

THE PROCESSES OF ENGAGING IN MANDATED ADDICTION TREATMENT: A  
GROUNDED THEORY

by

Lucy McCullough

B.Sc., University of Victoria, 2001

M.A., Ontario Institute for Studies in Education, University of Toronto, 2008

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## **Abstract**

The aim of this research was to produce a grounded theory that describes and explains the experience of mandated addiction treatment (MAT) using a Straussian (Corbin & Strauss, 2008) qualitative grounded theory method. Overall, clients' perspectives have been neglected in the creation and evaluation of MAT (Kras, 2013; Urbanoski, 2010). The main outcomes of interest in MAT research have been expressed as objective measures of abstinence, treatment retention, and recidivism.

This study provides an in-depth look into the experiential processes of entering, attending, and exiting MAT. Without this fuller picture detailing the process of the MAT experience, MAT programs continue to run the risk of infringing on civil liberties; undermining the integrity of the treatment endeavour; and reproducing inconclusive outcomes on decontextualized variables.

Forty adults (ages 25-64; 18 women and 22 men) were interviewed using a semi-structured interview guide. All participants had been institutionally referred through the criminal justice system, child protection services, or their employer. All interviews were subject to the constant comparative methods of open, axial, and theoretical coding to develop the model of MAT. The interview guide was modified three times over the course of the fieldwork in order to theoretically sample for the emerging concepts and categories and test for contradictory cases and opposing viewpoints.

The process of what participants do as they go through MAT is explained as “engaging” in the Theory of Engaging in MAT (TEMAT). There are four processes and two contextual categories that constitute TEMAT. The processes are: Choosing Treatment, Ready to Participate in Treatment, Treating Addiction Experiences, and Evaluating Mandated Treatment.

The personal contexts that frame the MAT experience are the contextual categories of Living Addiction and Living Sobriety. TEMAT illustrates the journey of MAT, describes the properties and characteristics of what participants do in each of the four process, and the relationship among the processes.

This study uniquely adds to the literature on MAT by showing the ways participants are active in assessing, choosing, and evaluating consequences, despite the mandated nature of their treatment. Implications for future research and clinical practice are discussed.

## Preface

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## **List of Abbreviations**

CETOP - Cognitive Enhancements for the Treatment of Probationers

CSC - Correctional Services of Canada

CMRS - Circumstances, Motivation, Readiness, and Suitability Scale

CORES - Community Oriented Programs Environment Scale

DATOS - Drug Abuse Treatment Outcomes Study

DTC - Drug Treatment Court

MAT – Mandated Addiction Treatment

MI – Motivational Interviewing

PRS - Pretreatment Readiness Scale

SACPA - Substance Abuse and Crime Prevention Act

SDT – Self-Determination Theory

SOCRATES - Stages of Change Readiness and Treatment Eagerness Scale

TCU – Texas Christian University

TCU-TMA – Treatment Motivation Assessment

TEMAT – Theory of Engaging in Mandated Addiction Treatment

TEQ – Treatment Entry Questionnaire

The Act - British Columbia's Community Care and Assisted Living Act

RCQ - Readiness to Change Questionnaire

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## **Chapter 1: Introduction**

In an attempt to deal with the perennial problem of addiction, many social institutions, including the criminal justice and child welfare systems, require individuals to attend addiction treatment programs in place of more traditional punishments and sanctions. Many other health and social services, including employers, are following suit (Miller & Weisner, 2002; 2000; Wild, 2006). However, despite this upward trend, MAT poses ethical and clinical challenges that are unresolved, and only partially explained by the dominant quantitative outcome and correlational research. This chapter introduces the clinical, ethical, and research problems posed by MAT; presents the research aims and questions; and defines the terms mandated, addiction, and treatment for the purposes of this research.

### **Mandatory Addiction Treatment: History, Issues, and Evidence**

In the past it was considered a crime to be addicted to or use illegal drugs (Balducci, 1999; Forrest, 1985), and the political and medical popularity of using forcible confinement or civil commitment to treat addiction has ebbed and flowed over the 20th century (Giffen, Endicott, & Lambert, 1991). In general, a more therapeutic approach to drug addiction has been incorporated into the criminal justice system culminating in the creation of Canadian Drug Treatment Courts (Allard, Lyons, & Elliott, 2011; Rowley & MacDonald, 2001).

The Canadian Drug Treatment Court (DTC) is an example of the incorporation of addiction rehabilitation into the criminal justice system. The first DTC was established in Toronto in 1998 followed closely by Vancouver in 2001. Since 2005, there has been a proliferation of DTCs across the country - up to thirteen as of 2015. The DTC provides diversion from incarceration by providing some non-violent offenders court monitored addiction treatment (Allard et al., 2011; Grant, 2005; PERNANEN, COUSSINEAU, BROCHU, & SUN, 2002). They

operate under a theory of coercion proposing that the power of the courts and the threat of incarceration promote treatment compliance (Inciardi, 1988; Werb et al., 2007). Offenders plead guilty and sentencing may be deferred to a later date or lessened depending on the client's level of cooperation with treatment programs.

Leading addiction researchers advocate for the mainstreaming of specialist addiction services into social and health services, rather than the majority being accessed privately or under coercive conditions (Miller & Weisner, 2002). Furthermore, it appears that those most in need of addiction services, based on psychosocial problems and addiction severity, are not necessarily the target of mandated treatment. In a comparison between mandated and non-mandated employees of a private, non-profit U.S. managed care health plan, the mandated group scored significantly lower on measures of family, psychiatric, alcohol, and drug problem severity (Weisner et al., 2009). Furthermore, in a study of the characteristics of people receiving treatment ultimatums from various sources, including employment, legal, medical, and family, Weisner, Hinman, Lu, Chi, and Mertens (2010) found that "behaviors that interfere with families or institutions are not often related to the severity of alcohol and drug problems, ultimatums from those sources may represent a social control function, rather than a mechanism for identifying those most severely in need of services" (p. 696). The potential social control function of mandated treatment, rather than a health service function, suggests a broader socio-political context. The experience of which can be only partially captured using correlational and quasi-experimental designs in the current research on MAT.

The normative mental health and addiction treatment models require personal problem recognition and desire for change. Yet, as Miller and Miller (1998) highlighted, "People who suffer from substance abuse and dependence are often nudged, pushed or coerced into screening

and assessment, and ultimately into treatment. When this happens, there are forces in play other than the needs of the client, and ethical dilemmas may arise” (p. 169). This is certainly the case in MAT, where treatment is initiated by outside social institutions. The independent social imposition of institutional mandates may add pressure or prescribed objectives to the therapeutic endeavour, undermining the presumption of honesty and genuineness in addiction treatment (Miller, 1999; Miller & Miller, 1998; Wild et al., 2001).

Clinical concerns related to treatment sought under social pressure include clients’ feelings of coercion and resistance to therapy, potentially low motivation to change, conflicts between legal objectives and counsellors’ therapeutic objectives (Rowley & MacDonald, 2001; Whiteacre, 2007), and counsellors’ discomfort with operating in a non-voluntary treatment model. Furthermore, pervasive negative perceptions that clients with substance use issues are manipulative and resistant to change may contribute further to counsellors’ trepidation (Ning, 2005; Patchell, 2005).

Findings in MAT studies are often conflicting and ambiguous depending on the stakeholder’s view. For instance, in a study by Wild et al. (2001) comparing the public’s, counsellors’, probation officers’ and judges’ attitudes toward compulsory substance abuse treatment found that counsellors and probation officers were less supportive of court mandated addiction treatment than the general public and judges. Furthermore, Wild, Cunningham, and Ryan (2006) found that counsellors perceive their clients as having lower levels of interest in addiction treatment when they know their clients have been mandated, but that these perceptions do not necessarily match clients’ interest in counselling. Wild and colleagues therefore alert researchers to the problem that the success of clients in MAT situations is highly contingent on a host of perceptual, emotional, and relational factors beyond the mandate. Moreover, the

participant's treatment endeavour may be hampered by both the social pressure under which it is initiated, and the reticence of treatment staff.

Researchers, addiction theorists, and policy analysts have argued that the coercive imposition of MAT by legal or other social institutions is currently not justified by moderate treatment outcomes (Allard et al., 2011; Carter, 2012; Room, 2003; Wild, Wolfe, & Hyshka, 2012). They claim that policies and programs that infringe on substance users' civil liberties and autonomous decision making should show greater benefits than treatment without social pressure in order to justify the coercive imposition placed on clients (Bersoff, 1992; Canadian Charter of Rights and Freedom<sup>1</sup>; Maddux, 1988).

The extant literature on the effectiveness of MAT at reducing substance use and recidivism is inconclusive and methodologically homogenous. MAT has primarily been studied using correlational and quasi-experimental designs within a quantitative framework, and yields variable results on substance use and recidivism outcomes. Some studies have shown that clients who are legally coerced into addiction treatment do as well as, and sometimes better than, those who enter treatment voluntarily, and that clients' perceptions of coercion can be positively related to their treatment engagement and outcomes (Fagan, 1999; Farabee, Prendergast, & Anglin, 1998; Kelly, Finney, & Moos, 2005; Young & Belenko, 2002). Other researchers take a more cautious stance on the efficacy of mandated treatment, claiming a paucity of treatment outcome measures (Gutierrez & Bourgon, 2009; Klag, O'Callaghan, & Creed, 2005; Parhar, Wormith, Derkzen, & Beauregard, 2008; Wild, 2006). Moreover, Miller (2000) argues that "studies of aggregate outcomes are insufficient" in explaining causal chains in treatment (Miller, 2000, p. 19). He demonstrates that the most influential components, theoretically, of reliable

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<sup>1</sup> Forcing individuals to undergo treatment for substance abuse may be seen as violating their civil liberties (Mugford & Weekes, 2006). See also *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11.



psychotherapy treatments do not always account for symptom alleviation<sup>2</sup>. Currently, there is no reliable theory of how MAT works. Rather, there are hypotheses about how social pressure and coercion might motivate and retain substance users in treatment to variable success.

Overall, clients' perspectives have been neglected in the creation and evaluation of MAT (Kras, 2013; Urbanoski, 2010). Even those studies that deliberately set out to account for experiential aspects of MAT, such as, views, interests, opinions, beliefs, values, feelings, and so forth, are problematic, since the main outcomes of interest have been expressed as objective measures. Client experience measured in such quantifiable terms cannot provide a rich description of MAT from the client's own perspective, and inadequately assesses client experience.

Having neglected rich description of client perspectives in the creation and evaluation of MAT, socially embedded mechanisms of change may only be partially uncovered through dominant correlational and quasi-experimental research designs. Without this fuller picture detailing the process of the MAT experience, MAT programs continue to run the risk of infringing on civil liberties; undermining the integrity of the treatment endeavour; and reproducing inconclusive outcomes on decontextualized variables.

### **Purpose and Research Question**

The purpose of this study was to describe and explain MAT participants' experiences of entering, attending, and exiting MAT through interviews using a qualitative grounded theory methodology. Furthermore, the aim of this research was to construct an overarching theoretical framework that would model MAT participants' first-hand experiences of the mandated process.

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<sup>2</sup> To make his point, Miller (2000) refers to the efficacious systematic desensitization therapy for phobias. Lang (1969), as referenced in Miller, notes that the two key components of treatment – successive hierarchy in exposure to feared stimulus and relaxation training - do not account for its benefits (p. 160-191).

The research question guiding the inquiry was: What is the theoretical explanation, grounded in the experience of mandated clients, of entering, attending, and exiting addiction treatment?

## Terms

It is important to delimit the terms *mandated*, *addiction*, and *treatment* so the reader may understand the scope of the MAT phenomenon explored in this study. Mandated refers to institutional or formal pressure to enter treatment. This study did not set out to account for the informal relationship pressures, for example, from family, that substance users often face<sup>3</sup>.

In particular, the three institutional-referrals included: the criminal justice system, child protection services, and employers (most commonly with unionized workers). Mandated participants did not include individuals subject to involuntary confinement, or civil commitment to treatment, which may be termed compulsory or involuntary treatment. Participants of this study could have decided to refuse treatment, but would face serious ultimatums of joblessness, childlessness, or incarceration.

Addiction is the recurrent use of substances causing clinical and functional impairment (American Psychiatric Association, 2013). *The Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association, 2013) differentiates between Substance-Related and Addiction Disorders such as gambling. Substance-related disorders are further categorized into substance-use and substance-induced disorders. Only substance-use disorders are included under the term *addiction* in this study; alcohol, opioid, and stimulant-related disorders were particularly prevalent among participants. The research participants did not undergo diagnostic screening. However, their “failure to meet major responsibilities at work, school, or home”, a DSM-V criteria for substance-use disorder, was evident by having been

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<sup>3</sup> A discussion of *coercion* as a distinct and separate issue from referral status or social pressure to enter treatment is presented in Chapter 2.

mandated to addiction treatment (American Psychiatric Association). In addition, the participants' common stories of recurrent chronic substance use indicated the disordered nature of their substance use.

Treatment was defined as attendance at any residential, outpatient, or community-based programs designed to educate and intervene on substance use behaviours. Treatment may take a variety of formats, including individual or group psychotherapy, didactic psycho-educational groups, or addiction support groups, such as, Alcoholics Anonymous. Informal, self-guided addiction treatments are not considered treatment for the purposes of this research. Treatment structure and content is discussed further in Chapter 4 under the heading Treating Addiction.

## **Overview**

Following this introduction, this dissertation begins with a review of the literature on the role of coercion in addiction treatment, and the MAT experience. Most of this research focuses on the relationship among the following variables: (a) demographic and psychosocial variables, such as, addiction severity, (b) social pressure, in the form of legal or other formal referral status; (c) measures of treatment interest, rationale, actions; and (d) treatment outcomes as measured by attendance, recidivism, and substance use. The need for more in-depth qualitative research on mandated treatment is presented in light of the current state of knowledge. This research takes a unique qualitative grounded theory methodological approach compared to the extant quasi-experimental quantitative research methods in the area. Chapter 3 presents my constructivist epistemological approach to the research question, as well as a detailed description of the grounded theory methodology, research setting, and criteria for rigour employed in this research. The grounded theory analyses of 40 qualitative interviews resulted in a theoretical explanation of the personal processes and contextual influences of the mandated treatment experience, which is

detailed in Chapter 4. Finally, Chapter 5 discusses the findings in light of the extant literature on MAT, Self-Determination Theory of motivation (Ryan and Deci, 1985), and Prochaska and Diclemente's (1982) Transtheoretical Stages of Change model. Clinical and policy recommendations to improve client experience in MAT, as well as recommendations for future research, are discussed.

## **Chapter 2: Literature Review**

In the past 30 years, researchers concerned to understand experiential elements and outcomes of MAT have used theoretically disparate lenses, ranging from disease models (Room, 1985, 2003), biopsychosocial models (Engel, 1977, 1980), Self-Determination Theory (SDT) (Deci & Ryan, 1985; Ryan & Deci, 2002), and the Transtheoretical Stages of Change model (Prochaska & DiClemente, 1982, 1983, 1986). These theories not only provide background to the empirical research on MAT, but also serve as justification for the common hypotheses that external pressure will hinder addiction recovery. The literature on MAT can be divided into studies of effectiveness and studies of experiential correlates of MAT. Effectiveness studies employ predictive and comparative statistical analysis to determine effectiveness of MAT programs at reducing substance use and recidivism. Research on the experiential correlates of MAT also use correlational and multiple regression designs to examine the relationships of mandates and coercion to aspects of behaviour, action, and beliefs making up the construct of motivation. This literature review tracks the evolution of MAT research from outcome-driven questions to more processes oriented questions concerning the psychosocial impact of mandates and coercion on treatment interest and intentions.

A major turning point in the research on MAT was the finding that many addiction treatment participants, both voluntary and involuntary, experience pressure and coercion to be in treatment, and that treatment interest and desire for change cannot be predicted by mandated status. The distinction between social pressure and coercion is discussed and highlighted as a turning point in MAT research towards understanding the psychosocial experience of MAT rather than substance use and recidivism outcomes. Finally, the argument is made that the dominant statistical designs and survey-based measures of treatment attitudes and beliefs in the

extant literature has limitations in capturing the decisional processes, interests, perspectives, and social contexts of the MAT experience.

### **Biomedical and Biopsychosocial Models of Addiction**

Addictive behaviours and their causes are well explained by the disease model, complete with physiological symptoms of increased tolerance, physiological and psychological dependence and withdrawal, and an apparent lack of control over this process. Moreover, the disease model places the problem of addiction squarely within the individual's malfunctioning neurobiology that propels them down a self- and socially-destructive path of intoxication, tolerance, craving, and dependency. The progressive incorporation of therapy into public institutions has been somewhat justified by a disease model of addiction wherein addicts may be conceptualized as sufferers of a disease over which they have little or no control (Jellinek, 1946; 1960; Morse, 2004; Room, 1985; 2003). Under this concept of addiction, institutional and socially coercive measures are justified to help addicts regain control. However, counselling practice may not fit well with the disease model. If the substance user is powerless to their flawed physiology, how will he or she find the agency and motivation necessary for successful engagement in counselling and change? The disease model largely ignores the socio-cultural and psychological contributors to the experience of addiction (Larkin, Wood, & Griffiths, 2006; Room, 2003).

Psychologists and researchers in the field of addiction treatment espouse a biopsychosocial (BPS) model of addiction (Havassy, Hall, & Wasserman, 1991; Marlatt, 1992) in an effort to incorporate the psychological, social, cultural, spiritual, and environmental factors that interact with the biological basis of addictive behaviors and experiences. The BPS model is meant as a framework to consider each of all these human elements in understanding the

evolution, maintenance, and recovery from addiction, and indeed their co-influencing effects. Most psychosocial research, including the present study, implicitly acknowledges the role of biology but explicitly strives to measure, describe, explain, and improve the psychosocial aspects of addiction. As Clark (2011) says, “It is illogical to assume that once you have found the pharmacological correlates of behaviour, you have found the reasons for doing it since all behaviour has a psychopharmacological correlate” (p. 58).

Although inseparable from other elements of BPS, the psychological facet of BPS emphasizes the thought processes of individuals who engage in addictive actions. For example, Marlatt, Tucker, Donovan, and Vuchinich, in a 1997 research monograph by the National Institute for Drug Abuse, used a BPS framework to investigate what they defined as *psychological components* and *psychosocial correlates* in help-seeking for addiction. Psychological components included personal beliefs and evaluations of help-seeking, such as, self-recognition of addiction, consideration of barriers and incentives to getting help, and felt coercion. Psychosocial correlates included demographic and psychosocial problems, such as, mental health, legal problems, and social functioning. They reported that substance-related problems, not substance use practices themselves, were more consistently predictive of treatment seeking.

The BPS model addresses the multiple problems inured in addiction. However, it is difficult to address the bio, psycho, and social aspects of addiction simultaneously, especially with quasi-experimental and correlational design research that needs to isolate variables to assess for their role and how they change. It can become cumbersome to hypothesize and measure the many psychosocial factors of addiction problems and recovery with multivariate designs. Qualitative designs have the flexibility to allow for the most salient experiential elements to

emerge both through talk and observation, and do not impose pre-established measures of the types of personal information that may be accounted for by the research.

### **Theories of Behaviour Change and Motivation in Addiction Research**

Motivation is a dynamic construct at the center of therapeutic action and change (Miller, 2006; Prochaska & Diclemente, 1982, 1986). Theories abound offering explanations on what it is and how to shape and enhance it. Self-Determination Theory (SDT) (Deci & Ryan, 2002) and Prochaska and DiClemente's Stages of Change model (Prochaska & DiClemente, 1982; 1986) are two such theories described below. In MAT research, the term motivation is commonly comprised of the linearly related, contiguous constructs (Hiller, Knight, Leukefeld, & Simpson, 2002) of Problem Recognition, Desire for Help, and Treatment Readiness, measured by the Texas Christian University (TCU) Treatment Motivation Assessment (TCU-TMA) Knight, Holcom, & Simpson, 1994; Simpson & Joe, 1993), along with constructs of Ambivalence and Taking Action as measured by the Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES) (Miller & Tonigan, 1996). These constructs are the target of multiple motivation scales associated with treatment engagement and retention cited throughout this literature review.

SDT is a multifaceted framework for understanding motivation and goal pursuits utilized by researchers in psychology, health care, education, social sciences, and other areas concerned with facilitating healthy actions, beliefs, and behaviours (Deci & Ryan, 2002; Ryan & Deci, 2000). SDT proposes action on a continuum of intrinsic and extrinsic motivation and as such provides a useful frame by which to link the social pressure, coercion, counselling, and individual change in MAT. It regards the actualizing tendency of humans to be active, growth-oriented, and propelled to engage in their surroundings. SDT expands Heider's attribution theory (DeCharms, 1981; Heider, 1958) to include the interplay between our intrinsic actualizing



tendency and the social context, which can serve to either enhance or restrain self-determined action (Ryan & Deci, 2002).

SDT posits three basic fundamental psychological needs: the needs for competence, relatedness, and autonomy (Ryan & Deci, 2000). Each is “an energizing state that, if satisfied, conduces toward health and well-being but, if not satisfied, contributes to pathology and ill-being” (p. 74). Social environments that allow satisfaction of these three needs support healthy functioning and foster self-determined behaviour and intrinsic motivation. Environments that thwart the attainment or satisfaction of these needs limit personal growth and health (Deci & Ryan, 2002). Part of the reason to be concerned with how coercive social pressures impact clients, counselling, and in some cases the existence of addiction services, is because such pressures may thwart both clients’ and counsellors’ sense of competence, relatedness, and autonomy.

Prochaska and DiClemente’s (1982, 1983) Transtheoretical Stages of Change model has become a commonly used reference among addiction clinicians for assessing readiness and progress in addiction recovery. There have been various iterations of the Stages of Change over 30 year, but most commonly there are five stages of change including pre-contemplation, contemplation, preparation, action, and maintenance (Prochaska & Velicer, 1997). In pre-contemplation, the client does not intend to take action and does not acknowledge problems related to substance use. In contemplation the client expresses an intention to change but is also ambivalent about the benefits of stopping substance use. In preparation the client has a plan of action toward change, such as, talking to a counsellor or attending 12-step meetings or addiction treatment program. The action stage is characterized by overt behaviour modifications, usually abstaining from substance use. Maintenance is defined as ongoing behaviour change defined

anywhere between 6 months and 5 years from the initiation of change. Maintenance differs from action in terms of improved self-efficacy and confidence in being able to maintain the abstinence behaviours of recovery. Some versions of the Stages of Change model have included relapse (Prochaska & Diclemente, 1982) as an incident of regression from action or maintenance to an earlier stages. Other iterations of the Stages of Change have also included termination (Prochaska & Diclemente, 1992) to signify the stable adoption of the new behaviour. The termination of addiction behaviours is maintained in ongoing recovery choices and behaviours. The inclusion of relapse as a part of change helps to acknowledge the recursive, non-linear process of change, although the Stages of Change model has been heavily critiqued on its conceptualization of human change as a series of exclusive, linear stages (Littell, & Girvin, 2002; West, 2005).

Each stage corresponds with a time frame. For example, the second stage, contemplation, is defined as the intention to change behaviour in the next six months (Prochaska, Johnson, & Lee, 2009). Without this six month timeframe around their intention, individuals would be considered in the first stage of pre-contemplation, or not in the change process at all. Prochaska and Diclemente were inspired to define a stage based, temporally bound model of change after noticing the lack of temporal bounds in other models. This suggests change is a process, rather than an event, in many theories of therapy and change (Prochaska, 1979).

In order for someone to successfully complete and progress through the first three stages they must find some value, whether for personal and external gain, in the idea of taking actions towards recovery. Many counsellors who are familiar with this literature may feel discouraged knowing that for some of their clients the legal, child protection or employer mandate is the primary motivation for entering treatment. The challenge to counsellors, therefore, is “more

about helping people to want the treatment than just getting them into treatment” (Stevens et al., 2006, p. 206).

Some researchers caution against over-using the Stages of Change model. Silverstein (1997), in his research on Stages of Change and addictions, cautions against using the stages themselves as markers of success and rather suggests focusing on the progression *through* the stages. Silverstein (1997) assessed court mandated and non-mandated clients attending the same outpatient treatment programs on their attitudes towards the treatment facility and staff, and on their stage of change at intake and at discharge. Attitudes were assessed using questionnaires and stage of change was assessed using a staging algorithm and a multi-component 32-item scale designed to identify stage of change. Interestingly, he found that mandated clients made the same gains as non-mandated clients in outpatient treatment programs but started at earlier stages, that is, pre-contemplation rather than contemplation (Silverstein, 1997).

### **Effectiveness of Mandates on Treatment Outcomes**

The literature on mandated treatment can be divided into two groups: treatment outcome research and experiential correlates of MAT. The early studies of the late 1980s and 1990s were outcome driven, assessing the relative impact of formal pressure on treatment outcomes such as substance use, recidivism, and treatment retention. The studies of the 2000s attempt to incorporate experiential correlates of MAT, while continuing to employ correlational and predictive multivariate statistical research designs. These latter studies assess the relationships of formal pressure and perceived coercion on a multitude of psychosocial variables, including demographic variables and psychological measures of interests, beliefs, and actions toward addiction treatment and change. Overall, the research in this area takes a post-positivist approach toward these issues, using survey data and statistical analysis to predict treatment

outcomes and the psychosocial experience of MAT. The present study employs interpretivist methods of interviewing and observation to contribute a rich description and inductively derived explanation of the MAT experience to the extant MAT literature.

While addiction treatment is increasingly being used as a resource by the criminal justice system in Canada, the United States, and Western Europe, there is no definitive evidence on the effectiveness of using social controls, such as, court mandates, on reducing substance use and recidivism. Some studies have shown that clients who are legally coerced into drug treatment do as well as, and sometimes better than, those who enter voluntarily. They have found that external pressure and elevated perceptions of coercion are positively related to treatment outcomes (Fagan, 1999; Farabee et al., 1998; Kelly, Finney, & Moos, 2005; Young & Belenko, 2002). The outcomes assessed are objective measures of treatment retention, criminality or recidivism, abstinence, and employment. However, other researchers have found that voluntary treatment is more significantly associated with reduced recidivism and attrition compared to mandated treatment, particularly mandated programs in prison (Parhar, Wormith, Derkzen, & Beaugard, 2008). Still others point to a paucity of valid treatment outcome measures when the primary measures being reported in the literature are treatment retention and self-reported abstinence over a short term follow-up period (Hiller et al., 2002; Klag, O'Callaghan, & Creed, 2005; Stevens et al., 2005).

Evaluations of the Toronto and Vancouver Drug Treatment Courts (Gliksman, Newton-Taylor, Patra, & Rehm, 2004; Millson, Robinson, Stringer, & Van Dieten, 2005, respectively) have failed so far to find compelling evidence that these programs are effective in reducing rates of recidivism and drug use. Over three and a half years, 322 participants were admitted to the Vancouver program (Millson, Robinson, Stringer, & Van Dieten, 2005) and 365 were admitted

to the Toronto program (Gliksman et al., 2004). Of those, 13% completed the Vancouver program and 15.6% graduated from the Toronto program. In addition, these evaluations did not have reliable comparison groups, for example, there was no randomized control group, or follow-up data on drug use or recidivism longer than 6-months post program. While these completion rates seem very low, without good follow-up data on the participants' post-program lives or comparative data on similar offenders it is difficult to judge the effectiveness of these programs using completion rates alone.

These findings from the Vancouver and Toronto evaluations do not necessarily mean that the drug counselling component of the Drug Treatment Courts is a failure. In a large retrospective study on the impact of treatment on program graduation rates, Taxman and Bouffard (2005) found that offenders who participated longer in treatment graduated at higher rates from drug court ( $\beta = .150, p < .01$ ). Offenders, or clients, graduated from drug court after completing a multi-phased treatment plan ranging from three to four phases, each lasting two to six, depending on the drug court. Therefore, a typical course of drug court ranges from 6 months to a year and a half. Common requirements, or phases, of drug courts included: abstinence from drugs and alcohol (sometimes requiring a detoxification program), consistently negative drug urine screens, regular attendance at group and individual counselling (which sometimes includes residential treatment) and, for some, attaining housing<sup>4</sup>. Client progress and continued enrolment in the program is at the discretion of the drug court judge who consults with treatment staff.

Length of stay in treatment, along with being white and having a high school diploma, were most predictive of graduation rates. Other demographic variables such as age, gender,

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<sup>4</sup> The requirements of the drug courts in the Taxman and Bouffard (2005) study are similar to those of the Vancouver Drug Treatment Courts, based on my observations (McCullough, 2011).

marital status, and criminal status did not significantly predict graduation. Taxman and Bouffard's (2005) study was exceptionally thorough - including over a year of fieldwork observation at 4 drug treatment court sites across the United States in Louisiana, Oklahoma, California, and Missouri, a multitude of interviews and surveys with counselling staff, and a retrospective multivariate analysis of 2,357 drug court clients exploring the impact of treatment participation on graduation rates, program re-arrests, and post-program re-arrests.

Studies of during-treatment changes comparing voluntary and involuntary clients show that both groups make positive changes on psychosocial variables. Prendergast, Farabee, Cartier, and Henkin (2002) compared voluntary versus involuntarily inmates admitted to a prison addiction treatment program on psychosocial variables of self-esteem, depression, anxiety, decision making, self-efficacy, hostility, risk taking, and social conformity on the TCU Self-Rating form (Institute of Behavioral Research, 2011; Simpson & Knight, 1998). They assessed the participants at the start of treatment and again just prior to release, a time span of approximately 8 months. All measures of psychological functioning showed significant improvements, with the exceptions of decision-making for the voluntary participants and self-efficacy for the involuntary group. Mandated clients may struggle to develop a sense self-efficacy toward treatment and recovery given the coercive circumstances. Finally, social conformity, a measure of social function, was significantly improved among the involuntary participants ( $p=.02$ ) but not among voluntary participants. Social conformity was measured with scales items, such as, "you have trouble following rules" and "you feel honesty is required in every situation" (Knight et al., 1994). That participants remained in treatment despite involuntary admission demonstrated a degree of social conformity in itself.

Kelly et al. (2005) found that clients entering treatment on a court mandate made similar therapeutic gains during treatment and had better treatment outcomes. The study consisted of 3,698 male participants in intensive 21- or 28- day residential treatment programs. There were three study groups: justice system involved mandated clients (JSI-M), justice system involved clients who had not been mandated to treatment (JSI) and clients who were not mandated nor involved with the justice system (no-JSI). The treatment outcomes of interest were abstinence, remission, substance-related consequences, arrests, and employment. Using separate regression models for each outcome variable, these 5 outcomes variables were regressed on each study group (JSI-M, JSI and no JSI) at 1 and 5 years follow-up.

The JSI-M clients were more likely to be abstinent (JSI-M = 53.9%, JSI = 45.3%, and No-JSI = 39.3%;  $p = .001$ ), in remission (JSI-M = 61.0%, JSI = 48.1%, and No-JSI = 43.8%;  $p < .001$ ), and free of substance-related problems at 1-year follow-up (JSI-M = 41.3%, JSI = 28.4%, and No-JSI = 27.9%;  $p = .05$ ) than were both the JSI and no-JSI groups. However, the differences between the groups diminished over time and there remained no significant differences between the groups on these outcome variables at the 5-year follow up. The variation in treatment outcomes seem to be reliably accounted for by the various social pressures and circumstance of the study groups; because the results held true even after controlling for the variables that differed between groups (i.e., age, ethnicity, motivation, clinical symptoms, substance related consequences, drug addicted identity, and prior treatment) in the adjusted regression model.

Kelly et al. (2005) also found positive during-treatment changes among all three groups on measures of coping, self-efficacy, and 12-step involvement. This is in contrast to the Prendergast et al. (2002) study above that found involuntary clients did not make the same

improvements on measures of self-efficacy as voluntary clients. The involuntary clients in Prendergast et al.'s study were in a prison-based treatment program, suggesting that the continual coercive context may inhibit improved self-efficacy scores. On measures of clinical symptoms, however, Kelly et al. found that the JSI-M group's symptoms did not decrease as much as the JSI and no-JSI groups. However, the JSI-M also had less severe clinical profiles at entry, which may explain the lack of reduction in clinical symptoms compared to the other groups at entry. Finally, clinical symptoms included measures of depression, anxiety, paranoid ideation, and psychoticism on the Brief Symptom Inventory (Derogatis & Melisaratos, 1983). However, exact areas of improved clinical symptoms were not reported in this study, limiting the article's applicability to clinical practice.

While Kelly et al.'s (2005) results showing that mandated treatment is as effective as voluntary treatment on substance use outcomes are compelling, it is important to critique their usefulness and impact. First, the JSI-M and the JSI group were far smaller than the No-JSI group (7%, 11% and 82% respectively). Therefore, any changes made by the men in the JSI-M or JSI groups would have a much larger impact on group trends than changes in the larger No-JSI group. Secondly, these findings are based on male veterans and are not readily generalizable to other populations. Finally, the JSI-M group had more favourable clinical profiles (fewer psychopathological symptoms and less severe substance dependence) and, not surprisingly, were less likely to have been to treatment and less motivated to change. Perhaps the criminal justice system is not adequately assessing the actual clinical profiles of clients before recommending or mandating substance use treatment. Recommending inappropriate clients for substance use counselling could over-burden the already limited intake services of clinics, violate our liberal



society's valued ethic of the least restrictive alternative (Lin, 2003), and undermine the therapeutic efforts of the courts, referring institutions, and counsellors.

### **Retention Mediates Positive MAT Outcomes**

One of the most robust findings on how mandates impact treatment outcomes is their positive association with treatment retention. De Leon (1988) reviewed the effects of legal referral on treatment retention in therapeutic communities<sup>5</sup> and found that legal referrals were significantly related to treatment retention, and that length of time in treatment was “the largest and most consistent predictor of treatment outcomes (i.e., criminality, drug use and employment)” (p. 632). The requirement for mandated clients to stay in treatment explains an indirect positive effect of mandate on treatment outcomes through retention. Indeed, the research presented below spans over 20 years and shows that formal treatment mandates encourage treatment retention.

Hiller, Knight, Broome, and Simpson (1998) found a positive significant relationship between legal pressure and retention among 2,605 participants in long-term residential programs. This research was part of a United States national evaluation of community-based treatment called the Drug Abuse Treatment Outcomes Study (DATOS). Following admission, socio-demographic background, education, alcohol and drug use history, illegal activity, and employment information was collected from participants. Pre-treatment legal status, urine screen requirement, and citing legal causes as a primary or secondary reason for entering treatment were indices of legal pressure. Participants were grouped into low, moderate, and high pressure groups depending on the number of legal pressure indices they endorsed. An additional variable of interest was the effect of legal supervision, such as, probation. The outcome criterion

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<sup>5</sup> Therapeutic community is a philosophy and method of addiction treatment where clients live together, partake in group therapy together, and do social and work activities together (see De Leon, 2000).

was 90 days or more retention in the residential treatment program. The combined effect of being under supervision and scoring moderate to high on the legal pressure index had the most significant impact on treatment retention. Programs containing a large percentage (86%) of clients under supervision, as well as feeling moderate to high legal pressure, were up to 1.7 times more likely to stay 90 days or longer in treatment. In contrast, those reporting no legal pressure or legal pressure as a secondary reason for treatment entry were significantly more likely to drop out early from treatment ( $b = -.35$ ,  $t(17) = -3.02$ ,  $p < .01$ ). In addition, those with more lifetime arrests were also less likely to remain in treatment for 90 days ( $b = -.16$ ,  $t(17) = -2.04$ ,  $p = .057$ ), suggesting that the impact of legal pressure on treatment entry wanes over time. Given the combined effects of legal supervision and reported legal pressure on treatment retention, the investigators suggested that an integration of the justice and therapeutic systems may reduce drug use. Finally, consistent with other studies, being older was significantly related to treatment retention ( $b = .30$ ,  $t(17) = 5.22$ ,  $p < .001$ ) as was having a high school education ( $b = .27$ ,  $t(17) = 3.68$ ,  $p < .01$ ).

Young and Belenko (2002) also found that coerciveness of treatment was positively correlated with treatment retention. Young and Belenko compared groups of clients who were court-referred to attend highly structured drug treatment programs with those referred to attend less structured programs. The highly structured programs were deemed to have more coercive policies based on the following four categories: (1) information given to the offender about the treatment mandate; (2) increased monitoring of adherence to mandate treatment, for example, with urine screening; (3) enforcement of treatment; and (4) severity of consequences for failure to comply with treatment requirements. Patients' score on a Perception of Legal Pressure questionnaire was also an indicator of the level of coerciveness of the program. Treatment

retention at one year was 70% among the highly structured group, 60.5% among the next most structured group, and 48.7% among the least structured group. In conclusion, while treatment retention itself tells us little about the therapeutic progress a client has made, it can be inferred that it has mediating effects towards positive outcomes.

Finally, in the lesser researched area of workplace mandates, Weisner et al. (2009) found that a workplace mandate to addiction treatment predicted abstinence at one year, with length of stay a mediating variable to that success. Weisner et al. studied the relationships between workplace mandates on treatment retention, employment problems, and abstinence at one and five year posttreatment. Seventy-five people with workplace mandates were compared to 373 clients without a mandate. All participants attended a recovery program administered by a large private, nonprofit U.S. managed care health plan. That the participant had private health coverage implies they were securely employed and likely had greater financial stability compared to criminal justice or child protection MAT clients. The two types of treatment programs were group-based outpatient and day treatment. Both modalities included group and individual counselling. Treatment lasted for eight weeks, with ten months of aftercare. Therefore, one year was the longest possible length of stay. Abstinence was assessed as no drug or alcohol use in the previous 30 days, and was corroborated by breath and urine analysis. Employment problems were assessed on the Addiction Severity Index (McLellan et al., 1992), along with other psychosocial problems in legal, medical, family, substance, social, and psychiatric domains.

Both groups made significant improvement on psychosocial functioning based on the ASI at one year follow-up. As would be hoped, those with a workplace mandate showed more significant improvement in employment problems compared to those without a workplace

mandate at one and five year follow up. Those with a workplace mandate had longer stays in treatment at one year follow-up compared to those without a mandate ( $t(91) = -3.29, p = .001$ ). Moreover, when length of stay was added to the regression models the effect of the mandate was diminished, and a longer stay in treatment predicted abstinence and lower employment problems over the mandate.

### **The Experiential Correlates: Mandates, Coercion, and Motivation in MAT Research**

With little differences found between mandated and voluntary participants on substance use, criminal, and psychosocial outcomes, research on MAT shifted focus in the 2000's from treatment outcomes to the more experiential aspects of MAT, including coercion, interest, desire, and intent. This multitude of personal perceptual factors are commonly grouped under the umbrella of "motivation" and "readiness" in MAT research. Many of the pioneers of this research reviewed below are members of the Institute of Behavioural Research at the TCU, including the authors Knight, Dansereau, and Simpson. As well, Hiller and Leukefeld at the University of Kentucky, and Canadian researchers Wild and Urbanoski, are main contributor to the extant empirical research on MAT.

Firstly, Wild, Newton-Taylor, and Alletto (1998) contributed substantially to this shift by questioning the assumption that coercion equates to mandated status. In their study of 300 clients entering substance use treatment in Ontario, Wild et al. assessed the predictive power of referral source, demographic, substance use, and psychological factors on clients' perceived coercion. Coercion refers to a client's sense of control, influence, and choice in the treatment decision. Perceived coercion was measured by the perceived coercion subscale of the MacArthur Admission Experience Survey developed by Gardner et al., 1993. The MacArthur scale contains 5 true-false items assessing clients' felt influence, control, choice, freedom, and

idea to enter addiction treatment<sup>6</sup>. They found that 37% of non-mandated clients reported experiencing coercion at entry to treatment. Conversely, 35% of legally mandated clients and 61% of other-mandated clients (reporting no legal problems or another referral source) did not report any perceived coercion. If coercion could be assumed from referral source, it would be expected that no non-mandated clients and all mandated clients would feel coerced.

Wild et al. (1998) found that perceived coercion was only partially predicted by referral source, and that there were a multitude of other structural and psychological factors that promoted coercion with equal influence. Demographic, or structural, variables accounted for 10.4% of the variance on the MacArthur Perceived Coercion Measure ( $F(6, 221) = 4.29, p < .01$ ). Such structural variables included older age ( $\beta = .13, p < .05$ ) and being mandated ( $\beta = .22, p < .001$ ), which were both positively related to perceived coercion. The average age was 36.6 years. Of the psychological variables, which accounted for an additional 7% of the variance in perceived coercion scores ( $\Delta F(5, 216) = 3.66, p < .001$ ), interpersonal pressures exerted by family and friends to enter treatment predicted significant variance ( $\beta = .22, p < .05$ ). As well, addiction beliefs, for example, “I regard myself as an alcoholic,” was inversely related to perceived coercion ( $\beta = -.22, p < .01$ ). This last finding speaks to the influence of personal beliefs and attributes on alleviating felt coercion in the face of social pressure. In particular, problem recognition is an established construct in the addiction motivation literature (Knight et al., 1994; Miller & Tonigan, 1996; Simpson & Joe, 1993), as discussed in the following studies.

Prendergast, Greenwell, Farabee, and Hser (2008) studied the relationship of coercion and motivation on treatment completion and re-arrest in an offender population. The participants

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<sup>6</sup> The Macarthur Perceived Coercion Scale has also been used as yes/no questions (Prendergast, Greenwell, Farabee, & Hser, 2008). The five questions are “Do you feel free to do what you want about treatment,” “Do you choose to enter treatment?,” “Is it your idea to enter treatment?,” “Do you feel you have a lot of control over whether you enter treatment?,” and “Do you feel you have more influence than anyone else on whether you attend treatment?”

were part of the Substance Abuse and Crime Prevention Act (SACPA) in California, a program that allows referral of non-violent offenders to be sentenced to probation with drug treatment instead of incarceration. All 1,708 participants had been court-referred to a SACPA treatment program. Information on demographics, alcohol and drug use, previous treatment, employment, and criminal justice involvement were collected on the Addiction Severity Index. Motivation was measured by scores on the SOCRATES subscales of Problem Recognition, Ambivalence, and Taking Steps. Coercion was measured on the MacArthur Perceived Coercion Scale (Gardner et al., 1993). The treatment outcomes of interest were treatment completion, any arrest, and drug arrests 12 months after treatment entry.

Similar to the Wild et al. (1998) findings, Prendergast et al. (2008) found that offenders reported low levels of coercion on the MacArthur Perceived Coercion Scale despite being under pressure to enter treatment ( $M = 1.6$ , range = 0-5). Indeed there was an inverse relationship between perceived coercion and motivation at treatment entry, with those having higher perceived coercion tending to score lower on the SOCRATES sub-scales of Recognition ( $r(1,706) = -0.17$ ), Ambivalence ( $r(1,706) = -0.13$ ), and Taking Steps ( $r(1,706) = -0.20$ ), all at a  $<0.0001$  significance. However, these correlations ranging between 0.13 and 0.20 are considered small, suggesting again that perceived coercion and motivation are separate constructs. Moreover, neither scores on coercion nor motivation scales significantly predicted treatment completion. The SOCRATES sub-scale of Problem Recognition was a significant predictor of any arrest (odds ratio = 1.02,  $p < 0.05$ , CI = 1.00-1.04). Those with higher scores on the sub-scale of Ambivalence were more likely to be arrested for a drug crime (odds ratio = 1.05,  $p < 0.001$ , CI = 1.03-1.07), whereas those with higher scores on Taking Steps subscale were less likely to be arrested for a drug crime (odds ratio = 0.98,  $p < 0.05$ , CI = 0.95-1.00). The researchers offered

that elevated scores on Recognition of Drug Problem and Ambivalence to Make Changes may be proxies for addiction severity, which increases likelihood of an arrest. In contrast, Taking Steps suggests clients are reducing or abstaining from substance use, decreasing re-arrests. Overall, however, the utility of predicting re-arrests based on treatment motivation is fairly weak, and there are likely a multitude of other life circumstances unrelated to treatment motivation that necessitate criminal activity. A limitation of this research may also be that the researchers' conceptualization of motivation is limited to the Stages of Change readiness measure, SOCRATES.

In line with the research interest on readiness and treatment outcomes in MAT, Knight, Hiller, Broom, & Simpson (2000) were interested to see the impact of both legal pressure and treatment readiness on treatment engagement and retention. This was part of the same DATOS data collection efforts described in Hiller et al. (1998) above with the same three indices of legal pressure<sup>7</sup> and the retention criteria of 90 days or longer. Readiness was conceived as the participant's perceived need for treatment in particular, rather than some other form of help, and was operationalized by a subset of DeLeon and Jainchill's (1986) Circumstances, Motivation, Readiness, and Suitability Scale (CMRS) (see also De Leon, Melnick, Kressel, & Jainchill, 1994). The 20-item sub-set used a 3-point response scale of "not at all", "agree somewhat", and "agree very much" to items, such as, "Basically, I don't see any other choice for help at this time except some kind of treatment." Engagement was conceptualized as three domains, including confidence in treatment, commitment to treatment, and rapport with the counsellor. Readiness and engagement were assessed in the first and third months of treatment.

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<sup>7</sup> The three indices of legal pressure include: pre-treatment legal status, urine screen requirement, and citing legal causes as a primary or secondary reason for entering treatment.

Treatment readiness among participants was high, with a score of 2.7 out of 3, and was significantly correlated with retention ( $b = 0.69, p < .001$ ). Legal pressure was also a significant predictor of treatment retention ( $b = 0.34, p < .001$ ), but was not related to treatment engagement. Treatment readiness, on the other hand, was significantly correlated to the engagement measures of confidence in treatment ( $b = 1.55, p < .001$ ), commitment to treatment ( $b = 1.48, p < .001$ ), and rapport with counsellor ( $b = 1.32, p < .001$ ). The present study builds on these findings that legal pressure does not preclude treatment engagement. It seeks to capture the psychological strategies and social circumstances of how client enter, attend, and exit mandated treatment, thereby contributing more nuanced data on the personal processes of MAT.

Hiller, Knight, Leukefeld, and Simpson (2002), building on their earlier work on legal pressure, readiness, retention, and treatment engagement cited above (Hiller et al., 1998; Knight et al., 2000), investigated the link between readiness and early treatment engagement in MAT. The participants had been mandated to a residential correctional treatment centre in Texas that served as a jail diversion option for offenders. They changed their measure of readiness from the CMRS in Hiller et al. (1998) to the TCU Treatment Motivation Assessment. The TCU Treatment Motivation Assessment is part of the larger TCU Treatment Motivation Assessment Self-Rating Form which conceptualizes motivation along three linearly related readiness stages of Problem Recognition, Desire for Help, and Treatment Readiness (Knight et al., 1994; Simpson & Joe, 1993). Therapeutic engagement was assessed on three scales measuring personal involvement, personal progress, and felt psychological safety in treatment. Personal involvement was their willingness to give and receive support from peers and staff. Personal progress was defined as positive changes in coping with emotional and psychological issues, as



well as on substance use goals. Psychological safety was reflected as trust toward peers and program staff. Readiness was measured in the first 24 hours of intake and engagement was assessed 30 days after treatment entry. After controlling for confounding factors, such as, age, arrest history, and drug problems, the motivational readiness scale Desire for Help was significantly positively associated with all three engagement measures, and Treatment Readiness was significantly positively related to both Personal Involvement ( $b = .16, p < .05$ ) and Psychological Safety ( $b = .19, p < .05$ ). With regard to demographic and drug use variables, being older was positively related to both personal progress ( $b = .02, p < .05$ ) and higher ratings of psychological safety and trust in treatment ( $b = .02, p < .05$ ). Those with cocaine ( $b = -.30, p < .05$ ) and opioid dependences ( $b = -.30, p < .05$ ), as well as those who were divorced or separated ( $b = -.34, p < .05$ ), were less likely to report personal progress over the first month of treatment.

Wild et al. (2006) used the motivational framework of SDT (Deci & Ryan, 1985) to assess the relationships between motivation types, coercion, and engagement at treatment entry among 300 clients seeking substance abuse treatment in Toronto. Twenty-five participants reported being legally mandated and 34 reported being formally mandated by their employer, or other health and social services. Client motivation was assessed using the Treatment Entry Questionnaire (TEQ), which consists of three subscales of external motivation, introjected motivation, and identified motivation. According to the Organismic Integration Theory, these are three forms of extrinsic motivation varying in their “relative autonomy” (Ryan & Deci, 2000, p. 71) on the continuum toward self-determined goal pursuits. External, introject, and identified motivation indicate increasing integration of external motivation with the self. The progression of these forms represents a person’s “taking in” of a regulation (Ryan & Deci, p. 71). Identified

motivation represents self-determined motivation where the individual identifies with the mandate and adopts the need to change. In introjected motivation, the individual may be somewhat internally motivated to avoid negative consequences of their drug use, such as through feelings of guilt. Finally, external motivation lacks self-determination and is represented by TEQ items stating coercion or external pressure as the sole reasons for entering treatment (Wild et al., 2006).

In Wild et al. (2006), client engagement was assessed on six measures designed to capture motivation to change substance use, attempts to change, and client interest in change. Specifically, the measures included: client perceived cost and benefit of reducing drug use; self-report attempts to reduce substance abuse; amount of substance use in the 90 days prior to treatment; a five-item scale assessing client interest in treatment; and a four-item scale assessing the counsellor's perception of client engagement.

Echoing Wild et al. (1998) previous findings, legal mandates were indeed significantly positively associated with external motivation ( $F = 3.44, p < .05$ ), however, non-mandated clients still ranged in internal and external reasons for seeking treatment, and legal coercion was only one of many factor that could facilitate or detract from identified motivation toward treatment. Similar to Knight et al. (2000) findings, they found that external pressure to change substance use or enter treatment did not predict treatment engagement measures, while motivation variables did. Most importantly, Wild et al. (2006) found no significant relationship between being externally motivated and being disinterested in upcoming therapy.

Internal, introjected, and external motivation variables were associated with engagement measures in various ways. Identified motivation was significantly related to perceived benefit of reducing use ( $\beta = .31, p < .01$ ); reduced alcohol use ( $\beta = -.28, p < .05$ ); and client ( $\beta = .55, p <$

.001) and therapist ( $\beta = .18, p < .05$ ) interest in treatment. Introjected motivation was significantly related to both perceived costs ( $\beta = .37, p < .001$ ) and benefits ( $\beta = .20, p < .05$ ) to substance use change, reflecting ambivalence toward change.

External motivation was moderately related to some engagement measures, including *fewer* perceived costs ( $\beta = -.19, p < .08$ ) and decreased 90 day alcohol use ( $\beta = -.24, p < .07$ ). In addition therapists incorrectly perceived externally motivated clients to have low interest in treatment ( $\beta = -.25, p < .01$ ). This misperception of treatment interest could impact the rapport building, treatment engagement, and therapeutic dynamic more generally.

Wild et al. (2006) are one of the few researchers who have used an SDT framework, even though the core hypotheses of many MAT studies reflect an SDT continuum. That is, that external mandates and pressure may inhibit personal interest and intention toward treatment goals. In relation to the earlier discussion distinguishing felt coercion from referral status, SDT makes an important distinction between autonomy and independence. It states that acting autonomously does not necessarily imply a complete absence of outside influence. Rather “one can quite autonomously enact values and behaviors that others have requested or forwarded, provided that one congruently endorses them” (Deci and Ryan, 2002, p.7). By asking participants to describe and explain the personal process of going through mandated treatment using semi-structured, flexible interviews, the present research hopes to capture a richer description of MAT participants’ values and beliefs than can be captured by pre-set questionnaires.

Stevens et al. (2006) broke the methodological mold of most MAT research and used a mixed method of survey data and interviews to compare the links between formal legal pressure, coercion, and treatment motivation. They compared mandated and voluntary participants

attending community-based treatment in five European countries. They hypothesized that entering treatment by a court referral would be associated with higher perceived coercion and that higher perceived coercion would be associated with reduced motivation. Perceptions of coercion were measured on a 5-point Likert scale from feeling “not at all” to feeling “extremely” pressured by 5 outside sources, including medical authorities, family and friends, employers, legal authorities, and “other.” They also measured demographic and psychosocial functioning, including substance use and psychiatric status. The outcome variable of motivation was measured using the Readiness to Change Questionnaire (RCQ) based on the Stages of Change model (Rollnick, Heather, Gold, & Hall, 1992). The three readiness stages of pre-contemplation, contemplation, and action were measured by the RCQ. In a multinomial regression analysis, they regressed legal status, any external pressure, treatment type, and number of prior treatment experiences on the RCQ. In addition, Stevens et al. interviewed 43 treatment participants and 37 professionals about procedures and processes involved in the treatment mandate, entry, and early treatment experiences. Data was collected within 2 weeks of treatment entry. Half of the sample was legally referred to treatment (50.7%).

In line with Wild et al.’s (1998, 2006) studies above, legally referred clients had higher perceptions of coercion compared to voluntary clients ( $Z = 3.321$ ;  $p < 0.001$ ). However, legally referred client did not necessarily have lower motivation, and the hypothesized “linear relationship between increased perception of pressure and decreased motivation” was not supported (p. 203). In fact, 22% of quasi compulsory treatment group reported no external pressure, and an even greater number (29%) reporting no legal pressure specifically. On the other hand, voluntary participants were not free of external pressure, with nearly two thirds (65%) of voluntary participants reporting some external pressure, and nearly a quarter (24%)

reporting some legal pressure. These findings reiterate previous findings that perceived coercion and felt pressure cannot be equated with mandated status (Wild et al., 1998) and that mandated status does not predict a lack of treatment motivation or engagement (Wild et al., 2006; Knight et al., 2000).

Some sources of pressure were more predictive of being in the action stage of readiness compared to others. For example, perceived pressure from medical authorities was more predictive of being in the action stage, while perceived pressure from family or friends reduced the likelihood of being in action. Different sources of pressure perhaps reflect the severity of the addiction. For example, by the time medical authorities are intervening, the individual has likely considered the negative effects of addiction and is less ambivalent about the need to change. Similarly, people in residential treatment were more likely in the action stage (odds ratio = 1.75,  $p < 0.05$ , CI = 1.11-2.76) than those in non-residential treatment. Entering residential treatment is perhaps an indication of increased commitment to treatment over non-residential treatment. In addition, pressure from “other” sources, including social services, fellow prison inmates, and peers in treatment, was predictive of the contemplation stage of change (odds ratio = 2.16,  $p < 0.05$ , CI = 1.15 - 4.0). This finding indicates that being in treatment can facilitate readiness.

Finally, and perhaps counter intuitively, those with *more* prior treatment episodes were significantly *less* likely to be in either the action (odds ratio = 0.96,  $p < 0.01$ , CI = 0.94-0.98) or contemplation (odds ratio = 0.98,  $p < 0.05$ , CI = 0.96-0.94) stage. This may reflect discouragement and lack of confidence in their ability to change substance use. Hiller et al. (1998) similarly found that offenders with a greater history of arrests were less likely to remain in a 90-day treatment program, perhaps also indicating decreasing interest and confidence over multiple contacts with judicial and treatment institutions.

The qualitative interviews targeted what Stevens et al. (2006) referred to as the “decision phase of court-ordered treatment” (p. 201), enquiring about procedures and processes involved in the treatment mandate, entry, and early treatment experiences. Three major themes emerged from the qualitative interviews, including, first, the role of the mandate in getting people into treatment, second, the difficulty of assessing motivation, and third, the importance of other influences on treatment motivation. First, client interviews revealed that the mandate was almost never the sole reason for doing treatment. Some reported choosing treatment because it was better than prison; however, many others had previously been considering treatment and were grateful to be there.

Second, the treatment professionals interviewed reported that assessing motivation prior to or at treatment entry can be difficult and even unnecessary given the multi-faceted and fluid nature of the construct. They noted that some clients may feign interest in treatment in order to “get out of prison” (Stevens et al., 2006, p. 204). Furthermore, they suggested that the need to demonstrate motivation at treatment entry is a matter of perspective: on the one hand that there needs to be “appropriate motivation in order to be prepared for the treatment,” or on the other hand that motivation can be expected to “progressively emerge through the treatment process” (p. 205).

The third qualitative finding asserted that client treatment interest and intent can only be understood in relation to multiple other influences, such as, perception of treatment quality. Stevens et al. (2006) labeled these related issues the “hidden” influences and “enabling factors” on motivation (p. 203). The present research also seeks to capture the processes and procedures by which mandated clients enter and participate in mandated treatment. Through more

qualitative interviews with mandated clients, and using a more flexible research design lead by emerging client reports, this research will help to uncover these “hidden” influences.

## **Conclusion**

The role coercive tactics and social pressure play in addiction treatment is questioned and debated in the literature. On the one hand, mandates are found to reduce limit engagement and autonomy, and increase resistance in treatment. On the other hand, external pressure may facilitate compliance to treatment, cooperation, and even commitment to the goals of counselling. It is through these manifestations that coercion and social pressure may uniquely impact addiction treatment. The extant MAT literature reports that mandated status is indeed associated with perceived coercion, however, no inverse correlation between mandated status and poor motivation or engagement has been confirmed. In addition, perceived coercion is not a strong influence on client motivation toward treatment. A number of studies highlight other demographic and psychological variables, particularly being older and increased addiction severity, which predict motivation to the same degree as external pressure (Hiller et al., 1998, 2002; Polcin & Beattie, 2006; Wild et al., 1998, 2006). These findings alert us to the fact that success of clients in MAT situations is highly contingent on a host of perceptual, emotional, and relational factors beyond the mandate.

Most of the research in this area takes a post-positivist approach to predict and describe the relationships between the social contexts of mandated status and counselling effectiveness, as assessed by objective measures of substance behaviour change, treatment retention or recidivism. The majority of MAT research is limited in its ability to explore the ways people experience coercion, given unique individual histories, social contexts, and perspectives on addiction and treatment (Klag et al., 2005; Polcin, 2001). There is recognition in the literature that behavioural

measures, such as treatment retention, do not fully capture personal engagement in therapy (Hiller, Knight, Broome, & Simpson, 1998). It is not possible, from a survey-based correlational study design, to capture the stories of how people approach MAT treatment and account for coercion. In addition, the extant literature lacks consistency in measure of motivation and engagement, likely because these are broad constructs that do not lend themselves easily to quantitative measurement. Interpretivist methods such as interviewing and observation about the client experience of MAT may capture the context of coercion beyond behavioural outcomes and objective measures. The present study contributes a qualitative approach to the current state of the knowledge on the MAT experience. It seeks to understand participant experience based on their own descriptions captured in semi-structured interviews.

Finally, issues of coercion and social pressure in counselling appear to be almost exclusively researched in relation to substance use and criminal offenders. Therefore, issues of coercion and social pressure in counselling are almost exclusively housed in addictions or criminal justice-related journals and almost absent from counselling and clinical psychology-specific journals. This is not surprising given that the social disruption caused by addiction has initiated a response from public health and the judicial system not seen in response to other mental health issues. This research uniquely investigates mandated treatment across multiple referral sources, including the criminal justice system, thus looking at the phenomenon of mandates as a shared experience across multiple referring situations, not just an experience for criminal offenders. In addition, this research combines the area of therapeutic experience, addiction treatment, public health, and criminal justice, in its exploration of MAT.



### **Chapter 3: Methodology**

The aim of this study was to construct a theory that would account for clients' experiences of entering, attending and exiting MAT. This chapter describes the qualitative research approach of grounded theory employed to achieve this aim. The chapter begins with a discussion of the grounded theory methodology and my constructivist epistemological approach to the research. Then, I provide a reflexive discussion of my relationship to the topic of MAT and addiction, and my sensitivity to the topic of MAT, followed by a description of the field. Next, data collection methods and theoretical sampling strategies are detailed, including a description of participant recruitment and interviewing procedures. Basic participant demographics and description of the various mandating institutions are also presented. The chapter goes on to present a detailed description of analysis, paying particular attention to the coding procedures and reflective analytic process of memo writing. Finally, this methodology chapter concludes with a discussion of the criteria for rigor and trustworthiness of findings.

#### **Grounded Theory and Epistemology**

In choosing a research method, it was important to me to employ a research design that would capture the socially layered nature of MAT. Indeed, both the unique research and clinical challenge to helping MAT clients lies in the dual forces of macro-level legal and socio-political interest, and micro-level personal interests that influence participant involvement. The inductive qualitative grounded theory research method (Corbin & Strauss, 2008; Glaser & Strauss, 1967; Strauss & Corbin, 2008) provided just the analytic tools, rigor and flexibility to reach these aims and answer the following research question: *What is the theoretical explanation, grounded in the experience of mandated clients, of entering, attending, and exiting mandated treatment?*

Grounded theory offers an integrative conceptual framework in which researchers may sift through all the ambiguities, perplexities, and contradictions that characterize the MAT experience. Rather than bracketing out factors that appear extraneous or peripheral to the social and psychological behaviour of interest (which is necessary in isolating the variable of interest in experimental or quasi-experimental designs), grounded theory requires that researchers find a way to account for all data using two quintessential grounded theory methods of constant comparison and theoretical sampling.

Constant comparison, as its name suggests, is the continual review and comparison of data<sup>8</sup> to the researcher's emerging data groupings (codes) and more abstract theoretical conceptualization of the MAT phenomenon (categories). If the data cannot be explained by a given conceptualization, or does not fit in a data grouping, the researcher is challenged to search out more data that will account for the ill-fitting data in their emerging theory through theoretical sampling. An example of theoretical sampling is revising interview questions to further explore and test an emerging area of importance as indicated by participant responses.

The goal of grounded theory is to move from description of participants' "substantive activities, interactions, sense-making and locatedness" toward a grounded theory of how participant move through MAT, effectively elevating our understanding of this experience from a descriptive level to a conceptual level (Henwood & Pidgeon, 2003, p. 134). While there are formal areas of counselling psychology that the research may speak to, such as the broad conceptual areas of recovery, change, and motivation, the aim of this research is toward substantive theory for understanding how mandated treatment is experienced for the specific social concern of addiction.

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<sup>8</sup> Barney Glaser, co-founder of the grounded theory method, famously states that "all is data" (Glaser, 2007), meaning all documents, literature and personal reflection pertaining to the social phenomenon of interest, and all observations, conversation, surveys, and participants responses in the field are eligible for analysis.

I take a social constructivist approach to reality and knowledge (Berger & Luckmann, 1966; Hacking, 2000). The concepts and knowledge presented as findings in this dissertation have been co-constructed with the research participants using interpretivist (Geertz, 1973) grounded theory methods. My approach to grounded theory is that of the later Straussian era (e.g., Corbin & Strauss, 2008) and rests on the philosophy of knowledge of symbolic interactionism (Blumer, 1969; Dewey, 1929; Mead, 1934).

The microsociological perspective of symbolic interactionism, considered a foundation of social constructivism (Lock & Strong, 2010), posits that truth and meaning are made between the negotiations of subject and object. The subject, or person, brings a socially constructed representation of the world to every interaction, which in turn colours how the object (be it people, things or ideas) is understood. Essentially it comes to be that all objects are symbolic by way of the human interpretation, thought and language; and given meaning in how we embody those symbols through our actions, such as, talk.

As mentioned, I am using grounded theory as outlined by Strauss and Corbin (1998; 2008). Grounded theory methods and procedures have been used from various epistemological stances. The key philosophical divide is between Barney Glaser's objectivist stance that theory is *discovered* through grounded theory methods (Glaser, 1992) versus constructivist grounded theorists (Charmaz, 2010; Corbin & Strauss, 2008) who claim that theories are *constructions* by the researcher with certain contexts, and that there is no experience outside of our social constructions.

Figure 1 below is a diagram modified from Crotty (1998, p. 5), outlining the hierarchy of philosophical and theoretical perspectives informing my approach to grounded theory method.

**Personal  
Epistemology:  
Constructivism**  
*Knowledge and  
meaning is  
constructed out  
of interactions  
between humans  
and their world,  
and is context  
specific.*

→ **Theoretical  
Perspective:  
Symbolic  
Interactionism**  
*Humans behaviour  
is social in origin;  
through interaction  
with our society we  
come to be persons*

→ **Methodology:  
Grounded Theory**

*An inductive method for developing mid-range theories grounded in data.  
Develops abstract concepts emerging from the data and specifies the  
relationship between concepts.*

└→ **Interpretative Methods:**

<u>Data</u>	↔	<u>Data Analysis:</u>
<u>Collection:</u>		-Constant
-Theoretical		Comparison*
Sampling		-open coding
-Interviewing		-axial coding
-Observation		-theoretical
-Field Notes		coding

*Figure 1. Philosophical, theoretical, and methodological hierarchy*

Finally, given my personal constructivist epistemology and symbolic interactionist theoretical perspective, the model of MAT experience laid out in this grounded theory is a helpful and plausible explanation of how participants engage in MAT, but is certainly not the ‘one-true-way’ of knowing how participants engage in the MAT phenomenon (Crotty, 1998, pp. 47-48). To help the reader gauge the validity of my findings, and to be reflexive (Finlay, 2002; Hall & Callery, 2001), I turn now to a description of my sensitivity to the topic of MAT.

## **Reflexivity and Theoretical Sensitivity to MAT**

Grounded theory has long debated the degree to which researchers can reliably “discover” and represent the social and psychological phenomena they study. In their inaugural guide to grounded theory, *The Discovery of Grounded Theory* (1968), Glaser and Strauss addressed the concern of researcher bias and subjectivity with a reliance on the constant comparative method and theoretical sampling. They felt that the constant checking of emerging concepts, purposeful seeking out of deviant cases to challenge their emerging understanding of the phenomenon, and openness to researching problems as they are presented in the field, ensured researcher objectivity. However, the “constructivist turn” (Howe, 2002) in social science research rejects the idea that researchers can be objective and encourages the use of qualitative, experiential methods (Gergen, 1985). Qualitative researchers in particular have worked to become reflexive on their process, and to lay bare their biases and preconceptions to the extent possible (Hall & Callery, 2001; Morrow, 2005).

While it was important for me to remain open to the problems of the field as they presented themselves, it is also important to recognize the knowledge I already had in this area of MAT. Some of this formal knowledge is presented in Chapter 2 with the literature review. It should be noted that the initial literature review was somewhat cursory as I did not want a-priori theories and MAT research to interfere with the emergent findings (Glaser, 1992). However, and in-line with my Straussian approach, my accumulated knowledge in the area of addictions, along with some reading of current MAT research, informed and guided the research aims and questions. Other knowledge was gained during the research. Below is a description of my research experience in the area of addiction more broadly.

My sensitivity to the problem of addiction has developed over a number of research projects and educational pursuits over the past ten years. I have had two primary areas of focus – tobacco control policies and mandated addiction treatment. My first foray into addiction work was conducting a systematic review of the international literature on the effectiveness of tobacco control policies (see Greaves et al., 2006). I later became critical of the stigmatizing effects of tobacco control's de-normalization policies, for example, the social effects of smoking restriction in outdoor public spaces (Bell, McCullough, Salmon, & Bell, 2010; Bell, Salmon, Bowers, Bell, & McCullough, 2010; McCullough, 2011a). I began studying and using qualitative ethnographic methods including observation and interviews, methods better suited to critical research (McCullough, 2011b).

Most influential in shaping my approach to this research are two studies I conducted on MAT since beginning my training in Counselling Psychology. First, my Master's thesis investigated, through qualitative interviews, addiction counsellors' approach to working with criminal justice and child protection mandated clients (McCullough, 2008). Second, I conducted an ethnographic inquiry into how legal and therapeutic approaches are combined and evident in the Vancouver Drug Treatment Courts (DTC) (McCullough, 2011b). As mentioned in the introduction Chapter 1, DTCs provide diversion from incarceration by providing court monitored addiction treatment programs. This second study in particular sensitized me to the legal pressures and treatment requirements participants' face in court mandated treatment.

For the ethnographic study, I observed eight DTC sessions, conducted interviews with five drug treatment court workers, including legal and management staff, and spent time observing this downtown neighbourhood wherein the cycle of addiction, crime, punishment, treatment and recidivism take place. A theme of re-parenting emerged from the data to explain

how the court encourages treatment compliance in the transition from addiction to recovery. Mothering narratives from the DTC judge seemed to temper the intrinsically coercive nature of the DTC. In addition, a biomedical model of addiction was invoked in the language and symbols of the DTC, providing rationale for legal coercion in treatment compliance.

Now, with this dissertation, I have had the opportunity to re-enter the field of this downtown Vancouver neighbourhood and to explore the topic of MAT anew, focusing on the central actors of this socially layered phenomenon. The substance users' firsthand viewpoint has been missing in my own construction of MAT and also in the extant literature on coercion in addiction treatment (Urbanoski, 2010). What's more, this research counter-balances the quasi-experimental approach used to assess the effectiveness of MAT by using the interpretivist, qualitative methodology of grounded theory.

### **Criteria for the Selection of Participants**

The inclusion criteria for this study were fairly liberal, with the understanding that more purposive theoretical sampling would unfold in tandem with the data analysis. All participants were over 18 years of age and spoke English fluently. There were no restrictions on gender, upper age limit, race or ethnicity. Participants must have been legally or formally mandated to addiction treatment by the criminal justice system, child protection services, or their employer in the past seven years. Participants received ten dollars cash remuneration for their participation. Prior to participant recruitment and data collection, I received ethical approval from UBC's Behavioural Research Ethics Board, certificate number: H12-02784.

### **Procedure for Participant Recruitment**

Recruitment strategies and locales varied, especially in the initial phase of data collection, and became more targeted to theoretically sample emerging themes and categories. The

following organizations were targeted as recruitment locales: residential treatment centres, recovery houses, and half-way houses in the Vancouver Lower Mainland; child and family-support agencies in the Lower Mainland, for example, West Coast Family Services, ATIRA women's housing organization, British Columbia Housing Association, the Elizabeth Fry Society of Greater Vancouver, the Vancouver Recovery Club, Alcoholics Anonymous and Avalon groups, and Vancouver Coastal Health Community Health Clinics. I requested the assistance of these organizations in communicating my study to their clients through information letters and posters. Appendix A shows the information letter and Appendix B shows the posters.

I created posters with images of men and women, which I posted equally. Many treatment facility, group homes, half way houses or recovery spaces are gender specific - the women's only branch of Alcoholics Anonymous, Avalon, for example. I therefore targeted such spaces with the appropriate study poster. See three versions of the poster in Appendix B.

In addition, I posted advertisements for the study in coffee shops, community centres, and in a downtown Vancouver neighbourhood newspaper. Finally, at the completion of each interview, I provided participants with a recruitment poster to share with their contacts. This garnered an additional two to three participants from each mandated category

## **Participants**

Forty participants were interviewed. Interviews took place across Vancouver and Victoria in various social housing complexes. However, half of the forty interviews took place in Vancouver's Downtown Eastside with residents of the neighbourhood. This neighbourhood is given particular attention as "the field" because it had the highest concentration of interviews and almost all participants had spent time in this neighbourhood, especially when they were actively engaged in their addiction.



Vancouver's Downtown Eastside has been dubbed, if erroneously, Canada's poorest postal code. It is the city's oldest neighbourhood and neighbours historic Chinatown. The neighbourhood is undergoing gentrification, with trendy restaurants, high-end independent clothing shops, and modern office spaces juxtaposed with the very visible problem of homelessness and addiction on the street.

The cycle of addiction, crime, punishment, and treatment is marked by the proximity of all of these services within the neighbourhood. In fact, the police station, court house, and community court, which offers treatment and jail diversion programs, are all located on the same block. There are multiple types of unstable housing in the neighbourhood, including social housing, recovery houses, and single room occupancy hotels available for rent on a short-term basis. This proximity of services and drug supply reflects a cycle of addiction, crime, and treatment and can make it difficult for residents to leave the Downtown Eastside.

All research participants had been legally or formally mandated to addiction treatment by the criminal justice system, child protection services, or their employer. Some participants were in an after-care group or other ongoing support group, such as Alcoholics Anonymous. A minority of participants were actively using at the time of the interview and were not engaged in any recovery activities. The structure of treatment programs varied across participants and referring situations. Treatment scenarios included: residential treatment centres; recovery houses and group homes; outpatient treatment programs; community-based recovery programs such as AA; and individual counselling. Finally, treatment ranged in length of time, from 28-day residential treatment up to a year of treatment activities.

Tables 1 and 2 outline participants' age, gender, referral sources, treatment setting, and number of MAT experiences. Employer-referred programs were the most uniform in their

requirements; requiring participants attend 28-day residential, licensed treatment centres. The exception to those who attended residential treatment were three participants who attended treatment programs in jail, and six who attended treatment on an outpatient basis in the community, including two participants who attended Vancouver drug treatment court.

Table 1 presents information on male participants' ages, gender, treatment setting, and mandating institution. Table 2 present the same information on female participants. Not surprisingly, child protection mandates were more prevalent among the women (n=10) compared the men (n=2), and criminal justice mandates were more prevalent among the men (n=14) compared to the woman (n=6). Also, men were more likely to have participated in MAT more than once (n=14) compared to women who had participated in MAT more than once (n=9). Given that recidivism is common among drug-using offenders and drug treatment may be utilized a number of times to divert from going to jail, there is a connection between criminal justice mandates and repeated MAT experiences, particularly in the male group.

Finally, the vast majority of participants were receiving income assistance, with only two living on retirement income and five who were employed. Income assistance consists of both social welfare and public disability income, but this information was recorded separately at the time of the interview.

Table 1. *Male Participants' Age, Mandating Institution, and Treatment Setting (N=22)*

Age	Most recent mandating institution (within 7 years)				Treatment setting of most recent or current mandate					Recency of MAT experience	Number of times attending mandated treatment	
	Criminal Justice System	Child Protection	Employer	Halfway House*	Treatment Centre	Recovery house	Community based**	Prison	Current	Retrospective	One	>One
30-39 N=7	6		1	4	1	1	1		4	3	2	5
40-49 N=8	5	2	1	1	6		1	1	3	5	2	6
50-59 N=5	2		3		2	2		1		5	2	3
60-69 N=2	1		1		2					2	1	1

\*Note: Those who were participating in MAT at a halfway house at the time of the study

interview had also previously participated in a prison-based substance use program considered a previous MAT experience.

\*\* Community based treatment includes house arrest, AA, counselling, 12-step or other substance use recovery groups, and drug treatment court day program.

Table 2. *Female Participants' Age, Mandating Institution and Treatment Setting (N=18)*

Most recent mandating institution (within 7 years)					Treatment setting of most recent or current mandate					Recency of MAT experience		Number of times attending mandated treatment	
Age	Criminal Justice System	Child Protection	Employer		Halfway House*	Treatment Centre	Recovery house	Community based**	Prison	Current	Retrospective	One	>One
25-29 N=2		2				2					2	2	
30-39 N=3	1	2				2	1				3		3
40-49 N=8	3*	4	1			4		3	1	2	6	4	4
50-59 N=2	1*	1				1		1			2	1	1
60-69 N=3	1	1	1			3				1	1	1	1

\*The woman in her 50s was under a conditional sentence, or house arrest, and one of the woman in her 40s has been under house arrest. They participated in community based treatment, such as, AA meetings and counselling sessions.

\*\*Community based treatment includes house arrest, AA, counselling, 12-step or other substance use recovery groups, and drug treatment court day program.

### **Data gathering procedures.**

Interviews were conducted over an 8-month period from October 2012 to May 2013, in Vancouver and Victoria, British Columbia. All potential participants initiated contact with me via phone. One individual contacted me via email to inquire about the study on behalf of her partner, but did not lead to an interview. Upon initial contact with the participants I conducted a

brief screening to ensure they had been mandated in the past seven years through the child protection or criminal justice systems, or by their employer, that they met the age requirements and understood the interview requirements.

The interviews took place in public places convenient for the participants. Locales included: coffee shops, participant homes, common areas of participants' residences, and quiet spaces in community centres. The majority of participants were interviewed in downtown Vancouver at social housing complexes or cafes. One interview was conducted at the University of British Columbia, and one interview was conducted in the staff lunch room at a participant's place of work. Five interviews were conducted in Victoria, B.C. at a residential social service agency for recently released inmates. These interviews were conducted in a private office.

Upon meeting, I provided the participants with a copy of the consent form (see Appendix C) and verbally reviewed the purpose and procedures of the research with them. The participants then read the consent forms independently and signed a copy. All participants were given a copy of the consent form to keep for their records. I requested to audio record the interview, and stressed that this was optional. However, no participants refused this request. Payment of \$10 was given prior to the start of the interview, and participants were reminded they could end the interview at any time. The interviews lasted approximately 1 hour long; the shortest interview was 30 minutes with one participant, and ranged up to 2 hours with several participants.

The interviews utilised a semi-structured interview guide shown in Appendix D. All interviews were audio recorded and transcribed. All data was transcribed into text, including field notes, information about participant demographics, and interviews. Other data included

field notes taken of my observations of the places and people at and around the interview sites, and relevant treatment centre and government websites and policy documents.

***Guiding and following the interviews.***

The use of the word “guide” represents the semi-structured, open, and process-oriented approach I took to interviews. This flexible approach to interviews and recruitment is essential in grounded theory in order to facilitate theoretical sampling. As seen in Appendix D, the questions were bulleted rather than numbered to indicate that there was not necessarily a sequential order to the way questions were asked. The guide was designed to focus the interview towards eliciting client perspectives that would answer the research question: What is the theoretical explanation, grounded in the experience of mandated clients, of entering, attending, and exiting addiction treatment?

In order to build a theoretical explanation from client experience, it was important to keep the data collection procedures flexible, and to remain open to novel, contradictory and even surprising reports. The initial interview guide shown in Appendix D shows the initial list of questions, and the two subsequently altered interview guides.

I discovered quickly after only three interviews that participants varied greatly in their interview style. Some readily started the interview with personal stories, beliefs, and opinions about their mandated treatment experiences before I would follow-up with clarifying and additional questions. Others preferred that I direct the interview, for example one participant suggested, “We just go through the list of your (the research) questions” (Jasmine, #2). I implemented two strategies to accommodate both interview styles. First, I invited each participant to begin the interview with whatever they felt was important. In the second iteration of the interview protocol, the question reads as follows:

- Start by telling me your thoughts on the topic of mandated addiction treatment and your experience. Or any thoughts you've had about the issue since our phone conversation and leading up to our meeting.”

The second strategy was to write out a timeline with the participants to serve as a visual aid. I always asked permission to initiate the timeline, and if participants found it distracting or overwhelming we put it away. The timeline tracked treatment experiences, relapses, “clean time”, and other life events, such as jobs and loss. The timeline was especially useful with participants who were more reluctant to initiate discussion because I was able to connect questions directly to their timeline, helping to personalize the questions. While I started the timeline, I would hand the timeline and pen to the participants at some point in the interview asking if there was anything they would like to add. I felt this was a symbolic act in sharing my researcher power with the participants. This moment of transference often ignited further recollection of treatment, MAT experiences, and discussion of their lives more generally.

The strategy of the timeline evolved both as a way to encourage discussion, and as a tool to facilitate comparisons among multiple treatment-related experiences. Participants would often recount both their mandated and voluntary experience. Furthermore, discussing both mandated and voluntary treatment experiences was fruitful in helping the participants specify what was unique about the mandated experience. In the initial interview guide, I included the question: “How many separate times have you sought treatment for addiction-related issues?” I formalized these comparison in the second iteration of the guide with these follow-up questions:

- When have you gone on your own? ... When were you required? .... Who required it?

To gather further data on the properties of “readying” for treatment, I extended this comparative line of inquiry to participants’ feelings *prior* to entering mandated versus voluntary treatment. The questions in the initial guide was:

- What did you think about, and how did you feel, when you first found out you were being mandated to addiction treatment? What do you think and feel about the mandated experience now?

This was extended in the second guide by asking:

- Compare your experience of being mandated and going on your own; What was it like when you were going to treatment on your own versus when you were told to go?
- Can you tell me how you felt before you went for treatment, knowing that you were expected to go? What were you thinking and feeling when you first arrived at treatment? What were the first few days like?

The data revealed that asking participants to compare their feelings just prior to entering mandated treatment versus entering voluntary treatment elicited information about how they prepared themselves towards commitment, or passive acceptance, of their time in treatment.

I made considerable alterations to demographic questions after the first 10 interviews. I originally placed a series of demographic questions on education, employment, ethnicity, and age at the end of the interview, preferring to ask more open-ended questions at the beginning. However, asking a series of demographic at the end served to depersonalize the participants and reinstate my outsider researcher status, positions that often contradicted the positive rapport that had developed over the interview. I began instead to listen for opportunities to clarify demographic information as it arose in the interview. The timeline facilitated this, as age, education, relationship and employment are all major markers in people’s lives. Furthermore, as



I became more familiar with the field and participants issues, it became clear that the majority of criminal justice referred clients had not completed high school and were unemployed; thus, asking directly about such status seemed shaming and unnecessary.

Finally, I feel my training as a counsellor put me in a good position to carry out grounded theory interviews. As a counsellor, I was able to identify and follow personally salient lines of inquiry. In a therapeutic interview, there is a dual process of inquiry: one that draws on meaningful themes, contradictions and overarching client goals across sessions; and one that attends to the client's immediate expression of thoughts, behaviours, and feelings. Similarly, grounded theory research interviews must be sensitive to participants in the moment while still working at achieving theoretical saturation. In this section on guiding and following interviews, I have presented a small selection of examples of how I was sensitive and responsive to my participants, including use of a timeline visual cue and changing the way I asked demographic information; and how I altered my interview strategies to develop TEMAT. There were numerous incidents of this during the fieldwork phase.

### ***Adapting language.***

After much deliberation and review of literature in the Canadian context, the term *mandated* was determined to best communicate the social pressure participants faced in undertaking treatment. As described previously, in this study mandated treatment is an institutional referral from child protection services, criminal justice system, or an employer. Wanting to remain open to participants' definitions of MAT, I included a note about using the participants' language in my initial interview guide. As can be seen in Appendix D, the third question states:

- How do you define mandated? Have you used this wording in referring to or thinking about your experience? If not, what wording have you used? (Note: I will adopt the participant's wording of "mandate" throughout the interview).

The ways participants described their formal referral to addiction treatment ranged along a spectrum of choice, from terms such as "forced" (Jason, #34; Derek, #20) to feeling that MAT was an "option" (David, #5). The range of views on the mandate is further captured in Chapter 4 by the process of Choosing Treatment. In this finding, participants described how they attributed the treatment ultimatums they faced and the choices they made in MAT.

However, I quickly discovered that participants did not always identify with the term mandated, or even know what it meant. In addition, it occurred to me that the term has negative connotations and may elicit a biased description from the participants. Exploring what this term meant to participants, and how they understood the social pressure they faced, became a point for theoretical sampling. In fact, I removed the question asking clients to define the term mandate in subsequent interview guides. Instead, I left the process of treatment entry more neutral, asking:

- Can you tell me how you came to be in treatment? Was it required? Explain. (Note: I will adopt the participant's wording of "mandate" throughout the interview.)

Finally, I also made various recruitment posters shown in Appendix B using the phrases "told to go" and "required to go," to not exclude potential participants who did not relate to the term "mandated."

## **Data Analysis**

I employed a multitude of grounded theory strategies that encourage both creative, abstract thinking, as well as accurate, rich description of participants' actions, perspectives, and

personal and social processes. I relied on the strategies articulated by Corbin and Strauss (2008) in *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory*. However, I also bore in mind the early works of Glaser and Strauss (1967) and their emphasis on the constant comparison of data to the emerging conceptualization of the MAT experience. This section describes theoretical sampling and the grounded theory analytic techniques of multilevel coding, memoing, and diagramming, used to develop codes, concepts, dimensions, and properties that ultimately made up the theory of engaging in MAT (TEMAT). All these sampling and analytic strategies facilitate theoretical saturation of codes. Codes and categories are considered saturated when no new categories emerge and codes from new data do not present new, unaccounted for angles on the phenomenon (Corbin & Strauss).

A grounded theory is comprised of categories, concepts, and codes. Codes are plentiful, and are fairly literal descriptions of what is happening in the data. Over the course of analysis, I worked to move up the conceptual ladder of coding to create broader terms that can accurately represented more data, which are termed concepts and categories respectively. Properties describe the features, or elements, of each concept, and dimensions describe their qualities, which are often on a continuum of stronger to weaker, for example. The four phases of coding used to achieve theory development and saturation were: (1) open coding, (2) axial coding, (3) theoretical coding, and (4) writing (Glaser & Strauss 1967; Strauss & Corbin, 2008). Memoing, which is a journal of the emerging analysis, and diagramming, were also important analytic techniques. Memoing happened at all stages of the analysis as I kept a running log of analytic queries and decision. Diagramming facilitates theoretical coding in particular. All of these strategies, and examples of their use, are described next.

I used NVivo data analysis software to assist in organizing and analyzing data. All data was stored or linked to the NVivo project “mandated treatment”. NVivo helped me to conceptually exploit the grounded theory methods (Bringer, Johnston, & Brackenridge, 2006; Corbin & Strauss, 2008; Gibbs, 2008). It allowed me to move easily between coding and writing, with minimal disruption to the analytic flow. The NVivo software not only assisted in the procedures of coding, writing memos, and searching for key terms in interview data, but also in relating and attributing codes. In addition, the visual model function of the program provided an opportunity to construct relationships among codes, which proved useful in hypothesizing about experience in the MAT data. Ultimately, the grounded theory of MAT, TEMAT, is presented as a theoretical schema in Chapter 4.

### **Theoretical sampling.**

Theoretical sampling is an ongoing grounded theory purposive sampling method. I pursued data collection and analysis in tandem, with analysis informing the direction of data collection. I was guided by the dual goal to understand the limits, or deviant cases, as well as the nuances of the developing explanation of the social phenomenon under study. Therefore, as I began to make sense of the data and group participants’ actions, processes, and reports into categories, I sought out new participants and questions that could provide more in-depth or opposing experiential accounts. Or, as Lincoln and Guba (1985) state, I sought out new data that could “uncover the full array of multiple perspectives” (p. 40).

Specifically, theoretical sampling was done in four ways: first, by revising the interview protocol and adding questions; second, by targeting specific MAT groups; third, by reviewing previously analyzed data in light of emerging concepts; and fourth, by testing the emergent categories and theories against new data. I altered the interview protocol three times to pursue

new issues raised by the participants and to test my emerging conception of the MAT experience. In addition to revising the interview guide, I targeted under-represented MAT groups. For the first two months of fieldwork the majority of participants were mothers mandated to addiction treatment by child protection services. To ensure the theoretical explanation of MAT was shared across other mandating scenarios, I targeted employer-referred clients through advertising locations and snowball sampling techniques. Recruitment of criminal justice clients progressed satisfactorily using original recruitment strategies.

Finally, the latter two approaches of testing both previously analyzed and new data against theoretical concepts are also constant comparison techniques and challenged me to continuously rethink my analysis in light of the data. The lattermost method of testing new data against developed categories was the beginning of the inductive-deductive cycle of theory building. I tested the last five interviews against the final coding structure to see if I had achieved saturation and fit. I was satisfied that theoretical saturation of the codes and categories had been met after 40 interviews. In conclusion, theoretical sampling and constant comparison are creative processes that affect every aspect of data collection and analysis. The evolution of data collection and analysis procedures is detailed in the following sections.

### **Open coding.**

Coding is the process of interpreting raw data and organizing those interpretations into conceptual grouping. Codes are shorthand text representations of the data, and the process of coding varies in its level of abstractness. In the very early stages of analysis, I employed open coding. The term “open coding” denotes the unencumbered nature with which I reviewed the early data and experiences in the field. I reviewed the data “line-by-line” in the microanalysis tradition (Strauss & Corbin, 1998). Any text to which a code is applied is called an incident. An

incident may be as small as a single word that seems to carry a lot of emotion, description, or action, or as long as a few lines of text. Particularly meaningful and frequently emerging codes were noted as potential categories. Categories are conceptual groupings of codes that speak to a shared process.

In-vivo codes are labels for data grouping that use the actual words of research participants rather than being named by the researcher (Corbin & Strauss, 2008). I sought out in-vivo codes where possible in the early stage of line-by-line coding. This keeps the coding, and ultimate conceptualization, as close to the data as possible. Examples of in-vivo codes included: *caught in the system, facing consequences, out of chances, and light switch moment*. Below is an excerpt of line-by-line coding with participant #11.

**Participant #11**

**November 27, 2012**

**Time stamp: 25 mins to 38 mins**

**Text**

**Code**

LM: you thought you were going to lose your job?

-uncertainty  
-facing consequences

P#11 (Lily): I didn't know there were any options, really. I knew about this thing in [treatment centre] from when I went before, but I didn't really believe I had that bad a problem, I guess. It was this denial.

-denying

And what really made me go get help was that I did tried suicide (whisper). And my son did come and take me to the psych ward for 6 weeks so, um. Then, the union they did help me.

-mental health, trauma context  
-personal reasons  
-structural supports

I think the suicide was desperation because I was so ashamed and trying to go back to work. Workaholics is insanity, it's just insanity.

-shaming consequence  
-coping, stress context

Above are examples of in-vivo codes, such as “denying,” and slightly more conceptual codes such as “coping,” where Lily’s drug use is considered a coping strategy in the context of stress and work. The reader will recognize these above codes as properties in Chapter 4.

The search for process in the data was key in facilitating the emergence of a theoretical explanation of the experience of entering, attending, and exiting addiction treatment. In coding, Corbin and Strauss (2008) suggest researchers ask themselves, “What are the participants doing as they describe their experience” (p. 68)? Asking “what participant are *doing*,” rather than, “what are they *saying*?” helps to distinguish process from description. I analyzed all data with an eye towards participant actions, processes, and meaning of the MAT experience. This process-based analytic lens is represented in the majority gerund codes, or action words, used to explain the processes involved in the MAT experience. Corbin and Strauss (2008), and Charmaz (2010), emphasize the importance of gerund codes to facilitate the analysis of process rather than topics or themes.

For example, the contextual category called Living Addiction in TEMAT, was originally labelled “background.” Here, participants were describing their life circumstance prior to MAT. As I analyzed further, with an eye toward process, their actions of hiding, pretending and denying drug use emerged. Therefore, I relabelled the “background” section as Living Addiction to more accurately represent these actions. Continuing up the conceptual ladder from open-coding toward theory, I will next describe the development of concept and categories in my analysis.

### **Categories and concepts.**

The open coding process created hundreds of codes that represented many hours of interviews and months of fieldwork. As open coding progressed, the same code could be applied to multiple incidents from various participants. The credibility of a code was strengthened the more data it accurately represented. As codes became heavy with data, they grew into concepts and categories.

Categories are high-level concepts wherein I merged concepts with similar properties. Properties are the characteristics of a category, and dimensions are the range of a given property (Strauss & Corbin, 1998). For example, the physical environment, scheduling, and staffing of the MAT programs are all properties that defined the concept of *structure* in the category Treating Addiction. The structure then varied by the dimensions of *quality* and *professionalism*. This analytic coding process culminated in six categories. Four categories explained the core processes of engaging in mandated addiction treatment, and two were contextual categories that situated the MAT phenomenon in the personal and social contexts of the participants' lives.

Categories and concept were developed using the more abstract coding procedures of axial coding (Charmaz, 2010). Axial coding is a more abstract process than open coding and brings coherences to the disparate codes produced in open coding (Charmaz, 2010). It is the process of relating categories to each other and defining their properties and dimensions. The "axis," in axial coding, is a central characteristic or phenomenon that accounts for various properties and dimensions of the participant experience. All four processes described in TEMAT, which include Choosing Treatment; Ready to Participate in Treatment; Treating Addiction Experiences; and Evaluating Treatment, may be considered axes along which there are various dimension and properties. I undertook the increasing conceptual work of axial coding by comparing raw data incidents to categories, codes to categories, and categories to categories. I reviewed data in all the codes and began aggregating, deleting, renaming, or changing codes according to emergent patterns in the data. I continued to compare incidents and codes to theoretical categories, eliminating codes that could be more parsimoniously subsumed under other categories. While open coding is designed to categorize incidents, axial coding aims to link categories, or themes, through sequencing or cause-effect hypothesizing.



The iterative coding process was facilitated by the NVivo data analysis software. In NVivo, all codes were linked to corresponding data, and were easily viewed, relabelled, and moved. Appendix E shows screen shots of the coding structure, including lists of the study's categories and properties. With the emerging coding structures visible in NVivo, I compared concepts, asked questions of their connections, and hypothesized the direction of those connections. The NVivo relationship tool allowed me to link codes, and describe the potential direction of the relationship among two or more concepts. For example, a link emerged between repeated, unsuccessful MAT experiences and viewing future MAT as a type of punishment – coded as “treatment sentence.” Moreover, participants' criticisms and negative experiences are embedded in all TEMAT processes, and became linked properties in a negative feedback loop towards lower levels of engagement.

In conclusion, the various stages of coding were not discrete. While it is not possible to start axial coding and concept building without first doing some open coding, once there is enough data for all levels of analysis to begin I employed all levels of coding repeatedly until the core category and theoretical structure was developed and saturated. The above coding examples show the systematic and varied procedures conducted in this grounded theory analysis. In the next sections, I will describe the more narrative and visual analytic strategies of memoing and diagraming.

### **Memoing.**

Memos were notes and general analytic musings, queries, and ideas, written in tandem with coding that served to deepen my conceptualization of the data. As is intended, memos served a dual purpose in this study as both an analytic tool and a journaling device of my analysis process (Corbin & Strauss, 2008). Through memoing, I detailed the meaning of a code

or category, clarified conceptual connections among codes, and identified gaps or contradictions in my emerging theory.

Below is an example of a memo associated with the first process of TEMAT - Choosing Treatment. This memo highlights the analytic debate I had between conceptualizing the first process of TEMAT as one of “Facing Consequences” or “Choosing Consequences.” Through multi-level coding, the creation of memos, and constant comparison with new and previously coded data, it became clear that the experience of facing consequences was a property of the contextual category Living Addiction rather than a major process, or category, of TEMAT per se. Instead, choosing consequences, and more specifically, choosing the consequence of treatment, emerged as the first process of four in TEMAT. In the memo I was ‘talking through’ my understanding of *how* participants make choices and what they are doing when they are making those choices.

### **Memo Example 1. Choosing Consequences, Choosing Treatment**

*Memo: Along with the concepts of Opting In and Opting Out of treatment, it seems that participants more "choose consequences" rather than "face consequence." I suppose they end up facing the consequences they have chosen, but the action is in the choosing rather than the facing. For example, an inmate may be told to participate in a treatment program or face loss of job, a ruling of poor behaviour (for which someone may be sent to the hole or remain in maximum security) or lose their stat (option to get parole after 2/3rds sentence served). These are consequences that the participant may choose from. It clearly becomes in their best interest to do the treatment programs and it seems that eventually the Correctional Services of Canada (CSC) consequences become so dire that most will participate in programs. There are a number of factors for each individual that led to choosing certain consequences over others.*

*For example, for one parolee (Len #33), the thought of sharing his personal information and being perceived as weak or vulnerable by other inmates was a deterrent to treatment. He said, "Also, you don't want guys knowing your personal business in there, guys will use it against you. It's a dog-eat-dog world in there. So, you're not going to feel comfortable opening up. You're never*

*going to fully open up in a program in an institution. Once you're inside you've got to be looked at like...not a punk, you know? You screw with me and you're gonna get hurt. So you're not going to want to put yourself out there in these programs 'cause you're not going to feel comfortable there.” So, for Jason (#34), being "profiled" by the CSC was a deterrent to participating in treatment programs.*

*Darrel (#22) brought the ideas of mandate and choice together in his description of how he felt going to treatment after the prosecution insisted on it was his last choice/option anyways, that at that point it didn't matter so much that he was being mandated just that he was out of options anyways and needed a place to live. He said: “Ya, I was in agreement because that was where I was going to live. I was going to regroup and get a job and get proper housing. I had nowhere else to go.”*

Appendix F shows two more examples of memos. The first is associated with the category Ready to Participate in MAT, and the other details the pressures incarcerated participants faced in choosing MAT.

At times, I drew directly from the memos in writing the findings. However, memos themselves could not form a coherent explanation of the MAT phenomenon alone. Through writing and diagraming, the memos were elaborated, trimmed, and disregarded depending on their ongoing fit with the data. In writing the findings section of Chapter 4, the analytic process was complete and the data were coherently laid out for the reader to decipher its usefulness.

Memos provided the opportunity for me to record my reflexive thoughts and positionality in relation to the research phenomenon. In this way, memoing contributed to the trustworthiness of the findings by exposing my interpretations and analytic process. All memos were written in the NVivo software, and a screen shot of the memo list can be seen in Appendix G. Finally, the reader may find it helpful to review the presented memos again after reading Chapter 4.

### **Diagramming.**

Diagramming is the process of visually mapping out the relationships among concepts and categories (Corbin & Strauss, 2008, p. 117). After creating hundreds of codes, and writing many analytic memos, diagramming offered a fresh visual approach to the data. Having to visually show the connections among categories, I was able to see missing connections between concepts and imbalance in the developing mode of the MAT experience. Moreover, summarizing the data into a visual diagram facilitated the grounded theory requirement for parsimonious explanation of social experience.

I began diagramming mid-way through data collection, once I had developed the preliminary coding structured and theoretical framework. In total, there were 9 iterations of the final theoretical model. An earlier and later iteration are shown below in Figures 2 and 3. The earlier model in Figure 2 was done in the final months of data collection, after approximately 30 interviews.

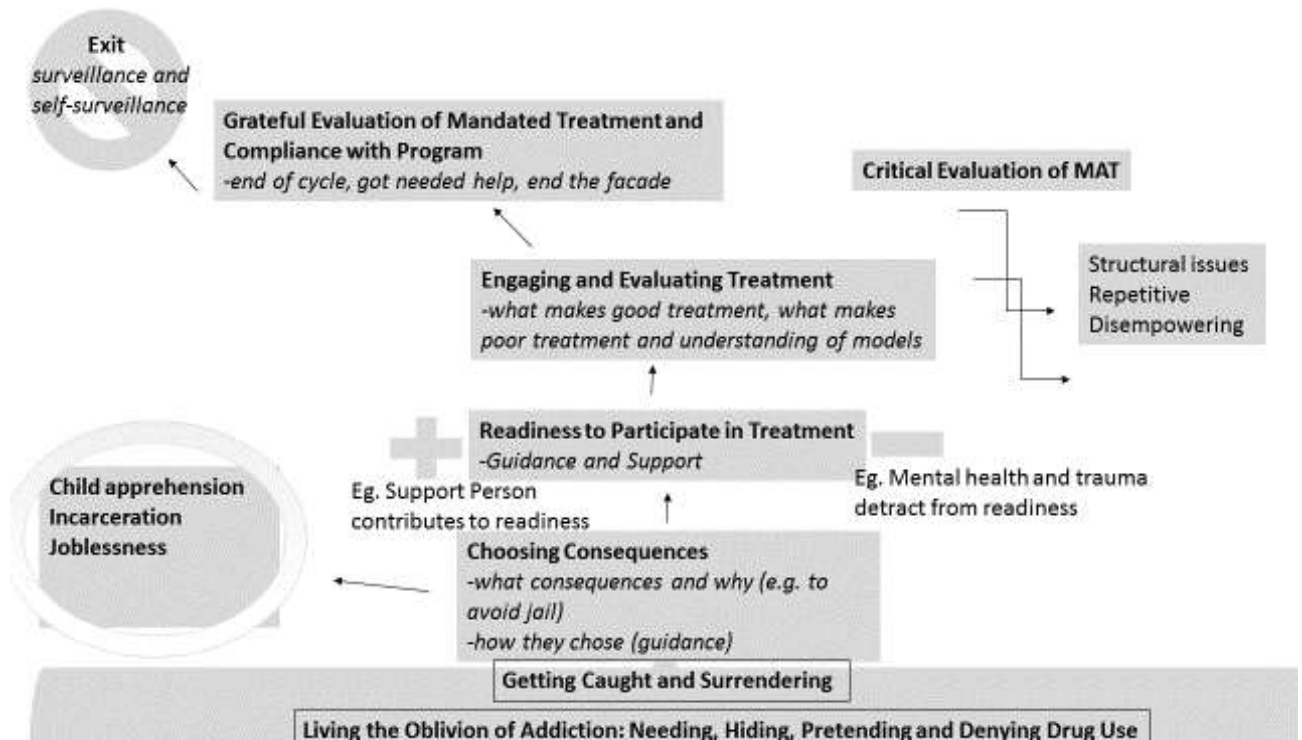


Figure 2. Example of Diagramming in Early Write-up. April 12, 2014.

The next model was produced in the final stage of write-up, as the connections among concepts became more clear and logical.

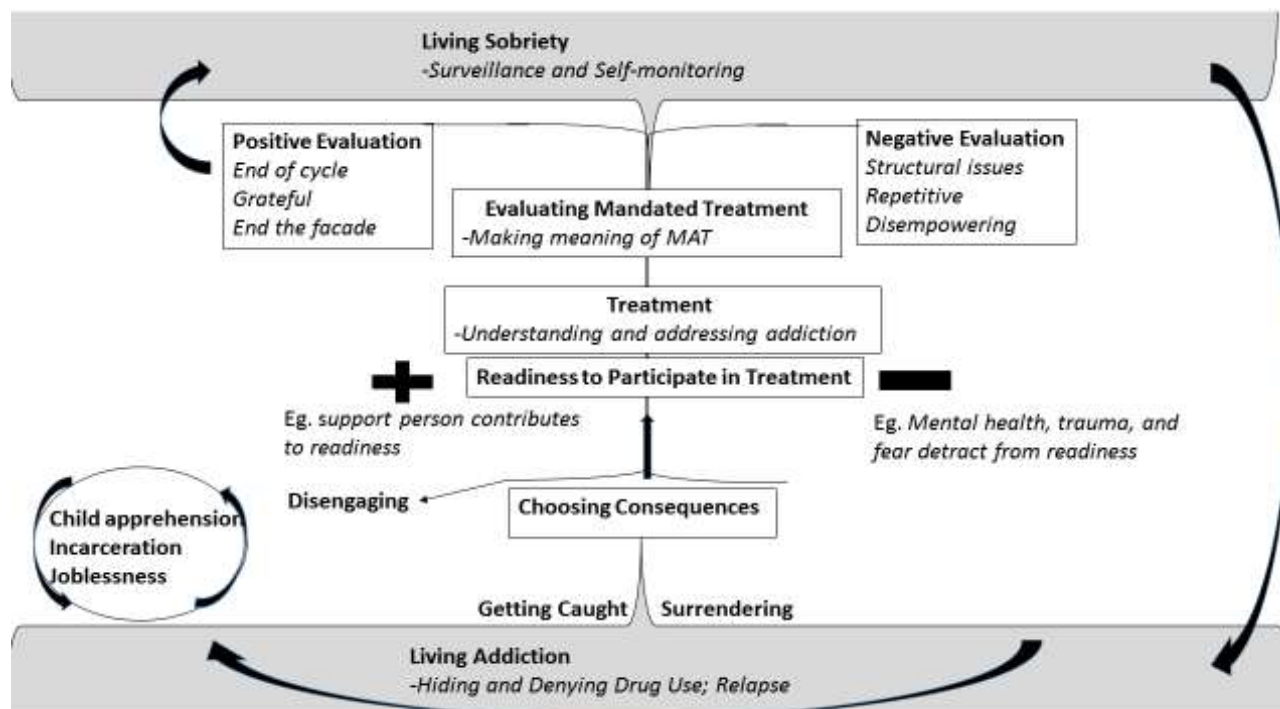


Figure 3. Example of Diagramming in End-Stage Write-Up. April 25, 2015.

In comparing Figures 2 and 3, the reader will notice the development of the contextual categories Living Addiction and Living Sobriety as borders, framing the core TEMAT processes. Through diagramming, I noticed the personal histories of trauma, addiction, and loss, and the ongoing struggle with sobriety and relapse that the majority of participants described, were not clearly conveyed in the theory. Re-conceptualizing the life experiences surrounding the MAT experience as contextual categories, rather than core processes, was a more accurate representation of when, where, and how engaging in MAT occurs. Ultimately, all findings were conveyed in a comprehensive visual schemata that represented the major processes and contexts of engaging in MAT. It serves as an important visual guide to the detailed descriptions of TEMAT processes in Chapter 4.

## **Ethical Issues**

All the participants were appraised of the purpose of the study and consented to have their interviews used as data for the study. At the time of consent at the start of the interview participants were paid and reminded they may stop the interview at any time. All participants were given a copy of the consent form and poster and were invited to contact me, the principal investigator, or the ethic boards if they had concerns about the research.

All participant information was kept secure and all interviews and field notes were stripped of identifying information, replacing real names with participant numbers and pseudonyms. Consent forms and hard copy field notes were kept in a locked cabinet at the University of British Columbia. The NVivo analysis software provided a single repository for interview data, field notes, and memos, and was password protected and stored on one computer only.

To the extent possible, interviews took place in private spaces, including homes, workplace meeting rooms, or offices at the University of British Columbia. However, ten of the forty interviews took place in public spaces, such as, coffee shops and community service agencies. In these cases, we sought out a quiet location and sat away from other patrons. These locations were all chosen by the participants and none of the participants expressed discomfort with the environment.

Throughout the interviews, I remained sensitive to any negative feelings or difficult memories participants may have experienced. At appropriate pauses and shifts in the interview topic, I inquired about the participant well-being and comfort. In the rare event a participant mentioned that they were finding the interview difficult, or I observed them in distress, I validated their feelings and acknowledged that we were discussing difficult periods in their life.

I provided them with options to re-direct the conversation, take a break, or stop the interview entirely. All participants were connected to support services as part of their ongoing connection to the mandating body or social housing. We discussed those services and I encouraged accessing those services should they feel upset after the interview.

Finally, it is important to acknowledge the power issues inherent in the researcher-researched relationship, especially in the context of Vancouver's Downtown Eastside and mandated individuals more broadly. As a vulnerable neighbourhood, the Downtown Eastside and its residents are heavily researched (Aube Linden, Mark, Werker, Jange, & Krausz, 2013). Research is part of the economy there, and many of the Downtown Eastside participants were also participants in other research projects. Paying research participants is the norm there and I felt paying was a tangible way to show respect and compensation for their time and limited resources (Craig, Fry, Hall, Ritter, & Jenkinson, 2006). In addition, the grounded theory method allowed the participants' lived experience to influence the direction of the research. As described in theoretical sampling above, the interview questions and sampling were revised and guided by the issues identified by the research participants.

### **Conditions and Criteria for Rigor and Credibility**

Corbin and Strauss (2008) distinguish between *conditions* and *criteria* for rigorous and credible grounded theory research. I first present the conditions for quality research and how those are present in this study, followed by the criteria for judging the rigor and credibility of grounded theory research.

#### **Conditions to foster quality research.**

The conditions for quality research are both personal and structural in nature, and I have divided the eight conditions into these two categories. Structural conditions are those that have



to do with the planning and execution of the research. These include a clear research purpose at the outset, use of the multiple grounded theory procedures, recognition of the impact of various methodological decisions along the way, and hard work. Personal conditions pertain to my personal and academic capability as a qualitative researcher. These include my research training, capacity for reflexivity, and empathy and interest toward the participants and topic. The structural conditions are presented first, followed by the personal conditions.

***Structural conditions.***

*A clear purpose at the outset of research: description versus theory.* As a reminder to the reader, the aim of this study was to construct an overarching theoretical framework that would model MAT participants' first-hand experiences of the mandated addiction treatment process. An important element of this research aim was the construction of a theoretical explanation of the MAT experience. Corbin and Strauss (2008) note that the challenge, especially for novice researchers, is to make the conceptual leap from description to theory in the analysis. This leap can only be made with the assistance of sufficient amounts of data to satisfy theoretical sampling, coding at all levels, memoing, and some kind of creative tool, such as, diagramming. In this study, in addition to rich description of the experience of MAT through categories and processes, a theory of the personal and social processes that explain how participants *engaged* in MAT was achieved. Therefore, the goal of the study is met in the innovative representation of the MAT experience as a process of engaging.

*Faithful application of the method.* Corbin and Strauss (2008) recommend employing as many of the grounded theory methodological strategies and techniques as possible to ensure rigor and prevent "methodological slurring" (p. 302). First and foremost, I employed the two fundamental grounded theory sampling and analytic techniques of theoretical sampling and

constant comparison respectively in the procedures described above. In addition, I conducted multiple levels of coding, memoing, and diagraming, all of which have been made available to the reader in the appendices.

*Implication of methodological decisions.* In addition to a faithful application of methods, I was also aware of the implication that each methodological decision had on the research (Seale, 2002). This is especially relevant with theoretical sampling, where I sampled new questions and different individuals to help challenge and develop emerging conceptualization of the research phenomenon. One such example of this was my decision to include participants' MAT experiences while in custody. I anticipated the criticism that the prison population and the dynamics of treatment programs in jail may be too different from the other mandated contexts on the "outside." However, I felt the in-custody experience could add dimension to both the criminal justice mandated experience on the outside, as well as deepen the understanding of the mandated context more generally. MAT in custody provided a comparison for the less restrictive criminal justice contexts outside of jail and prison. The fact that participants emerged as agentic engagers of treatment even in this context strengthens the credibility of the personal processes explained by TEMAT.

*Hard work.* Corbin and Strauss (2008) emphasize that the researcher must be willing to work hard to construct a credible grounded theory. I would extend this statement to include that the researcher may need to *work long* to construct credible grounded theory. All researchers doing good research work hard, but grounded theory often requires and benefits from a flexible research timeline. The requirement of constant comparison and to continually revisit analysis, recruitment, and data collection methods, such as, the interview protocol, required flexibility in the research timeline. Theoretical sampling, constant comparison, memoing, and field work

require time for analysis between data collection. Throughout the data collection and analysis process, I had to ride out periods of low recruitment, dead ends in the construction of theory and concepts, and seemingly endless hours of analysis to work through and understand the contradiction and connections in the data.

In this study, data collection and analysis went on for eight months (October 2012 – May 2013), after which I was satisfied that saturation of the categories had been reached. The final analysis and write up took an additional year to complete. While the core category of engaging and major concepts had been constructed during the data collection period, a little time away from the data contributed immensely in creating a final, parsimonious conceptualization of the data. In addition, during the year-long writing and editing process, I consulted with a number of experts in the fields of qualitative research, and addiction treatment and counselling. Their editorial suggestions and confirmation of the importance of the research also increased the study's rigor.

### ***Personal conditions.***

*Researcher reflexivity.* Throughout the research process, I acknowledged myself as the research tool and interpreter of data, and ultimately as part of the TEMAT representation (Hall & Callery, 2001). I exercised reflexivity in my memo writing and journaling, and sampled for opposing cases to my interpretation as a way of checking for biases in the analysis. For example, I sought out employer-mandated participants who chose joblessness over treatment, to further test a concept that employer mandates were the most compelling type of mandate among participants. Furthermore, theoretical sampling allowed me to be responsive and sensitive to the participants. For example, I altered the language of my interview guide and recruitment posters

to ensure I was not excluding or influencing individuals for whom the term “mandate” did not resonate.

*Training.* A rather obvious, but sometimes overlooked, condition for credible qualitative research is training. Corbin and Strauss (2008) point out that it is too often assumed that anyone can do qualitative research without formal training. While this is my first independent research project, I have assisted on multiple projects and trained with anthropologists on interpretivist, ethnographic fieldwork. I have studied and gained practical experience in using qualitative research methods through graduate qualitative research methods courses, research assistant experience, and in my own fieldwork into Drug Treatment Courts in Vancouver’s Downtown East Side. Furthermore, as a doctoral student in counselling psychology, I have extensive training in conducting individual interviews and listening without judgment of client experience. I believe this training helps to limit some degree of researcher bias in the interview.

*Empathy towards the topic, participants, and research.* This may seem in contradiction to the requirement for reflexivity and limiting researcher biases. However, Corbin and Strauss (2008) suggest that the researcher has to be willing and able to enter the participant’s world, and to be touched by the social and psychological problems they face, in order to “accurately capture the viewpoint of the participants” (p. 304). Over my 10 years of research in this area, I have become sensitive to the myriad problems of addiction, including trauma, poverty, homelessness, and mental health. My sensitivity to the participant’s comfort is evident in the rephrasing of the interview guide to better reflect and validate their experience. For example, I altered the interview guide to allow demographic variables to emerge as much as possible over the course of the interview, rather than putting othering questions about education, employment, or ethnicity up front. Furthermore, I preface the entire theory of engaging in MAT with a

contextual category that acknowledges the life experiences of stress and disadvantage which are the common antecedent to the MAT experience.

*Genuine interest in doing research.* The condition of researcher interest in treatment is related to the condition of training. In naming training as a condition for quality research, Corbin and Strauss (2008) warn that not everyone can do qualitative research; the condition of interest suggests that not everyone should have to. Corbin and Strauss note the misguided belief in graduate schools that “doing research is somehow the end all and be all of an educated person” (p. 304). I have been engaged in research in various roles for 15 years, first as a student, then as a research assistant, coordinator, and now as a doctoral researcher. While I also have a strong interest in counselling, this could have been largely satisfied with master’s level training and working as a counsellor. My interest in producing research in the area of addiction, and my quest for training and independence in that process, inspired this research.

### **Criteria for judging quality research.**

Corbin and Strauss (2008) outline 10 criteria for rigorous and credible research. The first two criteria of fit and applicability are concerned with the relationship of the research to its subjects, readers, and end-users. The other eight criteria ensure richness, logic, and depth in the grounded theory’s construction and presentation. I address each criterion below.

#### ***Fit and applicability.***

Fit and applicability were first established by Glaser and Strauss (1967) and remain among the gold standards for judging grounded theory today. TEMAT demonstrates fit in that it represents and resonates with the participants and other MAT stakeholders, including addiction and counselling researchers, and practitioners. Firstly, I conducted member checking with three participants in the early phase of analysis. All of these participants reported that the summary of

interviews and emergent codes was representative of their experience. Secondly, TEMAT is applicable and useful to addiction counsellors, MAT stakeholders, and researchers. I have shared the findings with one addiction researcher specializing in criminal justice issues, as well as three counselling psychologists and a social worker proficient in addiction models and treatment, all of whom report this to be representative and additive to their work in the addiction field. In reviewing this research, the addiction researcher D. Yalisove noted that client reactions to mandates and other treatment experiences are an important source of information that is rarely obtained (personal communication, September 11, 2015).

***Concepts, contextualization of concepts, and logic.***

These next three criteria help to ensure logical and clear presentation of the research findings. Firstly, findings should be organized around *concepts* to guide the reader through the findings; secondly, these concepts are *contextualized* by the systemic, social, and personal circumstances of the participants; and thirdly, there is a *logical* flow to the theory's categories. By employing multiple heuristic tools, including a visual model, interview excerpts, and discussion of methodological decisions, I strived to make the connections between data, concepts, and theory clear and logical. I used interview excerpts in Chapter 4 to give voice to the MAT experience and acts of engagements. Finally, I have provided background on many of the participants and treatment programs both in the methods and findings chapters to help the reader understand the personal and social contexts that explain the various processes and trajectories of engaging in MAT.

***Depth and evidence of memos.***

Descriptive and *deep* findings, as well as *evidence of memos*, provide insight into the data, allowing the reader to better judge the credibility of the grounded theory. Depth is

achieved through thorough and descriptive detail of the research findings, making them unique and additive to extant conceptions of MAT. I have provided description of all aspects of the research, including the field, the interview settings, and my own history with the research topic. In addition, in explaining the concepts and processes of TEMAT in Chapter 4, I provide detail on social and personal contexts of participant experiences as well as interview excerpts which serve to enliven and enrich the findings. *Evidence of memos* is evident in Memo Example 1 above and Appendix F in my description of analysis. Furthermore, the processes and properties of TEMAT explained in Chapter 4 are all elaborations of memos; therefore, memos are embedded throughout the findings.

***Variation, sensitivity, and creativity.***

Finally, meeting the three criteria for *variation*, *creativity*, and *sensitivity* of research findings insured further depth and complexity in this study. By acknowledging and including variation in the data Corbin and Strauss (2008) note that “the researcher is demonstrating the complexity of human life” (p. 306.) I discuss the wide range of personal and social contexts represented by the participants. I included various mandated situations of employer-, child protection-, and criminal justice-mandates, showing that while each group had unique social and personal circumstance, they also shared many core social and personal processes in engaging in MAT. The varied contexts of the participants’ lives and experiences strengthen the credibility of the shared process of engaging in MAT.

I demonstrated theoretical sensitivity through openness to novel and unexpected findings. On a number of occasions I altered my recruitment strategies and interview protocol. For example, I reflected the language participants used for “mandated” so as not to impose a

negative assumption implied by the term. I also used terms such as “required”, and “told to go,” in various recruitment posters as shown in Appendix B.

Finally, the criterion for creativity in qualitative findings was an ongoing reminder to me that social researchers are tasked with advancing a new understanding of a social problem, not just the dogmatic application of data collection and coding procedures. I feel I approached open coding in the spirit of creativity, and was not concerned about correctness or pre-existing theories when labeling and grouping the data. I approached the task of diagramming in a similar unconstrained manner, mapping coding connections and anomalies freely and continuously as evident by nine iterations of the schema. Finally, I feel my constructivist epistemological stance fostered my creative spirit as a co-creator in the representation of the participants’ MAT experience.

### **Summary of rigor and limitations.**

Throughout this section, I outlined the conditions and criteria for rigorous and credible research. The conditions are both personal in nature, relating to my own research skills and reflexivity in the research, and structural in nature, relating to sound planning and faithful application of the grounded theory methods. The ten criteria aim to ensure that the research is a faithful representation of the MAT lived experience I am purporting to explain; that it is useful and additive knowledge to MAT participants, researchers, and practitioners; and that the research is presented in a detailed and logical manner.

I met all the conditions and criteria for rigorous and credible research to various degrees. However, there are some limitations that, if addressed, could strengthen the applicability and fit of the research. These include: further member checking of the study findings with more participants; observation of the mandating and treating experience, perhaps spending time in a



treatment facility or with defence lawyers as they prepare participants for treatment; and more feedback from MAT stakeholders, such as, social workers, employers, and addiction counsellors, on the usefulness and applicability of the research to their practice.

## **Summary**

Grounded theory analysis is a recursive and enlightening process. The analytic tasks of typing up field notes, transcribing interviews, re-listening to audio files, repeatedly re-assessing the relationship of the data to the coding structure, and striving for an overall connection among codes constantly refreshed my perspective on the data. I eventually arrived at a core category and theoretical scheme explaining the client experience of entering, attending, and exiting MAT as a process of engaging. The process of writing the findings was an elaboration of the coding structure and memos. At times, the memos are included directly in the description of the codes. These sampling and analytic methods were designed to produce a maximally descriptive, and useful, social theory (Glaser, 1998). The criteria for judging TEMAT's usefulness and quality, and the ways in which those criteria were met, were described.

## Chapter 4: Findings

The research question being explored in this study is, “What is the theoretical explanation, grounded in the experience of mandated clients, of anticipating, attending, and exiting mandated treatment?” To answer this question, I interviewed 40 adults who had been through addiction treatment programs mandated by child protection services, employers, or the criminal justice system in Canada. The analysis was based largely on self-report retrospective interview data. Five participants were currently in mandated treatment at a halfway house as part of their prison release requirements, and five others reported pursuing ongoing recovery activities post-MAT. The other 30 participants had participated in treatment in the previous 1 to 7 years. Through theoretical sampling and constant comparative methods, one core organizing category entitled *Engaging in Mandated Addiction Treatment* (TEMAT) explains the experiences and processes of going through mandated addiction treatment (MAT).

Engaging is an intentionally broad term that encompasses the varying levels of agreement and commitment with which participants do MAT. Agreement and commitment are properties of the core category “engaging” and vary in range from lower to higher levels of commitment and agreement. On the low end, participants feel forced into treatment through ultimatums laid out by the mandating authority and go through the motions of treatment to alleviate or avoid negative consequences. They do not develop or apply personal meaning toward change. Participants with higher levels of commitment and agreement make a personal commitment to mandated treatment. The quality of the treatment experience and helping relationships influences participants’ readiness and commitment to treatment through the MAT process. The degree to which participants engage in MAT is associated with more positive or negative evaluations of the MAT experience, which in turn influence ongoing recovery efforts.

The theory of engaging includes four processes embedded in two contextual categories of Living Addiction and Living Sobriety. The theory explains the personal actions of engaging in MAT, as well as the personal, interpersonal, and systemic contextual factors that facilitate, limit, and prevent engagement in MAT. This chapter begins with a theoretical overview of the core category of Engaging and presentation of the TEMAT model, followed by an in-depth description of the major TEMAT processes and contextual categories.

### **Theoretical Overview of Engaging in Mandated Addiction Treatment**

The personal processes of going through mandated addiction treatment are continuously choosing, preparing for, and evaluating treatment choices, treatment experiences, and punishment. Engaging is the core category that has emerged from the data, within which all these processes can be organized and explained. The four TEMAT processes are: Choosing Treatment, Ready to Participate in Treatment, Treating Addiction, and Evaluating Mandated Treatment. These processes cut across all mandating circumstances of criminal justice, child protection, and employer referrals and speak to a shared, core experience of engaging in mandated treatment. Below is an explanation of each process and contextual category, including its properties, dimensions, types and conditions.

First, the phenomenon of interest – addiction - is described in the contextual category titled Living Addiction. Living Addiction explains the difficult personal and socioeconomic conditions of living with an addiction. It also describes the confrontation participants faced from employers, child-protection services, and the criminal justice system in the subsection Facing Consequences. Living Addiction articulates the grounds from which this inductive theory emerges.

Choosing Treatment is the first process in engaging and describes the first acts of engaging. It explains how and why participants accept the treatment mandate as a consequence for their law- or policy-breaking actions and the often reluctant nature of that choice. From here, participants ready themselves for treatment, attend treatment programs, and evaluate the entire MAT experience. Readyng, treating addiction experiences, and evaluating treatment are the most important and active processes of engaging in MAT. These three processes work as a feedback loop, constantly influencing and informing participants' increased or decreased engagement in treatment, towards more positive or negative evaluations of the MAT experience.

The theory concludes with a description of life after MAT in the contextual category Living Sobriety. It describes the ongoing work of recovery, and many participants are sober for varying lengths of time. However, despite being in recovery, for many there is continued sense of surveillance from the mandating institution. Therefore, there is no clear end stage to engaging in MAT, other than for those who choose to disengage and opt out of the mandated treatment option entirely.

Figure 4 models the processes of engaging in mandated addiction treatment. The model illustrates the multiple steps and potential cycles clients take on their journey engaging in MAT. The diagram is to be read from bottom up and then cyclically from top to bottom and between categories, keeping in mind that participants make new choices, leading to different outcomes, even after repeating the same cycle a number of times. Participants go on to Living Sobriety or Living Addiction after leaving treatment. Participants can disengage from MAT at any point and go on to face the original punishments of their children placed in care, incarceration, or joblessness. The contextual categories of Living Addiction and Living Sobriety surrounding the TEMAT processes in Figure 4 demonstrate the ongoing tension between sobriety and addiction,

which is partly explained by experiences in MAT. It is recommended the reader mark Figure 4 as it acts as a conceptual framework for the following explication of TEMAT. In addition, the relevant portion of Figure 4 is reproduced at the start of each section to help focus the reader's attention on the process and overarching theory of engaging.

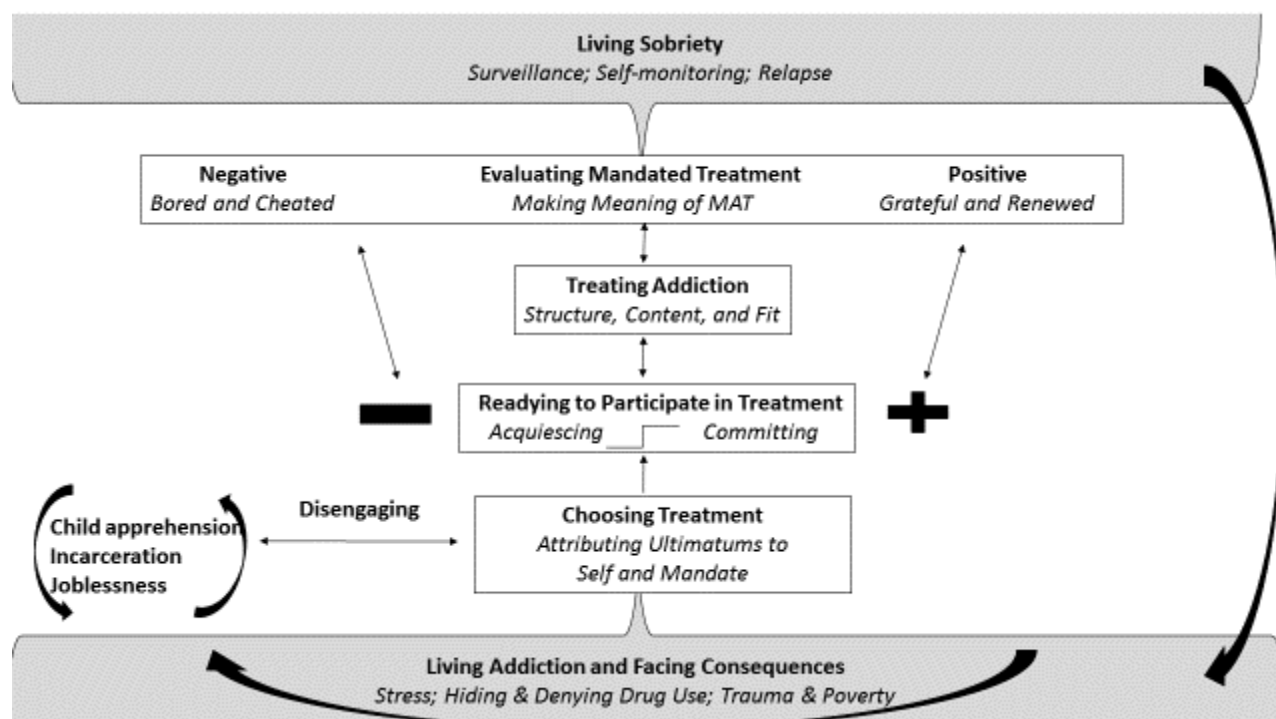


Figure 4. Model of Engaging in Mandated Addiction Treatment

## Living Addiction

*“At the time I was a harsh drug addict. I wasn't in good shape. You could tell by looking at me that I needed treatment.” (Jade, #4, 30 year old woman)*

Living Addiction describes personal and systemic conditions of TEMAT. Living Addiction is characterized by coping with stress; hiding and denying drug use; and confrontation with social authority. It is conditioned by common histories of trauma and poverty shared by the majority of participants. When asked about their experience of MAT, participants often began by describing their substance use behaviours and histories. The participants described using

substances to cope with stress and loss; hiding and denying the severity of their drug use to themselves and others; and fluctuating between clean time and relapse. The entire TEMAT process is predicated by a life and history of living addiction. Vancouver's Downtown Eastside is one such context for Living Addiction for many TEMAT participants. One participant who resided in a women's-only social housing complex said of the neighbourhood: "I feel like I'm in a box. I absolutely hate it. I sometimes lay here and just cry myself to sleep." She went on to say, "We're definitely not going to stop using (drugs) as long as we're down here" (Elaina, #6, 50 year old mother).

By the time participants are mandated to addiction treatment, and depending on their socioeconomic and employment status, there had often been a personal history of drug and alcohol use, failed treatment attempts, trauma, injury and/or loss that can span a lifetime. Gretta (#16), a 42-year-old mother of two, draws a strong link between trauma and addiction. She said: "Nobody wants to be a junkie. Nobody wants to do it. It's because 99% of addicts have had some kind of severe trauma in their lives - sexual abuse, mental abuse, physical abuse, whatever. That's why they do what they do." The link between trauma and addiction was echoed by many participants. Lisa (#7), a 42-year-old women, for example, described her long history with substance use preceded by sexual abuse. She said:

I was raped at 13. My uncle raped me. Took my virginity, took my innocence. After that I never had a childhood. And it just kills my mum and dad. It still hurts me that I never had a childhood. Ya. (pause). I started drinking at an early age. By the time I was 14 I was a full fledged alcoholic. When I was 15 I started experimenting with hard drugs. When I was 16 I started prostituting myself. When I was 16 I left Alberta and came to Vancouver. When I was 18 I was smoking rock. At 19 I started experimenting with

heroin. By the time I was 22 I was wired to heroin. That's all I ever knew - was to sell drugs to support my habit. Sell drugs, prostitute myself.

Lisa (#7) highlighted how addiction from a young age perpetuates a life of drugs and crime to the exclusion of other opportunities. Trauma and loss conditioned how participants engaged and evaluated mandated treatment.

Three participants were exceptions to the more common stories of early drug use, low levels of education, and abuse and trauma. These participants reported coming from well-off families, completed some college education and not starting using substances heavily until later in life (i.e., in their 30ths and early 40s). Moreover, the majority of participants in the employer-referred group began drug use later in life, after having time to establish a career. That they had established good jobs and in some cases were professionals (e.g., nurse) implies that these participants likely had more stable backgrounds with more affluence, educational, and family support. At the time of the interview the majority of later addiction onset and employer-mandated participants were engaged in recovery, and some had returned to work.

However, even for participants with careers and more stable and privileged backgrounds, the process of living addiction started before an addiction was established. Leanna (#1) noted that dissatisfaction with work contributed to her increased substance use. She said: "I became unhappy with my work; I just sort of gave up on it and I was introduced to cocaine and that was the worst thing anyone could have introduced me to at the time. That became my addiction."

Another participant, Brooke (#38), a 51-year-old outreach worker for a major health organization in Vancouver's Downtown Eastside, also noted job stress as an antecedent to her relapse. She said:

I'm an A type person, showing up early, but I had started to come in late. Some of the women I was working with had gone missing and one had passed away. Even my supervisor had said that in this frontline work where it's high stress and you're helping others, there is a huge percentage of people who, where if they are not addicted, they become addicted. A lot of it has to do with the pressure of the job.

Certain personalities are attracted to that job (A type). Nurses as well.

As Brooke (#38) noted, “where it’s high stress” there is risk for addiction, and this was the case for the vast majority of participants with or without stated trauma histories.

Active engagement with an addiction – finding, affording, using, and hiding substance use - was itself stressful and pre-occupying, punctuated by the relatively limited periods of enjoyment and relief provided by the substance. As Gretta (#16) said: “I just did it to get me through the day. Have a smile on my face. Keep me calm. It's not like I was smoking crack in front of my kids. You know?” Life became increasingly narrow and focused on drug use to the exclusion of other responsibilities and opportunities. As Darrel (#22) said: “I lost \$80,000. Car got re-possessioned, stopped paying mortgage, bills, everything. And I just didn’t care. I couldn't even get enough money to get the car out to sell it. At that point, it just doesn't really matter.” Paradoxically, many participants engaged in substance use to find relief from life stressors, only to be faced with the additional stress of having to manage the business of engaging in addiction.

Participants discussed hiding in two ways: from physical and psychological pain, and from being caught. As Carl (#23), a 53-year-old flight attendant, said:

It's not really a good life. I remember those days when I was using daily; you're not really living anymore. You're blocking every emotion. You're just numbing. I



don't want to regret what I could have been had I not been such a long using drug addict.

In order to present a positive image as worker, parent, or citizen, participants were invested in hiding and denying the severity of their addiction. However, these efforts were thwarted when employers, child-protection services, and the criminal justice system confronted their misbehaviours and mandated addiction treatment.

### **Facing consequences.**

This in-vivo code describes the initial confrontation with authority. At this point in the MAT process, the participants' substance use is associated with breaking rules of responsibility as employees, parents, or citizens and social controls are being placed on them. Participants are faced with joblessness, loss of child custody, or incarceration. Participants described this juncture as being "caught" (Steve #37 and Brooke #38), "out of chances," (Len #33) and a time "to face consequences" (Blair, #35). Participants described a range of feelings at being confronted, including relief and surrender; and shame, fear, and injustice.

Steve (#37), a 50-year-old man with previous treatment experience, identified with the feeling of being "caught" when confronted by his employer over his drug use, and related this to hiding and denying his drug use. He said:

Exactly! I had been caught (by his employer). You think you're pretty slick along the way; I'm thinking I'm hiding things pretty well. I always came up with what I thought was a plausible reason for not showing up to work. And deep down I knew it was all bullshit, and you think you can just carry that facade on forever.

Other participants, particularly employer-referred, also felt defensive, threatened, and fearful at the initial confrontation. Lily (#11), a 62-year-old nurse, described feelings of fear and

ridicule when confronted about her drug use. However, in hindsight, she saw her employers as caring and wanting to help. She said:

Oh my god, the fear! You think, ‘This is it. My life is over. I won’t be a nurse anymore!’...Looking back I could hear them in my head, ‘You’re bad, you need to go to treatment, you’re an evil person, you’re stealing drugs!’ I think what they really said was that, ‘We think you have a problem, you need some help, we can help you.’ These were good people. But all I could think was that this was a trap.

At confrontation, participants’ identities as workers and parents were questioned and threatened. Jolene (#10), a 60-year old woman, described the threat to her identify as a mother that her children being placed into care posed. She said: “You can imagine, being a mother all your life up to that point and then having no children, no spouse. I just started shaking, that’s how horrifying it was.”

Employer referred clients reported a sense of relief in being “caught” in their drug use, while those referred via child protection or criminal justice systems did not mention this. For example, Brooke (#38) said: “I think subconsciously I wanted to get caught. I think I just wanted them to say, ‘You’re drunk and now we’re going to help you.’ Rather than me just tell them. I didn’t have enough courage to do that. I was relieved.” As highlighted by Brooke, some employees were concerned about their own drug use prior to being caught. In contrast, stopping substance use was not typically brought up by the criminal justice and child protection participants as a primary goal, whose major struggles were financial. Either way, all participants were facing consequences at this stage and forced to choose between treatment and punishment. By choosing treatment, they began their process of engaging in MAT.

## Choosing Treatment

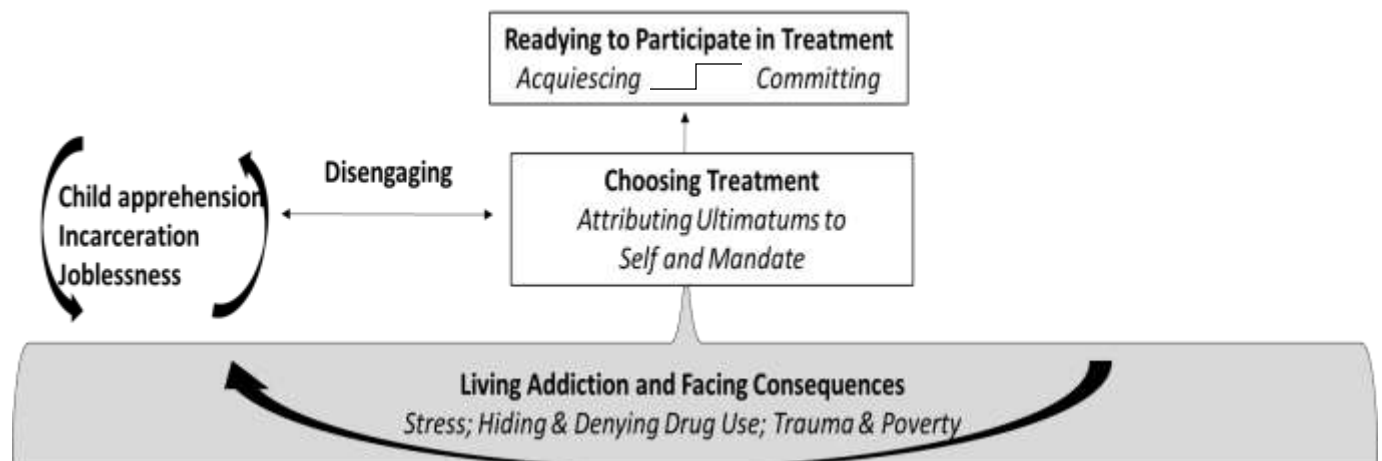


Figure 5. Choosing Treatment Process in TEMAT

*“It’s not really a mandate. It’s an option, a choice.” (David, #5)*

After the initial confrontation by employers, child protection services, or the police, participants were faced with choosing between punishments or treatment. This process explains how participants decided on treatment and the nature of that choice. The two types of choices participants made were ultimatums or opting out of treatment, coded as Disengaging. The majority of participants characterized mandated treatment as a Hobson’s choice<sup>9</sup> or ultimatum, with only one palatable option, while a minority described it as a dilemma<sup>10</sup> between two equally undesirable options, for example, jail versus treatment. In this process, participants described how they attributed the treatment ultimatums they faced and the choices they made in MAT.

For the majority of participants, choosing treatment was a way to avoid or alleviate the negative consequence of losing their job, their children, or their freedom. For others, mandated

<sup>9</sup> A choice in which only one option is given – a “take it or leave it” scenario. In the case of mandated treatment, attending treatment is the only alternative to the punishment they are facing.

<sup>10</sup> A choice between two or more unattractive options.

treatment was an alternative route off a path of destitution and death they believe themselves to be on. Finally, for some criminal justice referred participants, treatment was mandated once they had already been incarcerated. The unique pressures of choosing treatment once already imprisoned are described in the below sub-section Forced Choice in Custody.

### **Attributing ultimatums.**

*“I don't like to say mandated. I like to say ordered. Like, uh, they told you have to do it or there would be consequences.” (Blair, #35)*

Participants are either presented with, or present themselves, the option of treatment to delay, alleviate or avoid negative consequences. For example, a judge may include treatment attendance as a condition of a probation sentence. In some criminal justice and child-protection cases, the participants suggested the idea of treatment to the authority. Regardless who presents the idea of treatment, it appears to participants an ultimatum. Leanna (#1), a 41-year-old mother, described that her proposal to attend treatment ultimately was mandated by child protection services. She said:

And then I got another custody order, the last one, and then I proposed (name of treatment centre). But it became mandated, it was mandated... So, it became, “If you go, and if you complete the program, we’re going to give you the opportunity, that last final chance to take him (son) home. If you do not go and you don’t get accepted and you don’t complete this program we’re putting him up for adoption.”... So I, with everything I had, I just really, really, it was crunch time and sometimes that’s what it takes with me. I admit it.

That Leanna (#1) said participating in MAT was a “final chance” and “crunch time” suggests that the ability to make a choice was limited and ambiguous. Treatment was an escape route on

a certain path to jail, childlessness or unemployment.

Most participants did not see refusing treatment as an option. Therefore, they did not see they had much of a choice. Similar to Leanna (#1) above, Gretta (#16) and Alice (#21), two mothers, did not perceive treatment as an option they could refuse and were prepared to do “whatever it takes to get my kids back” (Alice #21). Alice (#21) went on to say, “I didn't want to hear nothing about treatment. I'm going to get my kids back...but I'm not going to treatment. But then when it was ordered I really didn't have a choice. I hated the whole 11 months (in treatment).” Similarly, Gretta (#16) recalled a clear ultimatum with regard to treatment. She said, “Because I had prior history with the Ministry (of child and family development), finally this time they said ‘Oh no, you're going to do this and this and that (attend treatment programs) or you're not getting your children back.’”

For some, treatment entry was an end to an unsustainable lifestyle toward homelessness and poverty. As Gretta (#16) describes: “I was accepting (of the mandate), surrendering, ‘cause, I didn't want to be a junky anymore. ‘Cause like it's no fun. You wake up, you don't have money, you're trying to find money.” Similarly, Darrel (#22), a 50-year-old man, was on the verge of homelessness and viewed mandated treatment as his only housing option. He said, “I was in agreement (with the mandate) because that was where I was going to live. I was going to regroup and get a job and get proper housing. I had nowhere else to go.” Whether to avoid jail, joblessness, childlessness, homelessness or poverty, the realization that treatment was the only alternative to such punishments and consequences is how participants come to choose and accept participation in mandated treatment.

Facing consequences and living addiction became one and the same when poverty and addiction reached life threatening lows. Derek (#20), a 52-year-old man in long-term recovery,

described that even his own self-referral to treatment felt like an ultimatum between living and dying. He said, “It really wasn't on my own. I mean, I decided. But I couldn't take it anymore. I was more afraid of living than dying. My brain was telling me, 'You need to do something here, 'cause this isn't living anymore.’” Derek (#20) left home when he was thirteen years old and had relied on crime to get by. He had been in and out of jail multiple times and had a serious opioid addiction for over ten years before starting recovery.

### **Forced choice in custody.**

*“They use every tool they can to punish you if you don't want to do programs.” (Robert, #12)*

For a sub-set of participants in this study, treatment only became an option after incarceration. At which point, the pressure to participate in treatment inside jail was even greater than the ultimatums faced outside, where imprisonment could be avoided. There were incentives outlined by the participants institutional probation officers (IPO) to participate in treatment programs inside, such as, getting early parole or probation, or moving to a more relaxed facility; but there were also punishments for refusing treatment, such as, being placed in solitary confinement or losing their statutory release date<sup>11</sup>. Blair (#35), a 42-year-old parolee at the time of the interview, explained that choosing treatment does not alleviate negative consequences for those in custody; it can only prevent further punishment:

The difference with mandated treatment in jail versus when offered in other cases is that if you don't do the program laid out by your IPO in jail you will be punished (e.g. prison job taken away, put in segregation, stat taken away). In other cases (mandated treatment outside), it's a matter of opting in to treatment or opting out and facing consequences of going to prison. But with the prisoners,

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<sup>11</sup> In most cases, offenders sentenced to a federal prison are release from custody to serve the last third of their sentence in the community.

they opt in and face consequences (of already being in jail), or opt out and get punished.

Eventually the ultimatums laid out by the correctional services and IPOs became dire enough that all the participants agreed to treatment programs inside. Derek (#20) described the “forced situation” of attending treatment programs in prison:

I was in jail but it (treatment program) was required because in order for me to get out I had to go through it. I mean, if I had said no I would have went to higher security, so it was a forced situations. ‘Cause if you're not going to do what they tell you then they move you up with the animals. I mean, I don't like to talk about people like that, but some of the people in there...

Jason (#34), a 38-year-old parolee, also described the mounting intensity of consequences he faced to attend treatment in prison. He said:

I just don't like the punishment part for if you refuse. They keep putting on the punishments more and more...taking away your pay, or you can end up getting shipped to a max (maximum security facility) for refusing a program. They use every tool they can to punish you if you don't want to do programs instead of just saying okay, well, you don't want to do it. So, like I said, they just keep trying to find things that work to get you take the programs.

After being subject to the demands of judges and multiple probation officers both inside and outside jail, some participants felt empowered against the criminal justice system to reject treatment. Some participants initially refused treatment recommendations in custody; but all eventually attended programs and some came to regret their initial refusal. Robert (#12) is one such parolee who came to regret his refusal to participate in treatment while in prison. He said:

Being stubborn cost me fifteen out of eighteen years. I just wouldn't give in. I would get so frustrated that they (Correctional Services of Canada, CSC) wanted me to do things and I would refuse to do things. And my family was dying and I would flip out and go to max (maximum security correctional facility) and I'd get stubborn and they would want me to do programs and I wouldn't do them. It was costly but I had just given up. I just didn't care. They'd be, 'Oh yeah, we'll let you sit here for a few years and we'll see.' A few years pass and I'm still there.

In conclusion, the idea of choice in custody is a bit of a paradox: inmates can participate in addiction treatment programs and continue to serve their sentence in custody, or refuse and face further deprivation of freedom in custody. Robert (#12), a 44-year-old parolee, had spent most of his life from the age of 13 under correctional supervision. His description of being a robot controlled by the system elucidates the lack of choice participants in custodial care have. He wished to have been given more choices with regard to treatment attendance and said:

I'm sort of institutionalized. I'm like a robot: do this, do that. I'm not really there.

Whereas if I was given the option. They (CSC) kind of treat you like a kid. You can't manage yourself. You can't make those decisions so we're telling you, 'You got to go to NA, to AA.' Why not give me the option? Put some trust in me and I'll make the choice.

At the time of the interview Robert (#12) was living in a halfway house for parolees. And for the first time in thirty years, he had proposed his own treatment plan to his probation officer and was taking an active role in his treatment.

Choice in TEMAT is conceptualized on a dimension of pressure from forced (feeling great outside pressure) to agreed (attributing pressure to both internal and external pressures). Participants felt more passive in their decision making when it is forced and more active when



they agree with doing treatment for personal reasons. Another course of action was when participants removed themselves from this spectrum of treatment pressure by opting out and disengaging from MAT entirely.

**Disengaging: Opting out of treatment.**

*“I would sooner finish my time in jail than sit in a treatment centre. I've been through it enough times to know what does and does not work for me.”– David (#5)*

“Disengaging” is a property of the “Choosing Treatment” and provides dimension to the concept of choice in mandated addiction treatment. As described above, for the majority of participants the choice to participate in mandated treatment was seen as a forced ultimatum, attributed to the mandating body. However, in four cases, participants opted for punishment rather than treatment. These participants came to view mandated treatment as more burdensome than jail or joblessness,<sup>12</sup> and opted out of treatment. Hence, opting out of treatment and disengaging demonstrated a choice, rather than an ultimatum, and provides the definitional limit to “mandated” treatment.

All participants opted for treatment the first time they were caught and faced with the MAT, but after cycling through the process of engaging in mandated treatment, returning to a life of addiction and crime, and facing consequences again, some opted for punishment over treatment. These participants decided it was easier, faster or less complicated to take the punishment rather than go through mandated treatment. They cited not being ready for treatment, wanting to do treatment on their own terms, and preferring the sometimes quicker and

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<sup>12</sup> Note: There were no reported child protection cases where participants opted for loss of child custody over treatment.

more clearly defined process of punishment over treatment<sup>13</sup>. In our exchange below, David (#5), a 36-year-old man mandated to treatment by the criminal justice system multiple times, described a sense of threat that pervaded his mandated treatment experiences, and eventually rejected mandated treatment options. He said:

No. I stopped going to treatment from 1998 until I was cleaned up in 2008 ‘cause I hated going to treatment. I didn't want anything hanging over my head while I was in treatment...The threat of jail if I don't do what they say, what the treatment centre tells me to do, or what the court tells me to do. So I like to have the choice of my own free will, not because I'm being told I have to do it. I didn't like that when I was a kid, and I don't like that as an adult.

That David spoke of desiring free will in choosing treatment speaks to the idea that mandated addiction treatment is undertaken under pressure and ultimatum.

Some participants lamented the protracted process of MAT. They suggest that serving jail time or quitting their jobs would be a more expedient consequence. Lisa (#7), a 42-year-old woman with a long history of drug and criminal justice involvement, wished she had opted for jail to “get done with it (punishment).” Lisa reported that opting for treatment ultimately extended her time in the criminal justice system because she was committing more offenses and accruing more charges while she was in treatment. Lisa had participated in the Vancouver Drug Treatment Court, which is a jail diversion program requiring attendance at an outpatient treatment facility. Sentencing is delayed while participants are in drug court. In addition, sentencing for further offenses committed while in drug court are delayed and will depend on how well participants engaged in and completed treatment. Lisa said:

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<sup>13</sup> Treatment programs became repetitive for many participants and required by multiple probation officers and MCFD social workers new to participants’ cases, despite previous treatment programs (see the section on feeling “cheated and bored” in the section on evaluating MAT experience below).

I tell people, 'Don't, do Drug Court. They'll string you along, they won't tell you nothing.' Three strikes (breaches of drug court conditions) and I end up doing Federal. A lot of people tell you that. Not only me, there's other people out there...I could have been out a long time ago. They played with me, those... The same judge as the Drug Court judge is the one who prosecuted me on Federal.

Lisa reported that in retrospect she would have opted out of treatment programs in favour of jail time.

Participants already in custody opted out of participating in treatment for custody-specific reasons. Some had practical concerns related to the risks of personal disclosure while in custody. Len (#33), a 38-year-old parolee, for example, was concerned that any personal information he shared while in treatment within CSC could be used against him. He said:

I've always had an adversarial relationship with CSC. I looked at it like, if I did take programs then that would give them actual insight into me and it would be more documentation they could put in my file to use against me in the future.

Because when I was getting a sentence I always knew there was a future sentence coming because I was never planning on changing my life. I was a criminal from a little kid on up and that was the life I wanted to live.

In addition, Len (#33) did not want to be perceived as weak or vulnerable by other inmates, and went on to say:

You don't want guys knowing your personal business in there, guys will use it against you. It's a dog-eat-dog world in there. So, you're not going to feel comfortable opening up. You're never going to fully open up in a program, in an institution. Once you're inside you've got to be looked like...not a punk, you know? 'You screw with me and

you're gonna get hurt!' So you're not going to want to put yourself out there in these programs 'cause you're not going to feel comfortable there.

Len highlighted the practical reasons that offenders may opt out of treatment in custody.

Participating in treatment programs in jail may carry risks that outweigh any benefits to be gained from attending treatment.

It is important to distinguish that it is not treatment per se that participants stated they were unwilling to engage with, it was *mandated* treatment and all its requirements, repetitions, and risks that eventually was avoided at any cost. Further discussion of participants' difficulties with mandated treatment is presented in the section about negative evaluations in the Evaluating Mandated Treatment process described later. Next, we explore the processes of readying for varying levels of engagement in MAT.

## Readying to Participate in Treatment

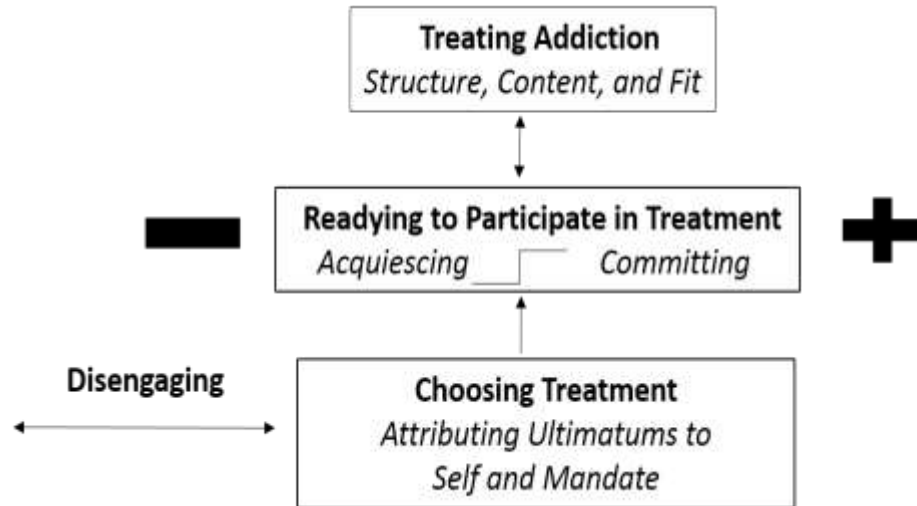


Figure 6. Ready Process in TEMAT

*“Because in the end if you don’t want to change, you won’t change. You have to be ready to change.” (Andrew, #31)*

In the process of engaging in MAT, the majority of participants chose treatment mandates before they had given recovery much consideration or prepared themselves for treatment. Readying to Participate in Treatment articulates how participants first agree, and then perhaps commit themselves, to treatment initiated under external forces. Readying is characterized by two sequential steps of Acquiescing to Treatment and then Committing to Treatment. In addition, readying is conditioned by treatment experiences and personal supports that positively influence readiness to commit to treatment. These steps and contextual factors are described below.

Readying for treatment may span multiple processes of engaging in MAT. The process of readying may begin prior to MAT, during living addiction, with some participants already considering treatment before being caught. Also, it reciprocally influences Treating Addiction experiences and Evaluating MAT, after participants have already entered and attended some

treatment. The extent to which participants complete both readying steps of (1) acquiescing and (2) committing is crucial to the successful engagement and positive evaluation of the MAT experience.

### **Acquiescing to treatment.**

The active process of readying, for most participants, began with the passive experience of acquiescing to treatment. Most participants agreed to treatment since they did not see the alternative punishment as an option. Jason (#34), a 38-year-old parolee, explained that participating in treatment was his only way out of a life in prison, and so he acquiesced to the decision. He said:

Ya, at first I didn't want to change, I only wanted to get out of prison early. That was my sole intent, my only goal. But along trying to do that I began to realize - what's the point in getting out early if I'm just going to go back to what I was doing. So the next time I screw up there isn't going to be a chance. The next sentence will be so long I'll probably spend the rest of my life in prison. And so I started looking at it: I don't just need to get out, I need to get out and stay out and not come back. And I knew because of my past history that they weren't going to believe me. That I would have to prove myself to them that I actually wanted to change. I knew I had to be open in these programs and participate in these programs and not just go through the motions or else they would not believe I was serious. At that time I still didn't think there was anything wrong with my life.

Jason highlighted the distinction between acquiescing and committing as “going through the motions” and “being open and participating” respectively. He was an example

of someone who acquiesced to treatment under the pressure of the criminal justice system, and then committed to the treatment process.

For some participants, acquiescing was the extent of their readying process. They had no intention of personalizing treatment or making long-term changes in their substance use. Their lack of commitment and effort toward treatment participation and change characterized low engagement, and they were more likely to drop-out. As Charlie (#24), a 30-year-old employee-referred participant, explained:

They (employer) sent me to (place of treatment) for 90 days. I only did a month.

I got fed up with it too. At first it's like a cleansing thing, but then you're pissed off because you have to be there. And in the end if you want to do rehab and all that you have to want to get off it. See I was ordered there, so I was like 'Oh shit, now I have to.' It's a jail sentence, right?

As Charlie highlighted, those who viewed treatment as a type of punishment, participated in MAT without committing personal effort toward change. The extent of their participation was to show up. Having the narrow view of treatment as punishment restricted their ability and desire to commit to treatment. Their treatment goals were articulated by phrases such as “getting done,” “serving time,” or, as Anne (#9), a 42-year-old child protection referred participant put it, “a gritting teeth kind of thing.” Those who did not go on to commit themselves to treatment, and whose goals remained to alleviate or avoid negative consequences throughout their engagement in MAT, were critical of the process of MAT. However, for the majority of participants in this study, acquiescing was a brief step in their overall engagement with MAT.

### **Committing to treatment.**

*“I felt I was ready to do the programs. I was apprehensive at first but I was at the period where I wanted to do it for me.” (Jamie, #32)*

All participants entered mandated treatment with goals towards avoiding or alleviating negative consequences. However, that is only the first step in the process of readying to participate fully in treatment. The next step is committing to treatment for personal reasons. The distinction between ‘doing it for them’ and ‘doing it for me’ was made a lot among participants and the readying steps of acquiescing and committing reflect these two sides. For example, Jamie (#32), a 36-year-old parolee, said: “I was apprehensive at first but I was at the period where I wanted to do it for me. I didn't want to do it for them. And so I went in there with an open mind.” David (#5) also highlighted that readiness is personal and cannot be mandated by others. He said, “No one's going tell me when I'm ready to stop using, only I can do that.” Participants cited time in treatment, exposure to others’ addictions and recovery stories, family, getting older, and exhaustion as influential factors and considerations in aiding their commitment to treatment and ‘doing it for themselves’.

The point where treatment goals became personal is hard to pinpoint and may emerge alongside the desire to avoid negative consequences. Jade (#4), a 30-year-old participant mandated by the criminal justice system, described these concurrent goals:

I could have just left (treatment) any time I wanted, but I would have had to deal with getting breached, going back to jail, so I just stuck it out and did it. ...but at the same time I was doing it, it was a good thing, and I was getting better and getting myself clean. It was a good thing.



Here, Jade was readying and committing to treatment while she was in treatment. Other participants also noted that “sometimes you need to be put into a program to identify for yourself what the problem is” (Andrew, #31, a 48-year-old parolee). It often took being in treatment, away from everyday stressors and substance use, for participants to have the space, time, and comfort with the treatment environment to be able to commit to the work of treatment and change.

Part of all mandated addiction programs included a group element, where participants heard and may have recognized their own experiences in others’. This connection to others’ stories facilitated understanding of one’s own addiction and commitment to treatment. Claire (#40), a 47-year-old social service worker and probationer, explained that “it was going to NA meetings that made me want to take recovery seriously.” She went on to say:

I think it was their stories. Just like my story, how abusive their families were and some of the things that happened in their life that trigger them to going in to drugs. Something hit home. And I just said: enough is enough! And it was just like that fast. ‘Cause I know that I’m an addict and I’ll always be an addict.

For Claire (#40), seeing her own story of trauma and addiction reflected in others’ stories, motivated her to want to change the cycle of (self-)abuse, trauma, and addiction.

The potential of recovering family connections through treatment drove many participants commitment to treatment. Harvey (#15), a 45-year-old child protection referred participant and probationer, described committing and engaging in treatment as a deep and honest process to keep his children. He said:

The first time I really didn't have to make changes. I had my mother there, my family. I knew I would get my kids regardless. The second time I could lose

them to the government. I had to dig deep and do the best I can and sincerely do the best I can.

The family connections, of course, applied to child-protection referred clients, but also to others who felt their relationships had suffered due to their addiction.

Others reported readiness as a more spontaneous and mysterious moment when multiple factors, both social pressures and personal desires, converge in the “right mindset” (Jennifer, #27, a 41-year-old nurse) for committing to treatment. They were not able to identify exact reasons they felt ready for treatment, and defined it as a personal, intangible, light switch moment. Jennifer (#27) said: “Since my early teens (pause) family, employer, none of it does anything. It's just about being in the right mindset. I've had times in my life where a light bulb goes on and a switch flips and there's no real reason for it except you're ready! I've had that experience, you just get to that point and then you want it, but it's not always on someone else's schedule.” For many participants, and for those who go on to make a positive evaluation of MAT, realizing personal goals for treatment further prepared them for the commitment and work of treatment.

In summary, Acquiescing and Committing are the two steps to the process of Ready-ing to Participate in Treatment. Participants may complete one or both of these processes to engage in MAT at higher or lower levels of commitment. While some participants accept they must attend and complete MAT to satisfy the social authority, they do not necessarily also commit themselves to the process of recovery. So, there may be readiness to attend MAT, but not necessarily readiness to engage or change. A small minority of participants actively agreed and welcomed treatment, and were committed to treatment at the time of being caught. For the majority, however, readying was a two-step process of first acquiescing and then committing.

The key elements of the treatment experience that inhibited and facilitated commitment and readiness to engage in treatment are discussed below.

## Treating Addiction

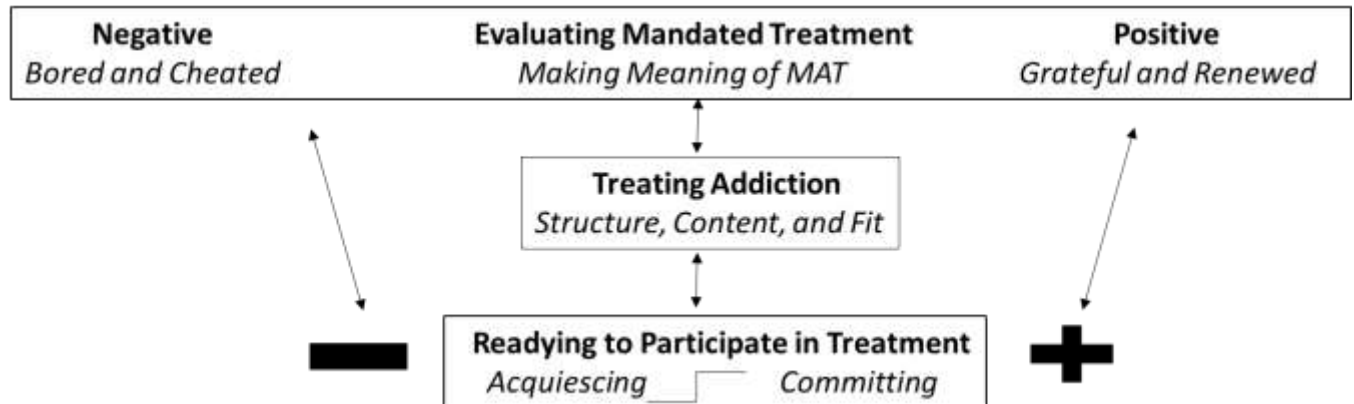


Figure 7. Treating Addiction Experiences in TEMAT

In the process of Treating Addiction, participants described the structural and content properties of their treatment experience, and explained how factors in both these properties impacted their engagement in MAT. Structural factors included the treatment facility, policies, procedures; and the quality of the interpersonal dynamic with treatment and MAT support staff. Treatment content describes the different MAT models and participants' sense of fit with the treatment content given (1) their religious beliefs, (2) cultural background, (3) previous treatment experiences, and (3) timing of the intervention in relation to other life events, such as, release from jail. This section concludes with a description of the undermining effect of the overall context of mandates on the ethos of honesty in treating addictions.

### **Treatment structure.**

Participants attended a wide variety of treatment structures and settings as part of their MAT experience, varying in duration, type of staff, and environment. Employer-referred participants all attended regulated residential treatment centres or recovery houses as defined by

the British Columbia's Community Care and Assisted Living Act<sup>14</sup> (The Act). Criminal justice- and child protection-referred participants, on the other hand, varied considerably. Many attended residential treatment at treatment centres, recovery houses,<sup>15</sup> or halfway houses (for parolees). Some attended a combination of outpatient programs, including: 12-step meetings, group and/or individual counselling, and urine testing. For example, Gretta (#16) described the mixed structure of her community-based treatment mandate by child protection services. She said, "I went to daytox. I did that program. I was always at the family preservation office. I had to do urine analysis three times a week. I had a drug and alcohol counsellor downtown at the native society. I did everything they asked." Participants reacted differently to different structures depending on their backgrounds, as will be explored in the below section on "fitting treatment content." However, the most salient structural difference in treatment was that between regulated and unregulated houses.

***Feeling exploited: The issue of unregulated recovery houses.***

The most notable distinction in treatment structure is between regulated and unregulated residential recovery houses. Regulated houses are licenced by the British Columbia Ministry of Health and follow the guidelines laid out in The Act. They have professionally trained staff in

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<sup>14</sup> British Columbia's Community Care and Assisted Living Act outlines that housing and hospitality services should provide assistance with activities of daily living, medication services, or psychosocial supports in a professional manner that respects the dignity of the residents. Facilities regulated by The Act are also subject to regular health and safety inspections.

<sup>15</sup> "Recovery houses" may or may not be licensed. The reader can assume the recovery houses referred to by participants are unregulated, unless otherwise noted. When participants refer to "treatment centres," these are licenced, government-subsidized facilities. Treatment Centres (also termed "adult primary treatment") are residential and government regulated in accordance with The Act. Treatment centres may be publicly-funded or private. Treatment is intensive, and all treatment activities are provided in-house with round-the-clock supervision. Clients cannot engage in outside work. Recovery houses (also termed "adult support recovery services"), on the other hand, are a less intensive residential program. They may be regulated or unregulated. Clients are required to reside at the house and observe a curfew, but are free to pursue outside treatment and other activities during the day. There is a focus on cooperative living, and residents contribute to household duties. Abstinence from substance use is a requirement of both, but may not be enforced at unregulated facilities. Recovery houses are more affordable than private treatment centres, and clients can stay longer. Regulated treatment centres often have wait lists, while recovery houses may have more availability.

addiction counselling and treatment. They require participants to remain on site, and provide all accommodation and food. At regulated houses, treatment activities make up most of the daily routine, with some leisure time.

Unregulated houses, on the other hand, tend to follow a peer-support model and clients can come and go more freely. They also have some treatment programming, usually consisting of a group meeting in the morning and attending a 12-step recovery groups in the community. The staff at unregulated houses are usually not professionally trained addiction counsellors; they are recovering addicts themselves and run a peer-support model.

A number of participants criticized the unprofessional, and often exploitive, conditions of recovery houses. Poor living conditions and lack of professionalism eroded treatment engagement at unregulated recovery homes. As Rav (#13), a 30-year-old man previously mandated to treatment by the criminal justice system, described, “You're living with five guys in a little bedroom. You have more privacy in jail. That's messed up. I've been in rooms no bigger than jail and you had to live with four people. Two bunk beds side-by-side. It's horrible.” The funding mechanism (government versus private) is an indication of quality of care in recovery houses. As David (#5) said, “Treatment centres are usually better because they're government funded. The private (unregulated) houses are just in it for the money.” Larry (#17), a 65-year-old man who had attended multiple treatment centres and recovery houses, also criticized the “money grab” of many recovery houses. The owners of these unregistered recovery homes collect the welfare cheques of their residents, effectively holding them hostage with no financial means to leave.

Finally, a lack of integrity and questionable sobriety of staff undermined participants' recovery efforts. Derek (#20) reported that there was “one guy” staffing the recovery house he

had been at, but that “he was probably supplying the other guys” with drugs for extra money. With drug dealing and use happening in some unregulated houses, participants could not pursue sobriety in a safe environment. As Claire (#40) said, “The recovery house wasn't helping me but I think going to NA was helping me....I was going to three, four meetings in a week. But I still craved (the drug). Because people were smoking (crack) in the house. I could smell it. It was just crazy.” Claire’s NA meetings helped her to stay engaged in MAT despite her living conditions. Treatment content factors, such as 12-step models, will be discussed further, but first the impact of treatment staff on engagement will be explored.

***Feeling supported by professional, flexible, and committed treatment staff.***

The interpersonal context of support and guidance with MAT treatment staff deepened participants’ engagement in MAT. The phenomenon of MAT involves many social service sectors and helping professionals, including: judges, employers, lawyers, union stewards, social workers, prison guards, parole and probation officers, and addiction counsellors and facilitators. This property defines relationships with, and characteristics of, the MAT staff. The dimensions of professionalism, flexibility, and commitment in MAT staff were key to participant feeling supported.

First, professionalism is defined as being knowledgeable, flexible, and non-defensive. Participants responded more positively to staff who demonstrated training, experience, and comfort with the addiction treatment material. Participants tended to dismiss treatment content delivered from manuals, and wanted to know that their facilitators understood their lived experience of addiction. Group facilitators who were inflexible and defensive with clients were written off by participants as undertrained and/or inexperienced. Participants could not build rapport with these staff or a connection to the treatment material and activities. Jason (#34) felt

that one prison guard-turned-counsellor's inflexible and didactic method of running treatment programs was an indication of her recent and brief training. He said: "Her program was horrible. She wouldn't listen to anything you had to say. 'This is the material. This is what I'm teaching.'" To participants, inflexible staff showed a lack of support and comfort with addiction issues.

Depending on their recency of sobriety and degree of professionalism, treatment staff's personal history of addiction can contribute to or detract from client connection and engagement in MAT. Sometimes, a personal history of addiction added to professionalism due to a deep understanding of the issues, and empathy for the participants. As Lisa (#7) said: "I like the facilitators, the counsellors. They've been there, they've done that. It's not from the book. They've all been drug addicts, they've all been alcoholics." Lisa was referring to a licensed residential treatment centre. Therefore, the staff would more likely have been formally trained.

Other times, sobriety fell short as a credential for helping other addicts. As Rav (#13) said, "These guys had only been clean for two weeks!" Darrel (#22) dismissed his counsellors' addiction history completely, saying, "A lot of these guys aren't really counsellors there, they don't know anything, they're former drug addicts most of them and this is what they've learned or they think they've learned." Participants wanted professional and knowledgeable treatment staff, which may develop through training, first-hand experience, or both.

A key dimension to a supportive MAT relationship is level of commitment to the participants. Commitment is defined by consistency and a genuine interest in helping participants recover. Consistency in treatment staff was a challenge in participants' MAT experience. Participants were often required to attend multiple programs, such as, residential treatment programs followed by community-based counselling, and there were often staff



changes in their MAT team along the way. These disruptions in staff jeopardized participants' sense of support and engagement. Tom (#39), a 45-year-old probationer who attended an MAT program while in jail, described "good" treatment being contingent on "connecting with the facilitator." He reported disappointment that "just when I get the connection going, I would have to move on."

Furthermore, without a sense of commitment from their support staff, participants in turn do not seek the support that is essential to engaging in MAT. After feeling "irked" when a "really good" and "sincere" probation officer left suddenly, Candice (#36), a 53-year-old serving a conditional sentence or "house arrest", said she was hesitant to make a commitment to future treatment staff. When her addiction counsellor could not confirm that she would be with her for the duration of her 6 month sentence, Candice said, "I would keep it light. I would just ask her for things, like 'can I get a bus ticket?'"

However, commitment from staff is reciprocal with participant commitment to treatment. As Gretta (#16) said, "I did the work faithfully. I went in, I listened, I shared, because you don't pass the course unless you participate. You have to give an effort. ... If they see you're willing to make a change then they (child protection workers) stop becoming rats and they start becoming advocates."

Finally, with a combination of commitment and understanding, Claire's (#40) probation officer demonstrated support despite periods of relapse. Claire said, "My probation officer is totally awesome. She said 'if you relapse don't freak out and not come and see me. Come and talk to me. I said 'will I go to jail? She said, 'no, you won't go to jail. We'll just see what led to that (relapse).'" In sum, the interpersonal context of support and therapeutic dynamic, improved through professionalism, flexibility, and commitment on the part of the MAT support worker,

can anchor participant engagement in the MAT process.

### **Fitting treatment content.**

Participants' religious faith and Aboriginal heritage<sup>16</sup>, history of treatment experience and failures, and timing of treatment are the personal contextual conditions that contribute to participants' sense of fit and engagement with the treatment content. An important property of treatment content is the theory of addiction held by the treatment centre and staff and the accompanying change-model and treatment strategies. All residential programs require participants to be abstinent from substances. In addition, abstinence was a condition of all criminal justice treatment orders, and an expectation for child protection and employer referred participants in non-residential MAT programs. In MAT, and in addiction treatment more broadly, 12-step models dominate the treatment scene. All participants had participated in 12-step treatment in the past, and the vast majority attend 12-step programs as part of their MAT experience. Other models participants mentioned were harm-reduction, trauma-informed treatments, and what participants called "knowledge-based" (Andrew, #31) programs.

Knowledge-based programs, such as SMART Recovery (Horvath, 2000)<sup>17</sup>, have an educational component about drugs and their effects on the brain; their mission is to empower clients to recover through teaching cognitive-behavioural techniques targeting irrational beliefs about the necessity of substance use in one's life and facilitating the discovery and use of alternative coping behaviours. While knowledge-based programs place the addict in control of their addiction, 12-step programs dispel the idea of self-control in addiction. Twelve-step programs encourage acknowledging personal faults and wrongdoings; seeking forgiveness and support from others and a higher power; and focusing on the present. Participants resonate with

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<sup>16</sup> The term Aboriginal includes First Nations, Métis, and Inuit peoples of Canada.

<sup>17</sup> SMART Recovery stands for Self-Management and Recovery Training.

some approaches over others; and a good treatment fit engages participants by making them feel helped and hopeful.

Fitting treatment is the degree to which participants feel ready for and helped by the treatment program. The three factors that impact fitting treatment are 1. religious faith and Aboriginal heritage; 2. novelty and fit of treatment content; and 3. timing. The personal contexts of religious faith and Aboriginal culture, and previous failed treatment experience, impact whether a treatment program is meaningful and helpful. Participants who have been through the same MAT programs repeatedly may require a new, not another, program to feel engaged. Participants noted trauma-informed programs and active, cognitive-based techniques as examples of novel and engaging treatment approaches that fit their experience. Finally, accurate timing of treatment positively impact fit, readiness, and engagement in MAT.

### ***Religious faith and Aboriginal heritage.***

Faith and heritage are important factors in creating a fitting treatment experience for participants. The two most prominent examples are the role of religion in 12-step programs and programs run by and for Aboriginal treatment participants. In AA, the Christian roots and religious language can encourage some participants and detract for others. Andrew (#31), for example, a “committed Christian” who “didn't have a problem with the spiritual side” of AA and NA lamented slightly the lack of AA focus in the addiction program he was participating in at the halfway house for parolees. Meanwhile, all four other participants from this same program praised its secular approach. Andrew (#31) went on to say: “[Facilitator name] runs a super program here. But it does sadden me that there is not more of a 12 step focus on his program. That’s what worked for me. And that’s what I’ve seen benefit others.”

Use of traditional Aboriginal healing practices and historical recognition of abuses on Aboriginal peoples facilitates fitting treatment for some Aboriginal participants. Three of the 10 participants who self-identified as Aboriginal attended Aboriginal programs. Aboriginal staff run these programs which often include traditional healing ceremonies, such as, smudges, sweat lodges and dance, and the counsel of an elder on staff. The Aboriginal treatment centres and recovery houses also take a trauma-informed approach to addiction treatment. Many Aboriginal participants had experienced abuse in residential schools and/or its effect on family breakdown, and found a focus on trauma essential to their recovery.

Lisa (#7), a 42-year-old criminal justice participant, was engaged in traditional Aboriginal healing with a staff elder in jail. She found it so beneficial that she actually refused her statutory release date for parole and opted instead to finish her sentence in jail. She said: "Parole board says they'll send me to [treatment centre]. I said, 'No, it's too late. I'll just stay here and finish my time. So I stayed and did my healing with my [elder]. We did smudges every day. We did sweats once a week.'" At the time of the interview, Lisa had abstained from heroin since her release and was working to get off methadone. Fitting treatment requires consideration of multiple personal contexts and learning from past treatment failures.

***Something different: Trauma and cognitive techniques.***

Fitting treatment is influenced by the personal context of failed treatment experiences. Many participants go through the same treatment programs multiple times, especially in custody, with their engagement waning more each time. A novel treatment approach can ignite hope in their recovery. For many, trauma-focused treatment was that new approach.

The following are a few examples of novel and engaging treatment components reported by participants. Cognitive therapy techniques like “ABC” to manage cravings<sup>18</sup> were “pretty good,” Candice (#36) said, “Because you could learn and utilize it in your life. You would actually learn some things”. Treatment techniques and activities provided novelty and engagement. Larry (#17) noted genealogy activities when “you draw and make connection to various people in your life” to be insight-building. He also noted psychodynamic activities, such as, “finding your inner child” was “one of the best things I ever did.” Many people felt helped through treatment activities and programs that were novel to them, especially after repeating programs multiple times.

Participants reported that addressing their trauma history in treatment ultimately helped them to engage in treatment and move towards recovery. In addition, they felt addiction programs that neglected to address trauma were not targeting the root of their addiction. Robert (#12), who had been in and out of jail all his life (30 years), described himself as a “robot” of the criminal justice system, and “institutionalized.” He said: “It was frustrating. I knew that I kept doing these programs over and over and they always hit on the same thing on substance abuse. But it never touched on my family history, on my growing up, on my witnessing abuses or being abused. Now they're finally dealing with the trauma.” At the time of the interview Robert was on parole and residing at a recovery house. He was focused on re-igniting his family connections.

Similarly, Blair (#35) explained that gaining an understanding of himself “beyond the drugs” was key to his engagement in treatment. He said, “I was looking for something that would be different...Like based upon what was wrong with me. What kind of problems did I have as a child? What caused me to go down the wrong path? I wanted to understand myself

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<sup>18</sup> ABC technique breaks down troubling situations into three categories: A. Activating situation (friends are drinking); B. Belief about A (“I need to drink too”); C. Consequences of having those beliefs about A (drinking).

beyond the drugs.” This distinction between “myself” and “the drugs” was made a number of times. Some participants found addiction management techniques more helpful (e.g. harm reduction; or managing craving through ABC); while others found a broader focus on personal problems and development a more fitting treatment approach.

### ***Timing.***

Fitting treatment is well timed in terms of participants’ receptiveness to the treatment approach being used and in relation to other life events taking precedence over treatment. As mentioned in the previous process on readying, committing to treatment is a key step in fully readying for treatment. If participants do not accept and commit to the change model of their program, they will not be receptive to engaging in the more deep, self-reflective, and often painful work of addiction recovery. The program material will be beyond their readiness resulting in a misfit and disengagement.

As discussed above, drug and alcohol treatments are not all alike. Therefore, readiness is not just a question of readiness for treatment, but can be a question of readiness for certain models of treatment. For example, some participants were not ready to work on trauma histories, and found trauma-informed addiction treatment programs “too intense” (Clara, #25). Clara said, “They are trying to open up a lot of wounds and I didn’t think I was getting any help and that’s why I left. It was making things worse...It could have been helpful if I had been ready or whatever.” Clara stated that she wanted to focus more on addiction and drug use itself, rather than on her abuse history.

In addition to readiness for certain change models and programs, the timing of treatment is an important factor in readiness and fit. The issue of timing can be especially challenging for MAT participants who do not initiate treatment themselves. Blair (#35) felt that doing treatment

close to his release from jail was actually harmful to his sobriety and re-entry into society. He explained:

I had just finished doing 4 years and I had completely put that (drugs) so far back out of my mind that I had changed my ways and I was clean and sober and I wasn't thinking of using. And just before you're going to get released they put you in this program and bring it all back to the forefront. They make you do role plays. That in itself is a trigger. And now you're thinking about drugs and start feeling cravings like you want to use all over again.

In summary, properly timed treatment in relation to other life events and readiness for the treatment approach contribute to treatment fit and client engagement in treatment.

**Mandate undermines treatment integrity.**

*“There are a few guys in each program that want to be there and are using these skills to try and change their lives. So how is it going to feel for these guys to be in this program with a bunch of other guys who are forced to be there?” (Jason, #34)*

Addiction treatment and recovery are intended to be implemented and pursued with honesty about one's addiction and with respect for sobriety (or the principles of harm reduction). Those who do not fully commit to MAT may feel “bitter, so (they) don't really get anything out of the program because (they) have to be there” (Blair, #35). This lack of interest and resentment undermines treatment integrity. These participants are unwilling to sincerely engage with the treatment material but feel compelled to complete the mandated treatment program. And Blair (#35) goes on to say, “You're not fully cooperating. You're not doing the homework.” This lack of commitment not only limits individual engagement in treatment, but also negatively impacts others in the treatment group.

All MAT programs include a group element. In fact, individual counselling was rare among the study participants. Recovery groups rely on respect for all participants' stage of recovery and shared dedication to the treatment material and tasks. When MAT clients do not share that dedication it weakens the group program for others. As Len (#33) said, "What pushes my buttons is listening to the guys that joke around and make it hard for us. Kind of pisses me off because I really want to get the most out of the program."

Finally, the mandate can create pressure to perform recovery in a way that meets the MAT facilitator's approval. Jason (#34), for example, was ready and committed to participate in treatment, but felt his performance in treatment must meet with the approval of the MAT facilitator. He said:

And you pretty much have to be in agreement with what they're telling you.

Their way is right. So, even if you're open to being in the program you're still chasing the carrot they're dangling in front of you. You still have to do the program their way in order to get that good report. Because it comes down to the report. You can end up doing a program over again because they could say, 'It doesn't look like you did too good here. Doesn't look like you learned anything.'

So, it's not a very good, or comfortable, environment to be doing these programs.

Jason highlights the paradox of pursuing self-improvement and personal change in a mandated context. Also, as discussed in the literature review, his experience of peer resistance is also perceived by counsellors, who may overestimate client resistance in a mandated context.



## Evaluating MAT

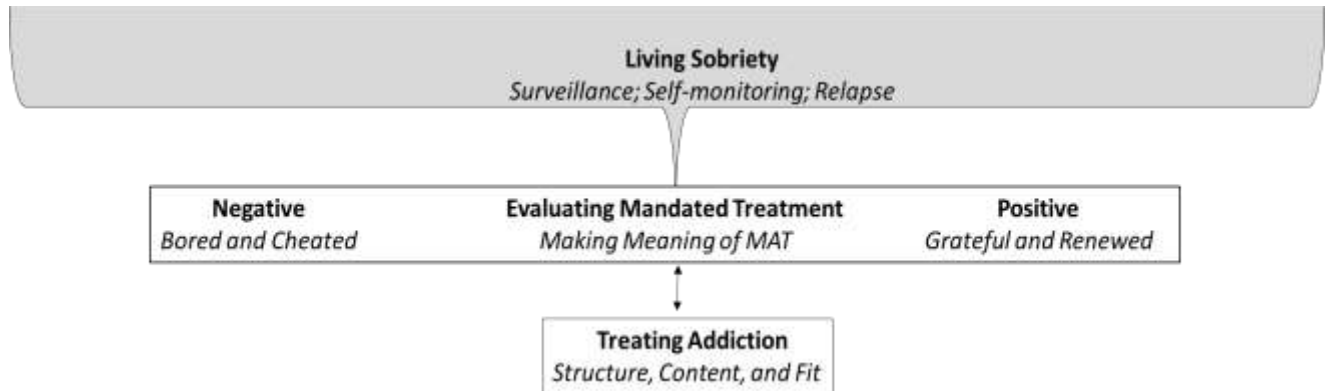


Figure 8. Evaluating Process in TEMAT

In the final TEMAT process of evaluating, participants are consolidating and making meaning of their MAT experience. Evaluating is an ongoing process throughout the MAT experience. However, it is not until exiting MAT, when the threat of the ultimatum has subsided, that participants are free to engage in reflection on the utility and success of the experience. The treatment experience of course influences the evaluation and, in-turn, the participants' positive evaluation increases a sense of treatment fit and readiness to engage with the treatment content. How they evaluate their treatment experience impacts their future intentions towards sobriety. Alternatively, with a more critical view on the MAT experience, some may choose to opt out and disengage from future MAT.

The properties of evaluating MAT are grouped into positive and negative evaluations. The key properties of positive evaluations are Feeling Grateful and Renewed. Repetitive treatment experiences and feeling cheated by the system, on the other hand, are common critiques of the MAT experience.

### **Grateful.**

Two women noted that without a treatment option from the courts they would have been on a downward spiral of worsening crimes and more jail time. Claire (#40) says:

If it hadn't been for the judge saying I'll let you out and look for a recovery house, I don't think I would have come out (of jail) straight. I think I would have been out for revenge on the judge. F- you guys then! I did my time and I can do what I want (use drugs). It would just be a big cycle again.

Deborah (#8) notes that mandated treatment interrupted her cycle of addiction, relapse, and recidivism. She said: “Ya. Because, jail would have hardened me. I wouldn't be here right now. I would be in a penitentiary doing the rest of my life. I just know my system. ...you learn in jail, in the penitentiary, in there you learn crime. You learn how to do the crime. And, where, if you're in a treatment program you don't. You go the opposite way.”

These women are exemplars of the ideal in criminal justice MAT; that is, to rehabilitate rather than punish drug users. As stated by the Provincial Court of B.C., “The Court recognized that a new approach to the prosecution and sentencing of drug-addicted offenders was needed; otherwise the “revolving door” of crime would continue to plague both the offenders and the community at large. The idea was that if the root cause of the street crime – drug addiction – is addressed, it should result in a reduction in criminal offending” (Provincial Court of British Columbia, 2014).

### **Renewed.**

For some participants, treatment is the first time in their lives they have had an opportunity to focus on themselves. Jolene (#10), a 60-year old woman, said: “That was

time for you and only you. That was really amazing. When I finally realized "ya, i dont' have to worry about the kids. And I didn't have to worry about a relationship. I'm going to be staying in a safe place. That was so amazing and such a weight off my shoulders. I believe that's the only time in my whole life that I only had to worry about me. I was 34 years old and that was the first time I only had to worry about me. That was amazing to me."

Many participants highlighted that having clean time, even for a short while, is worthwhile. Harvey (#15) described finding himself and a sense of hope during his clean time. He said:

After it was decided the children were going to go back to my family in Edmonton, it was a good thing. And I did make some progress. It was definitely not a waste of time. It was worthwhile. It was hard, it was worth it. It was a straight year, right! At that time I felt I had more choices in life, that I was more free. It was a hard time but a good time. I am grateful for that. It's a time I look at with appreciation and gratefulness.

### **Cheated and bored.**

In addition to the critiques of treatment structure and context outlined above in Treating Addiction, feeling bored by repetitive cycles of MAT and cheated out of the incentives that lead participant to choose MAT, such as, child custody, equated to low engagement and negative evaluation of MAT.

All 40 participants had attended treatment programs more than once, either voluntarily or by mandate. Multiple treatment attempts is the norm in addiction recovery but may have its limitation when mandated. The experience of attending multiple

treatment programs was boring and frustrating. David (#5), who eventually opted out of MAT, said: “As soon as you start your first day of the program it’s like, ‘Ugh, the same stuff over again.’ The same stuff I’ve done like 6 times.” Participants began to feel they are in a cycle of crime/addiction and treatment. At that point, treatment no longer presents new opportunities, but is rather viewed as a punishment. At that point, fit is an issue, and participants may respond better to a novel treatment approach.

Despite attending, and even positively engaging in MAT, it is not always possible to avoid the negative consequences laid out in the ultimatum at the start of MAT. When this happens, participants feel cheated out of the incentives for MAT in the first place. Harvey (#15) recalls feeling uninformed in decision made about the custody of his kids. He said:

They said after you do the treatment you’ll get your children back. Then I finished the treatment, then they said they were going ahead with full custody (adopting out). I was shocked. They put some rumours, they said I was abusing my kids. Which was totally wrong. It was just a bizarre bad situation at that time. I didn’t understand it then, and I don’t understand it now.

Elaina (#6), 50 years old and a mother of two adult children at the time of MAT, said, “They took the kids and hung them over my head. After all that work, after all of the hoops I jumped through and they still didn’t give them back to me.” Participants who did not achieve the intended outcomes of their participation in MAT became resentful and distrusting of the MAT process. Regardless of their success in treatment, these outcomes coloured a negative evaluation towards MAT.

### **Living Sobriety: Problems of Exiting and Recovering**

*“Once an addict, always an addict. You’ve got to remember that. It’s key.” (Claire, #40)*

As treatment-engaged participants exited treatment the primary challenge they faced in pursuing sobriety was relapse. They had to negotiate the tension between living addiction and living sobriety that was buffered briefly by MAT. Some wanted to reinstate their roles as workers and parents, and others saw those roles as threats to their sobriety. As Brooke (#38) said: “It was still too soon. They say after you leave treatment you should be clean and sober for a year before you take a job. It was too soon to go back to work. Those two drinks were a warning sign.” However, participants found that the ongoing involvement of the mandating institution in their lives made it difficult to leave MAT behind.

Employer-referred participants especially found ongoing surveillance from their employers after treatment difficult. Considering the relative stability associated with employment, employee-referred clients often had an opportunity to return to a pre-mandate life in a way criminal justice and child protection clients did not. Employer-referred clients may have returned to a job for years with the same supervisors, feeling they are under suspicion for the remainder of their time with that employer. Mark (#28), a 47-year-old employee with a major health care employer, said of this ongoing surveillance: “It's been 5 years now since this incident happened, I want this expunged from my record. This is wrong for these people (employer) to have this kind of power over me for the rest of my employment here!” Mark, with the support of his union steward, was able to get his addiction treatment records expunged from his file. However, with the same office manager in place, he had ongoing concerns about suspicions, relapse, and job termination.

Some participants felt they were being overlooked for promotions and others felt they were not being trusted with the same level of responsibility. Carl (#23), a 53-year-old who had long-desired his career, described hitting a low-ceiling at his organization after being caught

using drugs. He said, “I suspect I had a magic ‘x’ in my file,” preventing his promotion. He recalls wondering: “Is this thing always going to be over my head?”

Mandated treatment, and its associated consequences of distrust, does not have a clear end-point regardless of how participants were referred. Some criminal justice and child protection clients also complained of a belaboured exit process, reporting having to complete a repetitive “barrage” (Robert, #12) of treatment programs to meet requirements for probation or child custody. Elaina (#6), a 50-year-old mother of two adult children, lived in the Downtown Eastside and described ongoing requirements “after” MAT was complete. She said:

I've done every program you can imagine. They add more and more. Then they switch the social worker, then you've got a new social worker on your case who wants you to do something more. Then you do that. Then they switch social worker again. Then they want you to do more. That's what they do.

Openness about one’s addiction struggles was desirable for those employer-referred participants in a supportive work environment sensitive to issues of addiction. Steve (#37), a 50-year-old addiction outreach worker, was grateful for the ongoing sense of monitoring he received at work. He felt that knowing his supervisors were vigilant about signs of addictive behaviour, such as tardiness, helped to ensure his sobriety and long-term employment. He said:

The day that things don't look quite right anybody who's read my file are going to be on top of that and they're going to be in my face about it. And I've told them to please do that. ‘If you see that I’m not present, don't be afraid to call me on it. One, I want to keep my job, and two, I don't want to go back there.

In summary, the protracted exit from treatment is another example of how private addiction issues intersect with the public realm. MAT is not contained to the treatment

experience itself. It lives on in the files and memories of the mandating institutions, and in the ongoing pursuit of sobriety. For the most part, MAT participants view the continued sense of surveillance and suspicion over their substance use a burden. Alternatively, behavioural monitoring was viewed as a preventative relapse measure in the context of addiction support and understanding.

## **Summary**

In summary, the experience of entering, attending, and exiting MAT is captured and explained as a process of engaging. Engaging in MAT consists of four psychosocial processes of choosing, readying, treating addiction experiences, and evaluating MAT. The four processes are mutually informative, and participants move toward increased or decreased engagement depending on their personal histories, perspectives, and interactions with MAT personnel and structures.

Choosing is characterized as an ultimatum, and varies by virtue of attributing the MAT ultimatum to oneself or to the mandating body. Under the right conditions, readiness and commitment to treatment can emerge alongside the process of choosing and attributing the MAT ultimatum to oneself. However, even participants who externalize the MAT ultimatum can develop readiness, personal commitment, and overall positive engagement in treatment.

Readying emerged as an ongoing process, with the quality and evaluation of treatment enhancing or diminishing readiness at any stage in the MAT journey. A core property of readying is committing to treatment for personal reasons. Committing was facilitated by experiencing treatment benefits, such as, getting a break from day-to-day

stressor, or believing treatment could help in attaining other personal goals, such as, family reunification.

Finally, TEMAT is embedded between the contextual categories of Living Addiction and Living Sobriety. These categories reflect the tension that exists between sobriety and addiction where MAT operates. Importantly, the category of Living Addiction explains that histories of trauma, stress, unsuccessful treatment, and institutional involvement that impact participants' capacity, interest, and commitment to MAT. Living sobriety explains a cautious, potentially unstable state, as viewed by both the participant and mandating institutions. Living sobriety describes supportive versus suspicious surveillance post-mandated, and that employee-referred participants, for example, can struggle to return to a pre-mandate career trajectory under suspicious surveillance.



## **Chapter 5: Discussion**

The purpose of this research was to describe and explain the participant experience of the mandated addiction treatment process. Using a Straussian grounded theory approach, a theory of mandated addiction treatment was developed. The theory of engaging in mandated addiction treatment (TEMAT) explains how the core psychological and social processes of entering, attending, and exiting MAT may be understood as a process of “engaging.” Four core processes of TEMAT--Choosing Treatment, Ready to Participate, Treating Addiction, and Evaluating MAT--are embedded between the conditional categories of Living Addiction and Living Sobriety. Each process and category of TEMAT is comprised of participants’ actions in the form of commitments, evaluations, and apperceptions, that is, perceptions understood through past experience. Together, these processes explain how clients engage in MAT to varying degrees.

TEMAT theorizes mandated participants as agentic and engaged in MAT to varying degrees from the moment they are “caught” and presented with the mandate to attend treatment. In this sense, engagement is considered a fluid construct conditioned by myriad psychological and social factors, including: personal histories with addiction, sobriety, and treatment; life circumstances of disadvantage, trauma, and opportunity; and the quality of the treatment environment and interpersonal supports. Yet the role that personal circumstance plays in engagement is also emotional, as the participants’ affective evaluation of the MAT experience becomes a reflexive source for shifting attitudes and engagement in MAT. Ultimately, TEMAT's conceptualization of engagement as a socially recursive process may provide clients, practitioners, and researchers with a useful heuristic for examining clients’ experience and success in MAT.

That broad social external categories inadequately account for engagement experience in TEMAT is reflected in the research literature. Multiple studies found that felt coercion and mandated status did not predict substance use or criminal outcomes, while measures of motivation were more often correlated with outcomes (Knight et al., 2000; Wild et al., 1998). Prendergast et al. (2008), for example, found a marginal relationship between the motivational construct “taking steps,” as measured by SOCRATES (Miller & Tonigan, 1996), and fewer drug crime arrests, but that coercion did not predict treatment completion or overall re-arrests. On this lack of relationship between coercion and motivation measures on treatment outcomes, Prendergast et al. offer that “clients responses to treatment are subject to multiple influences - their perception of the fairness of the referral process, the degree to which they believe that they had a choice in entering treatment, and their readiness to participate in treatment” (p. 174). TEMAT helps to describe and explain these “influences” as perceptions, attributions, readiness, and autonomy supports. It also expands the circle of influence beyond psychological processes to show the social and personal contexts of each TEMAT process highlighted throughout this discussion.

In TEMAT, the social, personal, and historical contexts of participants’ lives emerged alongside the TEMAT core processes. These multiple personal factors condition the direction of all TEMAT core processes toward or away from MAT engagement and are highlighted through this discussion of TEMAT. In contrast, statistical research design on MAT often requires that social and personal context variables be measurable in the form of pre-determined education level, age, race, employment status, arrest and treatment history, and addiction severity constructs (see Prendergast et al., 2008; Stevens et al., 2006; Wild et al., 1998 for examples). To reiterate, one of the strengths of TEMAT's grounded approach is that it provides a vivid and

historically layered portrayal of MAT experience and of the relationship between clients and the treatment environment.

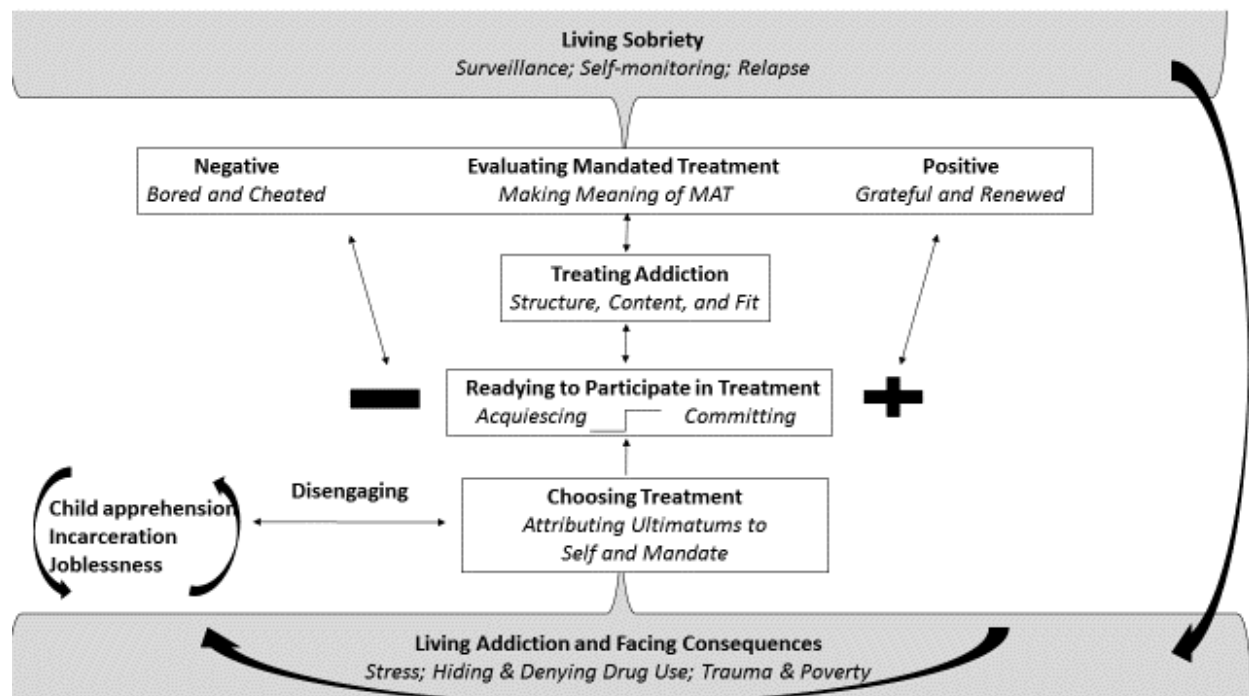
## **Outline**

This chapter begins with a review of the term “engaging” as the core category and explanatory term for the personal and social processes of how clients enter, attend, and exit MAT. TEMAT is then situated among the Transtheoretical Stages of Change Model and Self-Determination Theory (SDT). TEMAT findings are discussed in relation to SDT at various points throughout the discussion as a useful frame to compare and contrast TEMAT recommendations for supportive treatment. The role of social context in Attributing the MAT ultimatum is then discussed, followed by a discussion of the continuous, evolving nature of Readying in MAT. The central and permeating role of Treating Addiction experiences on all TEMAT processes is then presented. Then, TEMAT findings are further explicated through detailed policy and practice recommendations designed to facilitate client engagement in MAT. The chapter concludes with a presentation of the research limitations and suggestions for future research. The findings are discussed in relation to extant literature on the effectiveness and experiential correlates of MAT throughout. As well, the unique contribution of the client perspective and context is highlighted.

## **Engaging**

MAT participants’ perspectives, decisions, and evaluations of MAT are conceptualized under the core category of Engaging. In other words, TEMAT may be termed as the culmination of perceptions, actions, and contexts that tend toward either increasing or decreasing psychological engagement in MAT. Engaging generates the tension between positive and

negative treatment evaluations, illustrated as plus and minus signs in the TEMAT model reproduced below.



Key to understanding the term *engaging* in TEMAT is the interaction of personal psychological processes, such as attributing problems to oneself and committing for personal reasons, with contextual variables. For example, engagement is strengthened or weakened by the nature of participants' interactions with the stakeholders of MAT, including work supervisors, social workers, probation officers, treatment staff, peers, as well as their own treatment histories. Researchers in clinical, school, addiction treatment, and work settings utilize the term engagement to gain a positive psychological view of individual growth and change in students, clients, and employees with typically low motivation.

Investigating mechanisms for growth among survivors of post-traumatic stress, Roepke and Seligman (2015) hypothesize engagement as “‘new doors opening’ even as other doors slam shut in the wake of adversity” (p. 108). Researchers of child education privilege the term of

engagement over motivation since the former implies co-constructive involvement in tasks and activities in social context (Appleton, Christenson, Kim, & Reschly, 2006). Furthermore, researchers of addiction treatment conclude that “client engagement is one of the most important factors in retaining chemically dependent clients in treatment” (Sanders, 2011, p. 91). In fact, the U.S. Center for Substance Abuse Treatment suggests the incorporation of social variables and strategies targeted to improve client engagement in treatment. These strategies include engaging family, and assessing client levels of readiness to change in designing a treatment program (Center for Substance Abuse Treatment, 1999). The present research concurs with these strategies, and specific recommendations to expand the role of all MAT professionals, as well as including readiness training (Blankenship, Dansereau, & Simpson, 1999; Sia, Dansereau, & Czuchry, 2000), induction interventions (Farabee, Simpson, Dansereau, & Knight, 1995), and motivational interviewing (MI) (Miller & Rollnick, 1991, 2002), are made later in chapter.

### **Stages of Change and TEMAT**

The large influence the Stages of Change model has held on the theoretical and practical issues of addiction treatment has likely sensitized me to the concept of Readying, as well as the contemplative and preparatory processes of attributing and committing. TEMAT relates primarily to the first three stages of change - pre-contemplation, contemplation, and preparation - by accounting for the legal and formal pressures to enter addiction treatment, the processes of choosing treatment, and suggesting that readying is ongoing throughout MAT.

In the case of MAT, many participants begin treatment, that is, the actions of treatment, while still contemplating the pros and cons of taking steps towards change. They are not afforded the first three stages of pre-contemplation, contemplation, and preparation, unless they happened to be engaged in problem recognition and desiring help prior to getting caught by their

mandating institution. That clients' attendance in treatment does not necessarily reflect their motivational stage of change, or readiness, is supported by Silverstein's (1997) finding "that mandated clients made the same gains as non-mandated clients in outpatient treatment programs but started at earlier stages (i.e., pre-contemplation rather than contemplation)" (p. 99). Finally, TEMAT suggests that readiness for treatment, that is, engaging and developing a personal commitment for treatment, are appropriate goals for MAT, rather than substance use change per se.

In addition, the notion of sequential stages to human engagement and change is further destabilized by TEMAT findings. The valence of the TEMAT processes attributing, acquiescing, committing, and evaluating are continually evolving toward increased or decreased engagement in relation to (1) personal histories, (2) quality of MAT programs and relationships, and (3) affective evaluations on the fairness and helpfulness of the MAT. This rendering of stage-based models as being suspect in TEMAT reflects recent views of addiction psychologists. West (2005), for example, lists four reasons why psychologists ought to eschew Stages of Change models. He argues that the concept of 'stages' is arbitrary, unstable, conceptually muddled (stages incorporate conflicting constructs), and fail to incorporate the vital role of the social environment and biology in portraying readiness to change.

### **Self-Determination Theory and TEMAT**

The first two TEMAT processes of (1) Choosing Treatment and (2) Ready to Participate in Treatment, and their attendant processes of (1a) attributing ultimatums to the mandating institution, (1b) attributing ultimatums to self and circumstances, (2a) acquiescing to treatment, and (2b) committing to treatment for personal reasons, theoretically parallel external, introjected, and identified motivational styles in SDT. Put another way, participants' attribution

of the treatment ultimatum can be seen to indicate their level of identification with the treatment mandate (Ryan & Deci, 2000).

SDT proposes three types of motivation on a self-determination continuum: amotivation, extrinsic motivation, and intrinsic motivation (Deci & Ryan, 1985). Extrinsic motivation refers to the performance of an activity in order to attain some separable outcome, such as, employment in the case of employer mandated treatment. Intrinsic motivation refers to doing an activity for the inherent satisfaction of the activity itself. Creative pursuits are often cited as being intrinsically regulated. The mandated context inherently precludes individuals acting with intrinsic motivation. On the other end of the continuum, the MAT participants who disengage and opt out of treatment would fall into the SDT category of amotivation toward treatment.

### **The Social Context of Personal Attributing in MAT**

There is a fluid connection between attributing treatment ultimatums to oneself and attributing treatment ultimatums to the mandate, mediated by personal and social context. In TEMAT, for example, severe addiction, and related homelessness and financial strain, all attributable to oneself and outside socio-political forces, were experienced as pressures to enter mandated treatment. In this way, personal and contextual experiences problematized the binary of internal and external pressure that Wild et al. (2006), for example, attempt to capture on the TEQ measure of internal, introjected, and external motivation in their research on coercion, motivation, and treatment engagement. This fluidity among externally and internally attributed engagement influences is also presented in more integrative theories of addiction and motivation (e.g., West, 2005).

In attributing the MAT ultimatum to the mandate, participants chose treatment to avoid the dire alternative consequences of joblessness, childlessness, or incarceration. External

attribution of the treatment choice is not viewed as setting a course of low engagement for the entire MAT experience, but is an indicator that engagement is not yet maximal. In support of the finding that treatment engagement can develop despite early external attributions, Wild et al. (2006) found that external motivation was not related to engagement measures assessed in the first week of treatment. This discussion chapter goes on to suggest that Treating Addiction experiences further distance the constructs of external motivation at entry from treatment engagement at later stages of treatment.

In attributing the MAT ultimatum to themselves, clients recognized their lives had become unmanageable, as they faced poverty, criminal involvement, and parenting and work overload. In particular, TEMAT found that desire for reconciliation with family, feeling tired, and homelessness were some key personal reasons for committing to treatment. Therefore, they may be considered to have engaged in the motivational constructs of Problem Recognition (Miller & Tonigan, 1996; Simpson & Joe, 1993) and Desire for Change<sup>19</sup> (Rapp, Carr, Lane, Redko, & Carlson, 2008).

Attributing the MAT ultimatum to one's addiction-related problems is conceptualized as an act toward autonomous decision-making and positive engagement in TEMAT. Wild et al.'s (1998) findings that addiction beliefs, such as, "I regard myself as an addict," predicted decreased perception of coercion among drug user further supports this conceptualization. Similarly, Polcin and Beattie (2006) found that increased drug, alcohol, and family problem severity predicted increased motivation scores<sup>20</sup> with equal statistical strength with which institutional pressure negatively predicted treatment motivation. These findings further support

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<sup>19</sup> Rapp et al. (2008) distinguished between Desire for Help and a more general Desire for Change among treatment ambivalent client. They developed a motivation measure to assess the tenuous pre-treatment period. This is described further below.

<sup>20</sup> Motivation was assessed on the stages of change measure University of Rhode Island Change Assessment (URICA) scale by DiClemente and Hughes (1990).



TEMAT's assertion that the personal and social contexts of the MAT experience disrupt the binary between internal and external pressure.

### **Readiness Evolves**

However, participants who attribute internally may also be ambivalent about making the type of substance use changes laid out by the mandating body. Similar to their mandate-attributing counterparts, self-attributors desire to avoid negative consequences, but are also conflicted over their addiction, similar to introjected motivation (Deci & Ryan, 2000; Wild et al., 2006). Other researchers have also grappled with the role of early motivational processes on treatment engagement and outcomes.

Stevens et al. (2006) also found that mandates had a strong role in getting participants into treatment, and found a number of participants report "it's better than staying in prison" (p. 204). They interviewed 43 participants legally mandated to addiction treatment and 37 MAT professionals across five European countries about procedures and processes involved in the treatment mandate and entry, or as they put it the "decision phase of court-ordered treatment" (p. 203). In TEMAT, some MAT participants attribute their choice to enter treatment entirely to the mandating institution, Stevens et al. also found that some treatment professionals question the legitimacy of client responses on motivational assessments, suspecting participants may feign personal, identified interest in treatment just to "swerve" incarceration (p. 204).

Stevens et al. (2006) alert researchers to debate the extent to which participants need to be ready, interested, and desirous of substance use change prior to entering treatment, or whether such intentions should be expected to change and develop over the course of treatment. The present research comes down firmly in support of the latter. TEMAT posits that it is unrealistic that clients demonstrate high motivation, either verbally or on measures, at the start of mandated

treatment. TEMAT suggests that readiness and engagement should be the *targets* of change in a mandated context, not preconditions.

This ambivalence toward help in the form of MAT is supported by Rapp et al.'s (2008) assertion that the motivational dynamics of the pre-treatment phase are tenuous. Indeed, two of the four TEMAT processes – Choosing Treatment and Ready to Participate - are conceptualized as happening prior to, or concurrently with, treatment. In the creation of the Pretreatment Readiness Scale (PRS), Rapp et al. assessed the applicability of the TCU-TMA factors of Problem Recognition, Desire for Help, and Treatment Readiness to pre-treatment populations who were between intake assessment and treatment entry. Problem Recognition and Treatment Readiness factors were deemed applicable to gauging motivation of both pre-treatment and in-treatment populations. However, Rapp et al. found, through confirmatory factor analysis of the 23 TCU-TMA items, additional factors of (1) Desire for Change (developed out of Desire for Help) and (2) Treatment Reluctance better reflected pre-treatment participants' scores compared to the TCU-TMA.

The subtle change from Desire for Help to Desire for Change reflects that pre-treatment clients may want to see change in their life, but may not want help in the form of addiction treatment. In the TEMAT category Living Addiction, the majority of TEMAT participants did not recall desiring treatment help at the time of being “caught,” rather they were focused on coping with stress, and on hiding and denying their drug use. These Living Addiction dynamics, especially using substances to cope with stress, also align with the PRS's Treatment Reluctance factor. Treatment Reluctance on the PRS captures the hesitations and external pressures for entering treatment with items, such as, “Treatment seems too demanding for you,” and “You are going to treatment because someone else made you go.” Interestingly, Treatment Reluctance

was predicted by being court referred and being fearful of treatment. Recommendations for the use of the PRS with mandated populations are made below under Future Research.

### **The Scope of Treating Addiction Experiences**

Treating Addiction experiences are comprised of structure, content, and fit of varying quality, and influence participants' evaluations, readiness, commitment, and choice to attend MAT. Treating Addiction experiences are at the crux of the tension between living sobriety and living addiction that characterizes MAT. In particular, supportive staff and peers in a safe and secure treatment context are structural components that can facilitate increased commitment, readying, and positive engagement in treatment. Conversely, exploitive and unsupportive treatment experiences that thwart the basic psychological needs of autonomy, competence, and relatedness can undermine a sense of desire and efficacy in MAT, and loosen engagement with treatment goals.

#### **Quality residential treatment.**

TEMAT challenges research that attributes positive treatment outcomes to coercive pressure, suggesting that quality treatment structure and content can facilitate positive treatment engagement regardless of mandated status. Young and Belenko (2000) compared three groups of court-mandated clients in varying degrees of structured treatment environments. The highly structured treatment condition was considered to be more coercive because there was more communication with the client about the requirement and consequences of their mandated treatment conditions, along with urine screen validation of abstinence. In addition, participants in this highly structured, coercive condition, scored higher on a measure of perceived legal pressure. Young and Belenko found a positive relationship between coercive pressure and retention. However, TEMAT suggests that the more highly structured treatment environment

conveys better quality treatment, likely with an expectation of professionalism and more attention to client progress, facilitating increased client engagement in treatment.

Similarly, residential treatment settings may facilitate readiness and engagement to a greater degree than non-residential programs for mandated clients. Stevens et al. (2006) found that people in residential treatment were more likely to be in the action stage of change, according to the Readiness-to-Change Questionnaire (Rollnick et al., 1992), than those in non-residential settings. Furthermore, Stevens et al.'s qualitative interview findings align with TEMAT in the assertion that "motivation of mandated clients will depend on perception and quality of the treatment being offered" (p. 205). TEMAT participants' distinguished government regulated residential programs from unregulated recovery houses or outpatient treatment as providing the most professional, supportive, and comfortable treatment environment. Financial exploitation, poor living conditions, and unprofessional staff in many unregulated recovery houses bears out the assumption that a lack of autonomy supports hinders personal commitment, interest, or engagement in treatment.

TEMAT suggests that quality of treatment supports may be related to the source of the mandate. In the present study, for example, those with a workplace mandate attended regulated residential treatment centres or recovery houses for a minimum of 28-days with ongoing meetings with supervisors upon return to work. There was greater range in quality and style of treatment attended by criminal justice and child protection mandated clients, including unregulated recovery homes, community-based day programs, group, and/or individual counselling.

TEMAT participants noted that professionally run, residential treatment programs provided respite and quelled fears of treatment. In particular, many of the daily financial and

caregiver stressors described by the context of Living Addiction, which perpetuated the need for substance use, were taken care of in a quality treatment setting. Participants were therefore able to exercise coping strategies and autonomous action that had been limited in their pre-mandate, Living Addiction situations. In addition, some clients began to take ownership of the treatment experience, in turn, facilitating commitment to treatment for personal reasons. Finally, the stable and supportive structure provided by quality residential programs can be viewed as supporting the need for competency toward self-determined MAT goals, as outlined in SDT (Deci & Ryan, 1985).

### **Multiple MAT encounters and the challenge of prison-based programs.**

TEMAT contributes reasons of quality, fit, and repetition to explain Parhar et al.'s, (2008) systematic review findings that mandated programs in prison have the worst treatment outcomes compared to both voluntary prison-based programs and mandated community-based program. In terms of repetition, there is a cumulative effect of the arrest-treatment cycle that had some TEMAT participants feeling bored and frustrated with court-mandated treatment. Some even went on to prefer jail time over mandated treatment, noting that it was often shorter with clearer completion requirements. Hiller et al. (1998) and Knight et al. (2000) also reported that any motivating effect legal pressure may have to keep participants in treatment wears off over multiple arrests, finding that those with more lifetime arrests were less likely to remain in treatment of 90 days.

The coercive conditions of prison-based mandated treatment in particular can limit treatment engagement. Criminal justice-referred TEMAT participants noted poor fit with some prison based programs due to repetitive, manualized treatment content; minimally trained addiction treatment facilitators; and the poor timing of programs too close to their release date.

The challenges of mandated prison-based treatment relate to Prendergast et al.'s (2002) findings that offenders in involuntary prison-based treatment programs did not make the same improvement on self-efficacy measures compared to voluntary offenders. Self-efficacy in these studies related to a sense of control over one's life with items, such as, "You have little control over the things that happen to you" and "There is little you can do to change many of the important things in your life" (Simpson & Knight, 1998). It stands to reason that self-efficacy and a sense of control would be hindered among mandated prison-based participants, as TEMAT participants in custody weighed increasing custodial threats, such as, time in solitary confinement, as reasons to decide on treatment.

#### **Staff and peer support.**

Participants in the present study characterized quality treatment staff as flexible, professional, and committed to clients throughout their MAT journey. TEMAT implies the importance of both therapeutic and nontherapeutic MAT staff and peers on facilitating relatedness and personal engagement in treatment. For example, participants noted probation officers as important sources of consistent support throughout MAT. This echoes findings in criminological studies that probation and parole officers are key sources of therapeutic support (Kras, 2013). For example, Kras found that probationers and parolees reported a positive offender-officer relationship when the officer demonstrated commitment to the offender and some reasonable flexibility in the application of their conditions of release. This flexibility demonstrates a different relationship beyond one of enforcement.

The permeating effects of supportive staff on overall treatment engagement align with counselling psychology research on the therapeutic alliance (Gaston, 1990). The bond the client develops with the therapist has been found to be one of the most important contributors to

therapeutic effectiveness across treatment modalities and clinical issues (Horvath & Bedi, 2002; Warwar & Greenberg, 2000). Specifically, Connors, Carroll, DiClemente, Longabaugh, and Donovan (1997) investigated the relationship between therapeutic alliance, treatment participation, and drinking outcomes among outpatient and aftercare treatment participants. Therapeutic alliance was assessed on the working alliance inventory (Horvath & Greenberg, 1986), which is comprised of three scales evaluating the treatment goals, agreement over tasks of therapy, and the bond between the therapist and client. Both client- and therapist-rated working alliance predicted positive treatment participation, and reduced frequency and amount of drinking in the outpatient group. While this study was not done on mandated clients, given that research suggests that mandated and voluntary client have similar addiction treatment outcomes, it is deemed relevant to the present research.

TEMAT suggests that MAT staff and peer support are even more important in non-residential MAT settings. For example, TEMAT participant Candice (#36) was serving a conditional sentence. One of the limited occasions she could leave her home was for treatment activities. Therefore, formal recovery activities were limited to these therapeutic meetings. Candice recounted a positive relationship with a probation officer. She felt the officer was invested in her progress, and she looked forward reporting her recovery gains. When this probation officer was replaced by another officer whom Candice perceived to be less invested in her progress, she limited her disclosures. Connors et al.'s (1997) research on therapeutic alliance, treatment participation, and substance use outcomes in an outpatient population supports TEMATs emphasis on professional, committed, and flexible supports, especially in the absence of quality residential programs.

Candice's (#36) story exemplifies TEMAT's assertion that engagement is a reciprocal, recursive, social process, evolving between the varied social contexts of MAT and personal treatment histories, perspectives, beliefs, and intentions. Stevens et al. (2006), in their multi-national, mixed methods study, also found that perceived pressure from social services, including child protection services, treatment peers, and fellow inmates, was predictive of being in contemplation stage of change according to the Readiness-to-Change Questionnaire (Rollnick et al., 1992). Moreover, Stevens et al.'s qualitative findings, based on interviews with mandated clients and MAT professionals on the processes and procedures of the pre-treatment "Choosing Treatment" period, support TEMAT in suggesting that treatment engagement is the joint-responsibility of the client *and* the MAT professional to reach out, engage the client, and tailor treatment placements to the extent possible.

Peer interaction also mitigates levels of engagement in MAT. One participant, Len (#33), said: "What pushes my buttons is listening to the guys that joke around and make it hard for us. Kind of pisses me off because I really want to get the most out of the program." On the other hand, Claire (#40) found that "it was going to NA meetings that made me want to take recovery seriously. . . I think it was their stories. Just like my story." Evidence from qualitative research on women in MAT suggests that other clients can serve as supportive peers, helping one another to "imagine" alternative lives without drugs, and by serving as role models who facilitate engagement (Sowards, O'Boyle, & Weissman, 2006, p. 65). Thus, TEMAT showcases that supportive staff and peer interaction are core factors in the treatment structure, and important influences on engagement.



## **Clinical and Policy Recommendations: Enhancing Relational and Structural Supports**

TEMAT portrays clients in a complex relationship with MAT personnel and structures that impact the quality of personal engagement and readiness for substance use change. From a client's perspective, mandates, with their conjoining relationships between the client and myriad professionals, do not begin and end with their experiences in treatment. TEMAT implies that engagement in treatment may be enhanced by incorporating Motivational Interviewing (MI) techniques and other autonomy supports in relationships developed with clients over the course of MAT. In addition, quality structural supports are recommended to enhance feeling of competency and engagement towards current and future MAT goals. As a result, the following recommendations, echoed in the calls of researchers of addiction in adjacent disciplines of social psychology and psychiatry (e.g., Corrigan et al., 2012), are designed to help clients internalize mandates, increase treatment engagement, and optimize the benefits of treatment, rather than merely comply with the mandate *per se*.

### **Expand relational supports.**

TEMAT core processes of Living Addiction, Choosing, and Readyng show that the opportunity to engage clients in MAT begins prior to treatment entry. Therefore, the following recommendations argue for an expanded view of the treatment team to include paralegal and social actors of mandates. This structurally integrative approach (de Leon, 1989) to the traditional therapeutic alliance between counsellor and client underlies the fact that both peers and mandating professionals are intimately involved in confronting clients' substance use behaviours, encouraging their choice to attend MAT, and monitoring their adherence to the MAT requirements.

Probation officers, along with social workers and work supervisors, are nominated as important sources of support in addition to counsellors in TEMAT. However, their support potential is complicated by their authority to impose various work, child care, and legal sanctions. Kras's (2013) qualitative research on the role of probation officers in mandated treatment reflects this tension between authority and support. On the one hand, Kras found that offenders' perceptions of being stereotyped, threatened by legal sanctions, and disrespected by loud and harsh language from probation officers reinforced an authoritative relationship. On the other hand, offenders noted positive relationships when they perceived their probation officers to be fair, respectful in their tone, and kind. Specifically, fairness was defined as a willingness to consider leniency for bad behaviour in the context of the offender's circumstances. In TEMAT, flexibility is also noted as a key characteristic of supportive, professional MAT staff. Kras's recommendation aligns with TEMAT's - that probation officers' roles may go far beyond "keeping tabs" (p. 127), to the extent that probation officers "should play an equal part in treatment and supervision" (p. 127).

Social workers and child welfare workers in particular are involved in MAT participants' lives before, during, and after treatment. However, Trocmé, Kyte, Sinha, and Fallon (2014) suggest social workers' mandates to protect children can feel counter to their concurrent mandate to help families. All but two of the nine TEMAT parents felt unsupported in retaining child custody despite pursuing and completing MAT. These feelings are captured by the property "feeling cheated" in the TEMAT category Evaluating Treatment. In these cases, participants reported completing repeated treatment requirements, often at the request of multiple different social workers, with the understanding that their children would be returned to their care.

Participants became discouraged and disengaged from treatment with protracted, unresolved child custody issues.

On the other hand, TEMAT participants experienced their social workers as supportive if they were honest about the likelihood of child custody and committed to helping them complete treatment. For example, some child protection participants were fearful or apprehensive to attend treatment for the first time resulting in missed treatment start dates or attrition. In three cases, participants noted that their social workers acknowledged their apprehension as fear rather than defiance of the mandate. These social workers showed the client some leniency and offered them a second chance to attend treatment, even accompanying them to the treatment centre if deemed feasible and helpful. Of course, support and engagement are reciprocal, and participants who attended and shared their treatment progress received more support and leniency, developing a view of their social worker as an advocate. Social work scholarship and practice already emphasizes client choice and autonomy in their use of strength-based clinical techniques (Straussner & Senreich, 2002). The following recommendations also draw on these strategies to foster autonomy and engagement in MAT.

**Address ambivalence and clarify readiness.**

As detailed in the contextual category Living Addiction in Chapter 4, TEMAT shows that MAT participants experienced significant stress prior to confrontation with their mandating institution. The using of substances themselves - the high, reward, or relief achieved through substance use – was not usually deemed problematic. Rather, it was the multitude of associated stressors, such as, hiding and denying drug use from others, financial strains, and parenting stress, which participants may have wanted to change. The TEMAT processes of attributing to self and committing to MAT for personal reasons suggests that MAT goals may include family

reunification, parenting support, financial and housing stability, improved health, and preservation of professional identity. In support, Marlatt et al. (1997, cited as the National Institute for Drug Abuse) found that substance-related psychosocial problems, such as mental health and social functioning, are more strongly associated with treatment seeking than drug-use patterns. Therefore, it is recommended that both therapeutic and non-therapeutic MAT staff seek to understand the context of the client's life prior to entering mandated treatment in order to engage clients towards their own personal goals, not necessarily MAT goals of sobriety. MI techniques, as well as readiness training (Sia et al., 2000), cognitive induction techniques (Blankenship et al., 1999; Farabee et al., 1995), and other motivation activities (Czuchery & Dansereau, 2005) are suggested to help clarify MAT goals and encourage autonomous engagement early and through the MAT process.

### ***Motivational interviewing.***

MI is a therapeutic strategy that prizes empathy for the client, targets ambivalence, and enhances autonomy to facilitate changes in substance use (Markland, Ryan, & Rollnick, 2005; Miller, 2006). MI assumes that behaviour change always begins with ambivalence and discrepancy between evolving beliefs and current behaviours (Miller & Rollnick, 2002). MI interviewing techniques uniquely acknowledge the pros and cons of engaging in addictive behaviours. They are designed to enhance client contemplation toward changing substance use behaviours and preparedness toward action (Miller & Rollnick, 2002).

MI informs the MAT stakeholder or counsellor to remain empathetic to the clients' feelings of resistance and pressure to be in MAT. It is not their job to convince the participant of the utility of MAT, rather to explore their resistance as a normal part of change. Therefore, the recommendation to use MI techniques with mandated clients, in combination with TEMAT's

view that all clients are agentic despite the mandated setting, hopes to alleviate counsellor concerns that mandated clients are disinterested (Wild et al., 2006) or unaffected (Wild et al., 2001) by mandated treatment.

MI has been proven effective in a variety of formats, including groups (Lincourt, Kuittel, & Bombardier, 2002) and brief individual interventions (Borsari & Carey, 2005). Lincourt et al. (2002) found group MI sessions effective in increasing treatment attendance and completion. Lincourt et al. included clients mandated from multiple sources, including family court, department of social services, probation, and parole, as opposed to the criminal justice referred population in the majority of MAT studies. That TEMAT is also based on a variety of mandated sources increases the relevance of Lincourt et al.'s findings to TEMAT. Furthermore, group treatment was a core component of all MAT programs in the present study, and is therefore a realistic platform for MI interventions in MAT. Finally, given the varied treatment structures in the present study, the flexible application of MI is important.

Research by Borsari and Carey (2005) has shown that even one MI interview can reduce drinking among mandated college student drinkers. Given that Borsari and Carey were working with college students, I suggest that brief, single MI sessions may be effective with first time offenders, such as driving under the influence cases, or first-time employer referred clients. For child protection or repeat offender clients, who typically have protracted involvement with their mandating institutions, I recommend a longer course of MI group sessions and integration of MI techniques into their work with counsellors, social workers, and probation officers.

### ***Readiness training and motivational activities.***

In addition to MI techniques, there are a number of readiness and cognitive enhancement techniques that are recommended for use with mandated clients throughout treatment. For

example, Farabee et al. (1995) used a strategy called “cognitive inductions” to enhance cognitive dissonance in drug use among probationers mandated to a residential treatment program in Texas. The 33 participants were asked to list negative consequences of substance use as well as positive consequences of abstinence in seven domains, including: social, mental, behavioral, physical, emotional, motivational, and spiritual/philosophical. Unlike MI, the cognitive induction technique by Farabee et al. did not explore ambivalence of changing substance use behaviours.

Interestingly, Farabee et al. (1995) only saw a positive impact of the cognitive induction task in the group who had already spent a month in treatment. This research further supports TEMAT’s recommendation that engagement, interest, commitment, and readiness to participate in MAT evolve in conjunction with the treating addiction experiences and participant evaluations. Therefore, “induction,” or MI-type strategies, should be used regularly throughout MAT treatment encounters.

The TCU’s Institute of Behavioral Research has designed several treatment readiness and cognitive induction techniques for corrections-based substance abuse treatment participants through the Cognitive Enhancements for the Treatment of Probationers (CETOP) project (Blankenship et al, 1999). The standard CETOP readiness program is a 4-session program targeting self-esteem, confidence in making change, and identifying personal strategies and actions that will help make treatment more effective. Changes in motivation and confidence were each measured by questionnaires on a 7-point Likert scale comparing levels of motivation and confidence toward a number of change activities, such as, resisting drinking, from a month ago to now.

The readiness programs took place during the 4<sup>th</sup> and 5<sup>th</sup> week of treatment, again not at entry. There was a significant main effect of the standard readiness program on both treatment motivation and confidence, and an even greater increase in motivation and confidence among participants in the enhanced readiness condition that utilized games and action-oriented activities. Notably, increases in motivation and confidence were even more significant among the participants in the enhanced readiness program with lower education, which was deemed as below grade 10.

As part of the CETOP project, Czuchry and Dansereau (2005) studied the impact of four motivational activities designed to enhance probationers' knowledge, resources, and confidence to make change in substance use, as well as to enhance their acceptance of the process of change vis-à-vis treatment involvement. The motivational activities included a Downward Spiral board (Czuchry, Sia, Dansereau, & Dees, 1997), which is a role play activity where participants imagine the ongoing negative consequences of not taking action to change their substance use. Downward Spiral is designed to enhance thinking and knowledge of the ways drug use will continue to effect one's life if they do not change and hopefully decrease one's acceptance of this future. Another activity is called the Tower of Strengths designed to identify current and desired strengths (Sia et al., 2000) by selecting from a list of prosocial strengths. The third activity involves CD-guided tapes on relaxation and visualization strategies, called RAFTing and Mind Play, to help manage anxiety in imagined anxiety-provoking situations. The fourth activity is using self-guided materials designed to facilitate reflection on and development of personal strength. The Tower of Strengths, and RAFTing, and self-guided material all target personal resources and confidence to make change.

Czuchry and Dansereau (2005) compared groups of probationers in the motivational activities groups to those in treatment as usual. They assessed the impact of the four motivational activities on probationers' motivation and confidence for getting involved in treatment and for reducing risky behaviours. They also examined when in treatment changes to motivation and confidence occurred. They used the same motivation and confidence measures used in the CETOP study described above. Residential treatment was 4 months, and participants were measured midway through, towards the end, and 2 month post-treatment. Consistent with CETOP and TEMAT findings, it appears that motivation increases over the course of treatment. On motivation, there was a significant main effect for the treatment group toward both treatment and reducing risky behaviours at Month 4. On confidence, there was an overall effect of time in reducing risky behaviours and in treatment involvement, with confidence ratings being highest at Month 4. Not surprisingly, confidence ratings in treatment involvement were at their lowest 2 months post-treatment in aftercare. These results indicate that motivation and confidence build over time of treatment exposure. Overall, the strategies outlined in the CETOPS studies, along with MI techniques, are recommended to help address readiness throughout the MAT process.

Knowing that treatment engagement is continually evolving in MAT, staff are encouraged to regularly assess clients' perspective, interest, and rationale for treatment. Counsellors may follow MI or CETOPS readiness and motivational activities. Alternatively, they may also administer treatment readiness scales, such as, SOCRATES, TEQ-9, or the PRS (Rapp et al., 2008). In particular, SOCRATES and the PRS attempt to operationalize feelings of ambivalence and reluctance respectively, and the TEQ-9 assesses for external, introjected, and identified reasons for entering treatment.



In summary, when participants are first confronted with the ultimatum to attend addiction treatment, it is advised that they be approached in an empathic and supportive way, and that the mandating professionals seek the participant's perspective and attributions on being mandated to treatment. While mandating professionals, namely lawyers, probation officers, social workers, employers, or intake counsellors, may be convinced of the utility of MAT over alternative negative consequences, clients may not. This "moment of mandate" is an opportunity to alleviate fears about attending treatment, discuss previous experiences, and, to the extent possible, select a fitting treatment centre.

**Assess and acknowledge the personal and socio-political historical fit factors.**

TEMAT identifies four conditions that can enhance a sense of personal fit with treatment, and in turn improve engagement in treatment. These are: religious beliefs for the purposes of 12-step models; preference for Aboriginal treatment environments and traditional healing practices; previous treatment experiences and failures; and timing of MAT in the course of other punishments and sanctions.

Importantly, it is urged that policy makers and clinicians acknowledge that addiction problems and trauma issues for Aboriginal participants have their root causes in years of oppression, welfare colonialism, and poverty (Brown & Smye, 2002). Mandated treatment programs offered to Aboriginal MAT participants are, for the most part, a product of the mainstream, neocolonial healthcare system that tends to medicalize "social problems as arising from individual lifestyle, cultural differences or biological predisposition" (Brown & Smye, p. 29). Furthermore, treatment programs run by and for the Aboriginal community may better engage Aboriginal participants and empower their sense of identity (Health Canada, 2014). Three Aboriginal TEMAT participants found that some traditional healing practices of sweat

lodges, dance, and connecting with elders were therapeutic, facilitating a sense of support and engagement in the treatment process.

The fit factor of timing relates especially to criminal justice referrals, as treatment may be one of many correctional conditions to meet throughout the sentence. Some participants noted that treatment mandates imposed close to the end of a jail term could disrupt personal release preparations at the delicate time of re-entry into society. For example, TEMAT participant Blair (#35) noted that discussing drug use in MAT triggered cravings prior to his release that were otherwise not present after 4 years in prison.

Finally, participants noted both trauma-informed treatments and cognitive behavioral therapies (CBT) as useful and meaningful. CBT strategies provide concrete strategies for resisting cravings and staying abstinent, identifying thoughts that lead to drug use, and focuses on immediate problems and tasks of recovery (NIDA, 1998). It does not necessarily acknowledge or require spiritual or religious development or tasks and can therefore be adapted to suit the needs of the client.

Trauma informed treatment, such as Seeking Safety (Najavits, 2002), targets the dual diagnosis of post-traumatic stress disorder and substance use disorder also using CBT strategies. It helps individuals understand and value the need for personal and emotional safety, that substance-use can become a maladaptive attempt at seeking-safety, and promote healthy coping strategies to manage anxiety and uncomfortable emotions. In sum, trauma-informed treatment facilitate insight into why people use and strategies to cope with cravings.

### **Ensure quality structural supports.**

TEMAT suggests that a comfortable, safe, and supportive treatment environment can promote treatment commitment, engagement, and a positive evaluation of the MAT experience –

thus laying the ground work for continued success in recovery goals and/or future treatment engagement. The necessity for quality structural supports also reflects the SDT psychological need for competency. A safe, supportive, and professional treatment environment can support a client's sense of competency to change the substance use patterns that are embedded in an impoverished biopsychosocial and economic context. TEMAT's contextual category Living Addiction describes these multiple life stressors, including loss, trauma history, and poverty, that relate to and propagate substance use. Exploitive and unsupportive treatment settings, found in some unregulated recovery houses, thwart treatment competency and mimic the Living Addiction context.

Unregulated recovery houses are a key example of low quality treatment structures that thwart competency and discourage engagement, according to TEMAT participants. Substance use recovery houses fall under the Community Care and Assisted Living Act by promoting themselves as providing housing and hospitality services, as well as psychosocial recovery supports, mainly in the form of 12-step recovery meetings and a substance-free environment. However, a number of communities in Vancouver's Lower Mainland area have complained of drug dealing and related illegal activities at recovery homes (Sinoski & Pemberton, 2014). In addition, recovery house operators collect participants' welfare cheques directly, often leaving residents with meagre allowances and inadequate food supply.

While British Columbia has policies to ensure safe and respectful care in such community living environments through the Assisted Living Registry<sup>21</sup>, registration of addiction

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<sup>21</sup> The guiding principles for staff conduct and operations of registered recovery houses under the Assisted Living Registry are as follows:

- protect the health and safety of residents;
- value the perspectives of stakeholders — i.e., residents and their families/caregivers, community advocates for seniors and people with mental health and substance use problems, residents, operators, health authorities and other government agencies;
- partner with stakeholders to update health and safety standards;

recovery houses was made optional in 2001 (Stueck, 2015). At the time of data collection, the British Columbia provincial government had stopped registering recovery houses for over 10 years. Optional licensing was reinstated in spring 2013, as data collection was coming to an end (Stueck). Therefore, TEMAT participants were directly, negatively affected by this lack of oversight in the recovery house system. It is recommended that the Government of British Columbia reinstate the mandatory licensing of substance use recovery houses with the Assisted Living Registry, and that licensing be reviewed on a frequent, ongoing basis. By the same token, positive behaviours internalized by clients in professional and supportive MAT settings merits further investigations.

The present study's participants who attended unregulated recovery houses were mandated by the criminal justice system as part of a conditional sentence. In many cases, little to no research was done on the quality of mandated treatment facility, and the only requirement on the part of the judge was immediate treatment entry. It is recommended that the criminal justice system take a more vested interest in the recovery activities of offenders mandated to treatment. As TEMAT shows, low quality treatment structures can discourage commitment and engagement in MAT, and reinforce the view of treatment as punishment. Moreover, MAT participants with negative evaluations of MAT are more likely to disengage or minimally engage in any future MAT, effectively recreating the cycle of recidivism mandated treatment policies aspire to resolve.

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- promote client-centred services;  
- investigate complaints using an incremental, remedial approach;  
- ensure fairness, transparency and accountability in its administrative practices. (Province of British Columbia, 2015)

## **Limitations**

Limitations in data collection, data management, and analysis are discussed in relation to the overall rigour of the research, and strategies for addressing these limitations are suggested. These limitations point to recommendations for future research presented in the following section.

Much of the empirical research cited in the literature review was based on longer term, residential treatment programs of at least 90 days. The majority of residential treatment stays for TEMAT participants was between 28 days and 3 months, with varying length of community treatment required in conditional sentencing situations. The maximum treatment stay was one year. This is a limitation in my ability to compare these research findings to the extant MAT literature, and points to the unique limitations of MAT in Vancouver captured in this research.

As a solitary novice researcher in grounded theory, I encountered typical problems of a large amount of data, despite the assistance of NVivo data management. Voluminous data and data management are commonly discussed issues in grounded theory qualitative research (Bryant & Charmaz, 2007; Denzin & Lincoln, 1994). A team approach may have also contributed to the data management and analysis. While I consulted with supervisors and other grounded theory researchers throughout, a team approach to data analysis would have systematically included multiple perspectives on the coding process, effectively facilitating triangulation of codes and improved validity. Overall, a team analysis approach would emphasize the epistemological underpinning of grounded theory that knowledge is discursive.

Thick description of data in the present study acknowledges areas of conflict and contradiction. For example, David (#5) was the first client to mention opting out of mandated treatment, a novel course of action up to that point in the interviewing. From this, the concept of

disengaging emerged to help define the core category of engaging. Similarly, socioeconomic factors could have been teased out further in this study. For example, two participants, Leanna (#1) and Darrel (#22), had college-level educations and reported coming from economically advantaged, professional families. This deviated from the more disadvantaged backgrounds of the other child protection and criminal justice mandated clients. More theoretical sampling of data may further illuminate the significance of deviant cases.

Relatively small amounts of live observation and member checking limit this grounded theory to primarily interview data. Further field work, such as observation of MAT settings and member checking with current participants, would enrich the data and help limit researcher bias. In addition, corroborating data sources could help flesh out the properties, dimensions, and conditions of TEMAT categories, thus enhancing the explanation of engaging in MAT.

For example, in coding and writing-up participants' descriptions of treatment structures and program content, the variations of the treating addiction properties emerged along a dimension of quality, from poor to good. I feel I came to fully understand and develop an analytic eye towards dimensions later in the analytic process that may have been expedited by corroborating data. Finally, the "fit" of TEMAT to client experience would be more rigorous through extensive member-checking. In light of these limitations, the present findings can inform future research, policies, and clinical practice with mandated clients.

## **Future Research**

The following recommendations for future research aim to enhance, refine, and test TEMAT (Pratt, 2011) through both qualitative and quantitative methods. In the spirit of abduction (Reichertz, 2010), TEMAT can inform future research and provide a platform for hypothetico-deductive research, while also encouraging researchers to apply the constant

comparative method, thereby remaining open to opposing experiences that can modify and enhance TEMAT.

Firstly, constant comparison and theoretical sampling may be further applied to TEMAT categories. For example, future research may consider triangulating TEMAT with my previous ethnographic research on Vancouver Drug Treatment Courts (McCullough, 2011b). In addition, as highlighted in the limitations, socioeconomic histories and context were not sampled specifically, and the potential impact of those factors may be underdeveloped in TEMAT. TEMAT does highlight that financial stress is a property of the Living Addiction experience, but how this plays out is untold.

It is recommended to recast the TEMAT findings, and to pursue future experiential and efficacy research on MAT, within critical theoretical frameworks. In particular, historical abuses of Aboriginal participants were apparent in some of their stated preferences for Aboriginal treatment program and trauma services. -

The relationship of TEMAT categories and properties, and their impact on treatment, may be partially deciphered through correlational research. It would be helpful to confirm the relationship between the processes of Choosing and Ready, for example, considering important cognitive processes of attributing, committing, and evaluating were evident at these stages. For example, a correlation is hypothesized between (a) attribution of ultimatums to self and (b) readiness to change using self-report measures, such as, SOCRATES (Miller & Tonigan, 1996) or the Pretreatment Readiness Scale (Rapp et al., 2008). More specifically, a correlation is hypothesized between (a) attribution of ultimatums to self and (b) committing to treatment for personal reasons on self-report measures, such as, the TEQ (Wild et al., 2006). Further hypotheses for statistical designs are made throughout this section.

The category of Treating Addiction emerged as influential on all TEMAT processes towards more positive or negative engagement in MAT, and merits further investigation. It is recommended that more research be done to understand the ways that various aspects of treatment experience, including the quality of the therapeutic staff, relationships, programming, and physical environment of the treatment facility impact MAT participants' engagement, interest, and evaluations of the MAT experience. This research could be approached in various ways.

Firstly, researchers may better capture the aspects of the treatment process that account for therapeutic gains and positive evaluation through more qualitative field work at treatment facilities, including observation and discussion with clients and staff. Alternatively, researchers may test treating addiction experiences using predictive and correlational research methods. For example, the Community Oriented Programs Environment Scale (CORES) (Moos, 2003) measures perceptions of program environment, including dimensions of support and control in treatment. This measure may be correlated with readiness measures, such as, SOCRATES (Miller & Tonigan, 1996) or the TCU-TMA (Knight, Holcom, & Simpson, 1994; Simpson & Joe, 1993), and treatment evaluation measures.

TEMAT suggests that the quality of treating addiction experiences impact the overall development of treatment readiness and engagement among mandated clients. Therefore, it is recommended to administer all measures of treatment experience, readiness, and engagement at multiple points during treatment. A linear relationship between perceived treatment quality and readiness is hypothesized. Overall, research at treatment facilities would shed light on what Hiller et al., (2002) referred to as the “black box” of during treatment experiences (p.71).



Under the umbrella of Treating Addiction experience, the impact of therapeutic alliance in MAT also merits further research. Both TEMAT and Connors et al. (1997) suggest that the quality of the treatment relationship impacts treatment participation and even substance use outcomes. Specifically, TEMAT defines the properties of a supportive relationship as professional, flexible, and committed. This could be evaluated using quantitative measures of alliance, treatment outcomes, and perceptions. Alternatively, the therapeutic relationship may be targeted through qualitative methods, such as, the action-project method (Young, Valach, & Domene, 2005), which explores the joint actions and shared goals in human behaviour.

In fact, future research on the inter-subjectivity of the client experience in TEMAT more broadly is recommended. Research into how peer interaction impacts readiness, treatment evaluations, and perceptions of living sobriety is merited. In addition, research on MAT should extend to MAT staff, including lawyers, probations officers, and social workers. Research should investigate MAT staff perspectives and the nature of their interactions with MAT clients. Future research may ask: what is the nature of the conversation about mandated treatment pre-entry? How is it presented? Is the client's perspective on treatment and the role of their substance use in the mandate discussed? And, how might these early discussion impact how participants attribute the ultimatum to attend addiction treatment?

Finally, research on workplace mandates could be expanded. Comparatively little research was found on workplace mandates, even though TEMAT participants highlighted the importance of work supervisors on their choice to enter treatment and on their re-entry to work. MAT in child protection services and criminal justice systems are represented in the addiction, social work, and criminology literature, while treatment process research on workplace mandates are comparatively lacking, with the exception of Weisner et al. (2009).

## **Conclusion**

TEMAT explains the actions, perspectives, and beliefs of entering, attending, and exiting MAT as a continuum of engaging, influenced by personal histories and MAT supports. In collecting qualitative interview data from 40 participants, and attending to the contexts, conditions, and processes of their reported MAT experiences through grounded theory analysis, this research provides a holistic view of the MAT treatment experiences to compliment the majority survey-based, statistical research on MAT.

The present research responds to Kras' (2013) and Urbanoski's (2010) calls for a better understanding of mandated individuals' perceptions of the MAT process, after these researchers identified a dearth of experiential accounts in MAT research. More specifically, this research helps to answer Longshore, Prendergast, and Farabee's (2004) question: "What is the process by which clients entering treatment involuntarily later become actively engaged in it" (p. 110) – a question they deemed inconclusive in their extensive review of the literature on coerced addiction treatment for criminal offenders. In addition, the majority of literature in this area has focused on coercion in treatment for criminal offenders and has neglected to capture the core experience of MAT across other mandated situations. Finally, TEMAT uniquely contributes a four-process framework for conceptualizing the mandated treatment experience across workplace, criminal justice, and child protection mandates.

TEMAT unravels the apparent paradox of self-determination in a mandated context by revealing that the terms of addiction, mandates, and therapy are contingent on the dynamic of engagement of the individual client in relation to social context. TEMAT shows a synergistic relationship between quality of treatment content and structure, and engagement in treatment. Furthermore, TEMAT suggests that mandated conditions do not exclude the needs and ability

for psychological change. The theory inherently advocates that interventions and treatment programs respect the autonomy and psychological needs of clients, and draws on the SDT concepts of relatedness and competence to interpret the dimension of quality in the finding of Treating Addiction experiences.

A consistent finding in this research was that people who developed positive personal reasons for participating in MAT were more ready to participate in the MAT and showed higher levels of engagement. Conversely, these personal reasons could be undermined by exploitive and unsupportive treatment experiences that thwart the basic psychological needs of autonomy, competence, and relatedness. TEMAT articulates how clients step from acquiescing to committing to treatment in the stage of Readying. Some clients make the two-step process at treatment entry, others remain at the acquiescing step with resistance to participating in treatment. The scaffolding of desire and efficacy to take this next step of committing can be built by supportive staff in a safe and secure treatment context. Indeed, the degree of engagement expressed by the participants in the study is facilitated by the extent of support they receive from their social environment.

TEMAT participants clarified their intentions and commitment towards treatment in the course of treatment experience. With the anxiety of the unknown behind them, many participants discovered that after some attendance that treatment offers respite and companionship that in turn facilitates increased readiness to participate in treatment. This research uniquely positions readying as an ongoing process, and suggests it is not useful to measure readiness prior to treatment as commitment to change developed in TEMAT participants even post treatment while making positive evaluations of the treatment experience. This reflects the tenet in dynamic models of addiction (West, 2005) that motivation changes vis-

à-vis changes in behavior. In addition, Miller and Tonigan (1996) outline the importance of behavioural action, labelled “taking steps,” as a motivational factor on the Stages of Change readiness measure SOCRATES (Miller & Tonigan, 1996).

Finally, TEMAT addresses the ethical and clinical problems associated with MAT. For instance, TEMAT empowers MAT stakeholders to view mandated clients as active in the processes of engagement in MAT, rather than as resistant to therapy. Furthermore, TEMAT shows how counsellors and treatment institutions play key roles in supporting MAT clients’ psychological needs of autonomy, relatedness, and competency toward improved engagement. Finally, that TEMAT is constructed from the perspectives of clients ensures that experiential components of MAT, including beliefs, values, opinions, and personal histories, are represented in the extant MAT literature.

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## Appendix A: Invitation to Participate



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THE UNIVERSITY OF BRITISH COLUMBIA

Faculty of Education

Department of Educational and Counselling  
Psychology, and Special Education  
2125 Main Mall  
Vancouver, BC Canada V6T 1Z4

Phone 604 822 0242

Fax 604 822 3302

Dear [Recipient],

My name is Lucy McCullough and I am a doctoral student in Counselling Psychology at UBC. I am investigating the personal experiences and social processes of people who have been required to go to addiction treatment. I am writing to you because you have been identified as someone who works with people who may be interested in participating in this research. A brief description of the research is below, and a recruitment poster is attached. If you find it appropriate, I respectfully ask that you give this information to anyone you think may be interested in participating or post it on the notice board at your agency. Interested participants will contact me directly.

**Research Rationale:** Addiction treatment is increasingly being incorporated and used by the criminal justice system, employers, and child-protection services to help rehabilitate and provide diversion to substance users who are at risk of going to jail, losing their jobs or their children (Pernanen et al., 2002; Grant, 2005). However, these clients' perspectives have largely been neglected in the evaluation of how required addiction treatment works (Nace, 2007; Nolan, 1998; Wild, 2006; Urbanoski, 2010). Even those studies which deliberately set out to account for experiential aspects of treatment (i.e., client views, interests, opinions, beliefs, values, feelings) are problematic, since the main outcomes of interest have been expressed as objective measures such as recidivism rates, length of stay in treatment and two-week abstinence rates (e.g., Kelly, Finney, & Moos, 2005; Young & Belenko, 2002). This research seeks to understand the views, interests and values of clients required to go to addiction treatment. It attempts to uncover complementary interests and values of clients and the referring institutions that may lead to mutually desired outcomes, and which may seed a more comprehensive and nuanced understanding of how mandates work in addiction treatment. It is my hope that this research will contribute valuable knowledge on how to best help those suffering from substance abuse problems and the agencies and social services dealing with the social consequences of these problems.

**Method:** The research involves 1-2 hour long interview with eligible participants at a location convenient to them. I am currently working with the following Vancouver-based agencies in seeking research participants: Atira Housing; The Circle of Eagles Lodge Society; Westcoast Family Services, Avalon Women's Centres; and Raincity Housing. To date, most participants have been living in the greater Vancouver area. However, in order to strengthen the studies' finding, it is important to hear from a wider range of participants with varying experiences.

If you would like more information please contact me. Thank you for your consideration, your help is greatly appreciated.

## Appendix B: Recruitment Posters



### PAID RESEARCH OPPORTUNITY

## Were You Mandated to Addiction Treatment?



## We would like to hear about your experience!

**Why Participate?** To better understand what mandated treatment was like for you. Participation is confidential.

### What's Involved?

- A 1-2 hour interview, plus a possible follow-up call or meet-up to review this interview.
- Participants are given \$10 for the interview and \$10 for the follow-up conversation.
- Possible areas for discussion include: how you came to treatment; your perspective on treatment before, during and after; and what were the benefits and/or problems of being mandated to addiction treatment. Any experiences or reflections you want to share are welcome!

### Who Participates? People who:

- have been told to go to addictions treatment by, for example, the criminal justice system, child protection services, employment insurance services or their employer in the past 7 years;
- engaged in group or individual counselling as part of treatment'
- are over 18

**If you are interested, please phone [number] or email: [email]**



## PAID RESEARCH OPPORTUNITY

### Were You Told to Go to Addiction Treatment?



### We would like to hear about your experience!

**Why Participate?** To better understand what mandated treatment is like for you. Participation is confidential.

#### **What's Involved?**

- A 1-2 hour interview, plus a possible follow-up conversation to review this interview.
- \$10 for the interview and \$10 for the follow-up conversation.
- Possible areas for discussion include: how you got told to go to treatment; your perspective on treatment before, during and after; the benefits and/or problems of being mandated to addiction treatment. Any experiences or reflections you want to share are welcome!

#### **Who Participates?** People who:

- You were told to go to addictions treatment by the courts, child protection services, or your employer in the past 7 years;
- Engaged in group or individual counselling as part of treatment;
- Are 19 or over

**If you are interested, please phone [number] or email: [email]**

## Appendix C: Letter of Consent



a place of mind

THE UNIVERSITY OF BRITISH COLUMBIA

Faculty of Education

Department of Educational and Counselling  
Psychology, and Special Education  
2125 Main Mall  
Vancouver, BC Canada V6T 1Z4

Phone 604 822 0242

Fax 604 822 3302

### **Mandated Addiction Treatment Informed Consent Form**

#### Purpose

This project seeks to explore the experiences of people who have been mandated to addiction treatment. The purpose of this research project is to develop an explanation of the process of entering, attending and exiting mandated treatment based on client experiences and reports.

This research is being conducted as part of the requirements for Lucy McCullough's doctoral degree in Counselling Psychology at the University of British Columbia. The results of this research will be included in a dissertation that will become a public document in the university library once completed. The results may also be published in appropriate academic and/or professional journals.

#### Procedures

This study will involve an interview and a possible follow-up discussion. The interview will be one to two hours long. Following this, participants will be asked to explain and define from their experience "mandated" treatment. Participants will be asked to describe the nature and circumstances of their mandate and how it affected their decision to enter addiction treatment. Participants will be asked to reflect on what their thoughts, feelings, views and opinions of mandated treatment were before, during and after the experience. Some demographic information will be asked including age, employment and relationship status, and race and ethnicity. The questions are intended as a guide and the interview may cover additional topics at the participant's lead. All questions are optional to answer. The interview will be audio-taped and transcribed and given a code number to ensure your anonymity.

#### Confidentiality

Any and all information that is gathered during the research process will be kept strictly confidential. Any disclosures of child neglect or abuse must be reported. All research documents will be kept in locked filing cabinet and only Dr. Richard Young and Lucy McCullough will have access to the interviews. Participants will not be identified by the use of names or initials, only by a code number assigned to each interview. In addition, all identifying information about a third party will be removed from the transcript. The final report will use pseudonyms and avoid any details or information that could potentially identify an individual.

#### Compensation

Each participant will receive \$10 per interview.

#### Contact for Information about the Study



For any questions about the study's purpose or procedures, please contact Lucy McCullough at [phone] or [email]. You may also contact the Principal Investigator listed below.

Contact for Concerns about the Rights of Research Participants

If you have any concerns about your treatment or rights as a research participant, you may contact the Research Subject Information Line in the UBC Office of Research Services at (604) 822-8598.

Consent

Your participation in the study is entirely voluntary. You may refuse to participate in any section of the study and/or withdraw from the research at any time. Your signature below indicates that you consent to participate in the study. Your signature indicates that you have received a copy of this consent form for your own records.

\_\_\_\_\_  
Participant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of the Participant signing above

*The signature of a witness is **not required** for behavioural research.*

Principal Investigator: Dr. Richard Young, Professor  
Department of Educational & Counselling Psychology, and  
Special Education  
University of British Columbia  
[Phone]  
[Email]

Co-Investigator: Lucy McCullough, M.A., Ph.D. candidate  
Department of Educational & Counselling Psychology, and  
Special Education  
University of British Columbia  
[Phone]  
[Email]

## **Appendix D: Interview Guides**

### ***Initial Interview Guide (October 2012)***

- Can you tell me how you came to be in mandated treatment?
- How many separate times have you sought treatment for addiction-related issues?
- What was the experience of being mandated like for you?
- How do you define mandated? Have you used this wording in referring to or thinking about your experience? If not, what wording have you used? (Note: I will adopt the participant's wording of "mandate" throughout the interview)
- What did you think about, and how did you feel, when you first found out you were being mandated to addiction treatment? What do you think and feel about the mandated experience now?
- Can you tell me how you felt before you went for treatment, knowing that you were expected to go?
- What were your circumstances leading up to the mandate?
- Describe why you believe you were mandated to treatment? How do you define the behaviours that were the target of the mandate?
- Who, or what organizations, were important to this process of mandated addiction treatment? Describe their helpful, or unhelpful, contributions to your experience?
- Does/did the mandate to seek addiction treatment make sense to you? Why or why not?
- How did you deal with the mandate? How did you manage the treatment itself?
- Would you have sought treatment without the mandate? Why or why not?
- What do you see as the benefits of being mandated to addiction treatment? What are the problems of being mandated to treatment?

- How has this experience affected your life now?

### *Demographic Questions*

How old are you?

What is your race and ethnicity?

What is the highest level of education that you have completed?

Are you currently working? How many jobs? How many hours per week?

What is your main source of income?

What is your relationship status?

Single\_\_

Married\_\_

In a relationship, living together\_\_

In a relationship, not living together\_\_

Separated\_\_

Divorced\_\_

\*NOTE: Participant's current demographic information, as well as their information when they were first mandated, will be requested.

***Revision to Initial Interview Guide (Revised November 20 2012)***

**Key:**

**X = removed**

**... = new, expanded, or revised**

**R = remained**

- .... (After reviewing consent form and purpose of the study ask...) Start by telling me your thoughts on the topic and your experience. In thinking about this interview since our phone conversation, what would you like to share about your experience?
- ... Can you tell me how you came to be in treatment? was it required? explain. (Note: I will adopt the participant's wording "mandate" throughout the interview)
- **R:** What was the experience of being mandated like for you?
- ..... How many separate times have you sought treatment for addiction-related issues?  
....When have you gone on your own? When were you required? Who required it?
- **X:** How do you define mandated? Have you used this wording in referring to or thinking about your experience? If not, what wording have you used? (Note: I will adopt the participant's wording "mandate" throughout the interview)
- ... What did you think about, and how did you feel, when you first found out you were being mandated to addiction treatment? What do you think and feel about the mandated experience now? .... Compare your experience of being mandated and going on your own; What was it like when you were going to treatment on your own versus when you were told to go?
- .... Can you tell me how you felt before you went for treatment, knowing that you were expected to go? ....What were thinking and feeling when you first arrived at treatment?  
....What were the first few days like?

- **X** What were your circumstances leading up to the mandate? (note: this generally gets covered by the first questions about experience and circumstance)
- **X** Describe why you believe you were mandated to treatment? How do you define the behaviours that were the target of the mandate?
- .....\* Who, or what organizations, were important to this process of mandated addiction treatment? Describe their helpful, or unhelpful, contributions to your experience? \*this questions will be more targeted in third round of interviews
- ..... Does/did the mandate to seek addiction treatment make sense to you? Why or why not? ..... Did you understand the process? ..... Was someone helping you through it?
- **X** How did you deal with the mandate?
- **R** How did you manage the treatment itself?
- **R\*** (note: this questions also helps to answer the following question about the benefits of being mandated? and how it has affected your life?) Would you have sought treatment without the mandate? Why or why not?
- **R** What do you see as the benefits of being mandated to addiction treatment? What are the problems of being mandated to treatment?
- ..... How has this experience affected your life now? ....what do you think would have happened if you had not been required and gone to treatment?
- here is your timeline. What do you think when you see that? Is there anything missing, or event you could tell me more about?

..... ***Demographic Questions*** (Change to confirm demographics on age, ethnicity, education and employment as they arise. Only ask any outstanding questions at the end)

- How old are you?
- What is your race and ethnicity?
- What is the highest level of education that you have completed?
- Are you currently working? How many jobs? How many hours per week?
- What is your main source of income?

**R:** What is your relationship status? (Note: No need to ask directly, relationship issues are emerging as important personal contextual variable that influence treatment engagement)

Single\_\_

Married\_\_

In a relationship, living together\_\_

In a relationship, not living together\_\_

Separated\_\_

Divorced\_\_

\*NOTE: Participant's current demographic information, as well as their information when they were first mandated, will be requested.

### **For Third Interview Protocol (Revised February 27, 2013)**

#### **Notes:**

- following up on unregulated recovery houses, ask more about what treatment was like, what were the programs/organization of the treatment centre itself. Sample people currently in treatment
- is there one person who stands out as a support or helpful in this experience?
- I have noticed that when I can bring others experiences into the interview, it triggers a memory (e.g. the guard who was kind/helpful)

### *Third Stage Interview Guide*

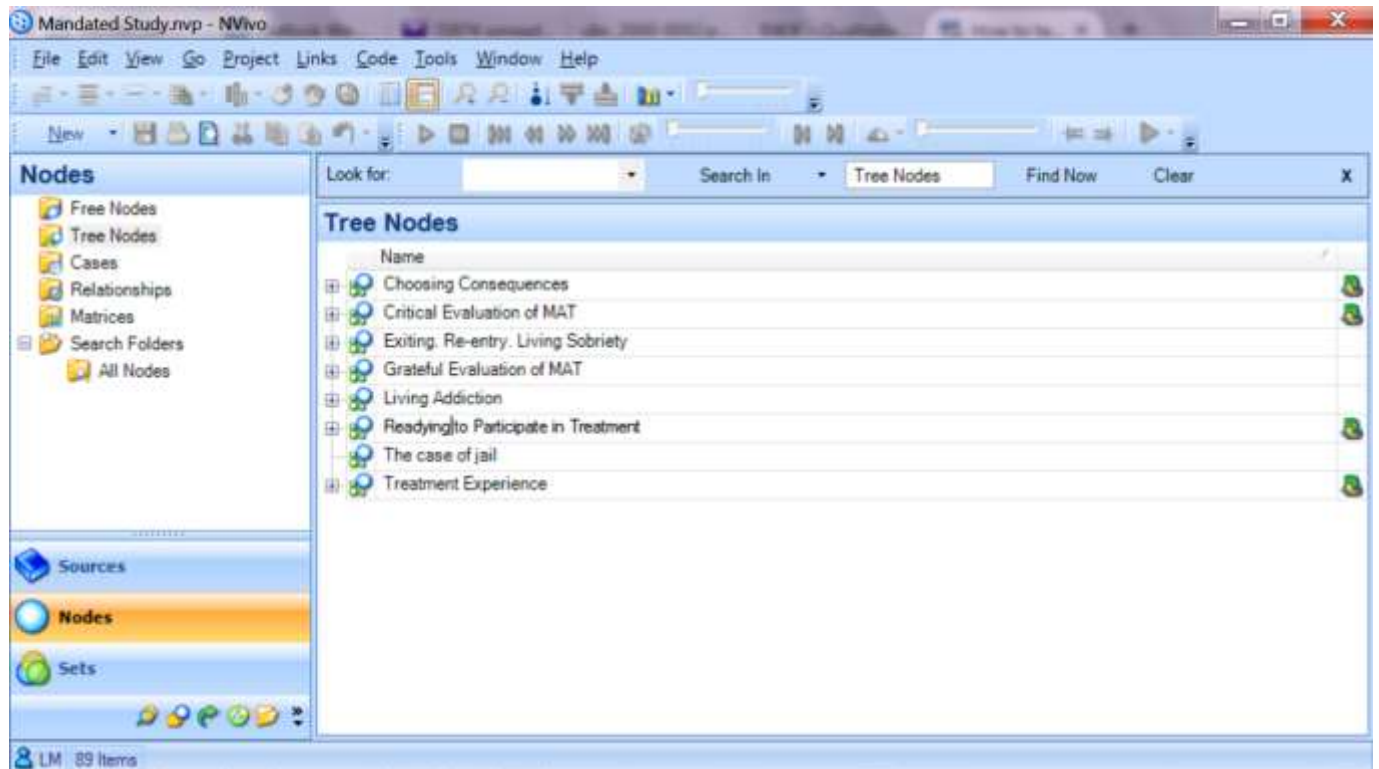
- **R:** Can you tell me how you came to be in mandated treatment?
- **R:** What was the experience of being mandated like for you?
- ..... How many separate times have you sought treatment for addiction-related issues?  
....When have you gone on your own? When were you required? Who required it?
- ... What did you think about, and how did you feel, when you first found out you were being mandated to addiction treatment? What do you think and feel about the mandated experience now? .... Compare your experience of being mandated and going on your own; What was it like when you were going to treatment on your own versus when you were told to go?
- ..... Does/did the mandate to seek addiction treatment make sense to you? Why or why not? ..... Did you understand the process? ..... Was someone helping you through it?
- What was/is treatment like for you?
- .... Can you tell me how you felt before you went for treatment, knowing that you were expected to go? ....What were thinking and feeling when you first arrived at treatment?  
....What were the first few days like?
- What was treatment like, what were the programs/organization of the treatment centre itself? What did you do in treatment? What do you think of that?
- Are there varying qualities of treatment centres and recovery house? Discuss structure, funding, regulations.
- .....Who, or what organizations, were important to this process of mandated addiction treatment? Describe their helpful, or unhelpful, contributions to your experience?

- is there one person who stands out as a support or helpful in this experience?
- **R** What do you see as the benefits of being mandated to addiction treatment? What are the problems of being mandated to treatment?
- Would you have sought treatment without the mandate? Why or why not?
- ..... How has this experience affected your life now (relationship with kid/partner/parents/etc, job, housing, opportunities)?

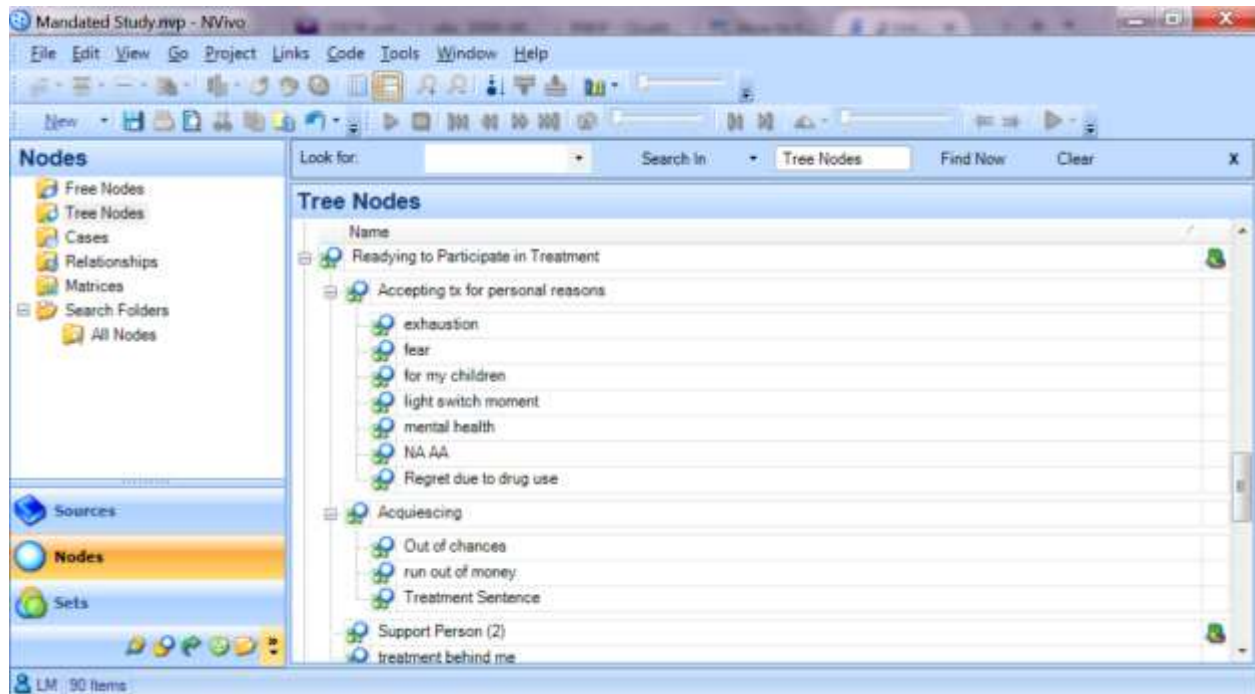


## Appendix E: Nvivo Screenshot of TEMAT Categories and Properties

Below is a screen shot of the major categories listed in NVivo. The plus sign to the left of the category name indicates the multiple concepts and codes contained under each category. NVivo terms superordinate codes, such as categories, “tree nodes,” and singular codes “free nodes.”



Next is a screen shot of the category Ready to Participate in Treatment, expanded to show the concepts and codes that define it.



A defining process, or property, of *how* participants ready to participate was “Accepting Treatment for Personal Reasons” which is shown above. Reasons for accepting treatment included exhaustion and to keep custody of or contact with children, which are embedded in yet another layer of the coding expanded and shown above.

## Appendix F: Memo Excerpts

### Excerpt 2: Ready to participate in treatment (Acquiescing and committing)

In this memo, I am trying to understand how participants prepare themselves for treatment in a mandated context. It became clear they are all readying themselves for attending treatment with varying degrees of commitments, either with less engagement by acquiescing or more engagement by committing to treatment for personal reasons. The following musings are an insight into my analytic efforts towards understanding these routes and process of readying.

*Memo. As I asked the following questions:*

*-Would you have sought treatment without the mandate? Why or why not?*

*-What do you see as the benefits of being mandated to addiction treatment? What are the problems of being mandated to treatment?...*

*The general sentiment was: 'I don't think they should be doing it (MAT), but I wouldn't have gotten better if they hadn't,' or, 'It didn't work for me, but it might work for others.' Almost all participants recognized a social value in MAT, even if it didn't benefit themselves. If it did benefit them, then they noted the mandate as an essential part of their readying for treatment. As Andrew (#31) said: "Sometimes you need to be put into a program to identify for yourself what the problem is." Along these lines, Jade (#4) says: "I think it should be a choice, not something I have to do to get methadone. But then again I would never have seen that counsellor if it was a choice." The experience of MAT and pressure to enter treatment began a process of treatment engagement to varying degrees.*

*Sometimes there was continuous pressure on participants from the referring social institutions to enter treatment, and constant reminders of the serious consequences they face. With the continued pressure to enter treatment, many eventually agreed. This happened in criminal justice and child protection cases in particular. Ongoing pressure may lead to participants acquiescing to treatment attendance, but may not facilitate readiness, autonomy or personal commitment to treatment.*

*There appear to be a number of factors influencing the processes of Ready to participate in treatment and Treatment Experiencing. For example, the code "repetitive," representing multiple MAT experiences, seems to have inhibitory and facilitative effects on readying and engaging. On the one hand, they feel they are not getting anything out of treatment anymore, and on the other, previous programs lay the groundwork, or plant the seed, for later recovery. Derek noted that while he was not interested in treatment when he was mandated by CSC, it did get him "familiar" with treatment and lay the ground work for future successful treatment. Other influences include religious beliefs (e.g. more receptive to AA model).*

### Excerpt 3. MAT in Custody

In the memo below I am working through contradictions and drawing out dimensions of the concept of choice in MAT. The experience of MAT in custody, which eventually became its own property entitled "forced choice in custody," helped to flesh out the dimension of pressure in choosing MAT. Experiences of MAT in custody exemplify the most extreme forms of pressure some clients faced in entering MAT.

*Memo: The category "choosing treatment" is challenged by the experience of MAT in custody. While choice is largely defined as an ultimatum in all cases of MAT, choice is even more limited in the case of custody, and participants are even more likely to attribute that ultimatum to the mandating institution – criminal justice system. For these participants, treatment only becomes an option after incarceration, so they are already in a state of punishment at the time of the MAT ultimatum. At which point, the pressure to participate in treatment while in custody can be ongoing, and ultimatums increasing in severity.*

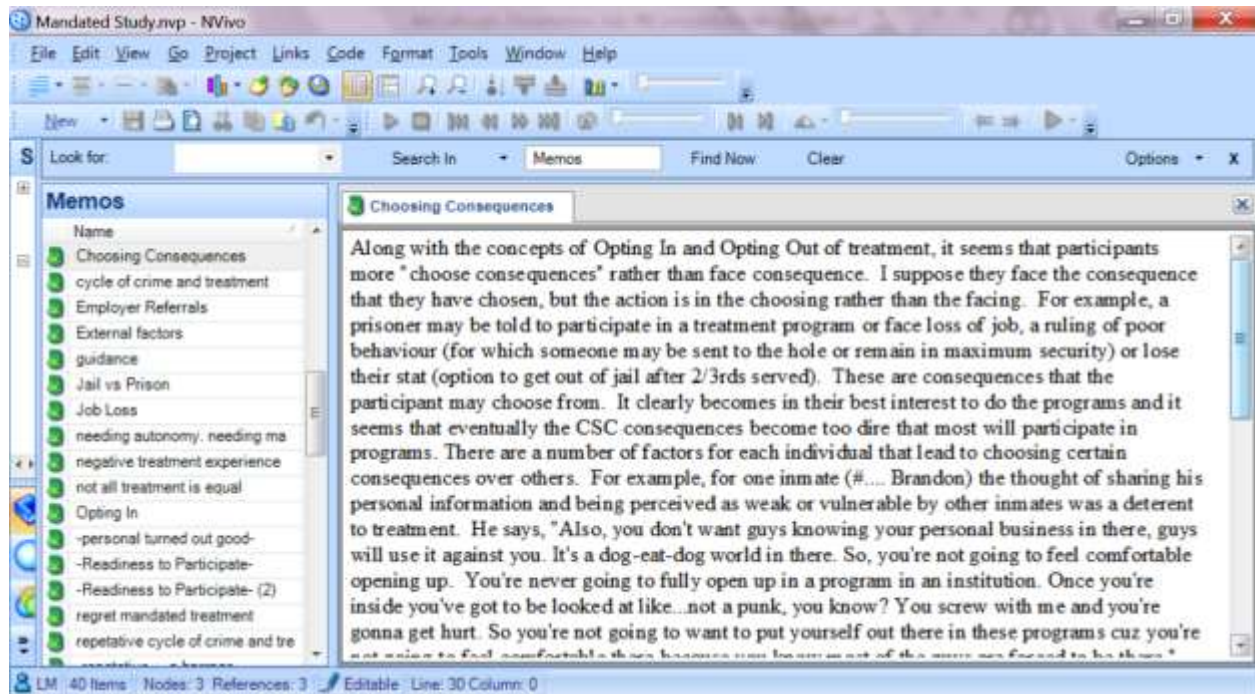
*There were incentives outlined by the participants' institutional probation officers (IPO) to participate in treatment programs inside, such as getting early parole or probation, or moving to a more relaxed facility; but there were also punishments for refusing treatment, such as being placed in solitary confinement or losing their statutory release date. As Len (#33) and I exchanged: "LM: were you in agreement to go to OSAPP (prison treatment program) at the time?"*

*Ben: No, you don't have to be in agreement to anything. It's what they think is what you do." There is no opting in, there is just you do it or you get punished.*

*This information was largely detailed by the 5 interviews conducted in March, 2013, with the parolees at the halfway house in Victoria, BC. These descriptions highlight the dimension of pressure in MAT, with examples of the most pressurized MAT scenarios.*

## Appendix G: NVivo Screenshot of Memos

Example: Memo for the category Choosing Consequences (later relabelled Choosing Treatment)



Above is an expansion of the memo entitled Choosing Consequences stored in NVivo. The reader can see a portion of the list of all the memos on the left side column, tagged with green notebook symbols.