APPROACHES TO TREATING MANDATED VERSUS SELF-REFERRED CLIENTS AMONG ALCOHOL AND OTHER DRUG COUNSELORS

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PROJECT

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Division of Social Work
Abstract

of

APPROACHES TO TREATING MANDATED VERSUS SELF-REFERRED CLIENTS AMONG ALCOHOL AND OTHER DRUG COUNSELORS

by

Christopher S. Bates

Given the general acceptance of the importance of the therapeutic alliance in alcohol and other drug (AOD) treatment, it becomes vital to understand factors contributing to the creation and sustainability of the therapeutic relationship. This study explores one aspect: the treatment approaches of AOD counselors’ towards mandated and self-referred clients. This qualitative, exploratory study uses grounded theory and a social constructivism philosophical approach. Phenomenological content analysis using latent and manifest coding was applied to the interviews. The subjects were nine AOD counselors currently employed in the field for at least two years in Yolo, Sacramento, and Alameda counties. Three themes emerged: 1) all AOD clients are coerced into treatment, whether or not by the criminal justice system; 2) counselors frequently employ a different approach to clients mandated by the criminal justice system during the initial stages of treatment; and 3) counselors perceive that employment and structure in the client’s life have an impact on treatment outcomes. Implications for social work practice and policy are discussed.

_________________________, Committee Chair
Maria Dinis, Ph.D., MSW

_________________________
Date
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Chapter 1

THE PROBLEM

Introduction

This chapter will describe the research question to be addressed in this project. There will be a discussion of why the question is of interest and important. Then there will be a description of the background of the research question, followed by a precise statement of the research problem. Next there will be a description of the purpose of the study, an examination of the theoretical framework for the research, definition of terms used in the research, a statement of the assumptions in the study, a discussion of how the research will benefit the field, a description of the delimitations of the project, and finally a summary of the chapter, and a brief summary of the other chapters.

How are you impacted by the attitude of authority figures? Do you absorb the hostility of a highway patrol officer who stops you for speeding? Are you more likely to follow the healthy eating suggestions of a dietician who is stern and lecturing, or one who appears knowledgeable and empathic? Are you more successful in an endeavor if your mentor appears to expect you to succeed? Or does an expectation of failure become a self-fulfilling prophecy?

This study will explore one aspect of the question of the impact of projected expectations, or assumptions about likely outcomes, by figures placed in positions of authority. Specifically the study will look at the approaches of alcohol and other drug (AOD) counselors’ towards mandated and self-referred clients. Daily anecdotal life is full
of experiences that provide evidence that the attitudes and expectations of others have an impact on our own behavior. Even in situations as simple as checking out at the grocery store the attitude of the clerk has an impact on our decision to return to that store. If a clerk is slow, distracted, or rude we are likely to think twice about returning to that store. But what about situations were we do not have a choice - the aforementioned highway patrol officer, a boss at work, or even a teacher at school? How much more significant is the attitude of people with some degree of power over us? Do their assumptions about us become apparent in our interactions? And what is the impact of our absorption of those assumptions?

Where does authority come from? Max Weber proposed three conceptions of authority: 1) traditional, which derives from mutually agreed and long standing established roles such as patriarchy, 2) charismatic, which relies on the exceptionalism of the authority figure and emotional attachment to that individual, 3) legal-rational, where authority rests on bureaucratic policies based on rational values and rules (Pace & Hemmings, 2007). According to Pace and Hemmings, sociologists later developed a fourth type of authority to supplement those proposed by Weber. It was professional authority, and relied on the expertise required to achieve a mutually agreed upon goal. Pace and Hemming’s review of the literature of authority as it relates to the traditional educational classroom has application in AOD treatment. The relationship of AOD counselors and their clients parallels many aspects of the relationship of teachers and their students. The counselor and teacher are placed in positions of authority, both legal-
rational authority as envisioned by Weber and professional authority as developed later, and the client and student are both placed in the position of learners. In the case of mandated clients the parallel to students extends even further to their non-voluntary presence in the classroom. The question of authority, and its impact on treatment outcomes, is an intrinsic component of the AOD treatment formula, and this research seeks to inquire into that question.

Volumes, indeed whole careers, have been dedicated to the study of the impact of authority on those placed in the position of being acted upon by authority. Selecting just two studies, one micro level and one macro level, illustrates that no matter all the other considerations, authority unquestionably has an impact. In their study McLellan, Woody, Luborsky and Goehl (1988) followed 61 clients at a methadone treatment facility after they were reassigned from two counselors who had resigned to four new counselors. All other aspects of the clients’ treatment remained the same before and after they started working with the new counselors. The clients of one of the counselors had significantly improved treatment outcomes while the new clients of another counselor had fewer measurable successes, and in fact had decreased positive outcomes. The study authors arrived at two conclusions. First, that counseling is a significant ingredient in treatment, and second that there are measurable differences in the success of different counselors.

The macro study by van den Bos, Wilke, and Lind (1998) investigated the interplay of the development of trust and the perception of fairness of people placed in a position of authority. In the study students read scenarios that were tailored to instill a
sense that the authority was either fair or unfair. The students then used Likert scales to rate the fairness and trustworthiness of the authority in question. The authors concluded that in the presence of information indicating the authority figure was fair the students were likely to trust the authority. In any case, the study demonstrates that no matter the subject matter or research question, those in positions of authority have an impact on the perceptions and reactions of clients, or in this case students, who interact with them.

**Background of the Problem**

The 2009 National Survey on Drug Use and Health (NSDUH) annual report from the Substance Abuse and Mental Health Services Administration (SAMHSA) (2010) provides evidence that alcohol and substance abuse are at significant levels in the United States. The report compiled results from surveys of approximately 67,500 people. The report focused on trends between 2008 and 2009, as well as between 2002 and 2009. The principal finding of the 2009 NSDUH were that 21.8 million Americans older than 12 years old were current users of illicit drugs with in the past month. This number represents 8.7 percent of the population. The rate of use in 2009 was higher than in 2008, 8.7 percent versus 8.0 percent. Among the trends noted in the Highlights section of the report were: methamphetamine use increased from 2008 (314,000) to 2009 (502,000), marijuana was the most commonly used illicit drug, and that there was an increase in marijuana use from 2008 (15.2 million) to 2009 (16.7 million), cocaine use remained constant at between 1.6 and 1.9 million, use of illicit drugs by youth between the ages of 12 and 17 increased from 9.3 percent of the population to 10.0 percent. Other factors
noted by the report included: 17.0 percent of unemployed adults older than 18 were
current illicit drug users, and 10.5 million people older than 12 reported driving under the
influence of illicit drugs in the previous year.

The 2009 NSDUH report also found that 23.5 million respondents to the survey
needed treatment. The report defined treatment need as either actually receiving AOD
treatment at a specialized facility, or having DSM IV diagnosis of a substance abuse
disorder. Of the 23.5 million individuals needing treatment, 2.6 million actually received
treatment; leaving 20.9 million people diagnosed as needing AOD treatment at a
specialized facility without treatment. Of those, 1.1 million reported they thought they
needed treatment. Within that group 34.9 percent actually sought treatment, while 65.1
percent reported not making any effort to find treatment.

**Statement of the Research Problem**

As an exploratory study, this project will inquire into the approach adopted by
AOD counselors towards their clients. In particular the study will ask if the manner of the
client’s referral to the agency has an impact on the counselor’s approach to the client. For
purposes of this study clients are divided into two groups, mandated and self-referred. As
stated in the National Association of Social Workers Code of Ethics (1999), Section 4.01,
Competence, it is important that social workers to be self-aware about their treatment
approaches as part of their professional practice. This study will contribute to the base of
knowledge about AOD counseling, and provide an opportunity for study subjects and
readers to examine their own practice.
Purpose of the Study

The purpose of this research project is to explore the relationship between AOD counselors’ varied approaches to clients. The study will benefit the practice of AOD treatment on the micro, mezzo and macro levels. On the micro level, individual counselors who participate in the study will benefit from the examination of their own practice. On the mezzo level, agencies involved in the study through the participation of counselors employed at the agency will benefit by the improvement in the individual work’s increased self-awareness and self-examination. And, other employees at the agency may benefit from discussion of the project by participants, as they also examine their own practice. On a macro level, the practice of AOD treatment benefits from greater self-examination, and from the continuous reassessment of practices by those employed in the field.

Research Question

This study investigates the following research question: Do alcohol and other drug counselors use different approaches for mandated versus self-referred adult clients?

Theoretical Framework

This study applies a Foucauldian lens of power and the nature of knowledge to the overall theoretical paradigm of social constructivism theory. Also relevant to the study are the theoretical findings about the primacy of the therapeutic relationship above and beyond the specific modality of the therapy. The researcher will explain social constructivism theory, followed by a condensed discussion of Foucault’s notions of...
power and knowledge as they apply to social work. Finally there will be a discussion of
the therapeutic alliance, and its significance in the process of client change.

**Social Constructivism Theory**

Social constructivism theory holds that what is “known” is known by a consensus
of agreement among those who know it. In other words, participants in the knowing
mutually agree upon, or construct, the knowledge that then becomes a common
understanding of how the world is viewed, and of how the world functions. These
participants engage in discourse with each other that results in an agreement, stated or
unstated, about how the world, or some part of it, works. As Cottone (2007) further
defines social constructivism he noted that by its very nature it cannot be held to a single
definition. As knowledge, and the perception of that knowledge, grow and change the
agreement of what is known will shift. Cottone noted that a consensus grows around a
meaning by cultural understandings, and by the use of language. This puts both language
and cultural agreements at the center of learning. This element of social constructivism
illustrates the “social” part of the theory. Using language to exchange concepts of
understanding with others, individuals further develop their own unique construction of
the world, and their place in it.

Cottone (2007) also noted that change is a key element of social constructivism.
This notion is captured in the ancient Greek saying “no one can cross the same river
twice.” The meaning is that there is constant flow and change in the world, and that each
individual encounters a new world every time he or she interacts or intersects with the
world. Another key concept discussed by Cottone is the relation of cause and effect, and how there are multiple causes for any single effect. Since each individual constructs meaning, then each perceiver of any event also constructs cause. The viewer of the event determines the cause, and since there are multiple viewers of any single event social constructivism holds that there would be multiple causes.

Cottone (2007) summarized social constructivism as including these elements: primary importance of human relations, containing an explanation about how reality is understood, change is basic and intrinsic to any understanding, the process of mutual agreement in building knowledge, and that cause and effect also are constructed and therefore not singular. He proposed that these elements, when taken all together, constitute a paradigm approach to interrupting, and being in, the world. By attributing social constructivism with the status of a paradigm Cottone endowed it with the authority of a model that can be invoked as a guiding principal in research projects.

Foucault and Power and Knowledge

Foucault’s conceptual toolkit of inquiries into the history and nature of modern institutions provides a framework to view the health and social service agencies (Gilbert & Powell, 2009). The authors argued that Foucault’s conceptualizations of power, knowledge, and bio-power together provide a valuable set of ideas to interrogate contemporary institutions, and constructions of self. In particular, they point to the profession of social work as one that is revealed by Foucault’s line of questioning.
Chambon, Irving and Epstein (1999) defined Foucault’s concept of power as manifested through out the social structure. They caution that defining any of Foucault’s broader concepts is a risky endeavor as the concepts changed over the course of his life-long project, and furthermore he reconceived them as he addressed different issues at different times. However, the authors have related Foucault’s work to the profession of social work, and have created a Glossary from which working definitions can be applied to the field. They noted that he did not view the notion of power as necessarily a negative force, nor did he place power in the sole location of macrostructures, such as government, or bureaucracy. He saw it as dispersed and manifested at all levels of social systems. Chambon, Irving and Epstein also state that power is a central concept for Foucault. To help locate power Foucault points out that where there is power this is resistance, and that frequently the resistance is easier to identify than the power. The importance of power is its ability to shape and guide the topic of discussion, and therefore the arenas of the possible within social contexts. As the authors note, the distribution and exercise of power across the social spectrum uses action and knowledge to direct the flow of possibility.

Chambon, Irving and Epstein (1999) briefly define Foucault’s concept of knowledge as the “partial and selective representation of reality.” (p. 275). They note that knowledge and power are inextricably linked, as one contributes to the other, and as they both are deployed through out the social context. The relationship between power and
knowledge is central to both concepts, as the one is dependent on the other, and together, the two create, and then strengthen each other, causing both to grow.

Chambon, Irving and Epstein (1999) define Foucault’s concept of bio-power as the tool that allows for inquiry into the relationship of power and the human body. Bio-power addresses the activity of making the human body the subject of interventions by the government. Bio-power encompasses the processes of birth, death, sex, and in its most extreme form, imprisonment. The last most clearly illustrates the intersection of power and bio-power. The authors propose multiple readings, in the sense of meanings, of Foucault’s concepts, and reiterate that complexity and multiple meanings where central to Foucault’s work. Chambon et al. encouraged the use of Foucault’s tools to examine the field of social work as the historical certainty of modernity, with it’s solution oriented approach, gives way to the postmodern, with its emphasis on uncertainty and a world continually in flux.

**Therapeutic Alliance and Success**

In their discussion of the generalist-eclectic approach to social work practice Coady and Lehmann (2008) reviewed the literature, including two meta studies, concerning the so-called equal outcomes phenomenon. As they described it, the equal outcomes phenomenon states that there is no correlation between the specific therapeutic modality employed and successful outcomes for clients. The authors cited numerous studies that found equal effectiveness for various therapeutic methods, hence the term equal outcomes. In particular Coady and Lehmann noted several studies that established the
The significance of relational factors such as empathy, warmth and genuineness on the part of the therapist as the strongest indicators of client outcomes. They continue with a discussion of B.E. Wampold’s work in the area. He concluded that 70% of the therapeutic effect is due to factors that are common to all therapy modalities, in particular the therapeutic relationship. Coady and Lehmann further noted several studies that found that the significance of the therapeutic alliance could be found in the treatment of depression and anxiety, two of the most common issues for presenting clients.

Imel, Wampold, Miller and Flemming (2008) conducted a meta analysis of studies of different treatment approaches specifically for alcohol disorders. They included 30 studies with 3,503 patients in the analysis. The study concluded there was no difference among treatments for alcohol disorders. The authors noted that most of the studies ignored the counselor as a variable in the study. They also noted that there is a need for more research on the complex relational aspects of the interactions between the counselor and the clients. They concluded that factors that are universally present in all treatment approaches, such as the therapeutic alliance, need to be studied to assess their impact on client outcomes. In any case, they find that the specific treatment modality employed is not a predictor of successful outcomes.

**Application of Theoretical Principals**

This research project focuses on the perspective of the counselor as it applies the two theoretical approaches, social constructivism and items from Foucault’s toolkit, and the evidenced based study of the counselor versus therapeutic modality debate, to the
research question. The counselor, and his or her approaches, is the subject of this research, and although the client is clearly central to the question, it is the position and beliefs of the counselor that are under examination. Reducing the numerous and complex relationships involved in AOD treatment to just one appears to disagree with one of the basic holdings of social constructivism, that meaning is mutually agreed upon. However, for this study it is the meaning constructed by the counselor that has primacy, and to which the theoretical constructs will be applied.

Social constructivism is relevant to several aspects of the research. In particular the construction of knowledge/truth by common agreement is fundamental to the research. On a macro level, society in the United States in 2011 has agreed that the use of some substances in any quantity is unacceptable, while other substances can be used in some quantities, but not more than defined by the state. And, to further complicate the picture there is agreement in California about the use of marijuana, which disagrees with the agreement reached at the Federal level of society. Foucault’s notions of bio-power can be seen very clearly in the forcible detention and jailing of citizens who do not abide by these macro level agreements of what is acceptable.

On the micro level, social constructivism raises the question, have AOD counselors constructed a “truth” about a given group of clients who happened to have a circumstance in common with each other: in this research the cause of their presence in treatment. The notion of cause and effect is also central to the study – what is the cause of a client being in treatment? And does the cause have an effect on the counselor?
Furthermore, and of particular significance for this project, what meanings do the counselors attach to the cause of the clients presence in treatment. And, do the client and the counselor attach different meanings to the cause, and for both of them what is the effect of the meaning of the cause? Foucault’s conceptulization of power and knowledge relates to the placement of bio-power directly into the hands of AOD counselors who, in some cases, have the power, direct or indirect, to influence if a client is placed in jail. How does the possession of that power impact the counselor’s approach to clients over whom that power is held, as opposed to clients for whom that power is in fact no power since they will not be impacted by it?

Less theoretical, but still a guiding principal for the study, is the evidenced based research into the impact of the counselor and the treatment outcomes. The consensus is that the therapeutic alliance is of primary importance. This study seeks to address one aspect of that alliance, the approach of the counselor and if it is impacted by the referral source of the client. In light of the evidence based professional agreement that the counselor is crucial to the outcome, it seems valuable to evaluate all aspects of the counselors’ approach and attitude.

In summary, the paradigm of social constructivism applies to this research by virtue of its proposition that meanings are constructed by communities, in this case AOD counselors. Also, by its stress on the importance and fluidity of cause and effect, which are represented in this research by the circumstances of the clients’ presence in treatment. Foucault could have used the patchwork alcohol and drug laws in the United States and
California to illustrate his discussion of bio-power. The other item from his toolkit that bears directly on this research is the idea of power and knowledge and how they constantly interact with each other. And finally, the importance of the counselor in the outcome of the therapeutic process speaks directly to the importance of the approach of the counselor towards the client.

**Definition of Terms**

The following terms are used throughout this project and are common to the field of alcohol and substance abuse treatment.

**Coercion.** Forcing or compelling an individual or group to perform (or stop performing) some activity (Barker 1987).

**Counseling.** A procedure often used by clinical social workers and other professionals from various disciplines in guiding individuals, families, groups, and communities by such activities as giving advice, delineating alternatives, helping to articulate goals, and providing needed information (Barker 1987).

**Mandated.** Ordered, obligatory (Oxford English Dictionary, online).

**Self-referred.** The referring of oneself to an expert or (esp. medical) specialist for advice or treatment (Oxford English Dictionary, online).

**Assumptions**

The following assumptions have been made in this study: 1) that AOD counselors know if a client was mandated or self-referred to treatment 2) that AOD counselors do not intentionally discriminate or treat one group of clients in a way intended to have
unsuccessful outcomes 3) that clients perceive counselor’s attitudes even when still
physiologically impacted by drugs 4) that AOD counselors have knowledge of individual
clients’ methods of payment for treatment.

Justification

The results of this project may assist social workers and other professionals in the
field of alcohol and substance abuse treatment to evaluate their practice. As noted in the
National Association of Social Workers Code of Ethics (1999) in Section 4, Social
Workers’ Ethical Responsibilities as Professionals, 4.01 Competence, it is a part of
ethical practice to remain informed and proficient in the area of practice. This includes
remaining current on research and professional literature in the field of practice.
Furthermore, social workers should critically examine their own practice as it relates to
the emerging research in the field of practice. Hepworth, Rooney, Dewberry Rooney,
Strom-Gottfried and Larsen (2010) state that “self-awareness and self-evaluation” (p. 76)
are both important aspects of ethical and competent professional practice.

Implications of this project for the field of social work include contributions to the
body of knowledge related to social worker’s direct practice with clients. In particular,
the project will investigate the possibility that the client’s source of referral for services
might have an impact on the services they receive. Specifically, the project may enhance
social worker’s self-awareness about their attitudes and approaches to some client
populations, such as clients who have been, or may soon be, incarcerated. Knowledge of
different approaches towards different client populations may assist social worker in their
direct practice, in particular as they attempt to build a therapeutic alliance with their clients.

**Delimitations**

This quantitative, exploratory study does not use any surveys, beyond gathering basic demographic information about the counselors interviewed, or experiments, so generalizable statistical data will not be derived. No information about client behavior or outcomes is discussed or analyzed. The focus is solely on counselor’s approach, and the use of interviews to gather that information further delimits the study by removing the ability to independently verify the results. The interview subjects are limited to nine AOD counselors in Yolo, Sacramento and Alameda counties.

**Summary**

Chapter one contains an introduction to the subject of the study, a discussion of the background of the problem, a concise statement of the problem, the purpose of the project and a description of the theoretical framework applied to the study. The chapter continues with definitions of terms, limitations of the study and a summary.

Chapter two of the study is a review the literature that is relevant to the study. It contains sections on: history of alcohol and drug treatment, treatment of mandated clients, self-referred clients treatment, treatment outcome factors, impact of counselors on treatment outcomes, and gaps in the literature. Chapter three details the research methods employed by the study. In chapter four, the findings of the research are presented. In
chapter five, the results are discussed and their relationship to the research question is examined. Implications and recommendations for social work practice are also discussed.
Chapter 2

REVIEW OF THE LITERATURE

Introduction

The literature review will be organized into six sections. The first section will review the history of alcohol and drug treatment, with a focus on trends since the start of the first War on Drugs during the presidency of Richard Nixon. The second section will examine the research as it relates to clients who are mandated to treatment. The third section will review the literature concerning self-referred clients. In the fourth section, the research concerning factors effecting treatment outcomes will be described. The fifth section will examine specifically the role of the counselor in alcohol and other drug (AOD) treatment, and in particular their impact on treatment outcomes. The final section will describe gaps in the literature.

History of Alcohol and Drug Treatment

Humans have been ingesting psychoactive drugs since the beginning of recorded history. Inaba, Cohen and Holstein (1997) catalog a history of consumption starting with evidence of Neanderthal usage of medicinal plants over 50,000 years ago and progressing to the cultivation of poppies by Sumerians 6,000 years ago, the use of beer as a reward for slaves constructing the pyramids in ancient Egypt, writings on poppy juice as a useful painkiller by the so-called Father of Medicine, Hippocrates, marijuana use by 5th century B.C.E. Taoist priests in China, the use of Khat, a stimulant, by Arab soldiers in the 13th century to prevent fatigue and hunger, inhaling of nitrous oxide as an intoxicant in 19th
century Britain, all the way to the intricate chemical variations of psychedelics, such as LSD-49, in 20th century America.

Inaba et al. (1997) attribute Dr. Benjamin Rush with initiating the first temperance movement in the United States around 1785. Rush praised moderate use, but warned against intemperate consumption, going so far as to publish a printed “Moral and Physical Thermometer” (p. 16) which listed suicide, death, or the gallows as the eventual end for those who over indulged in alcohol. The authors go on to note the passing of the first prohibition law in the United States by Maine in 1851. Soon after one-third of the states had some form of law controlling the sale and consumption of alcohol. The temperance movement stalled while the nation engaged in the Civil War, however it moved forward after the war, and gained strength as it became the prohibition movement in the early 20th century. As noted by Inaba et al. (1997), by 1918 opiates, cocaine, and alcohol had been regulated by the Federal government, and with the tight control of the supply an active market developed in illegal drugs and alcohol. By 1937 marijuana had joined the list of drugs regulated by laws.

Hubbard, Simpson and Woody (2009) and Warren and Hewitt (2010) both cited President Richard Nixon’s War on Drugs, and the passage of related legislation and establishment of agencies charged with conducting different parts of the war, as the beginning of the modern era of drug and alcohol regulation in the United States. Hubbard et al. (2009) and Warren and Hewitt both noted the concentration on research, and the development of evidenced-based treatment modalities during this period. They also both
note the shift from viewing alcohol and drug addiction as a moral issue to the
development of a scientific basis for treatment. They both observe the movement of
treatment for alcohol in particular from the territory of self-help organizations, lead by
Alcoholics Anonymous, to the realm of science and professionals. Warren and Hewitt
focus on the accomplishments of the National Institute on Alcohol Abuse and
Alcoholism, and its study of genetics, medications, epidemiology, plus that agencies’
dissemination of evidence-based scientific information and resources to professionals
engaged in AOD treatment.

Hubbard et al. (2009) note the shifting focus of treatment emphasis as the political
priorities of the party currently in power in Washington DC had an impact of funding
directions. They note that treating veterans returning from the war in Vietnam with heroin
addiction was the only wide ranging effort that received unanimous political support.
Despite the shifting focus of treatment modalities, they note a constant movement
towards evidenced-based, and professionalized treatment, over the last forty years.

Hubbard et al. (2009) also observe the importance of the focus on community
based treatment centers that started with the passage of The Narcotics and Addict
Rehabilitation Act of 1966. They also note that this act initiated the most recent era of
mandatory treatment in place of incarceration. In a review of the recent trends of
evidence-based treatment and coerced treatment, Wild (2006) notes that there has been
extensive research into the effectiveness of coercive treatment. He reviewed 170 studies
conducted between 1988 and 2001. Responding to research on coerced treatment,
McLellan (2001) directly addressed the development of punishment versus reward in AOD treatment. He concluded after his evaluation of over 50 studies devoted to the impact of punishment as an element of treatment that it is not effective, and that outcomes are at best unpredictable.

According to Humphreys and McLellan (2010), the Obama administration is continuing the focus on evidenced-based treatment, and is placing particular emphasis on brief intervention methods, as well as integrating AOD abuse and dependence issues into the general health care system. The authors state that the administration’s first step is to coordinate the multiple efforts undertaken by different federal agencies that currently occur without any overall coordination. Towards this end, President Obama announced the development of the President’s National Drug Control Strategy in May of 2010. The strategy includes coordination of efforts by all departments and agencies, plus acknowledgement that individuals diagnosed with AOD disorders are individuals, and hence should have treatment modalities that fit their particular situation. Humphreys and McLellan note in particular the administration’s acknowledgement of the importance of effective early interventions using evidenced based modalities. Other aspects of the President’s strategy include integration of services for substance abuse clients into the mainstream health care system, expansion of both Drug Courts to divert individuals with substance abuse or dependence issues from jail or prison to treatment, and emphasis on treatment options for individuals being released from prison as part of reentry programs.
Treatment of Mandated Clients

The recent literature focuses primarily on two aspects of the treatment of mandated, or coerced, AOD clients. The focus of the majority of the current research poses questions around the impact of coercion on client’s motivation for treatment, and how success rates of the treatment efforts compare between individuals who do not enter treatment completely voluntarily and individuals determined to be in treatment on a voluntary basis. Additionally, for the most part, research side steps the issue of the ethical and moral questions around requiring individuals involved in the criminal justice system to enter treatment. Instead, the focus is primarily on addressing the related question of the link between criminal behavior, and substance abuse or dependence.

Klag, O’Callagan and Creed (2005) engage in an extensive discussion of the exact nature of coercion, drawing distinctions between legal coercion and informal coercion and formal yet non-criminal coercion. The authors note the first use of coercion in the United States occurred in the early 1920s with morphine maintenance clinics. They continue by describing the range of current legal coercion from civil commitment to mandatory treatment, all the way to the choice between treatment and incarceration presented by diversionary programs such as Drug Court. Informal coercion consists of the pressure felt by treatment clients from family and friends who threaten withdrawal of support, or deliver ultimatums about cutting off relationships. Klag et al. (2005) define formal non-criminal coercion as the pressures exerted by employers or government agencies that are not part of the criminal justice system, such as Employee Assistance
Programs or Child Protective Services. The authors are unique in drawing these distinctions in their approach to research around issues of mandated treatment.

The moral and ethical considerations of mandating AOD treatment are essentially avoided by focusing on the relationship of criminal activity and substance abuse. Prendergast, Greenwell, Farabee and Hser (2008), Klag et al. (2005), and Sia, Dansereau and Czuchry (2000) all cite extensive research documenting the relationship of criminal activity and substance use, and not only the intrinsic illegality of processing or consuming legally controlled substances, but the related violent and property crimes that grow from such use. All three assert without question that the relationship has been well established and can be taken as fact. Klag et al. (2005) propose there is increasing willingness to impose more forceful pressure on substance users to engage in treatment instead of incarceration given the following consistent conclusions: treatment of any kind decreases crime and substance use; there is social pressure to find alternate approaches to substance related crime; research concludes that incarceration is not an effective treatment method; external coercion motivates individuals to treatment; and the increasing awareness of the monetary cost of incarceration versus treatment. Currently, the researchers take as established the association of substance abuse and criminal behavior, and move on to research questions focused primarily on the motivation of coerced individuals, and their success rates of treatment.

Having established the link between substance abuse and criminal behavior Prendergast et al. (2008), Klag et al. (2005) and Sia et al. (2000) all investigate the
motivation to change of individuals mandated to treatment. Prendergast et al. (2008) examined the perception of coercion and the motivation to change of 1,708 participants in California’s Substance Abuse and Crime Prevention Act (SACPA, popularly referred to as Prop 36), using standardized measurement instruments. Coercion was measured using the McArthur Perceived Coercions Scale, and the Stage of Change Readiness and Treatment Eagerness Scale (SOCRATES) which measured motivation. Individuals in the study had opted into the SACPA program, and scored relatively low on the Recognition and Ambivalence factors in SOCRATES. On the other hand scores were relatively high on the Taking Steps indictor. The authors concluded that since the individuals in the study had decided to participate in the SACPA study, they considered that they had already taken action with regard to their substance use even if they had not recognized it as a problem, or were ambivalent towards treatment. When the independence of perceived coercion and motivation to change were examined, the authors concluded that perceived coercion did not predict treatment outcomes. The authors also concluded variables other than perceived coercion were associated with treatment outcomes. In particular gender, age and race all had a significant predictive rate of outcome success. Prendergast et al. concluded that perceived coercion is not associated with treatment outcome, and that motivation is not related. Furthermore they state that counselors should not assume coerced clients perceive themselves as coerced, or that they lack motivation to change.
Sia et al. (2000) studied the impact of a program designed to enhance treatment readiness. They referenced a previous study that showed coerced clients scored significantly lower on a readiness for treatment and desire for help measurement. The study divided 500 participants into two groups, one received training specifically designed to increase readiness to change, while the other group received the standard treatment. The study concluded that clients receiving the readiness to change training were more satisfied with treatment and had improved outcomes. The authors concluded that the training increased motivation to change and openness to treatment.

Finally, Copeland and Maxwell (2007) concluded that there has not been enough research to draw any conclusions. They cite numerous studies showing perceived coercion as a predictor of both successful and unsuccessful treatment outcomes. They also reference research that is inconclusive on the subject. However, in their own study of cannabis users in Texas, they concluded that legally coerced clients have more successful outcomes than non-legally coerced clients. Their final observation is that coercion is a psychologically complex phenomenon, and that more research into the issue is required.

Research exploring exactly what promotes success in mandated clients generally concludes that mandated clients are similar to non-mandated in that they are a heterogeneous group that varies just as much in individual motivation and likelihood to succeed as voluntary clients. Butzin, Saum, and Scarpitti (2002), Anglin, Urada, Brecht, Hawken, Rawson and Longshore (2007), Nolan and Thompson (2007), and Urbanoski (2010) all assert that coercion by itself is not found to be the deciding factor in treatment
success. Urbanoski contended that the client’s perspective on coercion should be included in any research on the factors that impact successful outcomes. She placed emphasis on the individual nature of each client’s perception of coercion, and how that unique perception makes generalizations about mandated clients troublesome.

Butzin et al. (2002) noted the research that has shown beneficial outcomes related to mandated treatment. They observed that there is little specific knowledge about different factors that contribute to success. The authors studied 1,660 clients who were involved in the Delaware Drug Court. They found that employment was the strongest indicator of success in treatment. They concluded that Drug Court resources would be best deployed by taking into account each participant's individual characteristics and treatment needs. Anglin et al. (2007) examined methamphetamine user in California who had been diverted from prison to treatment by participation in Prop 36. They concluded that many factors might contribute the treatment success. For example, they noted that White and Hispanic clients present with differing cultural norms, and therefore would require ethnic-specific treatment protocols. In their study of 80 participants in a treatment program Nolan and Thompson (2009) found that the only statistical difference between the 38 voluntary and 42 mandated clients was the higher rate of violent crime reported by the mandated clients. The study participants completed questionnaires at three stages during treatment using four different standardized measurement tools. The primary conclusion was that there was little distinction in the psychological profile of the two
groups. The coerced clients varied as group during the first 5-6 weeks of treatment, however the authors noted that overall the success rates did not vary.

**Self-Referred Clients Treatment**

The current literature addressing self-referred, or voluntary, clients is limited. Given the historical shift in the focus of AOD treatment towards evidenced-based and research driven methods and programs, recent studies have focused on the client base which is mandated, or coerced, into treatment. The latter client base presents more easily defined research questions, is more easily identified by its involvement in the criminal justice system or other government agencies, and also invites research due to its intersection with the debate surrounding the government’s cost of treatment versus incarceration. In contrast, self-referred, or voluntary clients are, by definition, more difficult to locate by their absence from government agencies or jurisdiction. Also, research centered on self-referred client lacks the financial incentive presented by mandated clients given that, unlike mandated clients, voluntary clients pose no direct expense to any level of government. By their very nature, voluntary clients in outpatient treatment are more difficult to locate. Furthermore they may be less inclined to participate in research than mandated clients, who may perceive a benefit to cooperation in research, no matter how clearly stated the separation is between treatment and research.

As result of all of these influences, there is limited research literature addressing voluntary clients and their experience of AOD treatment. However, there is considerable
research into the nature and effectiveness of 12-Step programs, and in particular Alcoholics Anonymous (AA). Even this research does not directly address the issue of voluntary participation in 12-Step programs, but rather focuses on other issues surrounding these programs. The issue of voluntary versus mandated is subsumed in the research by the question of motivation to change. The other occasions for discussion of voluntary clients is their rare use as points of comparison, or control groups, for research that is primarily investigating mandated clients.

Klingemann and Bergmark (2006) directly address the ubiquitous nature of evidenced-based research and treatment approaches. They note that in Sweden the value of coerced treatment cannot be promoted in the absence of positive outcome data, even if the coerced clients disagree. The authors point primarily to the professionalization of treatment, and the resulting attempts to codify and measure inherently subjective components. They point to the never-ending growth of research results, which they call a body of knowledge that is constantly being revised, and is therefore always uncertain since the next set of research results may contradict the current ones. Klingmann and Bergamn point to the decreasing trust of professional elites by their clients as paving the way for acceptance of alternative methods. They concluded that the vast amount of research showing that client motivation to change, the importance of individualized treatment, and the significance of the relationship between the healing entity and the client, together outweigh the constantly shifting results of the professional research.
There is broad consensus in the literature that the 12-Step model is more successful than unsuccessful. Among the research in agreement that 12-Step involvement results in positive outcomes are Brown, O’Grady, Farrell, Flechner and Nurco (2001), Kelly, Magill and Stout (2009) and McKellar, Stewart and Humphreys (2003) who all concluded that 12-Step program attendance had some positive impact. Mandated versus volunteer status was not included in any of these studies as a measurable criterion, and therefore they did not arrive at any explicit conclusions concerning this aspect of treatment as it relates to 12-Step attendance. Brown et al. (2001) asserted that clients referred by the criminal justice system are encouraged rather than required to attend 12-Step meetings, thereby concluding that they are all voluntary. If this conclusion is accepted, their research can be taken to reflect the attitudes of individuals who are in treatment on a voluntary basis. The authors attribute success to frequent attendance, more severe drug use, and potential consequences deriving from their AOD use. In particular, they note individuals with possible consequences that include incarceration have more successful outcomes.

McKellar et al. (2003) studied 2,319 alcohol dependent men over two years. They summarized the debate about the effectiveness of 12-Step programs. The authors noted that those in favor of 12-Step programs cite numerous studies that show 12-Step attendance coincides with decreased alcohol consumption. This research is countered with research that asserts that individuals attending 12-Step meetings are highly motivated to start with, and those who do not succeed stop attending, and therefore at not
included in measurements of outcomes, thereby inflating the apparent success rate. They also noted that most studies agree that 12-Step programs are, by their very nature, difficult to access using evidenced-based research methods. In their own research, the authors do not include mandated versus voluntary status; however, in its place they include motivation in their model. They concluded that motivation did not impact the relationship between attendance and decreased alcohol consumption. The authors concluded that success is achieved by participants who have their motivation reinforced by participation in 12-Step meetings, and that the greatest impact on their success is their early experience of feeling like whatever level of motivation they arrived with, it is nurtured by their experience in 12-Step meetings.

In their meta-analysis of research on AA, Kelly et al. (2009) noted that the overwhelming majority of the literature concludes that AA is in some measure successful. The authors do not include mandated versus voluntary status in the criteria they reviewed for the studies they examined. Again, the implicit assumption is that 12-Step attendance is by its nature voluntary. They cited numerous studies that concluded that the particular theoretical model used in treatment does not impact the results. Kelly et al. (2009) concluded from examining the research that the salient factor is participation in treatment, not which treatment method or model is used. They cite studies of the Project MATCH data, which concluded that 12-Step participation was at least as effective as treatments based in cognitive-behavioral therapy, or motivational enhancement therapy. They concluded that the reasons for AA success are its availability
at times convenient to the participant within their communities, its very low cost, and that participants themselves decide when and how often to go, and exactly how deeply involved to become. All of these elements contribute to the voluntary nature of the program.

**Treatment Outcome Factors**

The published research into factors that have a significant impact of treatment outcomes varies widely in its conclusions. Research points to spirituality, (Longshore, Anglin, & Conner, 2008; Stewart, 2009); motivation to change and whether it is internalized or externalized, (Burke & Gregoire, 2007; Gossop, Stewart & Marsden, 2006; Conner, Longshore & Anglin, 2009; Klag, O’Callaghan & Creed, 2005; Prendergast, Greenwell, Farabee & Hser, 2008); and severity of pre-treatment addiction, (Stewart, 2009; Burke & Gregoire, 2007). Furthermore, research can be found that credits various other factors, such as employment, education level or demographic measures, (Butzin, Saum, & Scarpitti, 2002; Prendergast, Greenwell, Farabee & Hser, 2008).

In their meta-analysis of the effectiveness of drug treatment in the United States, Prendergast, Podus, Chang and Urada (2002) concluded that treatment is effective. They examined the results of 78 studies and concluded that AOD treatment as currently practiced in the United States reduces both drug use and criminal activity. They go on to state that other meta-analysis have come to the same conclusions. They concluded that further study should focus on how treatment works, and how it can be tailored to the unique needs of different client populations.
Longshore, Anglin, and Conner (2008) and Stewart (2009) both directed their research towards the impact of spirituality on AOD treatment and outcomes. They both conclude that spirituality has a positive influence on treatment outcomes. Longshore et al. (2008) conducted a meta-analysis of research into religiosity and spirituality in the field of drug and alcohol treatment. They concluded that there is enough evidence of the positive influence of these factors that a model should be developed to more specifically measure and apply evidence based standards to the study of spirituality and treatment. They also concluded that the effectiveness of spirituality as a factor in successful outcomes is enough to merit training AOD treatment staff in its use. Stewart studied 301 subjects who attended 12-Step meetings and measured numerous variables including severity of substance use, consequences of substance use, depression, health, quality of life, social support and demographic characteristics. He concluded that increased spirituality was associated with regular 12-Meeting attendance, and that increase 12-Step attendance was associated with increased abstinence. Spirituality was the only measure that yielded statistically significant results.

Motivation to change is the subject of many studies. Included in these studies are Burke and Gregoire (2007), Gossop, Stewart and Marsden (2006), Conner, Longshore and Anglin (2009), Klag, O’Callaghan and Creed (2005) Prendergast, Greenwell, Farabee and Hser (2008), all of which considered motivation, or readiness, to change in their research on AOD treatment outcomes.
Burke and Gregoire (2007) considered the impact of coercion and motivation to change, and how the two influence each other. They concluded that so many factors were at work with each individual client that their study did not provide enough data to separate the impact of external coercion and its impact on motivation to change. Further complicating the picture, they included severity of substance use prior to treatment. This factor’s impact on motivation to change further complicated the ability of the study to discern the sole source of the client’s motivation to change. Prendergast et al. (2008) also studied the interaction of motivation to change and coercion. The authors used the McArthur perceived Coercion Scale and Stages of Change and Treatment Eagerness Scale (SOCRATES) to measure motivation to change and perceived coercion in 7,416 participants in California’s Substance Abuse and Crime Prevention Act. They concluded that a number of other variables were linked to treatment outcomes, including age, demographic profile, and prior arrest history. Overall they concluded that coercion and motivation measures could not predict rearrest or drug use after treatment.

Gossop et al. (2006) measured the success of the SOCRATES scale in predicting the use of illicit opiates after treatment. They concluded that this measurement of readiness to change had no predictive value of illicit drug use after treatment for the 1,075 subjects in the study. They also considered which specific drug was being used prior to treatment and did find an association between heroin use and motivation to change. They concluded that the pretreatment motivation might be less influential in the outcome than the process of the actual treatment. Conner et al. (2009) also concluded that
the process of treatment needed to be considered by treatment professionals. They collected data on 465 drug users who had been mandated to treatment by the courts. They concluded that when both internal and external motivation to change was high, the client’s attitude towards treatment was likely to be more favorable. They advised treatment professionals to focus the process of treatment on transforming external motivation to change (for example, a court order to treatment) into internal motivation.

Klag et al. (2005) studied the evidenced-based research into the impact of coerced treatment over the prior 30 years. They concluded that the studies present an inconclusive and mixed pattern of results that, taken together, cannot be used to promote any evidence-based conclusion about coercion and AOD treatment. They noted that the research has included non-empirical studies; the assumption that coercion can be directly attributable to the referral source; the research does not employ a consistent definition of coercion; the studies assume that background factors, such as age, severity of drug use, employment, and antisocial traits, are comparable for the two groups; and finally, the research has assumed that coercion is binary, either present or not present, and thus have focused on the extremes of the spectrum.

Severity of pretreatment addiction as a predictor of post-treatment success was part of the research conducted by Stewart (2009) and Burke and Gregoire (2007). Stewart used the Timeline Followback (TLFB) method to operationalize severity of use. However, the results were not statistically significant. Burke and Gregoire (2007) related severity of addiction to coercion into treatment. They employed the fifth edition of the
Addiction Severity Index (ASI) to access pretreatment use and post treatment success. They concluded that the relationship is a complex one, however they did find lower levels of severity post treatment for subjects who had been coerced into treatment versus those who entered treatment voluntarily. They noted that intentional examination of the factors and attitudes that propel clients into treatment all deserve close examination on an individualized basis. And, that establishing treatment goals based on each client’s individualized presentation will start to build the therapeutic relationship that is the foundation of change and growth in treatment. The research concerning the impact of the therapeutic relationship will be discussed in the next section.

**Impact of Counselor on Treatment Outcomes**

A review of the recent literature on the research into the impact of AOD treatment counselors on the treatment outcomes of their clients reveals that there is an impact. Several meta-analysis have addressed the matter, and concluded that the research does agree that the counselor has an influence (Hughes, Hayward & Finlay, 2009; McLellan, Woody, Luborshi & Goehl, 1988; Phillips & Bourne, 2007; Meier, Donmall, McElduff, Barrowclogh & Heller, 2005). An analysis of multiple studies focused on the strength of the early therapeutic alliance and its place in retention in treatment (Meier, Barrowclough & Donmall, 2005). At least two studies describe the development of AOD counselor attitude measurement scales to further this branch of the research (Shearer & King, 2001; Kasarabada, Hser, Parker, Hall, Anglin & Chang, 2001). Finally, other studies note that the particular modality of treatment does not reach a level of significance when measured
against other factors in treatment success (Imel, Wampold, Miller & Fleming, 2008; Prenergast, Podus, Chang & Urada, 2002).

There seems to be agreement in the recent research that counselors do have an impact in some aspect of the treatment of AOD clients (Hughes, Hayward & Finlay, 2009; McLellan, Woody, Luborshi & Goehl, 1988; Phillips & Bourne, 2007; Meier, Donmall, McEluff, Barrowclogh & Heller, 2005). When the issue is addressed, the question is not if there is an influence, but rather the nature of the influence. Hughes et al. (2009) studied the perception of mental health patients receiving involuntary treatment, and investigated their experience of staff as caring, supportive or indifferent. No matter whether the individual patients perceived the staff as caring or indifferent, the staff did have a measurable impact on the patients.

McLellan et al. (1988) had the opportunity to isolate counselor impact when two counselors unexpectedly resigned from a methadone maintenance program and their clients were reassigned to four counselors already on staff. Results of the study showed both clinically meaningful and statistically significant results. Given that all aspect of treatment remained constant except for the counselor, the authors concluded that the reduced or increased methadone levels, changes in urine test results, as well as other measures of treatment, were due to the change in counselor, and the impact of the new counselor on the treatment process of the individual patient.

Phillips and Bourne (2007) commenced their study with the understanding that counselor beliefs and values play a role in treatment progress. They acknowledged the
complexity of AOD treatment, and the interplay of multiple issues that impact treatment. But, nonetheless, they concluded that the internal values and assumptions of AOD workers have an impact on retention and progress through treatment. The authors cited numerous studies as evidence that the therapeutic alliance is an important aspect of treatment. They focused their study on the relationship between the therapeutic alliance and retention in treatment, stating the need for their inquiry arises from the need to investigate the reasons for the previously established importance of the therapeutic alliance and its impact on client retention.

Meier et al. (2005) also took as established that the counselor has an impact on treatment outcomes. They examined the association between the nature of the therapeutic alliance early in treatment and dropouts from treatment. Other factors were acknowledged, but primary importance was placed on the impact of the counselor as the key to treatment retention.

Imel, Wampold, Miller and Fleming (2008), Prendergast, Podus, Chang and Urada (2002), and Meier, Barrowclough and Donmall (2005) conducted meta-analysis that in part addressed the role of the counselor in the treatment process. In all three studies, it was found that the specific treatment modality, or method, did not have as much of an influence as the counselor alliance. In fact, Prendergast et al. (2002) examined 78 studies and found that the less theoretical grounding in the treatment program, the higher the positive effect of treatment. They found that the relationship between modality and lack of a theoretical grounding was consistent across different treatment modalities. They did
find that in some cases individualized treatment is more appropriate for selected clients, such as methadone maintenance for opiate addicts. Interestingly, they also found that the higher the level of researcher alliance to whatever treatment modality was being used, the greater the impact of the counselor.

Imel et al. (2008) also found counselor allegiance to the particular therapeutic modality being employed reflected in the results of the treatment, with more loyalty resulting in more positive outcomes. The authors analysed 30 studies that had researched the impact of at least two specific therapeutic modalities in AOD treatment. Their ultimate conclusion was that there was no evidence that any particular type of therapy was superior, or inferior, to any other. They concluded that the next step in the research should be a continuing and broadening examination of the impact of the counselor in the therapeutic process.

Meier et al. (2005) premised their meta-analysis on the findings that the therapeutic alliance is a regular predictor of engagement and retention in AOD treatment. They followed Imel’s et al. (2008) call for research into the nature and development of the therapeutic relationship by examining 18 studies in detail for their research into the therapeutic alliance and its development. They concluded that there is a widely consistent finding that early alliance and engagement, and retention in treatment is related. Their findings focused on retention in treatment. They were unable to draw any conclusions about long-term treatment outcomes.
Shearer and King (2001), and Kasarabada, Hser, Parker, Hall, Anglin and Chang (2001) both researched and developed measurement instruments to be used by counselors and in research about counselor impact. Both sets of authors based their conclusion that there is a need for such instruments in the established research that counselors have a significant impact on treatment. The researchers further concluded that there was a need for counselors to be able to measure their attitudes and beliefs around issues of treatment. They agreed that the counselor is a critical component of the AOD treatment process, and that research into the counselor impact on treatment requires established and repeatable criteria to further the body of knowledge regarding AOD treatment.

Finally, primary results of two of meta-analysis, Prendergast et al. (2002), and Imel et al. (2008) pointed towards counselor impact and away from other factors in the treatment of AOD clients. In particular, Prendergast et al. (2002) found evidence of differences in treatments for alcohol disorders. They stated that their findings were in accord with the preponderance of psychotherapy research that there is little evidence that any single treatment modality or therapy type is inferior to any other. They continued to state that the research literature should go on to consider exactly what is at work in the change process that is observed in AOD treatment.

**Gaps in the Literature**

The most common limitation noted in the research reviewed for this literature review involved study participation limitations, such as self-selection of study participants (Kelly, Magill & Stout, 2009); non-response rates (Anglin, Urada, Brecht,
Hawden, Rawson & Longshore, 2007); inclusion in a study based solely on agency funding, (Stewart, 2009); and use of self-reported data (Kellar, Stewart & Humphreys, 2003). Two studies reported limitations based on the lack of data concerning motivation for treatment (Wild, 2006; Prendergast, Podus, Chang, & Urada, 2002).

Numerous studies have been published that noted limitations concerning the role and training of the counselor in the treatment process (Nolan & Thompson, 2009; Meier, Barrowclough & Donmall, 2005; Kasarabada, Hser, Parker, Hall, Anglin & Chang, 2001). In their meta-analysis of 20 years of research into the therapeutic alliance in the AOD treatment field Meier et al. (2005) noted a major difficulty in conducting the research for their project was lack of evidence regarding the exact nature and impact of the therapeutic alliance. They stated that at the time of their research this issue had not been addressed in the research.

This project addresses the call for research into the approaches, practices, and impact of AOD counselors on the treatment process made by Shearer and King (2001), Meier, Barrowclough and Donmall (2005), Kasarabada, Hser, Parker, Hall, Anglin and Chang (2001), and Nolan and Thompson (2009). Related to this gap in the research is the call for additional research into an evaluation of the factors relating to mandated client’s perceptions of their treatment by Prendergast, Greenwell, Farabee and Hser (2008), and Butzin, Saum and Scarpitti (2002). This research study also addresses the call by Meier et al. (2005) for investigation into the factors that contribute to the client-counselor
relationship, and how that relationship interacts with the client treatment retention and outcomes.

**Summary**

In Chapter two, the literature was reviewed that relates to the subject of this study. The following topics were discussed: history of alcohol and drug treatment; treatment of mandated clients; treatment of self-referred clients; factors that have an impact on treatment outcomes; counselor attitudes towards clients and the impact of those attitudes on outcomes; and finally gaps in the literature were reviewed. The next chapter will describe the methods used by this study. Chapter 3 will review the methodology applied to the research, and will discuss how this qualitative, exploratory project used grounded theory and social constructivism as well as phenomenological content analysis.
Chapter 3

METHODS

Introduction

This chapter describes the methodology and research design employed for this project. The chapter includes details of the methods used in the design of the study and the analysis of the interviews. The criteria for selecting participants to be interviewed, details of the interview process, and development of the interview questions are all described. Finally, there is a description of the steps taken to protect the safety of the human subjects.

Research Question

This project investigates the following research question: Do alcohol and other drug (AOD) counselors use different treatment approaches for mandated versus self-refereed adult clients?

Research Design

The researcher employed a qualitative approach for this research project. This exploratory study used grounded theory as the guiding paradigm. A social constructivism philosophical standard was employed in the evaluation process. Finally, this project used phenomenological content analysis while latent and manifest coding was employed to identify themes and motifs within the nine interviews that were conducted. Detailed descriptions and discussion of each element of the framework for the research design of this project follows.
Qualitative Approach

The qualitative approach is commonly used when the research question aims to gain deep insight into issues of human conduct that are not easily reduced to numerical values. (Rubin & Babbie 2008) For example, questions exploring the roots of prejudices, or investigations of apparently irrational behavior such as homeless people refusing shelter in freezing weather conditions, would both benefit from the depth of analysis allowed by qualitative research methods. Qualitative methods are also particularly effective for investigating subtle distinctions and nuances of attitudes or behaviors (Royse 1991). The data is collected in qualitative research using direct in-person observation, in-depth interviews, and/or participant logs. The data collected is usually in the form of words, either the written observations of the researchers, the spoken words of the participants, or the recorded actions of the participants. In more complex studies video recordings might be used, in which case both words and pictures are used. The data are not standardized as in quantitative studies. Qualitative research requires an interpretation by the researcher of the data for analysis and finding motifs, themes, common threads, or the absences of such commonality. Qualitative research allows for the participants to more directly engage in the research by using their own words and behavior instead of requiring the participant to select from pre-formulated responses created by the researcher. (Rubin & Babbie 2008)

Among the advantages of the qualitative research approach are the direct contact between the researcher and the research participant. This allows the researcher to notice
and record affect and reactions to questions in addition to the actual answers to the interview questions (Cresswell 2009). Furthermore, the researcher can ask clarifying and follow-up questions as needed. Qualitative research also allows for a greater depth of understanding by not limiting the replies allowed by the participants to preselected answers. The meaning and experiences of the participants are the focus of qualitative studies, rather than a meaning or explanation brought to the research by the researcher. This approach can also be relatively inexpensive depending on the exact design of the research study (Creswell, 2009).

Disadvantages to consider when using the qualitative research approach include its inherently subjective nature and lack of generalizability. By its very nature qualitative research integrates some of the subjective and personal biases of the researcher. During the analysis phase the very meanings of the words used by the participants are open to interpolation by the researcher. Due to the small sample size and the inherently subjective nature, qualitative research it is not generalizable to large populations. Another disadvantage is that the research is very difficult to duplicate. And, there is a greater potential for the bias of the researcher to be communicated to the research participants during an in-person interview than other data collection techniques (Rubin & Babbie 2008).

Exploratory Studies

The project is exploratory in nature and was designed to provide a starting point for further investigation. As Rubin and Babbie (2008) note, exploratory studies aim to
establish a research base from which additional questions can be investigated with more specific research questions. As they also note a shortcoming of exploratory studies is that they rarely provide a satisfactory answer to the research question.

**Grounded Theory**

The guiding paradigm for the research was grounded theory. Grounded theory does not seek to confirm or disconfirm a particular hypothesis, but rather asks a more general question that seeks to explore the broader aspects of the subject of the study, and possibly generate trends or theories that address the question. The method is inductive, starting with the observations of the subjects and looking for themes or patterns within their observations. Further studies using grounded theory might explore other themes generated by the current study (Rubin & Babbie, 2008).

**Social Constructivism**

According to Creswell (2009) social constructivists believe that individuals continually seek understanding of the world by attaching meanings to their experiences. The meanings are multiple and varied, which leads to complex and even contradictory constructions of understanding for the individual. Cottone (2007) states that as individuals engage with the world they strive to make sense of it, while simultaneously existing in that world and absorbing its culture. They bring their own social expectations and historical learning to each encounter, and those elements are unknowingly integrated into the meaning they attach to the encounter. Thus, Creswell (2009) and Cottone (2007) both contend that social constructivist research engages with the participant in the
knowledge that participants have attributed meanings to their experience that include history, socialization, and cultural norms. Creswell (2009) concludes that researchers seek to understand those meanings as they are returned to the world of action within the participant’s lives. A part of social constructivist research is understanding the various elements that the individual employed in finding meaning and understanding in their life. Researchers use open-ended questions and focus on the context of the participants to explore their understanding of the world. In the end, the researcher’s goal is to understand the participants understanding of the world (Creswell, 2009).

**Phenomenological Research**

As Creswell (2009) describes it, phenomenological research is a method that uses the experiences of participants and their description of those experiences to understand the essence those human activities. He states that the goal is to develop an understanding of lived experiences by closely examining a number of subjects. The phenomenological study inquires into the experiences of the participants, and the situations and context in which they experienced them. Hamill and Sinclair (2010) describe three schools of phenomenological research, Husserl’s descriptive approach, Heidegger’s interpretive hermeneutic approach, and finally a combination of these two approaches called the Dutch Utrecht School. The author’s further note that Husserl’s approach involves the description of everyday experience as perceived by individual observes. They itemize four primary steps in this etic approach: bracketing, intuiting, analyzing and describing.
Content Analysis

Content analysis is a systematic method of examining the content of communications. It involves counting words, phrases, concepts, or column inches, minutes of airtime, number of hits on a website. The technique can be applied to any form of communication that has been recorded in some manner so that a detailed coding of the communication can take place (Royse, 1991). A conceptual framework is applied to the communication to be analyzed. Content analysis allows for the coding of manifest and latent content. Manifest content is the clearly visible and apparent content of the communication. For example the number of times a specific word is used, or the number of minutes dedicated to specific topic. Latent content refers to the underlying meaning of the communication. Latent content analysis seeks to understand the overall meaning of the commutation by reviewing it in its entirety and making an assessment (Rubin & Babbie, 2009). This study employed both methods of content analysis.

Advantages of using content analysis include: it is unobtrusive, in this study the interviews were recorded and that was the only indication of the analysis apparent to the participant, it is financially affordable, it is an effective method to use with a large volume of material, such as the entire content of interviews, no specialized training is needed to do the analysis, and the results can be verified by recoding (Royce, 1991; Rubin & Babbie 2008). Disadvantages of content analysis include: the material must be recorded in some from, which my be considered intrusive by the participants, reliability
may decrease if coding is completed by more than one researcher, and coding categories need to be clearly defined for reliability (Royse, 1991; Rubin & Babbie, 2008).

**Study Population**

Participants in the study were alcohol and substance abuse counselors who had been employed in the field at the time of the interview for at least the last two years and as many as thirty. They worked with adults in a variety of agencies including community-based non-profit clinics, large medical providers, and therapists in private practice. The participants had a minimum level of AOD training of California Association of Alcohol and Drug Abuse Counselors (CAADAC) Certificate, or up to a Masters level degree. The focus of the interview was the participants counseling approach to mandated versus self-referred clients.

**Sample Population**

The study was conducted by interviewing employees of various AOD treatment agencies in Yolo, Sacramento, and Alameda counties. The snowball sampling method was used in the study. The sample size was nine AOD counselors. According to Rubin & Babbie (2008), snowball sampling method is indicated for exploratory studies such as this one. Snowball sampling functions by expanding the subject pool when asking each subject to identify other possible subjects. The advantages include building a group of subjects with a degree of homogeneity while also opening the pool of potential subjects to counselors not known to the researcher. It was important to the study to have a group of subjects with varied experience in the field, but also with work experiences similar
enough to each other to make analysis and comparisons valid. The snowball method was judged to achieve those goals. Participation in this study was entirely voluntary. All counselors who were directly spoken to, and asked to be part of this study agreed to participate.

Instrumentation

Data was gathered using standardized open-ended interviews that were recorded. Each interview lasted between 30 and 45 minutes. The interviews were conducted at a time and place convenient for the participant. All interviews sites were private and agreed to in advance of the interview. To address the possibility of compromising internal validity through instrumentation changes as described by Rubin and Babbie (2008) a standardized list of questions was developed prior to data gathering. Ten questions were developed and designed to stimulate unique responses from each participant addressing the same subjects across all interviews. (See Appendix A). Two questions asked about AOD training and work experience. The other eight questions asked about the individual counselor’s work experience and approach with mandated and self-referred clients. The questionnaire was used to ensure that all interviews were conducted uniformly and consistency. The reason for seeking uniformity was twofold. First, uniformity standardized the actual interviews to ensure consistency of topics covered, and to decrease the possible interjection of the interviewers biases into the interview. Second, the standard order of questions and responses made content analysis coding more uniform.
by imposing an order on the interview. Also, using standardized questions guaranteed that all participants were given the same opportunity to voice their views on the topic.

As noted by Rubin & Babbie (2009), a disadvantage of the standard open-ended interview is that it can impede the natural flow of conversation by relying solely on predetermined questions. To counter this effect, the interviews included flow up questions intended to illicit further information on the topic of the original question. The follow up questions also allowed for flexibility on the part of the researcher to pursue topics at greater depth with individual participants who had more experience in different aspects of the field of research.

Advantages of open-ended questions are that they allow the respondents to express their reply in their own words and to reply in as much depth as they want. Open-ended questions also allow for complex answers and for the use of self-selected vocabulary. Furthermore, over the course of all of the interviews, they allow for a variety of responses from each participant. Disadvantages of open-ended questions include: differences in participant’s ability to accurately articulate their answers, long replies can be time-intensive to transcribe and code, open-ended replies may wonder off the topic of the question, and answers that vary greatly from each other may be difficult to compare and develop common themes (Neuman 2004).

The interview process mimics a social relationship and requires adherence to social norms and expectations. The researcher must follow specific guidelines when conducting face-to-face interviews. Effective research interviews follow the following
steps. The appearance and demeanor of the researcher should at all time be professional without being stiff or intimidating. Clothing should be neat and appropriate to the field of research and the time and location of the interview. Researchers should neither over dress, nor under dress but rather their appearance should mirror that of participants. Researchers should appear interested in the subjects at all times, and actively communicate a desire to hear what the participant has to say. Next, the researcher should be familiar with the questions and the general field of the subject of the research. It is important for the researcher to put the subject at ease by being at ease with him or her self, and to make the interview a relaxed and comfortable experience. The researcher should know when to use follow up questions to clarify answers. Probes can also be used to return the interview to the subject of the question. Finally the researcher should at all time be polite and at the end of the interview thank the participant for their time and for participating in the research project.

**Data Gathering Procedures**

The researcher asked AOD counselors known to him for the names AOD counselors they thought might be interested in participating in this study. The counselors were then contacted by phone or email and given a brief description of the project and asked if they were interested in participating. If they were not interested, the researcher thanked them for their time and made no further contact with them. If they expressed interest, the researcher emailed The Consent to Participate in Research form
(See Appendix B) along with his email address to continue communications to set up interviews.

The participants were interviewed at a time and public location convenient to them (e.g., library room). The interview started with a review and signing of the Consent to Participate in Research form. Then the four demographic questions were answered, and then the ten research questions were asked. Each interview was recorded using an Olympus digital voice recorder, model VN-7600PC. The interviews lasted between 20 to 35 minutes. At the end of each interview, the participants were thanked for their time, and offered a $10 gift card from a coffee shop chain. Each participant was also offered the option of receiving a summary of the research findings.

**Data Analysis**

Subsequent to the interviews, all of the recordings were transcribed into word processing documents and printed. The data was then reviewed and analyzed for themes, differences, motifs, concepts and connections. The researcher used a system of color-coded highlighting to identify relevant passages as representing common themes, significant differences, over-arching motifs or cross-interview connections.

The researcher read all interviews through in one sitting consecutively. Three themes were indentified, and key words for each theme were noted. The researcher then read each interview in detail using manifest coding to highlight each instance of the key words. Finally, during a third reading that focused on the passages around the highlighted
key words, latent coding technique was employed to determine the underlying meaning contained in the text where the key word appeared.

**Protection of Human Subjects**

A Request for Review by the Sacramento State Committee for the Protection of Human Subjects was submitted as required to the Division of Social Work Committee for the Protection of Human Subjects. After review, the committee approved the study as “Minimal Risk” to the subjects, approval number 10-11-029. No subjects were contacted or data collected before the approval was received.

All participation was voluntary and all of the alcohol other substance abuse counselors were advised that participation was voluntary. They were also advised that they could decline to answer any specific question, and that they could end the interview at any time. Subjects were referred to using a “pseudo” name through out the study. Subjects were also instructed to not use the actual names of any of their clients but to refer to them as the client or another non-specific moniker. All information from the interviews was held as confidential. The recording of the interviews were erased as soon as they were transcribed. All print outs of the interviews were kept in a locked cabinet at the home of the researcher and were destroyed after completion of the analysis in June 2011. The participants were advised of the study process and confidentiality in the Consent to Participate in Research form. (See Appendix B). All participants read and signed a Consent to Participate in Research form, which was kept locked and destroyed at the completion of the research.
Summary

This chapter focused on the qualitative, exploratory, grounded theory study design and social constructivist, phenomenological content analysis methods used for this study. This research study investigated the approaches taken by alcohol and other drug treatment counselors towards mandated versus self-referred clients. The sampling techniques and criteria for inclusion were described. In addition, this chapter detailed the method of collecting and analyzing the data, and finally reviewed the procedure for protecting the human subjects.
Chapter 4

DATA ANALYSIS

Introduction

Interviews were conducted with nine alcohol and other drug (AOD) counselors in various locations in Yolo, Sacramento, and Alameda counties. The nine participants had worked as counselors in the AOD field for at least two years, and for as many as thirty years. All were actively employed as counselors at the time of the interview. The goal of this study was to investigate the following research question: Do alcohol and other drug counselors use different approaches for mandated versus self-referred clients? The participants were asked a series of ten questions (See Appendix A) regarding their experience and approaches to working with mandated and self-referred clients. The interviewees utilized their knowledge and understanding of their clients, together with their experience in the AOD field, and finally their own knowledge of their personal practice techniques, as well as the programmatic requirements of the agencies where they were employed, when responding to the interview questions.

Three primary themes emerged from the interviews: 1) all AOD clients are coerced into treatment, even if not by the criminal justice system; 2) counselors frequently do employ a different approach to clients mandated by the criminal justice system in the initial stages of treatment; and 3) counselors perceive the financial implications of treatment such as continued employment, and the presence of structure in the client’s life, as having an impact on treatment outcomes.
This chapter will present demographic information about the study participants. Next, the replies to several of the interview questions will be described in detail. Finally, each of the three themes will discussed, including highlight quotes from the interviews illustrating the themes. To protect the identity of the interviewees all study participants were given a fictitious name.

**Participant Demographics**

There were nine participants in the study: three were male, six were female and three were non-Caucasian, six were Caucasian. Four of the participants had credentials that included a California state level certification. Five of the participants had Masters level degrees. Several of the Masters level participants had additional training that included California or Federal certification in AOD assessment and/or treatment. There was a wide range of length of work experience, ranging from two to thirty years of employment in the field. The total number of years employed in the field was ninety-four, with a median of almost ten a half years. Places of current employment included non-profit community based clinics, individual counseling practice, a large comprehensive health care provider, and for profit AOD treatment companies.

**Interview Question Responses**

Question three of the interview directly asked the project research question in the form “Do you think you personally have a different approach with mandated versus self-referred clients?” Four of the participants replied No, the other five participants replied Yes. Three of the four who replied No gave a single word response and required follow
up questions to encourage elaboration. The fourth No response was immediately followed by a description of how the counselor actually treats mandated clients differently in the initial stages of treatment. Kathy stated, “I tend to do a lot more reminders of their requirements and what can make someone look like they’re doing well versus someone getting in front of the judge and being discharged or remanded on the spot.”

The five interviewees who acknowledged taking a different approach with the two populations all stated the difference was in the beginning of treatment, and that it was a slight difference aimed at the mandated clients. Laura indicated she spoke to mandated clients “About the consequences because they have additional consequences than just our program.” Laura elaborated about her approach, explaining, “Not so much stricter because it’s the same program, but I’m much more open and direct with them.” Connie noted that she “sets up the guidelines much bolder and directly.” Depending on her initial assessment, Kerry noted that she might have mandated clients “Write – it’s basically write what we can do for you besides help you with court or a legal mandate.” All five interviewees noted that both populations enter the same treatment program, and therefore have the same requirements for graduation.

Question nine addressed the issue of agency level distinctions in treatment approach. The question was: “Did you ever work at an agency where different approaches were intentionally used?” Eight of the participants replied No. The single Yes response involved the use of methadone by some voluntary clients at an agency that had a majority of mandated clients who were required to remain totally abstinent during
treatment. The interviewee disagreed with the policy of allowing different requirements for some clients and did not remain at the agency.

Individualization of counselor approach to treatment, and variance from established agency protocols, is addressed on a limited basis in the literature. Among the findings in their meta analysis of twenty years of literature on the role of the therapeutic alliance, Meier, Barrowclough and Donmall (2005) found few studies that evaluated the specifics of the development of the therapeutic relationship. However, they reviewed one that found women and men have different engagement styles, with men responding to a more utilitarian style while women respond to a more empathetic counseling style. The study points to the importance of individual counselor and client relational style in the process of engagement in treatment. Phillips and Bourne (2007) related AOD counselor values to treatment outcomes. They concluded that counselors who scored higher in the “openness to change value” (p. 38) were more suited to work in the field because they adopt their treatment approach and practice to each client. The authors stated that AOD counselors who vary from the established treatment protocols might be more successful because they pursue individualized treatment that is attuned to the needs of each client. And finally, McLellan, Woody, Luborsky and Goehl (1988), concluded in their study of sixty-one patients who were assigned to new treatment counselors that the “initial performance of the counselor … may be the best indication of future therapeutic efficacy” (p. 430).
Combining the replies by the study participants to questions three and nine, it appears that most agencies apply a single programmatic approach to all clients. However, within agencies counselors are allowed discretion to make individual judgments about the emphasis placed on different aspects of treatment. Furthermore, over half of the counselors interviewed have determined that mandated clients benefit from a more direct approach at the start of treatment.

**Universality of Coercion**

Six of the participants noted that, to one degree or another, everyone entering AOD treatment is under the influence of some coercion. Robert stated it this way, “At some level of another, whether it’s legal, whether it’s medical, whether it’s the wife, whether it’s your job, the universe is giving you an arm twist technique to get help on some level or another.” Laura expressed similar observations, “Well, and sometimes pressure from family. There usually is coercion of some kind.” Kerry drew a parallel between legal mandates and family pressure, “You could say on some level it’s like family probation. Like, their family is wanting them to be here.” Trisha also saw family pressure, “95 percent of the time people walked into the treatment program because somebody pushed them through the door. They were coerced, you know, and generally it was family.” Don summarized the presence of coercion in self-referred clients as follows:

On the other hand, some of our insurance or self-pay clients are here because they’re starting to see the negative effects of their behavior and the chemical use,
whether it’s their wife saying you’re all jacked up or you call in sick so many times and you need help.

Craig noted that coercion could be an inadvertent side effect of requirements at his agency for access to services other than AOD treatment, “Clients frequently are very good at picking up, you know, the pseudo-mandate.” He elaborated that clients at his agency “need money and housing, a lot of support.” And that their attitudes are “If you want me to sit in an AOD program three days a week I’ll do that too.”

Foucault’s notion of bio-power is the most applicable theoretical perspective of this study to view the theme of coercion. Given the agreement by the majority of the study participants that some form of coercion is present in AOD treatment, and as noted in Chapter 1 of this study, given Foucault’s definition of bio-power as the subjection of the human body to interventions by the government, the notion of universal coercion to treatment clearly illustrated Foucault’s point. As Kathy notes, “And, if they (mandated clients) have slipped, they seem to recommit at a more intense level because they recognize that they’re that much closer to going to prison” and “because they desperately don’t want to go to prison.” Also, as noted above in the discussion of AOD counselor’s initial approach to mandated clients wherein the counselors remind them of their consequences for not succeeding in treatment, bio-power is at work through the person of the counselor as she or he reminds mandated individual’s of the nature of their mandate. The mandate includes the very essence of Foucault’s notion of bio-power, in which the state literally takes possession of the body of the individual.
Foucault’s conception of power as dispersed throughout society is also illustrated by the dispersal of government mandated bio-power into the hands, and mouths, of AOD counselors. And, finally, the presence of resistance, which Foucault saw as a primary pointer to power, is clearly present in mandated clients. But, more importantly for this study the perception of resistance is present in the belief of AOD counselors that they need to counter perceived resistance in the early stages of treatment by mandated clients by providing more direct and clear statements of program requirements, and possible individual consequences to mandated clients.

Among the recent literature noting some degree of universal coercion Burke and Gregoire (2007) start their study by asserting, “Research indicates that only a small proportion of individuals with alcohol and other drug (AOD) problems seek help voluntarily” (p. 7). The authors included the National Survey of Drug Use and Health (NSDUH), (2003) among the citations for this claim. Conner, Longshore and Anglin (2009) consider the roles of internal and external factors in treatment. They note, “there are often external pressures, such as pressure from family and loved ones or from the criminal justice system, on an individual to get help and to change their behavior” (p. 156). Klag, O’Callaghan and Creed (2005) reviewed thirty years of research into the use of legal coercion in AOD treatment. The authors noted that there are several types of coercion, and included informal and formal non-criminal coercion in their review of the research. They noted “Evidence shows that family and friends can be effective sources of social pressure for substance users to enter treatment” (p.1779). They also referred to
studies indicating that family and friends exert coercion by threatening to sever ties with the individual unless they enter treatment. In their study of 27,198 Texas adults in treatment for primary drug use of cannabis Copeland and Maxwell (2007) found that 69% were formally involved in the criminal justice system. The balance of non-coerced participants reported referral sources of “self (20%), social services or protective services (26%), community mental health centers (8%), family or friends (6%), or local councils on alcohol and drugs (6%)” (p. 111), indicating that non-criminal pressures played a role in the majority of so-called non-coerced clients.

Wild (2006) and Prendergast, Greenwell, Farabee and Hser (2008) both included the concept of perceived coercion in their study. Wild (2006) noted, “Also, many clients who enter treatment under legal social controls view this source of social pressure as less influential than informal social network pressures” (p. 41). He also noted findings that informal coercion may occur more often than legal referral when all addiction services are taken into account. Prendergast et al. (2008) also noted that perceived coercion is a complex matter, and that ultimately its impact depends on the perceptions of the client. They cite a study of 300 clients in treatment that found that 35% of those referred by an external source did not perceive that they had been coerced. However, 35% of the self-referred clients did report being coerced into treatment.

**Early Attention to Mandated Clients**

As noted above, five of the nine study participants stated that they employ a different approach toward mandated clients during the early stages of treatment. Rhonda
noted “Mandated, the first thing I do is try to get them on board and put them on a schedule and talk to them about you know, the need that they have for the services that we’re providing.” And, “So I try to keep them on a schedule. I keep track of what they’re doing because they have to have so many groups and so many tests.” Connie stated “Probably a little tougher with mandated clients.” And “So probably much – set up the guidelines much bolder and direct.” Kerry noted that she gives clients on probation writing assignments to help the client assess their own situation. She stated, “Take a look at yourself. Do some writing for us. Write – it’s basically, write what we can do for you besides help you with court or a legal mandate.” Laura reported being “much more open and direct with them.” And “About the consequences, because they have additional consequences than just our program.” And, finally, Kathy said that she reiterates the consequences of not succeeding in treatment to mandated clients more often. “I tend to do a lot more reminders of their requirements and what can make someone look like they’re doing well versus someone getting in front of a judge and discharged and remanded on the spot.”

On a theoretical level the agreement by multiple AOD counselors that mandated clients require more attention during the early stages of treatment illustrates a primary aspect of the social constructivism paradigm. As noted in Chapter 1 of this study, social constructivism holds that knowledge is manufactured by a consensus of those who know a particular thing. In this case, what is known by AOD counselors is that mandated clients have more serious consequences than non-mandated clients. This common
knowing among AOD counselors creates a cause (being mandated) that impels them to act in a similar manner to avoid a commonly agreed effect (more serious consequences). Social constructivism holds that cause and effect are not singular, but rather are unique to each perceiver, or actor, in an event. Indeed, the common agreement by AOD counselors about the causes and effects of being mandated, or not mandated, takes on a whole new implication when linked to the evidence-based research about the impact of the therapeutic alliance. As described in Chapter 1, many studies have concluded that the single most significant aspect of AOD treatment is the building of a therapeutic alliance. The evidence also suggests that empathy, warmth, and genuineness on the part of the counselor are strong indicators of client success.

The research on therapeutic alliance, and early intervention and engagement, suggests that both lead to retention in treatment, and successful completion of treatment programs. Meier, Conmall, McElduff, Barrowclough and Heller (2005) concluded in their study of 187 clients in a residential treatment program that a weaker alliance is more likely to lead the client to leave treatment prematurely. They concluded that the counselor’s own rating of the therapeutic alliance was the strongest single predictor of length of retention in treatment.

Meier, Barrowclough and Donmall (2005), Phillips and Bourne (2007), and Copeland and Maxwell (2007) all agreed that the therapeutic alliance was a predictor of retention and/or completion of treatment. All three studies also found that establishment of the therapeutic alliance early in treatment was significant. Meier et al. (2005) noted in
their Abstract, “A key finding is that the early therapeutic alliance appears to be a consistent predictor of engagement and retention in drug treatment.” Phillips and Bourne (2007) noted that within the AOD treatment community the therapeutic alliance is generally accepted as important. They cited research that supports the importance of early engagement and its relation to retention. Finally, Copeland and Maxwell (2007) found that early and brief interventions have been established as effective in the treatment of cannabis abuse.

**Impact of Structure and Finances**

Five of the study participants mentioned the financial implications of treatment as having an impact on clients. Two of the five also mentioned the presence of structure in the lives of clients as having an influence on treatment. These two linked financial security, or having a job, to structure. Kathy directly linked the two concepts,

The structure is helpful and the finances are helpful and maintaining things for yourself and your family and kind of working through life in a different way, it’s really productive and I definitely see a higher success for people like that.

Trisha also linked structure and financial security, “if they come to see me as a private client, generally they have a job, they have, you know, financial resources, something.” She continued, “They don’t have all the social problems that somebody maybe who is, you know, and I think that makes recovery much harder.” Laura stated that she saw an association between job lose and treatment consequences, “There are huge financial consequences if you lose, you know, you livelihood.” Connie linked education and job
status to investment in treatment, “So education does play a role in motivation.” And “I
deal with a lot of doctors and nurses, pharmacists, who are overseen by a medical board,
who really value what they do for a living.” Finally Robert perceived that individuals
who pay for treatment themselves are more committed than those who do not.

I think the people who are putting themselves through here are more committed,
yes, than like say if their parents are paying for it or it’s on their parent’s
insurance, I say yes, that commitment level is more when it’s on their own dime.

The same theoretical lens of social constructivism applies to the perceptions of
counselors about the impact of structure and financial security, or employment, as was
applied to the theme of different approaches early in treatment for mandated clients. Over
half of the counselors interviewed perceived a relationship, or cause, between structure in
the client’s life or being employed, and an effect, including retention, engagement or
success in treatment. The attribution of an impact on treatment to a structured life by the
counselors illustrates social constructivism’s concept that each individual attributes an
effect to one of many possible causes. In this case, the counselors selected the cause of
structure and or financial implications, and attributed positive treatment outcomes to that
cause.

The research literature notes that multiple factors can contribute to treatment
outcomes. Butzin, Saum, and Scarpitti (2002) and Prendergast, Greenwell, Farabee and
Hser (2008) both noted a variety of factors that can influence treatment outcomes. Butzin
et al. (2002) noted that mandated clients who were most likely to complete treatment
shared several traits, including being married, or once married, Caucasian, having a higher level of education, and to be employed. Prendergast et al. (2008) found that prior arrest, youth, and race were variable that were associated with treatment outcomes. They also found that primary drug problem was not a predictor of treatment completion.

**Summary**

In this chapter, the data from the study were analyzed and discussed. Chapter 5 is a description of the conclusions and recommendations. The limitations of this study and the implications for social work practice and policy are also discussed.
Chapter 5

CONCLUSIONS AND RECOMMENDATIONS

Introduction

This chapter will discuss the conclusions reached in this project. The three themes that emerged during the interviews will be discussed as they relate to each other, and to alcohol and other drug (AOD) treatment and counseling. The chapter will also discuss recommendations for future studies, enumerate the limitations of this study, and outline the broader implications of the study for social work and practice.

Conclusions

This study asked the research question: Do alcohol and other drug counselors use different approaches for mandated versus self-referred clients? The answer to the question is Yes. As the study participants elaborated on this question, the first study theme emerged. The majority of counselors reported using a different approach, and specified that the difference occurred during the initial stages of treatment with mandated clients. The counselors also stated that their agencies did not programmatically employ different approaches. Combining these two responses it appears that agencies allow individual counselors discretion in the exact approach and treatment implementation that they employ. Given this latitude, AOD counselors have determined that clients who are mandated to treatment require a more direct approach early in treatment. The counselors stated that they employ these more direct tactics because the mandated clients have more severe consequences, not because they are more resistant to treatment. Counselors appear
to have concluded that a mandate to treatment does not impact willingness or readiness to engage, but it does place a responsibility on the counselor to clarify and be emphatic with the mandated clients about the program requirements, as well as the clients’ position relative to re-incarceration.

Furthermore, AOD counselors appear to recognize the legal-rational and professional authority (Pace & Hemmings, 2007) that they are endowed with while working with mandated clients. As Connie said, “set up the guidelines much bolder and direct, in a way that I am responsible to mandate back to the employer, or the railroad, or the Department of Transportation, and your employer.” This sense of responsibility becomes complicated when combined with the theme that emerged from the interviews that all clients are coerced into treatment. Most of the counselor’s felt that all, or almost all, clients arrived in treatment as the result of coercion. They noted that for so-called self-referred clients the coercion might be from friends or family threatening to sever ties to the client. Given this theme, and the counselors stated emphasis on being more direct with clients mandated by the courts or their employers, it appears that counselors place more significance on the consequences of state or employer enforced consequences than on the impact of lose of family and or friends.

The third theme to emerge from the interviews was the awareness by AOD counselors of the impact of the financial implications of treatment, in particular the need for success in treatment to remain employed, or to retain licensure. Related to financial stability was the recognition that structure, as represented by employment as well as
family and friends, had a positive impact on treatment. A conclusion that can be drawn from this theme is that AOD counselors take an ecological perceptive towards their clients. In particular they realize that their client’s lives are complex systems, and that treatment is one aspect of that system that is interacting with the other elements of the system while the client is in treatment. The awareness of AOD counselors that their clients have complex lives is also present in the recognition that on some level all clients are coerced, and that family and friends can have a significant impact on the actions of clients. Counselors understand that clients do not appear in treatment from a vacuum, but that they have complex, and sometimes conflicting, elements in their lives outside of treatment that can have an impact on what happens in treatment.

Finally, what are the implication of the results of this study on the creation and sustainability of the therapeutic alliance? It appears that AOD counselors make a conscious effort to engage mandated clients in treatment in a more direct and pointed manner. The result of this early active organization of the mandated client’s experience in treatment might result in an early bond between counselor and client. As Meier, Barrowclough and Donmall (2005) stated in their Abstract, “A key finding is that the early therapeutic alliance appears to be a consistent predictor of engagement and retention in drug treatment.” Given the early and relatively intense attention given to mandated clients, it appears that a mandate to treatment can have an advantageous impact on engagement in treatment, and hence with retention and successful outcomes.
Recommendations

There three areas where this study makes recommendations: future research, individual AOD counselor practice, and AOD agency policies. The recommendations are presented below.

Future Research

The results of this study illuminate the need for further study into the actual practice approaches and techniques of AOD counselors. Phillips and Bourne (2007) concluded their study into the values of AOD counselors with a recommendation for future exploration of the links between AOD counselor values and client outcomes. They stated that their study is the first in a continuing research program into the subject. Meier, Barrowclough and Donmall (2005) concluded that the variation in therapeutic alliances continues to be unexplained. They call for more studies on the relationship, how it is established and how it develops over the course of treatment, and in return how the growth of the relationship impacts treatment. This study also concludes the field of AOD treatment would benefit from further investigation into all aspects of the AOD counselor’s approach to treatment, and in particular the initial engagement with clients and how the therapeutic alliance is initiated and sustained.

The need for study in the area of counselor approach lead Kasarabada, Hser, Parker, Hall, Anglin and Chang (2001) to develop a self-assessment instrument for AOD counselors. The authors stated that there was “surprisingly little research concerning the assessment of therapeutic approaches of counselors in the field” (p. 274). They noted
numerous therapeutic approaches to treatment depending on the treatment modality use by the agency. They asserted that there was a need for a consistent measurement across all treatment modalities of the counselor’s approach. This study endorses the development and use of such instruments by individual AOD counselors, and the agencies where they work.

**AOD Counselor Practice**

This study points towards several recommendations for individual AOD counselor practice. The first is to continue to recognize and take into account the complexity of the life situations in which clients find themselves. The study found that AOD counselors recognize that clients have coercion, negative consequences and the need for financial security and life style structure all operating in their lives while they are in treatment. Maintaining an ecological based perspective on clients is recommended to best assist clients in receiving the full benefit of treatment.

Another recommendation is that AOD counselors continue to consistently review in a critical manner their practice. As called for by the National Association of Social Workers *Code of Ethics*, Ethical Principals, Competence, social workers should continually strive to develop professional skills. This study also recommends that AOD counselors endeavor to be aware of their individual practice styles and how they impact each client. Indeed, counselors would benefit from the administration of a self-assessment instrument similar to the one developed by Kasarabada, Hser, Parker, Hall, Anglin and Chang (2001).
Treatment Agencies

Recommendations for treatment agencies include continuing to allow individual AOD counselors the freedom to use their own unique approach with each client while maintaining an agency-wide program that is consistently applied to all clients. This combination of structure with allowance for individual application of the structure appears to be the paradigm already at work based on the results of this study. However, treatment agencies also should put in place procedures to insure that AOD counselors are continually reevaluating their practice.

Limitations

Limitation of this study included the disadvantages of using the qualitative research approach including its inherently subjective nature and lack of generalizability. By its very nature qualitative research integrates some of the subjective and personal biases of the researcher. During the analysis phase the very meanings of the words used by the participants are open to interpolation by the researcher. Due to the small sample size and its inherently subjective nature, qualitative research it is not generalizable to large populations. Another disadvantage is that the research is very difficult to duplicate. And, there is a greater potential for the bias of the researcher to be communicated to the research participants during an in-person interview than other data collection techniques (Rubin & Babbie 2008).

Limitations specifically applicable to this study include the limitations of work experience of the study participants. Some participants had only worked in agencies with
a majority of mandated or self-referred clients, and therefore had no frame of reference outside of the primary population represented within their agency. This limitation applied to the researcher also, who at the time of the research was an intern at a community based clinic that served primarily mandated clients.

**Implications for Social Work Policy and Practice**

The implications of this study will benefit the practice of AOD treatment on the micro, mezzo and macro levels. On the micro level, individual counselors who participated in the study will benefit from the examination of their own practice. Counselor interactions with clients, and other agencies involved with their clients, may also benefit from the counselor’s self-examination and clarification of their approach to some client populations. Clients of the counselors who participated in the study will benefit from the counselor’s consideration of their practice techniques. The snowball effect will spread the discussion of the research question to other counselors, who will also benefit from consideration of their own practice.

On the mezzo level, agencies involved in the study through the participation of counselors employed at the agency will benefit by the improvement in the individual worker’s self-awareness and self-examination. And, other employees at the agency may benefit from discussion of the project by participants, as they also examine their own practice. Agency level consideration of the question of different approaches to different client populations will increase transparency and programmatic consistency. And, agency
policies can be considered in light of the findings of the research, which will in turn improve treatment.

On a macro level, the practice of AOD treatment benefits from greater self-examination, and from the continuous reassessment of practices by those employed in the field. Other macro benefits include the employment of the ecological perspective by AOD counselors as they consider the wider implications of their different approaches with mandated versus self-referred clients. There could also be an impact on the recidivism rate for mandated clients as counselors actively engage mandated clients in treatment due to the newly discovered commonality of that practice.

**Conclusion**

The purpose of this study was to contribute to the understanding of the factors that impact the creation and sustainability of the therapeutic relationship in AOD treatment. This study explored one aspect of the issue: the treatment approaches of AOD counselors’ towards mandated and self-referred clients. The research suggests that AOD counselors frequently do employ a different approaches during the initial stages of treatment with clients mandated by the criminal justice system. The study also suggests that AOD counselors believe that all clients are coerced into treatment, whether or not by the criminal justice system, and that counselors perceive that employment and structure in the client’s life have an impact on treatment outcomes. Therefore, there is a need for additional research into the creation and sustainability of the therapeutic alliance, including the impact of individual counselor techniques on different client populations.
Other areas of study should include client’s self-perception of their reasons for being in treatment, and the impact of that perception on engagement in treatment. Further research should consider how to maximize counselor impact on client engagement and retention in treatment.
APPENDICES
APPENDIX A

Interview Guide

Demographic Information
1. What is your gender? Male  Female
2. What is your ethnicity? Caucasian  Non-Caucasian
3. What is your education? CAADAC Certificate  College Degree: BA  MA  PhD
4. How many years have you worked in the AOD treatment field?

Interview Questions
1. Briefly, please tell me about your training as an AOD counselor.
2. Briefly, please tell me about your work experience as an AOD counselor.
3. Do you think you personally have a different approach with mandated vs.
self-referred clients? If so, which approach(es) work best with which clients?
4. Do you think there should be differences in treatment
approaches/programs for mandated vs. self-referred clients? If so, why or
why not? Please describe the differences.
5. Do mandated vs. self-referred clients have different success rates? If so,
explain why or why not, and please describe the differences.
6. Do mandated vs. self-referred clients have different levels of commitment
to treatment? If so, explain why or why not, and please describe the differences.
7. What do you think about the impact on the commitment of many
mandated clients who do not pay for their treatment?
8. What do you think about the impact on the commitment of many self-referred clients who pay for their own treatment?
9. Did you ever work at an agency where different approaches were intentionally used?
10. If yes, what do you think was the impact on clients who received the different approaches?

We are almost out of time and I want to thank you very much for talking with me, and to ask one more question. Do you have any thoughts on the subject of mandated vs. self-referred clients that have not been covered by my questions?
APPENDIX B

Consent to Participate in Research

**Purpose of the Research:** You are invited to participate in research conducted by Chris Bates, a MSW graduate student in the Division of Social Work at California State University, Sacramento. The purpose of the research is to investigate the approaches taken by alcohol and other drug (AOD) counselors when they treat mandated and self-referred adult clients. This research is important as a contribution to the development of effective treatment modalities for AOD programs.

**Procedures:** After reviewing this form and agreeing to participate in this study, you will be invited to schedule an interview at your convenience. The interview will take approximately 45 minutes. The interview will be recorded on a digital recorder, transcribed onto paper, the data file erased immediately after transcription, and the paper transcription shredded upon completion of the project (June of 2011). The interview will include four questions for demographic purposes. As a participant in the interview you can decline to answer any individual question(s), skip questions, or you may also end the interview at any time.

**Risks:** There are no foreseen risks to participating in the project. You may decline to be a participant in this study without any consequences.

**Benefits:** Participating in the interview may further your professional development by focusing attention on your practice as an AOD treatment counselor, and your individual approaches to different segments of the client population.

**Confidentiality:** All information connected with the project is confidential and every effort will be made to protect your privacy. The digital recording of the interview will only be played to transcribe the interview and then will be erased. Each interviewee will be given a pseudonym name to be used in the transcriptions and in the final written project. Only the researcher and his thesis advisor will have access to the transcriptions. All transcribed interviews and consent forms will be shredded after the project is completed in June of 2011.

**Compensation:** You will be offered a choice of either a Starbucks or Peets gift card valued at $10. Also, if you elect, you may receive a copy of the Conclusions section of the project, which will be emailed directly to you. Alternatively, a bound copy of the entire project will be available in the library at the California State University, Sacramento after the project is completed.
Contact Information: If you have any questions about this research, please contact Chris Bates at (415) 515-6014 or by e-mail at csb76@saclink.csus.edu. You may also contact my project advisor Maria Dinis, Ph.D., MSW, at California State University, Sacramento, (916) 278-7161 or by e-mail at dinis@csus.edu. Your signature below indicates that you have read this page and agree to participate in the research.

________________________________ ___________________
Signature of Participant   Date

Yes, I would like a copy of the Conclusion section of the final project emailed to me at:

_____________________________________________
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