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Developing a Penal Abolitionist Application to Drug Treatment Drawing from Insider Perspectives and Lived Experiences

Denise Woodall[2] and **Miriam Boeri**[1]

Abstract

As evidence of a failing war on drugs mounts and a deadly opioid crisis continues, U.S. drug policy is slowly changing to less punitive responses to drug use. Collaborations between treatment programs and law enforcement gained praise from politicians, but concerns regarding the impact of increased surveillance and the rising culture of control call for greater focus on these governing relationships. Framed within an abolitionist perspective, and incorporating insights from successful models of decriminalization in Portugal and deinstitutionalization in Italy, our analysis of in-depth interviews with 117 people who are actively using opioids seeks to understand their perspectives on treatment drawing on lived experiences. Findings reveal a need for a paradigm shift in drug policy as well as treatment practices and increased access to targeted social resources in the community. An application of penal abolition policy requires decriminalizing (or legalizing) drug use and creating commissions composed of community members, peers, and professionals disconnected from the criminal justice system.

[1] Bentley University, Waltham, MA, USA
[2] University of North Georgia, Dahlonega, GA, USA

Corresponding Author:
Miriam Boeri, Bentley University, 175 Forest Street, MOR 193, Waltham, MA 02452, USA.
Email: mboeri@bentley.edu

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Personal Reflexive Statements

Miriam Boeri: My older brother used prescription opioids when he was twelve years old, spent his youth in juvenile detention homes, became dependent on heroin as a young adult, and lived most of his adult life in prison. His story, chronicled in my book Hurt, was the impetus for my interest in drug use as a research focus. The heartbreaking significance of my brother's life and those of the generation coming into adulthood under the war on drugs, most tragically for people of color, shows that drug policy in the U.S. must change or more generations will needlessly suffer. As an ethnographer, I spent more than twenty years talking to people who use illegal drugs in social settings where they live, work and play. Fortunately, I was trained in how to write grant proposals, which allowed me to continue this kind of research, as well as support and train other researchers in ethnographic methods and pay my study participants for their time. This paper is based on NIH-funded ethnographic research among people who use opioids in suburban towns, a largely ignored population that was highly impacted by the recent opioid epidemic. Based on their insights, and models that have worked in other countries, this paper presents an alternative to treatment policy and practice in the U.S., drawing from abolitionist philosophy.

Denise Woodall: I have worked with drug users seeking recovery in the community context for nearly 16 years, and I have researched drug use and users' experiences for nearly 10 years. I have also been directly impacted by substance dependence in my youth. After seeing possibly hundreds of people who use drugs seek recovery and fail to remain completely abstinent for long, I sought to discover the many ways that drug users manage to improve their lives and to understand their struggles with conventional treatment. The modes of treatment available in the U.S. today work for some people, but unfortunately, not enough. I desire to see innovative, creative, open, and flexible approaches to helping people who use drugs improve their lives if they need it, and to help them minimize harm if they feel they don't. In my mind, the need for new ideas and fresh approaches is urgent.

Introduction

An onslaught of evidence has increased public awareness of the failure of the war on drugs (Alexander 2012; Boeri 2018; Inciardi 2008). Acknowledgement of the social injustices and racial disparities spawned by this Lernaean hydra has ignited prison-reform movements across the United States (U.S.) calling for an end to the incarceration of people who use illegal substances. Since drug violations have been the

primary driver of the prison population since the war of drugs began in 1971, providing treatment instead of a criminal conviction could signify the eventual demise of the "prison industrial complex" (Davis 1998). Yet, treatment often remains under the control of law enforcement. Compulsory drug treatment within the criminal justice system has increased, and special courts for "drug offenders" have been launched across the nation (Nolan 2009; Werb et al. 2016). Mandated and coerced treatment include those who are provided a choice between treatment or jail by judges, as well as those given the option of treatment or losing their jobs, children, friends or families. Treatment is an ambiguous concept and treatment programs are typically unregulated, leaving the definition of success unevenly defined (Calabria et al. 2010).

Policy and practice governing drug use and treatment is controversial politically and ideologically (Fraser, Moore, and Keane 2014; Garland 2001). Practice addressing heroin use became less punitive in the U.S. since the contemporary "opioid epidemic" emerged as a problem primarily among white, working and middle-class populations (Cicero et al. 2014), triggering a national movement toward treatment rather than jail for people with opioid dependence (Fedders 2019). With over 2 million people diagnosed with opioid use disorder in the U.S., and overdose deaths doubling since 2010, federal and state governments are funding programs to provide more access to treatment (Collins Koroshetz, and Volkow 2018; Hedegaard, Warner and Miniño 2017; Jones 2013). Recent conceptualizations of drug addiction as a chronic illness require long-term, and sometimes lifelong, treatments (McLellan et al. 2014).

Progressive politicians, activist organizations, concerned citizens, and even some law enforcement organizations are seeking policy that places people with drug use problems in the care of the medical establishment instead of the criminal justice system (Reinarman 2015; Yerramsetti et al. 2017). Abolitionists question the effectiveness of reforms and the tethering of medical and social services to institutions of punishment (American Friends Service Committee 2014; Native Youth Sexual Health Network n.d.; Schept 2015). As more voices join in the chorus of prison reform, few are taking a critical look at how this great awakening is impacting the people it claims to be helping.

Our goal in this paper is to inform policy initiatives, practices, and community activism related to drug treatment by applying tenants of abolitionism. We analyze the narratives of people who are using opioids to gain an insider understanding on their perspectives on treatment, how they think treatment could be better, and what they see as alternative strategies. We situate our analysis in the abolitionist possibilities for drug treatment that have been envisioned, and even practiced, by the Young Lords, the Black Panther Party, the Native Youth Sexual Health Network, and other abolitionist organizations.

To honor the harms that our participants experienced at some time in their opioid-use trajectories while also remaining open enough to express the daily variation in their using experiences, we attempt to communicate their experience accurately. To accomplish this while still engaging with the practitioner vernacular, we decided to

use the term “misuse.” “Misuse” is defined as the use of opioids in a manner that causes health or social problems (McLellan 2017). Although the word “misuse” may or may not be the word participants used to report health or social problems resulting from their use, we considered “misuse” to be general enough language to allow participants to broadly conceptualize those problems. Although their particular problems are often related to the illegality of opioids, the social conditions of capitalism, the limitation of services, the deterioration of community, and the social stigma of drug use, their problems may also be related to the pharmacology of the substance. For example, they often feel a daily “need” for it, miss out on important life events and social roles in the face of powerful physical cravings to use, and they may experience feelings of being unable to live without it. All of these factors, social and pharmacological, can lead to, or be conceptualized as, “misuse.” We articulate the participants interpretation of their experiences in line with the mission of the Native Youth Sexual Health Network’s indigenous transformative resurgent philosophies in that we believe that researchers and practitioners do not know more about drug use than the directly impacted participants do. Therefore, regardless of our theoretical or philosophical leanings we strive to honor the harms of opioid use and its treatment that all of our participants reported to varying degrees.

The category of opioids includes prescription analgesics (e.g., oxycodone), illegal opioids (e.g., heroin), and synthetic forms of opioids, such as fentanyl. Our data is drawn from in-depth interviews collected during ethnographic research in the suburbs of Atlanta, Georgia and Boston, Massachusetts (US). The following background provides a brief historical and social context of U.S. drug policy and an overview of treatment practices and models.

Background

Political and Social Background

The term “prison industrial complex” is attributed to Angela Davis (1998), who argued that imprisoning people for alleged crimes takes care of social problems like homelessness, drug addiction, and unemployment by hiding them from public view. In the same year, investigative journalist Eric Schlosser used the concept of an industrial complex to illustrate the profitable relationship between government and corporations in which “the raw material of the prison industrial complex is its inmates: the poor, the homeless, and the mentally ill; drug dealers, drug addicts (sic), alcoholics, and a wide assortment of violent sociopaths” (Schlosser 1998:7) The prison industrial complex was fueled by the mass incarceration of people who use drugs, eventually making the total budget of the federal and state criminal justice system larger than the share of public funding for the poor (Alexander 2012; Wacquant 2009).

The dramatic increase in building prison facilities continued unabated, despite increasing reports of human rights violations and injustices (Brownstein 1996; Gray

2001; Haney 2008; Lyons and Rittner 1998). The profit incentive for the special interests of the prison industrial complex was far-reaching (Inciardi 2008). Industries profiting from rising prison populations included private services (transportation, food, healthcare, repairs) and materials (beds, bedding, clothes, kitchen equipment, cleaning materials, locks, weapons). Direct public funding for incarceration also funded facilities such as detention centers, processing centers, halfway houses, and immigration detention centers. Entire communities were built or revitalized by prisons or related industries funded by the government to maintain the prison industrial complex, which became too massive to unravel from drug war policy. As the public demand for treatment alternatives mounted, treatment became incorporated into this system.

Treatment for Drug Use and the Criminal Justice System

Treatment for people who used or misused drugs is often implemented in the criminal justice system through compulsory or coerced means (Nolan 2009; Werb et al. 2016). Treatment-oriented programs and services for the incarcerated or convicted were found to result in more time incarcerated or under the jurisdiction of the criminal justice system (Isaacs 2014; Parsons et al. 2014). Collaboration with the treatment facilities and programs lent law enforcement not only a stamp of legitimacy to control drug users but also ensured the flow of money from public and private entities. In response to the community's cry to stem the rising tide of opioid addiction, law enforcement embraced the "prevention sector," diverting more funding into its own coffers (Garland 2001).

Recent programs initiated to address the opioid crisis include police collaborating with community partners to link those in need of treatment with services (Boeri 2018; Collins, Lonczak and Clifasefi 2017; Fedders 2019). Treatment was viewed more favorably than incarceration in the public mind, which was in part due to the construction of addiction as a disease that was legitimized by biomedical science (Fraser et al. 2014; McLellan et al. 2014). Instead of being the "bad guys" who were arresting and sending their citizens' sons and daughters to jail, now police were offering them an opportunity for treatment. Policymakers and politicians praised the new collaborations between law enforcement and treatment industries (Ellement 2017). A few, however, called for closer attention to such partnerships when considering that even in the most heralded programs, control remained within the carceral state (Boeri 2018; Fedders 2019; Roberts 2019).

Conventional Treatment Models

Treatment can range from the more formal and standardized programs that include evidence-based strategies, such as cognitive behavioral therapy, to very informal programs with more or less structure, such as group meetings and sober houses. Conventional treatment might include detoxification, medication-assisted treatment,

professional psychiatric and psychological counseling, group meetings based on 12-step, and structured social activities, although this is not an exhaustive list. Formal treatment can range from expensive private residential rehabilitation to nonprofit or government-supported treatment programs. Nonprofit treatment is usually not entirely free of cost but often offers a sliding fee with a reduced rate. Since 2014, under the Affordable Care Act, insurance obtained in Health Insurance Exchanges or provided by Medicaid must include services for substance use disorders, but insurance generally covers treatment only up to 30 days (Buck 2011).

Some form of a 12-step program (e.g., Narcotics Anonymous) is used in many types of treatment programs, whether private, public, or in the criminal justice system (David 2011). Community-based 12-step group meetings are often the only treatment option for people who cannot afford private treatment or are on a waiting list for a place in a public program. Participation in 12-step groups are generally part of (or the only) aftercare recovery maintenance. Recovery itself is a troublesome and often vague concept that can be defined as total abstinence of all drugs or a lifelong process of being in recovery (Cloud and Granfield 2004; Laudet and White 2008; Substance Abuse and Mental Health Services Administration 2019).

Community-based treatment initiatives have gained popularity in the last few decades. Often operated by staff who live in the community, they are aware of the social, economic and cultural problems that impact drug use (Aguirre-Molina and Gorman 1996). Community-based treatment includes a variety of strategies that also may provide aftercare programs (Aletraris et al. 2014). However, these programs often rely fully on grants, donations, and charitable contributions, which do not provide a stable source of income. While peers (people who have knowledge of problem drug use and recovery through experience) have a long history of involvement in treatment, they have been gaining more respect with a shift toward paying recovery peers who are licensed (White 2004). The peer movement embraces multiple pathways to recovery and advocates for services to address the social, health, and economic problems associated with problem drug use or dependence.

One of the most successful community-based and peer-led programs for people who are using drugs is the harm reduction model. Harm reduction is a grassroots public health approach aimed to reduce the harms of drug use rather than treating or punishing people who use drugs. Harm reduction emphasizes quality of life for the individual and the community, acknowledging social injustice and human rights, while not minimizing the real harms associated with drug use behaviors (Des Jarlais 1995; Marlatt et al. 1997). While harm reduction programs increased around the world, they stagnated in the U.S. until recently. With the rise in opioid overdose deaths, harm reduction strategies have been embraced by public health agencies throughout the states. One of the most prevalent of harm reduction services is the "syringe exchange program," which proliferated in other countries but only recently began to operate legally in the U.S. (United Nations 2011, 2016). One harm reduction strategy that had not yet been implemented in the U.S. is supervised injection facilities (i.e., overdose prevention sites), which have been shown to reduce the

spread of infectious diseases and reduce costs to the community for medical emergency services and overdose deaths (Kerr et al. 2005; Pinkerton 2010).

Medication-assisted treatment (MAT) has become the gold standard for people with opioid dependence (Volkow et al. 2014). Studies consistently show the effectiveness of MAT, such as methadone, buprenorphine, and other formulations of opioid agonists (Connery 2015; Friedman and Schwartz 2012; Mittal et al. 2017). Since opioid use is viewed as a chronic disease, long-term management with MAT is suggested (McLellan et al. 2000). Concurrent illegal substance use while on MAT is not uncommon, although research shows that relapse rates are generally lower for people using MAT than for other treatment models (Clark et al. 2015; Connery 2015; Volkow and McLellan 2016).

Penal Abolitionist Application to Drug Use and Treatment

While abolitionist frameworks have been applied to analyze drug use and drug policy, rarely has an abolitionist approach been applied to treatment (Malloch and Munro 2013). Abolitionist thought is ever-evolving and takes many forms (Carrier and Piche 2015). Criminal institutions, conceived of as those that sanction criminal wrongdoing, are only the most visible form of power. A shadow carceral states operates whereby institutional annexations (framed as alternatives) and administrative-style sanctions deprive people of their liberty (Beckett and Murakawa 2012). Blurred boundaries between state and social control mechanisms reach far beyond prison walls (Cohen 1985). David Garland (1990) notes that an empirical focus on carceral state powers alone neglects to illuminate other forms of penalties, such as those that arise in webs of cultural meaning. These shape the field of decisions through which actors make choices (Green 2015; Schept 2015). Michel Foucault's (1977) *carceral archipelago* exercises social control and discipline through technologies from prison into other institutions and structures in society (Schept 2015). Drawing on many of these notions, contemporary penal abolitionists call for a broad understanding of penal power and the carceral state (Beckett and Murakawa 2012; Brown and Schept 2017; Carrier and Piche 2015; Coyle and Schept 2018; Dobchuk-Land 2017; Schept 2015). Penal abolitionists seek to actively abolish penal structures, theoretically reconceptualize oppression, and promote the creation of a more just society (De Haan 1990).

In this paper, we propose the following tenants of an application of penal abolitionist philosophy to drug use and treatment: 1) Legalize drugs and cease the imprisonment of people for drug crimes; 2) Distrust coerced treatments by powerful social institutions; 3) Critique modes of treatment that foreclose individual sovereignty and employ technologies of power; and 4) Recognize the lived-experience of substance dependence and its harms. While not yet fully conceptualized within an abolitionist framework, we offer a brief description of these tenants.

First, abolitionists seek to decriminalize all drugs and cease the punishment of people who use drugs. Abolitionists differentiate themselves from criminal justice

reformers in that such decriminalization of drug use is a step toward the ultimate aim of dismantling the prison system (Davis 2011).

Second, penal abolitionists are aware of, and at least suspicious of, coerced treatment. They are most opposed to punitive, governing-style models that conflate services with punishment (Beckett and Murakawa 2012; Schept 2015). Drug courts, for example, are arguably a segment of the carceral archipelago animating strict mechanisms of social control via treatment models that blend punitive and therapeutic rationalities (Boldt 1998). Drug courts sustain some of the same failed rehabilitative ideals of punishment from decades ago. Private prison corporations are switching their investments away from prisons and into coerced treatments, further blurring the lines and conflating the relationships between punishment and rehabilitation (American Friends Service Committee 2014). Treatment can also be coercive without such direct ties to prisons. A variety of social institutions may strong-arm users into treatment (i.e., welfare, child protective services, employers, and family members). Such entities implement punishments by another name in the form of sanctions, such as denial of social service benefits, forced removal of children, and loss of housing, employment, or familial roles.

Third, abolitionists are critical of the deployment of services or treatments that expand disciplinary technologies of power (Brown and Schept; Carrier and Piche 2015; Coyle and Schept 2018; Schept 2015). The disease-model of addiction, for example, positions people who use drugs as pathological and excessive consumers with an absence of will, which removes the idea that they have any capability of self-governance (Szott 2015). Treatment models often employ carceral logics that construct people who use drugs as helpless people who cannot manage their own lives nor have credible ideas about their own treatment. These treatment institutions exert immense control over their bodies. Treatment discourse provides a narrative that makes two claims: (1) people who abuse drugs have no control over their use, and (2) their use can be controlled though participation in mutual help groups (Weinberg 2000). Control through MAT has been added to this discourse to address physical opioid dependence (Volkow et al. 2014).

Treatment interventions can be a punishment in disguise (Hannah-Moffat 2001). Scott and Gosling (2016) point out that drug interventions rarely contextualize the client in embedded social inequalities, poverty, or racism. Instead they incorporate punitive-rationales rather than respect-driven logics. Relations between staff and residents in treatments often mimic prison-life, operating as total institutions (Goffman 1961). Users are encouraged to overcome, rather than challenge, institutionalized-violence or structural inequalities. Because of this treatments may have limited capacity to solve problems in the absence of attending to social harms. Drug treatments, from abolitionist perspectives, are carefully considered for their carceral technologies in use and for their approaches of asking clients to accept social conditions and harms. Such treatments may be considered yet another prison without walls (Cohen 1980) or semi-penal institutions (Barton 2017).

Because of the potential for treatment models to recreate carceral logics, abolitionists are suspicious of progressive alternatives to prisons. They are critical of the ways in which carceral-expansions can occur under the guise of prevention, treatment, or service augmentation (Dobchuk-Land 2017). Furthermore, treatment programs are often attached to an array of social institutions that are used to control marginal populations (Schept 2015). Modern drug treatment models, professionalization, and standardization are viewed by abolitionists as systems of power that dominate and govern marginalized people, particularly in the way that only certain drugs are viewed as acceptable for use (e.g., coffee, nicotine) while others are not (e.g., marijuana, cocaine) (Coyle 2014).

Acceptable substances are often defined in terms of their legality within treatment settings. This is particularly important, as the use of MAT is arguably an extension of yet another form of institutionalized power dictating what one can physically ingest, as purported by big pharmaceutical companies. Harm reduction techniques, including MAT, have been articulated as progressive alternatives so long as the approaches regard people who use drugs as agentic participants in their own lives (Critical Resistance 2012).

Fourth, and finally, abolitionists seek to ground their analysis in the reality of harm that people experience (Saleh-Hanna and Affor 2008). To accomplish this, it is imperative to refrain from over-romanticism of drug use and to acknowledge the real harmful effects that drug dependence can have on some people. Of course many people who use drugs may have never experienced dependency, while others have. Some people, but not all, become dependent or experience a host of problems as a result of their use. While many of these problems stem from the illegality of drug use and the urgent social conditions that surround it, there is also sufficient research showing that harm to self or others can be a direct result of the pharmacological effects of using a drug. The increase in opioid overdose mortality rates provides the most dramatic evidence that using drugs can be detrimental to quality of life as well as to life itself (Scholl et al. 2019).

The idea that drug use can turn into something confining and harmful by its own right may be a contentious idea for abolitionists as they look primarily to social systems' role in driving harm. Certainly, the compounded harms of racism, sexism, and capitalism devastate most chances for sustained drug use to be a pleasant experience, and drug use under the conditions of a racist imperial patriarchy is likely to turn to dependency. The double-whammy of oppression and dependency can be clearly very difficult to treat. Regardless of those limitations, abolitionists ought to actively contend with the realities of oppression and dependency that people experience today. Some people who use drugs find themselves dependent on a substance in ways that reduce their daily lives to repeating patterns of compulsions to get, use, and find ways to acquire more. They may also commit harms that they might not have otherwise.

We look to indigenous transformative resurgent organizations for solution inspirations. Native Youth Sexual Health, for example, articulates philosophies

important to this conversation. They advocate for community safety models that steer clear of attempting to define what harm is for people and allow people who use drugs to be considered the experts in their own lives. In this research, we attempt something similar. We listen to opioid users describe their experiences, we strive to believe that participants know what harm is, and when they tell us that they are dependent on a drug and it causes problems in their lives -we believe them. They have a right to be free to make choices, that is to use or not use. Anything less is confining and problematic.

Also particularly useful in this conversation is the perspective of the Black Panthers, the Young Lords, the acupuncture movement, and the insights of Dr. Mutulu Shakur who conceptualized substance dependence and MAT as forms of chemical warfare on low-income black communities. In their analysis, they acknowledge the harms of substance dependence. Their message serves as an example of how we can acknowledge the harms of substances on some people, in some situations, at some time while still framing those problems as a subversive harm on the whole of a community. We can accomplish this while remaining rooted in abolitionism by critiquing the system's heavy-handed and limited treatment options that denied people's chances for recovery. In the case of the Young Lords, they critique the unfair standards of the American Medical Association that prevented black acupuncturists from practicing in their communities, which led to the takeover of Lincoln hospital on November 10th, 1970 and the creation of the People's Drug Program, which offered free services to substance dependent people in their communities. The Young Lords understood the individual pains of addiction, but they also acknowledged how conventional treatment programs were bedfellows to many oppressive social apparatuses.

It would be unwise and inhumane to fail to consider the ways in which substance dependence entraps, coerces, and harms people. For decades, songs have been written about this phenomena (e.g. James Brown's *King Heroin*, *Down in a Hole*, by Alice in Chains, The Postal Service *This Place is a Prison*, Lil Wayne's *I Feel Like I'm Dying*, and Macklemore's song *Drug Dealer*). Not all people who use drugs will experience such dependence. In fact, some will experience freedom. This is also culturally expressed through music as well (e.g. Sia's song *Chandelier*, Amy Winehouse's *Rehab*, and Young Thug's *Ecstasy*). Drug use can be liberating, but also confining. An abolitionist understanding means that we want people to have choices, those who want to experience their substance can and those who no longer wish to, can stop. Our participants communicate both. They communicate freedom or ecstasy at times and at other times they experience being trapped or "handcuffed" by drugs or medications. As researchers, it is our responsibility to acknowledge the variety of experiences within each user's life.

How we conceptualize the problem, informs our solution. Therefore, we conceptualize the piece of the substance dependence puzzle that relates to the internal, psychological, and pharmacological processes within a person as a shift in one's desires. Atte Oksanen's (2013) articulation of a theory of addiction from a Deleuzian

perspective is useful for abolitionists. Addiction, according to Oksanen, is characterized as an experience of changes and alterations of one's desires, which can become reduced to repeating the use of drugs. Recovering people can increase their capacity for new connections of desire, but with limited options, that can make change difficult. Those who experience such reductions in desire may find themselves confronted with treatment modalities that exchange one cage (substance dependence) for another (total institution). Thinking about drug use versus drug dependence as a spiraling spectrum that one vacillates back and forth across rather than a hard line someone crosses, is a useful justification for developing individualized tool kits to help people move toward a place on the spectrum where they find a satisfactory balance of desires. Singular rigid treatment models through which we propel people through and measure their success against predetermined notions of what their lives "should" look like, will be ineffective.

The four approaches of abolitionist philosophical positions on drug treatment were drawn from a body of literature that scantly theorizes drug treatment directly. In light of this, theorizing is open to exploring reforms that, although not abolitionist in their mention, may make fruitful contributions to the dismantling of the prison system and carceral forms. Since new and innovative approaches to reducing the harms of drug use and substance dependence that embody abolitionist philosophies are yet to be fully theorized by scholars, potentially viable options are ideas put forth by those directly impacted (i.e., people who use drugs). Alternative modalities that could be considered abolitionist approaches by scholars incorporating the perspectives of those who use drugs include social recovery (Boeri 2018; Boeri, Gibson, Boshears 2014), acupuncture (Shakur 2018), therapeutic communities (Scott and Gosling 2016.), art therapy (Aletraris et al., 2014), and Housing-First initiatives (Tsemberis, Gulcar and Nakae 2004; Washington 2018). While some of these models are successfully applied to other populations, they can be merged with an abolitionist approach to drug treatment. More is needed in the way of solidly articulating abolitionist visions of drug treatment. Two European models involving decriminalization and deinstitutionalization can be instructive for developing a more advanced abolitionist application to drug treatment by incorporating non-coercive models that have been shown to be successful.

The Portugal Experiment

In 2001, Portugal decriminalized use of all drugs, and drug regulations were processed in noncriminal settings separate from the criminal justice system (Greenwald 2009). Members of the newly formed "Commissions for Dissuasions of Drug Addiction," issued an "infraction" with a fine and a warning to people who caused problems due to their drug use, and the Commission members decided the course of action for those with multiple infractions through discussion with the individuals who were demonstrating a need for more help. For some the course of action might be enrollment in school, for others help with familial problems, work issues, or

substance dependence. Drug use was no longer a criminal offense but instead a public health and/or social concern. Results from the experiment show that drug consumption, addiction, and infectious disease linked to drug injection decreased, while the number of people treated for substance misuse increased (Beyrer et al. 2010). The change in policy was associated with a 50 percent reduction in individuals convicted and imprisoned for drug trafficking (Laqueur 2015). Not only did Portugal show that humanitarianism could work, but it also provided strong evidence that mass incarceration does not work (Beyrer et al. 2010).

The Trieste Model for Mental Health

Since substance dependence is framed as a mental health disorder (McLellan 2017), an effective model developed for people with mental health illnesses can provide insights for developing new models of drug treatment. In the town of Trieste, Italy, psychiatrist Franco Basaglia implemented an anti-institutional model for people with mental health illnesses, founded on the "negation" and "destruction" of the traditional mental asylum (Portacolone et al. 2015). The model facilitated social inclusion in the community instead of isolation in mental health facilities. The right to housing, employment, and full participation in social life was a central tenant of this model.

The development of this model required challenging prevailing medical, social, and legal justifications for the segregation of individuals with mental illness. To build a model grounded in the reality of the everyday life of people with mental health illnesses, Basaglia not only relinquished his academic position but also abandoned the "scientific model of psychiatry" (Dell'Acqua and Mezzina 1998**)**. Instead, he walked the streets and talked with people who were suffering from mental health issues in order to learn what they needed. The result was the "Trieste Model" adopted in Trieste and eventually implemented throughout Italy.

The Trieste Model required a paradigm shift in mental health philosophy and treatment practice, as well as in policy. The biological model of mental health was replaced with a social model. The "psychotherapy model" was replaced with a "relationship model" (Dell'Acqua and Mezzina 1998). The determination of services was based on human rights and dignity instead of economic rights and cost containment (Portacolone et al. 2015). Instead of controlling patients, mental health providers worked with the "users of the services" to understand their "life projects" and identify new social networks for social support in the community (Portacolone et al. 2015). The community environment of Trieste, and the political and social situation of Italy's healthcare system, facilitated the implementation of this model.

For such a model to be effective, structural changes in the political and social context are needed, as well as openness to radically new ideas. Community-based models of treatment for people with substance use problems must be developed based on the views of people who have firsthand experience with contemporary treatment. Here the perspectives of people who misuse opioids and experienced

many types of treatment are analyzed within an abolitionist philosophy to inform further development of a penal abolitionist application to treatment.

Method

Study Design, Data Collection, and Settings

The data analyzed for this paper were drawn from a larger qualitative study on opioid use in suburban communities where overdose mortality rates were increasing. Qualitative methods included ethnographic fieldwork and in-depth interviews collected from people who were actively misusing opioids (Charmaz 2014; Laenen 2011). The data used for this analysis were from study sites in suburban towns around Atlanta, Georgia and Boston, Massachusetts. Suburban areas were identified as outside the city limits and within an area where people commuted to the city to work. The authors of this paper conducted the ethnographic fieldwork in the Atlanta and Boston suburban sites between June 2017 and September 2018. The states of Massachusetts and Georgia provided diverse perspectives from people living in a state that has public-funded healthcare (MassHealth) and a state with no public healthcare option. Public funded drug treatment is available in Massachusetts, providing free access to MAT. In contrast, it is difficult to find free or low-cost drug treatment in Georgia, where MAT was expensive or out-of-reach for many who needed and desired it.

Ethnographic fieldwork provided access to opioid-using networks (Copes et al. 2018). Fieldwork was aided by research assistants trained in ethnographic research and community consultants, who are people in the community who have knowledge of settings of opioid use (Page and Singer 2010). During fieldwork, the investigators talked with people on the streets and other public spaces, and left fliers or cards with the study contact information. Participants were recruited in the field directly or indirectly through fliers and word-of-mouth. Criteria for participation included having misused opioids in the last month, being 18-years-old or older, and residing in a suburban area. Targeted and snowball sampling methods were used to ensure diversity in race and gender and expand on emerging findings (Watters and Biernacki 1989).

Interviews were conducted in participants' homes, private offices in community-based organizations, library rooms, the investigators' cars, and public but semi-private locations, such as parks, under bridges, or in homeless encampments. No identifying information was obtained. A brief survey was collected on an iPad, which provided a life history visualization that informed the in-depth interview (see Boeri et al. 2011; Whalen and Boeri 2014). The audio-recorded interviews were transcribed verbatim. The study was approved by the Institutional Review Board (IRB) from the principal investigators' academic institutions, and a "Certificate of Confidentiality" was obtained from a federal agency to protect study data and interviewers from subpoena. Participants were provided a consent form that was

read, and oral consent was audio-recorded so no signatures were needed. Participants received $40 for their time. Interviews lasted between two to four hours.

Analysis

Grounded theory informed the investigation and analysis (Glaser and Strauss 1967). Grounded theory is responsive to subjective meanings revealed by participants during the interview and meanings that emerge during analysis (Charmaz 2014). Data analysis and data collection were conducted concurrently. A modified form of grounded theory was used for the analysis of the qualitative data. By modified grounded theory we mean that only parts of the transcript were coded for this paper and not a line-by-line analysis. First, responses to the question, "If you could design any type of treatment, what would that look like?" was coded, and then a word search was conducted to find other places in the transcript where treatment or recovery were mentioned.

The NVivo software program was used for qualitative data management. The codes and conceptual linking of codes were discussed by both authors to develop categories that best represented what participants were portraying, resulting in numerous variations of codes and categories. The themes were organized into a framework that provided a better representation of treatment from the perspectives of participants by identifying patterns and links between themes and sub-themes.

Sample and Demographics

The sample consisted of 117 participants, including 61 in Atlanta and 56 in Boston. During quality control of the data, three interviews were excluded from the analysis due to excessive inconsistencies found between data sources. The final sample include 47 (40 percent) participants who identified as female, 69 (59 percent) as male, and one participant who identified as nonbinary. Race and ethnic categories were separated. Among the total sample, 15 (12.8 percent) identified as black or African American, 1 as American Indian, 14 (12 percent) as more than race, and 87 (74.4 percent) as white. Hispanic or Latinx accounted for 21 percent of the sample. Self-reported education included 20.5 percent without a high school diploma, 40.2 percent with a high school diploma or equivalent, 28.2 percent with some college but no degree, and 10.3 percent with an associate college degree or higher.

Each interview was given a numbered code to reflect the field site location and to protect anonymity. With the large number of participants in this study, giving pseudonyms was seen as a potential harm. Since we did not ask for the real names of the people we interviewed, the actual name of a participant could inadvertently be used as a pseudonym. Therefore, we use the code numbers to identify participant quotes in this paper. A code number starting with an "A" was drawn from the Atlanta suburban sample, and a code starting with a "B" from the Boston suburban sample. In some cases a quote is shown as a conversation between the participant (indicated

as "P") and the interviewer (indicated as "I"). Places where words were omitted from the quotes that do not change the meaning are indicated by an ellipsis. Some words, such as "like," were deleted when said repeatedly. Words inserted in brackets are meant to clarify meaning, drawing from the broader context of the quote.

Results

Some components of treatment were viewed as beneficial by some participants, while others viewed them as harmful. Participants articulated that being forced to comply with a practice that does not fit their needs is problematic. We asked participants about their previous experience with treatment and asked them to design any kind of treatment they wanted. We categorized those findings by (1) perspectives on types of treatment programs or strategies they experienced, (2) views of ideal treatment, and (3) suggestions for alternative strategies. Primarily, we thematized components of treatment that participants reported as ideal, or at least, useful. Notably, the reported approaches are understood to not work for everyone, but ought to inform policy and practice in ways that honor the individual and social needs of individuals seeking treatment.

Perspectives on Contemporary Treatment Programs

The model known as 12-step used in Alcoholic Anonymous (AA) and Narcotics Anonymous (NA) is one of the most prevalent strategies employed in treatment today (Humphreys 2002; Kelly and Moos 2003). Participants' views on 12-step were mixed. Some were critical, such as A17, who repeated a common grievance:

> Like 12-step is not for everyone! Yet, if you ask every treatment center in the country, like, are you a 12-step-based treatment program, probably 90% will say yes, we are. So immediately you've alienated everyone who doesn't believe in God or a higher power, just right off the bat. So there you get 50%, they'll be out. They'll be gone, using again within two, three weeks.

In contrast, B30 said the 12-step program was "perfect . . . Just being able to meet with other people, like-minded people, and talking about your problems and, you know, being able to identify with other people is really the best way to get clean." However, identifying with others who have problems with drugs was not for B22, who complained: "I don't want to hear someone else's life story." Diverse perspectives such as these were prevalent among participants who had experience with 12-step group meetings, indicating that while this model is pervasive, it is not effective for all.

Participants also expressed contrasting views on MAT (e.g., methadone, Suboxone). Participants often said they used MAT drugs obtained illegally when they could not find heroin, although this put them at risk of dependence on a drug whose

withdrawal symptoms were reportedly worse than heroin. B27 expressed this opinion:

> I've eaten it on the street, wafers of methadone, you know, when I was sick. And when you're doing heroin, you may catch a methadone habit, too, you know. If I couldn't get dope, I would get these orange biscuits, which were 40-milligram methadone wafers. Now it doesn't take too many 40-milligram methadone wafers to get you really, really sick.

B11 had similar views. Having been in a methadone program paid by public healthcare in Massachusetts, he lost access to MassHealth when he became employed and applied for private insurance. While waiting for his insurance paperwork to be processed, he began to withdraw from methadone and had to seek opioids on the street to address his withdrawal symptoms:

> I just tried to get on the suboxone clinic right from the transition. I wouldn't even have used [heroin] if I could have went right to the Suboxone clinic. I would have just went and wouldn't even have picked up heroin. I only did because I waited three days, and on like the third day . . . like dope [heroin] lasts three days; methadone lasts about a month. . . . You're talking a month and a half of pure, hardcore withdrawals that makes—methadone is so much harder to kick than heroin ever is. It's liquid handcuffs.

A41, reiterated that methadone had a harder withdrawal than other opioids and detoxification services should take this into consideration:

> Like they put methadone in the same class as heroin to detox from, and it's way different. I've always had trouble. 'Cause I was tryin' to get off the [methadone] maintenance stuff and no treatment place will keep me long enough—or no detox place. A longer detox would be better for whatever drug.

Others recalled experiences in which they thought MAT providers could be more compassionate, such as A12, who implied that profit was more important than treating people who needed MAT:

> And I would try to address the underlying issues, you know, as to why. I know my childhood probably influenced [my drug use] a lot, and the stuff that I've been through over the years. . . . They don't care if you don't eat. They don't care about any of that. They have resources, but as far as caring. I went up there and haven't had the money to dose, and they're like 'I'm sorry, I can't help you.' . . . They don't give a shit. All they care about is money, and that's the bottom line.

A45 expressed a common grievance voiced by others regarding the need to go to the clinic daily or become sick: "I feel like that they should, . . . give you more take-homes. It is so hard to get up there every freakin' day." B03 echoed another oft-

repeated complaint: "You become a slave to methadone" Others expressed harmful health effects of methadone, such as B43, who said:

> I was on methadone maintenance for a little while. It completely ruined my teeth, my bones, all this stuff, and I was only on it for a couple years. So that makes me not want to take it or anything like that.

Access to a MAT program was a frequent problem. Participants in Georgia usually could not afford MAT, such as A43 who lamented, "I'd been on Suboxone after that one treatment, and I actually loved—I mean I didn't wanna use, my emotions were stable, I didn't hurt myself." However, she did not have money or insurance to remain in the MAT program.

For some, MAT was presented as a coerced option, such as for women who were threatened to lose their children if not participating in a MAT program. B12 was a patient at a methadone clinic and continued methadone throughout her pregnancy, as directed by the medical and social service staff who governed her life they found out she had used heroin while pregnant:

> When you get pregnant, they scare the crap out of you. They say you cannot stop using [methadone], you have to continue this program, because I was a heroin addict at that point. They said I had to continue doing something whether it be Suboxone or methadone—you can't stop using . . . So they punch that into you from the get go, that you have got to be on some sort of treatment. I'm like "What? I can't just stop using and be clean?". .That's what my doctor told me, that if I just stopped cold turkey, I could miscarry. So they pushed me over to the Subutex. Of course they have no blocker [opioid antagonist] so I was kind of abusing here and there. So they said I needed a higher form, so they put me on the methadone.

She stayed on methadone throughout her pregnancy, yet she was concerned. In her words, "there's no studies out there yet to show whether or not this is a good idea" to be on methadone throughout your pregnancy.

A few people suspected ulterior motives for the pervasive promotion of MAT by medical staff to address an opioid crisis they knew was started by prescription drug companies. B43 mumbled: "You know, the government and the health industry want people to be sick so they can profit." B03 also believed that MAT was good for the business sector:

> You can't stop the big business. Like the lobbyists in Washington, and like the people, the lawyers for Big Pharma—they have all the resources. There's no way that you can—you don't have billions of dollars to fight that. You know what I mean? They're going to have a pill for everything. They're going to have a magic pill for, like, it's like that shot now, the Vivitrol shot.

Others pinned their hopes on Vivitrol, a relatively new MAT at the time. B01 declared: “It’s the best thing that ever came out, and it’s non-addictive.” In contrast, B03, did not view Vivitrol as the answer to addiction, since it addressed only opioid use:

> I: What do you think of Vivitrol? Tell me, because some people do think that’s an answer.
> P: It’s an answer to use cocaine, because people just shoot, inject cocaine on it, and it still doesn’t block that (laughs).
> I: But cocaine’s different than heroin, don’t you think?
> P: A lot of people start using them indiscriminately. When you start using, when you start injecting drugs, you start to pivot more toward indiscriminate use between cocaine and whatever you can get.

B03 saw the current gold standard of MAT as a potential pathway to other drugs, which was not an uncommon transition found in the participants’ trajectories.

Beyond MAT, many revealed multiple tensions and conflicting views with strategies used in conventional treatment models. Counseling, appreciated by some of the participants, was seen as not provided often enough, or with empathy. When asked what he would like to see more in treatment, A25 took a pragmatic view:

> Probably talking to my counselor more. . . . I talked to him the other day. They don’t, you know, . . . “you doin’ so good.” But still, I need to talk to somebody sometimes, you know. But a perfect world, man, that’s not going to happen.

The tone that A25 used when saying “you doin’ so good” implied the counselor was apathetic and better counseling was desired. In a similar vein, A28 was disappointed in the counseling he received:

> I was looking forward to it [counseling] because of everything I’ve been through in my life. I was like, this is counseling. It doesn’t just have to be about my heroin use. It could be about anything. It’s counseling. How to make me whole. Working on my triggers.

Unfortunately, A28 did not receive the breadth of counseling he desired, Addressing root causes of substance misuse was often part of the discussion of what was missing in conventional treatment, as A44 explained:

> First things first—you gotta get to the root of the problem. . . . And you gotta figure out how bad it messed that person up. And a lotta [treatment] folks don’t take time—a lot of treatment programs don’t take time for that. They don’t. You gotta be able to sit down, earn those folks trust one-on-one, and really get down to the nitty gritty. I mean basically, you can’t do it in a month, you can’t do it in four months, you can’t do it in six months. ‘Cause I’m 33 and this goes all the way back ‘til I was six.

Structure in a treatment program was seen as helpful for some participants. A13 said one of the best models was an inpatient program that had a lot of structure: "It was tough. It reminded me of the military. They cut your hair off when you come in. I needed structure." Likewise, B26 thought the structure in residential programs was helpful, but they needed more structure in aftercare: "I think definitely follow-up, aftercare. I do great in structure. It's when I get out on my own." Others argued that they needed more freedom A22 said "I wouldn't force grown adults to go to groups . . . if they want to lay down for that hour, go for it." A01 said, "We need to be able to live our lives a little bit, I don't need to be micro-managed." So needs for structure varied by participant.

Typically, participants said they liked to have someone to talk to who understood addiction from experience. B29 explained, "They need more people who have actually lived it." B23 echoed this view, "I mean the doctors and nurses that work there, well, they've never been addicts. So when you go to talk to them to say, hey, listen, they really don't understand, you know, your pain." While many were excited about peer mentors, others reported that their peer mentors relapsed, and relapse was seen as contagious. Having many people in treatment together in one place was viewed as harmful to B11, who explained:

> It's too many people locked together and once one . . . all it takes, I've seen it happen before, I've seen the whole place be packed and everybody's doin' good. One person relapses, it goes. Before you know it, the whole place is empty, dude.

While having a mentor, called a sponsor in 12-step programs" is a common practice in treatment philosophy, many had a story of a mentor or sponsor who relapsed after years of sobriety.

Perspectives on Ideal Treatment

Since all participants had experiences with conventional treatment of some kind, their views on ideal treatment sometimes resembled what they had experienced already, as illustrated by A35:

> It would be a 3-phase treatment center. You come in. For the first 15 days you just chill out. You take your vitamins, you drink some water, you watch some TV, you get food in your system. . . . then for 30 days you take 'em to meetings, and take 'em to a gym and kinda, you know, you live in a house. They get 'em a sponsor. You know, steps 1, 2 and 3, and get 'em maybe started on a 4-step. Once you get that done, well, now it's time to implement a job. And then you go to the 3 rd phase and now there's still a halfway house manager. They make sure you're on time, they piss test you, whatever. You go to and from work, while having to go to meetings, and then you phase out. And once you hold that down for like 6-7 months, now you go to a three-quarter house and you're doin' your own thing. But once you get to a three-quarter house, I'm gonna put

> you as a buddy to the new people that come in. Once or twice a week you gotta go to the 1st phase part and share how you were just where they were, and whatever, and help.

While A35 described a conventional model, including a residential program and 12-step meetings, this same model did not work for him. Moreover, phases that involve more than the 30 days paid by insurance were often inaccessible. Most of the participants said their treatment program lasted 30 days, and they were on their own to find halfway houses, three-quarter houses, and 12-step meetings.

When asked what their dream design for a treatment program would look like, responses revealed a common desire for full social reintegration in society, including more mental stimulation, physical activities, and developing closer relationships with others who are not necessarily peers. Though it is unclear that addressing this issue alone would result in success, as they define it.

Keeping busy by attending classes was an activity that some said prepared them for a better life. A32 said that attending college had worked for her in the past: "I started going to school again. . . . I started taking summer classes. That gives me a purpose." Likewise, B11 proudly said, "I just graduated from college—it turned my whole life around."

Challenging physical activities such as engaging in sports were a desired feature mentioned by many of the participants. Some recalled enjoyable activities they remembered while in treatment. A21 described the activities in one program he liked:

> They had a ropes course there that was, that was pretty neat. Like we went hiking and mountain-biking, and like I like shit like that. . . . You know, we had a fucking basketball court out there. We went out there and played softball. It was cool, man.

In contrast, A57 suggested rest was needed initially, but added that it was not beneficial to stay isolated from society too long:

> I just want to go sit and eat food and sleep for at least a month. Take some time off of work, and time to just relax and focus on yourself. . . . If I had to say a time, I'd say 6 months. Because I also don't want to stay away from like the real-life stuff for too long, because then it gets hard to transition back in.

Participants expressed a strong desire to develop relationships that went beyond counselor/client or doctor/patient roles. Some wanted to be around people who were not using. B18 desired to be "somewhere where there's other people that are clean and sober. I don't like to be alone." A32 expressed the need for an intimate relationship that was not necessarily sexual, but about being connected:

> I would want them to design something very intimate. Not like large classes but like one-on-one; the intimacy being able to be vulnerable with somebody, and feel like you wanna have that connection with somebody that you want to make proud. Like the

> Greeks would have the mentor/mentee as soldiers, and they would sleep together, and they, you know, had like a romantic relationship with each other. But they were more likely to save each other in battle. And kind of in the same way, without the sex, but to care about somebody, and to really connect with them on a human level. . . . You work out with them every day, and you push each other. You meditate with them, you do yoga with them, you stretch with them. So it's not only physically beneficial for you but it's mentally, because you're having those conversations, and you feel like you're being cared about, and you have that support. . . . Like having a whole lifestyle shift.

A32 described a relationship with a trustworthy person with whom to engage in new life-changing activities, leaving the old "lifestyle" behind. Others also suggested this was essential for transitioning to social life after treatment.

B43 needed help to rejoin society: "I'm pretty crippled socially. That's the thing, I need help. . . . My sobriety liaison has been one person who's helping me relearn how important it is to be social and have connections." While social reintegration was often their goal, for many it was a struggle, and unsuccessful attempts to reintegrate were a cause for relapse.

Alternative Strategies for Treatment

Treatment strategies often focus on changing the individuals, as some participants revealed when they repeated the treatment philosophy, such as "you have to want it" and "it's the individual's choice." But their narratives indicated that strategies external to the individual and often unconventional were desired.

Acupuncture and yoga were viewed as beneficial to those who had experience with these strategies in treatment or on their own. A37 said, "I would offer art therapy and yoga . . . like it's helped me anyway [in] my own therapy for myself."

Many participants said marijuana (cannabis) helped them to reduce or stop use of opioids. A01 described her views and experience of cannabis as a self-treatment option:

> Weed's freaking awesome. I don't care what anyone says. It's awesome. And I would be smoking it now, but I'm on probation so I can't. It's like, I'm not willing to risk it. . . . Since the early 2000's have been on probation. . . . you know, a lot of times when I could have just smoked a bowl and be completely content with that, you know, I mean to like relax me, or whatever—that wasn't an option, So it was like, well, I guess we have to go get some dope [heroin]. You know, and then that just makes you spiral out of control. Smoking weed, you are not going to lose control of your life. You will on the hard drugs, so it kind of sucked that I—if I wouldn't have been on that probation, my life probably would have gone completely different, but I didn't have that option.

Kratom is another drug that is not considered a treatment strategy by any conventional treatment practice but was used successfully by some participants to

reduce or stop using opioids. A01 was enthusiastic in her support for kratom, which she used to taper off methadone:

> Apparently, people have known about kratom for a long time. I was on methadone and I was working at a bar, and one of my regulars, who I've become friends with, I was just kind of telling 'em like this methadone is killing me, "I'm like freaking miserable. I want to get off this shit. I hate it." And he was like, "you know, well I've—I've known a lot of people, I've known a lot of people that have said that they used kratom to get off opiates." And I'm like, "How do you spell that?" . . . So I go bust out my laptop, I google kratom near me. There's a head shop like a mile and a half from here. I get my roommate, we get in the truck, I'm in my pajamas. I go in, I get a bottle of it and I come home, I take five capsules, which is five grams of it. I'm talking about 30 minutes later, it hit me like a wave of relief. I was no longer in pain. I was no longer anxious, and I was like . . . holy shit, . . . It's miraculous.

Another participant suggested pharmaceutical-grade heroin maintenance, a strategy used in other countries, could more effectively address the U.S. opioid crisis. In his view, some people will need to stay on MAT the rest of their lives, and pharmaceutical grade heroin was preferred over methadone or Suboxone. B03 explained his argument persuasively:

> People have proved—whether they're going to get the death penalty or not for getting high or not—they're still going to use. So we [opioid users] have won that battle. So if you gave it [heroin] to people under a supervised, you know, a setting where they could use it with clean needles and professionals to see if they, you know, make sure no one overdoses . . . that's the only way to beat it.

According to B03, making drugs legal and providing safe addictive drugs would increase participation in treatment and harm reduction practices, thus benefitting both society and individuals:

> But if you give it to people, you can give them paperwork that says this is how you get clean, or the reason why people get clean. Help them with the pillars of staying strong and staying clean—having a job, having a place to live, having education—things like that. You can also give them, you can say, here's your drugs so you don't have to prostitute or break into a vehicle. Here's your drugs, but also here's information if you don't want to use anymore. Here's a clean place to do it. Make them take that education for the free drugs. I mean people would do a lot, they've proven, for free drugs. You got to use that, use that for them, to help them. Don't use it against them, but use it to actually help those people. Use their addiction towards recovery for them.

Passionate and pragmatic calls for legalization came from participants in both Georgia and Massachusetts. A39 described how he thought a radical policy change would solve some of society's worst drug problems:

> I'd make all drugs legal. . . . I would legalize all drugs—everything. That would stop the black market. That would stop all the killing. Not all the killings, but it would stop probably 50% of the killings that were drug related.

Discussion and Conclusions

An examination of insider perceptions of drug use treatment, also known as "knowledge from below," can better inform treatment program development and policy (Fessel et al. 2019:132). One clear implication of this analysis is that more alternatives are needed. The participants provided a number of treatment strategies that can be incorporated into pre-existing models or be available as stand-alone initiatives. Some liked 12-step, while others disliked it. Some advocated for structure, while others needed less micromanaging. Some desired rest, food, or sex while others desired any variety of medication assistance, marijuana maintenance, or Kratom to help reduce their opioid cravings. Art, animals, music, energy healing, yoga, acupuncture, and sports were reported as components of effective treatments—for some. Several preferred inpatient, while others preferred outpatient. Some desired peer mentors, while others had devastating experiences with them. The most fundamental lesson about treatment from these participants is that a one-size-fits-all approach is unlikely to be successful. Participants made it clear that different individuals have different needs. Therefore, treatment strategies should vary by person and social conditions. What may work for some, may not work for others.

MAT, for example, has been found to be effective for addressing opioid dependence in some (Connery 2015; Volkow and McLellan 2016), but not for others who were represented in this sample. Different forms of MAT had varied effectiveness in helping people cease the misuse of opioids. Different aspects of MAT, both inadequate delivery and the drug itself, created problems in their lives. Their views are informative for improving treatment models (Bourgois 2000). Participants' varying needs calls for them to be more fluid, encompassing of individual difference, less assumptive and reductive, more transformative, and led by those directly impacted. Most participants in this study were not given a choice of treatment options. For many, it was difficult to financially afford any kind of treatment. Analysis of their treatment stories and views indicates that treatment needs to be targeted to individual needs, not the other way around (Laenen 2011).

Informed by abolitionist philosophy, we understood modern treatment approaches to be part of a politically-sanctioned governing practice (Rhodes et al. 2019). Our findings strongly support an argument for fundamental drug policy change. The political and social injustices created and perpetuated by the war on drugs has ignited prison-reform movements across the US, but those with years of problem substance use have numerous barriers to accessing the basics needs, such as housing and employment. Full social integration into society is almost impossible to achieve for those with criminal records. Drug policy reform that links treatment with

law enforcement has been shown to be susceptible to corruption and abuse (Gray 2001; Roberts 2019). Radical drug policy reform is needed to dislodge treatment from the criminal justice system. Decriminalization and deinstitutionalization is essential in order to shift money from governing institutions to community-based services that can provide resources needed for social reintegration (Greenwald 2009; Tsemberis et al. 2004; Wilkinson and Marmot 2003).

A policy of decriminalization or legalization is compatible with an abolitionist approach. Drawing from the successful aspects of Portugal's decriminalization policy, a policy that replaces the court system with "commissions" of knowledgeable and compassionate peers and professionals from the community can better target treatment and resources to individual needs. Our findings suggest that not all people with substance use problems will need to make use of the "commission," since they can often meet their recovery goals in the community under a policy of decriminalization or legalization.

An abolitionist approach is skeptical of governing-style treatment models that conflate services with punishment. This analysis shows that radical shifts in treatment philosophy and practices also are needed. For this we draw on the Trieste Model, which focuses on deinstitutionalization and social integration facilitated by the community (Portacolone et al. 2015). Access to new social networks is essential for successful reintegration of people who have been isolated from society. Findings from this study show that social reintegration remains problematic, particularly when the roots of drug use have not been addressed and punitive responses have severed ties to social capital. Facilitating access to new social networks is the premise of social capital building (Boeri, Gibson and Boshears 2014; Woodall and Boeri 2014; Zoorab and Salemi 2017; Zschau et al. 2015). Grassroots and community-based services can facilitate social capital building by working in collaboration with the "commission" to deinstitutionalize drug treatment (Kahn et al. 2019; Mezzina 2018; Rhodes et al. 2005).

In accordance with peacemaking perspectives and transformative justice approaches, we recognize that systems of power like racism, sexism, ableism, and imperialism need eradication to achieve a world without prisons. To end confinement, the multiple compounding and interwoven axes of oppressions that people who use drugs are embroiled in, must also be abolished. Until then, we as penal abolitionists are tasked with figuring out what practices we stand behind in the current moment. We ought to explore what non-reformist reforms are best to pursue that provide people with the greatest chance at freedom and the maximum power choice. That means the choice to use opioids, or to not use opioids must be realizable for the individual. The latter may, or may not, require outside help. It is important for abolitionists to be guiding what form that "help" takes.

This paper has its limitations. The sample is not representative of all opioid-using populations and findings are not meant to be generalized. Only two suburban areas are included in this study and more research is needed in urban, suburban, and rural areas to build on the findings presented here. Race, gender, social-economic status,

and age differences are not examined in this paper due to space limitations, and these need to be included in the development of new drug policy and alternatives to contemporary treatment. The term "treatment" was used to elicit participant strategies they thought would help them reduce the harm of opioid use. That language can arguably limit the participants' ability to creatively express their desires. Also, the risks and benefits of decriminalization versus legalization must be further explored in the political and social context of the US landscape.

In conclusion, our findings show that a comprehensive change in treatment philosophy is needed to provide treatment responsive to individual lives, social support composed of trusting (not governing) relationships, and social resources accessible in communities where people live. Informed by abolitionist philosophy, we propose facilitating access to treatment options and social capital through a "commission" composed of community members, peers, and professionals that are disconnected from the criminal justice system is needed. They should be people who are dedicated to alleviating the individual struggles that can be associated with use of opioids as well as to abolishing the social conditions that drive and exacerbate its harms.

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ORCID iD

Miriam Boeri https://orcid.org/0000-0002-7118-0040
Denise Woodall https://orcid.org/0000-0002-1627-0975

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