing MOUDs as not being in recovery, diminishing the value of MOUDs. One suggestion for people using MOUDs is to explore more welcoming groups or alternative peer recovery supports (Krawczyk et al., 2018).

There are recent efforts to expand community-based peer support specifically for people using methadone. Such support groups include Methadone Anonymous (Ginter, 2012), Medication Assisted Recovery Support (MARS; Ginter, 2012) and the Ability, Motivation, and Inspiration Group (AIM; Krawczyk et al., 2018). These groups recognized the need for peer support but sought to remove the stigma associated with traditional twelve-step recovery groups. While theoretically, these groups may decrease internalized stigma for people using MOUDs, there is not a significant body of research on their impact on self-stigma.

Strategies to Manage Public Stigma

A wealth of studies examining stigma reduction initiatives addresses public forms of stigma. While research on these strategies is mixed, typical approaches include education and health literacy campaigns, contact-based methods, protest and advocacy, and legislative and policy change (National Academies of Sciences, Engineering, & Medicine, 2016). There is relatively little data to demonstrate which approaches work to combat the stigma associated with substance use disorders. It is also unclear if findings related to mental illness generalize to substance use disorders (National Academies of Sciences, Engineering, & Medicine, 2016).

Education and Health-Literacy Campaigns

Anti-stigma campaign approaches utilizing education present scientific information about a condition to dispel misinformation or contradict negative beliefs and attitudes (National Academies of Sciences, Engineering, & Medicine, 2016). One example is education to counter the idea that people with mental illness are violent murderers by showing statistics that homicide rates do not differ between those with mental illness when compared to the public (Corrigan et al., 2012).

Educational campaigns can be designed at the local, national, and international levels to employ a range of methods (Griffiths et al., 2014; Kitchener & Jorm, 2008; Quinn et al., 2014), including distribution of fact sheets, flyers, public service announcements, and podcasts (Corrigan et al., 2012). Given the scale and scope of these approaches, education interventions are the most-evaluated stigma reduction tactics (National Academies of Sciences, Engineering, & Medicine., 2016). Typically, educational campaigns aim to reduce public stigma but are also effective in alleviating self-stigma.

The effectiveness of educational interventions in creating lasting change in public attitudes and perceptions is mixed (Corrigan et al., 2012; Smythe et al., 2020). Educational campaigns focusing on the biogenetic origins of mental illness reduce blame for the illness attached to people. However, biogenetic explanations appear to increase public aversion, perceptions of dangerousness, and pessimism about a person’s ability to achieve recovery (Loughman & Haslam, 2018). Additionally, educational campaigns may have unintended and stigmatizing consequences.

Several researchers who have conducted meta-analyses on biogenetic or neurobiological explanations of mental illness theorize that this type of information may emphasize and reinforce the differences between the person affected (Larkings & Brown, 2018; Loughman & Haslam, 2018; Schomerus et al., 2012). Additionally, while widely purported to reduce the stigma associated with substance use disorders, the "brain disease" model of addictions (Leshner, 1997; Volkow et al., 2016) is controversial and did not result in reduced stigma toward PWUDs (Rundle et al., 2021; Satel & Lilienfeld, 2014; Trujols, 2015). The controversy encompassing the brain disease model, like with other mental illnesses, overly focuses on biological aspects of the disorder, and minimizes other psychosocial factors that contribute to use and relapses (Hart, 2017; McGinty & Barry, 2020; Satel & Lilienfeld, 2014).

McGinty and Barry (2020) theorized that stigma-reduction messaging needs to emphasize societal-level causes rather than individual-level causes of SUDs. Secondary to cognitive bias, people tend to assume that an individual's actions are more dependent on personal characteristics rather than situational or societal level factors (McGinty & Barry, 2020). As a result of cognitive bias, people will attribute addictions to poor choices rather than factors including poverty, trauma, or lack of access to evidence-based treatments. Research to test societal-level messaging is needed.

While the evidence for effective messaging to reduce stigma is murky, several principles drawn from randomized messaging experiments offer guidance to stigma reduction campaigns, including using person-first language (Ashford et al., 2019; McGinty & Barry, 2020). Research demonstrates that terms, such as substance abuser or schizophrenic, are more likely to exacerbate stigmatizing attitudes when compared to terms such as "a person with a substance use disorder" or "a person with schizophrenia" (Ashford et al., 2019; McGinty & Barry, 2020). Other stigmatizing language used by healthcare professionals in the treatment of people with substance use disorders, including the use of "dirty" versus "clean," "addict," and "junkie," must be eliminated (Botticelli & Koh, 2016; Wakeman, 2019). Additionally, messaging highlighting that treatment works were effective in reducing HIV-related stigma (McGinty et al., 2015) and among healthcare professionals exposed to visual and narrative vignettes on addiction stigma (Kennedy-Hendricks et al., 2022).

Contact-Based Initiatives

People without stigmatized conditions may have little meaningful contact with individuals who hold those conditions. This lack of contact fosters fear and distrust of the stigmatized group (J. E. Cook et al., 2014). Contact interventions aim to reduce this interpersonal divide and promote positive connections and interactions between these groups (National Academies of Sciences, Engineering, & Medicine, 2016). People with lived experiences interact with the public and a range of healthcare professionals describing their challenges and success stories. These interactions show evidence of reducing both public stigma and self-stigma by creating a sense of empowerment (Corrigan et al., 2013). As with other stigma reduction interventions, the strength of the research is limited, with studies lacking methodological rigor, reporting bias, and lack of lasting effect (Jorm, 2020). Continued efforts to expand and strengthen this research are needed.

Protest and Advocacy Efforts

Protest and advocacy efforts are typically carried out at the grassroots level by people who have experienced discrimination and by their advocates. The goal of protests is to advance the civil rights of those affected. Efforts may include letter writing, product boycotts, or public demonstrations (Arboleda-Flórez & Stuart, 2012). Protest messaging and advocacy can engage stakeholders by raising awareness about the harmful effects of stigma and offer opportunities to develop a sense of solidarity and purpose (Arboleda-Flórez & Stuart, 2012). Campaigns target politicians, journalists, or other community officials with the goal of suppressing negative attitudes or removing negative media content. Additionally, these campaigns may focus on legislative reform with the goal to enhance protections, increase access to resources, reduce inequalities, or to create awareness regarding policy concerns.

Advocacy and protest campaigns are the least researched stigma-reduction interventions and may create both intended and unintended consequences (National Academies of Sciences, Engineering, & Medicine, 2016). For example, the AIDS Coalition to Unleash Power (ACT UP) began in 1987. Activities included members chaining themselves to the office of pharmaceutical companies. This action is credited with changing the ways HIV/AIDS medications were developed and delivered. In 1989, ACT UP members occupied St. Patrick’s Cathedral to protest the policies of the Roman Catholic archbishop of New York. There was a public backlash resulting in a reframing of the public debate to focus on issues of religious freedom and a backlash from prominent New York City leaders (DeParle, 1990). Available evidence concerning outcomes of protests related to mental illness may, in some instances, show positive outcomes; however, protests may strengthen negative public opinion in others (Corrigan et al., 2001). Further research is needed.

Legislative and Policy Actions

Legislative action is effective in changing social structures and individual behaviors though these efforts may not change attitudes (Stuart, 2017). While the first portion of the literature reviewed here documents the cataclysmic and far-reaching effects stemming from the so-called war on drugs and associated legislative and policy actions, the United States also has a history of using legal and policy interventions to normalize and protect stigmatized groups (J. E. Cook et al., 2014). Of historic note is the passing of the Civil Rights Act of 1964, which prohibited discrimination by race, color, religion, and national origin through all public accommodations (National Academies of Sciences, Engineering, & Medicine, 2016). During the 1960s and 1970s, there was a significant drop in the mortality rate of Black Americans that can be linked to legislation prohibiting racial discrimination in Medicare payments (Krieger et al., 2008). Similarly, after same-sex marriage laws were legalized in Massachusetts, longitudinal studies among males with marginalized sexual identities demonstrated a decline in medical and mental healthcare visits (Hatzenbuehler et al., 2012).

Despite examples of policy action that is well-intended and moves to reduce or eliminate the impact of stigma, there is much work to be done. As with other anti-stigma reduction interventions, a solid evidence base is lacking (McGinty & Barry, 2020; Rüsch & Xu, 2017). In the United States, researchers have found that people with mental illness favor approaches that address structural and institutional discrimination (Pietrus, 2013). Additionally, mental health advocates and stigma researchers recommend efforts to move away from “soft goals” of public education and attitude change and expanding focus on “hard goals,” including legislative and policy change promoting social equity to improve the overall quality of life for people with mental health and SUDs (Arboleda-Flórez & Stuart, 2012; Livingston, 2021; Pietrus, 2013).

Structural stigma is persistent and remains understudied (Hatzenbuehler & Link, 2014; Rüsch & Xu, 2017). Furthermore, there is a call to address multiple aspects of stigma and discrimination simultaneously with a focus on the reduction of stigma over time (Rüsch & Xu, 2017). One noted advance in the field of mental health and SUD care systems is the acceptance that everyone, including healthcare providers, education systems, and other societal agents, can contribute to the reinforcement of stigmatization and prejudice against people with mental health and SUDs (Loch & Rössler, 2017).

Thus far in the chapter, I have reviewed a range of interventions that target stigma reduction for SUDs. Overall, the stigma on the mitigation of stigma is mixed and remains largely understudied. What follows is a brief review of structural competency, an approach that may for practitioners in healthcare. In closing, the rationale for the current study is presented.

Structural Competency and Study Rationale

Interventions addressing stigma must be present in healthcare training (Crapanzano et al., 2014). Since the onset of the opioid crisis, there has been a call to medical schools to address curriculums and expand educational and training opportunities (Sokol & Kunz, 2017).

It is necessary to enhance and revamp education systems across all sectors that impact those with OUD, including nursing (Calcaterra et al., 2019), social work (Vitásková & Pavlovská, 2018), counseling (Aletraris et al., 2016), and as discussed, addiction counseling training (Chasek & Kawata, 2016). Education on stigma reduction in the mental health and SUD education system has primarily focused on stigma at the social, interpersonal, and public levels with little to no attention to the problem of structural stigma (Sukhera et al., 2021).

One promising educational framework for addressing structural stigma is structural competency (Hansen & Metzl, 2016; Sukhera et al., 2021). Structural competency is intended to instill an awareness of the social and institutional structures impeding the United States healthcare system (Hansen & Metzl, 2016). Structural competency is aimed at enhancing healthcare professionals' ability to recognize and respond to social and structural determinants that produce and maintain health disparities (Sukhera et al., 2021). It directs clinical training to intervene at the level of social structures, institutions, and policies to improve population health and promote health equity. An educational framework rooted in "structural humility" was proposed by Sukhera et al. (2021, p. 175) to address structural competency; it has four components:

1. To recognize structural forms of stigma
2. To reflect critically on one's own assumptions, values, and biases
3. To reframe language away from stereotyping to the use of empathetic terminology
4. To respond with actions that actively dismantle structural stigma

Given the all-encompassing stigma and punitive regulatory system associated with the use of methadone to treat OUD, understanding addiction counselors' awareness of structural stigma and level of social competency may mitigate or escalate potentially harmful and stigmatizing communication when negotiating the rule structure of MMT. The concept of *cultural health capital* (CHC; Shim, 2010) offers a theoretical tool to examine how stigma unfolds during interactions between addiction counselors and patients.

Shim (2010) expanded on the conceptualization of cultural capital set forth by Bourdieu (1990). Bourdieu defined cultural capital as the use of cultural practices and products such as dress, style, verbal skills, scientific knowledge, and educational credentials as forms of capital. He described the use of these types of capital as a means of social distinction and practices of dominance in maintaining class hierarchy contributing to the maintenance of inequality. Link and Phelan (2014), using these concepts, introduced the idea of *stigma power,* defining it as the capacity to keep people "down, in or away" (p. 24) by using stigma-related processes. These processes are often hidden or misrecognized and less obviously related to the interest of the stigmatizers (Link & Phelan, 2014).

In a similar vein, Shim (2010) applied this to the healthcare field as a theoretical framework for understanding how social inequalities operate in patient-provider interactions and shape the tone and experience of healthcare. He asserted that CHC refers to the “range of cultural skills, verbal and nonverbal competencies, and interactional styles that can influence healthcare interactions in a historical moment (Shim, 2010, p. 2). Components of CHC used by either patient or provider can include verbal skills and proactive attitudes about accumulating biomedical knowledge and using that knowledge for disease management.

Chang et al. (2016) applied CHC concepts when analyzing qualitative interviews of provider-patient interactions around substance use in the setting of cardiac care. CHC concepts demonstrated how cultural views of substance use impacted the interactional dynamics between providers and patients. Specific to this framework are the concepts of *habitus* and field, which “set the social position and expectations of providers and patients in ways that exacerbate the formation of stigmatizing behaviors” (Chang et al., 2016, p. 91). Bourdieu (1990) asserted that conditions associated with a particular class produce a state of habitus or systems of “durable, transposable dispositions” (p. 53). Habitus in this context refers to attitudes and dispositions acquired through historical, biographic, and social experiences that form the basis of our frame of reference in addition to structuring our actions.

Chang et al. (2016) noted that the interaction of habitus, individual attitudes, and experiences that occur in specific fields or settings have distinctive norms and rules, and offers explanatory power for why patients who use substances face stigma. Habitus arises from individual experiences but cannot be separated from an individual’s structured experiences as a member of a particular social group. Those actions, though not predetermined, are structured by our stratified past (Chang et al., 2016). In the field of healthcare, where differences and inequalities arise in clinical interactions situated by norms and rules, substance use stigma is produced, exacerbated, or negotiated between provider and patient (Chang et al., 2016). For example, most providers in this study considered patients who used substances to be a waste of time and resources. In other interactions, either the provider or patient mobilized knowledge and experiences to mitigate stigma and thus improve the quality of the interaction.

Specific to the current study, the use of methadone to treat people with OUD is shaped by institutional stigma, structural stigma, and structural racism because of policy framed by the war on drugs—and specifically a war on drug users. Before the current opioid crisis, drug policy sought to control and punish the drug user, often framed as an inner-city person of color. The subsequent structuring and framing of the treatment system for OUD with MMT, as discussed, more closely represents a carceral system than a treatment system (Earnshaw et al., 2013; Hansen & Roberts, 2012; Netherland & Hansen, 2017). It is a system of care whereby addiction counselors leverage a rule structure to move people into recovery.

As highlighted in Chapter I, qualitative studies from patients' perspectives have documented that negative interactions with staff in MMT programs pose barriers to patients' retention. To date, however, specific research on providers working in OTPs is limited. There are several studies of note undertaken in China. Li et al. (2012), utilizing questionnaires, found that the presence of stigmatizing attitudes of methadone providers leading to a decreased desire to interact with patients. Another study using case vignettes found that methadone providers held stigmatizing attitudes towards people who use drugs (Luo et al., 2019). Another study employed education tactics to improve provider patient communication (Li et al., 2019). Results indicated that providers who were trained in the intervention continued to sustain improved interactions two-year post baseline. While these studies are based in China, the results may be relevant to the United States context, given the worldwide presence of stigma against PWUDs. However, to date, there are no known studies examining the lived experiences of addiction counselors' interactions with patients and the enactment of rule structures. The focus of previous research on lived experiences of addiction counselors includes experiences with scaling up treatment admissions (Oberleitner et al., 2019) and experiences in burnout (Beitel et al., 2018).

The current examination explores the lived experience of the therapeutic relationship and clinical reasoning in a highly regulated, stigmatized environment. Clinical reasoning is described as a complex process within individuals. These processes are both cognitive and interactive. And they are predominantly unobservable; at times automatic and subconscious; and always multifaceted and context-dependent (Higgs & Jones, 2018). In the MMT environment, the addiction counselor tasked with enforcing a punitive rule structure is also a product of their acculturation to PWUDs and the SUD treatment system. The therapeutic relationship in MMTs, influenced by both a rule structure and culture, maybe a mediator or moderator for the patients' continued engagement in life-saving treatment.

The timing of my study is critical. As a result of the COVID-19 pandemic, for the first time since its inception, the regulatory structure of MMT is being evaluated for change. Numerous researchers have recommended that changes, including the use of telemedicine and increased flexibility around access to take-home medication, should continue (Green et al., 2020; Stringer et al., 2021; Treitler et al., 2022) with other stakeholders calling for the dismantling of OTPs (Simon et al., 2022).

While it is unlikely that OTPs will be dismantled, based on the energy within advocacy groups and the scientific community to overhaul the regulations of MMTs and expand access to methadone in the community, it is essential to describe and understand addiction counselors' structural competency of the methadone system of care and their meaning-making of interactions while they are leveraging rule structures in the clinical interaction. My study employed a critical phenomenological methodology to uncover clinicians’ experiences, beliefs, and attitudes around the use of methadone and the patients they treat. The results of this study may offer opportunities to enhance training to reduce the enactment of stigma and discrimination in the context of clinical interactions within OTPs.

CHAPTER IV: METHODOLOGY

This study focused on the intersection of culture, policy, and the clinical practice of addiction counselors in an opioid treatment program (OTP) utilizing methadone maintenance treatment (MMT). As described in the previous chapters, the phenomena encompassing treatment for OUD with methadone is complex, multi-faceted, and laden with stigma. At the center of this phenomenon are addiction counselors, who, like other healthcare professionals, dedicate their time to promoting and enhancing the health and well-being of their patients. Intertwined with their practice are the historical, cultural, and sociopolitical influences throughout each of these provider's lifespan, including, but not limited to, their families of origin, primary education, secondary education, political affiliations, federal and state regulations, and institutional culture forming their beliefs. Each of these influences frames and informs the practitioners' understanding of people who use drugs, their approach to care, and their interactions with their patients. Chapter II described the influences shrouding treatment utilizing methadone. The aim of the current study was to elucidate counselors' lived experiences and sense-making in the context of the MMT program environment and thereby to understand how culture and regulation influence and shape the clinical relationship.

The current study employs a critical phenomenological methodology. Phenomenology is a qualitative research technique intended to make explicit the implicit structure and meaning of human experience (Atkinson, 1972). Critical phenomenology moves beyond the classical approaches of phenomenology that are often criticized for failing to account for how social and historical structures shape life experience (Guenther, 2019). Critical phenomenology utilizes the lens of critical theory to inform the interpretation of narrative experiences. According to

Guenther (2019), "Critical phenomenology is not just to interpret the world, but also change it" (p. 16).

The overarching research questions of this study were:

1. In what way do addiction counselors reflect or mitigate the broader social stigmas around MMT and those who utilize it? And where do those views come from?
2. How does this show up in addiction counselors' everyday interactions with patients?
3. How did the COVID-19 waivers to MMTs change addiction counselors' views and practices (or not)?
4. How do addiction counselors' narratives of interactions with patients maintain the stigmatized identities of patients?

Research Philosophy and Approach

Utilizing critical phenomenology, the aim of this study was to uncover how addiction counselors' narratives of interactions with patients maintain or mitigate the stigmatized identities of people utilizing MMT for OUD. Qualitative designs require certain philosophical assumptions (Creswell & Poth, 2016). Ontological—concerning the nature of reality—and epistemological—how the researcher knows what they know—are assumptions often emphasized by researchers; however, of significance to the current study is the *axiological* dimension—"the nature, types, and criteria of values and value judgments" (Merriam-Webster, n.d.)—because research is recognized as a value-laden (Creswell & Poth, 2016). To uncover the value-laden features of addiction counselors' lived experiences, the study incorporated both descriptive and analytic interpretations of the lived experiences of addiction counselors employed by OTPs.

Creswell and Creswell (2017) put forward that the transformative worldview "holds that research needs to be intertwined with politics and a political change agenda to confront social oppression at whatever levels it occurs" (p. 9). They asserted that transformative research holds that constructivist researchers do not go far enough. Transformative researchers assert put forth "an action agenda for reform that may change the lives of participants, the institutions in which individuals work or live, and the researcher's life (Creswell & Creswell, 2017, p. 9). The transformative worldview embraces but transcends social constructionism focusing on groups or individuals who may be marginalized, incorporating theoretical perspectives of critical theory, critical race theory, and disabilities theories, within the analysis (Creswell & Creswell, 2017).

Social constructivism's tenets support an orientation that people construct their realities through everyday social interactions (Burr, 2015). Social interactions do not stand in isolation from historical and cultural norms (Burr, 2015; Creswell & Creswell, 2017). These interactions are also context-bound by situation, place, and time (Hiller, 2016). As such, the constructivist researcher is interested in the processes of interactions among people focusing on contextual issues such as a person's life or work to understand the historical and cultural underpinnings of a phenomenon (Creswell & Creswell, 2017). Counselors' lived experience is not devoid of historical, sociopolitical influences. The constructivist orientation resonates; however, the aim of my study is not only to shine a light on addiction counselors' lived experiences of operating in OTPs, but also to critically examine whether addiction counselors' perceptions and beliefs reflect and reinforce the stigmatized identities of people with OUD. For this reason, critical phenomenology has been employed.

Phenomenology

Phenomenology is a family of qualitative methodologies (Gill, 2014) well suited to exploring peoples' experiences. Areas of study, including organizational research, pedagogy, and psychology (Gill, 2014). Increasingly, phenomenological approaches are used in the healthcare industry (Neubauer et al., 2019; Rodriguez & Smith, 2018), Phenomenology's roots are both in philosophical schools and research methods approach (Bloor & Wood, 2006). The different approaches are grounded in differing conceptualizations of conceiving the "what" and the "how" of human experience. What follows is an overview of the historical roots of phenomenology as a research approach, the main branches of corresponding methodologies, and the rationale of the method employed in the current study. The two main branches of phenomenology now considered are transcendental (Husserl, 1999) and hermeneutic (Heidegger, 1962/1996).

Transcendental Phenomenology

Phenomenological traditions evolved over the centuries; however, Edmund Husserl is generally credited as the most influential philosopher of transcendental or descriptive phenomenology (Bloor & Wood, 2006). Husserl was originally trained as a mathematician; however, his attention steadily shifted to philosophy. Husserl (1970) was critical of psychology as a field, asserting it went wrong in applying methods associated with the natural sciences to human issues (Laverty, 2003). He believed researchers who only attended to external, physical stimuli and correlated those with other isolated responses missed important variables of human perception and, as a result, created highly artificial situations (W. T. Jones, 1975). Rejecting positivism's focus on absolute, objective observations, Husserl asserted that phenomena as "perceived by the individual's consciousness should be the object of scientific study" (as cited in Neubauer et al., 2019, p. 92). His philosophical approach equally valued objective and subjective work leading to what he termed "pure phenomenology" (Laverty, 2003, p. 21).

Phenomenology is the study of lived experience, also referred to as life-world (van Manen, 2016). Husserl (1970, 1975) argued that no assumptions, scientific theory, nor deductive logic should inform phenomenology's inquiry—only what is given directly to an individual's awareness (Moran, 2002). Phenomenological inquiry, otherwise stated, is like a natural scientist uncovering something previously unknown (Staiti, 2012). Scientific knowledge, according to Husserl, rests on inner evidence, or what appears in consciousness is where the phenomenon is to be studied (Husserl, 1970). Husserl (1975) asserted:

> For me the world is nothing other than what I am aware of and what appears valid in my cognitions .... I cannot live, experience, think, value, and act in any world which is not in some sense in me, and derives its meaning and truth from me (p. 8).

For Husserl, subjective and objective knowledge are interwoven. Grasping the totality of a phenomenon is understanding it as lived and experienced by a person (Neubauer et al., 2019). Husserl (1970) argued that the lived experience of a phenomenon had facets that were similarly perceived by people who experienced the phenomenon (Neubauer et al., 2019). Husserl termed these "universal essences" in which the researcher can develop a generalizable description (Moustakas, 1994; Neubauer et al., 2019).

In transcendental phenomenology, the researcher is tasked with assessing and suspending any preconceptions or biases about what is being studied to achieve transcendental subjectivity (Lopez & Willis, 2004). The researcher's goal is to not influence what is being observed but to stand apart from their own subjectivity and to capture the descriptions given by participants. The researchers must suspend any theories or preconceived knowledge of the object of their study by "bracketing off" any previous knowledge or understanding of the phenomena (Moustakas, 1994; Neubauer et al., 2019). The researcher then considers each participant's descriptions of their individual experiences and then constructs a collective unified synthesis of the phenomenon meanings and essences.

Interpretive Phenomenology and Critical Phenomenology

Interpretive phenomenology (also called hermeneutic phenomenology) began with the work of Martin Heidegger, who initially trained under Husserl (Zahavi, 2018). While both approaches to inquiry are concerned with the lifeworld of individuals and uncovering their experiences, the ways of carrying out the investigation differ. Heidegger came to challenge key aspects of transcendental phenomenology, specifically Husserl's focus of inquiry. While Husserl was interested in the nature of knowledge, Heidegger held an ontological focus on the nature of being and the temporality of a phenomena (Neubauer et al., 2019; Zahavi, 2018).

Heidegger focused on what he termed *dasein* which translates to "the situated meaning of a human world" (Laverty, 2003, p. 4). For Heidegger, consciousness is not separate from the world but a construction of historically and socially lived experiences influenced by the culture an individual is raised in and how they come to understand their world (Laverty, 2003; Munhall, 1989). Quite simply stated, a person's consciousness and experiences cannot be divorced from the person's history, social, and cultural context. Interpretive phenomenology examines participants' narratives to understand what they experience in their lifeworld.

Another key difference between descriptive phenomenology and interpretive phenomenology is the role the researcher takes in examining participant narratives. In descriptive phenomenology, the researcher is asked to suspend or bracket any preconceived notions or theories about the phenomenon (Moran, 2002; Neubauer et al., 2019). Interpretive phenomenology recognizes that the researcher, like the participant, cannot rid themselves of their lifeworld but instead uses their knowledge and experience to inform the study (Neubauer et al., 2019). The researcher's lifeworld leads them to consider a particular phenomenon and work within their framework, acknowledge their own preconceived notions, and examine their subject experience (Neubauer et al., 2019). Theory is not used in a formal way to test a hypothesis, but more specifically, a theoretical orientation or a conceptual framework can be used to focus the inquiry (Lopez & Willis, 2004). The theoretical orientation can assist the researcher in making decisions informing their methodology, including the study sample and research questions to be asked. Using an orienting framework can also make explicit study assumptions and the researcher's frame of reference (Lopez & Willis, 2004).

Heidegger (1962/1996) discussed the concept of co-constitutionality (Koch, 1995). This considers the meanings that the researcher arrives to be a composite of meanings expressed by both the participants and the researcher (Lopez & Willis, 2004). Intersubjectivity, according to Gadamer (1976), is a "fusion of horizons" (p. xix) A horizon is the background of various assumptions, ideas, and meanings that one acquires in living. These backgrounds are fluid and may change secondary to time and events in the world. When people interact with others in getting to know each other, "it is based on a personal horizon of experiences and meanings" (Lopez & Willis, 2004, p. 730). The act of interpretation, therefore, is always bounded by separate and intersecting horizons of people (Geanellos, 2000). This means that within any interpretive study, there is no one true meaning produced, but multiple meanings that must be logical and plausible within the framework of the study. As asserted by Lopez and Willis (2004) in their discussion of the different phenomenological approaches, the "researcher is obligated to go further by interpreting the meanings for practice, education, research, and policy to create informed and culturally sensitive healthcare knowledge" (p. 730).

It is in this step that interpretative phenomenology becomes critical phenomenology. Critical phenomenology is understood as a historical-transcendental inquiry (Oksala, 2022). The researcher utilizes an orienting framework to question the first-person accounts of lived experience. It incorporates the phenomenological reduction of Husserl's transcendental phenomenology and then, through the interpretative lens utilizing social theories, reveals not only the “universal and essential” but also exposes “the historical, intersubjective, and perspectival nature of all experience” (Oksala, 2022, p. 142).

Rationale for Methodology

The aim of this study is to uncover how addiction counselors’ narratives of interactions with patients maintain or mitigate the stigmatized identities of people utilizing methadone maintenance treatment for OUD. When considering the branches of phenomenology, given the backdrop of the historical, socio-political, and cultural forces which shroud the use of MMT, descriptive phenomenology, while useful in describing the lifeworld of addiction counselors, does not go far enough. Descriptive phenomenology focuses on participants’ accounts of what occurred with their narratives are considered separate from their context (Maxwell, 2005).

For Heidegger (1962/1996), the term “lifeworld” reflects that individuals’ realities, which, without fail, are influenced by the world in which they live (Neubauer et al., 2019). The lifeworld of addiction counselors is context-bound by historical and cultural influences. Also of significance is the temporality of this study. The current opioid crisis and an evolving regulatory structure secondary to the pandemic provide a unique moment to examine the experiences, beliefs, and attitudes of addiction counselors providing care within an MMT program. In fact, examining the life experience in addiction counselors’ narratives of their interactions with people in care necessitates an awareness of the historical and cultural influences of the power structures regulating treatment. As such, capturing, not merely describing, the essence of the lived experience of addiction counselors was necessary to critically examine their narratives.

Langdridge (2008) asserted that it is essential that phenomenologists attend to power and politics as lived by participants as a mechanism for social change. This can be accomplished using such mechanisms as intersubjectivity, embodiment, and discourse to critically examine the life world of participants so that experiences immersed in power and politics may be identified (Langdridge, 2008).

In the current study, these tools were essential to shedding light on cultural influences on addiction counselors' attitudes and beliefs. Addiction counselors are not typically educated in the socio-cultural or historical underpinnings of the treatment system within the United States and receive education that is biased towards abstinence-based treatment approaches (Rieckmann et al., 2011; J. S. Stanley, 2021). Secondary to a lack of exposure to the nuances of war on drug policies' influences on culture and regulation, addiction counselors providing treatment with methadone may unknowingly replicate these stereotypes and prejudices.

The role of the researcher in the process of using hermeneutics also resonated with my choice for utilizing critical phenomenology. The task of researchers is to interpret the narrative provided by the participants within their contexts, to illuminate the fundamental structure of participants' understanding of being and how those understandings shaped decisions by the individual (Heidegger, 1962/1996). Researchers in this tradition are not asked to separate their own lived experience or bias from the study but to acknowledge their experiences openly and employ them in the interpretative process. My own education and journey as both a practitioner and clinical manager in treatment utilizing methadone led me to the choice of this study and provided a unique perspective to analyze clinicians' narratives from a historical and sociocultural perspective.

Research Design

Phenomenologists are "reluctant to formalize their methodology into step-by-step procedures" (Aagaard, 2017, p. 523), and, as such, there is no specific way to conduct a phenomenological study (Aagaard, 2017; J. A. Smith & Osborn, 2003). My study entailed individual interviews of addiction counselors employed by OTPs providing care for people with OUD within MMTs in the state of Connecticut.

Study Sample

The current study employed a snowball variation sampling technique to locate and invite the participation of 26 addiction counselors employed within opioid treatment programs (OTPs) utilizing MMT in the state of Connecticut. Connecticut is a state that is home to multiple OTPs with varying treatment philosophies, including the organization where I am employed and as such, provided a good network of diverse programs to recruit from.

Snowball sampling, also called chain sampling or chain referral, is a non-random sampling method where initially, participants are engaged through a convenience sample and are then asked to refer others from the target population to participate (Ruel et al., 2016). This sampling method is helpful in obtaining a target group that is not easily reached and may be dispersed geographically, and additionally when it is likely members of the population may know each other (Heckathorn, 2011). What follows is a discussion of the rationale for employing snowball sampling in the study.

As a reminder, there are multiple layers of regulations guiding the use of methadone to treat OUD. These include federal, state, local, and clinic level regulations and policies. The sample is being limited to a single state secondary to variations across states in the regulation of methadone treatment programs, including the enactment of waivers under the pandemic. Connecticut is a state that allows clinics to adopt the emergency waivers granted by SAMHSA. While clinics were all afforded the ability to utilize these waivers, there was significant variation in their implementation (Heimer et al., 2020). The variations included the implementation of telehealth and providing patients access to take-home medication to reduce trips to the clinic.

These measures were specifically implemented to reduce exposure to COVID-19. The variations of implementation and continuation of the use of the waivers rested on the discretion of medical directors and clinic leadership's decisions.

My sampling goal was to include addiction counselors from a broad range of these clinics because they reflect different approaches to OUD and MMT, ranging from more restrictive to less restrictive interpretation and application of regulations. The rationale for this sampling was that I sought to interview a range of participants operating under similar macro-level influences (federal and state regulatory structures) with the intention of potentially highlighting meso-level (institutional) and micro-level (individual) differences in cultural influence.

I decided to include counselors from my own organization in the sample because my organization is one of the least restrictive organizations in Connecticut in its approach to OUD and particularly MMT. For this study, it was important to capture the full range of treatment settings under which counselors practice, and my own organization is likely the lowest barrier setting in the state, as evidenced by our adoption of the pandemic waivers (Heimer et al., 2020). It is also the only organization in the state to employ an open-access model of care. The open access model has been demonstrated to improve access and retention to care (Lachapelle et al., 2021; L. M. Madden et al., 2018). The stated treatment culture where I am employed is dramatically different than other treatment cultures across the state, and, as such, it was hypothesized that counselors might experience different clinical relationships with clients than counselors practicing in more restrictive programs and settings. The inclusion of counselors in my organization did pose ethical considerations, which I discuss further in subsequent sections.

In Connecticut, there are 29 OTPs across five geographic regions. Each of these clinics is in the larger cities or towns, with none located in suburban or rural areas. While there are 29 independently licensed facilities, there are 11 parent companies with multiple locations (See Table 4.1). Of the parent companies, eight are not-for-profit organizations, two are for-profit, and one is a federally qualified healthcare system. While each of these programs is required to abide by federal and state-level policies governing OTPs, each agency and each location retain their own clinic-level policies and practices as well as their own unique cultural norms.

Table 4.1

Methadone Programs by Region

Region	Facility Name	# of Locations	Profit Status
REGION ONE	Connecticut Counseling	1	Non-Profit
	Liberation Programs	2	Non-Profit
	New Era	1	For-Profit
	Regional Network	2	Non-Profit
REGION TWO	APT Foundation	4	Non-Profit
	Chemical Abuse Services Agency	1	Non-Profit
	Connecticut Counseling	1	Non-Profit
	Cornell Scott Hill Health	2	FQHC
	New Era	1	For-Profit
REGION THREE	Community Health Resource Center	1	Non-Profit
	Root Center for Advanced Recovery	3	Non-Profit
REGION FOUR	Health Care Resource Center	1	For-Profit
	Root Center for Advanced Recovery	5	Non-Profit
REGION FIVE	Connecticut Counseling	3	Non-Profit
	Root Center for Advanced Recovery	1	Non-Profit

Appropriate candidates were employed at an OTP utilizing methadone a minimum of six months prior to the initiation of the pandemic waivers and through the date of the interview. The rationale for the length of time of continuous employment was to ensure that each participant was trained and worked in an OTP under the more stringent regulations and through the loosening of regulations.

Participant Recruitment

Participants were both directly and indirectly recruited. For the direct recruitment of individuals outside of my own organization, I contacted counselors with whom I have established relationships. As well, I asked for referrals from my colleagues who also have connections at outside clinics. I reached out to counselors via brief phone calls or an introductory letter/email providing an overview of the study (see Appendix A for recruitment phone call script and letter/email sample). Additionally, I contacted peer directors and supervisors at other centers to request to present an invitation to counselors to participate in a staff meeting. While at those meetings, I described the study using a script (Appendix B), including a description of appropriate candidates. A sign-up sheet was distributed for individuals who wished to be contacted for participation in the study. Utilizing the contact sheets, I followed up with a brief phone call or email to describe the study and then emailed the informed consent information electronically. Individuals who agreed to participate signed informed consents and returned them either by fax or scanned through email. A time was scheduled for the interview.

Indirect recruitment occurred by asking individuals who participated in interviews for other people who might be interested in participating in the study. The participants were given my contact information and the introductory letter to forward to potential candidates. As potential participants contacted me, I provided information regarding the nature of the study and if individuals were willing to proceed, informed consent was obtained, and an interview time was scheduled.

In recruiting counselors to participate from my own organization, I needed to ensure I avoided role conflicts and the potential for coercion. Therefore, I did not conduct the recruitment and interviews of addiction counselors at the APT Foundation. I was granted permission by the Foundation's CEO, the Director of Research, and the APT board to utilize the time of a research assistant (RA) employed by the APT Foundation. The RA holds a master's degree in public health. As part of her duties, she conducted recruitment within our organization to protect the confidentiality of addiction counselors. Additionally, the APT Foundation awarded me funds to provide a nominal incentive of a $25 gift card to both internal and external participants to them for their participation.

Recruitment of participants within the APT Foundation followed the process described above but was conducted by the RA. A mass email was sent out to counselors describing the study and given the contact information of the RA. For individuals who expressed an interest in being contacted, the RA followed up with a phone call, fully describing the study, gaining consent, and scheduling a time for the interview. The overview of the study included a description of the measures to ensure confidentiality. Due to the size of our organization, potential participants were likely aware that I was the researcher, so there were no attempts to hide my identity as the investigator. They were informed that the APT Foundation was supporting my research, but it was a separate project from the organization. They were assured there were no consequences or benefits to or from the organization related to their participation. The letter they received explained that I did not have access to their identity and that transcripts of interviews were de-identified first by the RA and then reviewed by the faculty sponsor. All recruitment materials were submitted to and approved by the Institutional Review Board for the Protection of Human Subjects (IRB) at Antioch University.

Interviews and Interview Process

Interviews were conducted via video conference. Interviews were semi-structured and lasted from 35 to 75 minutes. The nature of the interview questions is discussed below. Prior to the interview, participants were informed of the nature of the study, potential risks and benefits of participation, assurances of confidentiality, and informed consent obtained, including permission to record the session. Interviewees received a $25 gift card as a thank-you for participating in the study. At the completion of the interview, participants were asked if they knew other addiction counselors who would be interested in participating. The RA managed all intra-agency referrals to ensure confidentiality, and I managed all external referrals.

Prior to the start of formal interviews, the RA and I piloted the versions of the interview guide separately. She conducted the pilot interviews with a PhD psychologist who had extensive experience in qualitative interviews. Those interviews were completed by videoconference. After the completion of the interviews, we met as a team and debriefed to improve the interview guide. We each conducted two pilot interviews prior to the initiation of the study. Data from those pilot interviews were not used in the analysis.

For the interviews included in the data set, the RA conducted interviews with clinicians employed by the APT Foundation, our agency, while I conducted the interviews with participants from outside of the agency. During each interview we journaled reactions, significant pauses, and emotional responses. The interviews were transcribed through transcription software and de-identified.

Interview Questions

Table 4.2 presents the research questions, a sample of associated interview questions, sensitizing concepts gleaned from Chapter II, and selected references.

Table 4. 2

Research Questions (RQ) and Sample Interview Questions

RQ 1: In what way do addiction counselors reflect the broader social stigmas around MMT and those who utilize it? And where do those views come from?		
Sample Questions	Sensitizing Concepts	References
How did you come to work in substance abuse treatment? *How did you first learn of methadone maintenance?*	• Cultural orientation • Recovery status • Training	Aletraris et al. (2016); Dodes and Dodes (2015); Stöffelmayr et al., (1999)
RQ 2: How does this show up in addiction counselors' everyday interactions with patients?		
Sample Questions	Sensitizing Concepts	References
What is it like to be an addiction counselor- *Describe what your day is like?* *What is it like working with your patients?*	• Stigma • Criminalization • Burden of regulations	Dollar (2019);Frank, (2018); E. F. Madden, (2019); McGinty et al., (2018)
RQ 3: How did the COVID-19 waivers to MMTs change addiction counselors' views and practices (or not)?		
Sample Questions	Sensitizing Concepts	References
How did your clinic and your practice change since COVID? *Did it change your interactions with clients?* *How did you feel about it?*	• Fears of diversion • Safety • Shared decision making	Deegan and Drake (2006); del Pozo and Rich (2020); Figgatt et al. (2021)
RQ 4: How do addiction counselor' narratives of interactions with patients maintain the stigmatized identities of patients?		
Secondary Analysis	Sensitizing Concepts	References
Using a critical lens, are addiction counselors mitigating or perpetuating stigmatized identities of people utilizing methadone?	• Structural competency • Structural violence • Structural racism	Hansen and Metzl (2016); Jackson et al. (2022); McGinty et al. (2018)

The first three interview questions were intended to capture the lived experiences of counselors and their sense-making of their experiences. The final research question represented an interpretive, critical analysis of clinicians' experiences.

The first research question probes the ways addiction counselors reflect or mitigate the broader social stigmas around MMT and those who utilize it and where those views come from for them. To uncover counselors' feelings and attitudes regarding the work they engage in, participants were invited to describe how they came to the field, whether it was part of their own recovery process, due to a family history of substance use disorders, or some other pathway that led to what many counselors describe as a personal calling to the field. This initial question led to an unfolding of prompting questions intended to illuminate each clinician's own historical and cultural orientation to their work. Secondary or follow-up questions were used to re-focus the interview to the counselor's initial experience of MMT and their journey leading them to become employed in a program using MMT. These questions elicited their historical and cultural orientation to MMT, how they framed the identities of those they serve, in addition to their attitudes/beliefs around continued drug use.

The second research question on how stigma shows up in addiction counselors' everyday interactions with patients, was explored by inquiring about counselors' day-to-day experiences with patients in their MMT practice. Highlighting clinicians' depictions of their daily experiences sheds light on their orientation to the rule structure of methadone treatment, illuminating underlying beliefs and attitudes that may, in practice, stigmatize patients. An example was a counselor who expressed frustration with a client's behavior suggesting, as I interpreted it, a lack of awareness of the structural issues imposed by the regulatory structure. Additionally, if counselors' stories depicted concerns of safety to the community, this might reflect an underlying narrative about the need to be concerned about patients diverting methadone by selling it, a myth unsupported by the literature but an often-articulated prejudice about MMT. If counselors' voiced frustrations with patients' continued use of MMT rather than striving toward abstinence, this might reflect an underlying orientation that "real" recovery from substance abuse requires abstinence rather than managing addiction with harm reduction. The third research question explored if the COVID-19 waivers changes addiction counselors' views or practices.

The final research question reflected the critical interpretative analysis of the addiction counselors' narratives through the concepts of critical theory, structural violence, structural stigma, and structural competency. The question was used to evaluate if counselors maintained or mitigated patients' stigmatized identities.

Also in Table 4.2 are sensitizing concepts linking the interview questions back to concepts discussed in the literature review. For example, interview questions listed under Research Question 1 were intended to elicit counselors' beliefs around the role of methadone treatment as either a steppingstone to recovery (abstinence preferred culture) or a means of establishing recovery by itself. Appendix A presents the complete interview guide.

Data Analysis

The data analysis of this phenomenological study was informed by the works of Langdridge (2008) and Oksala (2022). I began with immersion into the qualitative interviews revealing the epoch, or essence (Oksala, 2022), of the experiences of addiction counselors' narratives of their lived experiences of clinical practice in the context of OTPs. After the first three transcripts were obtained, I read them through twice before coding began. During these initial reviews, I documented my reactions to broad segments of the transcripts. Following this review, I went through these three transcripts with an open inductive coding phase to develop the initial codebook. I utilized a concept coding approach (Corbin & Strauss, 1990) to remain close to the participants' meaning and sensemaking of their lived experiences.

To guard against coding bias, I utilized a coding team consisting of a doctoral colleague who recently completed her dissertation work and the RA who conducted internal interviews and transcripts. Each coder utilized the preliminary codebook and independently coded the same three transcripts. Each identified and added codes that were discussed and if pertinent to the research questions were added to the code book.

We achieved over 80% inter-rater agreement during coding phase. On items for which there were discrepancies, we discussed and resolved those. This process established a check for my own potential bias in coding. I reviewed the initial transcripts with the additional codes added to the book and independently coded the remainder of the transcripts.

For the second and subsequent cycles of coding, I utilized an abductive process. Abduction uses both inductive and deductive elements allowing for cycling between data and theory (Pierce, 1903/1978). Using a critical theoretical lens, I analyzed initial coded segments utilizing sensitizing concepts, including power structures, stigma, and recovery orientations, to identify themes of both stigmatizing interactions and mitigation of stigma.

Upon completion of the coding, transcripts of interviews were compared and grouped into categories of most, moderate, and least stigmatizing beliefs, attitudes, and interactions. Demographic data, including age, gender, race, and recovery status, were analyzed to see if there were any trends that appeared associated with stigma.

Quality of Method

Appraisal of the quality of a phenomenological study begins with assessing the study's trustworthiness. While establishing what constitutes trustworthiness in a qualitative study remains debated (Leung, 2015), the criteria defined by Lincoln and Guba (1985) are widely accepted. Components of trustworthiness included credibility, dependability, confirmability, and transferability (Guba & Lincoln, 1994) and were addressed through the following descriptions.

Credibility

Methods to establish credibility, according to Lincoln and Guba (1985), include prolonged engagement in the data, triangulation, and peer debriefing. Each interview was fully read twice prior to initiating coding. Over the course of recruitment through the completion of the interviews, the RA and I debriefed our own reactions to the interviews.

Transferability

One technique to facilitate transferability is thick description of the phenomena (Creswell & Miller, 2000; Guba & Lincoln, 1994). Lincoln and Guba (1985) asserted that the use of thick description is a way of achieving external validity. Using thick descriptions by describing the phenomena in sufficient detail, allows others to evaluate the extent to which conclusions drawn from the researcher "are transferable to other times, settings, situations, and people" (Amankwaa, 2016, p. 122). Thick description, as detailed in the current methodology, includes the use of note-taking during the interviews and journaling throughout the coding process, and in the final document. This allows the consumer of the research to make informed decisions regarding the applicability of this study to their own projects (Merriam, 1995).

The current study is a highly contextualized exploration of the lived experiences of addiction counselors employed at OTPs before and during the pandemic. Additionally, it is specific to addiction counselors working under the regulatory structure within the state of Connecticut. While the study employed methods of thick description, the results may not be suited in states with other regulatory environments.

Confirmability

According to Lincoln and Guba (1985), methods to establish confirmability include utilizing an audit trail, reflexivity, and triangulation. Detailed record keeping of every aspect of the study, as outlined by Amankwaa (2016)., including note-taking and journaling, established an audit trail. Additionally, I utilized a reflexive journal to document methodological decisions and to reflect on my own values and interests throughout the research process, including noting my positionality later in this chapter. This writing process assisted in the identification of my own preconception, values, and assumptions that came into play during the research process (Amankwaa, 2016). Lastly, to ensure confirmability, this study included triangulation of the data. Triangulation is defined as the use of multiple sources to understand the data (Amankwaa, 2016) and was achieved by including multiple people in the process of data coding.

Dependability

The dependability of a qualitative study refers to the ability of researchers to replicate the study. This can be achieved through an in-depth description (Stenfors et al., 2020). Thus far in this chapter, efforts have been made to detail each step that was undertaken in the execution of the study.

Positionality

In discussing their positionality, the researcher delineates, “his or her own position in relation to the study, with the implication that this position may influence aspect of the study, such as the data collected or the way in which it is interpreted” (Qin, 2016, p. 1) within their study (Savin-Baden & Howell-Major, 2013). It influences how research is designed and conducted, its outcomes, and results (Coghlan & Brydon-Miller, 2014) as well as the research project itself (Grix, 2018). In essence, every phase of qualitative research is affected by the researcher's positionality (Coghlan & Brydon-Miller, 2014).

As discussed in Chapters I through III, my experiences as I progressed through my role as a research assistant, clinician, and director employed by an agency with a mission to provide care to individuals with OUD led me to engage in this research. At the center of my experience is witnessing, experiencing, and, unfortunately, secondary to racially driven drug policy, enacting stigma. These experiences shaped my beliefs and values forming my transformative worldview (Mertens, 2007) that centers my research with a social justice orientation.

According to Mertens (2007), the researcher in this context is "one who recognizes inequalities and injustices in society and strives to challenge the status quo, who is a bit of a provocateur with overtones of humility, and who possesses a shared sense of responsibility" (p. 212). The description she provided is both powerful and cautionary. The statement demonstrates the social justice goals of the researcher but also acknowledges the necessity of understanding the responsibility of the researcher and the ethical considerations of the researcher process. It demands that the researcher practice reflexivity and acknowledge and disclose their selves in their research, seeking to understand their part or influence on it (Holmes, 2020).

Reflexivity increased my sensitivity to the ways in which I shaped the design of the study, including the ways in which my prior assumptions and experiences may influence the data collection process.

In this study, I am positioned as an outsider with inside knowledge. While I engage in counseling activities in my organization, as a director, I hold power that is different from frontline counselors. My day-to-day activities provided me with the unique opportunity to influence how our medical team puts policy into action, which directly affects the day-to-day lives of our patients. This is a very different position than that of counselors internal or external to the APT Foundation who may or may not feel empowered to critically examine or consider the consequences of policy actions applied and may simply respond to patients in a more formulaic fashion rather than discuss and review options that may better serve the patient and still uphold evolving policy and regulatory structures.

As a person who previously worked as a frontline addiction counselor, I experienced working within a stagnant and punitive regulatory structure. In my experience of counseling in the context of treatment utilizing methadone, a pitfall is for counselors to become rule focused versus person focused. Pending on the supervisory culture and philosophical climate at an agency rules and fears of risk may take priority over a more patient-centered focus and influence clinical attitudes and beliefs.

My experience as a counselor was before the shifting regulatory climate enacted under COVID-19. What I do not have is the lived experience as a counselor in the current evolving regulatory environment, so I needed to hold caution that I did not bias the data through my own assumptions. The use of bracketing or suspending my assumptions (Lopez & Willis, 2004) in the initial description of addiction counselor experience minimized bias. Additionally, working with a team of coders to review codes and flesh out themes assisted in minimizing bias. Later analysis was informed by my direct experience utilizing a critical lens.

Ethical Considerations

Ethical considerations arise in all phases of a study, from design to reporting (Arifin, 2018; Sanjari et al., 2014). Included in these considerations are “anonymity, confidentiality, informed consent, the potential impact of the researcher on participants and vice versa” (Sanjari et al., 2014, p. 14).

At the outset of my study design, I wrestled with the decision to include participants from my organization. Given the number of OTPs utilizing methadone, finding sufficient participants was not anticipated. Due to my role at the APT Foundation and position of power, the inclusion of counselors within my organization posed ethical challenges. As outlined earlier, my agency is philosophically different from other agencies across the state in that we provide a unique, low barrier to admission and high barrier to discharge orientation. Our philosophical orientation, as such, may influence clinicians' attitudes and differentially orient their beliefs when working with patients and as such, was thought could offer added insight into counselors' lived experiences.

Confidentiality

Confidentiality was assured through a variety of strategies. For the interviews conducted at the APT Foundation, I did not have access to any information that identified participants. The RA held the informed consent and sign-up sheets with the counselors' names in a locked cabinet. Similarly, I retain in a locked cabinet the informed consent and sign-up sheets of participants from organizations other than the APT Foundation. The consent forms will be held for three years as required by federal law and then destroyed.

Transcriptions from APT Foundation employees went through two layers of de-identification to ensure the confidentiality of the participants. The transcriptions were de-identified first by the RA and then reviewed by the study's faculty sponsor as a check on de-identification before the data came to me as the dissertation researcher. For external interviews, I de-identified the transcriptions. De-identifying the transcripts ensures that quotes used from the transcription in the findings and discussion sections maintain confidentiality.

Additional measures to ensure confidentiality included safe storage of all data. Data stored electronically was kept on password-protected systems. Paper files, as mentioned, were in locked cabinets. Only those with the need to access the data were allowed access to electronic information or paper files. Information with names and contact information, such as sign-up sheets, are stored separately from the data and no names are attached to the data.

Informed Consent

Obtaining informed consent involves ensuring that participants fully understand what is being asked of them, are aware of any potential risks of the study, know what is being asked of them, and that they possess freedom of choice to decide on whether to participate (Arifin, 2018).

As part of ensuring the protection of participants, all written materials were submitted to the IRB for review; this included a written script utilized to describe the study to potential participants, a contact sheet for interested parties to note their name to be contacted by the study, and a written description of the study and types of question that could be anticipated. The informed consent form was submitted to the IRB and granted approval. At the time the participant agreed to engage in the interview, the informed consent was forwarded electronically for a request to sign. Once signed, interviews were scheduled.

Potential Impact of the Interview on Participants

During the interviews, addiction counselors discussed their lived experiences of working with clients. This conversation could trigger an emotional response. Prior to the start of the interview, counselors were reminded that their participation was voluntary and that they could end the interview process or decline to answer questions at any time. During the interview process, the interviewers were provided with a respective, professional, and collegial atmosphere. If counselors experienced an emotional response and wanted support, APT employees would be reminded of the availability of the Employee Assistance Program, for non-APT participants, numbers for crisis hotlines would be provided. Additionally, if they expressed ethical concerns regarding the interview, they would be reminded that they could contact the chair of the IRB committee at Antioch University.

Potential Impact of the Interview on Interviewers

The RA and I checked in with each other regularly and debriefed as needed. This afforded us both an opportunity to discuss issues that arose, provide feedback about managing the interview process, and an opportunity to discuss our own emotional responses to the interviews. As part of the data collection, notes were maintained of the debriefing sessions and served as additional information regarding the data.

Chapter IV Summary

In Chapter IV, I have described the philosophical origins of phenomenology and the rationale for the use specifically of critical phenomenology as a methodology to explore the lived experiences of addiction counselors employed by MMTs. As discussed, the treatment of SUDs, and specifically those with OUDs utilizing methadone, are highly stigmatized. The use of critical phenomenology allowed for an exploration of the experiences, beliefs, and attitudes of addiction counselors to identify if they carry and transfer stigma to those they serve. Chapter V details the data gathered from the interviews to identify the themes uncovered in the interview process.

CHAPTER V: FINDINGS

The current study examined the lived experiences of addiction counselors employed by opioid treatment programs (OTPs) providing methadone maintenance treatment (MMT). The study was conceptualized and undertaken because of regulatory waivers enacted by OTPs to reduce exposure to COVID-19. These changes represent a shift away from a punitive system that is more in line with a carceral system rather than a system of care. The United States continues to experience a significant loss of life due to opioid-related overdoses. Agonist therapies, particularly methadone, continue to be underutilized for the treatment of OUD. In response to these crises, the Substance Abuse Mental Health Authority (SAMHSA) proposed sweeping changes to the regulatory structure of OTPs making permanent the flexibilities incorporated during the pandemic and including a dramatic and necessary philosophical shift moving away from criminalizing people with OUD. What follows is a description of the findings of the current study, including an exploration of the demographic data of participants and themes expounded to answer the following research questions:

1. In what way do addiction counselors reflect or mitigate the broader social stigmas around MMT and those who utilize it? And where do those views come from?
2. How does this show up in addiction counselors’ everyday interactions with patients?
3. How did the COVID-19 waivers to MMTs change addiction counselors’ views and practices (or not)?
4. How do addiction counselors’ narratives of interactions with patients maintain the stigmatized identities of patients?

Participant Demographics

The current study's findings reflect the experiences of 26 addiction counselors working in OTPs in Connecticut a minimum of six months before the enactment of COVID-19 waivers through the time of the writing of the findings. Participants were recruited throughout the state; however, only four agencies were represented in the study sample. Participants were predominantly located in the cities of Bridgeport and New Haven (*N*=22, 85%), with two from Hartford and New Britain. Table 5.1 displays the demographic makeup of interviewees, including self-reported gender, age range, highest degree obtained, and reported recovery status.

Table 5.1

Participant Demographics

Demographic Category	Data Range/Category	Frequency *N* (%)
Gender	Men	11 (42)
	Women	15 (58)
Age	20–29	0 (0)
	30–39	1 (3.9)
	40–49	5 (19.2)
	50–59	9 (34.5)
	60–69	10 (38.6)
	70+	1 (3.8)
Race	Black	5 (19.2)
	White/Non-Hispanic	13 (50.0)
	White/Hispanic	7 (27.0)
	Multi-Racial	1 (3.8)
Education	High School	1 (3.8)
		8 (30.8)
		6 (23.0)
		11(42.4)
Recovery Status	Considers self in recovery	11 (42.4)
	Considers self not in recovery	15 (57.6)

In addition to the specific demographic dated collected, three participants noted during the interviews use of MMT to address their personal OUD and another five participants reported that they either had an immediate family member or a significant other who utilized MMT. Other participants who identified as being in recovery commented on other SUDs that did not include opioids.

Participants reported employment histories at OTPs ranging from the minimum required for inclusion in the study of 4.5 years to over 30-year histories of employment as addiction counselors. Ten participants reported over 10 years of working in OTPs. Educational backgrounds varied among participants, including individuals trained in social work, counseling, medical, and substance abuse-specific counseling. Also, when discussing training and education backgrounds, except for one participant, everyone reported learning about methadone regulations through employment at their OTP.

Findings: Research Question 1—Counselors' Reflecting or Mitigating Stigma

The first research question explored how addiction counselors reflect (or mitigate) the broader social stigmas around MMT, those who utilize it, and where those views originated. As a reminder from the literature review, in the United States, stigma towards those who have OUD arises from individuals who maintain power structures, including regulatory systems and media narratives. When OTPs were designed, black and brown people were associated with OUD, resulting in a significantly different regulatory structure established during the current opioid crisis. Since the implementation of OTPs methadone, the use of methadone and those who utilize methadone remain stigmatized by the public and mainstream medical community. A central question of this dissertation is the stigmatization of methadone present among addiction counselors. What follows is a review of their initial experiences with methadone, people who use methadone, and exposure to the regulation of methadone.

Sources of Addiction Counselors' Attitudes and Beliefs

I identified five themes illustrating addiction counselors' orientation or framing of MMT and those who utilize it. The themes include early negative experiences of methadone, abstinence-based recovery orientation, Lack of exposure to methadone, personal history using methadone, and whole-person views. Following the description of the themes, I provide further analysis of the potential relationship of these themes and their influence on the ways addiction counselors reflect or mitigate the stigma associated with methadone.

Early Negative Experiences. Some participants noted negative experiences with methadone or people who utilized methadone before becoming employed at OTPs. These participants typically had family members engaged in MMT or other early experiences with people using methadone. These participants often described negative behaviors exhibited by their family, including the following example from a participant whose uncles utilized methadone.

> From my uncles, I just know that they used to say, "Oh, they sell their bottles," and you know, and stuff like that, you know, when my uncle was there, and they get bottles every weekend, they get bottles and I was like, "What is this?"

In addition to personal exposure to people who utilized methadone, participants discussed experiences during their education, training, or employment experience that disparaged the use of methadone. One participant elaborated as follows:

> I first heard all the negative stuff about methadone and was as a counselor for a long time. I've worked in just about every aspect of recovery along the way, inpatient, outpatient, detox, supportive housing, dual diagnosis, I worked in all those fields. And I never got to methadone. I just didn't want to because of all the stuff I heard about it

Abstinence-Based Recovery Orientation (Versus Harm Reduction Orientation). Participants discussed their own use of substances and recovery journey leading to their pursuit of counseling work. These participants reported that the substances used were not opioids.

> Well, it has a lot to do with giving bac—I am in recovery, I'm an alcoholic in recovery. And when I got through that process, by going to AA and receiving services ....I wanted to go back to school.

Lack of Exposure to Methadone. Participants reported little to no training related to methadone or methadone regulations prior to coming to work in the treatment programs. Secondary to this lack of previous exposure, their orientation occurred within the OTPs where they were employed. As one participant commented. "I answered an ad for a methadone clinic, I had to actually go to the library and look up methadone." Another noted, "I really don't, I just know what was handed down to us, you know, from our administrative staff."

Participants' understanding of the methadone regulations revolved around the need for safety to the public and liability protection of the treatment programs. As one participant stated when responding to the purpose of the regulations,

> Well, I think so the methadone wouldn't be misused. Okay, you know, and, um, and to protect our organization number one .... When they leave, you know, when a patient leaves the clinic, we ask them to have a locked box, they should have a locked box for their bottles and years and years ago thank God nothing happened, but somebody had left their bottles in a cab, that's not good.

In addition to the purpose of protecting others, participants discussed the need to also protect patients from their own behavior.

> Well, I think the rules are to, to keep people safe, you know. Regarding medication recalls, for example, I mean, we have to make sure that our clients are taking their dose, you know, as prescribed, and they are not taking more than they should actually, we had a case where the client had monthly bottles, and she was taking like, like, you know, high amount of methadone every day and then buying on the street, you know, so I think that is very important, because just to, say, to keep our clients safe ....So, I agree with the rules. I started learning about the rules when I when I started working here. And I agree with them it's hard, but I think, you know, is the proper way.

Personal History Utilizing Methadone. As noted in the demographic section, three participants discussed their own use of methadone for the treatment of OUD. Their experiences shaped their orientation and grounding as a counselor in an OTP.

> So, since I knew what methadone was, that was my goal to work in a methadone. Yeah, so I love it. I love what I do. I get very frustrated with the politics a lot of times and not just agency politics, but the overall politics around that around methadone, the discrimination, the stigma, I get very frustrated the way that our clients are treated in different community agencies, including the medical field, I get very frustrated with the way some of our clients are treated by some of the staff here, quite frankly.

Whole-Person Views. A final theme I identified relating to how counselors anchored their beliefs and approach to patients utilizing methadone treatment entailed their views of patients as people. Participants recognized that the people participating in the programs carried multiple identities beyond a person who used drugs. By seeing the whole person, participants recognized the burden of utilizing methadone maintenance within a heavily regulated OTP.

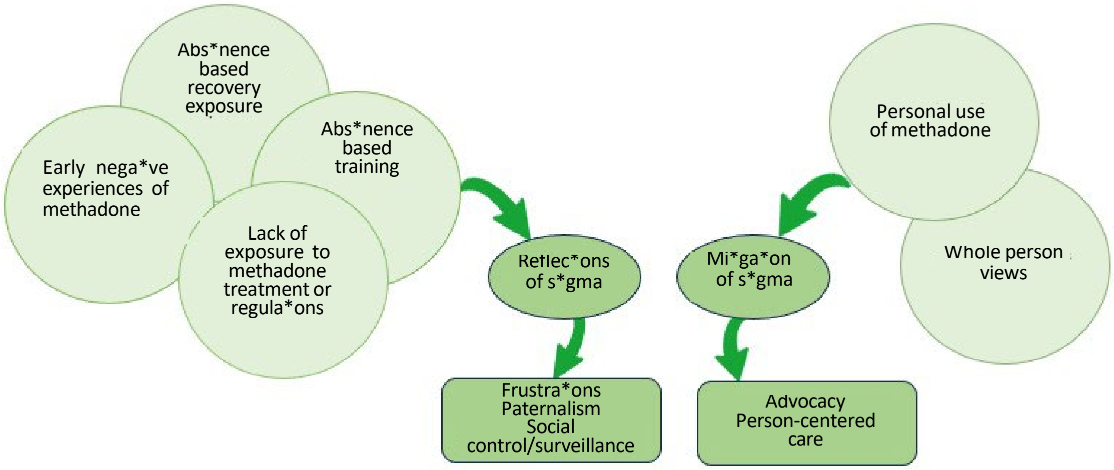
> Yes. For the grace of God, there go I. So that person sitting in the chair, on the side of my desk, I look at them as if that was my mother, my father, my sister, my brother, whoever I love and care about, how would I want them to be treated? If I was sitting there, how would I want to be treated?

Summary of the Origins of Addiction Counselor Beliefs

The above themes describe aspects of experiences and beliefs framing addiction counselors' cultural orientation to MMT. These orientation themes' relationship to themes reflecting the ways in which addiction counselors reflect or mitigate stigma were further explored by examining the frequency of intersecting codes as well as an overall evaluation of the transcripts. The relationship between themes reflecting the origins of counselors' beliefs to themes reflecting/mitigating stigma is depicted in Figure 5.1.

Figure 5.1

Origins of Themes' Relationship to Themes Reflecting or Mitigating Stigma



The themes encompassing the origins of counselors' beliefs associated with stigmatization include early negative experiences of methadone, abstinence-based recovery orientation, and lack of exposure to regulations. The remaining themes contribute to the mitigation of stigma by addiction counselors. Analysis of other demographic data and education did not appear to affect stigmatizing attitudes toward using methadone or people in care.

The above sections describe the origins of counselors' perspectives or cultural orientation towards methadone. What follows is a description of the themes I identified from the coded segments regarding how addiction counselors reflect or mitigate the stigma encompassing people with OUD and MMT.

Themes and Subthemes Reflecting Stigmatization

This section begins with a review of the themes identified on stigmatization. The primary themes identified include frustrations expressed by counselors, paternalistic approaches to treatment, and the need for social control and surveillance. Table 5.2 depicts both the primary themes and subthemes identified.

Table 5.2

Reflections of Stigma: Themes, Subthemes and Examples

THEME	SUBTHEME	EXAMPLE
Frustrations	Harm Reduction is not treatment	Belief harm reduction is enabling illness
	Programs are too lenient	Belief management allows/increases symptomatic behavior
	Patients act-out	Counselors are frustrated and personalize patients' behavior
Paternalism	Belief that methadone should lead to abstinence including withdrawing from methadone	Belief it is necessary to indoctrinate recovery
	Clients need protection	Belief patients are unable to partner in decision making around care
Social Control/ Surveillance	Protecting the Public	Belief patients will hurt other people through diversion
	Holding Accountable/teaching responsibility	Belief counselors must hold patients accountable for their choices
Intervention Stigma	Viewing buprenorphine as a superior medication	Held misconceptions regarding buprenorphine

Frustrations. In interviews, participants expressed three types of frustrations which contribute to the stigmatization of people who utilize methadone and stigma reflected towards the methadone treatment programs. One counselor's comments illustrate the frustration with interventions that encompass harm reduction:

> But unfortunately, now with the harm reduction, what we're doing is we're missing the point. We're not telling you to stop using everything. But we're going to encourage you to cut back; we're going to give you a medication because unfortunately, yes, it's harm reduction. But in the long run, when you continue to use, there are two outcomes. It's
>
> either you get arrested doing something illegal, or you die from an overdose: there is no ifs or buts about it. We know this person is using, but we have to have a plan in place.

The counselor here references enabling patient to continue to use substances. The frustration illustrates the thinking and conceptualization of treatment, which holds an abstinence-based recovery orientation. Keeping to an abstinence-based recovery-oriented frame misses the intention of harm reduction. Harm reduction is to provide a person with whatever tool they need to mitigate the harm caused by active substance use. Simply stated, it is to keep the person alive so that if they choose to move into the recovery process, they can.

Similarly, another subtheme was evident as participants expressed frustrations with treatment programs that chose to be less punitive in practice. Practices included creating systems that improved access and retention, continuing to allow people who use substances to stay in treatment, and practices that recognized that some of the patient's behavior reflected power struggles inherent with required regulatory practices. Overall, less punitive programs reflect an understanding that the people they serve may not have adequate coping skills to navigate punitive regulations gracefully.

The final subtheme reflecting the stigmatization of patients entails participants' frustrations with patients in care. These frustrations often reflect power struggles by counselors with patients who may not want to participate in counseling or frustrations with patients who continue to use substances.

> And all they want to do is dose, they don't want to see a counselor, they don't want, they have too many things in their lives to do. And some of them just, you know, will excuse the French, but bullshit their way as to why they shouldn't be there, or want to have something to do, I got this appointment and all that. So those are the things that are not easy to Deal with. With these clients because some of them feel that's all they want to do come in those out the door, they don't, they don't want any more help. They don't want anything; they don't want anyone to stop them in their tracks for anything.

Paternalism. A paternalistic approach to healthcare is characterized by the attitude of knowing better or an air of superiority by the provider (S. M. Gallagher, 1998). It is an attitude the caregiver expresses as overprotection as opposed to including the patient in the decision-making process (Fernández-Ballesteros et al., 2019). The over-regulated nature of MMT contributes to this attitude. Participants expressed an attitude of over-protection for clients.

> I'm not a cop, I'm not your mother, I'm not your probation officer. This is medication, this is a narcotic. And we're responsible, and that we need to know you're okay. And you're also bringing narcotics home, where a dog, a child, a partner could get a hold of it, potentially, and die.

In addition to expressing an attitude of over-protection regarding the potential harm to a patient, when discussing the perceived benefits of the regulatory structure, participants displayed a doggedness in moving patients into active recovery.

> And you know, the clients come in, they don't have any order in their life. So that helps with the structure, they've got to do certain things to get certain thing, you got to stay clean and sober, which is why you're there in the first place. And then you get rewarded with take home bottles and so forth.

Social Control/Surveillance. As discussed, the MMT is more closely aligned with that of a carceral system rather than of a healthcare setting. Participants reflected these sentiments by their desire to monitor patients to protect the public from harm. One commented,

> I think it's a safety measure that they want to protect the state of Connecticut or whatever state is governing it, I do feel is a safety measure. And, and safety is good. We need it, we need to be able to have some things in place, or we just give out bottles like crazy. And we can't do that because we have to be concerned about the people in general, the community in general also is concerned. So, on a safety measure, I get it, we're worried about the children, we're worried about seniors, we worry about the animals.

In addition to protecting the public, participants asserted agency over patients reflecting a desire to hold them accountable and teach them responsibility. One counselor said:

> One thing I do think that we need to do as for this, to address some of the behaviors that lead to the continued use, I think sometimes we feel so bad about the situation and things are going to that we're not holding them accountable for the behaviors that lead to them continually doing the same things over and over again. And I think we have to find a way to be able to appropriately address those issues, without making the person feel, you know, extremely bad, but they need to understand that these are the things that keep you sick.

Intervention Stigma. Participants expressed stigmatizing views in elevating the use of buprenorphine over methadone. Buprenorphine, like methadone, is an agonist medication to treat OUD; however, it is regulated very differently, leading to many misconceptions regarding the utility or benefits of each. One participant noted, "That involved . . . suboxone, which I actually think . . . it's a nicer drug, but it's for a particular population. Methadone is better for another group of people."

Themes and Subthemes Reflecting Mitigation of Stigma

While reflections of stigma are present in the coded transcripts, so are efforts to mitigate stigma. These themes and subthemes, depicted in Table 5.3 include advocacy and person-centered care.

Table 5.3

Mitigation of Stigma

THEME	SUBTHEME	EXAMPLE
Advocacy	Recognizing/navigating treatment burden	Pushing prescribers for take homes or over-looking rules
	Recognizing stigmatizing behavior in staff	Addressing staff that mistreat clients
Person-Centered Care	Respect for self-agency	Recognizing patient choice
	Embracing harm-reduction	Provides and supports all measures of harm reduction

Advocacy. Participants took on the role of advocacy for patients in the clinic. This was meant either advocating with supervisory staff and/or medical staff to increase the availability of take-home medication or navigating other aspects of regulatory burden on behalf of the patients. One participant reflected,

> I will certainly try to run cover for people. I am not looking to add more difficulties on their already impossible life. I would always advocate for bottle privileges. In the minute they were due, like if they were due weekend bottles, I would have the dates counted down because I know what a jam that is not to have to come down here Saturday morning. I would be very much advocating for bottle privileges. And if for whatever reason they were revoked, I would always run cover- build a good case for them, why they should be just temporarily taken away. I'd certainly be compassionate about that. Not hard-assed about it. Because I don't want to layer more complexities onto people's already difficult life.

In addition to advocating to lessen the regulatory burden for patients, participants also found themselves in the role of advocacy to mitigate stigmatizing acts or poor treatment by fellow staff members.

> Well, they're definitely [taught] to think of themselves as being second class citizens. I had a guy who said the nurse was mistreating him at the window, whatever. And he came up and he was upset, and I sent an email out for on his behalf.

Person-Centered Care. The participants who were able to see beyond the addict identity and embrace a whole-person view more often engaged in a more person-centered care approach. Person-centered care approach incorporates a total person approach (mind, body, soul) and looks beyond the diagnosis with the aim of empowering the person to make self-directed decisions to move towards well-being (Gethin et al., 2020).

> We're so quick to say, “Oh, you know, when I hear the counselor say,” [and] “Oh, he or she ain't got no place else to go. They can wait.” How do you know what she or he got to do? You don't know.” And for the people who have to come here, get medicated and go home and get the kids ready for school and they gotta get ready for work. And they do this all over again.

Summary of Findings Related to Research Question 1

Research Question 1prompted an exploration of how addiction counselors reflected or mitigated the broader social stigmas around methadone and people utilizing methadone and where those views come from. Analysis of the transcripts evidenced multiple types of enacted and perceived provider-based stigma, including stigma towards methadone. The themes reflecting stigma appeared linked to a lack of exposure to the regulations and methadone treatment, early adverse experiences with methadone, and a strong recovery orientation. Analysis of the transcripts also evidenced mitigation of stigma which was most closely associated with the personal use of methadone and a strong whole-person view of patients. Implications of the themes will be discussed in Chapter VI. What follows next is a review of the findings of research question two.

Findings: Research Question 2—Counselors' Response to Stigma in Patient Interactions

In this section, I explore how stigma and mitigation of stigma show up in addiction counselors' everyday interactions with patients. First, I explore behaviors and attitudes that reflect stigma, followed by mitigation of stigma.

Stigmatizing Interactions with Patients

Participants revealed a range of interactions that conferred stigma toward patients. Interactions included engaging in power struggles, characterizing patients, punishment, and shaming.

Power Struggles. Participants revealed engaging in power struggles with patients. As a result of power struggles.

> The clients that are so deep into their addiction, or they're so deep into the all the falsehoods about addiction, and they're just resistant, And that's always difficult. I can be kind of hard-headed like them. So I've clashed a few times with people.

Characterization of Patients. Participants labeled or characterized patients, as seen in the above power struggle, where the participant characterized the patient as resistant. Additionally, participants categorized patients as "deserving" or "not deserving," as well as labeling patients as "clean" or "dirty."

> You know, so, I mean, we have clients who are clean and it's like, okay, well, this person is deserving, where you have this person who's using and even if they had the bottles, but now they're using Okay, so now those bottles need to be taken away, because it's a privilege.

Punishment. The methadone rule structure is a system of punishment. Simply enforcing the rule structure, for example, when a patient submits a toxicology screen that is positive for illicit substances, necessitates a reduction or revocation of take-home medication, is an act of punishing patients for the very symptoms they are in treatment for.

> A lot of the times when you do like, let's say they earn bottle privilege, they feel awesome. They feel like they have accomplished something that they never had accomplished before. And I feel sorry, when they do end up, you know, those that do end up losing it. And I end they, if they lose it, you know, for a positive and I said, Listen, this is not the end of the world. We're gonna get them back.

In addition to the rule structure, participants also invoked punishment in reaction to behaviors.

> Both folks were in a group that they really, really were devoted to. But they had some behavior in the group that I had to pull them up on. And one time I was out of the group, and I think it was, and this was years ago, and it was someone who was new, a new counselor, or she was an intern. And while I was out the story that I got, from her was, the group member just gave her a terrible time. And I, maybe, I don’t know, because he didn’t maybe handle it well, but maybe I could have handled it differently when I came back, you know, in hindsight, but I asked a member to take a break from the group. And there was another incident where another individual was in a group we were doing, I think it was methadone 10 . . . I had to pull them up on their behavior with another staff member.

Shaming. In addition to the above incidents of stigmatizing patients, participants describe using shame as a motivator.

> I was just so that person sat down and I can tell you, they actually looked at me and said “you‘re being an asshole.” I said, “You can‘t call me that.” Next thing you know I was crying. “You can’t call me an asshole.” And he explained, he says, “You have so much potential. And you sit here and you're wasting it,” and I was just like, “Wow, do you see that in me?” And I use that same, that same spiel for my people too.

Summary of Findings Related to Research Question 2

Research Question 2 explored how everyday interactions with patients convey stigma. These interactions included engaging in power struggles with patients, characterizing patients in a demeaning light, engaging in punishment, and using shaming tactics.

Findings: Research Question 3—COVID-19 Waivers' Impact on Counselors' Views/Practice

What follows is a review of the findings on the third research question, which was whether the COVID-19 waivers to addiction counselors' views or not. The emergency waivers granted to OTPs during COVID-19 represented the first significant regulatory changes to MMTs since its inception. The loosening of these regulations, as discussed, was long called for by researchers, patients, and advocates. This change created a natural experiment to test the potential impact of permanent changes on the regulatory structure.

Thus far, the findings highlighted the origins of counselors' beliefs and attitudes, the relationship between beliefs and attitudes to counselors' reflection/mitigation of stigma, and how stigmatizing attitudes are reflected in everyday practice. What follows is an exploration of counselors' experiences under the relaxed regulations and if their practices changed. Two significant areas of change allowed for under the waivers were the implementation of telehealth and the relaxation of access to take-home medication.

Telehealth

OTPs, for the first time, were able to implement telehealth counseling. Individual sessions were permitted through telephone and video formats. Group sessions were only permitted in video format. Participants discussed a range of experiences and views with telehealth as now discussed.

Discomfort with the Practice of Telehealth. Participants expressed discomfort and ambivalence toward the use of telehealth. They recognized that some of their discomforts were in the newness of the practice.

> Telehealth is . . . it's great for some people and then and you got to understand the majority of us were not experienced being a telehealth provider prior to this. I know it existed, but it wasn't something that we were truly experienced. And you know, we would we obviously talked to talk to them over the phone, but it's not like a full-on session.

Additionally, participants expressed concern feeling that the remote sessions were less impactful than in person sessions.

> I mean, it does a little bit because when you're on the phone with somebody, you can't see their reactions. You can't see their body language. It's very easy to just give one word answers to all the questions. I'm sure what they're when you're sitting in front of somebody, it's different. You want to elaborate. It did change it, change how we interacted in that way, the sessions weren't as robust anymore. You didn't get as much information from them.

Participants also expressed concern that they could not see the patients diminishing their ability to assess the patient.

> I would say yes, I would say yes, it did change interactions, as well. Well, it's different when you speak to someone on the phone versus when you speak to them in person, you know? Because to me when you speak to talk person face to face, you're looking at them, you know, versus on the phone, they can hide stuff from you over the phone, they can say anything on the phone, you know. But you know, everything can be hunky dory where, you know, you're talking to them on the phone. And when you're facing them, that's, that's totally different. You know, I have more to say, you know, when you're facing them, or sometimes they don't have that much to say it all depends.

Experienced Positive Changes with Telehealth. Participants also recognized positive changes associated with increased flexibility and accessibility for patients using telehealth.

> And it really kind of made our relationship smoother . . . just having someone that they can talk to I think that that was a huge benefit. I think that helped build the relationships. I think it made people closer I think they felt heard and that their needs were met.

Participants also noted that because of patients being away from the clinic and being in more control of when and how they engaged in counseling sessions changed the quality of patient engagement.

> And we started, you know, being able to do our sessions via telehealth, which was something completely different. You know, I noticed that some of my clients were more confident to share over the phone. Yeah, not . . . not all of them with some of them. Nothing changed. But the I noticed that some clients, instead of 30-minute sessions session, they stay one hour on the phone, you know, and telling you about all the problems and this and that. So, I think telehealth help a lot.

In addition to patients' engagement in counseling sessions, participants recognized using telehealth sessions, the quality of their interactions changed.

> I felt like I somehow, for some people, the conversations felt more casual because we're on the phone. And so it wasn't that I was disclosing, but it was more I was and they were in their home. And, they had to know I had an animal. But you know, and I learned more about what was going on with them. Like the client that had the mental health, he was telling me about all these foods, he's cooking and recipes, and, and sharing things about what he was doing at home. So, I was learning. In some ways, there was some more personal connection, which was kind of a weird thing, but it definitely occurred, you know, so it would have been almost like a balance of both.

Counselors had a range of experiences associated with the implementation of telehealth ranging from concerns regarding the ability to appropriately monitor and assess patients to experiencing a more personal, whole-person-centered session. The range of experiences associated with relaxed guidelines for take-home medication was similar.

Take-Home Medication. As a result of COVID-19, SAMHSA issued emergency orders relaxing provisions in administering take-home medication of methadone. Regulations previously were tied to the length of treatment and eight-point criteria, including no recent drug use, lack of behavioral problems at the OTP, absence of criminal activity, and stable social relationships. As an example of the stringent nature of time in treatment criteria, patients were not afforded any take-home medication during their first 90 days of treatment. Additionally, patients could only earn up to a week's worth in the first nine months of treatment. The relaxed provisions removed the time in treatment requirements, changing the language to reflect assessed stability in treatment. For example, individuals deemed "stable" could receive 28 days of take-home medication, and those who are "less stable" could receive up to 13 days of medication. For those that were unstable, it was up to the discretion of medical personnel to determine if any take-home medication would be given. Counselors as with the provision of telehealth, expressed mixed experiences and desires related to take home medication.

Fears. Participants noted concerns regarding people who decompensated during the pandemic. They attributed some of the health decline to increased freedoms and decreased scrutiny by OTPs. When discussing family members that utilized methadone, they noted,

> They were doing great before COVID. COVID allowed them to have monthly take home bottles when they weren't supposed to. They went from healthy. And it bothers me, because I understand that we tried to do what we could for the clients, and to make things better for everyone. But they gave him them an opportunity to go do whatever they wanted. If that's happening with them, imagine how many other clients that happened to—"I don't have to report. All I got to do is go pick up my bottles. Oh, they're not watching. They're not supervising urines?" So COVID changed that a lot.

Ambivalence. Participants expressed that the increased access to bottles posed an adjustment to how they approached their work. The change increased anxiety while still giving them an opportunity to re-evaluate their work.

> Well, I had to change my approach. I used to be I used to be very, I am very concerned about safety and risk. And, and I've had to kind of be more open to Okay, well, there's not too much we can do when somebody leaves this building. Whether they whether they sell their bottles, whether they drink them all like that's out of our hands and you know, I had to work through that those own challenges and I'm just do the best I can when I meet with people to check in and assess. I think I may be a little more lenient around bottles, again, assessing for safety.

Open to Increased Take-Home Flexibility. As one participant asserted regarding the relaxed guidelines for take-home medications, "I believe they should stay exactly the way they are right now." Participants believed that having access to take-home medication increased their overall motivation to engage in the recovery process.

> We had clients on bottles, take home bottles, that helped a lot of the clients out a lot to take home bottles, being able to take home, their bottles not being in the clinic very often, you know, from what I saw, some of them didn't use as much or they stop using and they were more into their recovery because they didn't have to come to the clinic daily. So if you come into clinic three times a week, or maybe twice a week, you know, that that's a plus for them, you know, and that helped them out.

Summary of Findings Related to Research Question 3

Participants expressed various experiences and views associated with telehealth and increased take-home flexibilities. These views included concerns and fears about continuing these new practices—many hoped that telehealth and flexibilities with take-home medication would remain. Similarly, participants acknowledged shifts in practice around engagement with patients related to their comfort level with telehealth and facilitating access to take-home medication. These changes also were influenced by organizational views and practices associated with the provisions. Some participants noted a return to the old practice, and others continued to engage and champion the new regulations.

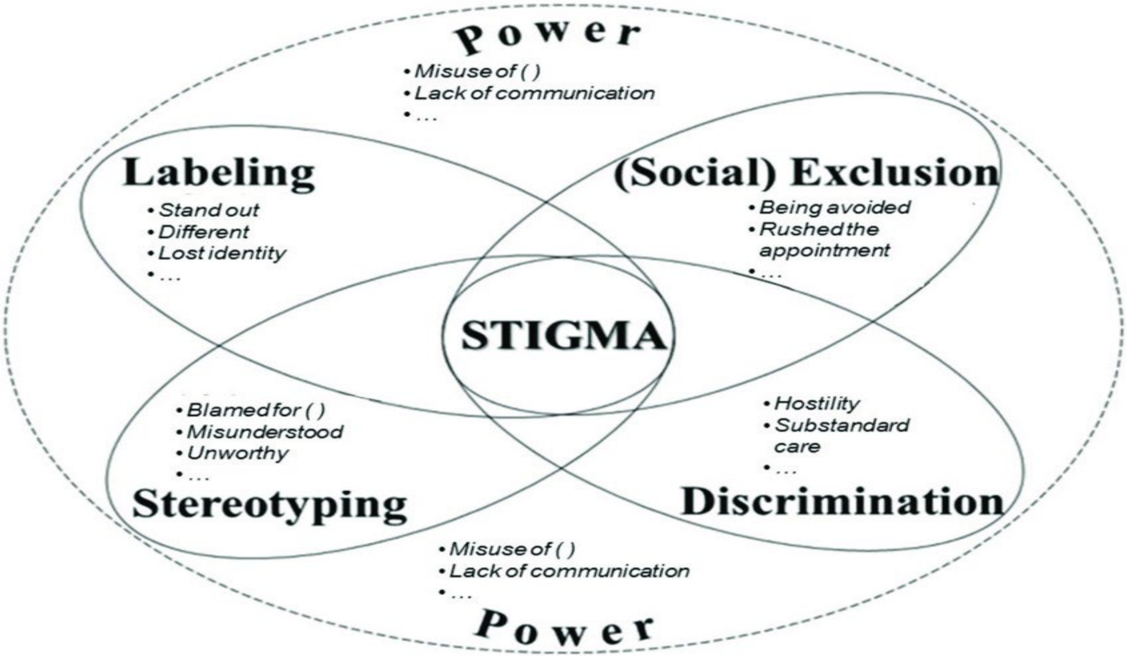
Findings: Research Question 4: Counselor Interaction Narratives and Maintaining Stigma

Thus far, I have reviewed the origins of views associated with stigma or mitigation of stigma, how addiction counselors reflect or mitigate stigma, and the impact of COVID-19 emergency waivers on addiction counselors' beliefs and practices. Next, Research Question 4—how addiction counselor narratives of interactions with patients maintain the stigmatized identities of patients—is now explored.

Utilizing a critical lens, Research Question 4 probes how addiction counselors' narratives of interactions with patients maintain stigmatized identities. Stigma is a socially constructed phenomenon maintained and reinforced through policy structures and carried out through clinical practices. Stigma is conveyed through labeling, stereotyping, exclusion, and discrimination. Figure 5.2 depicts how addiction counselors maintain the stigmatized identities of patients.

Figure 5.2

How Counselors Maintain Their Identities



Note. From "Stigma of Addiction and Mental Illness in Healthcare: The Case of Patients' Experiences in Dental Settings," by M. A. Brondani, R. Alan, & L. Donnelly, 2017*, PloS One*, *12*(5), p. 6 (https://doi.org/10.1371/journal.pone.0177388). Copyright 2017 by Brondani et al. Creative Commons Attribution (CC BY) license

Stereotyping

Common Assumptions or Stereotypes of People With OUD. Participants expressed a range of stereotypes regarding the people they cared for, including the following.

> I think structure is good. And, and I think a lot of lot of them lack structure. I think the more lenient we are on them, the less structure there isn't in life, and I feel they just become wild, you know, they do what they want to do.

The depiction of the wild patient separates patients from society, reinforcing the root image of an addict out of control. The propagation of this image necessitates the counselor to provide structure and apply disciplinary power as described by Foucault (1977). One participant observed:

> Like, the clients sometimes say that all you guys manipulate me with the bottles. It’s like I’m being controlled. No—and I said, “Listen: these bottles don’t belong to us, and they don’t belong to you. It belongs to the state, you know. They're . . . it's a federal guideline that we have to abide by. We’re not punishing you. And, and I always tell them, and I said, Listen, in your house, you got rules, right? Everywhere you go in life, it there’s rules—we have to follow them.

Exclusion

Participants engaged in acts that excluded patients from activities. As described earlier, one member noted,

> Both folks were in a group that they really, really were devoted to. But they had some behavior in the group that I had to pull them up on . . . but I asked a member to take a break from the group.

Participants also banded together when applying an administrative action as in the denial of take-home medication or reduction in take-home medications. This action served to deflect the decision-making authority to the collective staff so as to push away any reaction by the patient.

> I don’t know to say this, but you know how clients can be manipulative? They can manipulate. So, if I have a rapport with a client and I say, no man, I can’t do this. And they go, “No, that's just you, you don't want me to do this.” Then I usually point to somebody else who sits in the meeting and say, “This is why you shouldn't do that.”

Discrimination

Operating in the regulatory structure of methadone requires addiction counselors to distinguish some groups of patients from others. Participants characterize patients with language including “deserving” and “not ready.” The following participant labels and discriminates groups of patients as “responsible” or “irresponsible.”

> People have to have to earn the privilege to progress in the program, they have to, they have to show that they are responsible enough to take care of this powerful, powerful medication, people can die from it.

Through discrimination, counselors asserted that use of disciplinary power both protects the patient and provides motivation.

> And then to give them some motivation to work toward earning some, as we call it, the COVID bottles. And so now, "if you're able to maintain those, good, then maybe, you know, in a while you can earn another bottle." I see it as a motivation, you know, a motivational piece. Recognize that we're protecting you [the patient] too.

Labeling Staff and Programs

Also of significance was staff labeling other staff with such terms as "enabling" or "being passionate." In the example of the participant below, this staff member is labeled, separated, and discriminated against by other staff for his work as an advocate for patients in situations where flexibility can be provided to the patient.

> Well because even though we were going to close like I say you don't understand this guy missed two days. He's gonna go out there and use, you got to medicate them. Nope- they got to be on time I already closed the window. My supervisor wants to tell me Al you have to stay in your lane. You have to stay in your lane because even today, I advocated strongly for the client. I mean, sometimes when were in the meetings other clinicians go all right Al it gets to a point where I work should I work harder than the client, which I do look at that. I do, I do realize it and I look at it, because you know, I don't know some people say I'm that encouraging bad behavior. Other people say that I'm passionate. It's a fine line to walk.

Participants also labeled programs, characterizing them as "lenient" or "chaotic."

Summary of Findings Related to Research Question 4

This section has described several ways that participants stigmatize patients. Their narratives of interactions demonstrated acts of labeling, discriminating, applying power, and isolating or excluding patients. Stigma is also applied to programs that attempt to mitigate regulatory burdens and embrace harm reduction strategies. Additionally, there is evidence that counselors who attempted to mitigate the regulatory structure and for programs that incorporate less punitive harm reduction approaches are stigmatized.

Chapter V Summary

This chapter discussed the analysis of 26 interviews with addiction counselors employed by OTPs utilizing MMT to answer the following questions:

1. In what way do addiction counselors reflect or mitigate the broader social stigmas around MMT and those who utilize it? And where do those views come from?
2. How does this show up in addiction counselors' everyday interactions with patients?
3. How did the COVID-19 waivers to MMTs change addiction counselors' views and practices (or not)?
4. How do addiction counselors" narratives of interactions with patients maintain the stigmatized identities of patients?

Thematic analysis of the transcripts reveals patterns reflecting both stigma and mitigations of stigma. The origins of their beliefs and attitudes appear to be associated with the participant cultural orientation of methadone treatment, including their recovery status, previous negative experiences with methadone, personal use of methadone, and absence of exposure to methadone regulation before employment.

As a result of COVID-19 emergency waivers, OTPs could relax the punitive structure of MMT. These measures, though temporary, were the first substantial changes to the regulatory system in over forty years. This natural experiment allowed practitioners in OTPs, including addiction counselors, to change how they operated and interacted with patients. Analysis of the transcripts suggests a substantial range of reactions and experiences associated with implementing telehealth and relaxation encompassing take-home medication. Participants'views on the regulatory changes ranged from significant fears to ambivalence and welcoming change. In addition to the range of opinions regarding changes, participants discussed some positive changes associated with their views, including more "leniency" in supporting patients receiving take-home medication and how they interacted with patients during telehealth sessions.

Lastly, transcripts were analyzed to explore how addiction counselors' narratives maintain the stigmatized identities of people with OUD. As described above, participants engaged in labeling, stereotyping, discrimination, and exclusion of patients. These acts are components of stigmatization.

Personal Reflections on the Findings

As noted throughout the dissertation, I am a long-time practitioner and manager of an OTP utilizing methadone. As a practitioner, I am not immune from engaging in any of the beliefs, attitudes, or actions described by the participants. When I came to work at an OTP, I had no experience with methadone or the regulatory system encompassing the treatment. I am not someone who identifies as a recovering person. I am someone who, over the years, intentionally sought knowledge and education based on science regarding the rule structure, allowing for my practice to evolve accordingly.

I would consider myself a champion of the changes under the emergency waivers. However, I also have moments of hesitancy and uncertainty with my actions- am I doing the best for the patient now? Will my actions contribute to the patient being hurt or dying? The ambivalence I describe is juxtaposed with a desire to reduce the stigma applied to the people under my care. In the upcoming chapter, interpretations and implications are explored.

CHAPTER VI: CONCLUSION

Despite being one of the most effective treatments for OUD, MMT remains under-utilized by people who would benefit. The restrictive and punitive framework, coupled with stigma, remains a critical factor in the underlying treatment gap (Cheetham et al., 2022; Wakeman & Rich, 2018). At the heart of MMTs are addiction counselors. They are charged with upholding a regulatory structure constructed to monitor and control people with OUD. The current study aimed to examine the narratives of lived experiences of addiction counselors employed by OTPs to investigate if and how they enacted or mitigated stigma towards their patients and where their views of MMT originated. The study additionally examined if the evolving regulatory environment and lived experiences with those changes altered addiction counselors' views of or shifted their practices with MMT. A critical phenomenological methodology was employed to explore addiction counselors' experiences to answer these specific research questions:

1. In what way do addiction counselors reflect or mitigate the broader social stigmas around MMT and those who utilize it? And where do those views come from?
2. How does this show up in addiction counselors' everyday interactions with patients?
3. How did the COVID-19 waivers to MMTs change addiction counselors' views and practice' (or not)?
4. How do addiction counselors' narratives of interactions with patients maintain the stigmatized identities of patients?

As a reminder, the historical roots of MMT were closely tied to Black, inner-city communities. The dominant power structures of the United States explicitly designed MMTs to monitor and control a racially depicted group of people who needed care (Hansen & Roberts, 2012). This regulatory structure starkly contrasts the system of care enacted for the current opioid crisis, which was perceived to impact White, often suburban young men described as "the new face of addiction" (*Fox News* as cited in Netherland & Hansen, 2016, p. 665).

CRT examines how the social construction of race and institutionalized racism perpetuate a racial caste system. It is a system that relegates people of color to the bottom tiers of society, including in healthcare systems. An essential concept of CRT is "intersectionality," which recognizes that race intersects with other identities, including sexuality, gender identity, and, relevant to the current study, people who use drugs. CRT acknowledges that racism remains enmeshed in the American fabric (George, 2021). Racism is a fundamental cause of health inequities.

This study provided an exploratory evaluation of the intersections of culture, regulatory structures, and racism in the context of the substance abuse treatment system of the United States The findings shed light on counselors' beliefs and attitudes, contributing to our understanding of the impact of the intersection of hegemonic cultural values and structural racism in undermining the health of PWUDs with OUD.

Essential concepts to understand this study's findings include structural racism, structural stigma, critical race theory (CRT), and intersectionality. Structural racism and structural stigma are racism or stigma that is codified by laws and policies (Jackson et al., 2022). CRT, originating in legal scholarship, asserts that the color-blindness of the law actually normalizes and perpetuates racism by ignoring the structural inequalities engrained in our social institution (Delgado & Stefancic, 2023). It examines how the social construction of race and institutionalized racism perpetuate a racial caste system in a system that relegates people of color to the bottom tiers of society, including in healthcare systems. An essential concept of CRT is intersectionality, which recognizes that race intersects with other identities, including sexuality, gender identity, and, relevant to the current study, people who use drugs. CRT acknowledges that racism remains enmeshed in the American fabric (George, 2021). Racism is a fundamental cause of health inequities. These concepts provide an essential framework in understanding the implications of this study and necessary future studies.

Analysis of 26 interviews of addiction counselors employed at OTPs in Connecticut revealed evidence of stigmatization towards people who use MMT and the treatment itself, thus illustrating the influence of a racialized system of care. An examination of participant demographics and recovery status suggests that stigma towards PWUDs remains culturally entrenched, even among counselors passionate about providing care to those with OUD. Culture is the mechanism by which race and other identities are constructed and takes on meaning (Griffiths et al., 2010), as this study's findings suggest, as an essential factor that may contribute to the health and wellness of people utilizing MMT.

Presently, legislation is being reviewed that potentially will make permanent some of the regulatory changes afforded by emergency waivers granted during the COVID-19 pandemic which provided more flexibility and less daily patient surveillance in use of MMT. These regulatory changes begin to unravel structural stigma and structural racism. While not explicitly noted in the language of the law, these changes incrementally address racialized aspects of care by substantially reducing the treatment burden and decreasing some of the criminalizing elements of care. The proposed changes shift from a carceral system of care to one centered on clinical decision-making and patient wellness. The proposed legislation explicitly recognizes research that demonstrated that these flexibilities facilitate access to treatment and significantly eliminate criteria that promote stigma and discourage people from accessing care from OTPs (Health and Human Services Department, 2022)

While these regulatory changes represent an opportunity for enhancements to clinical practice, secondary to deep-rooted cultural attitudes and beliefs, the findings of this study suggest that counselors are not prepared to embrace these changes fully. What follows is a discussion of the intersection of the cultural orientation of counselors, compelled by a punitive regulatory system enacting macro and micro-levels of stigma on people utilizing MMTs. I will discuss potential theoretical connections, limitations of the current study, as well as considerations for future studies. In addition, I will discuss the implications of these findings for policy and practice to reduce the culturally entrenched stigma of addiction, even among counselors, to enhance care for people utilizing methadone.

Synthesis and Interpretation of Results for Research Questions 1 & 2

In this study counselors evidenced both enactment and mitigation of stigmatization, sometimes simultaneously. Broad themes in the data reflect stigma around MMT among counselors, including frustration, attitudes of paternalism, and feeling compelled to surveil patients' behaviors. Some participants expressed these reflections of stigma through mechanisms of labeling of patients, power struggles, punishment, and shaming. Alternatively, other participants mitigated stigma through their advocacy efforts and adopting whole-person views of patients.

The stigmatization imposed by study participants poses implications concerning how the treatment is conceptualized and administered with pronounced consequences to patients. The beliefs and attitudes of addiction counselors' views reflect a war on drugs racially biased culture designed to segregate people labeled as "other" by the White, male, able-bodied, and financially secure dominant class. Embodied by the counselors, the cornerstone of MMTs was historically built on and maintained by structural and institutional racism. MMTs, siloed from traditional medical practices, is a system that reinforces racial inequalities through both cultural processes and power structures. As illustrated in the upcoming sections, these processes and structures interact, creating stigma and limiting life opportunities for people utilizing MMT, including restricting access to work, disrupting social relationships, and accessing equitable healthcare (Earnshaw et al., 2013).

Interpretation and Implications of Participants' Frustrations

Three sub-categories comprised the theme of frustration: counselors' frustrations towards the programs, frustrations with clients' behaviors, and frustrations encompassing harm reduction. Participants conveyed frustrations with treatment programs that embraced harm reduction orientation, characterizing programs as "too lenient" and saying that patients "act out." In essence, participants felt that programs not upholding a strict rule structure were enabling what they typified as patients' bad behavior and continued use of substances.

MMT was established as a culturally racist system. Cultural systems of racism maintain the social conditions that shape racial inequities in health through policy, decision-making, practice, and perception (Cogburn, 2019). As part of these systems, cultural processes "automate racially biased beliefs, discriminatory messages, and behavior" (Cogburn, 2019, p. 744). The expression of frustration by counselors in this context is a frustration towards programmatic policies that were moving away from what have long been the established norms of an abstinence-based/recovery-oriented cultural system, that emphasized social control. The frustrations expressed by counselors towards programs is an expression of resentment towards facilities moving away from the long-standing normative structure framing people with OUD as deviants. The counselors' expressed frustration represents hegemonic values that stigmatize and marginalize PWUDs and, as such, are expressions of a structurally racist system of care.

Counselors' characterizations of and framing of programs improving practices to improve people's health with OUD is alarming and is in opposition to best practice research. OTPs are long criticized by patient advocates and the research community for administratively discharging patients from treatment. Such discharges entail a rapid tapering from methadone, putting the patient into opioid withdrawal. Reasons for administrative discharge may include continued substance use, behaviors associated with active use, or issues with service payment. Premature discharge from OTPs substantially harms the person with OUD, including death (Davoli et al., 2007; Woody et al., 2007). Based on best practices established by research, some programs have embraced low threshold programs (Working Group on Best Practice for Harm Reduction Programs in Canada, 2013). Low-threshold programs continue to treat people despite ongoing substance use and behaviors associated with continued use, such as emotional dysregulation and impulsivity. Research consistently demonstrates the benefits of harm reduction measures (Stancliff et al., 2015); however, harm reduction measures and programs that embrace them remain outside the typical and historical normative structure of MMTs.

Despite the documented evidence of harm reduction through managing addiction with medication like MMT rather than complete abstinence as the only version of SUD recovery, counselors do not fully embrace these practices. As typified by one participant's statement, "Because we treat our patients so good that, yes, we make them comfortable, and they just get comfortable. And they just don't do anything; it just comes back to the harm reduction."

There is a common mythology amongst the Alcoholics Anonymous community, the public, and abstinence-based treatment communities that someone with SUDs must experience the consequences of their addiction. In this example, the participant sees harm reduction as a threatening treatment fabric. In making an individual "comfortable," the program is not allowing a recovery process to begin. Making a person with addiction feel the consequences of their addiction is considered "tough love" (Earnshaw et al., 2013) and necessary, for some counselors, as part of their role in facilitating recovery for PWUDs.

Similarly, another participant noted, "I think that meeting a client where they're at is beneficial, but with that being said, I think there's a fine line between harm reduction and enabling." While seeing some benefit of harm reduction practices in treatment, this participant does not embrace the full range of life-saving practices secondary to it being outside of the normative cultural experience of MMTs. This attitude expressed by participants of the current study is consistent with other research on healthcare professionals who work with PWUDs that finds a negative attitude toward harm reduction is closely aligned with abstinence orientations (Aletraris et al., 2016; Javadi et al., 2022).

Counselors' stance on harm reduction measures and programs that embrace harm reduction practices reinforce multiple levels of stigma directed at the patient and organization attempting to reduce treatment barriers. It represents structural stigma/structural racism, which fuels multi-layered or intersectional stigma by labeling some patients or programs as good or bad. Counselors are social actors of MMTs who are influenced by culture but also shape and re-create culture through their beliefs, attitudes, and behaviors (Griffiths et al., 2010). Counselors, in this instance, are framing as "bad" the patients or programs that operate outside of expected cultural norms, exacerbating and, in so doing, exacerbating stereotypes. It is clear, though, that a lack of willingness to shift these normative (i.e., stigmatizing) cultural perspectives around MMT and fully adopt harm reduction practices into our system of care will result in more preventable deaths.

Despite attempts by some organizations at the program level to create low-threshold programs, the rule-driven nature of MMTs continues to center the counselor as a disciplinarian. Participants in the current study held views emphasizing the necessity of the rule structure, viewing them as essential elements in the counseling process. For example, participants said, “The regulations helped me do my job” and “I’m good at sticking to my guns.” These participants feel empowered by the rule structure, and enacting these structurally racist regulations uphold the cultural norms of the White, dominant class.

While the regulatory structure of methadone reinforces the counselor’s role orientation as a disciplinarian, counselors additionally are trained primarily with an abstinence-based recovery orientation (Dodes & Dodes, 2015; Duryea & Calleja, 2013) born out of the self-help group Alcoholics Anonymous (AA) and its spin-offs. AA’s cultural framework espouses Christian values and suggests that the “addict” will have a spiritual awakening whereby god would alleviate them of the ills of substance use (Dodes & Dodes, 2015). AA is a step-based program based on “suggestions” to achieve abstinence. Language within the rooms of 12-step meetings and the language of participants in this study characterize patients as “not ready” to engage in the recovery process. The characterization of “not being ready” separates the patient from those deemed “ready,” code for worthy or unworthy. For example, one participant referring to patients noted, “You got to be clean and sober, that’s why you came here in the first place.”

As exemplified above, counselors’ consideration of some patients as deserving and others as “not ready” or undeserving underscores the multiple layers of the intersectional stigma that people utilizing MMT face. Participants continue to frame some patients as deserving and others as not. Research indicates that people in diverse settings who encounter intersecting stigma may experience negative impacts on their physical and emotional health (Turan et al., 2019). For people who utilize methadone, the varying attitudes of counselors may contribute to less empathetic counseling or supportive interventions leading to premature discharge for some. Additionally, the person who used MMT or knew of someone who experienced stigma at the hands of counselors further fuels intervention stigma, that is, a stigma levied at the medical intervention itself (E. F. Madden, 2019) and, in so doing, decreases the likelihood people who would benefit will seek it out.

Interpretation and Implications of Paternalistic Attitudes

Participants expressed a range of paternalistic attitudes and behaviors towards people who use drugs. Paternalistic attitudes and behaviors, like the expression of counselor frustrations, are a symptom of the cultural structure of MMTs. The example expressed above by the participant labeling the patient as not being ready, in addition to being an expressed frustration by the counselor, additionally espouses a paternalistic attitude whereby the counselor knows what is best for the patient.

People who utilize methadone enter treatment for a host of reasons beyond the goal of abstinence or recovery. Motivations may include escaping criminalization and reducing exposure to harm (Frank, 2018; Mateu-Gelabert et al., 2010). People utilizing methadone, for example, may stop using opioids; however, they may not be interested in ceasing cocaine or other substances. Others may not intend to stop opioid use and simply be looking to avoid experiencing withdrawal. Secondary to being in a treatment setting, my experience is that many patients are not empowered to express their true treatment motivations and goals. In practice, the attitude expressed and potentially enacted during counseling sessions by the counselor above is an exertion of power silencing the patient.

In the public realm, marginalized social groups often face problems of representation (Herzog, 2018). The silencing of these groups, and as relevant to this study, PWUDs, worsens dehumanization and suffering through the exclusion of decision-making processes. This exclusion typically occurs communicatively (Habermas, 1984) or discursively (Foucault, 1971) produced mechanisms in processes of public communication and are forms of silencing or making that group invisible (Herzog, 2018).

Recently the Urban Survivors Union Methadone Advocacy and Reform Working Group, which consists of researchers and advocates with lived experience utilizing methadone, issued the Methadone Manifesto (Simon et al., 2022). They presented a scoping review of the literature related to the harms of policy and regulation of MMTs interwoven with examples of lived experience to advocate for reform in the historical moment of potential regulatory change to MMTs. They highlighted that treatment planning is intended to be a counseling process whereby the patient discusses their personal treatment goals. The counselor and patient, in theory, through a shared decision-making process, establish objectives and interventions as to how the patients' goals will be achieved. The reality this group reveals—and I also have seen this in practice—is that counselors pre-emptively prepare a plan that the patient is asked to sign regardless of patient input (Simon et al., 2022). This silences the patient and makes them invisible.

Secondary to an inability to be comfortable in openly discussing their motivations become an issue of social justice (Herzog, 2018). It diminishes the patient and a willing counselor's ability to explore harm reduction measures (Simon et al., 2022); as such, it diminishes the life chances of patients who use drugs. Additionally, the resulting dance between patients unable to define their treatment goals and counselor perceiving and enacting stigma creates environments positioned for power struggles. One participant, noting his frustration with paternalistic values, stated, “I can be kind of hard-headed like them. So, I’ve clashed a few times with people.”

In this example, the participant utilizes what Foucault (1977) described as disciplinary power. The counselor is defining clients who may be responding outside of expected norms, as resistant to interventions. This gives the counselor the authority to “clash” with the patient to get their points across. Also of concern, some participants suggested that patients are sometimes inadequate as partners in decision-making, describing them as “resistant,” “defiant,” or “too deep in their addiction.” Furthermore, counselors expressed steadfastness in moving patients to abstinence, inconsistent with the patients’ own goals. Such attitudes contribute to alienating or shaming patients. Paternalistic approaches to care that espouse a philosophy of “We know, you don’t” (Fernández-Ballesteros et al., 2019) in the context of the opioid crisis, contribute to decreased access and retention in the use of MOUDs (Blanco & Volkow, 2019).

A scenario that frequently occurs is a counselor refusing patient requests related to their dose. The counselor may feel that the patient is not appropriate to have their dose increased because of their use of other substances or because they believe the patient is already on too high a dose. A patient may not want their dose increased for various reasons. However, as this participant described,

> I always tell my clients, you know, when they don't want to increase the dose, or blah, blah, blah, I always tell them, you know, “Just think about it, you go to use drugs, instead of having a proper dose, you know, at least with methadone,” because they said, however, methadone is another drug. So, I always tell them at least methadone is a prescribed medication.

Paternalistic stances, as illustrated above, discount patients’ experiences and goals, potentially a form of silencing patients. The disparity between the counselors’ goals and the patient's goals may aggravate the patient's frustration, resulting in them precipitately leaving treatment. Paternalistic attitudes do not support best practices espoused by the Institute of Medicine's (2001) recommendation for chronic disease management.

Interpretation and Implications of Social Control

Participants discussed the urgency of monitoring patients. The need to surveil patients often incorporated the discourse of holding patients "accountable" or keeping patients and others "safe." Surveillance or control of patients centered both on protecting the public and the need to protect the patient from themselves. One participant noted, "Methadone, because there's the implications of methadone. I mean, it could be dangerous if it got out on the street."

Similar fears arise with patients' ability to care for themselves and, when in doubt, necessitate close monitoring. As one participant stated,

> We had to do it. "Do not take methadone with benzodiazepines because you can overdose, you know, we're not gonna give you a bottle because you're gonna die. Right?" We're directly responsible for that; we have to control it.

While it is true that methadone in the wrong hands can lead to an overdose, most diversion of methadone centers on "indigenous harm reduction strategies" (M. Harris & Rhodes, 2013, p. e43). These strategies include the diversion of methadone, which can consist of holding doses for days if that the person cannot get to the clinic or is selling to another individual who may not wish to enter treatment. A significant concern related to the relaxation of guidelines for take-home medication was the increased availability of methadone would lead to an increase in overdose deaths associated with methadone. Rates of deaths related to methadone have remained stable since the waivers went into effect (Brothers et al., 2021; C. M. Jones et al., 2022).

As previously discussed, the positioning of addiction counselors as disciplinarians shackles MMT to the power structures of a carceral state (Bourgois, 2000; B. L. Stanley & Basu, 2023). The stigma expressed and enacted by addiction counselors within the regulatory system of

MMT amplifies the identity of the person utilizing methadone as the deviant addict (B. L. Stanley & Basu, 2023). It simply does not reflect best practice interventions afforded to people utilizing mainstream medicine.

Personal Reflections on the Stigmatization Processes

Analysis of the narratives provided by addiction counselors suggests the origins of their beliefs, feelings, and attitudes are closely rooted in a culture born out of the “war on drugs” ideology that elevates an abstinence, recovery orientation of care (Frank, 2020). It is a culturally racist system of care intended to focus efforts on monitoring and controlling a deviant population historically tied to the Black community. Participants who conveyed stigma embodied and enacted the cultural norms through expressions of frustration, paternalistic attitudes, and exertion of social control.

The origins of addiction counselors’ beliefs and attitudes in the current study appear to be connected to early negative experiences with methadone, abstinence-based recovery orientation, and lack of exposure to methadone. Counselors, as social actors, are integral to creating and reinforcing the racially stigmatized system of MMT. Beliefs are reinforced by their negative (and positive) experiences of methadone and the people who were using it. Additionally, training systems that emphasize abstinence-based approaches and elevate abstinence as the goal further shape counselors’ beliefs and influence their actions. Equally significant is the lack of exposure addiction counselors had to MMT regulations before being employed as providers of methadone. The lack of education encompassing the historical roots of MMT is an enactment of power through normative silence. Participants said they had had little formal education regarding methadone and were oriented to the rule structure of the clinics where they were employed. As a counselor who came to the field devoid of knowledge about methadone or methadone regulations, my cultural orientation hinged on the perspective of the organization's leadership.

As the organizational leadership evolved, so did my practices and cultural orientation to MMT and the people I serve. Earlier in my career, my opinions and attitudes that caused stigma towards people with OUD and MMT were no different from those described in the present analysis. My shift in thinking occurred because of my willingness to question practices and outcomes of the practices on the people I served: People were leaving treatment. People were incarcerated. People died. These losses occurred because of the specific practices upheld by the treatment systems intended to support well-being and recovery.

My evolution in practice occurred through a recognition that the system is broken. Additionally, as I discussed in Chapter I, my organization was fortunate enough to have had a change in leadership. As a result of a progressive new leader, our organization evolved, creating a low-barrier treatment system. We created a system of care that minimized administrative barriers to admission, maximized patient choice of counseling modalities, and embraced harm-reduction practices eliminating punitive discharge practices. While such systems have evolved, not all counselors have adopted our more whole-person, harm-reduction philosophical stance or practices. The findings of the current study shed light on the stigma brought about by counselors and the origins of those beliefs as entrenched in hegemonic cultural values that are mutually reinforced by a punitive regulatory system. These findings reflect the theoretical constructs of structural racism/stigma, intersectionality, and disciplinary power. However, additional theoretical constructs may offer additional insights into counselors' reluctance to change their beliefs and attitudes.

Interpretation and Implications of Mitigation of Stigma

Participants who could see beyond the addict identity of the patient and instead recognize the whole person were more likely to engage in behaviors that decreased stigma, emphasizing a person-centered approach. These efforts respected patients' self-agency. One participant posed critical questions inspiring their approach to counseling: "What gives you meaning? What do you want to do? How do you want to proceed?" Another participant emphasized the individual needs of patients:

> I try and find every way to work with them to get a work around to meet their particular needs. And even though it's the rules, I want to . . . you know . . . find a way to make the rules work for them. So, if you need to come in at six o'clock in the morning today, and three o'clock in the afternoon, tomorrow, I'm going to work with you.

Also, participants who had personal experience utilizing an MMT as part of their own journey had unique insights regarding the needs of patients.

> So it isn't that I'm an inspiration cuz I got out, but . . . they teach me more than that, because, you know, just seeing them. I mean, every day dealing with their challenges, and staying engaged, and medication. That's a lot of people, people sometimes don't realize what it takes to be in a methadone program.

Each of the participants can recognize the unique and whole person they are caring for and, in so doing, acknowledge that persons need to pursue their needs and life as they choose independently. The participants also know the unique challenges imposed by the regulatory structure on the people utilizing services and suggest partnering with them to best support the patient's goals. Participants who mitigate stigma embrace PWUDs' right to self-determination.

One study of interest related to this finding is from Gwadz et al. (2022) who highlighted the relevance of self-determination theory in the framework they created to promote health and wellness among Black men with HIV. *Self-determination theory* is a macro theory of human motivation that recognizes the innate and fundamental need for autonomy, competence, and connection to others (Gwadz et al., 2022). The theory simply stated is that people need to feel in control of their own decisions and goals, be afforded the ability to master skills, and have a sense of belonging to others. The most willing and robust forms of motivation arise when each of these qualities arises. Self-determination theory asserts that if any of the above needs is hindered or obstructed in the social context it will have a detrimental effect on wellness (Deci & Ryan, 2008).

As noted in the examples above, within a challenging regulatory framework the participants strive to recognize and support their patient's autonomy. They see the unique person and recognize the confines and intentions of a regulatory structure that diminishes autonomy and, in so doing, assists the person in navigating those challenges. The attitudes and stances of these participants are starkly different from those who value and embody the mechanisms of control imposed by the regulatory structure.

In addition to these participants' recognition of the need for agency, they also value and employ a person-centered approach. The National Institute of Medicine (2001) urged healthcare providers to offer person-centered services. Two essential elements of person-centered care include individualizing health services to patient needs and treating the whole person rather than just the disease (Balbale et al., 2015). The participants above demonstrate the person-centered approach by recognizing the person's unique challenges and thus offering flexible treatment options.

Participants who engaged in stigma mitigation were more likely to embrace the scope of harm reduction practices as part of allowing self-determination for patients. One participant commented, "So really, it's to give them support and keep them alive for another day till they can have those conversations and that lucidity."

A recent study explored people with OUDs ideal treatment system. One component of that perfect treatment system incorporated the full range of harm reduction practices, including tools and resources to limit the use and syringe exchange (Andraka-Christou et al., 2021). Participants of the current study embraced person-centered approaches; one stated,

> Everyone's reasons for being in a program like methadone are all different. I mean, people can get methadone just because they want to reduce the amount of money they're spending on heroin. So, like, everyone's thoughts behind it vary.

In valuing and respecting each patient's unique treatment goals and right to self-determination, counselors were more likely to encourage the full scope of harm reduction measures. As one participant stated, "I feel that clients come to you. You have to meet them where they are . . . harm reduction. What do they need right now? Help the client make it through their day safely."

Personal Reflections on Mitigation of Stigma

Participants who were able to mitigate stigma in the MMTs were individuals who held whole-person views of the patients they cared for or had personally utilized methadone. They appeared to recognize everyone's need for self-determination respective to their wants for that person's life. They more fully embraced the elements of person-centered practices described by the Committee on Quality of Health Care in America, Institute of Medicine (2001) as demonstrated in their advocacy in assisting patients with harm reduction tactics and navigating the rule structure.

The exploration of both stigma and mitigation of stigma, and where those attitudes and behaviors arise from when examined through the theoretical lens of structural racism, intersectionality, self-determination theory, and harm reduction as a movement offers insights into potential interventions at the programmatic level that may unravel the long-standing cultural norms of MMPs. The current study highlights the cultural underpinnings of MMPs, specifically how counselors embody and react toward their patients because of racially created and institutionalized culture. Currently, the federal government is standing on the precipice of change, necessitating the leadership of MMT need to be readied to support and empower change.

SAMHSA recognizes the imperative need to address the rule structure which fuels structural stigmatization of the use of methadone and the people with OUD (Health and Human Services Department, 2022). Embracing a holistic, person-centered approach within a rigid rule structure may increase patient engagement; however, exploring and understanding the range of experiences by counselors charged with implementing the loosened regulations offers opportunities for leadership interventions.

The emergency waivers issued during COVID-19 provided a natural experiment by allowing MMTs to implement telehealth and relaxed guidelines towards take-home medication. For the first time in the history of MMTs, clinical judgment guided the application of the rule structure; however, were counselors ready to embrace these temporary guidelines?

Synthesis and Interpretation of Research Question 3

To offset the risk of infection from COVID-19, SAMHSA allowed states to adopt temporary waivers that included telehealth and relaxed guidelines in providing take-home medication. Connecticut fully embraced these waivers. While some states chose to adopt measures guided by their unique philosophies, programs further interpreted the waivers. Under medical providers' direction, counselors implemented this guidance into practice.

As a long-time program director, I found it hard to contain my enthusiasm for implementing the new measures. I understood that the intention was to reduce the risk of contagion from COVID, but I also knew these changes could be game changers. I met with our medical director for guidance; I was even more delighted to hear them tell me I was being conservative in my thinking. I quickly adapted my views and have not looked back. My clinical approach has changed dramatically and unaltered over the course of the pandemic and through the writing of this dissertation. What I found is that I am a bit of a unicorn. Each of the agencies outside of the APT Foundation began to roll back practices allowed under the emergency waivers. Some, for example, re-instituted supervised urine testing or moved to reduce or eliminate flexibilities in the provisions of take-home medication. Even within my agency, while I was steadfast in my practice, other supervisors and clinical directors reverted to more conservative clinical practices.

Participants in the study, some of whom work within my agency—a low barrier MMT —expressed ambivalence in using telehealth and increasing access to take-home medication. As seen above, some participants voiced trepidation in using telehealth, being unable to fully monitor patients, while others found their sessions more engaging. Similarly, participants voiced varied thoughts and feelings about the increased flexibility of take-home medication.

Word choice by participants who were more reluctant to issue take-home medication centered on whether patients “deserved” take-home medication based on “accountability,” “responsibility,” and “safety.” These participants believed that take-home medication was a “privilege.” On the other hand, participants who were more open to giving take-home medication spoke of “flexibility,” embracing the notion that patients could self-manage outside of the clinic.

The trepidation and resistance to implementing the waivers suggest how far-reaching and engrained the regulatory structure combined with a culture created to segregate the other influences clinical judgment and thinking. That resistance remains despite programmatic philosophies to embrace change is a further suggestion of the seemingly insurmountable force of an abstinence-based, recovery-oriented command and control demonstrated by counselors providing treatment for OUD.

Shifting the regulation did allow for some counselors to test their perceptions. As one participant commented,

> I had to change my approach. I used to be, I used to be very, I am very concerned about safety and risk. And, and I've had to kind of be more open to . . . Okay, well, there's not too much we can do when somebody leaves this building.

While others remained steadfast with their convictions that "it's a privilege" and take-homes "need to be earned." For some participants in the current study and others working in MMT nationwide, COVID-19 and implementing emergency waivers are what Mezirow (1991) referred to as a "disorienting dilemma." A disorienting dilemma is a crisis that triggers a questioning of assumptions that may transform beliefs and allow for new meaning-making of that experience (Mezirow, 1991). Some participants begin, as above, questioning their need (and ability) to control patient behavior. In so doing, an opportunity arises by which long-standing normative behavior and values can be questioned and potentially changed.

The opioid epidemic has not abated. Overdose deaths continue at high levels, disproportionately affecting Black and Brown communities (James & Jordan, 2018). Since implementing the relaxed regulations, researchers have fervently studied the impact of these changes. A recent meta-analysis of these studies (Krawczyk et al., 2023) noted that while many providers embraced the flexibilities, many also expressed concerns that the increased flexibilities would lead to patient destabilization and an increase in "undesirable patient behaviors" (Krawczyk et al., 2023, p. e241).

As noted in Chapters I and II, I am employed by an agency that is progressive in its stance towards reducing the treatment burden for the people we serve. Despite our overarching philosophy, among counselors and the range of clinical staff, hesitancy to change remains.

Cultural orientation and institutional stigma appear to have deep-seated roots. These entrenched roots pose a significant concern in our ability to re-wire the experience of MMT and better attract and retain people in care; however, there also appear to be, as will be discussed, opportunities to challenge and unravel long-standing norms.

Synthesis and Interpretation of Results for Research Question 4

The aim of the current study, utilizing a critical lens, was to explore addiction counselors' framing of interactions with patients and their beliefs about the people using MMT and the treatment itself. My analysis of the findings uncovered evidence of both stigma and mitigation of stigma primarily influenced by the counselor's cultural orientation towards PWUDs and MMT.

The study explored addiction counselors' meaning-making of interactions while leveraging the rule structure of MMT. The narratives show the reinforcing nature of a punitive rule structure, guided by, and implemented under the war on drugs as a mechanism of social control. The MMT system was established to disenfranchise PWUDs who, at the time of initiation, were more closely associated with People of Color. MMT was established not as a program of wellness but as a racially biased system meant to monitor and control people with OUD. To date, it is a system linked to minoritized persons who use drugs compared to the White-privileged treatment protocols created for the "new face of addiction" in the current opioid crisis.

The participants' descriptions readily show the repercussions of these policy structures and cultural influences. Despite their passion for the work and concern for the people they care for, addiction counselors echo the stigma and normative biases established in the regulatory system and reinforced by culture. These structural impediments of stigma are particularly evident in counseling interactions among people with OUD who may not be interested in achieving abstinence, suggesting that intersectional stigma is levied on those who continue to use substances. The presence of these intersecting stigmas suggests that the most vulnerable people to the ills of substance use are more disenfranchised by counselors and, as such, may be more likely to leave treatment.

In 2020, fueled mainly by the influx of fentanyl, there were over 100,000 people lost to overdose deaths (CDC, 2021) and death rates are not declining. Pharmacological treatments for OUD, particularly methadone and buprenorphine, are highly effective in reducing the risk of overdose (Santo et al., 2021) but remain grossly underutilized. In the United States as of 2020, only 311,000 people received methadone (SAMHSA, 2022), less than 5% of the estimated 7.6 million people with OUD receive care (Krawczyk et al., 2022).

The COVID-19 epidemic provided an opportunity to move barriers, including political willpower, to implement these changes. These changes may be a step to improve access and retention in the use of MOUDs. The opioid epidemic shows no sign of slowing, and People of Color are disproportionally affected by overdose deaths. Between 2013 and 2017, deaths from synthetic opioids other than methadone increased eighteenfold among Black people and twelvefold among Hispanic people compared with a ninefold increase among White people (Spencer et al., 2019). MOUDs not only provide a path to wellness and health but protect people who use opioids against the risk of overdose (Davis & Carr, 2019).

While the agonist MOUDs are lifesaving medications, they remain underutilized among Black and Brown people with OUD (Stein et al., 2018). As discussed throughout this study, methadone was established as a criminalized modality of care as a mechanism to control Black and Brown heroin users. While methadone was “designed” to address the use of this population, the stigma and high burden demand of methadone treatment contributes to low access and retention of use in Black and Brown communities. Access to the less stigmatized medication, buprenorphine, is more difficult to access in Black and Brown communities. Barriers include lack of prescribers in these communities and insurance barriers (Lagisetty et al., 2017; Stein et al., 2018). The lack of access to and retention in the use of these medications poses substantial, and disproportionate health risks including the increased risk of death to Black and Brown PWUDs.

While SAMHSA is considering making permanent regulatory changes that improve access and retention to the use of both MOUDs, it is essential to consider if regulations that remove long-standing structural policies that have created and maintained racial disparities in health, go far enough. For example, one study recommended the loosening of methadone regulations and considering creating access to office-based methadone long utilized in other countries (Andraka-Christou, 2021). In addition to continuing to examine and challenge macro-level impacts on racialized drug policies, studies need to be implemented examining programmatic practices that improve access and retention to MOUDs for Black and Brown PWUDs. I will discuss this further when describing my ideas on needed further research.

The current study explored the beliefs and experiences of addiction counselors providing methadone treatment, highlighting the structural and cultural barriers imposed on people utilizing treatment contributing to premature discharge. Counselors, much like the public, embody socially constructed beliefs and attitudes regarding people with OUD and reinforce the stigmatized identities of people with OUD through their interactions in the treatment setting.

An interesting theme that I found was that some counselors stigmatized other counselors and treatment systems who attempted to decrease treatment burden by characterizing them as enabling use. This stigma suggests the relative strength imposed by the racially-culturalized systems that filter through educational and training systems, creating a hegemonic-normative treatment structure. My study also demonstrates that while changing the punitive regulatory structure is necessary, those changes alone will not alleviate the long-standing shadow of stigma enshrouding MMT.

Throughout my training and in subsequent supervisory sessions, I often heard language promoting the idea of the "addict" needing to "hit rock bottom" and that people needed to feel the "consequences" of their actions. Training systems sorely lacking any orientation around methadone coupled with punitive regulatory system till now reinforce stigmatizing beliefs and attitudes. They force counselors to act without partnering with the client when determining what will promote health and well-being. Even as SAMHSA acknowledges, the burden-laden system that fuels stigma towards people with OUD and MOUDs, addiction counselors largely remain entrenched in their convictions.

While demonstrating the presence of stigma, the data of this study also evidences potential opportunities to mitigate stigma, mainly through promoting whole-person views, increasing counselors' understanding of the regulatory structure, and intentionally hiring counselors with personal experience with methadone. The themes generated that reduce stigma and broader considerations regarding policy change suggest opportunities for future studies.

Study Implications and Recommendations

The present study elucidates the complex interactions of hegemonic cultural beliefs and values with the punitive regulatory framework of OTPs. These systems operate to create and maintain a structurally racist system of care. Culture and policy structures work in a reciprocal fashion imposing stigma on PWUDs, particularly those who use opioids, in a system where race has been used to define who is deserving of medicalized care and who is deserving of criminalization.

CRT provides a necessary lens through which policymakers, educators, and members of the healthcare system can examine and challenge long-standing, racist power structures inherent in the United States substance use disorder treatment system. The beliefs and attitudes of addiction counselors brought to light in this study's findings reflect the systemic punitive, racialized system of care. The findings of this study, taken together with research contributing to the development of this study, demand a call to action from policymakers, educators, OTP managers, and clinicians to address healthcare disparities contributing to the ongoing loss of life and the resounding implications of those losses on our society. Based on my research I now recommend specific action steps for policymakers, healthcare educators, and opioid treatment programs and counselors

Recommendations for Policymakers

I call on policymakers to intentionally and persistently engage with researchers who have laid out a vast body of recommendations to deconstruct war-on-drug policies that continue to harm people disproportionally based on race and other marginalized identities. Measures include challenging the United States preference for abstinent-based treatment and embracing the range of harm reduction practices and treatment approaches embraced by other nations. For example, Canada, Europe, and Australia allow for methadone to be accessed both in specialized clinics and in pharmacies (McCarty et al., 2021) as well as expediting regulations and payment structures that allow for the use of mobile methadone (Buning et al., 1990; Joudrey et al., 2021). Policymakers have the ability and responsibility to implement the regulatory changes to allow for the implementation of these innovations. The use of pharmacy-based methadone and mobile methadone units has been demonstrated to increase access to methadone and potentially reduce stigma to the use of methadone. As these enhancements to access methadone are employed, researchers will need to examine strategies that break barriers among Black and Brown people who distrust the use of methadone. Partnering, for example, with initiatives that have expanded access to buprenorphine in Black and Latinx communities (Bellamy et al., 2021) and bringing mobile methadone to identified churches may enhance access and patient choice of MOUDs.

In addition to re-imagining and changing the OTP model, regulators at the federal level must gain the willpower to embrace the full range of demonstrated harm reduction practices including safe consumption sites (Yoon et al., 2022) and syringe service programs (Jarlais et al., 2015). Lastly, federal lawmakers must take the bold step to de-criminalize drugs. Mass incarceration of predominantly Black, Brown, and impoverished people who use drugs remains a scandal in the United States

Additionally, OTPs in the United States are often run as for-profit entities. While these agencies have provided life-saving medications to people who are able to utilize these systems, individuals with a lack of access to insurance or insufficient financial resources to access care likely disadvantage Black and Brown people who would benefit from methadone. Regulatory structures that incentivize not-for-profit agencies to open low-barrier clinics or other strategies that challenge the insurance and for-profit industry are needed.

Recommendations for Healthcare Educators

The findings of this study point to the necessity to recruit, train, and retain people who look like the community they serve. Recruitment needs to include not only people of color but people who have (or continue) to utilize MOUDs in their own care. People who utilize MOUDs, in my experience, face barriers to education secondary to policies or practices suggesting individuals who identify as in recovery cannot be actively maintained on a MOUD and provide treatment. These practices elevate, in my opinion, continue to elevate abstinence-based treatment preference and stigmatization of the use of MOUD.

Recommendations for Opioid Treatment Programs and Counselors

As a long-time manager of an OTP and as reflected in the findings of the study, I have seen clinical staff reinforce and perpetrate stigmatizing actions and attitudes both directly in our interactions with patients and indirectly in demeaning language that we use in our records and other communications. As managers, we need to address this directly in supervisory sessions. As clinicians, we need to hold each other accountable and call out stigmatizing behaviors that disenfranchise the people in our care. Additionally, as program managers, we can take steps in our hiring practices to create a care team reflective of all the identities we serve.

This study reflects the collective structural forces created and reinforced at every societal level. The implications of counselor stigma are, as stated, a single symptom with wide-ranging implications. In addition to this broad discussion of implications raised by these findings, specific directions of future research are discussed below.

Study Limitations

Although this study contributes to the understanding of how addiction counselors perceive and enact stigma and where those beliefs arise from, several limitations to this study warrant consideration. One limitation of phenomenological designs is that there is no clear method or formula for conducting a study and as described by Dukes (1984), is more a perspective on what constitutes knowledge in understanding humans. I employed a critical phenomenological design that allowed for the interpretation of the data utilizing sensitizing constructs from theory and my socio-cultural experience in analyzing the transcripts. While I used multiple coders in the analysis process and remained close to the original transcripts in interpreting the data, my insight may reflect my cultural bias.

Phenomenological studies are not intended to produce theory or to be generalizable across populations. The purpose is to uncover lived experience of a phenomenon in a place and moment in time (Oksala, 2022). The purpose of this study was not to generalize findings across counselors or treatment populations, or to broader populations, but to shine a light on the perspectives of individuals providing frontline care to individuals with OUD with the intent to improve clinical practice and engagement. Counselors' experiences in OTPs in Connecticut may not be generalizable to counselors in other regions. Further, while I made efforts to draw my sample from a broad range of clinics in Connecticut, I could not recruit counselors from the full spectrum of OTPs in the state. Given that the findings did not appear to be influenced by clinic culture, as evidenced by counselors from the more progressive system expressing the same beliefs and attitudes as those from more conservative systems, additional insights might have been gained with broader inclusion. However, the power of the social stigma of methadone may outweigh the organizational culture of programs in influencing counselors' perspectives on MMT and the patients who receive it.

As an additional consideration in the study design, I sought to include participants who had experience with the regulatory structure before the start of the pandemic through the time of recruitment. As a result, participants were long-term employees and, as such, may have had different training and cultural experiences than counselors who are newly engaging in the field. Investigating the perceptions of counselors who have been more recently trained and hired by OTPs is one area of future research.

Lastly, confirmation and interpretation of transcripts were not reviewed with participants. This decision was made secondary to the sensitive and complex nature of the interpretations and to ensure the timeliness of completing data collection and analysis. While this level of review poses a limitation, thematic saturation was obtained in the 26 interviews helping to provide trustworthiness of the data.

Directions for Future Research

This study is one of the few that explore the experiences of addiction counselors employed by OTPs. To my knowledge, it is the only study exploring how counselors perceive and enact or mitigate stigma in the counseling relationship, which warrants future research. In the face of the ongoing opioid crisis, an increased understanding of the complexity of the interaction of racially biased, normative cultures, regulation, and stigma encompassing MMT and the people who utilize it offers potentially life-saving insights to increase engagement in treatment.

Recommended Research for Enhanced Understanding of Addiction Counselor Stigma

Additional studies are needed to validate perceived and enacted stigma by counselors working in OTPs in varied geographic regions, along with the inclusion of newer counselors with a more diverse range of work and training experiences. Such studies may elucidate additional regional or cultural differences, further enhancing our understanding of the scope of the nuanced effects of stigma.

Recommended Research on Intersecting Identities of Patients

My findings suggest that knowledge regarding methadone treatment, the historical implications of policy, and the impact of regulations is all but absent in education and training curriculums. Additionally, the themes generated here point to the need to better understand intersecting identities of people utilizing treatment face differing stigmatization by addiction counselors.

Increasingly, there are calls for clinical science to embrace and center social justice, intersectionality, and diversity within clinical work, theory, and research (Buchanan & Wiklund, 2020). My study suggests not only education and training gaps regarding the socio-historic background of methadone, but also indicates the need for increased attention to identifying treatment barriers and retention gaps based on community-level data. For example, as discussed, Black and Brown people with OUD are less likely to utilize and be retained in either agonist MOUD. The availability of methadone is concentrated in urban, lower-income, Black and Brown communities. The clinic that I manage, for example, is in the heart of an impoverished, Black and Brown urban area. Nationally, Blacks are more likely to use methadone more often than buprenorphine secondary to policy construction, insurance, and access (Andraka-Christou, 2021). Interestingly, the patient census at the APT Foundation (2023) comprised just under 22% of Black patients.

This disparity raises several important considerations. We have made concerted efforts to improve access and retention to treatment through policies that reduce treatment burden and embrace harm reduction; however, have we and others neglected considering the complexities of intersecting identities? Is racial bias perpetuated at the clinic level? What would anti-racist outreach and treatment look like?

I have pointed out earlier that CRT provides an essential lens to examine the impacts of proposed and enacted policy changes to ensure that race and other marginalized identities benefit from these changes and are not left in the margins. In critically examining and questioning who would benefit from policy change, inequities in healthcare can be removed. For example, does specifically examining/addressing race or other intersecting identities in treatment outcome data, only recreate similar hegemonic-value-based clinical judgments in our clinical interactions? Have we inadvertently reinforced negative racialized stereotypes? It is known that People of Color are more likely to experience unstable housing (M. M. Jones, 2016) and unemployment (Bureau of Labor Statistics, 2018). In applying the regulatory structure of MMT, these two factors—unstable housing and unemployment—would lead to decreased take-home medication schedules, increasing the burden of treatment.

The disparities in the numbers of Black and Brown people engaged in treatment within an inner-city clinic demand an examination of clinic practices that may be contributing to the lack of access and retention of services. As the regulatory structure evolves, clinical judgment is relevant in deciding who receives take-home medication, and as such, what steps are needed to that mitigate structural disadvantages. Additionally, drawing from the success of researchers such as Bellamy et al. (2021), studies examining the implementation of mobile methadone and pharmacy-based methadone and that are culturally responsive may offer opportunities to engage Black and Latinx communities.

Recommended Research for Counselor Education and Practice

The current study offers insights into addiction counselors' beliefs, attitudes, and behaviors toward MMT and people utilizing it. Future research must include testing training and educational modules for counselors within existing OTPs (and beyond) to create a new cultural orientation that acknowledges and addresses a criminalized, racialized system of care. Gwadz et al. (2022) put forth one potential theoretical framework that may be beneficial in addressing the systemic issues embedded in OTPs. In their recent study, workers sought to improve engagement in care with Black and Brown people living with HIV. The population they looked at significantly overlaps with the populations utilizing or would benefit from methadone. Gwadz et al.'s framework integrates the theoretical concepts of CRT harm reduction, and self-determination theory.

CRT aims to illuminate racial phenomena, expand public health discourse about the social effects of structural racism, and challenge racial hierarchies (Delgado & Stefancic, 2023). Behavioral interventions generally cannot change structural or systemic factors; however, they can acknowledge and seek to circumvent structural racism and barrier to health outcomes (Gwadz et al., 2022).

Harm reduction is not only a specific intervention to reduce the negative effects of drug use but is also a social justice movement built on respect for the rights of PWUDs. The strategy establishes a perspective that allows counselors to work together with PWUDS on their goals to reduce the harm of drug use embracing self-determination (Gwadz et al., 2022). While not explicitly discussed in training, self-determination theory is an essential underpinning of the motivational interviewing (Gwadz et al., 2022), an evidence-based practice widely used in the treatment of SUDs.[1] It is intended to be a collaborative counseling approach to promote behavior change that elicits patients' values, perspectives, and questions and identifies ambivalence to foster motivation to change (Vansteenkiste et al., 2012). Education linking these theoretical frameworks with relevant interventions would offer participants a socio-historical context and targeted person-centered interventions for people with OUD in an evolving OTP structure.

In a similar vein, the underlying assumptions of *structural competency*—which strives to instill an awareness of the socio-cultural and institutional structures that impede our healthcare

---

[1] Gwadz et al. (2022), explain *motivational interviewing* as "an evidence-based directive and collaborative counseling approach for behavior change that elicits participants' values, perspectives, and questions, identifies ambivalence and discrepancies, and corrects misinformation with permission, to thereby foster durable intrinsic motivation and readiness for change" (p. 6).

systems (Hansen & Metzl, 2016)—coupled with the concepts of *cultural healthcare capital* (Shim, 2010)—which draws awareness to unconscious, habitual schemes of perception, thought, and action—may also offer insights into further training interventions.

Training that employs techniques derived from the above theoretical concepts may increase the collective consciousness of counselors of the historical and cultural roots of MMTs and those who utilize them. However, changing healthcare systems is challenging (Berwick, 2003). Stigma encompassing SUDs remains persistent and challenging (Kelly et al., 2015; Zwick et al., 2020). To date, based on the literature review provided in Chapters II and III, while there is a solid understanding of how micro and macro stigma impact people with OUD, minimal comprehensive inroads have been made to reduce stigma.

Additionally, addressing stigma reflected among clinicians may prove challenging. As such, a change management approach may be beneficial to address clinic-level outcomes. For example, early in this study, I discussed a “plan, do, study, assess” method utilized by my organization to improve overall access to care (L. M. Madden et al., 2018). We were quite successful in addressing targeted issues to enhance care. Utilizing these interventions while attending to structural racism and stigma may be beneficial.

Concluding Thoughts

Momentum continues to gain in the public because of increased awareness drawn from 50 years of research documenting the ill effects of the U.S. war on drugs–specifically, the war on some people who use drugs. As a result of the opioid epidemic, so many lives are needlessly lost daily. In part, the loss of these people rests in the hands of policymakers, who until now have not had the political willpower to change the MMT regulatory system. Methadone treatment is one of the most researched applications of any medications. In the United States, despite this vast knowledge base, methadone remains one of the most poorly understood and most stigmatized treatment interventions. As a colleague and mentor of mine frequently states, “It’s methadone, not plutonium.” It is a medication that saves lives.

Even as SAMSHA moves to change the regulatory system and potentially position providers to improve treatment and partner with patients, stakeholders are jockeying to limit access to both telehealth and take-home medications while others are calling for a complete dismantling of MMTs. The system needs to be completely overhauled. There is a wealth of information from other countries that have less restrictive access to methadone, including hybrid models utilizing both dispensaries and pharmacies. These show positive patient outcomes. For the first time in my career, I am optimistic that the Federal Government will make a significant step to move the system where it needs to go. This includes recent federal policy change allowing for the implementation of mobile methadone (El-Sabawi et al., 2021) increased enthusiasm examining the benefits of pharmacy-based methadone, and at the state level, increased implementation of overdose prevention and safe-consumption sites. Most importantly, while my research shows some mechanisms by which counselors unintentionally engage in stigmatizing practices, it also sheds light on potential paths to move forward.

In closing, I cannot emphasize enough that the stigmatizing attitudes, beliefs, and behaviors discussed in this study reflect complex forces. Each counselor I interviewed and all counselors I work alongside daily, believe they are doing what is right and just to promote health and well-being among their patients. Over my career, there is nothing that was said by a counselor documented in these transcripts that I, too, did not think or say at some point. It reflected my training; it reflected my experience.

Counselors can be helped to increase self-awareness of their perspectives and support them in making positive changes. People with lived experience utilizing MOUD can be actively and proactively invited to the table. The pandemic was a disorienting phenomenon and may serve as a significant catalyst for change to the treatment systems, specifically for those with OUD in the United States. Researchers, practitioners, and policymakers hold the knowledge and tools to create an anti-racist substance abuse treatment system that promotes dignity and well-being to all PWUDs who may or may not be ready, willing, or able to move towards abstinence. As a professional who has dedicated her career to working with people with OUD, the current study offers me the next steps as I promote programmatic change.

References

21st Century Cures Act of 2016. Pub. L. No. 114-255. 130 Stat. 1033 (2016). https://www.govinfo.gov/content/pkg/PLAW-114publ255/pdf/PLAW-114publ255.pdf

Aagaard, J. (2017). Introducing postphenomenological research: A brief and selective sketch of phenomenological research methods. *International Journal of Qualitative Studies in Education*, *30*(6), 519–533. https://doi.org/10.1080/09518398.2016.1263884

Aarons, G. A. (2004). Mental health provider attitudes toward adoption of evidence-based practice: The evidence-based practice attitude scale (EBPAS). *Mental Health Services Research*, 6(2), 61–74. https://doi.org/10.1023/B:MHSR.0000024351.12294.65

Abraham, A. J., Andrews, C. M., Grogan, C. M., D'Aunno, T. P., Humphreys, K. N., Pollack, H. A., & Friedmann, P. D. (2017). The Affordable Care Act transformation of substance use disorder treatment. *American Journal of Public Health*, *107*(1), 31–32. https://doi.org/10.2105/AJPH.2016.303558

Abraham, A. J., Rieckmann, T., McNulty, T., Kovas, A. E., & Roman, P. M. (2011). Counselor attitudes toward the use of naltrexone in substance abuse treatment: A multi-level modeling approach. *Addictive Behaviors*, *36*(6), 576–583. https://doi.org/10.1016/j.addbeh.2011.01.030

Acker, C. J. (1993). Stigma or legitimation? A historical examination of the social potentials of addiction disease models. *Journal of Psychoactive Drugs*, *25*(3), 193–205. https://doi.org/10.1080/02791072.1993.10472271

adelaide12. (2018, August 17). This comment is directed towards "ILiveHere"—As a current patient of the APT Foundation, I find it imperative to clear up your ignorant and misguided viewpoints [Comment on the article "OD toll hits 77; Cops arrest suspect"]. *New Haven Independent*. https://www.newhavenindependent.org/index.php/article/22_od_on_bad_drug_batch/

Agamben, G. (1998). *Homo sacer: Sovereign power and bare life.* Stanford University Press.

Ahern, J., Stuber, J., & Galea, S. (2007). Stigma, discrimination and the health of illicit drug users. *Drug and Alcohol Dependence*, *88*(2–3), 188–196. https://doi.org/10.1016/j.drugalcdep.2006.10.014

Aletraris, L., Edmond, M. B., Paino, M., Fields, D., & Roman, P. M. (2016). Counselor training and attitudes toward pharmacotherapies for opioid use disorder. *Substance Abuse*, *37*(1), 47–53. https://doi.org/10.1080/08897077.2015.1062457

Aletraris, L., Shelton, J. S., & Roman, P. M. (2015). Counselor attitudes toward contingency management for substance use disorder: Effectiveness, acceptability, and endorsement of incentives for treatment attendance and abstinence. *Journal of Substance Abuse Treatment*, *57*, 41–48. https://doi.org/10.1016/j.jsat.2015.04.012

Alex, B., Weiss, D. B., Kaba, F., Rosner, Z., Lee, D., Lim, S., Venters, H., & MacDonald, R. (2017). Death after jail release: Matching to improve care delivery. *Journal of Correctional Health Care*, *23*(1), 83–87. https://doi.org/10.1177/1078345816685311

Alexander, M. (2020). T*he new Jim Crow: Mass incarceration in the age of colorblindness*. The New Press.

Alimoradi, Z., Golboni, F., Griffiths, M. D., Broström, A., Lin, C.-Y., & Pakpour, A. H. (2020). Weight-related stigma and psychological distress: A systematic review and meta-analysis. *Clinical Nutrition*, *39*(7), 2001–2013. https://doi.org/10.1016/j.clnu.2019.10.016

Allen, B., & Harocopos, A. (2016). Non-prescribed buprenorphine in New York City: Motivations for use, practices of diversion, and experiences of stigma. *Journal of Substance Abuse Treatment*, *70*, 81–86. https://doi.org/10.1016/j.jsat.2016.08.002

Allen, B., Nolan, M. L., & Paone, D. (2019). Underutilization of medications to treat opioid use disorder: What role does stigma play? *Substance Abuse*, *40*(4), 459–465. https://doi.org/10.1080/08897077.2019.1640833

Allen, B., Harocopos, A., & Chernick, R. (2020). Substance use stigma, primary care, and the New York state prescription drug monitoring program. *Behavioral Medicine*, *46*(1), 52–62. https://doi-org.antioch.idm.oclc.org/10.1080/08964289.2018.1555129

Amankwaa, L. (2016). Creating protocols for trustworthiness in qualitative research. *Journal of Cultural Diversity*, *23*(3), 123–127.

Amram, O., Amiri, S., Panwala, V., Lutz, R., Joudrey, P. J., & Socias, E. (2021). The impact of relaxation of methadone take-home protocols on treatment outcomes in the COVID-19 era. *The American Journal of Drug and Alcohol Abuse*, *47*(6), 722–729. https://doi.org/10.1080/00952990.2021.1979991

Andraka-Christou, B. (2021). Addressing racial and ethnic disparities in the use of medications for opioid use disorder: Study examines racial and ethnic disparities in the use of medications for opioid use disorder. *Health Affairs*, *40*(6), 920–927. https://doi.org/10.1377/hlthaff.2020.02261

Andraka-Christou, B., Gabriel, M., Madeira, J., & Silverman, R. D. (2019). Court personnel attitudes towards medication-assisted treatment: A state-wide survey. *Journal of Substance Abuse Treatment*, *104*, 72–82. https://doi.org/10.1016/j.jsat.2019.06.011

Andraka-Christou, B., Randall-Kosich, O., & Totaram, R. (2021). Designing an "ideal" substance use disorder treatment center: Perspectives of people who have utilized medications for opioid use disorder. *Qualitative Health Research*, *31*(3), 512–522. https://doi.org/10.1177/1049732320971231

Andrews, C. M., Shin, H.-C., Marsh, J. C., & Cao, D. (2013). Client and program characteristics associated with wait time to substance abuse treatment entry. *American Journal of Drug and Alcohol Abuse*, *39*(1), 61–68. https://doi.org/10.3109/00952990.2012.694515

Anstice, S., Strike, C. J., & Brands, B. (2009). Supervised methadone consumption: Client issues and stigma. *Substance Use & Misuse*, *44*(6), 794–808. https://doi.org/10.1080/10826080802483936

Anvari, M. S., Kleinman, M. B., Massey, E. C., Bradley, V. D., Felton, J. W., Belcher, A. M., & Magidson, J. F. (2022). "In their mind, they always felt less than": The role of peers in shifting stigma as a barrier to opioid use disorder treatment retention. *Journal of Substance Abuse Treatment*, *138*, Article 108721. Https://doi.org/10.1016/j.jsat.2022.108721

Appel, A. (2018, September 13). APT In the crosshairs. *New Haven Independent*. https://www.newhavenindependent.org/index.php/archives/entry/apt_foundation_clinic_hearing/

APT Foundation. (2023). *Provider quality dashboard. Reporting period: July 2019–June 2020*. Retrieved August 19, 2023, from https://portal.ct.gov/-/media/DMHAS/qualityreports2020/4thQuarter/APT-Foundation-Inc.pdf

Arboleda-Flórez, J., & Stuart, H. (2012). From sin to science: Fighting the stigmatization of mental illnesses. *The Canadian Journal of Psychiatry*, *57*(8), 457–463. https://doi.org/10.1177/070674371205700803

Arifin, S. R. M. (2018). Ethical considerations in qualitative study. *International Journal of Care Scholars*, *1*(2), 30–33. Https://doi.org/10.31436/ijcs.v1i2.82

Ashford, R. D., Brown, A., & Curtis, B. (2019). Expanding language choices to reduce stigma: A Delphi study of positive and negative terms in substance use and recovery. *Health Education*, *119*(1), 51–62. https://doi.org/10.1108/HE-03-2018-0017

Atkinson, M. (1972). A precise phenomenology for the general scholar. *The Journal of General Education*, *23*(4), 261–297.

Attewell, P., & Gerstein, D. R. (1979). Government policy and local practice. *American Sociological Review*, *44*(2), 311–327. https://doi.org/10.2307/2094513

Bailey, M. (2011, May 25). Parents oppose school's move. *New Haven Independent*. https://www.newhavenindependent.org/article/parents_oppose_esums_move

Balbale, S. N., Turcios, S., & LaVela, S. L. (2015). Health care employee perceptions of patient-centered care. *Qualitative Health Research*, *25*(3), 417–425. https://doi.org/10.1177/1049732314553011

Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. *Psychological Review*, *84*(2), 191–215. https://doi.org/10.1037/0033-295X.84.2.191

Bandura, A. (1999). A sociocognitive analysis of substance abuse: An agentic perspective. *Psychological Science*, *10*(3), 214–217. https://doi.org/10.1111/1467-9280.001

Bandura, A. (2006). Toward a psychology of human agency. *Perspectives on Psychological Science*, *1*(2), 164–180. https://doi.org/10.1111/j.1745-6916.2006.00011.x

Bao, Y., Williams, A. R., & Schackman, B. R. (2020). COVID-19 could change the way we respond to the opioid crisis—for the better. *Psychiatric Services*, *71*(12), 1214–1215. https://doi.org/10.1176/appi.ps.202000226

Barry, C. L., McGinty, E. E., Pescosolido, B. A., & Goldman, H. H. (2014). Stigma, discrimination, treatment effectiveness, and policy: Public views about drug addiction and mental illness. *Psychiatric Services*, *65*(10), 1269–1272. https://doi.org/10.1176/appi.ps.201400140

Barry, D. T., Irwin, K. S., Jones, E. S., Becker, W. C., Tetrault, J. M., Sullivan, L. E., Hansen, H., O'Connor, P. G., Schottenfeld, R. S., & Fiellin, D. A. (2010). Opioids, chronic pain, and addiction in primary care. *Journal of Pain*, *11*(12), 1442–1450. https://doi.org/10.1016/j.jpain.2010.04.002

Bass, P. (2018). OD toll hits 77; Cops arrest suspect. *New Haven Independent*. https://www.newhavenindependent.org/index.php/archives/entry/22_od_on_bad_drug_batch/

Baum, D. (2016). Legalize it all. *Harper's Magazine*. https://harpers.org/archive/2016/04/legalize-it-all/

Beitel, M., Oberleitner, L., Muthulingam, D., Oberleitner, D., Madden, L. M., Marcus, R., Eller, A., Bono, M. H., & Barry, D. T. (2018). Experiences of burnout among drug counselors in a large opioid treatment program: A qualitative investigation. *Substance Abuse*, *39*(2), 211–217. https://doi.org/10.1080/08897077.2018.1449051

Bell, J., & Strang, J. (2020). Medication treatment of opioid use disorder. *Biological Psychiatry*, *87*(1), 82–88. https://doi.org/10.1016/j.biopsych.2019.06.020

Bellamy, C. D., Costa, M., Wyatt, J., Mathis, M., Sloan, A., Budge, M., Blackman, K., Ocasio, L., Reis, G., Guy, K., Anderson, R. R., Copes, M. S., & Jordan, A. (2021). A collaborative culturally-centered and community-driven faith-based opioid recovery initiative: The Imani Breakthrough project. *Social Work in Mental Health*, *19*(6), 558–567. https://doi.org/10.1080/15332985.2021.1930329

Ben Natan, M. B., Beyil, V., & Neta, O. (2009). Nurses' perception of the quality of care they provide to hospitalized drug addicts: Testing the theory of reasoned action. International *Journal of Nursing Practice*, *15*(6), 566–573. https://doi.org/10.1111/j.1440-172x.2009.01799.x

Benz, M. B., Cabrera, K. B., Kline, N., Bishop, L. S., & Palm Reed, K. (2021). Fear of stigma mediates the relationship between internalized stigma and treatment-seeking among individuals with substance use problems. *Substance Use & Misuse*, *56*(6), 808–818. https://doi.org/10.1080/10826084.2021.1899224

Berman, M. I., Morton, S. N., & Hegel, M. T. (2016). Health at every size and acceptance and commitment therapy for obese, depressed women: Treatment development and clinical application. *Clinical Social Work Journal*, *44*(3), 265–278. https://doi.org/10.1007/S10615-015-0565-Y

Berwick, D. M. (2003). Disseminating innovations in healthcare. *JAMA*, *289*(15), 1969–1975. https://doi.org/10.1001/jama.289.15.1969

Beyrer, C., Malinowska-Sempruch, K., Kamarulzaman, A., Kazatchkine, M., Sidibe, M., & Strathdee, S. A. (2010). Time to act: A call for comprehensive responses to HIV in people who use drugs. *The Lancet*, *376*(9740), 551–563. https://doi.org/10.1016/S0140-6736(10)60928-2

Blanco, C., & Volkow, N. D. (2019). Management of opioid use disorder in the USA: Present status and future directions. *The Lancet*, 393(10182), 1760–1772. https://doi.org/10.1016/S0140-6736(18)33078-2

Bloor, M., & Wood, F. (2006). *Keywords in qualitative methods: A vocabulary of research concepts*. SAGE. https://doi.org/ https://doi.org/10.4135/9781849209403

Blumer, H. (1986). *Symbolic interactionism: Perspective and method*. Univ of California Press.

Botticelli, M. P., & Koh, H. K. (2016). Changing the language of addiction. *JAMA*, *316*(13), 1361–1362. https://doi.org/10.1001/jama.2016.11874

Bourdieu, P. (1990). *The logic of practice* (R. Nice, Trans.). Stanford University Press.

Bourgois, P. (2000). Disciplining addictions: The bio-politics of methadone and heroin in the United States. *Culture, Medicine and Psychiatry*, *24*(2), 165–195. https://doi.org/10.102“/A:1005574918294

Breen, T. (2019, October 11). “Walking zombie” houses plague the hill | *New Haven Independent*. https://www.newhavenindependent.org/article/ward_street

Breland, J. Y., Wong, J. J., & McAndrew, L. M. (2020). Are common sense model constructs and self-efficacy simultaneously correlated with self-management behaviors and health outcomes: A systematic review. *Health Psychology Open*, 7(1). https://doi.org/10.1177/2055102919898846

Brener, L., Von Hippel, W., Kippax, S., & Preacher, K. J. (2010). The role of physician and nurse attitudes in the health care of injecting drug users. *Substance Use & Misuse*, *45*(7–8), 1007–1018. https://doi.org/10.3109/10826081003659543

Brondani, M. A., Alan, R., & Donnelly, L. (2017). Stigma of addiction and mental illness in healthcare: The case of patients’ experiences in dental settings. *PloS One*, *12*(5), Article e0177388. https://doi.org/10.1371/journal.pone.0177388

Brothers, S., Viera, A., & Heimer, R. (2021). Changes in methadone program practices and fatal methadone overdose rates in Connecticut during COVID-19. *Journal of Substance Abuse Treatment*, *131*, Article 108449. https://doi.org/10.1016/j.jsat.2021.108449

Buchanan, N. T., & Wiklund, L. O. (2020). Why clinical science must change or die: Integrating intersectionality and social justice. *Women & Therapy*, *43*(3–4), 309–329. https://doi.org/10.1080/02703149.2020.1729470

Buning, E. C., Van Brussel, G. H. A., & Van Santen, G. (1990). The “methadone by bus” project in Amsterdam. *British Journal of Addiction*, 85(10), 1247–1250. https://doi.org/10.1111/j.1360-0443.1990.tb01598.x

Bureau of Labor Statistics. (2018). *Labor force statistics from the current population survey*. U.S. Department of Labor. https://www.bls.gov/web/empsit/cpsee_e16.htm

Burke, E., Pyle, M., Machin, K., Varese, F., & Morrison, A. P. (2019). The effects of peer support on empowerment, self-efficacy, and internalized stigma: A narrative synthesis and meta-analysis. *Stigma and Health*, *4*(3), 337–356. https://doi.org/10.1037/sah0000148

Burr, V. (2015). *Social constructionism* (3rd ed.). Routledge. https://doi.org/10.4324/9781315715421

Calcaterra, S. L., Bach, P., Chadi, A., Chadi, N., Kimmel, S. D., Morford, K. L., Roy, P., & Samet, J. H. (2019). Methadone matters: What the United States can learn from the global effort to treat opioid addiction. *Journal of General Internal Medicine*, *34*(6), 1039–1042. https://doi.org/10.1007/s11606-018-4801-3

Campbell, N. D. (2010). Toward a critical neuroscience of “addiction.” *BioSocieties*, 5(1), 89–104. https://doi.org/10.1057/biosoc.2009.2

Campbell, N. D. (2012). Medicalization and biomedicalization: Does the diseasing of addiction fit the frame? In J. Netherland (Ed.), *Critical perspectives on addiction* (pp. 3–25). Emerald Group Publishing. https://doi.org/10.1108/S1057-6290(2012)0000014005

Carey, K. B., & Carey, M. P. (1993). Changes in self-efficacy resulting from unaided attempts to quit smoking. *Psychology of Addictive Behaviors*, *7*(4), 219–224. https://doi.org/10.1037/0893-164X.7.4.219

Carl, A., Pasman, E., Broman, M. J., Lister, J. J., Agius, E., & Resko, S. M. (2023). Experiences of healthcare and substance use treatment provider-based stigma among patients receiving methadone. *Drug and Alcohol Dependence Reports*, *6*, Article 100138. https://doi.org/10.1016/j.dadr.2023.100138

Center for Substance Abuse. (2005). *SAMHSA/CSAT treatment improvement protocols*. Substance Abuse and Mental Health Services Administration. https://www.ncbi.nlm.nih.gov/books/NBK82999/

Centers for Disease Control. (2021). *Drug overdose deaths in the U.S. top 100,000 annually.* . https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2021/20211117.htm

Centers for Medicare and Medicaid Services. (2008). *The Mental Health Parity and Addiction equity Act (MHPAEA)*. https://www.cms.gov/CCIIO/PROGRAMS-AND-INITIATIVES/OTHER-INSURANCE-PROTECTIONS/MHPAEA_FACTSHEET

Chang, J., Dubbin, L., & Shim, J. (2016). Negotiating substance use stigma: The role of cultural health capital in provider–patient interactions. *Sociology of Health & Illness*, *38*(1), 90–108. https://doi.org/10.1111/1467-9566.12351

Chappel, J. N. (1973). Attitudinal barriers to physician involvement with drug abusers. *JAMA*, *224*(7), 1011–1013. https://doi.org/10.1001/jama.224.7.1011

Chasek, C., & Kawata, R. (2016). An examination of educational and training requirements in addiction counseling. VISTAS Online, Article 86. https://www.counseling.org/docs/default-source/vistas/article862016.pdf

Cheetham, A., Picco, L., Barnett, A., Lubman, D. I., & Nielsen, S. (2022). The impact of stigma on people with opioid use disorder, opioid treatment, and policy. *Substance Abuse and Rehabilitation*, *13*, 1–12. https://doi.org/10.2147/SAR.S304566

Christie, C., Baker, C., Cooper, R., Kennedy, P. J., Madras, B., & Bondi, P. (2017). *The President's Commission on Combating Drug Addiction and the Opioid Crisis.* U.S. Government Printing Office. https://trumpWhitehouse.archives.gov/sites/Whitehouse.gov/files/images/Final_Report_Draft_11-15-2017.pdf

Ciccarone, D. (2019). The triple wave epidemic: Supply and demand drivers of the US opioid overdose crisis. *International Journal of Drug Policy*, *71*, 183–188. https://doi.org/10.1016/j.drugpo.2019.01.010

Cicero, T. J., Ellis, M. S., Surratt, H. L., & Kurtz, S. P. (2014). The changing face of heroin use in the United States: A retrospective analysis of the past 50 years. *JAMA Psychiatry*, *71*(7), 821–826. https://doi.org/10.1001/jamapsychiatry.2014.366

Clarke, S., Taylor, G., Lancaster, J., & Remington, B. (2015). Acceptance and commitment therapy-based self-management versus psychoeducation training for staff caring for clients with a personality disorder: A randomized controlled trial. *Journal of Personality Disorders*, *29*(2), 163–176. https://doi.org/10.1521/pedi_2014_28_149

Cogburn, C. D. (2019). Culture, race, and health: Implications for racial inequities and population health. *The Milbank Quarterly*, 97(3), 736–761. https://doi.org/10.1111/1468-0009.12411

Coghlan, D., & Brydon-Miller, M. (Eds.). (2014). *The SAGE encyclopedia of action research*. SAGE.

Committee on Quality of Health Care in America, Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century*. The National Academies Press. https://doi.org/doi:10.17226/10027

Comprehensive Addiction and Recovery Act of 2016. Pub. L. No. 114-198. 130 Stat. 695 (2016). https://www.congress.gov/114/plaws/publ198/PLAW-114publ198.pdf

Comprehensive Drug Abuse Prevention and Control Act of 1970, Pub. L. No. 91-513, 84 Stat. 1236 (1970). https://www.govinfo.gov/content/pkg/STATUTE-84/pdf/STATUTE-84-Pg1236.pdf

Conner, K. O., & Rosen, D. (2008). "You're nothing but a junkie": Multiple experiences of stigma in an aging methadone maintenance population. *Journal of Social Work Practice in the Addictions*, *8*(2), 244–264. https://doi.org/10.1080/15332560802157065

Connock, M., Juarez-Garcia, A., Jowett, S., Frew, E., Liu, Z., Taylor, R., Fry-Smith, A., Day, E., Lintzeris, N., & Roberts, T. (2007). Methadone and buprenorphine for the management of opioid dependence: A systematic review and economic evaluation. *Health Technology Assessment Programme*, *11*, 1–171. https://doi.org/10.3310/hta11090

Conrad, P., & Barker, K. K. (2010). The social construction of illness: Key insights and policy implications. *Journal of Health and Social Behavior*, *51*(1_suppl), S67–S79. https://doi.org/10.1177/0022146510383495

Cook, J. E., Purdie-Vaughns, V., Meyer, I. H., & Busch, J. T. A. (2014). Intervening within and across levels: A multilevel approach to stigma and public health. *Social Science & Medicine*, *103*, 101–109. https://doi.org/10.1016/j.socscimed.2013.09.023

Coon, S. A., Hill, L. G., Hutchison, R. I., Arnold, L. M., JarrettI. B., Ottney, A. R., ... & Bratberg, J. P. (2020). Mobilizing pharmacists to address the opioid crisis: A joint opinion of the ambulatory care and adult medicine practice and research networks of the American College of Clinical Pharmacy. *Journal of the American College of Clinical Pharmacy*, *3*(8), 1493–1513. https://doi.org/10.1002/jac5.1331

Cooper, L. A., Beach, M. C., Johnson, R. L., & Inui, T. S. (2006). Delving below the surface. *Journal of General Internal Medicine*, *21*(1), 21–27. https://doi.org/10.1111/j.1525-1497.2006.00305.x

Corbin, J. M., & Strauss, A. (1990). Grounded theory research: Procedures, canons, and evaluative criteria. *Qualitative Sociology*, *13*(1), 3–21. https://doi.org/10.1007/BF00988593

Corburn, J. (2007). Reconnecting with our roots: American urban planning and public health in the twenty-first century. *Urban Affairs Review*, *42*(5), 688–713. https://doi.org/10.1177/1078087406296390

Corrigan, P. W., Bink, A. B., Schmidt, A., Jones, N., & Rüsch, N. (2016). What is the impact of self-stigma? Loss of self-respect and the "why try" effect. *Journal of Mental Health*, *25*(1), 10–15. https://doi.org/10.3109/09638237.2015.1021902

Corrigan, P. W., Markowitz, F. E., & Watson, A. C. (2004). Structural levels of mental illness stigma and discrimination. *Schizophrenia Bulletin*, *30*(3), 481–491. https://doi.org/10.1093/oxfordjournals.schbul.a007096

Corrigan, P., Markowitz, F. E., Watson, A., Rowan, D., & Kubiak, M. A. (2003). An attribution model of public discrimination towards persons with mental illness. *Journal of Health and Social Behavior*, *44*(2), 162–179. https://doi.org/10.2307/1519806

Corrigan, P. W., Morris, S. B., Michaels, P. J., Rafacz, J. D., & Rüsch, N. (2012). Challenging the public stigma of mental illness: A meta-analysis of outcome studies. Psychiatric services, 63(10), 963-973. https://doi.org/10.1176/appi.ps.201100529

Corrigan, P. W., & Phelan, S. M. (2004). Social support and recovery in people with serious mental illnesses. *Community Mental Health Journal*, *40*(6), 513–523. https://doi.org/10.1007/s10597-004-6125-5

Corrigan, P. W., & Rao, D. (2012). On the self-stigma of mental illness: Stages, disclosure, and strategies for change. *Canadian Journal of Psychiatry*, *57*(8), 464–469. https://doi.org/10.1177/070674371205700804

Corrigan, P. W., River, L. P., Lundin, R. K., Penn, D. L., Uphoff-Wasowski, K., Campion, J., Mathisen, J., Gagnon, C., Bergman, M., & Goldstein, H. (2001). Three strategies for changing attributions about severe mental illness. *Schizophrenia Bulletin*, *27*(2), 187–195. https://doi.org/10.1093/oxfordjournals.schbul.a006865

Corrigan, P. W., Kosyluk, K. A., & Rüsch, N. M. D. (2013). Reducing self-stigma by coming out proud. *American Journal of Public Health*, *103*(5), 794–800. https://doi.org/10.2105/ajph.2012.301037

Corsi, K. F., Lehman, W. K., & Booth, R. E. (2009). The effect of methadone maintenance on positive outcomes for opiate injection drug users. *Journal of Substance Abuse Treatment*, *37*(2), 120–126. https://doi.org/10.1016/j.jsat.2008.11.004

Cowles, C., & Singer, J. A. (2020). *War on us: How the war on drugs and myths about addiction have created a war on all of us*. Fildago Press.

Crapanzano, K. A., Hammarlund, R., Ahmad, B., Hunsinger, N., & Kullar, R. (2019). The association between perceived stigma and substance use disorder treatment outcomes: Areview. *Substance Abuse and Rehabilitation*, *10*, 1–12. https://doi.org/10.2147/SAR.S183252

Crapanzano, K., Vath, R. J., & Fisher, D. (2014). Reducing stigma towards substance users through an educational intervention: Harder than it looks. *Academic Psychiatry*, *38*(4), 420–425. https://doi.org/10.1007/S40596-014-0067-1

Crenshaw, K. (1991). Mapping the margins: Identity politics, intersectionality, and violence against women. *Stanford Law Review*, *43*(6), 1241–1299. https://doi.org/10.2307/1229039

Creswell, J. W., & Creswell, J. D. (2017). *Research design: Qualitative, quantitative, and mixed methods approaches*. SAGE. https://doi.org/10.3316/qrj0602205

Creswell, J. W., & Miller, D. L. (2000). Determining validity in qualitative inquiry. *Theory Into Practice*, *39*(3), 124–130. https://doi.org/10.1207/s15430421tip3903_2

Creswell, J. W., & Poth, C. N. (2016). *Qualitative inquiry and research design: Choosing among five approache*s. SAGE. https://doi.org/10.1177/1524839915580941

Csete, J., & Catania, H. (2013). Methadone treatment providers' views of drug court policy and practice: A case study of New York State. *Harm Reduction Journal*, *10*(1), Article 35. https://doi.org/10.1186/1477-7517-10-35

Cunningham, J. A., Sobell, L. C., Sobell, M. B., Agrawal, S., & Toneatto, T. (1993). Barriers to treatment: Why alcohol and drug abusers delay or never seek treatment. *Addictive Behaviors*, *18*(3), 347–353. https://doi.org/10.1016/0306-4603(93)90036-9

Davis, C. S., & Carr, D. H. (2019). Legal and policy changes urgently needed to increase access to opioid agonist therapy in the United States. *International Journal of Drug Policy*, *73*, 42–48. https://doi.org/10.1016/j.drugpo.2019.07.006

Davoli, M., Bargagli, A. M., Perucci, C. A., Schifano, P., Belleudi, V., Hickman, M., Salamina, G., Diecidue, R., Vigna-Taglianti, F., & Faggiano, F. (2007). Risk of fatal overdose during and after specialist drug treatment: The VEdeTTE study, a national multi-site prospective cohort study. Addiction, 102(12), 1954–1959. https://doi.org/10.1111/j.1360-0443.2007.02025.x

Deci, E. L., & Ryan, R. M. (2008). Self-determination theory: A macrotheory of human motivation, development, and health. *Canadian Psychology/Psychologie Canadienne*, *49*(3), 182. https://doi.org/10.1037/a0012801

Deck, D., & Carlson, M. J. (2005). Retention in publicly funded methadone maintenance treatment in two western states. *Journal of Behavioral Health Services & Research*, *32*(1), 43-60. https://doi.org/10.1007/BF02287327

Deegan, P. E., & Drake, R. E. (2006). Shared decision making and medication management in the recovery process. Psychiatric Services, *57*(11), 1636–1639. https://doi.org/10.1176/ps.2006.57.11.1636

DeFulio, A., Stitzer, M., Roll, J., Petry, N., Nuzzo, P., Schwartz, R. P., & Stabile, P. (2013). Criminal justice referral and incentives in outpatient substance abuse treatment. *Journal of Substance Abuse Treatment*, *45*(1), 70-75. https://doi.org/10.1016/j.jsat.2012.12.012

del Pozo, B., & Rich, J. D. (2020). Revising our attitudes towards agonist medications and their diversion in a time of pandemic. *Journal of Substance Abuse Treatment*, *119*, 108139. https://doi.org/10.1016/j.jsat.2020.108139

Delgado, R., & Stefancic, J. (2023). *Critical race theory: An introduction* (4th ed.). NYU Press. https://doi.org/10.18574/nyu/9781479818297.001.0001

Delphon-Rittmon, M. (2015). *Promoting a recovery-oriented service system*. Connecticut State Department of Mental Health and Addiction Services. https://portal.ct.gov/DMHAS/Initiatives/Recovery/Recovery-Initiative

DeParle, J. (1990). Rude, rash, effective, Act-Up shifts AIDS policy. *The New York Times*, B1, p.1. https://timesmachine.nytimes.com/timesmachine/1990/01/03/771690.html

DiClemente, C. C., & Hughes, S. O. (1990). Stages of change profiles in outpatient alcoholism treatment. *Journal of Substance Abuse*, *2*(2), 217–235. https://doi.org/10.1016/S0899-3289(05)80057-4

Dobson, K., & Stuart, H. (2021). *The stigma of mental illness: Models and methods of stigma reduction*. Oxford University Press. https://doi.org/10.1093/med/9780197572597.001.0001

Dodes, L., & Dodes, Z. (2015). *The sober truth: Debunking the bad science behind 12-step programs and the rehab industry.* Beacon Press.

Dole, V. P., & Nyswander, M. E. (1966). Rehabilitation of heroin addicts after blockade with methadone. New York state journal of medicine, 66(15), 2011–2017. https://doi.org/10.1097/00043764-196604000-00“28 ”

Dollar, C. B. (2019). Criminalization and drug “wars” or medicalization and health “epidemics”: How race, class, and neoliberal politics influence drug laws. *Critical Criminology*, *27*(2), 305–327. https://doi.org/10.1007/s10612-018-9398-7

Drug Addiction Treatment Act of 2000, Pub. L. No. 106-310. 114 Stat. 1101(2000). https://www.govinfo.gov/content/pkg/PLAW-106publ310/pdf/PLAW-106publ310.pdf

Dukes, S. (1984). Phenomenological methodology in the human sciences. *Journal of Religion and Health*, *23*, 197–203. https://doi.org/10.1007/BF00990785

DuPont, R. L. (2018). The opioid epidemic is an historic opportunity to improve both prevention and treatment. *Brain Research Bulletin*, *138*, 112-114. https://doi.org/10.1016/j.brainresbull.2017.06.008

Duryea, D. G., & Calleja, N. G. (2013). Current expectations and existing deficits among addiction specialists. *Alcoholism Treatment Quarterly*, *31*(2), 254–269. https://doi.org/10.1080/07347324.2013.771990

Earnshaw, V. A. (2020). Stigma and substance use disorders: A clinical, research, and advocacy agenda. *American Psychologist*, *75*(9), 1300–1311. https://doi.org/10.1037/amp0000744

Earnshaw, V., Smith, L., & Copenhaver, M. (2013). drug addiction stigma in the context of methadone maintenance therapy: An investigation into understudied sources of stigma. *International Journal of Mental Health & Addiction*, *11*(1), 110–122. https://doi.org/10.1007/s11469-012-9402-5

Elafros, M. A., Mulenga, J., Mbewe, E., Haworth, A., Chomba, E., Atadzhanov, M., & Birbeck, G. L. (2013). Peer support groups as an intervention to decrease epilepsy-associated stigma. *Epilepsy & Behavior*, *27*(1), 188–192. https://doi.org/10.1016/j.yebeh.2013.01.005

El-Sabawi, T., Baney, M. Canister, S. L., & Weizman, S, R. (2021, August 4). The new mobile methadone rules and what they mean for treatment access. *Health Affairs Forefront.*https://www.healthaffairs.org/content/forefront/new-mobile-methadone-rules-and-they-mean-treatment-access

Eyre, E. (2017, May 9). Trump officials seek opioid solutions in WV. *Charleston Gazette-Mail*. https://www.wvgazettemail.com/news/health/trump-officials-seek-opioid-solutions-in-wv/article_52c417d8-16a5-59d5-8928-13ab073bc02b.html#sthash.c2sNdh5r.dpuf

Fairley, M., Humphreys, K., Joyce, V. R., Bounthavong, M., Trafton, J., Combs, A., Oliva, E. M., Goldhaber-Fiebert, J. D., Asch, S. M., & Brandeau, M. L. (2021). Cost-effectiveness of treatments for opioid use disorder. *JAMA Psychiatry*, *78*(7), 767–777. https://doi.org/10.1001/jamapsychiatry.2021.0247

Fan, D. P. (1996). News media framing sets public opinion that drugs is the country's most important problem. *Substance Use & Misuse*, *31*(10), 1413–1421. https://doi.org/10.3109/10826089609063984

Fareed, A., Casarella, J., Amar, R., Vayalapalli, S., & Drexler, K. (2009). Benefits of retention in methadone maintenance and chronic medical conditions as risk factors for premature death among older heroin addicts. *Journal of Psychiatric Practice*, *15*(3), 227–234. https://doi.org/10.1097/01.pra.0000351884.83377.e2

Farmer, P. E., Nizeye, B., Stulac, S., & Keshavjee, S. (2006). Structural violence and clinical medicine. *PloS Medicine*, *3*(10), 1686–1691. https://doi.org/10.1371/journal.pmed.0030449

Farnum, S. O., Makarenko, I., Madden, L., Mazhnaya, A., Marcus, R., Prokhorova, T., Bojko, M. J., Rozanova, J., Dvoriak, S., Islam, Z., & Altice, F. L. (2021). The real-world impact of dosing of methadone and buprenorphine in retention on opioid agonist therapies in Ukraine. *Addiction*, *116*(1), 83–93. https://doi.org/10.1111/add.15115

Faulkner, K. K., & Faulkner, T. A. (1997). Managing multiple relationships in rural communities: Neutrality and boundary violations. *Clinical Psychology: Science and Practice*, *4*(3), 225. https://doi.org/10.1111/j.1468-2850.1997.tb00111.x

Fernández-Ballesteros, R., Sánchez-Izquierdo, M., Olmos, R., Huici, C., Ribera Casado, J. M., & Cruz Jentoft, A. (2019). Paternalism vs. autonomy: Are they alternative types of formal care? *Frontiers in Psychology*, *10*, Article 1460. https://doi.org/10.3389/fpsyg.2019.01460

Ferri, M., Amato, L., & Davoli, M. (2006). Alcoholics Anonymous and other 12-step programmes for alcohol dependence. *Cochrane Database of Systematic Reviews*, 2. https://doi.org/10.1002/14651858.CD005032.pub2

Fiellin, D. A. (2007). The first three years of buprenorphine in the United States: Experience to date and future directions. Journal of Addiction Medicine, *1*(2), 62–67. https://doi.org/10.1097/ADM.0b013e3180473c11

Figgatt, M. C., Salazar, Z., Day, E., Vincent, L., & Dasgupta, N. (2021). Take-home dosing experiences among persons receiving methadone maintenance treatment during COVID-19. *Journal of Substance Abuse Treatment*, *123*, Article 108276. https://doi.org/10.1016/j.jsat.2021.108276

Fisher, G. (2014, December 19). The drug war at 100. *SLS Blogs.* https://law.stanford.edu/2014/12/19/the-drug-war-at-100/

Foucault, M. (1971). Orders of discourse. *Social Science Information*, *10*(2), 7–30. https://doi.org/10.1177/053901847101000020

Foucault, M. (1977). *Discipline and punish: The birth of the prison* (A. Sheridan, Trans.). Vintage Books.

Foucault, M. (1978). *The history of sexuality* (1st American ed.). Pantheon Books.

Frank, D. (2011). The trouble with morality: The effects of 12-step discourse on addicts' decision-making. *Journal of Psychoactive Drugs*, *43*(3), 245–256. https://doi.org/10.1080/02791072.2011.'05706

Frank, D. (2018). "I was not sick and I didn't need to recover": Methadone maintenance treatment (mmt) as a refuge from criminalization. *Substance Use & Misuse*, *53*(2), 311–322. https://doi.org/10.1080/10826084.2017.1310247

Frank, D. (2020). Methadone maintenance treatment is swapping onedrug for another, and that''s why it works: Towards a treatment-based critique of the war on drugs. *International Journal of Drug Policy*, *83*, Article 102844. https://doi.org/10.1016/j.drugpo.2020.102844

Frank, D., Mateu-Gelabert, P., Perlman, D. C., Walters, S. M., Curran, L., & Guarino, H. (2021). "It's like 'liquid handcuffs": The effects of take-home dosing policies on Methadone maintenance treatment (MMT) patients' lives. *Harm Reduction Journal*, *18*(1), 1–10. https://doi.org/10.1186/s12954-021-00535-y

Frazier, W., Cochran, G., Lo-Ciganic, W.-H., Gellad, W. F., Gordon, A. J., Chang, C.-C. H., & Donohue, J. M. (2017). Medication-assisted treatment and opioid use before and after overdose in Pennsylvania Medicaid. *JAMA*, *318*(8), 750–752. https://doi.org/10.1001/jama.2017.7818

Fugelstad, A., Stenbacka, M., Leifman, A., Nylander, M., & Thiblin, I. (2007). Methadone maintenance treatment: The balance between life-saving treatment and fatal poisonings. *Addiction*, *102*(3), 406–412. https://doi.org/10.1111/j.1360-0443.2006.01714.x

Gadamer, H.-G. (1976). *Philosophical hermeneutics* (D. E. Linge, trans.) .University of California Press.

Gallagher, J. R., & Bremer, T. (2018). A perspective from the field: The disconnect between abstinence-based programs and the use of motivational interviewing in treating substance use disorders. *Alcoholism Treatment Quarterly*, *36*(1), 115–126. https://doi.org/10.1080/07347324.2017.1355223

Gallagher, S. M. (1998). Paternalism in healthcare decision making. *Ostomy/Wound Management*, *44*(4), 22, 24–25.

Galtung, J. (1969). Violence, peace, and peace research. Journal *of Peace Resear*ch, 6(3), 167–191. https://doi.org/10.1177/002234336900600301

Geanellos, R. (2000). Exploring Ricoeur's hermeneutic theory of interpretation as a method of analysing research texts. *Nursing Inquiry*, *7(*2), 112–119. https://doi.org/10.1046/j.1440-1800.2000.00062.x

George, J. (2021, January 11). A lesson on critical race theory. *Human Rights Magazine*, *46*(2). https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/civil-rights-reimagining-policing/a-lesson-on-critical-race-theory

Gethin, G., Probst, S., Stryja, J., Christiansen, N., & Price, P. (2020). Evidence for person-centred care in chronic wound care: A systematic review and recommendations for practice. *Journal of Wound Care*, *29*(Sup9b), S1–S22. https://doi.org/10.12968/jowc.2020.29.sup9b.s1

Gill, M. J. (2014). The possibilities of phenomenology for organizational research. *Organizational Research Methods, 17*(2), 118–137. https://doi.org/:10.1177/1094428113518348

Ginter, W. (2012). Methadone Anonymous and mutual support for medication-assisted recovery. *Journal of Groups in Addiction & Recovery*, *7*(2–4), 189–201. https://doi.org/10.1080/1556035X.2012.705699

Godolphin, W. (2009). Shared decision-making. *Healthcare Quarterly*, *12*(Sp)), e186–e190. https://doi.org/10.12927/hcq.2009.20947

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity.* Simon & Schuster.

Gold, J. A. W., Rossen, L. M., Ahmad, F. B., Sutton, P., Li, Z., Salvatore, P. P., Coyle, J. P., DeCuir, J., Baack, B. N., & Durant, T. M. (2020). Race, ethnicity, and age trends in persons who died from COVID-19—United States, May–August 2020. *Morbidity and Mortality Weekly Report*, *69*(42), 1517–1520. https://doi.org/10.15585/mmwr.mm6942e1

Gonzenbach, W. J. (1992). A time-series analysis of the drug issue, 1985–1990: The press, the president and public opinion. *International Journal of Public Opinion Research*, 4(2), 126–147. https://doi.org/10.1093/ijpor/4.2.126

Graves, E., & Goodwin, L. R., Jr. (2008). Pharmacotherapeutic treatment of alcohol dependence: An overview. *Journal of Teaching in the Addictions*, *7*(1), 75–95. https://doi.org/10.1080/15332700802072290

Green, T. C., Bratberg, J., & Finnell, D. S. (2020). Opioid use disorder and the COVID 19 pandemic: A call to sustain regulatory easements and further expand access to treatment. Substance Abuse, 41(2), 147–149. https://doi.org/10.1080/08897077.2020.1752351

Griffin, M. M., Wendel, K. F., Day, T. L., & McMillan, E. D. (2016). Developing peer supports for college students with intellectual and developmental disabilities. *Journal of Postsecondary Education and Disability*, *29*(3), 263–269.

Griffiths, K. M., Carron-Arthur, B., Parsons, A., & Reid, R. (2014). Effectiveness of programs for reducing the stigma associated with mental disorders. A meta-analysis of randomized controlled trials. *World Psychiatry*, *13*(2), 161–175. https://doi.org/10.1002/wps.20129

Grix, J. (2018). *The foundations of research*. Bloomsbury Publishing. https://doi.org/10.1007/978-0-230-36490-5

Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), Handbook of qualitative research (pp. 105–117). SAGE.

Guenther, L. (2019). Critical phenomenology. In G. Weiss, A. V. Murphy, & G. Salamon (Eds.), *50 concepts for a critical phenomenology* (pp. 11–16). Northwestern University Press. https://doi.org/10.2307/j.ctvmx3j22.6

Gwadz, M., Cluesman, S. R., Freeman, R., Collins, L. M., Dorsen, C., Hawkins, R. L., Cleland, C. M., Wilton, L., Ritchie, A. S., Torbjornsen, K., Leonard, N. R., Martinez, B. Y., Silverman, E., Israel, K., & Kutnick, A. (2022). Advancing behavioral interventions for African American/Black and Latino persons living with HIV using a new conceptual model that integrates critical race theory, harm reduction, and self-determination theory: A qualitative exploratory study. *International Journal for Equity in Health*, *21*(1), Article 97. https://doi.org/10.1186/s12939-022-01699-0

Haas, A., Viera, A., Doernberg, M., Barbour, R., Tong, G., Grau, L. E., & Heimer, R. (2021). Post-incarceration outcomes for individuals who continued methadone treatment while in Connecticut jails, 2014–2018. *Drug and Alcohol Dependence*, *227*, Article 108937. https://doi.org/10.1016/j.drugalcdep.2021.108937

Habermas, J. (1984). Habermas: Questions and counterquestions. *Praxis International*, *4*(3), 229–249.

Hand, D. J. (2020). Methadone for opioid use disorder. In G. Moeller & M. Terplan (Eds.), *Substance use disorders* (pp. 139–154). Oxford University Press. https://doi.org/10.1093/med/9780190920197.003.0008

Hansen, H., & Metzl, J. (2016). Structural competency in the U.S. healthcare crisis: Putting social and policy interventions into clinical practice. *Journal of Bioethical Inquiry*, *13*(2), 179–183. https://doi.org/10.1007/s11673-016-9719-z

Hansen, H., & Netherland, J. (2016). Is the prescription opioid epidemic a White problem? *American Journal of Public Health*, *106*(12), 2127–2129. https://doi.org/10.2105/AJPH.2016.303483

Hansen, H., & Roberts, S. K. (2012). Two tiers of biomedicalization: Methadone, buprenorphine, and the racial politics of addiction treatment. In J. Netherland (Ed.), *Critical perspectives on addiction* (pp. 79–102). Emerald Group Publishing. https://doi.org/10.1108/S1057-6290(2012)0000014008

Hari, J. (2015). *Chasing the scream: The first and last days of the war on drugs*. Bloomsbury Publishing.

Harris, J., & McElrath, K. (2012). Methadone as social control: Institutionalized stigma and the prospect of recovery. *Qualitative Health Research*, *22*(6), 810–824. https://doi.org/10.1177/1049732311432718

Harris, M., & Rhodes, T. (2013). Methadone diversion as a protective strategy: The harm reduction potential of "generous constraints." *International Journal of Drug Policy*, *24*(6), e43–e50. https://doi.org/10.1016/j.drugpo.2012.10.003

Hart, C. (2013). *High price: Drugs, neuroscience, and discovering myself*. Penguin UK.

Hart, C. L. (2017). Viewing addiction as a brain disease promotes social injustice. *Nature Human Behaviour*, *1*(3), 1. Article 55. https://doi.org/10.1038/s41562-017-0055

Hatcher, A. E., Mendoza, S., & Hansen, H. (2018). At the expense of a life: Race, class, and the meaning of buprenorphine in pharmaceuticalized "care." *Substance Use & Misuse*, *53*(2), 301–310. https://doi.org/10.1080/10826084.2017.1385633

Hatzenbuehler, M. L. (2016). Structural stigma: Research evidence and implications for psychological science. *American Psychologist*, *71*(8), 742–751. https://doi.org/10.1037/amp0000068

Hatzenbuehler, M. L., & Link, B. G. (2014). Introduction to the special issue on structural stigma and health. *Social Science & Medicine*, *103*, 1–6. https://doi.org/10.1016/j.socscimed.2013.12.017

Hatzenbuehler, M. L., O’Cleirigh, C., Grasso, C., Mayer, K., Safren, S., & Bradford, J. (2012). Effect of same-sex marriage laws on healthcare use and expenditures in sexual minority men: A quasi-natural experiment. *American Journal of Public Health*, *102*(2), 285–291. https://doi.org/10.2105/ajph.2011.300382

Hayes, S. C., Pistorello, J., & Levin, M. E. (2012). Acceptance and commitment therapy as a unified model of behavior change. *The Counseling Psychologist*, *40*(7), 976–1002. https://doi.org/10.1177/0011000012460836

Health and Human Services Department. (2022). *Medications for the treatment of opioid use disorder. A proposed rule*. https://www.federalregister.gov/documents/2022/12/16/2022-27193/medications-for-the-treatment-of-opioid-use-disorder

Heckathorn, D. D. (2011). Comment: Snowball versus respondent-driven sampling. *Sociological Methodology*, *41*(1), 355–366. https://doi.org/10.1111/j.1467-9531.2011.01244.x

Heidegger, M. (1996). *Being and time: A translation of sein und zeit* (J. Stambaugh, Trans.). SUNY Press. (Original work published 1962)

Heimer, R., McNeil, R., & Vlahov, D. (2020). A community responds to the COVID-19 pandemic: A case study in protecting the health and human rights of people who use drugs. *Journal of Urban Health*, *97*(4), 448–456. https://doi.org/10.1007/s11524-020-00465-3

Helseth, S. A., Janssen, T., Scott, K., Squires, D. D., & Becker, S. J. (2018). Training community-based treatment providers to implement contingency management for opioid addiction: Time to and frequency of adoption. *Journal of Substance Abuse Treatment*, 95, 26–34. https://doi.org/10.1016/j.jsat.2018.09.004

Herzog, B. (2018). Invisibilization and silencing as an ethical and sociological challenge. *Social Epistemology*, *32*(1), 13–23. https://doi.org/10.1080/02691728.2017.1383529

Higgs, J., & Jones, M. (2018). Multiple spaces of choice, engagement and influence in clinical decision making. In J. Higgs, G. M. Jensen, S. Loftus, & N. Christensen (Eds.), *Clinical reasoning in the health professions* (4th ed., 33–44). Elsevier.

Hiller, J. (2016). Epistemological foundations of objectivist and interpretivist research. In B. L. Wheeler & K. M. Murphy (Eds.), *Music therapy research* (3rd ed., pp. 236–268). Barcelona Publishers.

Holmes, A. G. D. (2020). Researcher positionality—A consideration of its influence and place in qualitative research—A new researcher guide. *Shanlax International Journal of Education*, 8(4), 1–10. https://doi.org/10.34293/education.v8i4.3232

Hora, P. F. (2005). Trading one drug for another? What drug treatment court professionals need to learn about opioid replacement therapy. *Journal of Maintenance in the Addictions*, *2*(4), 71–76. https://doi.org/10.1300/J126v02n04_07

Howell, B. A., Puglisi, L., Clark, K., Albizu-Garcia, C., Ashkin, E., Booth, T., Brinkley-Rubinstein, L., Fiellin, D. A., Fox, A. D., & Maurer, K. F. (2021). The transitions clinic network: Post Incarceration Addiction Treatment, Healthcare, and Social Support (TCN-PATHS): A hybrid type-1 effectiveness trial of enhanced primary care to improve opioid use disorder treatment outcomes following release from jail. *Journal of Substance Abuse Treatment*, *128*. Article 108315. https://doi.org/10.1016/j.jsat.2021.108315

Husserl, E. (1970). *The crisis of European sciences and transcendental phenomenology: An introduction to phenomenological philosophy.* Northwestern University Press.

Husserl, E. (1975). *The Paris lectures* (J. N. Findlay, trans., 2nd ed.). Martinus Nijhoff.

Husserl, E. (1999). *The essential Husserl: Basic writings in transcendental phenomenology*. Indiana University Press.

Institute of Medicine (2001). *Crossing the quality chasm: A new healthcare system for the 21st century*. National Academy Press. https://doi.org/10.17226/10027

Irigaray, L., & Guynn, N. (1995). The question of the other. *Yale French Studies*, *87*, 7–19. https://doi.org/10.2307/2930321

Jackson, D. S., Nguemeni Tiako, M. J., & Jordan, A. (2022). Disparities in addiction treatment: Learning from the past to forge an equitable future. *Medical Clinics of North America*, *106*(1), 29–41. https://doi.org/10.1016/j.mcna.2021.08.008

Jaffe, J. H., & O'Keeffe, C. (2003). From morphine clinics to buprenorphine: Regulating opioid agonist treatment of addiction in the United States. *Drug and Alcohol Dependence*, *70*(2), S3–S11. https://doi.org/10.1016/S0376-8716(03)00055-3

Jaffe, S. (2023). Sackler money to go towards reducing overdose deaths. *The Lancet*, *401*(10392), 1918. https://doi.org/10.1016/s0140-6736(23)01178-9

James, K., & Jordan, A. (2018). The opioid crisis in black communities. *Journal of Law, Medicine & Ethics*, *46*(2), 404–421. https://doi.org/10.1177/1073110518782949

Janulis, P., Ferrari, J. R., & Fowler, P. (2013). Understanding public stigma toward substance dependence. *Journal of Applied Social Psychology*, *43*(5), 1065–1072. https://doi.org/10.1111/jasp. 12070

Jarlais, D. C. D. P., Nugent, A., Solberg, A. M. P. A., Feelemyer, J. M. S., Mermin, J. M. D., & Holtzman, D. P. (2015, December 15). Syringe service programs for persons who inject drugs in urban, suburban, and rural areas—United States, 2013. *Morbidity and Mortality Weekly Report*, *64(*48), 1337–1341. https://doi.org/10.15585/mmwr.mm6448a3

Javadi, R., Lagana, K., Krowicki, T., Bennett, D., & Schindler, B. (2022). Attitudes toward harm reduction among substance use treatment professionals in Philadelphia. Journal of Substance Use, 27(5), 459–464. https://doi.org/10.1080/14659891.2021.1961320

Johnson, K., Pinchuk, I., Melgar, M. I. E., Agwogie, M. O., & Salazar Silva, F. (2022). The global movement towards a public health approach to substance use disorders. *Annals of Medicine*, *54*(1), 1797–1808. https://doi.org/10.1080/07853890.2022.2079150

Jones, C. M., Campopiano, M., Baldwin, G., & McCance-Katz, E. (2015). National and State Treatment Need and Capacity for Opioid Agonist Medication-Assisted Treatment. American journal of public health, 105(8), e55–63. https://doi.org/10.2105/ajph.2015.302664

Jones, C. M., Compton, W. M., Han, B., Baldwin, G., & Volkow, N. D. (2022). Methadone-involved overdose deaths in the US before and after federal policy changes expanding take-home methadone doses from opioid treatment programs. *JAMA Psychiatry*, *79*(9), 932–934. https://doi.org/10.1001/jamapsychiatry.2022.1776

Jones, M. M. (2016). Does race matter in addressing homelessness? A review of the literature. *World Medical & Health Policy*, *8*(2), 139–156. https://doi.org/10.1002/wmh3.189

Jones, W. T. (1975). *The twentieth century to Wittgenstein and Sartre*. Harcourt Brace Jovanovich.

Jorm, A. F. (2020). Effect of contact-based interventions on stigma and discrimination: A critical examination of the evidence. *Psychiatric Services*, *71*(7), 735–737. https://doi.org/10.1176/appi.ps.201900587

Joseph, G., Torres-Lockhart, K., Stein, M. R., Mund, P. A., & Nahvi, S. (2021). Reimagining patient-centered care in opioid treatment programs: Lessons from the Bronx during COVID-19. *Journal of Substance Abuse Treatment*, *122*, Article 108219. https://doi.org/10.1016/j.jsat.2020.108219

Joudrey, P. J., Adams, Z. M., Bach, P., Van Buren, S., Chaiton, J. A., Ehrenfeld, L., Guerra, M. E., Gleeson, B., Kimmel, S. D., Medley, A., Mekideche, W., Paquet, M., Sung, M., Wang, M., You Kheang, R. O. O., Zhang, J., Wang, E. A., & Edelman, E. J. (2021). Methadone access for opioid use disorder during the COVID-19 pandemic within the United States and Canada. *JAMA Network Open*, *4*(7), e2118223–e2118223. https://doi.org/10.1001/jamanetworkopen.2021.18223

Kåberg, M., Karlsson, N., Discacciati, A., Widgren, K., Weiland, O., Ekström, A. M., & Hammarberg, A. (2020). Significant decrease in injection risk behaviours among participants in a needle exchange programme. *Infectious Diseases*, *52*(5), 336–346. https://doi.org/10.1080/23744235.2020.1727002

Kaiser Family Foundation. (2021a). *Opioid overdose deaths and opioid overdose deaths as a percent of all drug overdose deaths*. Retrieved August 14, 2023 from https://www.kff.org/other/state-indicator/opioid-overdose-deaths/?currentTimeframe=0&selectedDistributions=opioid-overdose-deaths--all-drug-overdose-deaths&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

Kaiser Family Foundation. (2021b). *Opioid overdose deaths by race/ethnicity*. Retrieved August 14, 2023 from https://www.kff.org/other/state-indicator/opioid-overdose-deaths-by-raceethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

Kampman, K., & Jarvis, M. (2015). American Society of Addiction Medicine (ASAM) national practice guideline for the use of medications in the treatment of addiction involving opioid use. *Journal of Addiction Medicine*, *9*(5), 358–367. https://doi.org/10.1097/adm.0000000000000166

Kapadia, S. N., Johnston, C. D., Marks, K. M., Schackman, B. R., & Martin, E. G. (2019). Strategies for improving hepatitis C treatment access in the US: State officials address high drug prices, stigma, and building treatment capacity. *Journal of Public Health Management & Practice*, *25*(3), 245–252. https://doi.org/10.1097/phh.0000000000000829

Katz, J., Goodnough, A., & Sanger-Katz, M. (2020, July 15). In shadow of pandemic, U.S. drug overdose deaths resurge to record. *The New York Times*. https://www.nytimes.com/interactive/2020/07/15/upshot/drug-overdose-deaths.html

Keller, D. S., & Dermatis, H. (1999). Current status of professional training in the addictions. *Substance Abuse*, *20*(3), 123–140. https://doi.org/10.1080/08897079909511401

Kelly, J. F., Wakeman, S. E., & Saitz, R. (2015). Stop talking 'dirty': Clinicians, language, and quality of care for the leading cause of preventable death in the United States. *American Journal of Medicine*, *128*(1), 8–9. https://doi.org/10.1016/j.amjmed.2014.07.043

Kennedy, A., Mikhaeil, J. S., Huang, A., & Wąsowicz, M. (2020). The opioid crisis in North America: Facts and future lessons for Europe. *Anaesthesiology Intensive Therapy*, *52*(2), 139–147. https://doi.org/10.5114/ait.2020.94756

Kennedy-Hendricks, A., Barry, C. L., Gollust, S. E., Ensminger, M. E., Chisolm, M. S., & McGinty, E. E. (2017). Social stigma toward persons with prescription opioid use disorder: Associations with public support for punitive and public health–oriented policies. *Psychiatric Services*, *68*(5), 462–469. https://doi.org/10.1176/appi.ps.201600056

Kennedy-Hendricks, A., McGinty, E. E., Summers, A., Krenn, S., Fingerhood, M. I., & Barry, C. L. (2022). Effect of exposure to visual campaigns and narrative vignettes on addiction stigma among healthcare professionals: A randomized clinical trial. *JAMA Network Open*, 5(2), e2146971–e2146971. https://doi.org/10.1001/jamanetworkopen.2021.46971

Kerr, T. (2019). Public health responses to the opioid crisis in North America. *Journal of Epidemiology & Community Health*, *73*(5), 377–378. https://doi.org/10.1136/jech-2018-210599

Kiriazova, T., Lunze, K., Raj, A., Bushara, N., Blokhina, E., Krupitsky, E., Bridden, C., Lioznov, D., Samet, J. H., & Gifford, A. L. (2017). “It is easier for me to shoot up”: Stigma, abandonment, and why HIV-positive drug users in Russia fail to link to HIV care. *AIDS Care*, 29(5), 559–563. https://doi.org/10.1080/09540121.2016.1259451

Kirk, T. A. (2011). Connecticut’s journey to a statewide recovery-oriented health-care system: Strategies, successes, and challenges. *Addiction Recovery Management*, 209–234. https://doi.org/10.1007/978-1-60327-960-4_12

Kitchener, B. A., & Jorm, A. F. (2008). Mental health first aid: An international programme for early intervention. *Early Intervention in Psychiatry*, *2*(1), 55–61. https://doi.org/10.1111/j.1751-7893.2007.00056.x

Knopf, A. (2016). For methadone, buprenorphine patients, sober housing may be hard to find. *Alcoholism & Drug Abuse Weekly*, *28*(9), 1–3. https://doi.org/10.1002/adaw.30486

Knopf, A. (2021). Does telehealth work for treating addiction? *The Brown University Child & Adolescent Psychopharmacology Update*, *23*(12), 5–8. https://doi.org/10.1002/cpu.30633

Koch, T. (1995). Interpretive approaches in nursing research: The influence of Husserl and Heidegger. *Journal of Advanced Nursing*, *21*(5), 827–836. https://doi.org/10.1046/j.1365-2648.1995.21050827.x

Krafft, J., Ferrell, J., Levin, M. E., & Twohig, M. P. (2018). Psychological inflexibility and stigma: A meta-analytic review. *Journal of Contextual Behavioral Science*, 7, 15–28. https://doi.org/10.1016/j.jcbs.2017.11.002

Krawczyk, N., Fingerhood, M. I., & Agus, D. (2020). Lessons from COVID 19: Are we finally ready to make opioid treatment accessible? *Journal of Substance Abuse Treatment*, 117, Article 108074. https://doi.org/10.1016/j.jsat.2020.108074

Krawczyk, N., Negron, T., Nieto, M., Agus, D., & Fingerhood, M. I. (2018). Overcoming medication stigma in peer recovery: A new paradigm. *Substance Abuse*, *39*(4), 404–409. https://doi.org/10.1080/08897077.2018.1439798

Krawczyk, N., Picher, C. E., Feder, K. A., & Saloner, B. (2017). Only one in twenty justice-referred adults in specialty treatment for opioid use receive methadone or buprenorphine. *Health Affairs*, *36*(12), 2046–2053. https://doi.org/10.1377/hlthaff.2017.0890

Krawczyk, N., Rivera, B. D., Jent, V., Keyes, K. M., Jones, C. M., & Cerdá, M. (2022). Has the treatment gap for opioid use disorder narrowed in the U.S.?: A yearly assessment from 2010 to 2019. *International Journal of Drug Policy*, *110*, Article 103786. https://doi.org/10.1016/j.drugpo.2022.103786

Krawczyk, N., Rivera, B. D., Levin, E., & Dooling, B. C. (2023). Synthesising evidence of the effects of COVID-19 regulatory changes on methadone treatment for opioid use disorder: Implications for policy. *The Lancet Public Health*, *8*(3), e238–e246. https://doi.org/10.1016/s2468-2667(23)00023-3

Krieger, N., Rehkopf, D. H., Chen, J. T., Waterman, P. D., Marcelli, E., & Kennedy, M. (2008). The fall and rise of US inequities in premature mortality: 1960–2002. *PloS Medicine*, *5*(2), e46. https://doi.org/10.1371/journal.pmed.0050046

Kulesza, M., Watkins, K. E., Ober, A. J., Osilla, K. C., & Ewing, B. (2017). Internalized stigma as an independent risk factor for substance use problems among primary care patients: Rationale and preliminary support. *Drug and Alcohol Dependence*, *180*, 52–55. https://doi.org/10.1016/j.drugalcdep. 2017.08.002

Lachapelle, É., Archambault, L., Blouin, C., & Perreault, M. (2021). Perspectives of people with opioid use disorder on improving addiction treatments and services. *Drugs: Education, Prevention and Policy*, *28*(4), 316–327. https://doi.org/10.1080/09687637.2020.1833837

Lagisetty, P., Klasa, K., Bush, C., Heisler, M., Chopra, V., & Bohnert, A. (2017). Primary care models for treating opioid use disorders: What actually works? A systematic review. *PloS One*, *12*(10), e0186315. https://doi.org/10.1371/journal.pone.0186315

Langdridge, D. (2008). Phenomenology and critical social psychology: Directions and debates in theory and research. *Social and Personality Psychology Compass*, *2*(3), 1126–1142. https://doi.org/10.1111/j.1751-9004.2008.00114.x

Larkings, J. S., & Brown, P. M. (2018). Do biogenetic causal beliefs reduce mental illness stigma in people with mental illness and in mental health professionals? A systematic review. *International Journal of Mental Health Nursing*, *27*(3), 928–941. https://doi.org/10.1111/inm.12390

Larney, S., Peacock, A., Leung, J., Colledge, S., Hickman, M., Vickerman, P., Grebely, J., Dumchev, K. V., Griffiths, P., Hines, L., Cunningham, E. B., Mattick, R. P., Lynskey, M., Marsden, J., Strang, J., & Degenhardt, L. (2017). Global, regional, and country-level coverage of interventions to prevent and manage HIV and hepatitis C among people who inject drugs: A systematic review. *The Lancet Global Health*, *5*(12), e1208–e1220. https://doi.org/10.1016/s2214-109x(17)30373-x

Larney, S., Zador, D., Sindicich, N., & Dolan, K. (2017). A qualitative study of reasons for seeking and ceasing opioid substitution treatment in prisons in New South Wales, Australia. *Drug and Alcohol Review*, *36*(3), 305–310. https://doi.org/10.1111/dar.12442

Larochelle, M. R., Bernson, D., Land, T., Stopka, T. J., Wang, N., Xuan, Z., Bagley, S. M., Liebschutz, J. M., & Walley, A. Y. (2018). Medication for opioid use disorder after nonfatal opioid overdose and association with mortality: A cohort study. Annals of *Internal Medicine*, *169*(3), 137–145. https://doi.org/10.7326/m15-0038

Larochelle, M. R., Liebschutz, J. M., Zhang, F., Ross-Degnan, D., & Wharam, J. F. (2016). Opioid prescribing after nonfatal overdose and association with repeated overdose: A cohort study. *Annals of Internal Medicine*, *164*(1), 1–9. https://doi.org/10.7326/m17-3107

Lassiter, M. D. (2015). Impossible criminals: The suburban imperatives of America's war on drugs. *Journal of American History*, *102*(1), 126–140. https://doi.org/10.1093/jahist/jav243

Laverty, S. M. (2003). Hermeneutic phenomenology and phenomenology: A comparison of historical and methodological considerations. *International Journal of Qualitative Methods*, *2*(3), 21–35. https://doi.org/10.1177/160940690300200303

Lawson, G., Trepal, H. C., Lee, R. W., & Kress, V. (2017). Advocating for educational standards in counselor licensure laws. *Counselor Education and Supervision*, *56*(3), 162–176. https://doi.org/10.1002/ceas.12070

Lennard, H. L., Epstein, L. J., & Rosenthal, M. S. (1972). The methadone illusion. *Science*, *176*(4037), 881–884. https://doi.org/10.1126/science.176.4037.881

Leshner, A. I. (1997). Addiction is a brain disease, and it matters. *Science*, *278*(5335), 45–47. https://doi.org/10.1126/science.278.5335.45

Leung, L. (2015). Validity, reliability, and generalizability in qualitative research. *Journal of Family Medicine and Primary Care*, *4*(3), 324–327. https://doi.org/10.4103/2249-4863.161306

Levander, X. A., Pytell, J. D., Stoller, K. B., Korthuis, P. T., & Chander, G. (2021). COVID-19-related policy changes for methadone take-home dosing: A multistate survey of opioid treatment program leadership. *Substance Abuse*, *43*(1), 245–252. https://doi.org/10.1080/08897077.2021.1986768

Li, L., Liang, L.-J., Lin, C., Feng, N., Cao, W., & Wu, Z. (2019). An intervention to improve provider-patient interaction at methadone maintenance treatment in China. *Journal of Substance Abuse Treatment*, *99*, 149–155. https://doi.org/10.1016/j.jsat.2019.01.022

Li, L., Wu, Z., Cao, X., & Zhang, L. (2012). Provider–client interaction in methadone treatment clinics in China. *Journal of Drug Issues*, *42*(2), 147–155. https://doi.org/10.1177/0022042612446593

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. SAGE

Lind, B., Chen, S., Weatherburn, D., & Mattick, R. (2005). The effectiveness of methadone maintenance treatment in controlling crime: An Australian aggregate-level analysis. *British Journal of Criminology*, *45*(2), 201–211. https://doi.org/10.1093/bjc/azh085

Link, B. G. (1987). Understanding labeling effects in the area of mental disorders: An assessment of the effects of expectations of rejection. *American Sociological Review*, *52*(1), 96–112. https://doi.org/10.2307/2095395

Link, B. G., Cullen, F. T., Frank, J., & Wozniak, J. F. (1987). The social rejection of former mental patients: Understanding why labels matter. *American Journal of Sociology*, *92*(6), 1461–1500. https://doi.org/10.1086/228672

Link, B. G., Cullen, F. T., Struening, E., Shrout, P. E., & Dohrenwend, B. P. (1989). A modified labeling theory approach to mental disorders: An empirical assessment. American *Sociological Review*, 54(3), 400–423. https://doi.org/10.2307/2095613

Link, B., & Hatzenbuehler, M. L. (2016). Stigma as an unrecognized determinant of population health: Research and policy implications. *Journal of Health Politics, Policy and Law*, *41*(4), 653–673. https://doi.org/10.1215/03616878-3620869

Link, B. G., & Phelan, J. C. (2001). Conceptualizing Stigma. *Annual Review of Sociology*, *27*(1), 363–385. https://doi.org/10.1146/annurev.soc.27.1.363

Link, B. G., & Phelan, J. C. (2006). Stigma and its public health implications. *Lancet*, *367*(9509), 528–529. https://doi.org/10.1016/s0140-6736(06)68184-1

Link, B. G., & Phelan, J. (2014). Stigma power. *Social Science & Medicine*, *103*, 24–32. https://doi.org/10.1016/j.socscimed.2013.07.035

Link, B. G., Struening, E. L., Neese-Todd, S., Asmussen, S., & Phelan, J. C. (2002). On describing and seeking to change the experience of stigma. *Psychiatric Rehabilitation Skills*, *6*(2), 201–231. https://doi.org/10.1080/10973430208408433

Livingston, J. D. (2021). *A framework for assessing structural stigma in health-care contexts for people with mental health and substance use issues.* Mental Health Commission of Canada. https://www.mentalhealthcommission.ca/wp-content/uploads/drupal/2021-05/Structural_Stigma_Assessment_Report_eng.pdf

Livingston, J. D., & Boyd, J. E. (2010). Correlates and consequences of internalized stigma for people living with mental illness: A systematic review and meta-analysis. *Social Science & Medicine*, *71*(12), 2150–2161. https://doi.org/10.1016/j.socscimed.2010.09.030

Loch, A. A., & Rössler, W. (2017). Who is contributing? In W. Gaebel, W. Rössler,–& N. Sartorius (Eds.), *The stigma of mental illness—End of the story?* (pp. 111–121). Springer. https://doi.org/10.1007/978-3-319-27839-1_6

Lopez, K. A., & Willis, D. G. (2004). Descriptive versus interpretive phenomenology: Their contributions to nursing knowledge. *Qualitative Health Research*, *14*(5), 726–735. https://doi.org/10.1177/1049732304263638

Loughman, A., & Haslam, N. (2018). Neuroscientific explanations and the stigma of mental disorder: A meta-analytic study. *Cognitive Research*, *3*, Article 43. https://doi.org/10.1186/s41235-018-0136-1

Luo, S., Lin, C., Feng, N., Wu, Z., & Li, L. (2019). Stigma towards people who use drugs: A case vignette study in methadone maintenance treatment clinics in China. *International Journal of Drug Policy*, *71*, 73–77. https://doi.org/10.1016/j.drugpo.2019.06.005

Lyons, N., Cooper, C., & Lloyd-Evans, B. (2021). A systematic review and meta-analysis of group peer support interventions for people experiencing mental health conditions. *BMC Psychiatry*, *21*(1), 1–17. https://doi.org/10.1186/s12888-021-03321-z

Madden, E. F. (2019). Intervention stigma: How medication-assisted treatment marginalizes patients and providers. *Social Science & Medicine*, *232*, 324–331. https://doi.org/10.1016/j.socscimed.2019.05.027

Madden, E. F., Christian, B. T., Lagisetty, P. A., Ray, B. R., & Sulzer, S. H. (2021). Treatment provider perceptions of take-home methadone regulation before and during COVID-19. *Drug and Alcohol Dependence*, *228*, Article 109100. https://doi.org/10.1016/j.drugalcdep. 2021.109100

Madden, L. M. (2017). *The US substance abuse treatment system as an expression of culture: Who uses the system as barriers to treatment are eliminated?* (Publication Number 10702919) [Doctoral dissertation, Union Institute and University]. ProQuest Dissertations & Theses Global.

Madden, L. M., Farnum, S. O., Eggert, K. F., Quanbeck, A. R., Freeman, R. M., Ball, S. A., Schottenfeld, R. S., Shi, J. M., Savage, M. E., & Barry, D. T. (2018). An investigation of an open-access model for scaling up methadone maintenance treatment. *Addiction*, *113*(8), 1450–1458. https://doi.org/10.1111/add.14198

Madras, B. K., Ahmad, N. J., Wen, J., & Sharfstein, J. S. (2020). Improving access to evidence-based medical treatment for opioid use disorder: Strategies to address key barriers within the treatment system. *NAM Perspectives*, *2020.* https://doi.org/10.31478/202004b

Magrath, S. M. (2016). *Medication assisted treatment and the three legged stool: Medical providers, chemical dependency professionals, and clients* [Doctoral dissertation, Antioch University]. Antioch University Repository & Archive. https://aura.antioch.edu/cgi/viewcontent.cgi?article=1308&context=etds

Magura, S., Nwakeze, P. C., & Demsky, S. (1998). Pre-and in-treatment predictors of retention in methadone treatment using survival analysis. *Addiction*, *93*(1), 51–60. https://doi.org/10.1046/j.1360-0443.1998.931516.x

Majer, J. M., Beasley, C., Stecker, E., Bobak, T. J., Norris, J., Nguyen, H. M., Ogata, M., Siegel, J., Isler, B., Wiedbusch, E., & Jason, L. A. (2018). Oxford house residents' attitudes toward medication assisted treatment use in fellow residents. *Community Mental Health Journal*, *54*, 571–577. https://doi.org/10.1007/s10597-017-0218-4

Mallatt, J. (2020). Unintended consequences of prescription monitoring: Policy-induced substitution to illicit drugs. *SSRN*. https://doi.org/10.2139/ssrn.3418615

Mapp, T. (2008). Understanding phenomenology: The lived experience. *British Journal of Midwifery*, *16*(5), 308–311. https://doi.org/10.12968/bjom.2008.16.5.29192

Maradiaga, J. A., Nahvi, S., Cunningham, C. O., Sanchez, J., & Fox, A. D. (2016). "I kicked the hard way. I got incarcerated." Withdrawal from methadone during incarceration and subsequent aversion to medication assisted treatments. *Journal of Substance Abuse Treatment*, *62*, 49–54. https://doi.org/10.1016/j.jsat.2015.11.004

Mark, T. L., & Parish, W. (2019). Opioid medication discontinuation and risk of adverse opioid-related healthcare events. *Journal of Substance Abuse Treatment*, *103*, 58–63. https://doi.org/10.1016/j.jsat.2019.05.001

Mateu-Gelabert, P., Sandoval, M., Meylakhs, P., Wendel, T., & Friedman, S. R. (2010). Strategies to avoid opiate withdrawal: Implications for HCV and HIV risks. *International Journal of Drug Policy*, *21*(3), 179–185. https://doi.org/10.1016/j.drugpo.2009.08.007

Matthews, S., Dwyer, R., & Snoek, A. (2017). Stigma and self-stigma in addiction. *Journal of Bioethical Inquiry*, *14*(2), 275–286. https://doi.org/10.1007/s11673-017-9784-y

Mauger, S., Fraser, R., & Gill, K. (2014). Utilizing buprenorphine–naloxone to treat illicit and prescription-opioid dependence. *Neuropsychiatric Disease and Treatment*, *10*, 587–598. https://www.tandfonline.com/doi/epdf/10.2147/NDT.S39692?needAccess=true&role=button

Maxwell, J. A. (2005). *Qualitative research design: An interactive approach* (2nd ed.). SAGE. https://doi.org/10.4135/9781529770278.n4

McCabe, S. E., Bostwick, W. B., Hughes, T. L., West, B. T., & Boyd, C. J. (2010). The relationship between discrimination and substance use disorders among lesbian, gay, and bisexual adults in the United States. *American Journal of Public Health*, *100*(10), 1946–1952. https://doi.org/10.2105/AJPH.2009.163147

McCarty, D., Bougatsos, C., Chan, B., Hoffman, K. A., Priest, K. C., Grusing, S., & Chou, R. (2021). Office-based methadone treatment for opioid use disorder and pharmacy dispensing: A scoping review. *American Journal of Psychiatry*, *178*(9), 804–817. https://doi.org/10.1176/appi.ajp. 2021.20101548

McCarty, D., Gustafson, D. H., Wisdom, J. P., Ford, J., Choi, D., Molfenter, T., Capoccia, V., & Cotter, F. (2007). The Network for the Improvement of Addiction Treatment (NIATx): Enhancing access and retention. *Drug and Alcohol Dependence*, *88*(2–3), 138–145. https://doi.org/10.1016/j.drugalcdep. 2006.10.009

McGinty, E. E., & Barry, C. L. (2020). Stigma reduction to combat the addiction crisis—developing an evidence base. *New England Journal of Medicine*, *382*(14), 1291–1292. https://doi.org/10.1056/nejmp2000227

McGinty, E. E., Goldman, H. H., Pescosolido, B., & Barry, C. L. (2015). Portraying mental illness and drug addiction as treatable health conditions: Effects of a randomized experiment on stigma and discrimination. *Social Science & Medicine*, *126*, 73–85. https://doi.org/10.1016/j.socscimed.2014.12.010

McGinty, E. E., Kennedy-Hendricks, A., & Barry, C. L. (2019). Stigma of addiction in the media. In J. D. Avery & J. J. Avery (Eds.), *The stigma of addiction: An essential guide*, (pp. 201–214). Springer Nature. https://doi.org/10.1007/978-3-030-02580-9_11

McGinty, E., Pescosolido, B., Kennedy-Hendricks, A., & Barry, C. L. (2018). Communication Strategies to Counter Stigma and Improve Mental Illness and Substance Use Disorder Policy. *Psychiatric Services*, *69*(2), 136–146. https://doi.org/10.1176/appi.ps.201700076

McLellan, A. T., & O'Brien, C. P. (2001). Drug dependence as a chronic medical illness [Letter]. *JAMA*, *285*(4), 409. https://doi.org/10.1001/jama.284.13.1689

McNulty, T. L., Oser, C. B., Aaron Johnson, J., Knudsen, H. K., & Roman, P. M. (2007). Counselor turnover in substance abuse treatment centers: An organizational-level analysis. *Sociological Inquiry*, *77*(2), 166–193. https://doi.org/10.1111/j.1475-682x.2007.00186.x

Merriam, S. B. (1995). What can you tell from an N of I? Issues of validity and reliability. *PAACE Journal of Lifelong Learning*, *4*, 51–60.

Merriam-Webster. (n.d.). Axiology. In *Merriam-Webster.com dictionary*. Retrieved August 7, 2023, from https://www.merriam-webster.com/dictionary/axiological

Mertens, D. M. (2007). Transformative paradigm: Mixed methods and social justice. *Journal of Mixed Methods Research*, *1*(3), 212–225. https://doi.org/10.1177/1558689807302811

Mezirow, J. (1991). *Transformative dimensions of adult learning*. Jossey-Bass.

Miclette, M., Cuan, I., & Meisel, Z. F. (2017, August 3). *Substance use disorder in America: Research to practice, and back again* [Conference presentation]. Proceedings from National SUD Conference Addressing the Gaps in Evidence-Based Policy and Practice. Philadelphia, PA, USA. https://doi.org/10.1186/s13722-018-0123-3

Moitra, E., Chan, P. A., & Stein, M. D. (2015). Open trial of an acceptance-based behavior therapy intervention to engage newly diagnosed HIV patients in care: Rationale and evidence of feasibility and acceptability. *Behavior Modification*, *39*(5), 670–690. https://doi.org/10.1177/0145445515590977

Moran, D. (2002). *Introduction to phenomenology*. Routledge. https://doi.org/10.4324/9780203196632

Morgan, P. A. (1978). The legislation of drug law: Economic crisis and social control. *Journal of Drug Issues*, *8*(1), 53–62. https://doi.org/10.1177/002204267800800104

Moustakas, C. (1994). *Phenomenological research methods*. SAGE. https://doi.org/10.4135/9781412995658

Munhall, P. L. (1989). Philosophical ponderings on qualitative research methods in nursing. *Nursing Science Quarterly*, *2*(1), 20–28. https://doi.org/10.1177/089431848900200109

Murakawa, N. (2011). Toothless: The methamphetamine "epidemic," "meth mouth," and the racial construction of drug scares. *Du Bois Review: Social Science Research on Race*, *8*(1), 219–228. https://doi.org/10.1017/s1742058x11000208

Murphy, S., & Irwin, J. (1992). "Living with the dirty secret": Problems of disclosure for methadone maintenance clients. *Journal of Psychoactive Drugs*, *24*(3), 257–264. https://doi.org/10.1080/02791072.1992.10471646

Mutter, R., & Duchovny, N. (2022). Recent federal responses to the opioid crisis. *NEJM Catalyst Innovations in Care Delivery*, *3*(6). https://catalyst.nejm.org/doi/full/10.1056/CAT.22.0345

Nadelmann, E., & LaSalle, L. (2017). Two steps forward, one step back: current harm reduction policy and politics in the United States. *Harm Reduction Journal*, *14*(1), Article 37. https://doi.org/10.1186/s12954-017-0157-y

Naeger, S., Mutter, R., Ali, M. M., Mark, T., & Hughey, L. (2016). Post-discharge treatment engagement among patients with an opioid-use disorder. *Journal of Substance Abuse Treatment*, *69*, 64–71. https://doi.org/10.1016/j.jsat.2016.07.004

Náfrádi, L., Nakamoto, K., & Schulz, P. J. (2017). Is patient empowerment the key to promote adherence? A systematic review of the relationship between self-efficacy, health locus of control and medication adherence. *PloS One*, *12*(10), Article e0186458. https://doi.org/10.1371/journal.pone.0186458

Narcotic Addict Treatment Act of 1973–74. Pub. L. No. 93–281 (1974). https://www.congress.gov/93/statute/STATUTE-88/STATUTE-88-Pg124.pdf

National Academy of Medicine. (2022, March). *Methadone treatment for opioid use disorder: Improving access through regulatory and legal change: Proceedings of a workshop*. National Academies of Sciences, Engineering & Medicine. https://nap.nationalacademies.org/catalog/26635/methadone-treatment-for-opioid-use-disorder-improving-access-through-regulatory

National Academies of Sciences, Engineering, & Medicine. (2016). *Ending discrimination against people with mental and substance use disorders: The evidence for stigma change*. The National Academies Press. https://doi.org/10.17226/23442

National Academies of Sciences, Engineering, & Medicine. (2019). *Medications for opioid use disorder save lives.* The National Academies Press. https://doi.org/doi:10.17226/25310

National Academies of Sciences, Engineering, & Medicine Committee on Medication-Assisted Treatment for Opioid Use Disorder. (2019, March 30). Barriers to broader use of medications to treat opioid use disorder. In M. Mancher, M., & A. I. Leshner (Eds.), *Medications for opioid use disorder save lives* National Academies Press (US). https://www.ncbi.nlm.nih.gov/books/NBK541389/

Netherland, J., & Hansen, H. B. (2016).The war on drugs that wasn't: Wasted Whiteness, "dirty doctors," and race in media coverage of prescription opioid misuse. *Culture, Medicine and Psychiatry*, *40*(4), 664–686. https://doi.org/10.1007/s11013-016-9496-5

Netherland, J., & Hansen, H. (2017). White opioids: Pharmaceutical race and the war on drugs that wasn't. *BioSocieties*, *12*(2), 217–238. https://doi.org/10.1057/biosoc.2015.46

Neubauer, B. E., Witkop, C. T., & Varpio, L. (2019). How phenomenology can help us learn from the experiences of others. *Perspectives on Medical Education*, *8*(2), 90–97. https://doi.org/10.1007/s40037-019-0509-2

Ng, J., Sutherland, C., & Kolber, M. R. (2017). Does evidence support supervised injection sites? *Canadian Family Physician*, *63*(11), 866–866. https://www.cfp.ca/content/cfp/63/11/866.full.pdf

Nixon, R. (1971, June 17). Remarks about an intensified program for drug abuse prevention and control. *The American Presidency Project*. https://www.presidency.ucsb.edu/documents/remarks-about-intensified-program-for-drug-abuse-prevention-and-control

Novak, P., Williams-Parry, K. F., & Chen, J. (2017). Racial and ethnic disparities among the remaining uninsured young adults with behavioral health disorders after the aca expansion of dependent coverage. *Journal of Racial and Ethnic Health Disparities*, *4*(4), 607–614. https://doi.org/10.1007/s40615-016-0264-6

Nowrasteh, A. (2014). *Obama's deportation numbers: Border and interior immigration enforcement are substitutes, not complements*. Cato Institute. https://policycommons.net/artifacts/1306159/obamas-deportation-numbers/1909450/

Nyblade, L., Stockton, M. A., Giger, K., Bond, V., Ekstrand, M. L., McLean, R. M., Mitchell, E. M. H., Nelson, L. R. E., Sapag, J. C., Siraprapasiri, T., Turan, J., & Wouters, E. (2019). Stigma in health facilities: Why it matters and how we can change it. *BMC Medicine*, *17*(1), 1–15. https://doi.org/10.1186/s12916-019-1256-2

Oberleitner, D. E., Marcus, R., Beitel, M., Muthulingam, D., Oberleitner, L. M. S., Madden, L. M., Eller, A., & Barry, D. T. (2019). "Day-to-day, it's a roller coaster. It's frustrating. It's rewarding. It's maddening and it's enjoyable": A qualitative investigation of the lived experiences of addiction counselors. *Psychological Services*, *18*(3),287–294. https://doi.org/10.1037/ser0000394

O'Byrne, P., & Jeske Pearson, C. (2019). Methadone maintenance treatment as social control: Analyzing patient experiences. *Nursing Inquiry*, *26*(2), Article e12275. https://doi.org/10.1111/nin.12275

O'Byrne, P., & Jeske Pearson, C. (2019). Methadone maintenance treatment as social control: Analyzing patient experiences. *Nursing Inquiry*, *26*(2), Article e12275. https://doi.org/10.1111/nin.12275

Oksala, J. (2022). The method of critical phenomenology: Simone de Beauvoir as a phenomenologist. *European Journal of Philosophy*, *31*(1), 137–150. https://doi.org/10.1111/ejop.12782

Palis, H., Marchand, K., Peng, D., Fikowski, J., Harrison, S., Spittal, P., Schechter, M. T., & Oviedo-Joekes, E. (2016). Factors associated with perceived abuse in the health care system among long-term opioid users: A cross-sectional study. *Substance Use & Misuse*, *51*(6), 763–776. https://doi.org/10.3109/10826084.2016.1155605

Pantelic, M., Steinert, J. I., Park, J., Mellors, S., & Murau, F. (2019). "Management of a spoiled identity": Systematic review of interventions to address self-stigma among people living with and affected by HIV. *BMJ Global Health*, *4*(2), Article e001285. https://doi.org/10.1136/bmjgh-2018-001285

Paquette, C. E., Syvertsen, J. L., & Pollini, R. A. (2018). Stigma at every turn: Health services experiences among people who inject drugs. International Journal of Drug Policy, 57, 104–110. https://doi.org/10.1016/j.drugpo.2018.04.004

Pascoe, E. A., & Smart Richman, L. (2009). Perceived discrimination and health: A meta-analytic review. *Psychological Bulletin*, *135*(4), 531–554. https://doi.org/10.1037/a0016059

Peacock, A., Leung, J., Larney, S., Colledge, S., Hickman, M., Rehm, J., Giovino, G. A., West, R., Hall, W., Griffiths, P., Ali, R., Gowing, L., Marsden, J., Ferrari, A. J., Grebely, J., Farrell, M., & Degenhardt, L. (2018). Global statistics on alcohol, tobacco and illicit drug use: 2017 status report. *Addiction*, *113*(10), 1905–1926. https://doi.org/10.1111/add.14234

Pescosolido, B. A., Martin, J. K., Lang, A., & Olafsdottir, S. (2008). Rethinking theoretical approaches to stigma: A framework integrating normative influences on stigma (FINIS). *Social Science & Medicine*, *67*(3), 431–440. https://doi.org/10.1016/j.socscimed.2008.03.018

Peterson, J. A., Schwartz, R. P., Mitchell, S. G., Reisinger, H. S., Kelly, S. M., O'Grady, K. E., Brown, B. S., & Agar, M. H. (2010). Why don't out-of-treatment individuals enter methadone treatment. *International Journal of Drug Policy*, *21*(1), 36–42. https://doi.org/10.1016/J.DRUGPO.2008.07.004

Pierce, C. (1978). Pragmatism and abduction. In C. Hartshorne & P. Weiss (Eds.) *Collected papers*, *Vol V* (pp. 180–212. Harvard University Press. (Original work published 1903)

Pietrus, M. (2013). *Opening minds interim report*. Mental Health Commission of Canada.

Proctor, S. L., Copeland, A. L., Kopak, A. M., Hoffmann, N. G., Herschman, P. L., & Polukhina, N. (2015). Predictors of patient retention in methadone maintenance treatment. *Psychology of Addictive Behaviors*, *29*(4), 906–917. https://doi.org/10.1037/adb0000090

Qi Gan, W., Kinner, S. A., Nicholls, T. L., Xavier, C. G., Urbanoski, K., Greiner, L., Buxton, J. A., Martin, R. E., McLeod, K. E., Samji, H., Nolan, S., Meilleur, L., Desai, R., Sabeti, S., & Slaunwhite, A. K. (2021). Risk of overdose-related death for people with a history of incarceration. *Addiction*, *116*(6), 1460–1471. https://doi.org/10.1111/add.15293

Qin, D. (2016). Positionality. In R. C. Hoogland, M. Wickramasinghe, W. C. A. Wong, & N. A. Naples (Eds.), *The Wiley Blackwell encyclopedia of gender and sexuality studies* (Vol. 4, pp.1–2). Wiley-Blackwell.

Quinn, N., Knifton, L., Goldie, I., van Bortel, T., Dowds, J., Lasalvia, A., Scheerder, G., Boumans, J., Svab, V., & Lanfredi, M., Wahlbeck, K., & Thornicroft, G. (2014). Nature and impact of European anti-stigma depression programmes. *Health Promotion International*, *29*(3), 403–413. https://doi.org/10.1093/heapro/das076

Reisinger, H. S., Schwartz, R. P., Mitchell, S. G., Peterson, J. A., Kelly, S. M., O'Grady, K. E., Marrari, E. A., Brown, B. S., & Agar, M. H. (2009). Premature discharge from methadone treatment: Patient perspectives. *Journal of Psychoactive Drugs*, *41*(3), 285–296. https://doi.org/10.1080/02791072.2009.10400539

Rettig, R. A., & Yarmolinsky, A. (1995). Methadone diversion control. In R. A. Rettig & A. Yarmolinsky (Eds.), *Federal regulation of methadone treatment* (pp. 92–112). National Academies Press.

Rhee, T. G., & Rosenheck, R. A. (2019). Buprenorphine prescribing for opioid use disorder in medical practices: can office-based out-patient care address the opiate crisis in the United States? *Addiction*, *114*(11), 1992–1999. https://doi.org/10.1111/add.14733

Rich, J. D., Wakeman, S. E., & Dickman, S. L. (2011). Medicine and the epidemic of incarceration in the United States. *New England Journal of Medicine*, *364*(22), 2081–2083. https://doi.org/10.1056/NEJMp1102385

Richter, L., Vuolo, L., & Salmassi, M. S. (2019). Stigma and addiction treatment. In J. D. Avery & J. J. Avery (Eds.), *The stigma of addiction* (pp. 93–130). Springer. https://doi.org/10.1007/978-3-030-02580-9_7

Rieckmann, T., Farentinos, C., Tillotson, C. J., Kocarnik, J., & McCarty, D. (2011). The substance abuse counseling workforce: Education, preparation, and certification. *Substance Abuse*, *32*(4), 180–190. https://doi.org/10.1080/08897077.2011.600122

Roberto, A. J., Shafer, M. S., & Marmo, J. (2014). Predicting substance-abuse treatment providers' communication with clients about medication assisted treatment: A test of the theories of reasoned action and planned behavior. *Journal of Substance Abuse Treatment*, *47*(5), 307–313. https://doi.org/10.1016/j.jsat.2014.06.002

Robertson, A., Walker, C. S., Stovall, M., & McCluskey, L. (2015). Use of evidence-based substance use treatment practices in Mississippi. *Evaluation and Program Planning*, *52*, 198–204. https://doi.org/10.1016/j.evalprogplan.2015.06.002

Robinson, S. M., & Adinoff, B. (2018). The mixed message behind "medication-assisted treatment" for substance use disorder. *American Journal of Drug and Alcohol Abuse*, *44*(2), 147–150. https://doi.org/10.1080/00952990.2017.1362419

Rodriguez, A., & Smith, J. (2018). Phenomenology as a healthcare–research method. *Evidence-Based Nursing*, *21*(4), 96. https://doi.org/10.1136/eb-2018-102990

Room, R., Rehm, J., Trotter, R. T., II, & Paglia, A.(2001). Cross-cultural views on stigma, valuation, parity, and societal values towards disability. In T. B. Üstün, S. Chatterji, J. E. Bickenbach, R. T. Trotter II, R. Room, J. Rehm, & S. Saxena (Eds.), *Disability and culture: Universalism and diversity* (pp. 247–297). https://doi.org/10.17730/humo.60.1.ba5dnhqr7ek65jbx

Roose, R., Fuentes, L., & Cheema, M. (2012). Messages about methadone and buprenorphine in reality television: A content analysis of *Celebrity Rehab With Dr. Drew*. *Substance Use & Misuse*, *47*(10), 1117–1124. https://doi.org/10.3109/10826084.2012.680172

Rosenberg, A., Groves, A. K., & Blankenship, K. M. (2017). Comparing Black and White drug offenders: Implications for racial disparities in criminal justice and reentry policy and programming. *Journal of Drug Issues*, *47*(1), 132–142. https://doi.org/10.1177/0022042616678614

Rosenthal, E. S., Karchmer, A. W., Theisen-Toupal, J., Castillo, R. A., & Rowley, C. F. (2016). Suboptimal addiction interventions for patients hospitalized with injection drug use-associated infective endocarditis. *The American Journal of Medicine*, *129*(5), 481–485. https://doi.org/10.1016/j.amjmed.2015.09.024

Rosino, M. L., & Hughey, M. W. (2018). The war on drugs, racial meanings, and structural racism: A holistic and reproductive approach. *American Journal of Economics and Sociology*, *77*(3–4), 849–892. https://doi.org/10.1111/ajes.12228

Ross, L. E., Doctor, F., Dimito, A., Kuehl, D., & Armstrong, M. S. (2007). Can talking about oppression reduce depression? Modified CBT group treatment for LGBT people with depression. *Journal of Gay & Lesbian Social Services*, *19*(1), 1–15. https://doi.org/10.1300/j041v19n01_01

Ruel, E., Wagner, W. E., III, & Gillespie, B. J. (Eds.). (2016). *The practice of survey research: Theory and applications*. In. SAGE Publications, Inc. https://doi.org/10.4135/9781483391700

Rundle, S. M., Cunningham, J. A., & Hendershot, C. S. (2021). Implications of addiction diagnosis and addiction beliefs for public stigma: A cross-national experimental study. *Drug and Alcohol Review*, *40*(5), 842–846. https://doi.org/10.1111/dar.13244

Rüsch, N., & Xu, Z. (2017). Strategies to reduce mental illness stigma. In W. Gaebel, W. Rössler, & N. Sartori (Eds.), *The stigma of mental illness—End of the story?* (pp. 451–467). Springer. https://doi.org/10.1007/978-3-319-27839-1_24

Saloner, B., & Karthikeyan, S. (2015). Changes in substance abuse treatment use among individuals with opioid use disorders in the United States, 2004–2013. *JAMA Network*, *314*(14), 1515–1517. https://doi.org/10.1001/jama.2015.10345

Sanders, J. J., Roose, R. J., Lubrano, M. C., & Lucan, S. C. (2013). Meaning and methadone: Patient perceptions of methadone dose and a model to promote adherence to maintenance treatment. *Journal of Addiction Medicine*, *7*(5), 307–313. https://doi.org/10.1097/ADM.0b013e318297021e

Sanjari, M., Bahramnezhad, F., Fomani, F. K., Shoghi, M., & Cheraghi, M. A. (2014). Ethical challenges of researchers in qualitative studies: The necessity to develop a specific guideline. *Journal of Medical Ethics and History of Medicine*, *7*, Article 14. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4263394/pdf/jmehm-7-14.pdf

Santo, T., Jr., Clark, B., Hickman, M., Grebely, J., Campbell, G., Sordo, L., Chen, A., Tran, L. T., Bharat, C., Padmanathan, P., Cousins, G., Dupouy, J., Kelty, E., Muga, R., Nosyk, B., Min, J., Pavarin, R., Farrell, M., & Degenhardt, L. (2021). Association of opioid agonist treatment with all-cause mortality and specific causes of death among people with opioid dependence: A systematic review and meta-analysis. *JAMA Psychiatry*, *78*(9), 979–993. https://doi.org/10.1001/jamapsychiatry.2021.0976

Santoro, T. N., & Santoro, J. D. (2018). Racial bias in the US opioid epidemic: A review of the history of systemic bias and implications for care. *Cureus*, *10*(12), Article e3733. https://doi.org/10.7759/cureus.3733

Satel, S., & Lilienfeld, S. O. (2014). Addiction and the brain-disease fallacy. *Frontiers in Psychiatry*, *4*, Article141. https://doi.org/10.3389/fpsyt.2013.00141

Savin-Baden, M., & Howell-Major, C. (2013). *Qualitative research: The essential guide to theory and practice.* Routledge. https://doi.org/10.4324/9781003377986-2

Schneider, A., & Ingram, H. (1993). Social construction of target populations: Implications for politics and policy. *American Political Science Review*, *87*(2), 334–347. https://doi.org/10.2307/2939044

Scholl, L., Seth, P., Kariisa, M., Wilson, N., & Baldwin, G. (2019). Drug and opioid-involved overdose deaths—United States, 2013–2017. *Morbidity and Mortality Weekly Report*, *67*(51–52), 1419. https://doi.org/10.15585/mmwr.mm675152e1

Schomerus, G., Schwahn, C., Holzinger, A., Corrigan, P. W., Grabe, H. J., Carta, M. G., & Angermeyer, M. C. (2012). Evolution of public attitudes about mental illness: A systematic review and meta-analysis. *Acta Psychiatrica Scandinavica*, *125*(6), 440–452. https://doi.org/10.1111/j.1600-0447.2012.01826.x

Schwartz, R. P., Kelly, S. M., Mitchell, S. G., Gryczynski, J., O'Grady, K. E., Gandhi, D., Olsen, Y., & Jaffe, J. H. (2017). Patient-centered methadone treatment: A randomized clinical trial. *Addiction*, *112*(3), 454–464. https://doi.org/10.1111/add.13622

Shapiro, J. (2018). "Violence" in medicine: Necessary and unnecessary, intentional and unintentional. *Philosophy, Ethics & Humanities in Medicine*, *13*, Article 7. https://doi.org/10.1186/s13010-018-0059-y

Shim, J. K. (2010). Cultural health capital: A theoretical approach to understanding healthcare interactions and the dynamics of unequal treatment. *Journal of Health and Social Behavior*, *51*(1), 1–15. https://doi.org/10.1177/0022146509361185

Shoptaw, S., Stein, J. A., & Rawson, R. A. (2000). Burnout in substance abuse counselors: Impact of environment, attitudes, and clients with HIV. *Journal of Substance Abuse Treatment*, *19*(2), 117–126. https://doi.org/10.1016/s0740-5472(99)00106-3

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, *112*(S2), S117–S122. https://doi.org/10.2105/AJPH.2021.306665

Smith, B. D., & Manfredo, I. T. (2011). Frontline counselors in organizational contexts: A study of treatment practices in community settings. *Journal of Substance Abuse Treatment*, *41*(2), 124–136. https://doi.org/10.1016/j.jsat.2011.03.002

Smith, C. B. R. (2010). Socio-spatial stigmatization and the contested space of addiction treatment: Remapping strategies of opposition to the disorder of drugs. *Social Science & Medicine*, *70*(6), 859–866. https://doi.org/10.1016/j.socscimed.2009.10.033

Smith, J. A., & Osborn, M. (2003). Interpretative phenomenological analysis. In G. M. Breakwell (Ed.) *Doing social psychology research* (pp. 229–254). Blackwell. https://doi.org/10.1002/9780470776278.ch10

Smythe, T., Adelson, J. D., & Polack, S. (2020). Systematic review of interventions for reducing stigma experienced by children with disabilities and their families in low-and middle-income countries: State of the evidence. *Tropical Medicine & International Health*, *25*(5), 508–524. https://doi.org/10.1111/tmi.13388

Sokol, R., & Kunz, K. (2017, September 19). *Training future physicians to address opioid crisis*. Association of American Medical Colleges. https://news.aamc.org/patient-care/article/training-future-physicians-address-opioid-crisis.

Sommers, B. D., & Rosenbaum, S. (2011). Issues in health reform: How changes in eligibility may move millions back and forth between Medicaid and insurance exchanges. *Health Affairs*, *30*(2), 228–236. https://doi.org/10.1377/hlthaff.2010.1000

Sordo, L., Barrio, G., Bravo, M. J., Indave, B. I., Degenhardt, L., Wiessing, L., Ferri, M., & Pastor-Barriuso, R. (2017). Mortality risk during and after opioid substitution treatment: Systematic review and meta-analysis of cohort studies. *BMJ*, *357*, 1–14. https://doi.org/10.1136/bmj.j1550

Soyka, M., Zingg, C., Koller, G., & Kuefner, H. (2008). Retention rate and substance use in methadone and buprenorphine maintenance therapy and predictors of outcome: Results from a randomized study. *International Journal of Neuropsychopharmacology*, *11*(5), 641–653. https://doi.org/10.1017/s146114570700836x

Spade, D. (2015). *Normal life: Administrative violence, critical trans politics, and the limits of law*. Duke University Press.

Spencer, M. R., Warner, M., Bastian, B. A., Trinidad, J. P., & Hedegaard, H. (2019, March 21). Drug overdose deaths involving fentanyl, 2011–2016. *National Vital Statistics System*, 68(3), 1–19. https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68_03-508.pdf

Staiti, A. (2012). The pedagogic impulse of Husserl’s ways into transcendental phenomenology. *Graduate Faculty Philosophy Journal*, *33*(1), 39–56. https://doi.org/10.5840/gfpj20123313

Stancliff, S., Phillips, B. W., Maghsoudi, N., & Joseph, H. (2015). Harm reduction: Front line public health. *Journal of Addictive Diseases*, *34*(2–3), 206–219. https://doi.org/10.1080/10550887.2015.1059651

Stangl, A. L., Earnshaw, V. A., Logie, C. H., van Brakel, W., C Simbayi, L., Barré, I., & Dovidio, J. F. (2019). The Health Stigma and Discrimination Framework: A global, crosscutting framework to inform research, intervention development, and policy on health-related stigmas. *BMC Medicine*, *17*(1), 1–13. https://doi.org/10.1186/s12916-019-1271-3

Stanley, B. L., & Basu, A. (2023). “Chemical jail”: Culture-centered theorizing of carcerality in methadone maintenance treatment and addiction recovery in the United States. *Journal of Applied Communication Research*, 1–18. https://doi.org/10.1080/00909882.2023.2180770

Stanley, J. S. (2021). *Education level, recovery status, and 12 step adherence: Surveying substance use disorder counselors opiate replacement preferences* (Publication Number 28775951) [Doctoral dissertation, Capella University]. ProQuest Dissertations & Theses Global.

Stanton, A., McLeod, C., Luckey, B., Kissin, W. B., & Sonnenfeld, J. (2006, May 5). *Expanding treatment of opioid dependence: Initial physician and patient experiences with the adoption of buprenorphine*. [Conference presentation] American Society of Addiction Medicine Annual Conference.

Stein, B. D., Dick, A. W., Sorbero, M., Gordon, A. J., Burns, R. M., Leslie, D. L., & Pacula, R. L. (2018). A population-based examination of trends and disparities in medication treatment for opioid use disorders among Medicaid enrollees. *Substance Abuse*, *39*(4), 419–425. https://doi.org/10.1080/08897077.2018.1449166

Stenfors, T., Kajamaa, A., & Bennett, D. (2020). How to… assess the quality of qualitative research. *The Clinical Teacher*, *17*(6), 596–599. https://doi.org/10.1111/tct.13242

Stöffelmayr, B. E., Mavis, B. E., Sherry, L. A., & Chiu, C. W. (1999). The influence of recovery status and education on addiction counselors' approach to treatment. *Journal of Psychoactive Drugs*, *31*(2), 121–127. https://doi.org/10.1080/02791072.1999.10471734

Strike, C., & Watson, T. M. (2019). Losing the uphill battle? Emergent harm reduction interventions and barriers during the opioid overdose crisis in Canada. *International Journal of Drug Policy*, *71*, 178–182. https://doi.org/10.1016/j.drugpo.2019.02.005

Stringer, K. L., Langdon, K. J., McKenzie, M., Brockmann, B., & Marotta, P. (2021). Leveraging COVID-19 to sustain regulatory flexibility in the treatment of opioid use disorder. *Journal of Substance Abuse Treatment*, *123*, Article 108263. https://doi.org/10.1016/j.jsat.2020.108263

Stuart, H. (2017). What has proven effective in anti-stigma programming. In In W. Gaebel, W. Rössler,–& N. Sartorius (Eds.), *The stigma of mental illness—End of the story?* (pp. 497–514). Springer. https://doi.org/10.1007/978-3-319-27839-1_27

Substance Abuse and Mental Health Services Administration. (2016, September 8). *Results from the 2015 national survey on drug use and health: Detailed tables.* https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015.pdf

Substance Abuse and Mental Health Services Administration. (2022). *Key substance use and mental health indicators in the United States: Results from the 2021 National Survey on Drug Use and Health* (HHS Publication No. PEP22-07-01-005, NSDUH Series H-57). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/report/2021-nsduh-annual-national-report

Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act of 2018. Pub. L. 115-271 132 Stat. 3894 (2018). https://www.congress.gov/115/plaws/publ271/PLAW-115publ271.pdf

Sukhera, J., Knaak, S., Ungar, T., & Rehman, M. (2021). Dismantling structural stigma related to mental health and substance use: An educational framework. *Academic Medicine*, *97*(2), 175–181. https://doi.org/10.1097/acm.0000000000004451

Taxy, S., Samuels, J., & Adams, W. (2015). *Drug offenders in federal prison: Estimates of characteristics based on linked data.*, Bureau of Justice Statistics. https://bjs.ojp.gov/redirect-legacy/content/pub/pdf/dofp12.pdf

Taylor, C. (2014). Biopower. In D. Taylor (Ed.), *Michel Foucault: Key concepts* (pp. 49–62). Routledge. https://doi.org/10.1017/upo9781844654734.004

Thompson, R. G., Wall, M. M., Greenstein, E., Grant, B. F., & Hasin, D. S. (2013). Substance-use disorders and poverty as prospective predictors of first-time homelessness in the United States. *American Journal of Public Health*, *103*(S2), S282–S288. https://doi.org/10.2105/AJPH.2013.301302

Torrens, M., Fonseca, F., Castillo, C., & Domingo-Salvany, A. (2013). Methadone maintenance treatment in Spain: The success of a harm reduction approach. *Bulletin of the World Health Organization*, *91*(2), 136–141. https://doi.org/10.2471/blt.12.111054

Trecki, J. (2022). Notes from the field: Increased incidence of fentanyl-related deaths involving para-fluorofentanyl or metonitazene—Knox County, Tennessee, November 2020–August 2021. *Morbidity and Mortality Weekly Report*, *71*(4), 153–155. https://doi.org/10.15585/mmwr.mm7104a3

Treitler, P. C., Bowden, C. F., Lloyd, J., Enich, M., Nyaku, A. N., & Crystal, S. (2022). Perspectives of opioid use disorder treatment providers during COVID-19: Adapting to flexibilities and sustaining reforms. *Journal of Substance Abuse Treatment*, *132*, Article 108514. https://doi.org/10.1016/j.jsat.2021.108514

Trujols, J. (2015). The brain disease model of addiction: Challenging or reinforcing stigma? *The Lancet Psychiatry*, *2*(4), 292. https://doi.org/10.1016/s2215-0366(15)00050-4

Tsai, A. C., Kiang, M. V., Barnett, M. L., Beletsky, L., Keyes, K. M., McGinty, E. E., Smith, L. R., Strathdee, S. A., Wakeman, S. E., & Venkataramani, A. S. (2019). Stigma as a fundamental hindrance to the United States opioid overdose crisis response. *PloS Medicine*, *16*(11), Article e1002969. https://doi.org/10.1371/journal.pmed.1002969

Turan, J. M., Elafros, M. A., Logie, C. H., Banik, S., Turan, B., Crockett, K. B., Pescosolido, B., & Murray, S. M. (2019). Challenges and opportunities in examining and addressing intersectional stigma and health. *BMC Medicine*, *17*(1), Article 7. https://doi.org/10.1186/s12916-018-1246-9

United Nations. (n.d.). *United Nations Conference for the Adoption of a Single Convention on Narcotic Drugs 24 January–25 March 1961, New York.* https://www.un.org/en/conferences/drug/newyork1961

United States Senate Committee on the District of Columbia. (1969). *Crime in the National Capital: Hearings Before the Committee on the District of Columbia, United States Senate, Ninety-first Congress, First Session on Drug Abuse in the Washington Area. March 25, 26; April 9, 10, and 11*, Part 2. U.S. Government Printing Office.

United States Sentencing Commission. (1995, February). Special report to Congress: Cocaine and federal sentencing policy. https://www.ussc.gov/sites/default/files/pdf/news/congressional-testimony-and-reports/drug-topics/199502-rtc-cocaine-sentencing-policy/1995-Crack-Report_Full.pdf

van Boekel, L. C., Brouwers, E. P. M., van Weeghel, J., & Garretsen, H. F. L. (2013). Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: Systematic review. *Drug and Alcohol Dependence*, *131*(1), 23–35. https://doi.org/10.1016/j.drugalcdep.2013.02.018

van Manen, M. (2016). *Researching lived experience: Human science for an action sensitive pedagogy.* Routledge.

Vansteenkiste, M., Williams, G. C., & Resnicow, K. (2012). Toward systematic integration between self-determination theory and motivational interviewing as examples of top-down and bottom-up intervention development: Autonomy or volition as a fundamental theoretical principle. *International Journal of Behavioral Nutrition and Physical Activity*, *9*(1), Article 23. https://doi.org/10.1186/1479-5868-9-23

Vestal, C. (2018, October 31). Long stigmatized, methadone clinics multiply in some states. *Stateline*. https://pew.org/2ABneWM

Vigilant, L. G. (2016). The stigma paradox in methadone maintenance: Naïve and positive consequences of a "treatment punishment" approach to opiate addiction. *Humanity & Society*, *28*(4), 403–418. https://doi.org/10.1177/016059760402800404

Vitásková, K., & Pavlovská, A. (2018). University education of social workers in addictological issues in Europe and the USA: A review. *Adiktologie*, *18*(2), 87–95. https://www.addictology.cz/wp-content/uploads/2019/02/04_vitaskova.pdf

Volkow, N. D., Frieden, T. R., Hyde, P. S., & Cha, S. S. (2014). Medication-assisted therapies —Tackling the opioid-overdose epidemic. *New England Journal of Medicine*, *370*(22), 2063–2066. https://doi.org/10.1056/NEJMp1402780

Volkow, N. D., Koob, G. F., & McLellan, A. T. (2016). Neurobiologic advances from the brain disease model of addiction. *New England Journal of Medicine*, *374*(4), 363–371. https://doi.org/10.1056/nejmra1511480

Volkow, N. D., & Morales, M. (2015). The brain on drugs: From reward to addiction. *Cell*, *162*(4), 712–725. https://doi.org/10.1016/j.cell.2015.07.046

Volkow, N. D., & Thomas, M. A. (2016). Opioid abuse in chronic pain—Misconceptions and mitigation strategies. *New England Journal of Medicine*, *374*(13), 1253–1263. https://doi.org/10.1056/NEJMra1507771

Wakeman, S. E. (2019). The language of stigma and addiction. In J. D. Avery & J. J. Avery (Eds.), *The stigma of addiction: An essential guide* (pp. 71–80). Springer. https://doi.org/10.1007/978-3-030-02580-9_5

Wakeman, S. E., & Rich, J. D. (2018). Barriers to medications for addiction treatment: How stigma kills. *Substance Use & Misuse*, *53*(2), 330–333. https://doi.org/10.1080/10826084.2017.1363238

Wallace, R. (1990). Urban desertification, public health and public order: "Planned shrinkage," violent death, substance abuse and AIDS in the Bronx. *Social Science & Medicine*, *31*(7), 801–813. https://doi.org/10.1016/0277-9536(90)90175-r

Wang, P. S., Angermeyer, M., Borges, G., Bruffaerts, R., Tat Chiu, W. T., de Girolamo, G., Fayyad, J., Gureje, O., Haro, J. M., Huang, Y., Kessler, R. C., Kovess, V., Levinson, D., Nakane, Y., Oakley Brown, M. A., Ormel, J. H., Posada-Villa, J., Aguilar-Gaxiola, S., Alonso, J., . . . Ustün, T. B. (2007). Delay and failure in treatment seeking after first onset of mental disorders in the World Health Organization's World Mental Health Survey Initiative. *World Psychiatry*, *6*(3), 177–185.

Western, B. (2006). *Punishment and inequality in America*. Russell Sage Foundation.

White, S., Foster, R., Marks, J., Morshead, R., Goldsmith, L., Barlow, S., Sin, J., & Gillard, S. (2020). The effectiveness of one-to-one peer support in mental health services: A systematic review and meta-analysis. *BMC Psychiatry*, *20*(1), 1–20. https://doi.org/10.1186/s12888-020-02923-3

White, W. L. (2014). *Slaying the dragon: The history of addiction treatment and recovery in America* (2nd ed). https://doi.org/10.3138/cbmh.18.1.157

Wilkerson, I. (2020). *Caste: The origins of our discontents*. Random House.

Woo, J., Bhalerao, A., Bawor, M., Bhatt, M., Dennis, B., Mouravska, N., Zielinski, L., & Samaan, Z. (2017). "Don't judge a book by its cover": A qualitative study of methadone patients' experiences of stigma. *Substance Abuse: Research and Treatment*, *11*. https://doi.org/10.1177/1178221816685087

Wood, L., Byrne, R., & Morrison, A. P. (2017). An integrative cognitive model of internalized stigma in psychosis. *Behavioural and Cognitive Psychotherapy*, *45*(6), 545–560. https://doi.org/10.1017/s1352465817000224

Woods, J. S., & Joseph, H. (2018). From narcotic to normalizer: The misperception of methadone treatment and the persistence of prejudice and bias. *Substance Use & Misuse*, *53*(2), 323–329. https://doi.org/10.1080/10826084.2017.1400068

Woody, G. E., Kane, V., Lewis, K., & Thompson, R. (2007). Premature deaths after discharge from methadone maintenance: A replication. *Journal of Addiction Medicine*, *1*(4), 180–185. https://doi.org/10.1097/ADM.0b013e318155980e

Woolf, S. H., & Schoomaker, H. (2019). Life expectancy and mortality rates in the United States, 1959–2017. *JAMA*, *322*(20), 1996–2016. https://doi.org/10.1001/jama.2019.16932

Working Group on Best Practice for Harm Reduction Programs in Canada. (2013). *Best practice recommendations for Canadian harm reduction programs that provide service to people who use drugs and are at risk for HIV, HCV, and other harms: Part 1*. https://www.catie.ca/sites/default/files/2021-11/3382_CATIE_CarolStrike_BestPracticeRecommendations_2021-EN-Final.pdf

World Health Organization. (2018). *WHO housing and health guidelines*. https://www.who.int/sustainable-development/publications/housing-health-guidelines/en/

World Health Organization. (2021). *Comprehensive mental health action plan 2013–2030*. https://apps.who.int/iris/rest/bitstreams/1371507/retrieve

Wykes, T., Bell, A., Carr, S., Coldham, T., Gilbody, S., Hotopf, M., Johnson, S., Kabir, T., Pinfold, V., Sweeney, A., Jones, P. B., & Creswell, C. (2021). Shared goals for mental health research: What, why and when for the 2020s. *Journal of Mental Health*, 1–9. https://doi.org/10.1080/09638237.2021.1898552

Yang, L. H., Wong, L. Y., Grivel, M. M., & Hasin, D. S. (2017). Stigma and substance use disorders: An international phenomenon. *Current Opinion in Psychiatry*, *30*(5), 378–388. https://doi.org/10.1097/yco.0000000000000351

Yarborough, B. J. H., Stumbo, S. P., McCarty, D., Mertens, J., Weisner, C., & Green, C. A. (2016). Methadone, buprenorphine and preferences for opioid agonist treatment: A qualitative analysis. *Drug and Alcohol Dependence*, *160*, 112–118. https://doi.org/10.1016/j.drugalcdep. 2015.12.031

Yellen, D. (1995). Reforming cocaine sentencing: The new commission speaks. *Federal Sentencing Reporter*, *8*(1), 54–58. https://doi.org/10.2307/20639852

Yoon, G. H., Levengood, T. W., Davoust, M. J., Ogden, S. N., Kral, A. H., Cahill, S. R., & Bazzi, A. R. (2022). Implementation and sustainability of safe consumption sites: A qualitative systematic review and thematic synthesis. *Harm Reduction Journal*, *19*(1), Article 73. https://doi.org/10.1186/s12954-022–00655-z

Zahavi, D. (2018). *Phenomenology: The basics*. Routledge. https://doi.org/10.4324/9781315441603

Zelenev, A., Shea, P., Mazhnaya, A., Rozanova, J., Madden, L., Marcus, R., & Altice, F. L. (2018). Assessment of barrier severity and willingness to enter opioid agonist treatment among people who inject drugs in Ukraine. *Drug and Alcohol Dependence*, *190*, 82–88. https://doi.org/10.1016/j.drugalcdep. 2018.05.027

Zwick, J., Appleseth, H., & Arndt, S. (2020). Stigma: How it affects the substance use disorder patient. *Substance Abuse Treatment, Prevention, and Policy*, *15*(1), Article 50. https://doi.org/10.1186/s13011-020-00288-0

APPENDIX A: INTERVIEW GUIDE

Introductory comments: Thank you for agreeing to speak with me today. As a reminder, your participation is voluntary and confidential.

I am interested in your experiences of working with people utilizing methadone treatment and your overall experiences of working in MMT- particularly over the course of the pandemic. I am hoping to hear some of your stories of your journey, including learning how you came to this work, your experiences with people in treatment before and through COVID as well as your thoughts post COVID.

Interview Questions:

1. How did you come to work in substance abuse?

   Prompts: was it a calling? Early background w/SUDs, training, philosophy of treatment

2. How did you first learn about methadone? What did you think about it? How about the people using the treatment? What were your first experiences like?

   Prompts: Understanding of the medication, early training experiences, exposure

3. What led you to your current position as a counselor providing methadone treatment? What is it like for you being a provider? Describe what a day is like for you and what your experiences are working with clients. Challenges/Joys of the day?

   Prompts: story of the day- story of clients- evoke feelings. early experiences with clients and reactions to the clinic and clients. Evoke rule structure experience, feelings with clients. Challenges of the day- joys of the day, What keeps you coming back?

4. Can you tell me about the people you treat? Who are they? What's it like providing services for them? How do they respond to being in the clinic and to the treatment?

5. Many patients use substances other than opioids or continue to use opioids, and struggle with those even though they are in treatment, *what's your experience* of this and how do you respond to their continued use- *prompt for an interaction*. Describe a scenario.

   Prompts: Clinic practices? Alignment with your own treatment philosophy- continued use of methadone? Clients investment in recovery?

6. There are a lot of rules associated with methadone, when did you first learn about these rules and what was your experience of them? What is the purpose of the rule

structure? How do you feel they support a person's recovery process? Give some examples.

Prompts: Encourage specific discussion on rules: diversion, observed dosing, observed urines

7. How do the rules impact your interactions with clients- example

   Prompts: around various rules such as diversion, observed dosing

8. Since COVID-19 began methadone rules have been relaxed. How did your clinic and your practice change since COVID? Did it change your interactions with patients? And how did you feel about it?

   Prompts: Focus on their description of practice: bottles, telemedicine

9. What did you experience with your patients? Give some examples. What did they experience? How did it change your approach to treatment?
10. The waivers remain on the books, at least for now. Has your clinic changed your approach to the waivers over time? Have you changed your approach? How so- and give some examples?
11. There is a lot of conversation going on about changing the rule structure of methadone treatment. What do you believe should happen? Would these changes support patients recovery process?
12. What else would you like to tell me about your experience working in MMTs with people who have OUD?

APPENDIX B: EXTERNAL INFORMED CONSENT

Study on Addiction Counselors Lived Experiences

You are invited to participate in my doctoral dissertation research on Addiction Counselors' lived experiences. Particularly, I am interested in hearing the experiences of **addiction counselors who are employed in programs providing treatment for opioid use disorder utilizing methadone**. Specifically, I am looking to interview counselors who were working at least 6 months prior to the onset of COVID-19 (March, 2020) through the present day.

Participating in the study means taking part in an individual interview with me that will last about 45 to 60 minutes. The interview can take place via Zoom video conference.

Your participation is voluntary. You are free to choose whether or not to participate in this study. If you choose to participate in an interview, you are free to decline to answer any question or to stop the interview at any time. Please know that there will be no hard feelings if you choose not to take part in the study or if you do participate and then withdraw.

Your participation is confidential. Your identity and the information you provide will be kept confidential. I will combine the information you provide with the responses of other study participants, and I will remove any identifying information from my notes and the transcript of our interview. You will not be named in any reports of this research. With your permission, I would like to record our interview for accuracy. Once I have transcribed the interview in writing, I will delete/erase the recording. Please initial here if you consent to be recorded: ____________

There are no known risks to participating in this study beyond those of everyday life. There is no direct benefit to you for your participation. However, by sharing your experience and insights in this study, you may contribute to our understanding of the lived experiences of addiction counselors working in OTPs and their relationship the individuals you serve.

If you have any questions, please contact me or my faculty sponsor using the information below.

Thank you for considering my request for your help.

Sincerely,

Kathy Eggert, Ph.D. Candidate, Antioch University
(email)
(phone number)

Beth Mabry, Ph.D., Professor, Antioch University
Graduate School of Leadership and Change
(email)

This study was reviewed by the Antioch University Institutional Review Board for the Protection of Human Subjects (Dr. Lisa Kreeger, Chair).

Signed Informed Consent (please print your name below, check the box yes or no, and date.

- I am age 18 or older
- I have read the above informed consent form
- I voluntarily agree to par9cipate in the study
- I give my consent for recording the interview

Printed Name of Participant:

____

Agree to participate: Yes_____. No______.

Date:________________________________

If you find that you want to talk with someone about your experiences or feelings after participating in this study, please contact the Crisis Text-line (Text HOME to (xxxx) or call (Toll free #)

APPENDIX C: INTERNAL INFORMED CONSENT FORM

Study on Addiction Counselors Lived Experiences

INFORMED CONSENT FORM

My name is Ermonda Markaj and I am a Research Project Coordinator at the APT Foundation. I am contacting you to invite you to an individual interview with me in my work with Kathy Eggert's doctoral dissertation research on Addiction Counselors lived experiences. Kathy, who is the director at the APT Congress Avenue location, is a Ph.D. candidate at Antioch University's Graduate School of Leadership and Change. She is interested in hearing the experiences of **addiction counselors who are employed in programs providing treatment for opioid use disorder utilizing methadone**. Specifically, she is interested in the perspectives of counselors who were working at least 6 months prior to the onset of COVID-19 (March, 2020) through the present day.

So that we can gather data and insights from APT counselors, I will conduct confidential individual interviews with counselors willing to be in Kathy's study. I will not reveal to Kathy or anyone else at the APT Foundation who takes part in the research or who declines to be in the study. Further, the data shared with me will be de-identified so that there is no way the researchers could identify responses with the person who provided them,

Interviews will last about 60 minutes. The interview will take place via Zoom video conference. With your permission, I would like to record our interview for accuracy. Once transcripts are completed and their accuracy verified, the recording will be deleted. Until then they will be password protected and only I, as the interviewer, will have access to them.

Your participation is voluntary. You are free to choose whether or not to participate in this study. If you choose to participate in an interview, you are free to decline to answer any question or to stop the interview at any time. Please know that there will be no hard feelings if you choose not to take part in the study or if you do participate and then withdraw.

Your participation is confidential. Your identity and the information you provide will be kept confidential. Prior to the transcripts being given to the researcher, Kathy, I will remove any identifying information from the transcripts and my notes. After I remove any identifying information, my notes and transcripts will be reviewed by the faculty sponsor on Kathy's dissertation project to help ensure identifying information is removed and your confidentiality is maintained. Only then will the information you provide be combined with the responses of other study participants and given to Kathy for analysis as part of her larger project. You will not be named in any reports of this research and Kathy will not know who chooses to participate or not in the study.

There are no known risks to participating in this study beyond those of everyday life. The only material benefit to you for your participation is a token of appreciation in the form of a $25 gift card. Some participants may find it gratifying to share their experiences and insights about their professional work. By participating in this study, you may contribute to our understanding of the lived experiences of addiction counselors working in OTPs and their relationship to the individuals you serve.

If you have any questions, please contact me or the faculty sponsor using the information below. **Thank you** for considering my request for your help.

Sincerely,

Ermonda Markaj
(email)
(phone number)

Beth Mabry, Ph.D., Professor, Faculty Sponsor
Graduate School of Leadership and Change
Antioch University, (email)

This study was reviewed by the Antioch University Institutional Review Board for the Protection of Human Subjects (Dr. Lisa Kreeger, Chair, email).

Signed Informed Consent (you may print, sign, and scan or take a picture of this page)

- I am age 18 or older
- I have read the above informed consent form
- I voluntarily agree to par9cipate in the study
- I give my consent for recording the interview

Printed Name of Participant:

____

_______________________________________ _________________

Signature Date

If you find that you want to talk with someone about your experiences or feelings after participating in this study, please contact the Crisis Text-line (Text HOME to XXXXX) or call 1-800-xxx-xxxx.

APPENDIX D: EXTERNAL INVITATION TO PARTICIPATE

Hi. My name is Kathy Eggert, I am a doctoral student completing my dissertation project through Antioch University Graduate School of Leadership and Change. I also have been employed at the APT Foundation where I am the director of one of our methadone maintenance programs.

I am interested in the lived experiences of addiction counselors who work providing treatment with methadone. I am particularly curious of your experiences both before the pandemic and up to now. I am looking to interview counselors/clinicians who were employed in methadone maintenance programs at least six months prior to the emergency waivers put in place by SAMHSHA- September 2019 through the present day.

Your participation is voluntary, and all the interview data will remain confidential. Interviews will be held on zoom for your convenience and take approximately one hour. The session will be recorded and transcribed. Once the transcription has been reviewed and de-identified, the recording will be deleted.

For people who participate, you will receive a $25 Visa gift card as a thank you for your time.

If you have an interest in learning more about the study, please feel free to call me at (phone number) or send me an email at (email address)

Thank you for your consideration and assistance,

Kathy

APPENDIX E: INTERNAL INVITATION TO PARTICIPATE

Study of Addiction Counselors' Lived Experience Working in Opioid Treatment Programs

Telephone Script or email for Participants Internal to the APT Foundation
Invitation to Participate: Lived Experiences of Addiction Counselors'
Dissertation Project: Kathy Eggert, Ph. D. Candidate, Antioch University
(email, phone number)

Clinical Staff,

Many of you know me as the director of the Legion Clinic. Additionally, I am a doctoral student completing my dissertation project through Antioch University Graduate School of Leadership and Change. My project has been reviewed and approved by both the APT Foundation Board as well as the Antioch IRB.

I am interested in the lived experiences of addiction counselors/clinicians providing treatment in methadone maintenance programs. I am particularly curious about your experiences both before the pandemic and up to now. I am interested in interviewing counselors/clinicians who were employed in methadone maintenance programs *at least six months prior to the emergency waivers put in place by SAMHSHA- September 2019 through the present day.*

Your participation is voluntary, and all the interview data will remain confidential. Your choice to participate or not has no bearing on your employment. Interviews will be held on Zoom for your convenience and will take approximately one hour. The interviews will be conducted by Ermonda Markaj, research assistant for the Foundation. The session will be recorded and transcribed, and de-identified. Once the transcriptions have been de-identified, the recordings will be deleted. At no time will I or other employees at the Foundation know your identity.

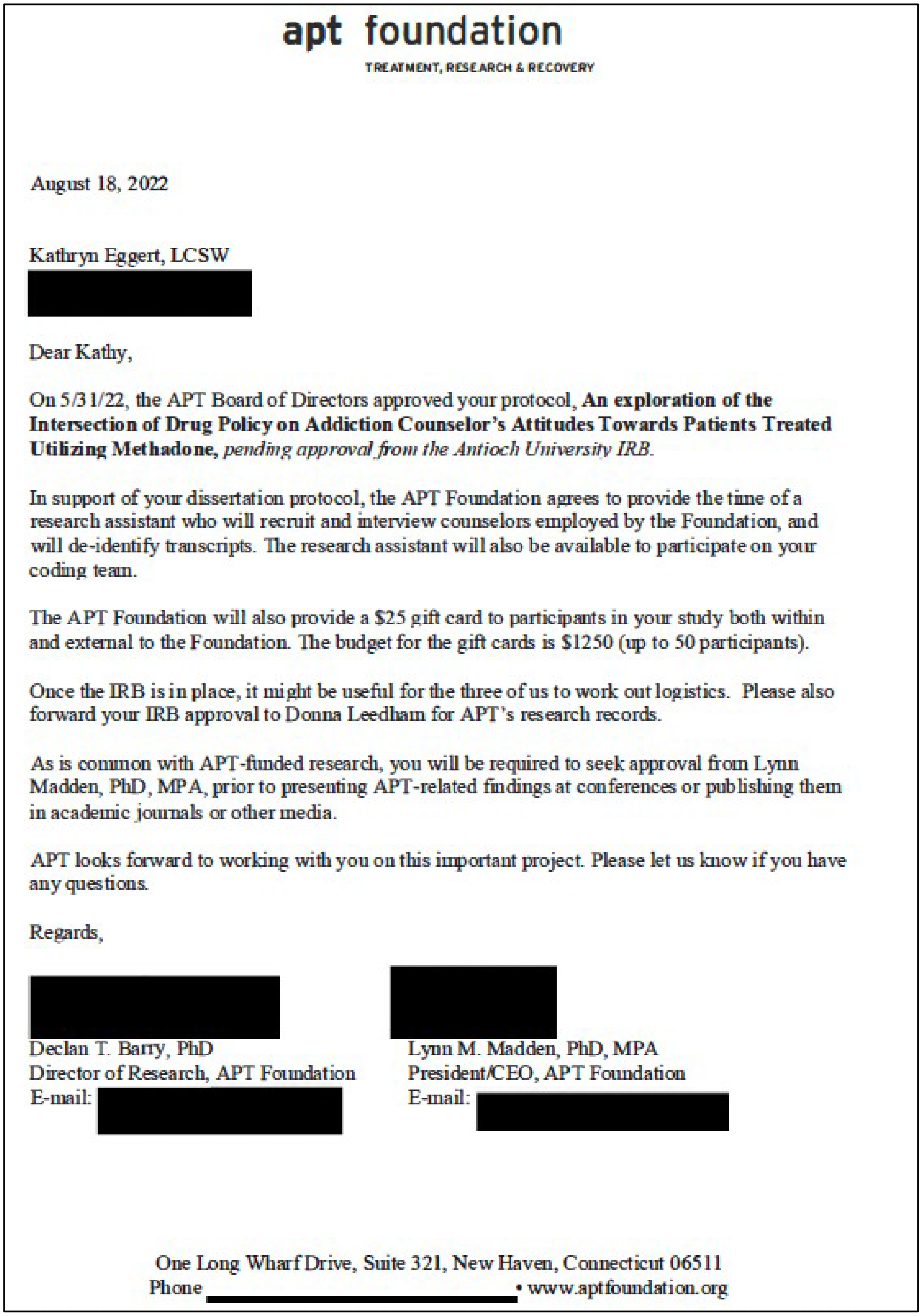
For people who participate, you will receive a $25 gift card as a thank you for your time.

If you have an interest in learning more about the study, please contact Ermonda Markaj at (xxx) xxx-XXXX.

Thank you for your time and consideration!

Kathy Eggert, LCSW, Ph.D. Candidate

APPENDIX F: LETTER OF AGREEMENT



apt foundation
TREATMENT, RESEARCH & RECOVERY

August 18, 2022

Kathryn Eggert, LCSW
[redacted]

Dear Kathy,

On 5/31/22, the APT Board of Directors approved your protocol, **An exploration of the Intersection of Drug Policy on Addiction Counselor's Attitudes Towards Patients Treated Utilizing Methadone,** *pending approval from the Antioch University IRB.*

In support of your dissertation protocol, the APT Foundation agrees to provide the time of a research assistant who will recruit and interview counselors employed by the Foundation, and will de-identify transcripts. The research assistant will also be available to participate on your coding team.

The APT Foundation will also provide a $25 gift card to participants in your study both within and external to the Foundation. The budget for the gift cards is $1250 (up to 50 participants).

Once the IRB is in place, it might be useful for the three of us to work out logistics. Please also forward your IRB approval to Donna Leedham for APT's research records.

As is common with APT-funded research, you will be required to seek approval from Lynn Madden, PhD, MPA, prior to presenting APT-related findings at conferences or publishing them in academic journals or other media.

APT looks forward to working with you on this important project. Please let us know if you have any questions.

Regards,

[redacted]
Declan T. Barry, PhD
Director of Research, APT Foundation
E-mail: [redacted]

[redacted]
Lynn M. Madden, PhD, MPA
President/CEO, APT Foundation
E-mail: [redacted]

One Long Wharf Drive, Suite 321, New Haven, Connecticut 06511
Phone [redacted] • www.aptfoundation.org

APPENDIX G: RESEARCH ASSISTANT CONFIDENTIALITY AGREEMENT

Study of Addiction Counselors Lived Experiences
Confidentiality Agreement: Research Assistants

I, _Ermonda Markaj_, acknowledge receiving training on confidentiality in relationship to the current study. I understand that to minimize conflicts of interest it is essential that other members of the research team (Kathy Eggert, Declan Barry, Ph.D.) at no time should be aware of the identities of counselors that are present for recruitment, screening, or subsequent declining to participate, or participation in the study. Specifically, I agree to the following:

1. Not reveal the identities of any counseling staff that are present at staff meetings where recruiting is occurring to any other employee.

2. Store all sign-up sheets or logs in a locked cabinet.

3. Make all calls, hold all interviews in a secure area aware from other staff members.

4. Follow the guidelines around de-identification including removal of names, utilize gender neutral language, deletion of references to locations, and other information that may contribute to recognition of a participant's identity.

5. Upon completion of transcription and de-identification of those transcriptions, delete the videos.

6. When meeting with the research team, refer to cases by assigned case number.

If questions or concerns arise at any point and time during the course of the study, general questions can be discussed with Kathy Eggert and/or Beth Mabry, Ph.D. faculty sponsor (See contact information below).

_E.Markaj________. ______11/29/22___

Signature Date

Contact Information:
Kathy Eggert
Office (Phone)
Cell (Phone)
(Eggert email)

Beth Mabry, Ph.D.
(Mabry email)

APPENDIX H: RESEARCH ASSISTANT TRAINING OUTLINE

Training Outline: Lived Experiences of Addiction Counselors'
Dissertation Project: Kathy Eggert, Antioch University

I: Review of Health Privacy
    A: Basic Information on Confidentiality
    B: HIPPAA
    C: Protected Populations (substance use disorders)
II: Overview of Human Participants in Research
    A: Belmont Report
    B: History & Ethical Principles
    C: Defining Research & Federal Regulations
    D: Informed Consent
    E: Conflicts of Interest
    F: Data Management
III: Review of Kathy's Dissertation
    A: Highlight Literature Review
    B: Research Positionality
    C: Research Question and Goals
    D: Review of RAs roles
    E: Review of Confidentiality Issues Specific to this Study
IV: Recruitment Procedures
V: Scheduling and Gaining Informed Consent
VI: Review Interview Guide, Sensitizing Concepts, Schedule Mock Interviews
VII: Transcription & Deidentification of Transcription
VIII: Record Management
IX: Coding, Coding Approach
X: Managing Conflict & Questions