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# The pros and cons of supervised urine tests in opioid replacement therapy: A study of patients' experiences

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## Summary

**Background:** In opioid replacement therapy (ORT), drug testing is performed continuously to ensure that patients are taking their prescribed medication, and to detect whether they have taken other, non-prescribed, substances. Typically, supervised urine testing is conducted, and in Sweden such testing is often an ORT precondition. **Aim:** This study investigates ORT patients' experiences of and views on supervised urine testing. **Methods:** Structured interviews were conducted with 90 Swedish ORT patients. During the interview, patients were asked to say what they thought about the supervised urine tests required. The answers were then analysed through content analysis. **Results:** Three main themes with sub-themes were found in the patients' statements. 1) The consequences of the test results (sub-themes: external control can provide assurance; proven drug intake may have negative consequences for patients; proven drug abstinence can yield advantages for patients), 2) The testing procedures (sub-themes: supervised urine testing is humiliating and causes harm; how you are treated is important; clinical culture and attitudes differ; stress, pressure and anxiety – tests can be difficult to perform), and 3) The structure of the testing (sub-themes: structure is needed in life; inflexible testing schemes can interfere with treatment goals; gathering people with similar problems can be counterproductive). **Conclusions:** Most interviewees found the testing functional as support or as proxy control in case of personal loss of control. However, supervised urine testing also constitutes a severe invasion of privacy. Less demeaning testing methods need to be developed and implemented.

*Key Words:* Methadone; Buprenorphine; Opioid Replacement Therapy; Supervised; Urine-test

## 1. Introduction

Taking supervised urine samples is a common method of drug testing. The method is often used in the treatment of addiction problems and in the judicial system, where the requirements for accurate and reliable results are high.

The method of supervised urine testing is used in opioid replacement therapy, ORT, where testing occurs frequently on regular basis for a long time [7, 17, 50].

Testing in order to check for potential drug use occurs frequently in many sectors, e.g. healthcare, dependency treatment, social services, law enforcement, working life, and education [6, 29, 36, 44, 46,

50]. Testing is performed routinely in order to obtain information ahead of medical care, in order to confirm criminal offences, or to confirm drug abstinence in some treatment settings and occupations.

Drug testing is usually performed through analysis of urine or blood samples, since this has proven to be a valid method, provided analysis and verification is performed at an accredited laboratory [6]. In urine, traces of substances can be detected for anything up to a few days or a few weeks after intake, depending on the substance. Blood samples give a snapshot of what the subject has in his or her veins at a given moment.

Trials are currently under way to develop and validate other testing methods, such as analysis of

saliva, hair, perspiration, and exhalation air [2]. For example, a mass spectrometric method for drug testing in exhaled breath has recently been validated and proved to be a robust screening method that can be routinely used in different drug testing activities [41].

ORT is a pharmacological therapy for opioid dependence using the substances methadone or buprenorphine. In accordance with research and guidelines, it is recommended to combine ORT with psychological or psycho-social treatment, and social support [27, 34, 48-50].

In highly structured ORT programs, drug testing is performed regularly, typically one to three times a week. The testing is mainly done using supervised urine tests, partly to check whether the patients are taking their prescribed medication, and partly to detect whether they have taken other, non-prescribed, substances.

Control measures are necessary within the ORT for patient safety reasons, as the drugs used in the treatment may contribute to overdose if the patient has extensive use of other tranquilising drugs. The purpose of the controls is also to reduce the risk of drugs ending up in the wrong hands. Methadone and buprenorphine are drugs with high misuse potential and are sought after in the illicit drug market. Diversion – patients selling to or sharing their medicine with others – is a problem that can lead to overdoses and death among people outside of treatment [21, 22]. Confirmed abstinence from other drugs can also be a marker for treatment compliance. In Sweden, ORT is regulated by a code of statutes issued by the Swedish National Board of Health and Welfare. The use of drug testing was not an explicit requirement in the statutes at the time the data were collected for this study, but was discussed in a section about involuntary discharge, which included criteria for when treatment should be discontinued. Two of these criteria were if the patient suffered repeated relapses into illicit drug use and/or repeated manipulation of urine samples. In practice, this meant that supervised urine testing became a condition for admission to ORT [43, 45]. Similar rules exist in several other countries [16, 39, 50]. In many clinics in Sweden, patients are obligated to sign ‘contracts’ when treatment is initiated, where issues such as routines and rules for urine testing are described. Such procedures are also common in other countries [3, 16, 30, 40].

In the concrete situation, supervised urine testing means that a member of staff observes the procedure to ensure that the patient provides their own urine and does not tamper with the sample. Clinics

use different methods to perform the supervision, e.g. bathrooms with transparent mirror-glass, or asking the patient to undress completely before entering the bathroom, and to remain naked while providing the sample. The testing situation can be perceived as a violation of privacy and as uncomfortable for both patients and treatment staff.

Although urine testing for decades has been the standard routine in ORT, research on how patients view such testing is limited. In a meta-analysis Dupouy points out: “Few studies, with poor quality, have assessed the value of UDS [Urine Drug Screening] in managing patients using psychoactive substances; though with insufficiency to demonstrate the interest of carrying out UDS. Therefore, pragmatic intervention studies are necessary” [11, p.11]. The field, in other words, is in need of further research with a focus on the patient perspective.

One study that focused on the patient’s experiences of testing, reported that the subjects viewed the testing as either mainly positive or mainly negative, although many of them expressed an ambivalent attitude to testing [42]. However, the deeper implications of this ambivalence have not been studied to any great degree. A conclusion drawn by the authors was that testing must be individualised: ‘Lack of strong empirical evidence demonstrating improved patient outcome related to urine testing suggests that the procedure should be determined based on individual patient goals.’ [42, p. 303].

Previous research highlights the importance of the relation and the therapeutic alliance between care provider and patient for a favourable treatment outcome [1, 3, 9, 10, 13, 18, 25, 26, 30, 35, 47]. To be attentive to the experiences, perceptions, and wishes of the patient is important when designing the treatment approach [3, 11, 13, 18, 40].

**Aim:** The purpose of this article is primary to analyse the experiences that ORT Swedish patients have of urine testing. The secondary aim is to analyse the specific method with which testing is performed.

Increased knowledge about the patients’ perception is important in order to develop ORT, partly to maintain positive aspects of testing, and partly to avoid or minimise negative aspects.

## 2. Methods

This material has been collected within the framework of a dissertation concerning replacement therapy for opioid dependence and will be used as a reference in the context of this work [30-32].

**Table 1.** Sub-themes

Consequences of the test results	The testing procedures	The structure of the testing
<ul style="list-style-type: none"> <li>External control can provide assurance</li> <li>Proven drug intake may have negative consequences for patients</li> <li>Proven drug abstinence can yield advantages for patients</li> <li>Proven drug intake may increase efforts in treatment</li> </ul>	<ul style="list-style-type: none"> <li>Supervised urine testing is humiliating and causes harm</li> <li>How you get treated is important</li> <li>Clinical culture and attitudes</li> <li>Stress, pressure and anxiety – tests can be difficult to perform</li> </ul>	<ul style="list-style-type: none"> <li>Structure is needed in life</li> <li>Inflexible testing schemes can interfere with treatment goals</li> <li>Gathering people with similar problems can be counterproductive.</li> </ul>

In this study, a total of 90 individuals (26% women and 74% men) participated in an interview. Their mean ages were 35.2 (sd=9.9) for women and 38.5 (sd=11.4) for men. They had used drugs for more than 20 years and all of them had been diagnosed with opioid dependence. Eighty-seven per cent injected drugs and had done so for more than 13 years. All of them had been in or were undergoing ORT.

All interviews were carried out by the main author (BM), who for 10 years had been working as a social worker and counsellor at a Swedish ORT clinic. The interviews were conducted at a venue chosen by the interviewees, usually in the respondent's home or at the clinic.

Before the interview, the interviewees were provided with written and oral information that participation was voluntary, and that they could withdraw at any point. They were also informed that the data would be treated with confidentiality, and that participation would not affect their treatment.

Within comprehensive structured interviews an open-ended questions was included and used for the present study. The question was: How do you feel about the supervised urine tests?

The answers were transcribed verbatim and immediately repeated to the interviewee, thus giving him or her an opportunity to confirm whether the answers had been taken down accurately, and to directly make the necessary corrections in the case of misunderstandings.

In the content analysis, themes and categories were progressively developed in order to catch various nuances in the descriptions by the interviewees [19]. The themes were presented and discussed within the research team to achieve an inter-judge consensus.

In the concluding phase of the analysis, data

were checked against the original data set in order to eliminate any discrepancies and deviations.

The study has been subjected to ethical review and was approved by the Regional Ethical Review Board in Linköping, on June 15, 2011 (2011/214-31), and on January 13, 2014 (2013/497-32).

### 3. Results

The majority of the interviewees stressed that they had ambiguous feelings about the testing situation. Through the content analysis, three main themes emerged: 1) the consequences of the test results, 2) the testing procedures, and 3) the structure of the testing. These themes in turn can be divided into sub-themes, as shown in Table 1.

In the following sections, we will give examples of how the interviewees described the testing.

#### 3.1. Consequences of the test results

The supervised tests can have several different perceived consequences for the patients. Some consequences have to do with the personal experiences of the patients, and some consequences relate indirectly to the environment's reactions to the test results.

##### 3.1.1. External controls can provide assurance

A dependency condition often means a loss of control in terms of continued intake of the drug despite a wish to cut down or quit altogether. The most common comment on the question how the interviewer's felt about supervised urine test was that the testing was perceived as providing assurance or safety, since the patients themselves experienced that they had insufficient internal behavioural control, as a consequence of their dependency issues. Conse-

quently, the testing regime brings about an external control which can be viewed as a positive factor when a person is trying to turn away from a situation where drug misuse has played a central role in everyday life. A number of typical quotes serve as an illustration. A man in his thirties said:

*In the early stages [of treatment], structure is good, I had to hand over samples three times a week, later on it was less often. Before you've settled properly, the tests are a good thing.*

A man in his forties, who had gone through ORT several times, expressed his views on testing as follows:

*It helps to have to hand over urine samples for the first year. Two weeks [between tests] is too long an interval, you know, once a junkie always a junkie.*

Several informants told us that they considered testing a kind of “safety net”. For instance, a woman in her fifties, who still stayed in touch with drug-using friends, and who occasionally was offered drugs and experienced a craving for them, told us:

*To provide the urine sample is positive because one cannot take illicit drugs. It is another reason not to take drugs.*

A man in his forties who, after one year of ORT, had been hired by an industrial company told us:

*The testing feels like a safety net. It's only if you have a job that the testing procedures need to be changed.*

These quotes highlight how the testing may function as an aid in the early stages of treatment, or at other times when a patient's social situation is insufficiently stable. In the second quote, the informant calls for more frequent testing in these situations – the expression ‘once a junkie, always a junkie’ refers to the fact that the informant does not trust himself when he is misusing drugs.

### 3.1.2. Proven drug intake may have negative consequences for patients

If test results indicate other substances than those sanctioned by the physician in charge of ORT – for instance, if another physician has prescribed prohibited substances, or illicit drugs have been taken – this may result in different actions by the treatment staff. One such measure could be to change the procedures, forcing the patient to attend the clinic more regularly in order to provide urine samples. As an ultimate penalty, the patient can be suspended from treatment, a repercussion all patients were well aware of.

Several interviewees pointed out that it can be difficult to tell staff what really happened, for exam-

ple after a relapse. This is what a woman aged around 30 said:

*It would be better if you could be honest with people. I can't be honest [about relapses] because then I'll lose my medication. I tell them what they want to hear.*

Many pointed out that it can be hard to predict the reaction or consequence to be expected in the case of a test result coming out positive, since responses are individually calibrated for specific patients in treatment. Most interviewees had friends who had been suspended from treatment for various reasons, such as various degrees of relapse issues.

### 3.1.3. Proven drug abstinence can yield advantages for patients

Another category of comments concerned the issue that the patients, thanks to the testing, were able to show that they were free from illicit drugs, which in turn could elicit positive responses from family, friends, or colleagues. Several of the interviewees pointed out how important it is to be able to show that their life and previous misuse-related behaviours have changed. Proven drug abstinence may mean increased trust from family members, employers, and the ORT staff.

A woman in her thirties, who had regained custody of her children, told us:

*It's fine to do the testing. I've got to prove so that everyone knows I'm drug-free. It's great to be able to show, and also prove that I'm free from drugs in case the social services threaten me or question me as a mom.*

To have quit drugs, and to have succeeded in fundamentally changing one's life, was also seen as something positive in and of itself. This is illustrated by the following quote from a man in his fifties:

*Urine testing is necessary in order to show whether you've taken anything. I'd like to confirm that I'm clean, that I'm a different human being now.*

### 3.1.4. Proven drug intake may increase efforts in ORT

Several of the patients explained that, when they suffered a relapse or told the staff that they had felt a craving, they had been offered greater support and more relapse prevention. Some told us that they had had positive experiences of receiving greater support in case of relapses, and this was because they had a good relationship with the treatment staff. A younger woman in her thirties, who had had several relapses, told us:

*It is good if they find out if there is something*

[drug intake]. Without them, I would still have been in trouble taking drugs.

One man in his fifties said:

*The nurse gave me security and support.*

### 3.2. The testing procedure

This theme concerns the specific situation when the supervised urine test is taken and refers to the interpersonal meeting, i.e. how the staffs meet the patients as individuals.

The majority of the interviewees, accordingly, acknowledged and recognised the objectives of testing, although many of them simultaneously condemned the way in which the testing was performed.

#### 3.2.1. Supervised urine testing is humiliating and may cause harm

That supervised urine testing can be perceived as humiliating or degrading was the most common theme in negative statements. Emotionally charged words, such as 'demeaning', 'horrible', and 'humiliating', were frequently used by the informants.

The way in which testing was performed – that the patients several times a week were forced to expose their intimate parts to someone else – was perceived as showing a lack of respect for the integrity and autonomy of the individual. A man aged about 25 described the situation tersely as follows:

*It's humiliating as hell. So fucking hard!*

A man in his fifties said:

*I hate handing over urine samples because I freeze due to the sexual assaults I suffered for many years as a child.*

In other words, the method in itself may mean that people with previous traumas are subjected to further degrading experiences. Another man, also in his fifties, who had been on treatment for many years, explained:

*I almost have to point out and remind the staff that I have to leave tests [according to the conditions of the contracts]. But it's still humiliating!*

These quotes illustrate that the individual experiences can be strongly linked to the method of supervised urine testing. Many of the interviewees reflected on the unequal distribution of power that exists between the treatment staff and the patients, which is manifested by the use of supervised urine testing. A man in his thirties put it this way:

*No-one feels comfortable having to provide supervised pee samples, you feel belittled.*

To feel 'belittled' may refer to, on the one hand,

having to perform an act – under conditional compulsion – perceived as demeaning, and, on the other, to the fact that the patients find themselves in a position of dependency, an unequal power relationship where they must obey in order to get access to their medication.

#### 3.2.2. How you are treated is important

To be treated with respect by the staff in this situation may lessen the discomfort, but cannot entirely offset the negative sentiments.

Several interviewees described their trust in the staff, the forming of a crucial therapeutic and personal relationship, while stressing that they wanted to be seen as individuals in need of individually adapted solutions within the framework of replacement therapy.

A man aged about 50, who felt that the staff trusted him after a year in treatment, told us:

*[Testing] is great! It may prevent people from using drugs and being thrown out [discharged from ORT]. I haven't taken anything, and it wasn't because of the urine testing. They trusted me.*

A woman aged around 20, said:

*I don't mind peeing because if not, things may happen ... It gives me an extra feeling of security, and the nurse represents security and support to me.*

These interviewees regarded the positive relationship with the staff as a very important factor for their perception of the testing situation. The treatment at the hands of the staff is a crucial and an important aspect of the care relationship created with the patient.

However, several interviewees were critical of the way they had been treated by individual members of staff. A woman aged around 50, who felt that she had been poorly treated, and overly controlled at a clinic, told us:

*I was treated like an addict [pauses briefly], terribly badly.*

To be supervised by a member of staff, who also may find the situation embarrassing and uncomfortable, is something most people probably would want to avoid, not least if one has no relationship with the person in question. A man about 50 years old explained:

*At the clinic in X-city the bathrooms were small, and the staff narrow-minded. They had a worse attitude there, they despised the patients.*

As can be seen from the quote below from a man around 40 years of age, there is no guarantee that they can choose which member of staff accompanies them into the bathroom.

*[I] felt embarrassed to sit and pee in front of someone. Humiliating that they are standing looking on [pauses briefly] you have to accept that women will go with you.*

The quote refers to a common rule at Swedish ORT clinics, namely that male treatment staff may not perform supervised urine testing on women, while male patients must accept female staff members overseeing the same form of urine testing on men.

The interviewees described how the reception and the testing situation at the clinic were influenced by preconceived notions and ideas of what characterises a person with dependency issues. This can be exemplified by the following quote from a man about 30 years of age:

*Urine testing is good, we're cheaters by nature.*

These ideas and notions not only describe that a larger number of the interviewees themselves regard the characteristics/identity assigned to people with addiction problems, but also how they think others, such as treatment staff, see people with addiction problems.

### 3.2.3. Clinical culture and attitudes

In a number of statements, the interviewees reflected on various alternative approaches to performing the urine testing. A number of the interviewees had been in replacement therapy for several years, and had experiences of testing procedures at various clinics. These interviewees often reflected on when it had worked well and not so well. For example, a man in his fifties, who had gone through ORT while in a correctional institution, put it this way:

*The centre in Y-city they had better test facilities where you don't see the staff.*

A man in his forties, who had undergone therapy at several different clinics, told us:

*Messy! Most clinics have no hatch, but a mirror. It's better in P-town where you are left alone and hand over your clothes through a hatch; you're alone in the lav. It's hard to pee with someone else in the room.*

A man aged about 45 explained:

*Urine testing in L-city was cool. At the clinic in W-city it was a bit ridiculous and over the top.*

Similar comparisons of what we could term reception cultures appear also in other statement by interviewees who had visited various clinics.

### 3.2.4. Stress, pressure and anxiety – tests can be difficult to perform

Testing can be perceived negatively in other

ways, for instance as a stressful moment. That an interviewee 'has difficulties peeing on demand', i.e. that it may be hard to pass water while a member of staff is watching, may cause stress and anxiety.

Several interviewees pointed out that they had to plan to ensure they could provide a urine sample on request. For example, they would not use the toilet on waking up, so that there would be a need to urinate when coming to the clinic. A younger man of the age of 25 said:

*It prevents you from taking other drugs – if you cannot control it yourself – if you have to enter the consulting office 2-3 times a week. But it's terribly boring and hard not to pee in the morning and to plan the urine tests.*

Several interviewees voiced the opinion that the medication caused them to 'freeze', even if they wanted to urinate, which caused distress and protracted the testing. Furthermore, staff members may also exhibit tension and irritability in these situations, further aggravating the ordeal. Not feeling trusted is another cause of distress for patients. The testing can be taken as a sign of a lack of trust, not least in the case of patients who have been in treatment for a prolonged period of time. A man in his thirties said:

*You feel under suspicion even though you're not trying any trickery.*

One side-effect of the medications used in ORT (methadone or buprenorphine) is that some patients experience difficulties controlling urination. For instance, this is what a man aged about 25 had to relate:

*It's no fun going in there [the bathroom]. It's harder for me to pee when I've taken opioids [the prescription medication methadone]*

## 3.3. The structure of the testing

The information here is mainly about the framework for the testing, i.e. when, where and how often the testing occurs. The testing routines are most often regulated at the clinics. For example, it may happen two or three times a week initially, and then more rarely when the patient is stable in treatment. Based on personal circumstances, the patients may need customised routines.

### 3.3.1. Structure is needed in life

Several of the interviewees said that the structure of attending the clinic, receiving their medication and providing a urine test constituted a welcome routine in their everyday life, a life that for many years had been characterised by chaos and unpredictability.

A man said:

*It's damn good at first, having routines so it works. It makes me feel good.*

But some pointed out that it was primarily in the beginning of the treatment process that the structure was perceived as positive:

*It was positive at the beginning. She [the nurse] recognised when I was not OK and had taken something. But there can be hitches sometimes, and I'm tired of it – that's the routine.*

### 3.3.2. Inflexible testing schemes can interfere with ORT goals

Some of the interviewees also voiced the opinion that the testing could disturb the rehabilitation process, and that it could be problematic to handle more high-intensity and inflexible testing regimes. In parallel with the testing, the patients are expected to work on their rehabilitation, such as following education or training courses or occupational activities. This has created a conflict-ridden situation for some patients who, for various reasons, have chosen not to tell their schools or employers that they are currently enrolled in ORT.

A man aged about 20 in full-time employment explained:

*Good, they're meticulous at the clinic. It was fast, but it's a shame that they didn't have better opening hours; it's hard to combine with work. I could have done my testing at the psychiatric emergency department instead*

For some patients, in particular those who did not live in larger urban areas with specialised dependency clinics, traveling to and from the clinic could be time-consuming. After years of drug misuse the majority of them had no driving licence, and were therefore dependent on public transport. A man in his fifties said:

*It's a hassle to travel long distances by bus in order collect medication and provide urine samples, two trips there and back, and each journey takes an hour.*

### 3.3.3. Gathering people with similar problems at the same location can be counterproductive

Several of the interviewees provided important information and pointed out some parts of the care plan that were clearly aggravating the person's rehabilitation. Although the structure of the testing could have a positive function, many people pointed out that having to attend a specific ORT clinic could jeopardise one's rehabilitation. The negative side of

the structure is that you cannot avoid meeting other people with similar problems. Or as a man of 25 said:

*Both good and bad [regarding the structure]. I do not want to run into other people that maybe neglect themselves, the "rabble" that whisper and tittle-tattle.*

A 40-year-old woman recounted:

*It is better to take your own responsibility and avoid meeting people with the same problem. It increases the risk of stuffing yourself [relapse in drug use].*

In practice, the structure of the treatment can be counterproductive to the goal of both patient and caregivers and instead can be part of the reason that a patient fails to adhere to the treatment plan.

### 3.4. Two different opinions in the same sentence

Dualism in the interviewees' experiences of testing featured in nearly half of the interviews.

The interviewees often pointed this out in the same sentence, or in consecutive sentences. The following quote by a man aged around 40 gives some examples:

*It feels degrading, but I'm used to the requirement [sighs dejectedly]. It's great to undergo testing so that everyone knows I'm clean. If I were to test positively, I would get help*

Or as a man aged about 30, who had been in treatment for four years, expressed it:

*It's part of the procedures, you have to do it [supervised testing]. It's six of one and half a dozen of the other – as if they're checking my private life*

One can accept the framework of recurrent testing, but still balk at the perceived humiliation of the urine testing itself. A man in his thirties expressed this as follows:

*It's positive [urine testing], I understand that it's necessary in order to show that I'm keen on getting back on the straight and narrow, to be motivated. But pissing with an audience is hard.*

Many found the testing method paradoxical, and felt equivocal about it. The external control functioned to provide reassurance and a support. However, the way in which the testing was done, through supervised urine testing, was seen as degrading.

## 4. Discussion

ORT is unique in many ways and differs from other treatment programs. The treatment is special in that it includes both extensive support and control and

that as a patient one has to undergo control to access the support and specific drugs. Similar rules occur in other addiction care, but such interventions are usually delimited in time, which ORT is not. In drug misuse/addiction care as well as psychiatric care, a person can be sectioned to care according to the Swedish compulsory legislation. However, ORT is always offered on a voluntary basis and is also considered to be desirable for a large number of people who depend on heroin or other opioids.

ORT has been controversial in many of the countries applying the treatment, but the conflict was particularly strong in Sweden when methadone therapy was introduced in the late 1960s [20]. The treatment has obvious medical advantages but also has moral aspects. The medical aspect is evident when opioid addiction is associated with premature death and severe comorbidity and also involves extensive social complications. The moral aspect, from the society, obliges patients who receive ORT to be compliant with the conditions that govern the treatment [21, 38]. Misuse is then considered immoral and ORT can also be perceived as “legal dope” by those who advocate total drug absence.

The results of this study show that the experiences of the testing situation are very varied among the interviewees. There is an understanding among a majority of the interviewees that testing is part of the treatment, and several referred to both themselves and others as “cheaters of nature”. At the same time the supervised testing process, as well as some of the consequences that may result from test results showing intake of non-prescribed substances, is perceived as something negative. What was positive was that the testing was perceived as a safety measure when the craving for drugs was difficult to resist. In addition, the testing could also provide proof that the person was “clean” (drug-free), and thereby could be considered reliable in other situations, such as taking care of their own children.

It was the supervised urine testing, the procedure itself, and sometimes the structure of the testing that were perceived as problematic. The procedure was experienced by the majority of interviewees as degrading, and sometimes memories of earlier misuse were revived. Being forced to expose one’s genitals to other people can be perceived as troublesome even in other healthcare sectors, but is accepted in cases of examination and care in connection with illnesses, for example, in gynaecological examinations or examination of the prostate. However, when confirming compliance with the treatment and that no other

drugs have been taken, exposure may have a different meaning, depending, inter alia, on the staff response and treatment.

The response from the staff is what appears most important in how the interviewees came to experience the testing situation. The interviewees who did not experience the situation as negative described the contact with healthcare professionals as positive and supportive. Some of the interviewees made comparisons between different clinics and described major differences in the treatment, and how it affected the satisfaction with care. Some of the interviewees claimed that they found the staff domineering, and that they felt they were regarded with suspicion, or even ill-will, in connection with testing. This was perceived as a lack of respect and authoritarianism on the part of the staff. Having to expose one’s intimate parts to others, as a condition for ORT, may be perceived as humiliating, even in cases where a positive relationship between patient and staff exists. Several interviewees described how the unequal power relationship was reflected in the way they were treated, and that they were still ascribed an ‘addict’ identity by staff. The interviewees stressed the importance of being allowed to feel like unique individuals, and many of them wanted an opportunity to influence the way testing was performed.

The interviewees also mentioned, on a number of occasions, that being referred to a specialist clinic for people with addiction related problems was itself a risk factor for relapse, since some of the other patients were involved in active misuse.

ORT has sometimes been described as “liquid handcuffs” [38], and as a medicalised system for controlling people with addiction problems [8, 37]. The use of supervised urine samples has been highlighted as a particularly intrusive aspect of ORT [14, 24, 37]. If the test routines are not guided by an ethical approach, they may risk stigmatizing patients as having a deviant identity, thereby counteracting rehabilitation [15].

The relationship between staff and patient is complex and may be associated with what Bourdieu calls symbolic power, an invisible power intrinsic to helping, supporting or caring for other people [4]. The care, i.e. the act of helping, may from this perspective be perceived as a “gift” that the recipient should show gratitude for. The staff member is the one who helps and offers care, and the patient as a recipient of the aid may be perceived as having a moral obligation to follow the rules and show that they “deserve” their place in ORT program [37, 38].

In order to ensure that patients follow the conditions for ORT, supervised urine tests are used. This means that the staff member has a dual role, one role as helper and care giver, i.e. the medical role, and another role as supervisor or inspector. These dual roles complicate the relationship between staff and patients, especially in cases where staff are mainly perceived as supervisors and not as supporters [25]. This is something that is reflected in the interview answers. Foucault coined the term “pastoral power” to refer to a kind of power exercise in which help and control unite, and argues that aspects of such power can be found in many welfare state practices [12, 23]. As several researchers have shown earlier, this applies to a large extent in ORT programs [5, 24, 37].

### *Clinical Implications*

The findings of this study highlight the importance of clarifying the role of the staff and visualising the power structure implicit in the relationship between the person who provides care and the person receiving care, support and assistance. It is especially important to clarify this in connection with the testing procedures, and to show how it may affect satisfaction with care. Although ORT is surrounded by structure, rules and controls, there is scope to increase the patient's influence regarding the testing process. For example, the patient should be able to choose the gender of the staff that conducts the testing.

From the point of view of both the staff and the patients, it is important that alternative testing methods are developed. There are ongoing attempts to do this, e.g. with tests of hair, saliva or exhalation air, and it is important that attempts at counselling offices are made to validate some of the most successful trials conducted in the laboratory environment (Meyer).

### *Limitations*

This research studied a limited population based on a Swedish context; thus, it may not be possible to generalise the results to other settings. However, supervised urine tests are a globally accepted and used method in dealing with addiction problems. Most probably, patients (and clinicians) in other countries face similar obstacles and dilemmas to those shown in this study.

Another limitation is the fact that the interviews were not audio-recorded and thus are not available to other researchers. The reason for this was that this study is part of a larger research project based

on structured interviews that includes several instruments such as the Swedish translations of SUDDS (Substance Use Disorder Diagnostic Schedule) and ASI (Addiction Severity Index). As these interview sessions were very extensive, and data was written down directly in the instrument form, no audio-recorders were used. However, some additional questions were asked at the same time the structured interviews were performed, for example concerning the experience of urine testing, and the statements from the interviewees were immediately written down verbatim. Since the first author wrote down the answers and then repeated them to the interviewees who could then correct their statement immediately, the data should be reliable.

## **5. Conclusions**

Most interviewees do not object to the function of testing as support or proxy control in case of personal loss of control. However, supervised urine testing also constitutes a severe invasion of privacy. Less demeaning testing methods need to be developed and implemented.

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#### Contributors

All authors were involved in the study design, had full access to the survey data and analyses, and interpreted the data, critically reviewed the manuscript and had full control, including final responsibility for the decision to submit the paper for publication.

#### Conflict of interest

All authors have no conflict of interest.

#### Ethics

Authors confirm that the submitted study was conducted according to the WMA Declaration of Helsinki - Ethical Principles for Medical Research Involving Human Subjects. The study has been subjected to ethical review and was approved by the Regional Ethical Review Board in Linköping, on June 15, 2011 (2011/214-31), and on January 13, 2014 (2013/497-32).

#### Note

It is the policy of this Journal to provide a free revision of English for Authors who are not native English speakers.

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