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## The Addiction Treatment Experience of Legally Mandated Opioid Users

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The Addiction Treatment Experience of Legally Mandated Opioid Users

A DISSERTATION

Submitted to the Faculty of  
Montclair State University in partial fulfillment  
of the requirements  
for the degree of Doctor of Philosophy

by

Kaitlin E. Deitz

Montclair State University

Upper Montclair, NJ

2023

Dissertation Chair: Dr. Dana Levitt

ADDICTION TREATMENT LEGALLY MANDATED

MONTCLAIR STATE UNIVERSITY

THE GRADUATE SCHOOL

DISSERTATION APPROVAL

We hereby approve the Dissertation

**The Addiction Treatment Experience of Legally Mandated Opioid Users**

of

Kaitlin E. Deitz

Candidate for the Degree:

Doctor of Philosophy

Graduate Program:

**Counseling**

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## ACKNOWLEDGMENTS

I would like to dedicate this dissertation to my late uncle, Raymond Pettus. He was one of my biggest fans, and I his. He had so much pride in me for pursuing a PhD and continued showing me his support until his final days. *I made it, Uncle Ray.*

I would like to express deep gratitude to my dissertation committee for their encouragement, feedback, and support throughout this dissertation process. I am deeply indebted to my dissertation chair, Dr. Dana Levitt, who continued to guide me toward success even during challenging times. I also owe many thanks to my colleagues for providing me with guidance and encouragement when I needed it most.

This endeavor would not have been possible without the hundreds, if not thousands, of clients whose lives have touched me throughout my career as an addiction counselor. Their lives, experiences, and deaths have had a resounding impact on my life's work and I never would have embarked on this doctoral journey had it not been for them. I hope this dissertation is a starting off point for effecting change for clients in the future.

My biggest thanks is to my family for their ongoing, enduring, unfailing support throughout my entire doctoral program, especially my dissertation. There were many times that my instincts told me to quit, but my family continued to insist that I had what it took to make it to the end. My mother, whose critiques, support, and unwavering devotion to ensuring that I graduated made this entire process possible. I would like to thank my fiancé for being a rock for me during this challenging, yet rewarding time.

## ABSTRACT

## The Addiction Treatment Experience of Legally Mandated Opioid Users

By Kaitlin E. Deitz

Clients who are legally mandated to addiction treatment for an opioid use disorder have high rates of treatment dropout, relapse, and recidivism. To gain a better understanding of the impact of treatment interventions on those measures, the author conducted a study to learn about the mandated treatment experience for opioid users from the clients' perspectives using qualitative interviews. The first theme derived from the data was The Mandated Counselor-Client Relationship with subthemes of Cookie Cutter Counselor, Feeling Commodified, and Collusion. The second theme derived from the data was Necessary Conditions with subthemes of Feeling Cared for and Trust. The findings of this study revealed that there are significant problems with current addiction treatment practices and highlighted what the participants found to be the most beneficial aspects of treatment. Implications for counselors and counselor educators are presented along with suggestions for future research.

*Keywords:* mandated, addiction treatment, counseling relationship

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## CHAPTER 1: INTRODUCTION

*I am writing this introduction with a fresh wound – a wound that I have tried to heal over the course of my career, but it keeps reopening. I have lost count at this point, but another client has died from an overdose. Another child no longer has a father. Another mother will be burying her child. Another group of friends are traumatized at the sight of their friend, cold and blue, with a needle in his arm. There will be lasting effects from his death. His death, which was preventable, will leave its mark on those close to him.*

*The opioid-using population is experiencing an epidemic, but I have heard it referred to as a pandemic because people believe that it will not resolve itself. Rather, more and more people will just have to die and that is a fact we need to accept. The individuals suffering in their addiction are not faceless names. They are human beings with lives and families and obligations and potential for greatness. They are individuals in need of treatment. Over and over again, if necessary. Addiction counseling professionals have a tough, taxing job working with this population for many reasons. The work is not done alone. There are individuals who are mandated to treatment through various referral sources, many of whom require treatment completion and maintained abstinence for diversion from incarceration, reunification with children, return to work, and restoration of licenses. The clients have something hanging over their heads in treatment and they feel it. They have an uncertainty about how honest they are allowed to be without receiving some type of discipline or consequence. They are adjusting from a life with one goal and no accountability to a life with a lot of structure, rules, consequences, and feelings. I can recall dozens, if not hundreds, of instances where clients share about the perception that their counselors are there for a paycheck and do not care about them.*

*There is a very real disconnect between the true nature of our helping profession and how it is being perceived by clients. How many rules are too many rules? At what point are we allowing for growth or enabling clients? Where do areas of gray become black and white? How is the power differential in this counseling relationship monitored to ensure clients are helped and not harmed? There are many questions about work with the opioid using population that deserve exploration because I know that these individuals deserve better. They deserve the instillation of hope, not the instillation of fear.*

### **Introduction**

Opioid use and associated deaths have reached epidemic proportions and are considered a public health crisis (National Institute on Drug Abuse [NIDA], 2019). According to the Treatment Episode Data Set (TEDS), in 2019, heroin was the primary substance for 666,000 people who sought addiction treatment and pain relievers were the primary substance for 721,000 people who sought addiction treatment (SAMHSA, 2020). While much attention has been paid to the causes of the opioid epidemic, there is an even greater issue burdening the country: addressing the addiction itself. Nationwide efforts have been instituted to try to curb this epidemic with massive monetary commitments aimed at treatment. The effectiveness of treatment, however, may be undermined by the real or perceived negative relationship between the client and counselor, especially in the legally mandated treatment population.

### **Background of the Problem**

The National Institute on Drug Abuse (NIDA) reported that opioid overdose deaths have increased eightfold since 1999 (NIDA, 2022). Aside from the potential death risk associated with substance use, there are a number of other factors associated with continued use of opioids: increased crime rate, higher medical costs, negative impact on trust and safety in society, and

family and social relationship issues (Hanson et al., 2015). Studies have shown that the longer a client is retained in substance use treatment, the more likely the client is to remain abstinent after completing treatment (Proctor & Herschman, 2014) and to improve their employment status, social and familial relationships, and mental health functioning (NIDA, 2019). Despite the literature showing positive results of addiction treatment, very few clients who need treatment receive it and, further, only about half of clients who enroll in treatment complete it (Brorson et al., 2013; TEDS, 2017). Two primary reasons for an incomplete treatment episode are clients dropping out and administrative discharge (Brorson et al., 2013; Walton, 2018; White, 2005). We need to first understand how treatment is delivered to clients to better understand the reasons clients drop out of or leave treatment prematurely.

Addiction treatment today occurs in different levels of care ranging from medically managed intensive inpatient services to low intensity outpatient treatment services (American Society of Addiction Medicine [ASAM], 2015a). Individuals seeking treatment are referred to an appropriate level of care following an assessment that evaluates the person on six dimensions: (1) acute intoxication and/or withdrawal potential, (2) biomedical conditions and complications, (3) emotional, behavioral, or cognitive conditions and complications, (4) readiness to change, (5) relapse, continued use or continued problem potential, and (6) recovery/living environment (ASAM, 2015b).

Clients may interact with professionals from various educational backgrounds when entering addiction treatment, including counseling, marriage and family therapy, social work, psychology, or pastoral care (Miller et al., 2019). Further, paraprofessionals make up a significant portion of addiction treatment providers in the United States (Miller et al., 2019). Paraprofessionals are individuals in recovery who may receive a certificate to work in the

profession as opposed to earning a graduate degree like the aforementioned professionals (West & Hamm, 2012). Steinfeldt et al. (2020) found that approximately 48% of addiction counselors in the United States are in recovery and that 47 of the agencies that participated in their study required a high school diploma or less to employ an addiction counselor. The background and training of the professional or paraprofessional may suggest variation in the nature of the therapeutic relationship, which may be significant in considering treatment efficacy for the client.

### **Addiction Treatment Overview**

Historical hindsight enables current addiction counselors, both professionals and paraprofessionals, to reflect on the development of their profession noting the progress that has been made to change treatment practices (White et al., 2005). While addiction treatment was riddled with blatantly unethical practices through the 1970s, there are still norms of addiction treatment that may be reflected upon in future years in the same way we view practices of our predecessors. For example, the use of confrontation tactics that included shame and humiliation were prevalent treatment interventions for decades, but have reduced in frequency and intensity (White & Miller, 2007). I will discuss the history of addiction treatment and ethically questionable approaches therein in greater detail in chapter 2 of this proposal.

Current deleterious treatment practices in the United States employ the use of administrative discharges (AD), releasing a client from treatment before they have successfully completed, as a means of promoting behavioral change when a client is noncompliant (Walton, 2018). White et al. (2005) learned that approximately 18% of clients are administratively discharged from treatment, while only 49% complete treatment successfully. AD can be used as a tool to address behavioral problems, ongoing substance use, or failure to comply with program

rules, but may have significant unintended consequences for the client, including incarceration or prolonged substance use (White et al., 2005). Addiction treatment programs could benefit from reviewing rules and policies of their facilities to deter AD from being regularly used and, instead, implement different treatment interventions to appropriately address problematic behaviors (White et al., 2005). The use of AD for minor issues in treatment could violate ethical codes of addiction treatment professionals (Walton, 2018).

The role of the counselor in the treatment process, without taking into account theoretical orientation or specific interventions used, has been established as having a significant impact on treatment engagement and retention (Martin et al., 2000; Miller et al., 2019). A critical aspect of the counseling relationship lies in the power imbalance between the counselor and client in all counseling settings (DeVaris, 1994). Power can be loosely defined as the ability to directly/overtly or indirectly/covertly influence another person, knowingly or unknowingly, to produce a desired behavior or thought (DeVaris, 1994). Theoretical perspectives, stereotyping, and countertransference can pose risks to the client as a function of the inherent power differential in counseling relationships (DeVaris, 1994). For example, a counselor who stereotypes a client may fail to fully evaluate, assess, and treat a client appropriately while holding their stereotype to be true, which could have a profound negative impact on the treatment experienced by the client, all while the client believes what the counselor says is true due to the power imbalance in the relationship. Counselors need to be reflective and actively aware of the power dynamics that exist within the counseling relationship to ameliorate the potential negative impact they can have on the therapeutic process (DeVaris, 1994).

### **Legally Mandated Treatment**

Addiction counselors differ from counselors who work with the general population in that many of them have a dual role, counselor and legal surveillance (Skeem et al., 2007), due in part to the high rate of clients who are legally mandated to treatment through parole, probation, intoxicated-driver legal entities, and family-related courts. “When treatment is mandated, true collaboration and partnership may be lacking. The provider’s control over the patient seems to render alliance lopsided” (Skeem et al., 2007, p. 298). The therapeutic alliance is an essential component of the treatment process and can be compromised when counselors act as gatekeepers of information that can control a client’s freedom from incarceration (SAMHSA, 2014).

Clients may be legally mandated to treatment by county jails, state prisons, probation, parole, or drug courts (Brinkley-Rubinstein et al., 2018). Available statistics show that the opioid-using population in the United States in 2019 was 67% White, 16% Hispanic/Latinx, 10% Black, and 7% other (SAMHSA, 2021). Despite rates of opioid use reflecting the diversity of the population in this country, federal prison inmates who are drug offenders are 58.7% White (including 33.4% Hispanic/Latinx), 37.7% Black, and 3.7% other (Wallace, 2019). In 2019, 96,000 people on probation/parole reported use of heroin in the past month and 269,000 reported illicit use of pain relievers in the past month (SAMHSA, 2021), but available data does not indicate how many of those individuals received treatment for their substance use. Maintained abstinence from mood altering substances and successful completion of treatment are contingencies for adjudication of legal problems. In a relationship where power is unbalanced at the onset (DeVaris, 1994), the added element of legal involvement further tips the scale to add to a counselor’s power (Skeem et al., 2007).

Vairo (2010) conducted an empirical study with 779 social workers to learn about their attitudes toward legally mandated clients using a series of vignettes. Vairo found that social workers have a negative perception of legally mandated clients when compared to their voluntary counterparts. Clinicians were less optimistic about legally mandated clients' recovery success, which may have a negative impact on the treatment services provided to the clients (Vairo, 2010). Vairo was able to gather information regarding subconscious views of counselors about their clients, highlighting countertransference about the legally mandated population. Unaddressed countertransference can lead to counselors exerting power or dominance over clients and, ultimately, can lead to disempowerment of the clients (DeVaris, 1994). The impact of a counselor's pessimism on a client's potential for sustained change deserves further exploration.

### **Problem Statement**

Clients seeking treatment deserve the same quality of treatment, whether they seek that treatment voluntarily or through a legal mandate. Clients are expected to receive ethically sound, multiculturally competent individualized treatment interventions by counselors who also act as advocates for their clients. Individuals seeking substance use treatment have multifaceted needs in pursuing recovery beyond simply addressing the impact of the substance on their physical and psychological health. "Although the inherent complexity of addiction is not necessarily new, our understanding of the degree of its complexity is a much more recent development" (Duryea & Calleja, 2013, p. 256-257). Clients who are legally mandated to treatment have more complex relationships with their counselors as their counselors may simultaneously act as legal surveillance and helping professionals (Skeem et al., 2007). High rates of treatment dropout with this population suggest that legally mandated clients are not being well-served (Ball et al., 2006;

Brorson et al., 2013), which has received little attention in research. Outcomes for efficacy of addiction treatment generally measure recidivism, maintained abstinence, and treatment completion rates, yet little is known about the impact of treatment interventions on these measures. To best improve addiction treatment, we need to learn more about the treatment experience from the clients' perspectives. Therefore, the research question guiding this study is:

How do legally mandated opioid users describe their treatment experience?

### **Significance of the Study**

The addiction population has felt silenced for years because speaking out about their treatment requires them to publicize their addiction (White, 2014). Further limiting their ability to advocate for themselves is their legal mandate to successfully complete addiction treatment. Previous research has not sufficiently addressed the treatment experience to more intimately learn about elements of treatment that retain clients and, also, elements of treatment that drive clients to leave. The opioid using population is experiencing a crisis (NIDA, 2019) and treatment facilities across the country need to employ ethically sound, multiculturally competent interventions to address the entire person while responding to each client as an individual. A meaningful and accurate way to learn about the treatment is to inquire within the population receiving it. We need to explore how a legal mandate impacts clients' treatment experiences and what influences positive and negative treatment experiences. Clients may present as resistant to the treatment process if they do not feel that their treatment is individualized and aligned with their values (Scott, 2000). The current study sought to empower opioid users who have been legally mandated to addiction treatment by providing them the opportunity to openly share about their varied experiences in treatment and what contributed to their successful completion, dropout, and relationships with counselors and other staff.



### **Methodology**

I employed qualitative interviews guided by phenomenology for this research study. Qualitative research aims to gain a deeper understanding of the subject being studied (Merriam & Tisdell, 2016). The population I studied is individuals with opioid use disorders who have been legally mandated to addiction treatment. I excluded from the research individuals who are actively using drugs due to their impaired ability to provide consent (Anderson & McNair, 2018). In chapter 3 of this dissertation, I will further discuss participant recruitment, data collection, and data analysis for the study.

### **Conceptual Framework**

I used critical theory as a theoretical lens to frame this study. The purpose of critical research is to challenge and analyze power dynamics with the goal of empowering those who are oppressed or marginalized (Merriam & Tisdell, 2016). I have established that multiple factors contribute to power imbalances in the addiction treatment of legally mandated clients (DeVaris, 1994). At times, the power can be used appropriately and, at other times, it can harm the client. It is my assertion that legally mandated opioid users in substance use treatment experience oppression as their voices may be silenced or disregarded by those who hold the power around them. Critical theory guided this research and appropriately framed the way that I approached data collection and data analysis. Questions were asked in such a way that power relations in addiction treatment were explored (Merriam & Tisdell, 2016) and empowerment of the clients were a focus of the results. The purpose of critical research is to establish “what is” so that possibilities of “what could be” can be explored (Morrow & Brown, 1994). This study delved into aspects of legally mandated addiction treatment that are not present in current literature, but have a significant impact on the treatment experience. The goal of this research was to learn

about the treatment experience of the legally mandated opioid users with the purpose of empowering them and, ultimately, implementing change in treatment programs based on what was learned through qualitative interviews. I will further discuss the elements of critical theory in chapter 2, and in chapter 5 discuss how critical theory was used to interpret the results of the study.

### **Positionality**

As a counselor who has been working with legally mandated opioid users for over nine years, I have had many experiences with the population of this study. I have seen the difference in treatment for people with legal mandates and for those without. I have heard the helplessness that clients experience when debating about whether or not they can advocate for themselves for better treatment. There have been times when clients would articulate their experience of having a counselor who “finally cares.” This research was borne from my experience in the field as a practicing addiction counselor. I have observed clinical practices that do not align with ethical principles of the counseling profession. For this study to be effective and rigorous, it was imperative that I verbalized personal experiences and biases in order to remove them from influencing data collection and analysis. Through journaling, discussing results with critical friends, and data analysis, I was able to manage biases to prevent them from influencing the results of this study.

### **Chapter Summary**

Opioid use in the United States has reached epidemic proportions and continues to prove problematic for substance users and society at large. Treatment interventions have been shown to be effective in reducing recidivism and reducing relapse. Despite the positive aspects of treatment, many drop out or are administratively discharged from programs. The client-counselor

relationship may have a greater impact on treatment outcomes than is currently understood. A large number of individuals who seek addiction treatment do so under legal mandate and are faced with significant negative consequences for failure to complete or comply with treatment, which complicates the treatment process and therapeutic relationship. As a practicing addiction counselor, I have firsthand knowledge about the role and experience of being the counselor for legally-mandated opioid users, but research is limited in accessing knowledge about the clients' experiences in addiction treatment when legally mandated. What makes incarceration more feasible than treatment? To what degree are the clients honest, allowing for a meaningful treatment experience? What makes treatment "good?" Qualitative research methodology is a meaningful approach to learn about the treatment experience of legally mandated opioid users, as I will discuss in the remainder of this dissertation.

### **Definition of Terms**

Addiction - “Drug craving accompanied by physical dependence that motivates continuing use, resulting in tolerance to the drug’s effects and a syndrome of identifiable symptoms” (SAMHSA, 2014, p. 291)

Assessment - “Evaluation or appraisal of a candidate’s suitability for substance [use] treatment and placement in a specific treatment modality/setting. This evaluation includes information on current and past [use] of drugs; justice system involvement; medical, familial, social, educational, military, employment, and treatment histories; and risk for infectious diseases” (SAMHSA, 2014, p. 292)

Coercion - “The use of incentives and sanctions to encourage participation in substance [use] treatment” (SAMHSA, 2014, p. 293)

Court-mandated treatment (Legally-mandated treatment) - “A court order to participate in treatment as part of a sentence or in lieu of some aspect of the judicial system” (SAMHSA, 2014, p. 294)

Drug courts - “Specialized courts commonly designed to handle only felony drug cases, usually involving adult nonviolent offenders. Drug courts can involve intensive monitoring, drug testing, outpatient treatment, and support services. They often operate with probation supervision and services” (SAMHSA, 2014, p. 294-295)

Parole - “The conditional release of an inmate from prison under supervision after part of a sentence has been served. The inmate is subject to specific terms and conditions which are monitored by an officer/agent” (SAMHSA, 2014, p. 297).

Pharmacotherapies - “Treatment of a disease with drugs. In substance [use] treatment, these include methadone, naltrexone, and buprenorphine” (SAMHSA, 2014, p. 297)

Probation - “A sentence in which the offender is allowed to remain in the community in lieu of incarceration. The individual is supervised and is ordered to comply with specific terms and conditions” (SAMHSA, 2014, p. 298)

Recidivism - “The commission of crime after an offender has been sentenced and/or released” (SAMHSA, 2014, p. 298)

Sanctions - “Legally binding orders of a court or paroling authority that deprive or restrict offender liberty or property” (SAMHSA, 2014, p. 299)

Treatment - “Refers to the broad range of primary and supportive services - including identification, brief intervention, assessment, diagnosis, counseling, medical services, psychological services, and follow up- provided for people with alcohol and illicit drug problems. The overall goal of treatment is to eliminate the use of alcohol and illicit drugs as a contributing factor to physical, psychological, and social dysfunction and to arrest, retard, or reverse progress of associated problems” (SAMHSA, 2014, p. 301)

Treatment matching - “Pairing clients with treatment and services that reflect their particular traits and needs in order to enhance the potential for better outcomes” (SAMHSA, 2014, p. 301)

## CHAPTER 2: REVIEW OF LITERATURE

The purpose of this literature review is to provide an understanding of existing knowledge related to the treatment experience for legally mandated opioid users in addiction treatment. The chapter will focus on individuals with substance use disorders and, particularly, opioid use disorders. The concept of legally mandated treatment will be explored and treatment implications will be discussed. Specific attention is paid to the dynamics in the counseling relationship and implications of the counseling relationship on treatment retention and completion rates. There is limited research available that addresses treatment interventions or implications with the legally mandated population; Wahesh et al. (2017) found that, from 2005-2014, 4.5% of articles published in counseling journals addressed addiction and were largely about nonclinical populations. Trends in opioid use and population demographics will be explored.

A history of addiction treatment in the United States is presented with ethical implications related to treatment interventions for a broad understanding of the problems experienced by legally mandated opioid users. Following the history, current treatment practices in addiction treatment will be broadly discussed and then applied specifically to the criminal justice population. The use of pharmacotherapies in the treatment of opioid use disorders is addressed and applied to the population of this study. Finally, the theoretical framework of this study will be introduced.

### **Legally Mandated Treatment**

To begin a discussion regarding legally mandated treatment, it is important to distinguish between mandated treatment and coerced treatment (Hachtel et al., 2019; Werb et al., 2016). Individuals are mandated to treatment by a judge following interactions with the criminal justice

system or penal courts as a stipulation of an agreed upon sentence and may be overseen by a probation officer, case worker, or parole officer (Hachtel et al., 2019). Werb et al. (2016) found that the terms coerced and mandated were used interchangeably in past research, but do not have the same meaning. Coercion refers to the perception that a person is forced to participate in treatment, whereas mandates result from courts recommending treatment and allow for choice or negotiation, however limited (Hachtel et al., 2019; Werb et al., 2016). While some legally mandated clients may feel coerced to go to treatment, the two terms do not always intersect. Coercion can be perceived by clients who voluntarily seek treatment due to pressure from family or employers (Hachtel et al., 2019; Urbanoski, 2010), however those clients are not mandated to treatment. Coercion is a feeling while a mandate is a legal sentence.

Urbanoski (2010) conducted a literature review of existing theoretical and empirical research regarding coercive treatment experiences and synthesized the data. A criticism of existing research showed that many studies measure treatment success in terms of treatment retention, which is inherently flawed because that research assumes “that treatment is both effective and that more is better than less” (Urbanoski, 2010, p. 5). Conversely, treatment completion or retention rates fail to account for cognitive engagement in the treatment process (Urbanoski, 2010), leaving a resounding gap in literature that requires a deeper, rather than broader, understanding of the treatment experience. One cannot assume that treatment attendance equates to active participation in the recovery process and that deserves further research. Also, for those who are more invested in their addiction, recovery may not come as easily (Urbanoski, 2010), necessitating varied treatment interventions. Abstinence-based programs that promote sanctions following a relapse may be too punitive, resulting in unnecessary consequences for clients (Urbanoski, 2010), which calls into question the cause for a helping professional to

implement consequences on a client. Finally, future research needs to address if the benefits outweigh the risks when infringing on a person's autonomy to seek treatment in the first place (Urbanoski, 2010).

The efficacy of mandated versus voluntary treatment is a consistent topic of debate. Treatment efficacy and treatment completion are not the same. Clients may complete treatment (achieve mutually agreed upon goals of treatment as established by the client and counselor), but interventions from treatment may not have long-lasting effects. Efficacy of treatment is generally measured by post-treatment substance use and recidivism rates (Werb et al., 2016). Werb et al. (2016) concluded, from systematic review of nine studies regarding compulsory treatment outcomes, that there was no difference in efficacy (abstinence and recidivism) in mandated versus voluntary clients in inpatient, outpatient, and prison-based treatment programs. However, Werb did find that there was potential for human rights abuses that could occur within the mandated treatment environment, showing a gap in existing literature about mandated addiction treatment.

In a quantitative study regarding treatment completion of mandated clients, Coviello et al. (2013) surveyed 160 individuals mandated to addiction treatment and found that mandated clients were less motivated at admission than voluntary clients, but had higher rates of completion and were ten times more likely to complete treatment (Coviello et al., 2013). Coviello et al.'s results aligned with Urbanoski's (2010) critical inquiry of coerced treatment in finding that legal pressure promotes longer retention in treatment. However, these findings give pause to researchers and practitioners seeking information about these populations as Werb et al. (2016) found that treatment efficacy has no difference on outcomes of mandated versus voluntary clients. The results of the above studies show that legally mandated clients



complete treatment at greater rates, but that does not ultimately result in greater rates of abstinence and reduced recidivism. Research needs to be conducted that explores mandated treatment practices to better explain why people who complete treatment do not necessarily remain abstinent and avoid legal issues.

Hachtel et al. (2019) provided a narrative review of literature regarding the impact of mandated treatment on the therapeutic process and outcomes. In this review, Hachtel et al. emphasized the importance of the therapeutic relationship in working with mandated clients. The literature review indicated that better rated therapeutic relationships were associated with better treatment compliance, reduction of symptoms, outcomes, quality of life, client satisfaction, personal trust, recidivism, reduced dropout rates, and reduced readmissions (Hachtel et al., 2019). Most favorable treatment ratings resulted from clients experiencing a powerful attachment in the therapeutic relationship as well as compassion, warmth, and intimacy (Hachtel et al., 2019). Some clients in mandated treatment feel stigmatized or dehumanized, which leads to lower treatment satisfaction (Hachtel et al., 2019). Authoritative and caring treatment styles result in motivation, outcomes, and alliance (Hachtel et al., 2019).

In a summary of the research by Skeem et al. (2007), Hachtel et al. (2019) noted that legally mandated clients prefer when counselors are “firm, but fair” and display care with an authoritative style. Hachtel et al. recommended that counselors work to limit the clients’ perceptions that they are coerced to treatment by reducing punitive measures in treatment and focusing on therapy rather than compliance based on the results of their study. Counselors have the ability to control, restrict, or influence behaviors of clients (Williams & O’Connor, 2019), which can negatively affect the treatment process.

While there is a distinction between mandates and coercion, the two do overlap and counselors can have an influence on the clients' perception of coercion throughout their course of treatment. Clients who feel coerced do not necessarily have a negative therapeutic relationship, but if they have a history of coercive experiences in treatment, they are more likely to feel devalued and discriminated against in treatment (Hachtel et al., 2019). Note that not all mandated treatment occurs with the addiction population. Mandated treatment expands to those with violent charges, sexual offenses, criminal issues, and mental health problems (Hachtel et al., 2019). The research in this area is inconsistent at best and requires further exploration to provide a deeper look at those treatment experiences.

### **Ethics in Addiction Counseling of Legally Mandated Clients**

The counseling profession is governed by six principle ethics that are designed to inform ethical decision making and behavior: autonomy, nonmaleficence, beneficence, justice, fidelity, and veracity (ACA, 2014). Each of these principles are intended to guide counselors to act within an ethical domain in treating their clients. In this section, I will explore how each of these ethical principles can be called into question with legally mandated opioid users in addiction treatment.

Autonomy is “fostering the right to control the direction of one’s life” (ACA, 2014, p. 3). Seeking addiction treatment for many is considered a voluntary decision to make changes to pursue recovery efforts, but for those who are legally mandated, the decision comes with heavily weighted consequences. An individual can be offered the option to seek treatment in lieu of jail or prison sentences. While this is a choice, for many it is an impossible choice. Once an individual enters the addiction treatment process, their enrollment is determined by a licensed or credentialed addiction treatment professional who determines the appropriate level of care for the person seeking treatment. While an individual may be prepared to enter Intensive Outpatient

treatment, a counselor may recommend that person to attend Long Term residential treatment for upwards of six months. The principle ethic of autonomy is brought into question as the person seeking treatment is not fully involved in the process of negotiating the treatment they will receive.

Nonmaleficence is “avoiding actions that cause harm” (ACA, 2014, p. 3). While counselors are helping professionals, it has been established that their role with legally mandated clients includes an extra layer of control or surveillance that is given by the criminal justice system. Treatment rule non-compliance resulting in administrative discharge from treatment is cited as an ethical issue in addiction treatment that, today, is commonplace. Administrative discharge can lead to client harm by leaving a client without treatment and possibly resulting in incarceration that can have long-lasting negative effects (White et al., 2005). Imagine administratively discharging vulnerable clients from residential treatment for, for instance, hoarding food in their bedroom. Upon leaving the building, the client relapses and overdoses. Were there more available treatment interventions to aid the client in the residential facility that did not require an administrative discharge?

Beneficence is “working for the good of the individual and society by promoting mental health and well-being” (ACA, 2014, p. 3). Reimbursable, evidence-based treatments within addiction treatment programs are vast. There are many addiction-related treatment interventions (e.g., relapse prevention, coping skills) that are infused into treatment programs in addition to trauma-informed interventions that may be delivered by paraprofessionals who lack appropriate training and education to deliver those treatment interventions. Simons et al. (2017) studied certified and licensed addiction counselors in Pennsylvania and found that paraprofessionals (those who are certified, but not licensed) are less comfortable treating individuals with

personality disorders, thought disorders, suicidal ideation, depression, and anxiety. While intentions may be good, we cannot say that we are doing good by failing to prevent harm.

Justice is “treating individuals equitably and fostering fairness and equality” (ACA, 2014, p. 3). Many treatment facilities integrate voluntary and mandated clients into the same programs. To determine justice in clinical practice would be to consider if both populations are treated the same. For example, research can explore what leads to administrative discharge for mandated clients versus those who are voluntary. Furthering a discussion regarding justice in addiction treatment, research can explore whether treatment interventions used with both populations are the same and care is taken to ensure equivalent time spent with clients in both settings.

Fidelity is “honoring commitments and keeping promises, including fulfilling one’s responsibilities of trust in professional relationships” (ACA, 2014, p. 3). Fostering trust can be a difficult task in working with legally mandated clients, considering their treatment progress and drug screen results are shared openly and frequently with referral sources (parole, probation, Drug Court). Developing trust requires some level of transparency, but research has little to no information regarding the experience of establishing trust with legally mandated clients.

Veracity is “dealing truthfully with individuals with whom counselors come into professional contact” (ACA, 2014, p. 3). Ideally, all helping professionals working with legally mandated clients would be honest with their clients. Yet, research has shown that counselors possess intervention stigma that may prevent them from providing all resources and treatment interventions available to opioid users. Further, communication that occurs between counselors and referral sources needs to be honest and based on objective information obtained in the treatment process. Do legally mandated clients question the truthfulness of information relayed

between their counselor and legal mandate? Do counselors reflect information they obtained honestly with their clients?

Each of the principles of the counseling profession provide an overarching idea of how to act ethically within the scope of the profession, and there are examples of how ethical principles could be violated in working with legally mandated opioid users. The ethical implementation of treatment interventions and other aspects of the role of counselor are critical in the treatment experience of their clients and lacks the critical lens of research from the perspective of clients.

### **Population Demographics**

Counselors cannot be blind to cultural groups whose substance use is more publicized, arrests occur more often, and who lack access to treatment services (Capuzzi & Stauffer, 2012). Across the United States, Cummings et al. (2014) found that counties that were more rural, had higher percentages of racial/ethnic minorities, and had more people uninsured were less likely to have access to substance use disorder treatment infrastructures that accept Medicaid insurance. The results of the Cummings et al. (2014) study are concerning when further looking into substance use rates in metropolitan versus nonmetropolitan areas in the United States. There were significant increases in reported past-month illicit substance use from 2003 to 2014 in both metropolitan and nonmetropolitan areas (Mack et al., 2017). In 2015, the overdose death rate in metropolitan areas was about 6 times that of nonmetropolitan areas, but, when reading the results per capita, the nonmetropolitan areas had higher rates of overdose deaths (Mack et al., 2017). Table 1 outlines the percentage increase of overdose deaths in the United States from 1999 to 2015, which shows that substance use disorders are not specific to one race/ethnicity and deaths have increased for every race/ethnicity in the United States, regardless of the place of residence. When considering the people afflicted by the opioid epidemic and risks for overdose deaths,

Table 1 outlines the vulnerability every population faces, further establishing a need to provide ethical, multiculturally competent treatment to this highly vulnerable population.

Table 1

*Overdose Death Rates by Race/Ethnicity in Metropolitan and Nonmetropolitan Areas in the United States* (Mack et al., 2017)

Race/Ethnicity	Area	Percentage increase
American Indian/Alaska Native	Metropolitan	261
	Nonmetropolitan	519
Black	Metropolitan	107
	Nonmetropolitan	148
Hispanic	Metropolitan	144
	Nonmetropolitan	201
Asian/Pacific Islander	Metropolitan	349
	Nonmetropolitan	64
White	Metropolitan	224
	Nonmetropolitan	343

To refer to the criminal justice population without discussing race and ethnicity would be failing to fully address the problem in this study. There are approximately 1.5 million drug-related arrests per year in the United States (Hart & Hart, 2019) and people of color are more likely to be arrested for those offenses than White individuals (Acevedo et al., 2019; Camplain et al., 2020; Hart & Hart, 2019). Not only are people of color arrested more often, they are also more likely to be incarcerated for nonviolent substance-related offenses and, at adjudication or sentencing, are more likely to receive prison sentences (Camplain et al., 2020). People of color who interact with law enforcement are less likely to be offered treatment opportunities and more

likely to receive the arrest-first approach (Hart & Hart, 2019), which is a result of long-standing systematic oppression and institutional inequality (Camplain et al., 2020). With arrest and sentencing rates differing greatly from statistics on actual opioid use, I wonder if treatment experiences for legally mandated people of color further the disparities in their criminal and legal experiences.

### **Trends in Opioid Use**

There are two major classifications of opioids: heroin and synthetic opioids (Oxycodone, hydrocodone, morphine, and fentanyl). Synthetic opioids were widely marketed in the 1990s and significantly contributed to the current opioid crisis in the United States (National Academies of Science, Engineering, and Medicine [NASEM], 2017). Several data sources have shown that there was a significant increase in prescription opioid use since 2002. Prescription opioid use, whether used legally or illicitly, continued to increase through the 21st century until prescription monitoring programs were introduced in 2010 (NASEM, 2017). Following the changes in prescribing of opioids, there was a straight line drawn to heroin use. Prescription opioids served as a gateway to heroin use as heroin is less expensive and more widely available in suburban and rural communities throughout the United States (NASEM, 2017). NASEM (2017) cited research that showed 80% of heroin users reported using prescription opioids prior to heroin use. An unintended consequence of the prescription monitoring program was increased heroin use, overdose deaths, and, ultimately, interactions with the criminal justice system (NASEM, 2017). People released from incarceration have been identified as the sub-population at highest risk for overdose death due to their lack of tolerance for opioids, social isolation, and extremely high relapse rates (NASEM, 2017). It was noted that while this population is most at risk, they also have higher treatment utilization rates than people who use other drugs (NASEM, 2017).

Pouget et al. (2018) studied racial and ethnic differences in trends of opioid use with over 65,000 White, Black, and Latinx individuals who entered 114 opioid treatment programs (OTP) in 37 states from 2005-2016. OTPs provide maintenance medication (methadone and buprenorphine) for individuals with at least one year of opioid use disorder histories. It should be noted that not all individuals with opioid use disorders seek treatment at OTPs, and, therefore, the data does not reflect the entire population due to stigma of medication assisted treatment (MAT), lack of access to OTPs, or legal impediments preventing legality of this treatment option. The participants in Pouget et al.'s (2018) study were 79.4% White, 8.1% Black, and 9.5% Latinx. In 2005, the Black and Latinx individuals were statistically significantly more likely to use heroin than White individuals (Pouget et al., 2018). By 2016, Black and White individuals had similar rates of use, but Latinx individuals were still more likely to have heroin as their drug of choice. Heroin use as a drug of choice has significantly increased since 2002 across populations, which has been shown as a quicker entry into the criminal justice system (NASEM, 2017). The type of drug used and the entry into treatment may be significant considerations in addressing recovery in treatment.

### **The Counseling Relationship**

The counseling experience is centered around the relationship between the client and counselor and is at the core of this study. The client-counselor relationship is an integral component of the treatment experience for all clients, and especially so for individuals who are legally mandated to counseling. Regardless of theoretical orientation, there are seven common elements of counseling:

1. Counseling requires counselors to respond to the thoughts, feelings, and behaviors of clients.



2. Clients need to experience understanding and basic acceptance by their counselors.
3. Confidentiality and privacy are crucial to counseling.
4. Counseling is voluntary.
5. Self-disclosure by the counselor is limited.
6. Counselors must be self-aware of how and what they are communicating to clients.
7. Counseling requires multicultural and cross-cultural competence. (Hackney & Cormier, 2013)

The third, fourth, and fifth elements above are of particular note when considering the counseling relationship for legally mandated clients. When working with the criminal justice system in addiction treatment, many aspects of treatment, including drug screen results and compliance with treatment rules and recommendations, are shared frequently (Skeem et al., 2007). The sharing of this information limits confidentiality for mandated clients. The concept of treatment being voluntary is questionable for legally mandated clients as their alternative option to participating in treatment is often incarceration. While that is a choice, for many it may feel like choosing between the lesser of two evils. Finally, limited self-disclosure on the part of a counselor is consistently taught in counselor education programs (Hackney & Cormier, 2013), but may not be as prevalent for all addiction treatment providers (i.e., paraprofessionals) as many people who enter the field identify as being in recovery and use their own stories of addiction and recovery as treatment interventions with their clients, leaving a gap in self-disclosure between those who have no personal experience with addiction and recovery and those who do (White, 2008).

Assuming that all of the aforementioned criteria exist in the counseling relationship, the first stage of the counseling process includes establishing the working relationship (Hackney &

Cormier, 2013). Establishing good rapport (a close relationship where the people involved understand each other's feelings or ideas) within the working relationship results in positive psychological growth, while poor or limited rapport can result in undesirable outcomes across counseling disciplines (Hackney & Cormier, 2013). There are many factors that can influence rapport in the counseling relationship, otherwise known as the therapeutic alliance or working alliance. The counseling relationship is dynamic and can change over time, but is heavily influenced by early interactions between the client and counselor (Hackney & Cormier, 2013). Clients who seek treatment voluntarily may have a different attachment to and relationship with their counselor than clients who are legally mandated to treatment as the existing power imbalance within the counseling relationship (DeVaris, 1994) is further skewed by the addition of legal surveillance (Skeem et al., 2007). There are significant implications for treatment engagement and outcomes when considering the strength of the therapeutic alliance. To what extent do we understand the client's experience with forming a therapeutic alliance when legally mandated to treatment?

The quality of the counselor-client relationship is more important than the interventions or treatment modality (Allen & Olson, 2016). The emotional bond between client and counselor and having a non-confrontational treatment style are important for alliance and treatment outcomes (Allen & Olson, 2016). The counseling relationship and treatment planning with mandated clients is different from standard counseling because traditional outcomes of treatment are combined with rule compliance. The counselor role, in the eyes of the client, carries a control element that is not necessarily present with clients who are not legally mandated to treatment (Skeem et al., 2007), as a failure to comply with treatment can result in incarceration. There is little known about the impact that counselor control has on the treatment experience of legally

mandated clients. Addiction counselors need to have an understanding of how they are perceived by clients to improve the therapeutic alliance and the overall goals of treatment. Treatment is intended to assist clients in implementing sustained change behaviors over time to prevent relapse, improve emotional and physical health, and reduce recidivism (NADCP, 2020).

The counseling relationship is nuanced and there are many factors that may influence the dynamic between the counselor and client. The counselor-client connection is critical in effective treatment and the therapeutic alliance accounts for variance in treatment outcomes (Horvath & Luborksy, 1993; Martin et al., 2000; Sexton et al., 2005; Skeem et al., 2007). For example, Ilgen et al. (2006) studied alcohol use in 753 outpatient clients for Project MATCH and found that a strong or improved therapeutic alliance was associated with decreased substance use. Hersoug et al. (2009) studied the working alliance in therapy with 201 patients and 61 therapists in a quantitative study and found that the emotional bond that forms between the counselor and client improves the therapeutic alliance from the client's perspective.

There are many factors that can have an influence on the development of the therapeutic alliance in addiction treatment, but accurate reflection of empathy is one of the most-cited aspects of the counseling relationship that creates a strong therapeutic alliance (Ritter et al., 2002; Wolfe et al., 2013). "This is a specific therapeutic skill that includes a commitment to understanding the client's personal frame of reference and the ability to convey this heard meaning back to the client via reflective listening" (Moyers & Miller, 2013, p. 879). Empathy is considered to be an evidence-based element of the counseling relationship as it can be measured by clients and researchers alike and, therefore, the impact of empathy can be studied in relation to outcomes in addiction treatment (Moyers & Miller, 2013). Empathy is significant in reducing treatment dropout and increasing positive treatment outcomes for clients (Moyers & Miller,

2013; White & Miller, 2007). However, a person-centered approach highlighted by empathy and unconditional positive regard is not prevalent in working with addiction as a trickle-down effect of the legacy of unethical treatment styles of the past.

Authoritarian confrontation in counseling, which can be conceptualized as the clinical opposite of empathy, has deleterious effects on clients (Moyers & Miller, 2013). Authoritarian confrontation became popular in the 1960s and 1970s and was widely accepted as necessary for treatment professionals to implement to break down the defenses that allowed addiction to flourish. Authoritarian confrontation styles of counselors have led to increased treatment resistance by clients (Moyers & Miller, 2013). Addiction treatment in the United States for several decades promoted and encouraged the use of authoritarian confrontation as an essential element of the experience in addiction treatment, but has been shown as a form of attack therapy that has a negative impact on treatment outcomes (Moyers & Miller, 2013). Sayings still used today (tough love, break 'em down to build 'em up) are used to justify these techniques that have been used by addiction counselors, but have serious implications for unethical practices and conflict with the aforementioned seven elements of the counseling relationship (White & Miller, 2007). While authoritarian confrontation may not be taught in classrooms of addiction counselors today, there is evidence to show that it is a prevalent practice today, lauded as acceptable as a function of treating addiction (Moyers & Miller, 2013), and ethically problematic practice with legally mandated clients.

Researchers have studied mattering, care, and hope to further contextualize important aspects of the counseling relationship that are lesser known or studied. Mattering creates a powerful dynamic in counseling (Rayle, 2006). Mattering can lead to increased investment in the counseling relationship by the client when they feel important and cared for (Rayle, 2006).

Caring was deemed an integral element of the counseling relationship and goes beyond counselors “just doing their job” (Halstead et al., 2002) and simply conveying empathy. Through qualitative interviews with 13 counseling interns, Halstead et al. (2002) learned that caring creates a dynamic in the counseling relationship and results in a meaningful human connection between the counselor and client.

Hope is also conceptualized as a transtheoretical factor that can lead to positive psychological change in a client and accounted for 15% of change in clients in mental health counseling (Larsen & Stege, 2012). “The experience of being in a relationship with another in a supportive and nonjudgmental counseling atmosphere offered clients a sense of hope” (Larsen & Stege, 2012, p. 47). In a qualitative study with ten client-participants, Larsen and Stege (2012) studied hope in the counseling relationship from the clients’ perspectives using video assisted recall. Researchers learned that the elements of the counseling relationship, including safety, acceptance, understanding, and counselor commitment, instilled hope in the clients (Larsen & Stege, 2012), further establishing that counselor behaviors to establish rapport, particularly in early sessions, is integral in establishing a healthy therapeutic alliance (Hackney & Cormier, 2013).

Vairo (2010) studied social workers’ attitudes toward mandated clients in an empirical study. Vairo’s study included 779 social workers and, using vignettes of client behaviors and scenarios, learned that social workers were pessimistic about sustained change for legally mandated clients in addiction treatment. Larsen and Stege’s (2012) findings showed that clients likely perceive their counselor’s negative view of their likelihood to sustain change for their recovery, further hindering the development of a therapeutic alliance. Mattering, instillation of hope, and feeling cared for as elements of the counseling relationship in addiction treatment or

with legally mandated clients is missing from existing literature, leaving one to question if these elements are present in those relationships and to what extent they have an impact on the treatment experience.

Allen and Olson (2016) studied the treatment experience of twenty individuals who sought inpatient and/or outpatient substance use treatment at a community agency. The interviews specifically explored the relationships of the clients with the counselors and their overall treatment experience (Allen & Olson, 2016). Researchers learned that the clients had both positive and negative experiences and described three critical elements of the therapeutic alliance: flexibility, negotiation, and motivational enhancement (Allen & Olson, 2016).

In Allen and Olson's (2016) study, flexibility refers to the counselor's ability to move beyond relapse prevention strategies to addressing historical shame, guilt, and disgust. Clients appreciated the ability to address emotional issues unrelated to recent substance use, which seems like a given, but is not treatment as usual for all clients (Allen & Olson, 2016). The theme of negotiation referred to the clients identifying "a supportive and non-confrontational environment as a key factor for creating an emotional bond with their therapist" (Allen & Olson, 2016, p. 722). Motivational enhancement described the idea that counselors were able to help clients resolve ambivalence about committing to change and taking an interest in improving the psychosocial functioning of the client, which went beyond simply achieving abstinence (Allen & Olson, 2016). While these elements of the therapeutic alliance may be considered perfunctory in general counseling, they are not always present in addiction counseling specifically. The results of this research further establish the need to know more about the treatment experience in addiction counseling with legally mandated clients.

### **History of Addiction Treatment and Ethical Implications**

Addiction treatment has been through many significant changes since its inception in the 1700s (White & Callahan, 2015). In his book, *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*, White (2014) outlined a detailed history of addiction treatment in the United States using historical artifacts, newspaper clippings, out of circulation journals, memoirs, and testimonies. White (2014) began the story of addiction treatment in the United States in the 1700s. Benjamin Rush, a physician and considered the father of addiction medicine, published a well-circulated inquiry outlining addiction, specifically “drunkenness” in 1784. In this work, Rush proposed the disease concept of addiction and the need for total abstinence (White, 2014; White & Callahan, 2015). Rush also proposed appropriate treatments or cures for addiction. Medicine at that time required physicians to find a balance in the body between blood, phlegm, black bile, and yellow bile. From that framework, Rush proposed that sweating, bleeding (with leeches or lancing), purging (with laxatives or emetics), blistering the skin, or ingesting other drugs were the cure for addiction. Further, treatment approaches consisted of Christian conversion, acute guilt or shame, linking alcohol use to a painful impression, vegetarianism, cold baths, acute disease, witnessing the death of a drunkard, and swearing an oath of abstinence. Rush also first proposed the idea of a Sober House, which did not initially garner any support within the treatment community. Initial treatment offerings were provided by physicians and lacked any research or evidence of effectiveness (White, 2014).

The nature of addiction changed with the introduction of morphine, cocaine, and hypodermic needles in the 1800s (White & Callahan, 2015). In the 1840s, problematic alcohol use was on the rise and treatment interventions were lacking. Treatment options at the time were available in almshouses, lodging homes, jails, workhouses, and lunatic asylums, although people

with substance use disorders were not welcome in any of the aforementioned facilities because they were considered social lepers and needed to be separated from society to prevent “the spread” of addiction (White, 2014). Therefore, specific institutions were created to treat addiction: inebriate homes and inebriate asylums. Inebriate homes were offered to the more affluent and provided minimal treatment, room, and board. These were eventually replaced by private sanitarium. Inebriate asylums were medical facilities where people of lower socioeconomic means received treatment. Physicians were there to address acute intoxication, but treatment interventions were minimal at best. At this time, in Massachusetts, social workers and physicians offered outpatient offices for people to seek treatment. Addiction treatment developed a negative reputation resulting from the overall lack of ethics in practices and the understanding of the desperation for treatments and “cures” (White, 2014; White & Callahan, 2015). Treatment facilities at the time were reported to have many ethical abuses including inappropriate discharge conditions, excessive use of confinement and restraints, and false claims of success (White, 2014).

In 1870, the American Association for the Study and Cure of Inebriety (AASCI) was developed (White, 2014). AASCI held four beliefs:

1. Intemperance is a disease.
2. It is curable in the same sense that other diseases are.
3. Its primary cause is a constitutional susceptibility to the alcoholic impression.
4. This constitutional tendency may be inherited or acquired (White, 2014, p. 37)

AASCI criticized the existing punitive approach to addiction treatment and called for the advancement of specialized facilities to treat addiction. These assertions were met with contempt by other addiction treatment leaders at the time. The primary providers of addiction treatment



were physicians, clergy, and lay therapists. There were opposing views on the etiology of addiction and people believed that it was either a vice, a crime, or a disease. Laws were passed to involuntarily commit patients to treatment for up to one year at a judge's discretion. Treatment facilities of the affluent did not accept patients through involuntary commitment and treatment only lasted about 4 weeks, which started a trend of one month of residential treatment that would last for decades.

In the 1900s, treatment practices were beginning to address patients individually and with varied approaches. Treatment included mutual support groups between patients, religious or spiritual interventions, isolation from their former life for an extended period of time, work and recreation, and music therapy. Counseling services were rarely offered to patients. Patients also received aversion therapy, electrotherapy, and hydrotherapy. Very few aftercare options were offered or available to patients once they completed their residential treatment (White, 2014).

With the good came the bad. At the same time that treatment approaches were somewhat improved though still unethical in nature, patients were voicing their criticism of current treatment practices. In response, Dr. T.D. Crothers, the editor of the *Quarterly Journal of Inebriety*, stated "cruelty to patients, poor food, neglect of proper care, and free whiskey, and patients running away all the time, bad, immoral influences from attendants, and unfit patients, are the common charges urged against every asylum in the country" (Crothers, 1906, as cited in White, 2014, p. 37). The allegations were vehemently denied, but also brought light to the fact that treatment providers were unable to listen to the treatment experiences of their patients. Even when concerns were voiced, patients in addiction treatment were silenced and discredited. This research highlights a systemic issue in the addiction treatment profession that endured for generations and will be further explained.

Early in the 20th century, many of the treatment facilities were closed due to prohibition and the passage of the Harrison Antinarcotic Act of 1914 (White, 2014; White & Callahan, 2015). Society at large began viewing people with substance use disorders as criminals and their disorder was shifted from being biological to psychiatric (White & Callahan, 2015). The negative views of individuals with substance use disorders led to more control being placed on them and left room for little agency (White & Callahan, 2015). People with substance use disorders were subject to involuntary sterilization as a means of natural selection (White, 2014). It appears, through this historical lens, that control and unethical practices were the norm for individuals in addiction treatment. One might question how likely a person would be to seek treatment if they know the environment they are entering is riddled with unethical practices, leaving the option of incarceration in lieu of treatment as more viable than treatment.

The development of Alcoholics Anonymous (AA) in 1935 changed the existing nature of addiction treatment as people with substance use disorders were aiding one another in pursuit of recovery in self-help groups (Hagedorn et al., 2012; White, 2014; White & Callahan, 2015; White & Miller, 2007). AA and its subsidiaries (e.g., Narcotics Anonymous, Cocaine Anonymous) changed addiction treatment as it led to the employment of people in recovery (paraprofessionals) as treatment providers (White, 2014; White & Miller, 2007). The term treatment provider is used loosely when considering the use of a paraprofessional delivering treatment interventions because there was no ethical standard or qualification for the paraprofessional within the treatment facility. It appears that an “anything goes” approach became the standard of care at the time.

In the 1950s, there were more dramatic changes taking place in the history of addiction treatment. First, Narcotics Anonymous (NA) was created due to the stigma of drug use and

alcohol users did not identify with drug users. The Hazelden Foundation, an AA 12-step abstinence-based treatment program, was developed and relied heavily on the premise that clients improve with the inclusion of a professional (psychologist or psychiatrist) and a paraprofessional in the treatment process (Anderson et al., 1999). Hospitals also began developing detoxification wards to allow for safe withdrawal from alcohol (White & Callahan, 2015), which was quite a departure from the previous treatment they received within medical facilities. Ground-breaking research conducted with people returning to society following residential forms of treatment birthed the concept of community-based outpatient treatment and a true continuum of care (White & Callahan, 2015). Although access to treatment increased and levels of care were becoming more defined, there was still a mysteriousness to the interventions with individuals seeking treatment. While some practices were improving, in the mid-20th century, paraprofessionals and lay therapists were the norm (Hagedorn et al., 2012) and addiction treatment required aggressive communication including, “frank feedback to profanity-laden indictments, screamed denunciations of character, challenges and ultimatums, intense argumentation, ridicule, and purposeful humiliation” (White & Miller, 2007, p. 13). The aforementioned confrontation techniques were viewed as necessary and not unethical.

There was one treatment program that made headlines regarding the unethical treatment practices taking place with drug users. A man in recovery from alcohol use developed Synanon, which was a treatment program created to specifically treat addicts (White, 2014). Synanon became highly profitable, widely duplicated, and believed that the use of strong confrontation tactics was curative in alleviating addiction to drugs (White, 2014; White & Miller, 2007). Treatment interventions including shame and humiliation were used to break down defenses that the treatment providers believed sustained addiction and addictive behaviors (White, 2014;

White & Miller, 2007). Upon entering the facility, all clients had their heads shaved and participated in a group called “The Game.” “The Game” required clients to point out each other’s inconsistencies, call each other out about lies, and challenge one another’s character. Synanon did not employ any trained professionals. Instead, they employed clients who became interns who became counselors who might relapse and become clients again. As a current treatment professional looking back on those practices, I would think that any facility conducting treatment like that today would be shut down. This calls into question whether or not those practices have actually stopped or if they have simply been brought into the shadows, considering that Synanon treatment programs were so widely duplicated nationwide. This furthers the discussion regarding ethical issues existing in addiction treatment.

In the 1980s and 1990s, master’s-level clinicians began working in the addiction counseling field (Hagedorn et al., 2012) and alcohol and drug users, who were previously treated in separate programs, were integrated into the same treatment programs. Previously, their substance use was considered to be different and received separate treatment (White, 2014). Ethical standards for mental health and addiction professionals were developed and, subsequently, treatment interventions decreased in severity (White & Miller, 2007). “A critical stage in the development of any profession is the articulation of standards of competency and standards of ethical practice” (White, 2014, p. 397). Paraprofessionals are still regularly employed in the field despite the fact that they need only possess a high school diploma and an addiction certificate to work in the same capacity as their Master’s-level colleagues (West & Hamm, 2012). Addiction treatment today offers many modalities depending on the severity of an individual’s substance use, co-occurring disorders, and their existing recovery environment. While many changes in addiction treatment have taken place, access to different treatment

options remains limited for individuals of lower socioeconomic status and is further restricted for individuals with legal mandates for treatment as they are not generally permitted to leave the state in which they reside. Legally mandated clients are exposed to addiction counseling professionals with an array of education (from high school diploma and certificate completion to doctoral-educated with multiple licenses) who also receive education in different backgrounds (social work, counseling, marriage and family therapy). Clients do not get to choose the addiction counseling professional to whom they are assigned. There are many implications to be made from inconsistency in preparation and delivery of treatment interventions in addiction treatment that deserve further exploration.

### **Current Practices in Addiction Treatment**

Treatment “refers to the broad range of primary and supportive services - including identification, brief intervention, assessment, diagnosis, counseling, medical services, psychological services, and follow up - provided for people with alcohol and illicit drug problems. The overall goal of treatment is to eliminate the use of alcohol and illicit drugs as a contributing factor to physical, psychological, and social dysfunction and to arrest, retard, or reverse progress of associated problems” (SAMHSA, 2014, p. 4-5). Addiction treatment today occurs in different levels of care: Level 0.5 Early Intervention, Level 1 Outpatient Services, Level 2 Intensive Outpatient/Partial Hospitalization Services, Level 3 Residential/Inpatient Services, and Level 4 Medically Managed Intensive Inpatient Services (American Society of Addiction Medicine [ASAM], 2015a; SAMHSA, 2006b; see Table 2). Levels 2 and 3 have subdivisions within their levels of care that will be further explained in Table 2.

Recommendations for an appropriate level of care (LOC) are critical in addiction treatment. For example, clients seeking treatment who have limited support, an unstructured

environment, and co-occurring disorders generally benefit from stabilization in residential treatment followed by outpatient treatment for a continuum of care (Finney et al., 2015). The ultimate goal is for clients to be referred to treatment in the appropriate level of care and to move up to more intensive or move down to less intensive levels of care based on ongoing needs (SAMHSA, 2006b). Clients are intended to enter treatment through a continuum of care as opposed to entering into a treatment program (SAMHSA, 2006b.).

**Table 2**

*Levels of Care for Substance Use Disorder Treatment of Adults (ASAM, 2015a)*

Level of Care	Criteria for Placement
Level 0.5 Early Intervention	Psychoeducation for those at risk for developing a substance use disorder or for those who do not meet criteria for a substance use disorder diagnosis
Level 1 Outpatient Services	Less than 9 hours per week of motivational enhancement therapy offered in a variety of settings
Level 2.1 Intensive Outpatient Services	9 or more hours per week of treatment to address multidimensional instability and can address both substance use and co-occurring disorders.
Level 2.5 Partial-Hospitalization Services	20 or more hours of services per week to address multidimensional instability and can address both substance use and co-occurring disorders. Clients treated in this level of care are assessed as not needing 24-hour care
Level 3.1 Clinically Managed Low-Intensity Residential Services	24-hour structure with counseling services offered at least 5 hours per week of clinical services. This level of care offers co-occurring and medical treatment in addition to substance use treatment.
Level 3.3 Clinically Managed Population-Specific High-Intensity Residential Services	24-hour care used to stabilize clients who pose imminent danger who have cognitive or other impairments. This level of care offers co-occurring and medical treatment in addition to substance use treatment
Level 3.5 Clinically Managed High-Intensity Residential Services	24-hour care used to stabilize multidimensional imminent danger and prepare clients for eventual outpatient treatment. This level of care offers co-occurring and medical treatment in addition to substance use treatment

Level 3.7 Medically Monitored Intensive Inpatient Services	24-hour nursing care or physician care to address problems identified in Dimensions 1, 2, or 3 ( <i>see below</i> ). Clients require medication or withdrawal management that was unable to be successfully addressed in a lower level of care. This level of care offers co-occurring and medical treatment in addition to substance use treatment
Level 4 Medically Managed Intensive Inpatient Services	24-hour nursing care and daily physician care for severe, unstable problems identified in Dimensions 1, 2 or 3 ( <i>see below</i> ). Counseling is available up to 16 hours per day.

To determine the appropriate level of care to address a client's substance use and potential for co-occurring disorders, counselors complete an assessment based on ASAM criteria that assesses clients across six dimensions: Dimension 1 acute intoxications and/or withdrawal potential, Dimension 2 biomedical conditions and complications, Dimension 3 emotional/behavioral conditions and complications, Dimension 4 treatment acceptance/resistance, Dimension 5 relapse/continued use potential, and Dimension 6 recovery/living environment (ASAM, 2015b; Finney et al., 2015; Mee-Lee & Schulman, 2015; see Table 3). Each dimension provides specific criteria to determine, based on a client's current state, what level of care would be most appropriate to address their needs.

Based on the information gathered in the initial assessment, counselors are required to refer clients to the least restrictive level of care, which is outlined in four major themes (SAMHSA, 2006a).

1. Patients should be treated in those settings that least interfere with their civil rights and freedom to participate in society.
2. Patients should be able to disagree with clinician recommendations for care.

While this includes the right to refuse any care at all, it also includes the right to obtain care in a setting of their choice (as long as considerations of dangerousness

and mental competency are satisfied). It implies a patient's right to seek a higher or different level of care than that which the clinician has planned.

3. Patients should be informed participants in defining their care plan. Such planning should be done in collaboration with their healthcare providers.
4. Careful consideration of State laws and agency policies is required for patients who are unable to act in their own self-interests. Because the legal complexities of this issue will vary from State to State the TIP [Treatment Improvement Protocol] cannot provide definitive guidance here, but providers need to consider whether or not the person is “gravely” incapacitated, suicidal, or homicidal; likely to commit grave bodily injury; or, in some States, likely to cause injury to property. In such cases, State law and/or case law may hold providers responsible if they do not commit the patient to care, but in other cases programs may be open to lawsuits for forcibly holding a patient.

Treatment offerings and justifications for duration and level of care have dramatically shifted since the mid-20th century. The considerations outlined by SAMHSA (2006a) in referring a client to the least restrictive level of care may seem rudimentary or commonsense, but there is an overarching entity when working with the legally mandated population that may infringe upon a client’s freedoms and civil liberties. Imagine a scenario where an outpatient counselor has been working with a “difficult” client for three months and the client relapses in one isolated event. The counselor has the ability to then continue working with the client in the outpatient setting or can potentially refer the client to residential treatment. The six dimensions of ASAM criteria may be flexible to some degree to justify such a treatment recommendation. Because there is an officer or judge overseeing the process, the client lacks autonomy in making



the decision to comply. What current available research fails to show is the impact that the aforementioned experience has on clients. As treatment providers, we need to know what it feels like for a client to be referred to a higher level of care that may disrupt their life or what it feels like to initiate MAT due to failed attempts at abstinence.

**Table 3**

*ASAM Criteria Assessment Dimensions (ASAM, 2015a)*

Assessment Dimension	Assessment and Treatment Focus
1. Acute Intoxication and/or Withdrawal Potential	Assess for acute intoxication or withdrawal management (particularly opioids, alcohol, and benzodiazepines). Withdrawal management can occur in different levels of care depending on the severity of withdrawal factors and substance of intoxication
2. Biomedical Conditions and Complications	Assess for and treat any co-occurring physical health conditions or complications. Assess for appropriateness of treatment availability within the facility.
3. Emotional, Behavioral, or Cognitive Conditions and Complications	Assess for and treat co-occurring mental health conditions or complications. Treatment can be provided by the substance use treatment facility or in coordination with a mental health treatment provider.
4. Readiness to Change	Assess for stage of change. If the client is not committed or ready to change, use motivational enhancement strategies to promote change behaviors. If ready for change, expand upon current motivation.
5. Relapse, Continued Use, or Continued Problem Potential	Assess for relapse or continued use potential and the degree of severity for this potential based on client's stage of change and substance use history.
6. Recovery Environment	Assess for client's current access to or use of recovery tools: family/significant others, housing, financial, vocational, educational, legal, transportation. Identify assets and needs for further support.

### **Pharmacotherapies and Their Stigma**

Over the course of the 20th and 21st centuries, medication to treat opioid use disorder has been developed to assist in the recovery process, but there exist several barriers to use with the legally mandated population. According to the National Institutes on Drug Abuse (NIDA, 2019), there are three forms of medication-assisted treatment (MAT) for opioid use disorder: buprenorphine, methadone, and naltrexone. Buprenorphine and methadone are partial agonist and agonist medications, respectively (NIDA, 2019). Naltrexone is an antagonist medication available as an oral pill or injectable dose (NIDA, 2019).

MAT has been cited as an evidence-based gold standard of care for individuals with opioid use disorder (Madden, 2019; NIDA, 2019). While there is a longstanding stigma against individuals with substance use disorders, and opioid use disorders in particular, there is a growing stigma against the use of MAT in treating OUD (Madden, 2019). Madden (2019) proposed that “intervention stigma” is a stigma that exists among professionals against a medical treatment. In a qualitative study interviewing 47 treatment providers regarding beliefs and judgments by addiction treatment professionals in MAT-based and abstinence-based treatment facilities, Madden learned that many actively practicing treatment professionals are opposed to the use of MAT as a part of treatment, despite the research and literature showing the effectiveness. MAT has been indicated as the best treatment option for the criminal justice population, but there is very limited access to or utilization of this medication (NASEM, 2017). People under legal supervision should have access to MAT, but the ongoing stigma surrounding addiction and MAT prohibits the expansion and availability of services. There should be increased funding provided to methadone providers and there should be increased provider locations nationally (Joseph & Woods, 2018).

Naltrexone is considered a form of MAT because it is specifically used to treat substance use disorders, but carries less stigma than buprenorphine and methadone (Ceste, 2019). Unlike buprenorphine and methadone, naltrexone does not prevent withdrawal. Rather, if administered to an individual who recently used opioids, naltrexone will precipitate withdrawal (SAMHSA, 2019). The injectable form of naltrexone, Vivitrol, has been shown to reduce cravings and has increased compliance because the half-life lasts for approximately 30 days (NASEM, 2017; SAMHSA, 2019).

Imagine a scenario where an outpatient client relapses on heroin and has developed tolerance and exhibits withdrawal symptoms as a result. A standard course of action on the part of the counselor may be to refer a client to Level 3.7 detoxification and residential treatment services, which would result in the client being away from home for approximately 30 days. While that may seem appropriate, upon further exploration, you see that the client is working full time for the first time in years and has finally established a stable living environment, both of which would be lost following 30 days in residential treatment. The counselor has the ability to refer a client for assessment for MAT (buprenorphine or methadone) and continued outpatient treatment services, allowing the client to remain at their job and in their living environment. Yet, due to the ongoing stigma of MAT and criminal justice systems not allowing the client to obtain MAT, the client will likely lose what they have gained, rendering the client unable to advocate for him/herself. MAT is the gold standard of evidence-based treatment for individuals with opioid use disorders, but the use of MAT as a treatment option is limited and the consequences of not permitting a client to receive Buprenorphine or methadone can impose more harm than good.

### **Addiction Treatment with the Criminal Justice Population**

The screening and assessment process with legally mandated clients may pose challenges that do not exist with those who seek treatment voluntarily. Clients may be compelled to leave out or minimize the severity of their substance use, necessitating information to be collected from collateral sources (SAMHSA, 2014). Assessments may be completed based on inadequate and/or inaccurate information, leading the counselor to take on a different role that parallels a detective (SAMHSA, 2014). It is important to note that there is not a one-size-fits-all approach to assessment and treatment recommendations. Clients who are placed in treatment settings that are more intensive than needed “may be disruptive or drop out of treatment prematurely” (SAMHSA, 2014, p. 43). Further, clients with less severe substance use disorders who are placed in treatment with more “seasoned” offenders and substance users are exposed to the effects of unhealthy attitudes, beliefs, and lifestyles (SAMHSA, 2014).

There are many issues that need to be addressed in addiction treatment and, while not all issues are relevant to each client, they need to be considered throughout the treatment process through ongoing assessment. The preliminary assessment should assess for needs for detoxification, co-occurring disorders, medical issues, family-related services, case management, legal problems, and educational or employment concerns (SAMHSA, 2014). Beyond those needs, counselors may need to address and have resources for homelessness, life skills training, criminality, manipulateness, anger/hostility, criminal identity, cultural identity, “person of status,” denial, resistance, guilt/shame and stigma, and boundaries (SAMHSA, 2014). Creating a therapeutic alliance plays a significant role in the treatment process and counselors need to be credible and show cultural competence (SAMHSA, 2014).

SAMHSA (2014) provided Treatment Improvement Protocol (TIP) 44 to highlight all relevant aspects of the treatment process with the criminal justice population. In their text, SAMHSA noted that counselors working with this population have additional leverage to increase retention and completion of treatment as they are responsible for reporting progress in treatment to the courts. Due to this role of the counselor, they can be perceived as adversarial to the client and results in limiting clients' self-disclosure. Because of the aforementioned role of the counselor, checks and balances need to be put in place to ensure that counselors act fairly and do not abuse the power they have over their clients (SAMHSA, 2014). Counselor power allows them to elicit compliance from their clients (Williams & O'Connor, 2019). Although clients are required to adhere to the demands of their legal mandates, counselors need to build in some flexibility to their requirements to increase likelihood of retention and completion (SAMHSA, 2014). Counselors need to be aware of the notion that the stipulations, or mandates, imposed on the clients leads to a lack of autonomy and that the power differential assumes that a counselor knows what is best for the client (Williams & O'Connor, 2019).

### **Theoretical Framework**

This literature review has established a long-standing history of problems or inconsistencies with addiction treatment over the course of decades. While efforts have been made to transform addiction treatment from an "anything goes," confrontational, authoritarian experience to one with standards of ethics and evidence-based treatment in clinical practice, there is still room for improvement for addiction treatment as a whole. More specifically, legally mandated clients have a different experience with treatment in that their willingness to participate in and comply with treatment are overseen by the criminal justice system, which can lead to very positive or negative outcomes for the clients, including incarceration in jail or

prison. The opioid use disorder (OUD) population, in particular, has even greater challenges in that there is a gold standard of treatment, MAT, which they are not always offered or allowed to receive due to parameters of the legal system dictating what would be considered appropriate treatment. To best understand the addiction treatment experience for legally mandated opioid users, I approached this study through a critical theory lens.

Critical theory ultimately has the goal of empowering the population being studied (Creswell & Poth, 2018; Merriam & Tisdell, 2016; Morrow & Brown, 1994) and to critique what is so that new possibilities can be developed for the future (Morrow & Brown, 1994). Critical theory is “a form of historical sociology” (Morrow & Brown, 1994, p. 10) and seeks to highlight power relations that create social struggles (Morrow & Brown, 1994). An important notion about critical theory is that the critique is meant to bring a problem to light in order to influence change, rather than comment on something that is considered “written in stone.” Critical research ultimately works to identify problems experienced by an oppressed population within a certain system or structure, challenge the status quo, and empower the oppressed individuals so that change can happen (Merriam & Tisdell, 2016).

Critical theory allows for this research to identify potential problems that exist for legally mandated clients in addiction treatment so that norms of treatment today can be transformed for the clients of tomorrow. Using critical theory to approach this study affords the participants the opportunity to expose and expand on the current state of mandated addiction treatment in order to carve a pathway for ways to improve upon treatment experiences. This literature review demonstrates progress and change over time with this population, while current research shows existing flaws in the way that treatment is conducted (overuse of administrative discharge, stigma toward medication assisted treatment, stigma regarding success of legally mandated

clients). Critical theory afforded me the opportunity to critique the intricacies of current problems with power structures influencing mandated addiction treatment while broadening the possibilities for the future of addiction treatment with legally mandated opioid users.

### **Chapter Summary**

A review of the literature shows an ongoing gap in existing research related to addiction treatment broadly, and with legally mandated opioid users specifically. Recent studies have shown the significant positive and negative impacts that the counseling relationship has on treatment completion and retention in counseling mandated clients (e.g., Hatchel et al., 2019; Werb et al., 2016), while lacking the voice of the clients in the research. Ethical principles of the counseling profession highlight many ways addiction treatment professionals can violate ethical standards in treatment with a population that is unlikely to self-advocate due, in part, to the parameters of their legal mandates (ACA, 2014). The population demographics of this research are varied as trends in opioid use show increased use across races and geographic locations in the United States. While more people who report recent use and seek treatment identify as White, people of color are more likely to be arrested and incarcerated for their substance use, overrepresenting people of color in the criminal justice involved population.

The history of addiction treatment showed how, for decades, treatment practices were unethical and lacked any form of professional standards in working with the addicted population (White, 2014). While practices have significantly improved from its inception, there are still inconsistencies in treatment delivery, due in part to the varied levels and philosophies of training and education for addiction treatment providers. Current treatment practices have become standardized with specific levels of care that have criteria to assist treatment providers in making appropriate treatment recommendations, but areas of gray leave room for counselors to

misinterpret or misuse their treatment recommendations, at times avoiding the use of pharmacotherapies due to stigma. Wahesh et al. (2016) showed that there is a lack of research on treatment with the addiction population and, of research that does exist, a small portion of it is qualitative. The use of critical theory in a qualitative study helped the researcher to explore the power dynamics in mandated treatment of opioid users with the goal of empowering clients and shifting the power imbalance that exists.



### **CHAPTER 3: METHOD**

The purpose of this chapter is to introduce the research methodology for this qualitative study. I employed a critical theory framework to bring to light a problem that is not currently understood. To obtain that information, I used qualitative interviews undergirded by phenomenology to explore the experience of addiction treatment for legally mandated opioid users. This approach allowed for a deeper understanding of the impact clinical interventions and treatment recommendations have on clients in addiction treatment in order to promote efficacious and ethical treatment practices in the future. The use of critical theory and a phenomenological approach will be explained in this chapter.

#### **Approach to Research**

Qualitative research aims to gain a deeper understanding of the subject being studied (Merriam & Tisdell, 2016). Addiction treatment research is dominated by quantitative methodology and lacks the depth of content that can be achieved through qualitative methodology (Wahesh et al., 2017). As a clinician, I have firsthand experiences with legally mandated clients that are not currently reflected in literature. Research has highlighted that there are issues with treatment that lead to dropout and poor outcomes, the counseling relationship is crucial in retaining clients in treatment, and counselors of legally mandated clients have different power dynamics than that of general counseling relationships. However, the voices of clients sharing that experience is missing.

The methodology for this research study was semi-structured interviews undergirded by phenomenology (Merriam & Tisdell, 2016). Participants all had the shared experience of being legally mandated to addiction treatment for an opioid use disorder and provided insights into their shared experiences. The philosophical perspective guiding the approach to this study is

phenomenological, attending to shared experiences of individuals and teasing out their interpretations of those experiences (Merriam & Tisdell, 2016). Participants in this study have shared experiences, but what differed was the way in which the clients interpreted those experiences. Semi-structured interviews allowed participants to share about their previous treatment experiences from their own perspective while speaking to a greater phenomenon of the shared experience of being legally mandated to treatment. Current data available about this phenomenon relies heavily on the counselors' perceptions of legally mandated clients or treatment outcomes of opioid users. Little is known about the actual experience of being legally mandated to treatment as an opioid user and insight into what leads to treatment outcomes for clients. I conducted semi-structured interviews to provide information that is missing from existing literature.

### **Research Question**

The research question that guided this study was: How do legally mandated opioid users describe their treatment experience?

### **Research Design**

#### **Context of Study**

The participants of this study, who will be further described in the following section, had the primary requirements of having been diagnosed with an opioid use disorder and attended addiction treatment through a legal mandate. Legal mandates for treatment occur between the client and either a judge, probation officer, or parole officer while a client is serving a parole or probation sentence. Participants have likely been incarcerated as a result of their drug-related criminal offenses, but that is not always the case as not all arrests result in incarceration. Participants who are involved with Drug Courts have different requirements for treatment and

compliance with treatment than those on probation with stricter, swifter consequences for failure to comply with treatment. Drug Court is a probation sentence designed specifically for individuals who have been convicted of drug related felony offenses and meet diagnostic criteria for a substance use disorder. Drug Court participants have consistent contact with their probation officer and judge and all participants are legally mandated to addiction treatment (Tiger, 2011). Many individuals who seek treatment do so multiple times. In a survey of individuals in long term recovery, Kelly et al. (2019) found that there was an average of 5.35 serious recovery attempts made before long term recovery for all participants, 8.48 attempts for individuals with an opioid use disorder. Kelly et al. (2019) also noted that over half of people seeking treatment have sought treatment before, showing that a majority of individuals in treatment have been in treatment previously.

### **Participants**

I used purposeful sampling to obtain participants for this study. The population for this research is adults who have been legally mandated to addiction treatment through probation, parole, or Drug Court with a primary diagnosis of opioid use disorder. Participants were required to have been in at least two prior treatment episodes to increase the participants' insight into their previous treatment experiences and to have the ability to make comparisons between treatment experiences. A treatment episode would include treatment admission in any level of care and could be one that was successfully completed or not. Clients were required to have been in treatment within the past year, but not currently in treatment to reduce any potential ethical issues that could have arisen by information shared in the interviews.

The participants were obtained through snowball sampling methods. I contacted colleagues in the addiction treatment field and peers who had interaction with individuals in

recovery to seek participants for this study. I attempted to stratify the sample by seeking participants who identified as either male or female and also those who identified as white or a minority/marginalized racial group. While men are more likely than women to use illicit substances, women may experience unique obstacles that pose issues for treatment that may not be experienced by men (NIDA, 2020) necessitating the voices of both women and men in this study. Approximately two-thirds of opioid users in the United States identify as White with the remaining one-third identifying as Black, Latinx, or other (SAMHSA, 2020), but opioid users in the criminal justice system are more likely to be people of color (Wallace, 2019). As the scope of this research focuses on the legally mandated population, it was important to try to include the experiences of people from diverse racial and ethnic backgrounds to give greater context to treatment experiences. The sample size of this study was 10 participants. I stopped seeking new participants when the point of saturation or redundancy occurred and no new insights were developed (Merriam & Tisdell, 2016). Table 4 below shows demographic and relevant background information about each of the participants in this study. Background of the participants includes number of previous treatment episodes, self-identified number of serious recovery attempts, and the amount of time they were incarcerated, including the number of bids (separate times incarcerated). All of the names of participants were changed to protect their anonymity.

**Table 4**

*Participant Demographics*

Name	Age	Race	Gender	Treatment episodes	Recovery attempts	Time Incarcerated
Sean	38	White	Male	8	2	60 days (5-10 bids)

Jared	35	White	Male	7	1	3 years (about 10 bids)
Jessica	43	White	Female	6	1	1 day
Wyatt	41	White	Male	20+	1	12 years (about 40 bids)
Darren	38	White Hispanic	Male	15+	1	14 years (about 20 bids)
Kenneth	37	Black	Male	20+	3	2.5 years (about 8 bids)
Ashley	40	White	Female	12	2	1 year (about 10 bids)
Dante	36	White	Male	2	2	2 years (about 3 bids)
Rebecca	34	White Hispanic	Female	16	5	6 years (about 10 bids)
Beth	33	White	Female	2	1	8 months (about 3 bids)

### Exclusions

Individuals were excluded from this study if they had been in treatment with me as an active counselor in order to prevent response bias and ethical conflicts with previous treatment. I also excluded any individuals who were actively using illicit substances as the intoxication could have prevented informed consent for the research (Anderson & McNair, 2018). Individuals who were currently in treatment were also excluded from this study to prevent any ethical concerns regarding current treatment issues that may be reported.

### Data Gathering Methods

Following Institutional Review Board (IRB) approval, I conducted semi-structured interviews with open-ended questions, as they allow for consistency between participants and add to the depth of responses (Heppner et al., 2016). Participants engaged in two rounds of interviews that lasted approximately 60-90 minutes and 45-60 minutes respectively. Analysis

began at the time of the first interview and I kept a research journal recording reactions and reflections to interview responses. See Appendix A for the interview guide I used for the first round of interviews. The second round of interview questions were determined following preliminary analysis of data gathered in the first round to clarify content, expand on themes, determine validity of interpretations to responses, and to address any information that was missed during the first round.

I conducted the interviews for this study using a technology platform (Zoom). The use of this platform helped to maintain the anonymity of participants as they were requested to turn their cameras off and change their on-screen user name for research purposes. Protecting the anonymity of participants was critical in that their substance use and criminal histories were addressed and could pose potential issues for them if these interviews were to take place in a different setting.

### **Data Analysis**

Data analysis began during the first interview using the constant comparative method. The constant comparative method is well-suited for research into social problems that may be considered taboo or carry stigma and allows for flexibility to generate theory (Glaser, 1965). The constant comparative method is used to generate or suggest properties about a general phenomenon and makes no attempt to prove causes for the phenomenon (Glaser, 1965). Constant comparative analysis occurs throughout the research process. To begin, I coded as many categories as possible, determined by information gathered in early interviews. Memos were recorded for each of the categories as new information was gathered (Saldaña, 2009). Data within the categories were compared and then data between categories were compared. Overlap did occur between categories (Glaser, 1965). Next, I reduced the use of terminology and reduced

the number of categories generated during early analysis to generate themes from data gathered. I attempted to seek alternative explanations of the perceptions of the treatment experience for legally mandated opioid users. Finally, the constant comparative method led to the development of an enhanced thematic understanding of the treatment experience of the participants (Glaser, 1965). Throughout the data analysis process, I kept a journal tracking my progress of determining appropriate themes that provided a thorough understanding of the phenomenon being studied.

### **Trustworthiness**

To ensure that the data collected was trustworthy, participants answered interview questions in two rounds. In the second round of interviews, participants had the ability to confirm or refute early research findings, also known as member checking (Merriam & Tisdell, 2016). Member checking allowed participants to determine if I misinterpreted interview responses. Further, an additional method to increase trustworthiness or validity of qualitative research is “adequate engagement in data collection” (Merriam & Tisdell, 2016, p. 246). It was my responsibility as the researcher to seek out information that might have supported an alternative explanation for the phenomenon being studied. Participants’ experiences in addiction treatment were explored through interviews with the expectation that there could have been multiple explanations for negative treatment experiences. It cannot be assumed that all experiences were negative and it was important to pursue the positive alternative to the study. I also consulted with critical friends and kept a journal to reflect on the ongoing research process. Critical friends are just that, people with whom I am close who were willing to provide professional critiques to challenge me to think critically about my research (Gunnar, 1999). I

established critical friends groups with professional colleagues and doctoral candidates, each of whom provided me with different perspectives for critiques of my research as it progressed.

### **Positionality**

I am an insider on the study in that I am a practicing addiction counselor working with legally mandated opioid users and have been for almost ten years. I have biases regarding the premise of this research and potential results of the research. Conversely, I am not a complete insider on this study as I do not identify with being a member of the population being studied. My role as an addiction counselor had the potential to lead participants to become hesitant answering questions and prompts due to biases they may have had toward individuals in my role. As a researcher, it was important for me to establish rapport with the participants and the researcher-participant relationship was introduced in the beginning of the study. Critical research required me to attend to the power dynamics that existed in the research context and my role as an insider was discussed prior to the interviews (Merriam & Tisdell, 2016). My insider status did have an impact on the depth of answers participants were willing to provide as they understood my experience working with the mandated population and, overall, wanted to help improve treatment through their participation in this study.

### **Chapter Summary**

In this chapter, I presented the methodology used to complete this study. The constant comparative method was used to analyze data collected through two rounds of qualitative interviews. Ten participants were recruited using snowball sampling methods and were able to share experiences in mandated addiction treatment that can contribute to existing literature to improve treatment practices. Data were analyzed through a critical theory lens as the goal of this study was to empower the people I studied and to give the participants voice where they



otherwise feel voiceless. In chapter 4 I will provide an in-depth analysis of the data I gathered in this study.

## CHAPTER 4: FINDINGS

In this chapter I introduce and explain themes I derived through the analytic process. During initial iterations of data analysis, I found that I was using a dichotomous lens to view the data (e.g., good vs. bad, right vs. wrong). However, I found that the data ultimately were not dichotomous in nature. Rather, there is a lot of grey; experiences that land on a continuum. Through open and axial coding, I was able to derive themes that wholly represented the data from the participants in this study. The two major themes I derived from the data were: The Mandated Treatment Counselor-Client Relationship and Necessary Conditions for Treatment. While each of the themes are unique and distinct, there is overlap between each of the themes describing the treatment experience for legally mandated opioid users. Each theme also has subthemes that will be described in detail later in this chapter. It is worth noting that I found there were issues related to ethical practice brought up by the participants, however they did not constitute an entire theme.

### Introduction to Themes

Having already been to treatment about five times over the course of ten years to address his heroin addiction, Jared, a participant in this study, shared about his most recent treatment and recovery attempts. His story exemplifies and is representative of many mandated addiction treatment experiences. His explanation of events that led to recovery gives an inside look at what may motivate mandated individuals to participate actively in treatment. After sitting in jail for a few months awaiting his Drug Court sentence, Jared was mandated to short term residential treatment. Jared was transported to treatment by the sheriff's office wearing a jumpsuit and shackles. When brought into the facility, Jared sat there observing his surroundings, waiting for the sheriff's officers to take off his shackles. Jared looked around and felt uncomfortable in his

surroundings as he did not feel that the area was conducive to getting better. Counselors, counselor aides/techs, and staff walked by him over and over again without paying him any attention. Before his shackles were removed, he already made the decision to run. And run he did. As soon as the sheriff's officers left.

Jared's run lasted a couple of weeks before he turned himself in. A few weeks later, Jared was mandated to residential treatment again, except this time he was mandated to long term treatment. He entered the twilight zone. He was again sitting in the back of a sheriff officer's car in shackles and a jumpsuit being driven to some unknown location where he was anticipating the same experience. This time was different. He was brought to a facility surrounded by farms and nature. When he entered the facility, staff offered him water and a cigarette. He observed fish in a large aquarium. Before the shackles were removed, he decided that he wanted to make it work in this facility. Jared's sharing of events during the interviews about his most recent treatment episodes shed light on subtle nuances of the mandated treatment experience that could be the difference between someone staying and going, trying and giving up, living and dying. Jared's experiences, along with the other participants in this study, magnified the lesser known or lesser acknowledged aspects of the mandated treatment experience for opioid users that I will explain in this chapter.

Following analysis, I derived two major themes from the data in this study. The first theme, The Mandated Treatment Counselor-Client Relationship, describes attributes of the counseling relationship that are unique to the mandated treatment experience. The theme and associated subthemes shed light on problematic aspects of the counseling relationship that were shared among the participants. The second theme, Necessary Conditions, highlights the significant impact that care and trust have on treatment and brings the reader into the payoff of

how far the little things go throughout the mandated treatment experience. In the Necessary Conditions theme, I provide the impact that counselors, other staff, and other clients have on mandated treatment. Over the course of the interviews, participants shared about lesser known or lesser discussed aspects of mandated treatment and some participants were able to share about the stark differences between private insurance and state funded treatment, as there are distinctions to be made. The depth of the themes will be presented throughout this chapter. The themes and sub themes for this study are shown in Table 5 below.

Table 5

*Summary of Themes*

Theme	Definition	Example
1. The Mandated Treatment Counselor-Client Relationship	The negative undercurrents of treatment experiences with counselors, are not necessarily overt and palpable, but sometimes subtle with deep impact.	I remember being in [a short-term residential program] and they would bring in recovery based different speakers. I've been to places where it's like, let's watch Law & Order all day. You know, that was mainly at detox. It was like, here's your pills, go watch TV...I got a lot of information in some of the places...Then it's like, here's a speaker from NA, here's a movie that might trigger you, here's All Dogs Go to Heaven.

1a. Cookie Cutter Counselor	Participants perceived that counselors conduct themselves in a robotic manner, failing to individualize treatment to their clients. Cookie cutter counselors fail to address specific needs of clients. Rather, they provide the same worksheets, information, and interpretations of events to all of their clients, leading to a disengagement in the treatment process.	The counselor by the book will pretty much treat everybody the same way. Like they wouldn't- it doesn't seem like they're getting up with the times. You know, they have this old school perspective...They're just not agreeable, you know. It's really hard to differentiate what's ego-driven, stubbornness, you know. Like, they're not really hearing me.
1b. Feeling Commodified	The experience of feeling like a commodity, or a paycheck, rather than an individual human receiving treatment. A lack of interpersonal dynamics with the counselors.	When I left [long term residential treatment], [my counselor] set [outpatient treatment] up for me, that was through my drug court...I didn't really have a choice in it. I didn't think I needed it...And I know how it goes through the court system. I was like, alright, this is gonna be forever and they're never gonna let me go and it's all a money thing...It was like, [my outpatient treatment program] wants money. They have this, you know, contract with drug court. And who's to say that I really need this...Like, I think I'm fine. I've not used in like close to a year...and they're telling me, 'okay, you need more treatment.' Because maybe they need more money.
1c. Collusion	The unspoken agreement of clients and counselors to do the bare minimum in the treatment program to allow for treatment completion to be reached. A failure of either party to work.	There is a fine line that I was very careful sometimes. Sometimes emotions got in the way and you were open, but they were also taught to know if you're being too quiet or you're being-like I tried to stay that medium. You know, give them a little, not everything. Because I didn't want to go to a halfway house, but I also didn't want to get stuck there for not participating, so I gave them that happy medium.

2. Necessary Conditions	Regardless of counselor or staff education, treatment interventions, or role in a facility, there are factors that have a significant impact on a client's willingness to participate in treatment; reciprocal relationship between care and trust.	It's nice and it's something I feel is needed, especially when you're going into a place like that. Like, you need somebody to be kind, you need someone to see you, you need someone to be like, 'hey, you need a cigarette and a glass of water?' You need a blanket just to make you feel welcome because it's already so raw. It makes a big difference.
2a. Feeling Cared For	Identified as the most important factor in treatment. Care can come from clinicians or other staff and has a significant impact on establishment of trust.	[Feeling cared about] had a huge impact on me...In the past, I've had counselors, like even when I was younger, that cared, but, I mean, I don't think I was ready. But this time, I know one of the reasons why I actually was able to get clean was because I felt like all the staff in there would like literally do whatever they could to help me—techs, counselors...So after I got out, and especially for somebody like me that was just like out on the street all alone, felt like nobody was there to help them in life. When you go in there and you find people really care, it's just very uplifting and it kind of motivates you to want to do the right thing. Just knowing people actually care and support you, it's huge. It's huge.
2b. Trust	Belief that treatment expectations will be met by treatment providers and the treatment environment is conducive to promoting change behaviors.	[Regarding trusting treatment] "It was my first time on supervision of any kind and I wanted to do the right thing, but I also didn't want to get in trouble. Even though I wasn't doing anything wrong."

2b1. Trust of counselors	Confidence in the competence and genuineness of counselors in mandated treatment.	There's some counselors I don't mess with at all. Like, I was all surface. Just get me out of this program. I mean, I'll make up something and let them think they fixed it. And I'm out the door. If I don't trust you, I'm not messing with you.
2b2. Trust of other clients	Faith that clients will maintain confidentiality of information shared in treatment and create a safe environment for treatment.	[A counselor] actually held this group and it was about trust. And everybody in group said that they would pick me 'could they trust me' and I couldn't pick out one person in the group that I would trust. I have such a big problem with trusting people.

### **The Mandated Treatment Counselor-Client Relationship**

The first theme of this study is The Mandated Treatment Counselor-Client Relationship. This theme provides insight into the ways that clients reflect upon and experience different aspects of their relationships with their counselors. I found that the treatment experience is not overall good or bad, helpful or harmful. It is not dichotomous. Rather, treatment includes an array of experiences on a continuum that shows an inconsistency in treatment delivery. The participants in this study shed light on elements of mandated treatment that deter them from fully engaging in or trusting the treatment process. What I found in this theme shows the ripple effect from decades of unstructured, unlicensed, and unethical treatment interventions that have trickled down to current treatment practices, as discussed in the literature review. Experiences of mandated clients are varied and complex. However, the negative undercurrents of those experiences, as expressed by the participants in this study, are not necessarily overt and palpable, but sometimes subtle with deep impact.

In chapter 2, I discussed the elements of the counseling relationship that are necessary for a positive treatment experience and I stressed the importance of the quality of the counseling relationship. What I found in this study, however, shows that the necessary elements of the counseling relationship are not always present and the therapeutic alliance is not always established within the mandated counselor-client relationship. The data I collected in this study allow for a deeper understanding of why the relationship with mandated clients and their counselors may not be strong or effective for treatment interventions to have impact.

The mandated counselor-client relationship is unique in that it has a coercive nature while also serving unhealthy purposes for both parties. During the interviews, I found that each individual (client and counselor) plays a role in the development of the relationship. While there may be many types of roles clients play in treatment, this study focused on how the clients experienced and would describe their treatment and counselors. From their perspectives, most of the participants agreed that there are counselors who show up to work for what seems like a paycheck and health benefits, but not as a helping professional. One participant shared that over the course of 20 years seeking addiction treatment, she learned to have very low expectations of treatment facilities and treatment providers as she was made to feel like another name on a roster as opposed to an individual seeking help.

When clients entered treatment through a legal mandate, there was a consensus among participants that they themselves were hypervigilant due to the nature of their drug-using lifestyle (i.e., stealing, selling drugs, manipulating, lying). The participants shared about being untrustworthy and living a life of criminal activity that they would project onto other clients and even staff. Their lifestyle led them to doubt the integrity of clients and counselors around them. Several participants viewed their counselors as an extension of the criminal justice system and



had their guard up in early interactions to get a sense for whether or not their counselor was on their side, as there is often a sense that the legal mandate is against them. Some of the participants shared that they would try to give each of their counselors a chance at establishing a relationship, but interactions that may seem benign or insignificant can have a lasting negative effect for the duration of the relationship. What I took away from the hypervigilance and cautious nature of the participants was that they entered treatment in a protective mode. The participants may have a resistant exterior, but, in reality, they are just protecting themselves from additional harm.

To further the discussion regarding harm that can take place in treatment, I will share the experience of Kenneth as he discussed what he perceived about his relationship with his most recent counselor. Kenneth is a Black male who grew up with an intact, high-achieving family. Kenneth stated that he was not raised to be a heroin addict. Despite how he was raised, Kenneth found himself addicted to heroin for several years and consistently sought treatment during that time. Eventually, Kenneth was arrested for and convicted of robbery. He noted and explained in detail that this was an attempted robbery, no one was harmed, no weapons were used, and he had never done something like that before. Regardless, Kenneth's attempted robbery is viewed as a robbery by the state of New Jersey and he pled guilty to a second-degree felony. While in treatment through Drug Court as a result of this criminal conviction, Kenneth talked about what it was like for him to share about his conviction with his counselor. In relaying this experience, Kenneth shared that his counselor made him identify as a criminal and provided him a workbook to complete about being a criminal. Kenneth took great offense to that because he felt like he was being pigeon-holed into a role in which he did not belong and that he was not being heard by his counselor. That early interaction with his counselor resulted in a sustained guard up for the rest

of treatment because he did not feel that he was being heard, rather he was being judged and stereotyped.

The following subthemes will further explore aspects of mandated treatment and give insight into the varied ways each of those themes are experienced or interpreted by the participants in this study.

### **Cookie Cutter Counselors**

During the first round of interviews, participants were prompted to share about their varied treatment experiences and what their relationships were like with their counselors. Each participant provided feedback about counselors that were impersonal and disengaged. Kenneth coined the term cookie cutter counselor when sharing about his experiences with counselors over the several years he had been mandated to addiction treatment. Cookie cutter counselors (CCCs) can be described as those counselors who are perceived by clients as individuals who conduct themselves in a robotic manner by doling out generalized, nonspecific information to their clients without addressing the needs of their clients. CCCs provide the same worksheets, information, and interpretations of events to all of their clients, leading the clients to disengage in the treatment process.

Upon further questioning and a second round of interviews, I found that each participant in this study had experiences with a cookie cutter counselor across their years seeking treatment. That is not to say that every counselor is a CCC, but they are prevalent and experienced by many clients. The participants in this study perceived many counselors as CCCs throughout their mandated treatment experiences. All of the participants in this study were able to share about experiences they had in group and individual counseling sessions with CCCs and explored what impact that had on the counseling process and their relationship. The participants agreed that

CCCs lead them to not want to participate fully in counseling as a client because they do not perceive their counselor as fully participating as a counselor. One example that was shared through the interview process of a CCC pertained to dating. If a client were to discuss a new relationship after being in recovery for two months, a CCC would tell a client that they should not date for the first year of recovery and leave it at that. The participants in this study indicated that an approach like that to counseling would lead them to disengage in the process because they felt that they were being fed lines from a script rather than having a helping professional assess and address their needs.

When prompted to discuss their experiences with CCCs, participants had slightly different variations of whom they encountered that fit the mold. CCCs could fit into one of three categories: very new to the field and unprepared (green), paraprofessionals integrating recovery fellowship jargon into counseling, or seasoned counselors who seem to treat all clients the same in an “old school” way. While their backgrounds may vary, their style of counseling is perceived as the same. CCCs provide the same feedback and interventions to each of their clients regardless of age, race, criminal history, mental health problems, or drug of choice. This appears to be an antiquated approach, which has been improved upon over the past several decades as a result of research, but the participants found that CCCs are not uncommon in practice. The participants did not find CCCs to be helpful or therapeutic.

Jessica shared about her counselor who was new to the field with a level of empathy for her. “She tried. She met me where I was at...But yes, she was very green.” At the time in her life when she was in treatment with a green counselor, Jessica shared that she was actively using numerous substances, overdosed, and was seeking custody of her child. However, her green counselor was unable to offer her treatment interventions appropriate for her at that time. For

Jessica, having a green counselor worked for her as she stated that she was not interested in actively participating in her recovery and her counselor was unable to provide the counseling services Jessica needed. Jessica's active substance use substantiated recommendations for residential treatment, but she was retained in outpatient treatment for several months. Jessica felt as though her counselor was underprepared to work with someone in active addiction. Jessica did not want treatment and felt that she did not receive it. Dante shared the same sentiment as Jessica when discussing a green CCC:

I feel like every counselor operates differently, right? Every counselor does go through a schooling and, yes, there is a textbook behind every counselor...but there are some counselors that might use the textbook more because that's all they know. You know, until they learn how to deal with their clients or they've been doing it for a while and you figure out other ways to go about things.

When discussing his green CCC, Dante showed a level of understanding regarding the lack of preparedness a green counselor has for the field. Through his quote, one can see how clients perceive their counselors' potential for effectiveness. Jared also reflected on his green counselor sympathetically because she was unable to bring a lot to the table as a counselor, but it was acceptable because she was young:

She couldn't have been more than 24 or 25, and I thought to myself, you're not going to teach me anything...I didn't like ask for another counselor or anything, but it just wasn't anything that worked for me...She had no experience, she was just young...She didn't have the knowledge to say anything back to me because she never dealt with [addiction].

This version of the CCC shows the clients' understanding and awareness of counselor preparation for the addiction counseling field. Jared shared that he had been in treatment many

times before that particular treatment episode and did not believe that a young, green counselor could say anything new or valuable that could help him in his recovery, but he was going to give her the opportunity to learn how to be a counselor with him as the guinea pig.

Rebecca described a different version of the CCC stating, “She’s good, but she’s just like rote, if that makes sense. She’s just like an NA kind of preach machine.” Rebecca went on to further state that “it’s so sad because I loved her too. She was so sweet. And she was actually good in groups, but like counseling wasn’t great.” In her interpretation of the CCC, Rebecca draws our attention to the infusion of recovery fellowship jargon into counseling. I have established the existing issues with blanket use of 12-step recovery fellowship material in counseling, due in part to individuals’ conflicting beliefs with the tenets of 12-step fellowships. Rebecca’s feeling that a counselor was an “NA preach machine” brings that issue to the forefront, showing the negative impact that can have on treatment. Wyatt described one of his CCCs with a related perspective:

I feel for [some counselors] because you’re constantly dealing with the same shit every day. It’s like being a TSA person. Like, ‘take off your shoes, take off your jacket, take off your belt.’ Like everybody has to repeat the same shit. Like, everyday you’re saying the same thing. It’s got to be annoying, but a lot of them are just rude. They are like [corrections officers] sometimes.

Rebecca and Wyatt described this robotic or “rote” counselor that has a repetitive, unoriginal way of speaking to clients that does not do much clinically for the clients. However, both Rebecca and Wyatt expressed empathy for those CCCs by stating that they either feel bad or it is sad that a counselor has little authentic, individualized information to contribute to the counseling experience.

Kenneth discussed his experiences with the third type of CCC, seasoned counselors, who seem to relay the same information to all of their clients, despite the information being irrelevant or outdated.

[They] put me in that category without seeing me for me. I see that in the counselors that have longer experience sometimes...The counselors that have been around for a while, as information changed, I don't think some of them have changed with it. And it's unfortunate...It's someone that's checked out...The counselor by the book will pretty much treat everybody the same way. Like they wouldn't- it doesn't seem like they're getting up with the times. You know, they have this old school perspective...They're just not agreeable, you know. It's really hard to differentiate what's ego-driven, stubbornness, you know. Like, they're not really hearing me.

Kenneth's experiences with seasoned CCCs shows some contrast with green CCCs in that green ones seem to lack knowledge while seasoned ones fail to adapt to changing knowledge. While the education, preparation, and age of a CCC may vary, the impact remains the same. Ashley shared:

I didn't even want to interact because...it's almost like I already knew what they were going to tell me...They all just were kinda the same. And after doing this for like 20 years, I kinda wanted them to prove to me that they were gonna treat me like a person. And then, when it didn't happen, it was like, 'yep, that's exactly what I expected from you.'

Ashley, who reported that she had been to treatment about 12 times over the course of 20 years, had become accustomed to having low expectations of treatment providers. Despite her many

less-than-ideal interactions with counselors during her 20+ years seeking addiction treatment, Ashley shared about one very positive interaction that stuck out to her.

There was one time I did have a session with my main counselor [in treatment] and I remember she said to me, she challenged me, and she said, 'you think a lot.' And instead of giving a cookie cutter answer, she asked me to find the answer myself...and she waited for me to say something and I thought about how distorted my thinking was. And that made me feel seen...It made me want to work with her more.

When reading and re-reading those two quotes by the same participant, I am taken aback at the amount of effort on the counselor's part used to engage Ashley as a client and to bring her in as a part of her own treatment. A simple prompt for her to think has resounded with Ashley for years as a positive counselor-client interaction. The CCC, on the other hand, has left little positive impact on clients. If anything, the cookie cutter counselor leads to clients disengaging in the counseling process.

The participants' experiences with CCCs teach us something valuable about the counseling experience. CCCs are the expectation. Clients expect to have counselors that will provide redundant worksheets, say the same one-liners they have been using for years, approach sessions with each client the same way, and expect the clients to achieve the goals of their treatment plan. However, when the participants had counselors who were not CCCs, they reported having significantly more positive experiences and learned more about themselves in the sessions. This is not to say that having CCCs causes clients to relapse or drop out of treatment, but it is a piece of a larger problematic puzzle.

### **Feeling Commodified**

An ongoing and underlying theme of the mandated treatment experience was the feeling of commodification. Commodification is the experience of feeling like a commodity, or a dollar sign, rather than an individual receiving treatment. There was a noted lack of interpersonal dynamics with the counselors when a client felt commodified. This theme was developed as I listened to participants share about their relationships with counselors and how they felt that some counselors went to work “just for a paycheck” and they were just another “ass in a seat,” particularly when they were in mandated treatment. Commodification furthers the idea that treatment duration and recommendations were based on financial motivation and not client need. For this subtheme, I will introduce experiences that led participants to feel like a commodity and what it felt like for them while in treatment.

Darren described his experiences with being mandated to treatment by the Department of Corrections (DOC) as a term of his state parole release:

Whenever I did a program through like DOC it was a complete joke. You could tell they just had people there for the money or whatever... This was mostly when I went to state-ran facilities. I mean through, like, prison and DOC... You could tell that it's nothing, but money because you go in there... and you don't talk to anybody. Like, you're just packed in a place and you don't even work on yourself.

In his description of treatment mandated by the DOC, Darren presented the idea that, although a person is in a mandated treatment situation, treatment is not necessarily being implemented by the counselors or treatment providers in the facility. Ashley aligned with Darren's sentiments, stating, “I wouldn't go expecting to actually get treatment because I knew the facility just needed to keep their roster full.” The takeaway from those two experiences is alarming in that the



concept of commodification is more of an expectation than the alternative and, in the participants' perspectives, there is nothing clinically beneficial taking place for the clients to prevent relapse and recidivism.

While the experience of feeling commodified can come from receiving no treatment while in a mandated facility, Jared shared another interpretation of commodification while mandated:

When I left [long term residential], [my counselor] set [outpatient treatment] up for me, that was through my drug court...I didn't really have a choice in it. I didn't think I needed it...And I know how it goes through the court system. I was like, alright, this is gonna be forever and they're never gonna let me go and it's all a money thing...It was like, [my outpatient treatment program] wants money. They have this, you know, contract with drug court. And who's to say that I really need this...Like, I think I'm fine. I've not used in like close to a year...and they're telling me, 'okay, you need more treatment.' Because maybe they need more money.

What Jared contributed to this study was the feeling that treatment is not necessarily mandated because the client needs it. Rather, treatment is mandated so that facilities that have contracts with legal mandates will stay afloat financially. Beth shared a similar sentiment to Jared when discussing her duration in mandated treatment:

So everything being the fact that I was court appointed. I felt like you know, they were getting money for me so I felt like I got to stay there longer because of it. Regardless of how good or bad I was doing like, they didn't care like I was going to be there for how long I was going to be there.

What can be heard in the participants' acknowledgement of their mandate is how it can be intertwined with the feeling of commodification. The participants are sharing that when they are in mandated treatment facilities, their progress and implementation of change behaviors may have nothing to do with how long it will take for them to complete the treatment episode. That insight into the treatment leads to a need to know how that feels for them and the impact that has on their participation in treatment and recovery. Ashley described the feeling of commodification:

When you are that person that is just another number, another dollar sign, it's like, 'you guys are making all this money, can you at least have better food for us?'. And counselors or techs would throw back 'well, you didn't mind not eating when you were on the street.' And it's like, yeah, well thanks because I'm not on the street. I'm trying to get help and you're making me feel like shit. I have always felt like a paycheck to the point where it was like why even go to treatment?

While describing this feeling, Ashley introduced the idea of reciprocity with financial gain for treatment facilities. Overall, feeling commodified in mandated addiction treatment leads the clients to disengage from the treatment process because, from their perspective, no matter what progress they make or effort they put in, they are just there to fill a seat so that people can get paid. For example, clients in long term residential treatment will be retained in treatment for exactly the same amount of time regardless of progress made throughout the treatment experience.

When discussing commodification, Jessica contributed alternative perspectives that she has had as she has been to treatment six times, but only one was legally mandated. She shared about what treatment was like for her when she was a self-pay client. There are many

implications of and differences with her self-pay treatment episodes versus the experiences of state-funded mandated treatment of others, some of which are alarming:

There was one time I was [in treatment] from April of 2018 to September of 2018. I had to pee in a cup for [my counselor] every time because, like I had one clean drug screen from everything and she's like, 'you should go frame this.' I don't even know how I did that. But all of the others I was using. When I first started I was very proud of myself, because I wasn't doing heroin, but I was doing Suboxone, alcohol and Xanax. And I guess she was like- obviously their suggestion to me was always 'you can't,' but I was also paying myself. The insurance wasn't paying. I didn't have insurance. So I think they might have kept me because of that.

In her recollection of events in an outpatient treatment program while being a self-pay client, Jessica shared that she remained in treatment without being kicked out for using drugs. Jessica felt that her treatment program wanted what was best for her considering they made recommendations for higher levels of care. However, Jessica remained an active client in an outpatient treatment program for about six months while actively using illicit substances, overdosing several times, and injuring herself while on the premises. Whereas mandated clients felt that they remained in treatment too long while not needing the treatment, Jessica, without being mandated, remained in outpatient treatment too long while desperately needing treatment in a higher level of care. Jessica did mention that the facility recommended that she attend their own residential treatment program, which is also a self-pay facility. Jessica reflected on this experience as she felt commodified considering she was paying out of pocket for each session she attended and her money could be used to keep the facility afloat. Regardless, as has been discussed in detail in Chapter 2, there are specifications for treatment in different levels of care

that exist regardless of mandate or payer source. Jessica's experience is distressing in that she experienced her facility retaining her in treatment for financial gain when she could have died. She could have died several times.

### **Collusion**

Collusion with counselors is the unspoken agreement of clients and counselors to do the bare minimum in treatment to allow for treatment completion to be reached; a failure of either party to put in the work. The participants in this study were very aware of treatment requirements to show they made progress that will result in treatment completion. Despite their decision to attend treatment, at times the clients had no desire to actually put in the work to sustain change. As a result, the participants alluded to this idea of "mailing it in" so that it looked like they put in work. At the same time, counselors, who are trained in making observations and assessments about their clients, are permitting this "mailing it in" of their clients' treatment and recovery processes. The participants determined what they would have to do and say to get by. Wyatt discussed how he would manipulate his counselors:

There is a fine line that I was very careful sometimes. Sometimes emotions got in the way and you were open, but [the counselors] were also taught to know if you're being too quiet or you're being-like I tried to stay that medium. You know, give them a little, not everything. Because I didn't want to go to a halfway house, but I also didn't want to get stuck there for not participating, so I gave them that happy medium.

In discussing the formula for how to complete treatment without revealing too much or saying too little, Wyatt shed light on the mutual failing that takes place in addiction treatment. From his perspective, the clients and counselors each fail to fully participate in treatment in a meaningful way. While people with substance use disorders have a reputation for being manipulative as a

character trait, not all of the blame of the mutual failing can be placed on the client. As Jared explained his relationship with one of his counselors:

He wasn't very personal. It was more like, we have this one hour session and that's all you're gonna get... 'Don't bother me other than that.' I didn't really like it. Okay, well, 'I'll tell you what you want to hear on our one on one, but don't expect anything else out of me.'

Jared's description of his relationship with one of his counselors continues this theme of two individuals putting in minimal work to get by. To put this in greater perspective, clients in a collusion relationship are observing the behaviors of their counselors and mirroring back what they are putting in. There is a reciprocal relationship to the minimal effort being put into treatment. This subtheme also highlights the ethical principle of beneficence and how some counselors fail to do good. Where we might seek out overt harmful behaviors with an ethical lens, it might be the covert failures that are having a significant negative impact on the treatment for mandated opioid users.

The participants in this study shared about and agreed upon aspects of the client-counselor relationship unique to mandated addiction treatment. I found that three prevalent elements of that relationship are collusion, feeling commodified, and cookie cutter counseling. Each of those aspects of the mandated client-counselor relationship validate reasons why a mandated opioid user may disengage from the counseling process while still maintaining attendance in treatment. Feeling commodified, cookie cutter counseling, and collusion are areas where treatment needs improvement based on the data gathered from the participants in this study. However, there are resounding positive aspects of treatment that have a direct impact on counseling that I will share in the next theme.

### Necessary Conditions

Throughout both rounds of interviews, it was evident that there were certain elements of treatment that were a common thread through each participant's positive experiences: feeling cared for and experiencing trust. It became clear from each of the participants in this study that feeling cared for by staff and trusting staff and other clients are wholly necessary for effective treatment to take place. Through data analysis, it appeared as though the necessary conditions are the antithesis of the aforementioned elements of the mandated client-counselor relationship. Feeling commodified, receiving cookie cutter counseling, and colluding to complete treatment are absent when trust and feeling cared for are present. I found this to be true of all of the participants' mandated treatment experiences. While there is no clear definition of the elements necessary to create a caring environment, all of the participants were able to contribute the elements that are present when care and trust are not.

While the concepts of care and trust are prevalent in counseling literature, they are either absent from or invisible specifically in addiction counseling research. Addiction counseling is a specialty within the counseling discipline; however, it is treated as though it is a separate profession by some researchers and clinicians. It is as though exceptions are made when counseling individuals with substance use disorders that permits less ethical and clinically acceptable behavior. Throughout the interview process, it became apparent to me that addiction counseling is continuing to be treated as an "other" in relation to general counseling practices. In this theme, I found that feeling cared for and experiencing trust are necessary for participants to perceive positive treatment experiences and that care and trust have a reciprocal relationship. Care can come from clinicians or other staff and has a significant impact on the establishment of trust.

Care and trust are important elements of the treatment experience that are necessary for true treatment to take place, however, the clients receiving that treatment generally operate from a lifestyle that lacks care and trust with self and others. Clients entering mandated treatment from the street or a jail setting are apprehensive about being trusting of others or experiencing sincere care as genuine. Several participants made mention of knowing when a counselor “actually cares,” which shows that they are looking for sincerity and genuineness in their relationship.

### **Feeling Cared For**

Feeling cared for was identified as one of the most important elements in addiction treatment by multiple participants in this study. Feeling cared for was mostly absent from existing research regarding addiction treatment or mandated treatment. The participants highlighted how much impact feeling cared for can have on individuals who care little for themselves. In active addiction, this population does not care about their physical appearance, mental health, social or familial relationships. Many people at this point in their addiction are at the brink of suicide, and feeling cared for can help reverse that thought process. Having a counselor that shows genuine care for their clients can instill hope and the desire to care for themselves. Darren, who has been to treatment over 15 times, shared about what it feels like to feel cared for in treatment:

This time, I know one of the reasons I was able to get clean was because I felt like all the staff...would literally do whatever they could to help me: techs and counselors....Especially for someone like me, that was just like out on the street all alone and felt like there was no one there to help them in life. When you go in [inpatient treatment] and you find out people really care, it's very uplifting and it motivates you to

want to do the right thing...Just knowing people actually care and support you, it's huge.

It's huge...I think [care] is the most important part of treatment.

In his most recent treatment episode, Darren shared about how the care of all of the staff members in a treatment facility can undo so much of the negative self-talk and low self-esteem that many clients experience in active addiction. The positive impact of care for that reason alone cannot be understated. In his statement about care, Darren discussed the significant positive impact that it had on him when people "actually care," which leads one to consider the alternative. Darren introduced the idea that it feels like people pretend to care in treatment and he can feel that, too. Ashley contributed a similar sentiment:

I think a [good counselor] is someone who like genuinely cares, not just pretends to care or is like paid to care....You can sense when somebody is really listening to you or trying to understand where you are coming from.

Authenticity is crucial in the counseling relationship and the clients are very aware of counselors who appear not to be authentic in their display of care toward their clients. Jared shared what it was like for him to be treated with care when he first arrived in a residential treatment program after sitting in jail awaiting treatment:

I think everybody has that feeling to want to be wanted or cared about. That's just like a natural feeling. And it did feel genuine when I was in treatment. Like, when I first got there, I was still in handcuffs and a lead tech was like welcoming me. I'm all nervous and he's welcoming. And we got kind of buddy-buddy with techs and they could tell when we were having an off day and they would check on me. I think it was genuine. It was really genuine.



Jared's experience relates to what Darren and Ashley contributed in that they experienced a genuine, authentic feeling of care when they were in treatment. Jared highlighted that the simple act of checking in on an individual can have a lasting impact and can lead a client to a long-lasting feeling of being cared for. It is important to note that Jared's experiences show the positive impact of techs (or counselor aides) on the treatment experience for a mandated individual.

In her discussion on the impact of feeling cared for in treatment, Jessica mentioned the importance of not only feeling cared for by her treatment providers, but also her legal mandate:

I mean, [feeling cared for] is so important...I even felt cared for by the drug court team...And I felt like they really wanted to see me be a mother, they really wanted to see me turn my life around...[A former counselor] talks all the time about the importance of community and that you're not just a number and I was never made to feel that way.

Even in drug court.

Jessica's experiences, which were unique compared to other participants as her many treatment episodes were mostly self-pay and only one was mandated, she was able to reflect on the positive feeling of feeling cared for by her treatment team and representatives of the criminal justice system. Treatment does not happen in a vacuum and there is a very real presence of the legal mandate when an individual enters treatment in lieu of prison. Feeling as though the counselors, counselor aides/techs, probation officers, and judges all want you to succeed and progress has a positive impact on treatment engagement and development of self-worth and self-esteem.

Feeling cared for can come from small, seemingly mundane or insignificant interactions like asking about the health of a client's family member, remembering events from a client's childhood, making sure the temperature is okay in the office, or joking around and allowing for

genuine humor. Clients can sense when a counselor is doing the bare minimum as opposed to when a counselor is working as a truly helping professional and showing care.

### **Trust**

Trust is the belief that treatment expectations will be met by treatment providers and the treatment environment is conducive to promoting change behaviors. What we need to consider about this population when discussing the establishment of trust is that their world prior to treatment generally thrives on a lack or absence of trust. Establishing trust with these clients takes more effort than one might assume considering their lack of trust with others or themselves. On the part of the counselor, establishing trust early in the treatment process is critical for an overall beneficial and positive treatment experience. Without establishing trust with clients, Ashley described what it felt like trying to participate in treatment:

You already have trust issues and then you're not getting any help from the staff or having an opportunity to open up to the staff. And then, you're in this group where you're supposed to just like open yourself up to all these strangers. And I'm like, I don't want to do that because I don't know these people and I don't know what they're gonna use against me. I am just trying to get through this.

What may have seemed like innocuous interactions in the hallway between Wyatt and a counselor in a residential program ten years ago have remained vivid for him:

I didn't like [one counselor]. It was like a power thing with him. The first day I was there, I didn't even say nothing to him and he comes by with a coffee and he's like 'won't be getting any of this.' I don't give a fuck. I'll never drink coffee again. Like, don't tell me I can't have it... They said I was getting too much mail or something crazy and they took my mail. And they weren't letting me have my mail and so like whatever, but then they

tried giving it back to me. ‘I don't want it now. Throw it out. I don't even care.’ Cut off my nose to spite my face? I'd cut my fucking head off.

Wyatt's description of his interactions with that one counselor can provide needed insight into the mindset of clients in the facility and what environmental elements are necessary to establish the safety for change. For Wyatt, he was not going to sustain change behaviors when he felt that he had to have his guard up with treatment professionals. Conversely, when a counselor can establish trust with a client in a meaningful way, the impact can lead to fulfilling treatment.

### *Trust In Counselors*

Trust of counselors is the confidence in the competence and genuineness of counselors in mandated treatment. Trust of counselors does not happen overnight as multiple participants shared that it was a process to feel like they could actually trust counselors. One of the overarching narratives about counselors was stated by Rebecca: “[Treatment] would be way more effective if drug court didn't turn counselors into cops.” In that statement, Rebecca spoke to the lack of trust that exists with addiction counselors in a mandated treatment setting. In her experiences, Rebecca felt that she could not fully trust that counselors would maintain appropriate confidentiality and put her needs before her mandate's needs. For her treatment to be effective, Rebecca needed to be sure that she could trust that her counselors would perform the duties of their jobs ethically. She needed to believe that the counselors would look out for her best interests.

Kenneth furthered the discussion about lack of trust for counselors when he recounted an experience when he was being bullied by his peers in treatment. Kenneth, a Black male on Drug Court, shared that he was struggling with issues about race and being bullied by his peers when he spoke about his bullying with the program director:

The director at the time, she was a tough one. You know, she was really tough and she didn't really have too much compassion for me. I was like, you know, that five-year-old boy getting fucking bullied. And I'm telling the teachers what's going on and no one believes me.

Kenneth's recounting of his experience with being bullied in treatment could have had a different outcome had his counselor or program director acted on his complaints. However, he was not taken seriously and kept his guard up, which prevented him from feeling that he could trust his counselor. Kenneth's experience with being doubted and not supported by the staff in his treatment facility had a lasting impact on his ability to fully engage in and trust the therapeutic process.

While some participants shared about issues with establishing or retaining trust with counselors and treatment providers, other participants shared about very positive experiences they had once they let their guard down and allowed themselves to trust their counselors. Darren shared about his experience building trust with his counselor in residential treatment:

It took me a little while to warm up with her, you know, I was fresh out of jail.... It was easy to trust her because she proved over and over again, like, she always had my back...I gave her basic trust at first, but after a while, like just being around her watching the way she is, knowing she doesn't like go back and talk about me to everybody unless it's for clinical purposes...I'm a big person on loyalty and she showed that she was loyal to me.

Darren's experience with establishing trust with his counselor displayed that he was always watching his counselor's interactions to ensure that she was genuine and acting in his best interest, highlighting this hypervigilance that other participants spoke to in regards to

establishing trust. Wyatt spoke to the establishment of trust with his counselors, but brought to light that his trust was never fully developed as he continued to have a guard up as a result of several years of active addiction and incarceration:

But you have to pick and choose who those people are...I've had probably four counselors that I let in. I've had a lot of counselors, but only four that I've talked to and I've never talked to each one about the same thing. They've all worked on different problems that I have or went through.

Despite his trepidations with fully opening up to his counselors while in treatment, Wyatt did allow himself to actively participate in his treatment and recovery after he was able to establish trust. Several participants spoke to the time and attention needed for trust to be established with their counselors. Dante identified work that he knew he needed to do while he was in long term residential treatment and that he was determined to address specific issues once he knew it was safe.

And like, but like when I went in [to treatment], like, 'I gotta focus on this', like, 'I'm in a good environment. I'm safe. I'm okay.' And like, building up the trust that somebody to be able to talk to him about. And that doesn't happen in a short amount of time, like building up that trust. It takes a while to build up that trust with somebody.

In his recollection of events building trust with his residential treatment counselor, Dante brings awareness to not only the need to allow trust-building to take time, but also that clients are aware of the need for trust to exist before they will be willing to put in the work. The participants' discussions of their need for trust in order to be able to fully benefit from treatment gives counselors insight that as much as counselors are assessing their clients, the clients are assessing their relationships with their counselors and move according to the depth of that relationship.

The concept of trust in addiction treatment is pervasive and is not only relegated to counselors, but is reflected in relationships with other clients, as well. As much as trust with counselors is a necessary condition for effective treatment, trust with other clients is as impactful and necessary for effective treatment. Depending on the treatment setting, other clients may be the roommate, neighbor, friend, or enemy of clients in treatment and all of them need to experience trust.

### ***Trust In Other Clients***

Trust in other clients occurs when there is faith that clients will maintain confidentiality of information shared in treatment and create a safe environment for treatment to occur.

Addiction treatment generally takes place in group modalities that is then supplemented by individual counseling sessions. For a true therapeutic experience to take place while in the group setting, clients need to feel that they not only trust their counselors, but also other clients.

Participants reported that trust had not been established with the other clients, which led to them not fully participating in group counseling. Beth shared about her experiences of trust with peers in inpatient and outpatient treatment:

For the most part, I did have my small group of people [that I trusted], but they didn't know what they were talking about. I mean, people would say, 'Hello, do this...do this and you'll get out [early] or making a joke of it because they had been there so many times. I mean, I didn't really know them and I wasn't there for that. And we were all sick...You know, a lot of people got in trouble and look for any way to get out and stuff like that, but I don't think IOP was as scary as inpatient because nothing was gonna send me back to jail from [IOP] unless I used.

Where Beth described her decision not to foster too many friendships while in inpatient or outpatient treatment as she found that many of the other clients were still sick, Jared shared about how group size determined his willingness to participate in group counseling:

In small groups, yes. But once it got like the larger groups, I felt like there was too many personalities for it to be 100% like a safe zone for you to say something.

By sharing about their experiences with trusting their peers in treatment, Jared and Beth, along with other participants in this study, agreed that their relationships with other clients in a treatment program can have a major impact on their participation in group counseling. Whereas some clients do not care how or what they share in treatment, most of the participants are reserved in group counseling sessions for self-preservation unless trust is established. There was this idea that being in treatment with other mandated clients who are “still sick” can impede upon the therapeutic process because the other clients have the potential to break confidentiality and do or say something that can have a negative impact on one’s mandate. For example, clients will be less likely to share openly about having cravings to use or serious problems in their lives out of fear that other clients will break confidentiality and tell their probation officer. Further, if some clients are not taking the treatment process seriously, clients who want to take it seriously will not buy into the process knowing that not everyone is in treatment for the same reasons.

Jessica compared her treatment experiences in mandated and voluntary treatment:

I would say it was harder to trust with mandated treatment. And I felt like I was going because I had to go, I wasn’t going because I was doing something for my recovery...whereas in [self-pay, voluntary] inpatient I enjoyed going to the groups. We built a really good rapport.

The insight provided by the participants in this study as it relates to establishing trust with peers in treatment provides deeper insight for addiction counselors in understanding group dynamics and levels of self-disclosure some clients are unwilling to have in treatment.

### **Chapter Summary**

In this chapter, I presented the findings of this study to answer the research question, “How do legally mandated opioid users describe their treatment experience?” I introduced and explained the two main themes I derived from the data in this study: The Mandated Client-Counselor Relationship (Cookie Cutter Counselor, Collusion, and Feeling Commodified) and Necessary Conditions (Feeling Cared for and Trust in Counselors and Other Clients). I provided raw data I collected through qualitative interviews to validate and provide deeper meaning to each of the themes and subthemes regarding the treatment experience for mandated opioid users. In the following chapter, I will provide a deeper meaning and implications of the findings from this study.



## CHAPTER 5: DISCUSSION

The purpose of this study was to explore the treatment experiences of individuals who were legally mandated to addiction treatment for an opioid use disorder. In chapter four, I presented the findings of this study through two major themes I derived from the data: The Mandated Client-Counselor Relationship and Necessary Conditions. The high rates of treatment dropout, administrative discharge, relapse, and recidivism lead to a need for greater understanding of how opioid users experience legally mandated treatment.

As I introduced in chapter one, addiction treatment in the United States has seen significant changes since its inception in the 1700s. However, there were blatant, significant, overt unethical practices taking place in addiction treatment through the 1970s (White et al., 2005). Treatment tactics and ethics have been established and improved upon since that time, but questionable treatment practices continue today that may be reflected upon years from now as being unethical or, at least, problematic. The counselor's role in the treatment process is known to have a significant impact on a client's engagement and retention in treatment (Martin et al., 2000; Miller et al., 2019). There is an existing power imbalance between counselor and client in any setting (DeVaris, 1994), but the power imbalance becomes even more unevenly skewed in favor of the counselor when the clients are legally mandated to treatment (Skeem et al., 2007).

Clients who are legally mandated to treatment for a substance use disorder, particularly an opioid use disorder as overdose deaths have significantly increased since 1999 (NIDA, 2022), deserve comparable treatment to those who seek treatment voluntarily. I used qualitative methodology, undergirded by phenomenology, to answer the research question, "How do legally mandated opioid users describe their treatment experience?" Qualitative methodology was instrumental to provide insight into treatment experiences of the participants in this study. This

chapter presents a findings summary, an interpretation of the findings through Critical Theory, as well as the implications of this study as it relates to current treatment practices and counselor education, limitations, and suggestions for future research.

### **Contextualization of Participants**

Before I discuss the findings of this study, I believe it is important to give context to who the participants were and what the process was like for them to participate in this study. The snowball sampling method that I employed was critical because the participants verbalized a need to have a sense of trust in me and my motives prior to answering any questions. Several possible participants who were referred by counselors in the field failed to follow through with participation, due in part to the lack of familiarity the individuals had with who I am as a researcher.

The participants who chose to complete the interviews for this study verbalized their desire to contribute positively to addiction treatment for people like them. Their motives seemed pure in that sense. The participants did not anticipate the questions or prompts and did not have a desire to demonize or glorify what they know of treatment. They did, however, appreciate the opportunity to share openly about their many and varied treatment experiences as they have never been given the opportunity to do so for themselves in the past. The participants' voices were always meant to remain the focus of this study as they have been missing from research, literature, and treatment itself. By listening to their own words and using their perspectives of their experiences to analyze the data, the participants were able to contribute significant valuable information to addiction treatment literature through this dissertation. This dissertation gave them the opportunity to be heard and not just listened to.

The experiences of the legally mandated clients in addiction treatment are difficult to capture fully as there are so many intersecting identities and previous experiences that contribute to who they are and how they perceive what they have gone through. For example, an individual who has experienced significant abandonment and loss may perceive punitive treatment practices in a very different way than an individual who has a history of severe physical trauma. Also, individuals who have a mindset of “I have nothing to lose” may approach treatment differently than someone who feels “I have everything to lose.” Some participants sought treatment with the intention of getting better while others attended treatment to delay incarceration, but with no desire to stop using drugs. The participants provided a window into their psyche when seeking treatment through a legal mandate that has been missing. Based on data gathered in this study, we know that many clients attend treatment while sharpening their manipulation tactics and treat it as more of a game or hoop to jump through while they sit next to others in the same groups with the same topics and the same treatment interventions and are treated the same as someone who wants nothing more than to get better forever. Counselors have the unique task of discerning which clients honestly want to change and which clients just want to slide through under the radar. Because of their differences, we must look at them as unique individuals as participants in this study and, more importantly, as clients. Before reading through the discussion of findings, I believe it is important to contextualize the information I present as it was offered by those who want to make a positive impact on a world many know little or nothing about.

### **Discussion of Findings through a Critical Theory Lens**

Research addressing the legally mandated treatment population is rarely collected from the clients’ perspectives and, even more rare, using qualitative methodology. This study indicates that the clients’ responses provide a perspective that can improve the addiction counseling field,

specifically, the essentiality of the counselor-client relationship. In addition, the findings provide a deeper understanding of elements that contribute to the strengthening and weakening of the counselor-client relationship.

Critical theory was selected as the theoretical and analytical framework for this study to identify and challenge assumptions about the criminal justice-involved opioid using population in an attempt to improve the addiction treatment they receive (Merriam & Tisdell, 2016). I sought information that would go against what we currently know or understand about the treatment experience for legally mandated opioid users with the goal of developing a better quality of treatment for this population. The overall treatment experience for legally mandated opioid users can be oppressive as their voices are often given little merit due in part to the way we, as a society, have viewed this population historically.

The results of this study contradict the decades-old, yet currently accepted, philosophy that individuals with substance use disorders need to be broken down in treatment to then be built back up. Participants shared that some individuals are on the brink of suicide when they enter treatment and want to feel cared for as opposed to being broken down by staff and other clients. Critical theory allows us to challenge and change that ongoing assumption about treatment and treatment expectations. Critical theory can be used to critique existing social structures and find ways to change them, particularly where there are instances of oppression that marginalize groups of people (Winkle-Wagner et al., 2019).

Critical theory is a social justice oriented analytical lens applicable for qualitative methodological enquiry (Winkle-Wagner et al., 2019). Paris and Winn (2013) remarked that “Critical qualitative inquiry is rooted in critical theories such that the research process becomes more ‘humanizing’ and possible ‘decolonizing’ for the participants and researchers” (as cited by

Winkle-Wagner et al., 2019, p. 8). The participants in this study voiced an inability to control what happens to them once they agree to terms of their legal mandate and other people have been given authority, or power, to make decisions for them. Critical theory offsets dehumanization, validating the importance of the clients' experiences and giving power back to the participants. Critical theory requires that the collection and analysis of data fosters change for marginalized populations. The marginalized population under consideration in this study are opioid users legally mandated to addiction treatment. This study has the goal of critiquing longstanding power structures in mandated addiction treatment to shift the focus of what it is to what it could be, that is, adhering to the context of a humanized interaction sensitive to the mandated client's needs.

### **Mandated Client-Counselor Relationship**

The first theme of this study, The Mandated Client-Counselor Relationship, introduced elements of treatment that are commonplace throughout different levels of care in mandated addiction treatment across New Jersey, but are rarely, if ever, mentioned in literature: cookie cutter counseling, feeling commodified, and collusion. This theme provided insight into inconsistencies in treatment delivery to the population being studied. Current research discusses how important the counseling relationship is to a client committing to change, reducing relapse, reducing recidivism, and overall improving their lives (Allen & Olsen, 2016; NADCP, 2020; Werb et al., 2016). Absent from the literature are the experiences of clients, particularly feeling that their counselors failed them.

Through a critical theory lens, we see the inequities in access to beneficial treatment as a way to further oppress a population who has established that they have little to no say in what treatment they receive, where, and by whom. Clients' decisions are made for them by the courts with the consequence of state prison sentences if they fail to comply. Rather than empowering

and giving voice to this population, the ongoing narrative instills in them that they cannot make good decisions for themselves and that they need to be broken down. The two participants who had attended private insurance/self-pay treatment facilities were able to articulate stark contrasts between the treatment experiences when they were mandated, which highlighted and validated that mandated individuals are treated differently when all else is the same (age, race, gender, drug of choice). It is as though, because individuals were arrested and mandated to treatment, conditions of treatment are altered or standards of treatment are lowered based on the participants' experiences.

Participants spoke to the importance of the counseling relationship and the impact of certain positive and negative aspects of that relationship. The idea that the relationship can change over time, but is heavily influenced by early interactions (Hackney & Cormier, 2013) was verified and validated by the participants in this study. Scott (2000) found that clients may appear to be resistant to treatment if they do not perceive their treatment is individualized or aligned with their values. The results of this study validated that finding over twenty years after Scott's study was published. Each of the participants in this study were able to share experiences they have had or have observed about issues with the quality of the client-counselor relationship in mandated treatment, which further validates the scope of this study. Through their open dialogue in qualitative interviews, the participants shed light on issues in treatment that need to be improved upon or changed in order to provide better substance use treatment for individuals with opioid use disorders.

### ***Cookie Cutter Counselor***

Cookie cutter counseling was experienced frequently by most of the participants in this study and has its own subtle nuances. The three types of CCCs each had their own specific

characteristics, but had the same overall impact on the counseling process for the participants. CCCs lead to a disengagement in the counseling process and were experienced as unhelpful and dehumanizing. While the participants in this study have come to expect and accept CCCs as a standard addiction counselor in mandated treatment, the status quo can be challenged and improved upon. “Critical perspectives generally assume that people unconsciously accept things the way they are, and in so doing, reinforce the status quo” (Merriam & Tisdell, 2016, p. 61). However, with the knowledge of the negative impact CCCs have on treatment, we can challenge what is and humanize clients through individualized treatment practices and oversight of the treatment process.

### *Feeling Commodified*

The experiences the participants shared about feeling commodified brings to light ethical standards of addiction counseling. Commodification takes away the human aspect of treatment and leads clients to feel like a cog in the wheel of a business as opposed to feeling like an individual seeking treatment. Participants in this study stated consequences to viewing a client as a dollar sign rather than a human as, much like CCCs lead to disengagement, feeling commodified also leads clients to disengage from the treatment process. Participants who felt commodified reported feeling dehumanized, which created space and distance in the counseling relationship where there should be closeness and emotional intimacy. Participants in this study shared about financial aspects of treatment and how it made them feel. For example, the participants were highly aware of how valuable they were to keeping a facility financially afloat and some believed that their treatment recommendations, which were backed by the courts, were made to ensure that treatment facilities generated income. There are opportunities for better treatment experiences if clients feel valued as people and not a financial asset to the facility.

### ***Collusion***

Looking at the broad implications of collusion in addiction treatment, I am drawn to the overt failure to do good, beneficence, as one of the six principle ethics of the counseling profession (ACA, 2014). This theme brings to light the experience of receiving no treatment while in treatment, which shows a failure of the counseling professional to do good. The theme of collusion was not derived from every single experience the participants had with their counselors. However, several participants mentioned the formulaic process for treatment completion with predictable, partially present counselors who hold a position of power in the counseling relationship. The process of mutually failing to provide (counselor) or take part in (client) treatment is an unhealthy, manipulative dance that can further a client's unhealthy, substance use-related behaviors that lead to their mandated treatment. It is as though, when collusion is taking place, the client is getting sick as opposed to getting better. Power dynamics are central to critical research (Merriam & Tisdell, 2016) and this study sought to show how those dynamics are exhibited in mandated addiction treatment. The theme of collusion shows how clients experience their counselors and feel that their counselors failed to meet their needs as clients while meeting the needs of the treatment facility and legal mandate. Collusion in addiction treatment can be seen as a means of further oppressing clients as the treatment experience was no longer viewed as treatment. Instead, treatment was viewed by some participants as a game to be played in order to avoid negative consequences.

### **Necessary Conditions**

While there is value in knowing areas where improvement is needed in addiction treatment for opioid users, it is equally valuable to know what is going right. It was important to hear from participants who had given up on themselves at one point in their lives and, eventually,



came to wanting a healthy life in recovery. The theme of necessary conditions highlights the two most important elements of treatment that I found through data analysis in this study: feeling cared for and trust.

The second theme of necessary conditions gives a different perspective on treatment. The first theme introduced unhelpful elements that are rather common in mandated addiction treatment, and the second theme provides insight into critical elements that help make treatment work. Where the first theme can be seen as a cautionary tale, the second theme is a tale of what to do as treatment providers. The establishment of trust and experiencing feeling cared for in treatment are elements of successful, beneficial treatment that participants in this study expressed. It is important to note that trust and care were established with counselors, program directors, and counselor aides, all of whom made a significant impact on the treatment experience, but are rarely, if ever, mentioned in literature. Further, research regarding care in treatment were absent from addiction treatment literature, which seemed to reinforce the age-old philosophy of breaking clients down to later build them up. The participants in this study were able to shed light on an element of addiction treatment that is fundamental.

While the impact of the first theme provides readers with ways that clients may feel oppressed in treatment, the second theme shows how certain aspects of treatment can humanize the clients. Humanization and empowerment of the participants is a goal of critical theory (Winkle-Wagner et al., 2019). The feeling of being dehumanized and commodified can be undone and replaced by genuine care and trust, which shapes the treatment experience as a genuine human interaction rather than a chore or unwanted task.

### *Feeling Cared For*

The experience of feeling cared for was a significant finding throughout each interview with all participants. As a clinician, I anticipated this result. As a researcher, I was unaware of the prevalence of care in addiction treatment as I found its absence from existing literature to provide meaning for its lack of prevalence in practice. I found very few studies (e.g., Halstead et al., 2002; Rayle, 2006) about the importance of feeling cared for in counseling, particularly in addiction treatment. The literature I did find was outdated, showing how feeling cared for is not a priority in research, despite the results of this study highlighting its importance in the mandated treatment experience.

The participants in this study noted that feeling cared for is important to them and has a significant impact on the entire treatment experience. The participants neatly placed feeling cared for at the top of the list of traits they find in a good counselor and what they want out of the treatment experience. When care is absent from treatment, clients feel the earlier-mentioned elements of the mandated client-counselor relationship. Feeling cared for may be the antidote to commodification, collusion, and cookie cutter counseling as care brought about humanization in the participants. Feeling cared for was the result of small interactions (e.g., offering a water or cigarette to a new client, offering helpful feedback in individual sessions) that occurred consistently for the participants and had a significant impact on their willingness to be open to the counseling process.

### *Trust*

Trust, much like feeling cared for, is necessary for effective treatment to take place per the participants in this study. I noted that participants were very transparent about why they are not open in treatment. As much as counseling professionals are trained to assess clients upon

initially meeting them, clients are doing the same of their counselors. The participants shared about early interactions with staff, mostly counseling staff, who they felt treated them poorly and tarnished the relationship that could have been established. The participants indicated that they watched how their counselors interacted with other clients and staff so that they could determine whether or not they were trustworthy. There was an imperativeness to ensuring that trust was established between counselors and clients and between clients so that the treatment experience could be enriching and valuable as opposed to being another manipulative experience for an individual who was mandated to treatment as a temporary jail diversion. Participants noted that the establishment of trust was critical to the treatment process and challenged the existing social structures that result in participants feeling less valuable or less human.

**Trust In Counselors.** The participants shared that, as clients, they were likely to mirror back to treatment staff how they were treated. When clients felt that their counselor worked more for the benefit of the courts than for the benefit of the clients, the clients reverted to behaviors that keep counselors at arm's length. However, when counselors were honest and were experienced as trustworthy to clients, the clients were more likely to be open to the counseling process. The participants in this study expressed wanting to know that they were heard and trusted as much as they were expected to trust the treatment staff. The current power imbalance in mandated treatment resulted in trepidation to be open in treatment, as several participants voiced that some counselors acted more like corrections officers than counselors. Further, while some participants were very aware of content on release forms used for communication with their legal mandate, other clients were wary of who would say what to whom, and would rather offer less honest information out of fear of consequences. Critical theory calls for a challenge to

the existing power structure in treatment facilities, so that trust may be earned by the client and the treatment staff, which makes treatment a more humanizing experience.

**Trust In Other Clients.** The participants in this study suggested that counselors were likely unaware of the depth of dynamics between clients as there could be long standing feuds from street life, recent negative events with roommates, cliques, and other issues. As I stated in chapter 2, there are certain conditions that must exist within the counseling relationship for treatment to take place and that remains true even when working in a group setting. Trust between clients was imperative for effective treatment in group counseling. Several participants shared that they did not feel completely safe sharing openly with the other clients because they viewed the other clients as still sick or untrustworthy. For successful treatment, counselors need to make sure that trust exists between clients. By talking about and challenging this issue, the participants in this study became empowered to enact change (Merriam & Tisdell, 2016). The participants voiced concerns about issues with trusting other clients because of how important it is to the treatment process and cannot be overlooked or understated.

The results of this study provided an uninhibited look at the mandated treatment experience for opioid users. The participants in this study shed light on areas of treatment that they felt needed improvement and other areas that are beneficial to their own recovery and change processes. Through the critical theory lens, the data were analyzed and framed ways to challenge the existing treatment processes and expectations of a marginalized group of individuals to empower them to be able to voice ways to humanize and improve treatment for the future. I found that critical theory alone did not fully encapsulate additional data I collected regarding the change process in recovery and chose to integrate a newer theory, desistance, to explain the results.

### **Theory of Desistance and Critical Theory**

Desistance is emerging as a theory being studied and better understood while critical theory has its roots established for 100 years. Desistance is “the process by which offenders give up criminal activity and become law-abiding citizens” (Weaver & Weaver, 2013, p. 259). Each of the participants in this study made the decision to no longer take part in criminal activity. I found that the theory of desistance could help to make meaning of the participants’ treatment and recovery processes. While desistance has been applied specifically to individuals who identify as criminals, the overlap between substance users and criminals is prevalent and fully represents the population in this study. Skjaervo et al. (2021) studied desistance following substance use treatment after establishing that desistance can be a positive consequence of recovery, treatment engagement has a significant impact on crime reduction within this population, and focusing on criminality in treatment can foster desistance. “It becomes increasingly clear that, in addition to treatment retention and time in treatment, the content and quality of the treatment [clients] receive are crucial factors for explaining the individual differences in treatment outcome and recovery” (Skjaervo et al., 2021, p. 10).

Recent research on desistance among substance users has been evolving and expanding our understanding of clients’ needs (Skjaervo et al., 2021; Weaver & Weaver, 2013). While clients may not be able to or feel empowered to articulate their needs in treatment, counselors can have a better understanding of how they need to show up for their clients by interpreting the participants’ treatment experiences through an integrative lens. Clients are not one dimensional, therefore their treatment cannot be one dimensional. Clinicians need to be able to view their clients in terms of their substance use and criminality needs by assessing and observing their clients in terms of the world in which they live. We can choose to humanize individuals with

criminal histories and opioid use disorders through empowering their voices and better meeting their needs as clinicians.

I collected data from each participant about how many times they have been in treatment and how many times they have seriously attempted recovery. For all of the participants, the number of recovery attempts was less than the number of treatment episodes. I found that, on average, the participants attempted recovery one time for every eight treatment episodes. The data collected regarding treatment episodes and recovery attempts has led to more questions than answers thus far. Are counselors failing their ambivalent clients? Are counselors adequately prepared to implement motivational interviewing techniques? Have some counselors given up? Are clients unable to be reached? Are we addressing the appropriate topics with the clients to promote sustained change? These questions ultimately put the burden on the treatment professionals. It can be easy to put blame on the clients for returning to substance use upon treatment completion. However, we need to look at the treatment the clients are receiving and whether or not that treatment is fully addressing the clients' needs. The collection of this data is a start for learning more about what leads to internal motivation for recovery and how treatment can better address and assess the state a client is in when they enter treatment. The present study, while having a small sample size, has been able to illuminate the concepts of motivation for treatment and motivation for recovery, which are not synonymous, although not enough data were collected to develop a cohesive theme. For the criminal justice-involved, legally mandated client who attends addiction treatment, I have found that there are more areas to explore regarding treatment-seeking behavior and recovery.

We can say from the results of the present study that mandated clients currently do not receive the same treatment as their voluntary, privately insured counterparts. There are clear

distinctions that can be made between the quality and style of treatment received by those who receive mandated treatment and those who seek treatment through private or self-pay voluntarily. The lack of treatment equity brings about further need to abolish the status quo of treatment as it is today and to find ways to improve treatment or critically review the premise behind mandated treatment as there are significant issues with mandated treatment delivery. Knowing that individuals mandated to addiction treatment are more likely to complete treatment, but not more likely to remain abstinent (Coviello et al., 2013; Urbanoski, 2010) speaks to the motivation of clients to comply with a mandate, but not actively participate in treatment, which leads to further inquiry regarding the ethical nature of mandated treatment.

### **Implications**

There are several implications from the findings of the current study for counselors and counselor educators. When I refer to counselors, I refer loosely and broadly to any professional or paraprofessional working in the addiction treatment helping profession.

### **Addiction Counselor Credentials**

Addiction counselors have varied educational backgrounds. While paraprofessionals may work in the same capacity as master's level clinicians, the treatment they provide is not the same. Simons et al. (2017) found that paraprofessionals are not as comfortable as their licensed counterparts providing counseling to individuals with personality disorders, thought disorders, suicidal ideation, depression, and anxiety, yet are more likely to work with criminal offenders than licensed counselors. Participants in the present study were able to identify counselors who were paraprofessionals and what they contributed to their treatment. The participants shared that paraprofessionals use their own treatment and recovery experiences as a road map for their clients. While one participant appreciated his counselor's recovery status, all other participants

found that there was little clinical value in the paraprofessional cookie cutter counselor.

Paraprofessionals have a valuable perspective that can assist clients in their recovery, but would be best served in the role of recovery specialist, which has become much more accessible and prevalent in addiction treatment in recent years (New Jersey Department of Human Services [NJ DHS], 2014).

### **Addiction Counselor Education**

The addiction counseling field would benefit from national standards for addiction counselor education. Like mental health counseling, addiction counselors enter the field from different disciplines, including counseling, social work, marriage and family therapy, and psychology. Each of those disciplines prepares individuals to provide counseling services through undergraduate or graduate education. However, counselor education does not fully prepare future counselors for working specifically with the addiction population. The participants in this study were very aware that, at times, they were treated as guinea pigs by neophyte counselors who appeared to have no experience dealing with or understanding addiction and shared that they tailored what they were willing or able to discuss in sessions to meet the preparedness of their counselors. Addiction counselors need to be prepared to meet the needs of their clients as the clients should not be expected to change their vernacular or level of comfort to meet the needs of their counselors. While this may not be realistic in the immediate future, I believe that a long-term goal should be standardized preparedness of addiction counselors to include undergraduate or graduate level education and nationally accredited addiction-specific coursework in order to meet the substance use and mental health needs of their clients.



### **Current Addiction Treatment Providers**

There is a gap in what we consider treatment to be and what treatment currently is, based on the findings of this study. There was a consensus among participants about the prevalence of CCCs, clients feeling as though they are commodified, and collusion between counselor and client for treatment completion, which seems counterintuitive when considering how counselors are educated for clinical practice. I propose that annual audits of treatment facilities that receive funding to provide mandated treatment go beyond chart audits and include interviews with clients and treatment staff. I believe that audits of facilities require the voices of clients in order to better understand the treatment being offered, impact of treatment interventions on clients, to empower the voices of the clients in a meaningful, humanizing way, and keep treatment providers accountable for the treatment they are responsible for providing. Audits that include interviews with clients could improve the accuracy of documentation with the goal of improving standards of care and outcomes for mandated clients. Addiction counselors may be in a position to advocate for their clients through such systemic change.

This study offers aspects of treatment that participants found to be unhelpful and harmful in some ways and important and necessary in others. Participants in this study underscored the importance of ensuring that treatment programs work to consistently meet the environmental and counseling relationship needs that the clients seek while in treatment. In an effort to improve counseling for mandated opioid users, counselors and administrative staff may benefit from consistently seeking clients' feedback throughout treatment to ensure that their needs are being met. Participants shared that meeting their needs was the exception to the rule in mandated treatment, suggesting that seeking clients' perspectives may help to improve treatment in these facilities.

The results of this study regarding the client-counselor mandated relationship highlight areas where clients perceive that counselors do not always provide individualized, multiculturally competent treatment. While all credentialed professionals and paraprofessionals require ongoing continuing education credits, there may be a gap between education and practice. All addiction treatment facilities could assess the clinical competence of their treatment providers to ensure that they are applying skills and updating their knowledge.

Currently, relapse and recidivism upon completion of mandated addiction treatment are not uncommon. Addiction treatment facilities might consider adopting standards for treatment success. Participants in this study suggested that treatment completion alone does not indicate growth or progress on the client's part. Standards for treatment success can assess actual growth and progress of the client and provide follow-up outreach at regular intervals for one year after completing treatment.

### **Breaking the Cycles within the System**

The feeling of commodification was prevalent throughout the interviews of this study with all participants. Feeling dehumanized, like a financial asset to a treatment program, as a client had a significant impact on the participants' perceptions of their treatment recommendations, cognitive engagement in the treatment process, and the length of time they were kept in treatment. Further, the unanticipated finding of collusion with counselors provided a deeper look at the nature of mandated addiction treatment. The participants provided insight into a system that seems broken. At times, clients are attending treatment as a means to an end while they feel as though their counselors are showing up to check boxes to satisfy funding sources and legal mandates. It appears that, from these findings, some mandated treatment keeps money in the agencies' and counselors' pockets without affecting change for the clients. Further, the

concept of readiness for treatment, which needs deeper exploration, highlighted the participants' acknowledgments that they internalize treatment when they want to, not when their counselors want them to. All of these findings beg the question, in mandated treatment ethical?

I documented decades and decades of ethical issues in addiction treatment that were overt and, at times, illegal by today's standards (White, 2014). However, mandated addiction treatment remains a dominant course of action for individuals involved in the criminal justice system. I found that several participants received no evidence-based, manualized, or standardized treatment during some, but not all, treatment episodes. The ethical implications of mandated addiction treatment call into question the entire system as there is a lack of accountability on the treatment providers and clients alike. We know that people relapse. We know that outcomes are not 100%. We know that treatment does not always have impact the first, fifth, or fifteenth time, yet individuals are still being mandated to treatment. It is as though society is accepting that poor outcomes are a part of addiction treatment. We need to do more to ensure that treatment providers are accountable for providing treatment that is consistent with current research results while screening for the appropriateness of mandating a significant portion of individuals in the criminal justice system to addiction treatment. We can acknowledge that some people do not want help just as much as some counselors do not provide help (collusion). While I found that there have been truly positive and beneficial counseling experiences provided to participants in this study (necessary conditions), that is the exception to the rule. The findings of this study provided a starting point for aspects of mandated addiction treatment that are falling short of acceptable standards, yet has become the status quo. Armed with that knowledge, there is an opportunity to break the cycles of mandated addiction treatment that clients have come to expect.

### **Kenneth's Story**

When seeking participants through snowball sampling, I attempted to stratify the sample by race and gender. I interviewed four women and six men, which provided adequate data to represent any potential gender differences in treatment experiences. However, only three participants identified as people of color. Two participants identified as White Hispanic and one male participant identified as Black, Kenneth. Data gathered from Kenneth was not enough to develop a theme based on his treatment experiences as a Black man, but his experiences are important to note as he did contribute valuable information about his mandated treatment experiences.

Kenneth discussed his upbringing and shared that he was not raised to be a drug addict. He provided a very detailed explanation about how he became involved in the criminal justice system. As I noted in Chapter Two, POC are more likely to be arrested than White individuals (Acevedo et al., 2019; Camplain et al., 2020; Hart & Hart, 2019), are more likely to be imprisoned for nonviolent drug offenses (Camplain et al., 2020), and are less likely to receive treatment as an alternative to incarceration (Hart & Hart, 2019). Kenneth contributed valuable information to this study that spoke directly how he experienced mandated addiction treatment as a Black man in the criminal justice system.

Kenneth shared about a crime he attempted to commit in order to obtain money to buy drugs, but was unsuccessful. Kenneth stated that, despite his failure to follow through with this crime, he was convicted of it and was sentenced to Drug Court. Kenneth shared about one counselor who forced him to admit to being a criminal as a part of his treatment plan while he was in long term residential treatment, despite sharing that he did not identify with being a criminal. Kenneth also shared about bullying that he experienced while in treatment and that staff in the treatment facility did not intervene even though he sought assistance with the

bullying. He described what it felt like for him to seek help with his safety and was belittled and turned away. Further, Kenneth stated that his White female counselor attempted to identify with him by sharing that she knew of a famous Black actor. In each of these instances, Kenneth's treatment experiences do not represent what one might consider appropriate in treatment and opens the door to further exploration of treatment experiences of POC who have been legally mandated to addiction treatment for an opioid use disorder.

### **What is the Gold Standard?**

Medication Assisted Treatment (MAT) is considered the gold standard of treatment for individuals with an opioid use disorder (Madden, 2019; NIDA, 2019). There are three types of MAT that can be prescribed: methadone, buprenorphine, and naltrexone (Ceste, 2019). When interviewing participants, I asked each of them if they have ever used MAT and what their experiences were with it. I anticipated significant, meaningful experiences regarding the use of MAT to treat an opioid use disorder considering its prevalence in research. However, one of the ten participants identified as currently being prescribed Suboxone (buprenorphine) while the rest of the participants shared that they were not on any medication. The participants were more eager to share about their stories of being in addiction treatment as opposed to exploring the use of MAT, so I followed their line of sharing as a researcher, allowing them to give voice to what they found important and pertinent.

Further questioning showed that most of the participants did not have a positive view of the use of MAT in recovery. The participants shared that they have used MAT as a part of their short-term detoxification while in a treatment facility or as a way of curbing withdrawal symptoms after obtaining it illegally outside of treatment. While MAT is considered the gold standard for treatment of the population of this study, the overwhelming majority of the

participants had a negative view of the use of MAT as a part of recovery. Knowing that avoiding withdrawal is the greatest motivator of an opioid user to commit a crime, do they avoid medication that has a side effect of eventual withdrawal out of fear of having that happen to them while in recovery? I believe that future research needs to explore individuals' experiences with MAT and what forms their views of this medication while research states that it is evidence-based and effective treatment.

### **Limitations**

This study sought to hear the voices of individuals who have recently been mandated to addiction treatment for an opioid use disorder. Qualitative methodology allowed for deep meaning making of data collected and allowed for the participants to openly share about treatment experiences, but the sample size was small at ten individuals and the data could have been richer with a larger sample size. Quantitative methodology would also increase the generalizability of the results of this study. While there was a richness and depth to the responses in this study, the snowball sampling method could have limited access to those who chose to participate. I requested current addiction counselors to refer former clients to participate in this study and it is likely that the participants who elected to participate were skewed to have a more positive view of or experience with their treatment providers. Participants who were recently administratively discharged from treatment may have a different perspective on their treatment experience, but were not in this study.

Hearing the perspectives of the clients was critical for this study, but it also limited the data collected. This study could have been enriched by triangulation of data by interviewing participants' former counselors to learn about specific experiences from both perspectives. Clients in mandated addiction treatment are complex individuals and the voices of counselors

can provide more context to elements that influence the client-counselor relationship. Member checking, analytic memos, and critical friends did add to the trustworthiness of data collected, but hearing from the counselors' perspectives could give more needed insight into relationship dynamics in treatment. The participants in this study sought addiction treatment in New Jersey exclusively, with two individuals' private insurance/self-pay treatment out of state as exceptions. Hearing from individuals who receive treatment across the United States would have provided deeper insight into mandated treatment for opioid users.

Recruitment for participants in this study was strained and there were several individuals who indicated they would participate and failed to follow through. There was intentionality placed on interviewing participants from diverse racial, ethnic, and gender backgrounds, but the sample was not entirely representative of legally mandated opioid users. Interviewing people of color with more intentionality could provide more explicit information regarding treatment experiences for marginalized communities who are oppressed. Further, I attempted to recruit participants through the court system in New Jersey, but was informed by a liaison that the courts were uncomfortable presenting this study because they felt the clients would feel coerced to participate.

For the purpose of this study, I chose not to include participants who reported having a severe mental health problem in addition to an opioid use disorder. I believe that there are additional aspects of the mandated treatment experience that were unable to be explored by excluding this population from the study.

### **Suggestions for Future Research**

The results of this study illuminated elements of the counselor-client relationship for mandated opioid users in addiction treatment that the participants found diminished the

relationship and other elements that enhanced the treatment experience. Future research could expand upon each of the existing themes in this study to provide additional breadth and depth to what was learned in this study. For example, cookie cutter counselors were determined to have three styles, each of which had similar impact. Future research can look further into each type of CCC and how they are experienced by clients.

Additional research can seek information about mandated addiction treatment through an ethical lens using a priori codes to intentionally seek information about principle ethics in mandated addiction treatment. I found that counseling ethics arose throughout the interviews, but data collected did not constitute an entire theme. Through different sampling methods, a different subset of mandated clients with opioid use disorders may offer different insight into the treatment experience.

Future research that could expand on the current results of this study should seek to triangulate data by interviewing addiction counselors and their clients to help better understand both perspectives of the treatment experience. The perceived treatment experiences of clients and counselors could be interpreted differently and hearing from both parties in the counseling relationship could add valuable insight into the dynamics of the counseling relationship and how perceptions of experiences shape the overall treatment experience.

Researchers may want to learn about specific treatment experiences with counselors who have different levels and types of education (social work, counseling, CADC). Level and type of education may have an impact on how addiction counselors approach their roles as addiction counselors and can further explain findings in this study. Participants in the present study were asked broadly about their treatment providers and thus the results do not differentiate the



professional orientation and identity. Researchers may learn more to determine if and how education and training influenced those client-counselor relationships.

This study aimed to learn about how clients experience mandated treatment and to explore the nuances of how they are treated while there. Through the initial analytical process using the constant comparative method, I learned that a common theme between the participants was that they sought treatment significantly more times than they identified having seriously attempted recovery. Participants were asked to explain the decision to seek treatment with no desire to benefit from it. I learned that there was never a time the participants went to mandated treatment unmotivated or ambivalent about recovery and had a counselor change their mind or motivate them to want recovery. The decision to change was internal and, generally, consequence-driven. For most of the participants, abstinence was required to keep them from incarceration, so that was the driving force for treatment compliance. Interestingly, for those participants with family court or child protective services involvement, custody and visitation with children was not a significant consequence to deter substance use. The data collected regarding recovery attempts and treatment episodes did not fully constitute a theme that could be presented thoroughly in Chapter 4, but deserves further exploration in future studies as the data suggested that this is an important, unexplored finding that could be studied through the lens of desistance theory.

Finally, future research may include intentionally interviewing individuals from marginalized communities. This study attempted to interview individuals from diverse backgrounds, but the extent of that diversity was not achieved in this study. A focus on the experiences of individuals from marginalized backgrounds can give deeper understanding of the mandated treatment experience for opioid users.

### **Conclusion**

In this chapter, I offered analysis of the findings of the study through a critical theory lens and further explored how desistance can explain the change process for individuals with substance use disorders and histories of criminality. I presented implications for findings of this study as they relate to current treatment providers and addiction counselor educators. I addressed limitations of this study and presented suggestions for future research to expand upon the findings and contribute to the addiction counseling literature and practice.

This study on the treatment experience of legally mandated opioid users provided insight into current addiction treatment practices that are found to be helpful and those that are harmful or non-impactful. This qualitative study is a starting point to fill the gaps in existing research that has ignored the voices of individuals with substance use disorders. The aim of this study was to better understand the treatment experiences of legally mandated opioid users in an attempt to inform treatment practices and counselor education in the future.

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**APPENDIX A**

## Dissertation Interview Guide

Do I have your permission to record this interview? Remember you do not have to answer any questions you are not comfortable answering. You can ask to stop at any time. Please keep your camera turned off and do not include your name on the screen.

Please do not disclose any illegal activities for which you were not previously convicted and sentenced. Also, do not mention specific names of other individuals throughout the interview.

Are you actively using drugs or alcohol?

Describe for me your treatment experiences.

Describe the relationship with your primary counselor.

You were legally mandated to treatment. Tell me about what that was like for you.

Would you have considered going to treatment if you weren't legally mandated?

Is your most recent treatment experience any different than before?

Have you previously dropped out of treatment? With incarceration as a consequence, describe that decision making process for me.

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