Storying Youth's Experiences of Coerced or Voluntary Residential Substance Abuse Treatment: A Narrative Research Project

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Abstract

The focus of this research is to examine the lived experiences of adolescents who voluntarily attended, or who were coerced to attend, a residential substance abuse treatment program. The intention of the research is to provide further context into understanding the lived experience of attending an adolescent treatment program. Minimal literature and research into the experiences of voluntarily or being coerced to attend treatment has been presented in the discourse on this topic. Therefore, this research will represent an exploration into further understanding these experiences in broader, yet more detailed terms.

The research involved interviewing 8 adolescents between the ages of 16 and 18 who were attending a residential substance abuse program. Adolescents described experiencing both internal and external pressure to attend treatment. Internal and external experiences occurred in both a temporal and locality context revealing valuable insight into the lived experience of being coerced or voluntarily attending residential substance abuse treatment.

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thesis, I thank you. I have to say that I have the greatest family in the world and I could not have done this without you.

Dedication

I dedicate this thesis to the young people who participated in the research. Your stories and experiences are a testament to your strength and resilience. I also dedicate this to the hundreds of young people I have worked with during my career. You inspired me to search further into the lived experience of residential treatment. Your stories remained with me throughout the research process. Thank you.

Chapter 1: Introduction

Being voluntary is always a good thing because the person is making the choice to come here and nobody else. Being forced is...it can be a good thing if your about to die or something but other than that I don't really see the point of being forced into anything really because I believe in free will.

Tanya

Coercing an individual to take part in substance abuse treatment is laden with ethical, practice, and legal issues (Anglin, Predergast & Farabee, 1998; Baer, Garrett, Beadnell, Wells, & Peterson, 2007). Although much quantitative research has been done on coerced and voluntary groups, minimal differences in variables that measure post-treatment outcomes have been reported between these groups. Further, few studies have specifically examined the lived experience of adolescents in these two groups who take part in residential substance abuse treatment programs. This research is critical to providing understanding to policy makers and those working within the human services field. Using a qualitative design, this research examined the experiences of treatment for youth ages 16 to 18 who report feeling coerced or not coerced to take part in a residential substance abuse program.

The topic of coerced and voluntary treatment has been an area that has emerged as a common topic of discussion throughout my career in the youth mental health and addictions field. At the beginning of my work in the addictions treatment field over ten years ago, it became evident that both the professionals as well as the clients held an opinion about coerced and voluntary treatment. Many of my colleagues working in the addictions field tend to hold to the notion that if a person does not want to change, then change is not likely to occur. It has been difficult for me to determine the source of this belief or how this

perception is reinforced in society, but I have heard on countless occasions, from clientele and clinicians that, "if you don't want the help then treatment just won't work." This perception is neither entirely correct nor incorrect. I have noticed that resistant clients can derive benefit from taking part in treatment services. My main contention with the notion of coerced approaches is that forcing a client to remain involved in a program they are not suited to, or prepared to be in, is fraught with practice and ethical implications. Therefore, by focussing on this topic in my research, I intend to assist in clarifying the client's perception of their experiences in treatment, as well as my own.

Examination of the research in the area of youth substance use treatment reveals a range of promising approaches (Erickson & Butters, 2005). Differences in treatment approaches, however, can conflict with the expectations of criminal justice authorities such as judges or probation officers, who are expecting referred clients to completely abstain from substance use (Marlatt, 1998). Since there is a higher rate of youth involved with the criminal justice system being referred to residential treatment programs, the type of service being offered can become a critical measure of success through the eyes of the referring agent (Marlatt, 1998). Given the higher proportion of criminal justice referrals, client retention in substance use programs has been considered extensively. Retention of clients in residential programs has been linked to their level of motivation, recognition of a substance problem, and development of a therapeutic alliance (Brocato & Wagner, 2008). Variables associated with treatment retention have also been linked to deterrence theory, which speaks to a process of decision making based on perceived consequences (Pogarsky, Pisquero, & Paternoster, 2004). Coerced and voluntary clients within a residential substance abuse

program may have a different view about why they chose to remain in a program and how their experience of being in the program influenced their decisions to alter their use of substances.

The concept of coercion and the value it has in assisting those with addiction and mental health problems has been presented by popular media sources for decades. Music and television have portrayed the concept of coerced treatment in a variety of ways. For example, in the A&E series *The Cleaner* (Semel, 2009), the main character is tasked with the responsibility of motivating people involved in substance use to face their addiction. Using whatever means necessary, substance users are confronted and pushed towards addressing their addiction issues (Appendix A). In addition, movies such as *One Flew Over the Cuckoo's Nest,* (Douglas & Zaentz, 1975) portrays the main character Randle McMurphy, played by Jack Nicholson, as a violent criminal who is placed in a psychiatric facility for assessment and treatment of his mental health problems. The movie highlights several scenes where McMurphy and the other patients on the ward are forced to undergo involuntary medical procedures including a famous scene where Nicholson's character undergoes electroconvulsive therapy (ECT) (Appendix B). Songs such as Amy Winehouse's (2006) song titled *Rehab* highlights an account of being forced to go to rehab (Appendix C). These works are a small sample of how coerced treatment is portrayed in the media. Furthermore, these works demonstrate value in forcing people to take part in treatment for addiction and mental health issues. In some cases, patients are portrayed as being out of control and in need of some form of intervention to become "normal." These kinds of portrayals are impactful due to the mass audience they reach. I have often felt that the

classic scene where Jack Nicholson's character undergoes ECT shaped, for many, an inaccurate representation of the effectiveness of ECT and how a patient responds physically while undergoing this kind of treatment. It is important to recognize that television shows, movies, and music have a strong influence in how coerced treatment is perceived by the public. Hence, these accounts shape the reality of how treatment approaches are viewed by society, and even those seeking help for addiction and mental health issues.

The important considerations described above raise significant questions that require attention. Why are coerced treatment approaches emerging as a common practice to address substance use in Canada? What influences contribute to success in treatment? Perhaps, most important to this study is what is the lived experience of being coerced or voluntarily entering into a residential substance abuse program. Further exploration into the lived experience of being in treatment is critical because much of the research in this area has tended to consider narrow interpretations of the experience of treatment.

Rationale, Significance, or Need for the Study

This study is significant in examining an aspect of youth treatment that has been largely overlooked in the literature. Many studies have examined the use of coercive techniques and linked them to outcomes of success. Most of these studies have been completed using quantitative research methods and have failed to consider the lived experiences of those coerced to take part in residential treatment. Through using a qualitative approach, it is anticipated that a clearer and more defined understanding of youth experiences in treatment was gathered. The outcome of this research could potentially influence policy within the program being researched as well as informing policy within

Northern Health. Although the size and scope of the study may be limited, the results may also provide some context for policy makers in the development of forced treatment approaches that have been and are being implemented across Canada. Generally, this research will add to the discourse on this topic. It will provide a much needed look into the lived experience of being coerced or voluntarily attending a youth residential treatment program.

Statement of the Research Question

This research examined the lived experiences of youth aged 16-18 who attended a residential treatment program and whether there are differences in treatment experiences of youth who report being coerced or voluntarily take part in a residential substance abuse treatment program. The main research question was: what are the lived experiences of youth who are coerced or who voluntarily attend a residential substance abuse program? The ideas central to this research are based upon the discourse within the literature on treatment approaches. Concepts related to coerced approaches have been examined in the literature and point to various outcomes concerning the practice of coercion (Anglin et al., 1998; Baer et al., 2007). This research aims to pick up the debate that has emerged from the literature on the topic of coercion and examine the lived experiences of coerced and voluntary clients who attend residential substance abuse treatment.

Coerced approaches are becoming the accepted norm in the treatment of youth substance abuse problems (Brecht, Anglin, & Dylan, 2005). Therefore, it is considered important to explore the lived experiences between coerced and non-coerced groups. This research is particularly timely given the ongoing and developing legislation in support of

coerced and mandated approaches across Canada and in North America (Healy, 2008; Mugford, 2006).

Definition of Terms

There are two central concepts to this research; coercion and voluntary. As well, clarifying terms such as youth and residential treatment program will provide understanding of how these terms were considered during the research. To examine these concepts, it is necessary to provide a definition of terms and explain how they will be considered in this research.

Definition of Coercion:

Coercion has been investigated using various techniques, yet the term remains largely undefined in the literature. According to Anglin et al. (1998), the reason is that many of the studies examining coercion use terms such as mandated, compulsory, pressured, or criminal justice referral interchangeably. This practice tends to lead to confusing portrayals of the information about the topic of coercion. One definition of coercion views it as a form of legalistic imposition on an individual to take part in treatment, either from a judge, probation officer, or some other agent of the criminal justice system and that failure to attend will result in some form of legally imposed consequence (Anglin et al., 1998). The Canadian Centre on Substance Abuse (CCSA) (Mugford, 2006) offers a somewhat different definition of coercion as "the delivery of substance abuse treatment services to individuals who are either reluctant or refuse to enter treatment unless they risk losing something important to them" (Mugford, 2006, p.1). In the CCSA definition, the person can still refuse

treatment, but will face a consequence as a result. The variation in terminology is important to the discussion of coercion. For the purposes of this review of the literature, coercion will be viewed through the lens of the CCSA (Mugford, 2006) definition of the term.

Definition of Voluntary:

According to the *Random House Webster's College Dictionary* (1991), the term voluntary is referred to as "done, made, brought about, or undertaken of one's own accord or by free choice" (p. 1493) and is defined using three criteria: a) acting or done without compulsion or obligation; b) done by intention, and not by accident; c) made without valuable consideration (Random House, 1991). These definitions of voluntary encompass how this term will be considered during the research.

Arguably, most clients entering into a residential treatment program would much rather be doing something else, but have recognized they could benefit by addressing their addiction issues. However, for the purposes of this research voluntary will refer to those clients who self report choosing to attend and do not face the loss of something important to them for leaving the program before completion.

Definition of Youth:

In this research several references to youth or adolescents can be found. The participants in the study were males and females ranging between the ages of 16 and 18.

Definition of Residential Treatment Program:

The term residential treatment program for the purposes of this study describes a substance treatment program located in the northern portion of British Columbia. Residents are required to reside at the facility while undergoing a range of interventions aimed at

addressing their use of drugs or alcohol. The length of stay is open based upon the individual need of the client. While at the facility the residents are under 24 hour supervision of youth counsellors and youth workers. The program follows a harm reduction philosophy and is funded through the Northern Health Authority.

Chapter 2: Literature Review

The Emergence of and Sustainability of Canada's Drug Strategy

The following section discusses Canada's Drug Strategy (CDS). This account is provided to demonstrate the historical and contemporary influences on Canada's drug polices. The emergence of coerced treatment approaches forms a significant part of the response to drug use in Canada, even though some of the claims about the viability of this approach remain spurious. Therefore, it seems necessary to provide a detailed and critical analysis of the factors influencing the current and future responses outlined in Canada's Drug Strategy.

Since introducing *The Opium Act* in 1908, the response of the Canadian government to the use of substances by its' citizens has taken a sometimes controversial, and at times a progressive approach in dealing with the social problems associated with substance use (Gordon, 2006). Some of the first government regulation of drugs came in response to a perceived threat to the "white" way of life presented by the widespread use of opium in the Chinese immigrant population. Although the use of opium was not identified by policy makers as having harmful health effects it was deemed to threaten the way of life for many white Canadians. Hence, the passing of *The Opium Act* was aimed at controlling the perceived harmful spread of the Chinese way of living (Gordon, 2006).

In the last twenty years, Canada finds itself in similar territory of trying to regulate the use of drugs through legislation. *The Controlled Drugs and Substances Act* (1996) represents Canada's most recent attempt to regulate the use of drugs by its citizens. The day

to day implementation of this Act are described in a document called Canada's Drug Strategy (CDS) (Hathaway & Erickson, 2003). CDS is aimed at providing police with broader powers in the detection and enforcement of drug crimes in Canada (Gordon, 2006). CDS is a federal policy developed by the Canadian government in 1987 (Hathaway & Erickson, 2003). CDS involved a range of opinion from various levels of government, addiction service agencies, non-government organizations, private sector, and special interest groups (Minister of Public Works and Government Services Canada (MPWGSC), 1998). Although this policy was developed using a consultative process, the consultation process alone does not, and did not in this case, ensure that the good intentions of the policy were met.

In order to examine CDS (MPWGSC, 1998), it is important to understand what the policy is focussing upon. The purpose of CDS is to reduce the availability and demand for illegal drugs within Canada. The CDS framework suggests focussing on research and knowledge development, knowledge transfer, prevention, treatment and rehabilitation, legislation enforcement and control, national coordination, and international cooperation to achieve these goals (MPWGSC, 1998). The strategy also points to two other key principles; that an appropriate legislative framework is necessary, and that prevention is the most cost effective strategy to address drug addiction issues. Generally, the purpose of the drug strategy is to reduce the level of harm associated with substance use on individuals, families, and communities (MPWGSC, 1998). With these goals in mind, the drug strategy has been maintained by the federal government since 1987 and has recently been renewed for an additional five years in 2008.

According to CDS, the policy has been developed through an extensive consultative process which involved various levels of government, addiction service agencies, non-government organizations, private sector, and special interest groups (MPWGSC, 1998). On the face of it, it appears the policy was developed in a comprehensive fashion using broad community participation to develop effective strategies to address the substance use problem in Canada.

As part of offering a critical analysis of CDS, it is important to understand and consider the policy from a historical and political context. In recent years, CDS was renamed by the federal governing Conservative party, lead by Stephen Harper, to the Anti-Drug Strategy. The premise behind this shift by the Harper government was to move responsibility for the federal addictions portfolio from Health Canada to the Ministry of Justice (Healy, 2008). This move by Harper demonstrated how the federal government was changing the focus of addiction policy from a health issue to a crime issue. The movement also signaled to the Canadian public that drug users are criminals and that they should be dealt with through punitive means. This new anti-drug movement was spurred on by focussing on high profile crimes in Toronto and Vancouver before the election, and presenting them as a crime wave sweeping across Canada. The answer, according to the Conservatives, was to get tough on crime by getting tougher on drugs and drug users (Healy, 2008). This political shift was presented to the Canadian public throughout the 2006 federal election as; if you did not agree with this policy then you are for the criminals--nobody wants to support criminals, do they? This strategy appealed to the Canadian public and spurred on a victory for the Conservatives in 2006 and again in 2008. It is important to note

that this strategy was effective for the Conservatives despite an overall decline in the crime rate as well as a decrease in the rate of drug use in Canada beginning in the 1970s (Healy, 2008).

The final consideration effecting Canada's response to substance related issues is through the North American Free Trade Agreement (NAFTA). Canada's involvement in NAFTA effects it's policies on issues such as drugs and crime. The United States' "war on drugs" approach is a dominant force within the context of border security. Since the US is the strongest player, from an economic standpoint, within the NAFTA agreement they are able to direct policy on border security issues in influential ways. Due to their level of influence, the US is able to exert leverage on policies relating to the flow of goods across the Canadian and Mexican borders, including the flow of illegal drugs. The result of this power differential is that Mexico and Canada have been pressured to adopt drug policies that are aligned with the US's "war on drugs" stance (Cottam & Marenin, 2005). Evidence of this shift towards US policy is provided in the discussion above that describes the Harper government's response to getting tougher on crime and drugs.

Furthering the analysis of Canadian drug policy, it is important to consider how the federal approach to drug problems effects the provincial response to drug issues. The following discussion focusses upon British Columbia's response to drug issues. In 2004, the British Columbia introduced a policy called *Every Door is the Right Door* (EDRD), a province-wide framework for the implementation and development of addictions programs. Generally, the document was developed to provide a framework for health authorities to implement and develop strategies to assist those involved in substance use in BC (Reist,

2004). The focus of the document parallels CDS policy but differs by its focus on decriminalizing addiction through implementation of harm reduction strategies. The main focus of EDRD is on providing a framework for health authorities to implement a continuum of services aimed a reducing and curbing the level of harm associated with substance use in BC. The driving force of the document indicates that to develop effective drug and alcohol services, a continuum of programs must be established to meet the vast array of needs of those involved with problem substance use (Reist, 2004). On the face of it, this policy seems to capture a wide range of the public needs on the issue of substance use.

Although the EDRD policy is encompassing and seems to meet a wide range of needs, it is important to consider how this policy is influenced by federal initiatives and strategies. The EDRD policy seems to enshrine the use of harm reduction approaches as the cornerstone of addiction programs. Programs such as needle exchanges and safe injection sites are currently being used in BC (Reist, 2004). However, the federal stance on getting tough on drugs seems to run counter to this practice and, hence, places these kinds of programs at risk of being seriously questioned and scrutinized outside the borders of BC.

The pressure placed on Canada to maintain a tough stance on drugs by the US is intense. The debate to decriminalize marijuana in Canada during the 1990s and early 2000s led to the US threatening to tighten border security as a means of protecting US citizens from the evils of Canadian marijuana (Cottam & Marenin, 2005). Shortly after, the decriminalization of marijuana debate virtually disappeared from the realm of Canadian politics and the media after the election of the federal Conservatives. In May 2008, Simon Fraser University criminologist and expert on the decriminalization of drugs, Neil Boyd,

provided comments on research he completed on the benefits and success of the safe injection program (InSite) in Vancouver. These positive findings were considered a blow to the Harper government who are attempting to close the InSite program by having it declared illegal through the BC Supreme Court ("Professor Neil," 2008). Considering this analysis, it is evident federal and provincial responses to addiction policy are both aligned and opposed to each other. This level of uncertainty leaves a significant gap and opportunity for provincial initiatives in this area to change to reflect the neo-liberal agenda of the BC Liberal government.

On a local Northern BC level, initiatives and gains have been made to implement and develop programs that are aligned with the principles discussed in the EDRD (Reist, 2004) document. For example, collaborative efforts that recognize the need for a continuum of services for youth have begun to be implemented within Northern BC. Addiction service systems have developed by integrating youth mental health and addictions services, to include a range of professionals working in teams to meet the comprehensive needs of youth. By working with the youth, their family, and other systems of care, a multi-systemic approach is taken with individual clients (DeWolf, Beach, Fawcett, & Dobrinsky, 2006). Despite gains being made, threats to programs and services in the North continue to be of significant concern. For example, in Prince George, a long standing adult addictions treatment program has recently been closed down in favour of a model of day treatment and supportive recovery ("Nechako Treatment," 2008). Although this model may be beneficial, it is being hailed as a cost savings mechanism by local health authority officials. The erosion and eventual closure of a residential treatment program in the North points towards

an overall provincial agenda of cutting services under the guise that some programs are not cost-effective.

Considering the discussion to this point, it is evident CDS is influenced on a number of levels. The alignment of Canadian economic and trade policies with those in the US (i.e. NAFTA) has corresponded with lateral pressure on Canadian social policy, specifically in the area of addiction policy (Cottam & Marenim, 2006). Policies such as NAFTA serve the interests of big business in the US as well as Canada (Cottam & Marenim, 2006). The interests of those with the most power in society are being served by CDS. Big business, bureaucrats, and professionals stand to benefit from policies that align themselves with the US. The development of Canada's drug policies using this economic lens represents a form of elitism to reinforce the status quo and the power differentials between social groups in Canada (Graham, Swift, & Delaney, 2003). This is problematic because it creates a situation where the health and well being of Canadians is being controlled by broader systems and groups that do not understand the seriousness and complexity of individual issues associated with substance use.

The example above highlights how a neo-liberal agenda permeates through Canadian, provincial, and local addiction policy. The focus of the policies reviewed refer to notions of cost-effectiveness, best-practices, and harm reduction. All of these terms seem like good ideas to consider when developing programs and services. However, what happens under the current structure, is that the broader (macro) issues end up influencing the local development of services (micro). The neo-liberal ideals of the federal government and ultimately big business in the US, influences the view of what services are cost-effective and

promote harm reduction through an anti-drug stance (Gordon, 2006). When these ideas begin to collide they become so convoluted they no longer work in favour of the service users, but instead serve the interests of elitist views of a small yet influential sector of society.

Practice Implications of Coercive Approaches: Ethical and Legal Considerations of Coercion

The analysis of CDS in the last section can be linked to practice issues for working with individuals with substance abuse problems. Specifically, the analysis raises the question of, whose interests are being served by implementing strategies that use coercion as part of assisting those with substance abuse issues? It seems that coercive approaches may serve the needs of those trying to demonstrate they are being tough on drugs and drug crime by forcing those with addiction issues to seek some form of substance abuse treatment. This raises critical ethical and legal concerns that must be considered in the discussion of coercive approaches. Criminalizing those with substance abuse problems demonstrates a move away from viewing addiction as a health issue and moving towards it towards being a criminal issue. Hence, the use of the courts to coerce or impose treatment on those with addiction concerns can be viewed as a response based on broader political pressures rather than it being an approach grounded in solid research or the well being of the individual. Therefore, emerging treatment strategies following those resonating from the United States should be questioned and be proven effective within the body of research on the topic of coercion.

As noted in the introduction section of this thesis, there are many sources within the literature that speak to youth involved in the justice system and being referred to treatment programs as part of the sentencing process (Brocato & Wagner, 2008; Marlatt, 1998). The practice of coercing youth, or anyone else for that matter, raises ethical issues that deserve some consideration. The Canadian Association of Social Workers (CASW) *Code of Ethics* (2005), discusses a client's right to self-determination. Further, it defines voluntary as "a patient's right to make treatment decisions free of any undue influence, such as ability of another to exert control over a patient by force, coercion or manipulation" (CASW, 2005, p. 11). Combining ethical issues put forth by the CASW with the concept of coerced treatment, raises broader implications for the client, society, and the individual practice framework of the practitioner mandating and/or providing treatment.

Beyond the social work realm, other professions have codes of ethics that recognize the importance of self-determination. These codes of ethics must be considered when coercing people to take part in treatment interventions and has been considered by the courts in the United States. The case of Sell v. United States raises important ethical issues around whether an individual can refuse treatment for mental health concerns. The outcome found that individuals can refuse treatment for mental health problems provided certain criteria are met. Generally, the criteria are used to determine whether the individual is a danger to themselves or others. In the Sell case it was determined that the criteria had not been met and that the individual had to be released from a psychiatric facility (Bassman, 2006).

Bassman's (2006) work examines issues related to the development of legislation and the rights and privileges afforded to the public and the extent that laws can intervene on the private lives and health concerns of the public. Bassman (2006) also challenges practitioners in the mental health field to examine their personal and professional ethics and beliefs regarding the treatment of those with mental health issues.

From a bioethics rather than legal standpoint, Caplan (2006) examines the ethical concerns associated with forced, mandated, and coerced treatment approaches. Generally, bioethics is concerned with considering the values associated with the self-determination of the patient or client in the medical services field. Caplan argues that it is sometimes necessary to force clients to accept treatment as a means to preserve their autonomy. Forcing someone to take medication to assist in their recovery is justifiable if it assists in restoring the capacity of the individual to self-determine. Caplan adds to his argument by linking the idea of coercion to the economic and social cost of addiction. If those involved in mandatory treatment are able to report an increase in their level of autonomy after being forced to take part in treatment, then a strong argument can be made that this approach should be considered for the greater good of the person and society (Caplan, 2006).

In Canada, political and legislative shifts concerning youth being coerced to take part in residential treatment or some form of substance abuse intervention is beginning to occur. For example, in Manitoba the implementation of Youth Drug Stabilization (Support for Parents) Act, came into effect in November of 2006. The Act summarizes the criteria necessary to involuntarily confine a youth to a treatment facility for stabilization. In order to enforce the act, the following criteria must be met: "is abusing one or more drugs severely

and persistently; is likely to deteriorate substantially either physically or psychologically as a result of severe and persistent drug/and or alcohol abuse; should be assessed by an addictions specialist to determine whether they should be detained at a secure facility to be stabilized; and has consistently refused to agree to a voluntary assessment, or has had one or more unsuccessful interventions to address his or her alcohol and/or drug abuse" (Youth Drug Stabilization (Support for Parents) Act, 2006). Similar, legislation is beginning to take effect in other provinces such as Alberta and Ontario (Mugford, 2006). Involuntarily placing someone in a facility for using drugs or alcohol represents a dramatic shift within Canada and has broader Charter of Rights and Freedoms implications beyond the scope of this literature review.

The political and legislative shift that has occurred points to an important trend for youth substance abuse treatment. The use of coercive treatment approaches seems to be taking foot in Canada. Although there may be legal grounds to enact this kind of legislation, a review of the literature on this topic reveals that the benefits of these approaches is mixed. Although much can be said about the positive benefits for coerced approaches one has to consider whether the benefits are outweighed by the ethical and legal considerations surrounding this topic.

Does Coercion Work?

Does coercion work? Multiple answers to this question exist. The threat of criminal sanctions for leaving treatment have been linked to increased length of stay in programs (Sung & Richter, 2007). Assuming the length of stay in a treatment program is a positive

indicator for long-term success, these kinds of results add to the argument in favor of coercion. However, it is important to recognize that the threat of sanction may not be the sole predictor of choosing to stay, and it may not predict long term outcomes post-treatment. In fact, other research has noted a difference in treatment outcomes based on the client's perception of the usefulness of the intervention (Baer et al., 2007). These ambiguous results make it difficult to determine one particular variable that predicts positive outcomes for length of stay as well as long term success. This ambiguity could be further clarified by research that employs a qualitative analysis to examine other variables that may influence positive treatment outcomes.

Three factors emerge as having a significant influence on retaining clients in both residential and community based programs. These factors include: a) having motivation to change; b) the development of a therapeutic alliance; and c) recognition that they have a substance abuse problem (Brocato & Wagner, 2008). Although these factors contribute to treatment retention they were not associated with long-term outcomes. Therefore, examination of outcomes over a period of six months or longer is an area that could be the focus of future research initiatives.

Research examining long term outcomes for those who are coerced to take part in treatment versus those who voluntarily attend reveals little difference between the two groups (Anglin, Predergast, & Farabee, 1998; Brecht, Anglin, & Dylan, 2005). These findings are important because they raise implications when combined with the results of

studies that view other factors such as motivation to attend treatment as being predictive of long term success post-treatment (Cosden et al., 2006).

As discussed throughout this review of the literature, few studies have been completed that explore the lived experience of coercion. Recent trends towards exploring a client's experience in treatment are beginning to take root (Album, 2007). These studies stand out from the bulk of research in the area of coerced approaches because they acknowledge the need for an in-depth exploration of typical treatment outcome measurements and provide knowledge about coercion from a user perspective.

Therapeutic Relationship

Research has been completed that examines the effects of coercive treatment on the therapeutic relationship. The bond between the therapist and the client is viewed as a critical component to facilitate change. Certain "facilitative conditions" (Hepworth et al., 2006, p. 86) are necessary to produce meaningful helping relationships, and are described as showing "empathy, unconditional positive regard, and congruence" (Hepworth et al., 2006, p. 86). These tenets, founded by Carl Rogers, are particularly important in building rapport (Zimring, 1994). Allowing clients to feel valued and at ease during their interaction with a social worker has been linked to increasing rapport (Lishman, 1994). Given the value placed on having a strong therapeutic bond between client and therapist, it is critical to reflect on how coercion affects this central tenet. When considering this topic, it important to examine the nature of the client-practitioner relationship when the practitioner has the capacity to

enact sanctions on the client for failure to abide by treatment expectations (Skeem, Louden, Polascheck, & Camp, 2007).

The strength of the dual role relationship is increased by the level of caring demonstrated by the clinician and the client's level of willingness to take part in the therapeutic process (Skeem et al., 2007). When the coercer is also the therapist it is important to acknowledge that a dual role relationship is created (Skeem et al., 2007). In 2001, the Canadian government released a document titled, *Best Practices Treatment and Rehabilitation for Youth with Substance Use Problems* (Currie, 2001). This document describes a range of issues related to substance abuse treatment. It identifies that youth are typically coerced into taking part in treatment by sources such as family, school or probation officers. The main point put forth in the document indicates that in order for positive outcomes to occur, youth have to have a positive experience in treatment. Furthermore, the overall philosophy of the treatment has to be client-centered. Another key finding of the document is that youth do not necessarily have to complete treatment to experience positive outcomes (Currie, 2001). Thus, coercion in itself is not necessarily a good or bad thing; success is based upon the approach of the therapist, and the level to which the client takes part in the program. Hence, determining whether coercion affects the intended positive experience while in treatment could have implications on the client's long term success. The power differences and the bond that is formed between the therapist and client is the subject of focus in this research. Understanding how a client perceives the therapist during treatment may also point to differences between coerced and non-coerced clients.

Therapeutic Process

Often, youth are referred to treatment programs by the criminal justice system, which often places conditions on clients to not use any substances. However, many are referred to harm reduction based programs where abstinence is not the primary treatment modality or measure of success (Marlatt, 1998). Therefore, mandated clients are left to determine how to achieve their treatment goals while balancing the expectations of the justice system. The conflicting expectations between the referral agent, treatment program, and client are all factors that must be considered when examining the topic of coerced and voluntary treatment.

The value of coercing a client to take part in treatment has mixed findings within the literature. One reason that might account for this inconsistency, is that social pressure to seek treatment has been found to be a strong determinant of whether a person will enter into a treatment program (Wild, 2006). This study departs from most of the literature on this topic by examining the effects of social pressure versus criminal justice pressure to enter treatment. The findings indicate that social pressure can be just as effective as criminal justice pressure when it comes to making the decision to enter treatment. Based on Wild's work, it is necessary to consider the concept of coercion beyond criminal justice influences as other factors may have an impact on a person's decision to take part in treatment.

Literature examining the philosophical underpinnings related to effective treatment, raise the question; why is coercing youth to take part in treatment considered necessary? Those who abuse substances typically have higher rates of violent behavior, criminal involvement, and psychiatric problems than those not involved with substance abuse

(Erickson & Butters, 2005; Winters et al., 2000; Zweben et al., 2004). Failure to address substance abuse problems can have severe societal and individual consequences. Therefore, forcing or directing an individual to take part in treatment is considered necessary to avoid the negative effects of substance use. Furthermore, these studies (Erickson & Butters, 2005; Winters et al., 2000; Zweben et al., 2004) find that completion of treatment is correlated with lower criminal recidivism rates. These studies add to the argument, that in order for someone to attend treatment they may require some level of coercion. Due to the potential for increased positive outcomes, including decreased recidivism, coercing a person to take part in treatment may have broader positive societal benefits. Although there are perceived benefits to coercing a person to remain in treatment, recognizing that this approach could negatively affect the client-therapist bond needs to be considered.

Family Based Interventions

A range of research (Barrowclough et al., 2001; Dembo & Walters, 2003; Kaminer, 2001; Kumpfer & Summerhays, 2006) has been completed on the topic of family involvement in treatment for those with addiction and mental health issues. Furthermore, specific treatment approaches have been measured and indicate that in order for treatment to be successful, family must be involved and treatment does not have to take place in a residential facility. Examining the literature on family based approaches, it appears there is value in coercing a person to take part in these kinds of interventions.

Integrated family models increase positive outcomes for clients with mental health and addiction issues (Barrowclough et al., 2001; Dembo & Walters, 2003; Kumpfer &

Summerhays, 2006). For example, an integrative model employing motivational interviewing, cognitive-behavioral therapy, and family participation for adolescents dually diagnosed with schizophrenia and substance abuse issues was found to be effective (Barrowclough et al., 2001). Although integrated models were found to be effective, there is no evidence to show that other models could have been incorporated with similar results. Regardless, the outcome of these studies demonstrate family based interventions are effective in increasing positive outcomes for adolescents with mental health and addiction issues.

Although research has noted the importance of family based models, a crucial question emerges about the ability of these interventions to be effective with those involved in the criminal justice system and who may not voluntarily take part in treatment. The use of structural family therapy has been found to have positive effects on substance abusing adolescents who are involved with the criminal justice system (Smith, Sells, Rodman, & Reynolds, 2003). Using a structural approach, parents were provided with psycho-education in a range of areas related to effective parenting. In addition, sessions involved the family and the adolescent working together to explore family systems and what changes might have positive affects on reducing the level of substance abuse and the youth's consequent involvement in the justice system. Working with families in this way led to a significant decrease in the adolescent's substance use over a twelve month period and subsequently their recidivism rates decreased. The use of structural family therapy allowed parents to reassert their parental role and begin assisting their child in making positive choices. It should be

noted, that even though the adolescents who participated in this research were successful in quitting their drug abuse, their overall attitude towards using drugs did not significantly change (Smith, Sells, Rodman, & Reynolds, 2003). This finding is interesting as it speaks to the notion that strong family systems are more valuable in effecting change than the attitudes and beliefs of individuals within the family. In addition, it adds to the evidence that coercing a client to take part in treatment could be useful in producing positive outcomes for the individual and their family.

In summary, the literature on the topic of coerced and voluntary treatment points to a growing trend towards the use of coerced approaches to address the needs of those with substance abuse issues. The use of coerced treatment approaches shows mixed results within the literature. Despite this ambiguity, these strategies are gaining momentum as favourable modalities of delivering service to those with substance use problems. Within the debate on this topic, macro forces such as NAFTA and the drug policy in the United States appear to influence Canada's drug policy and its approach to the provision of treatment services.

Treatment approaches need to be considered beyond marcoanalytic influences and be examined from ethical, legal, therapeutic, and family perspectives. Concepts such as free will and self-determination impact a person's decision process whether to attend treatment (Wild, 2006). Researching the lived experience of coerced and voluntary treatment using a qualitative design may lead to a deeper understanding of how emerging trends in treatment are experienced by service users.

Chapter 3: Research Methodology and Design

The following chapter will describe the underlying premise of the research design and methodology. To complete this task, I will begin by describing my personal stance on the issue of coerced and voluntary treatment. Second, I will describe the methodological approaches employed during the research as well as the research design. Finally, it is necessary to describe how the research design and methodology intersect with my personal stance on the research topic.

To begin, it is important to understand that many aspects of this research are fluid and that the methods employed during the research changed as the research progressed. For the most part, it was simple to follow the basic design of the research, however, the fluidity came during the data analysis phase of the research. As the analysis portion of the research unfolded, it became evident that I was not able to separate myself from the findings. Consequently, I was interpreting statements made by the participants based upon my assumptions and my personal lens concerning the topic. Reaching this point forced me to recognize that my experiences and interpretation of the data is as important to the research process as the information collected from the participants. According to Bruner (2004), experiences do not consist of one reality, rather there are multiple interpretations of the same event based upon variables such as who, when, and where. Embracing this notion led me to incorporate a autoethnographic lens (Chang, 2008) with the narrative design (Clandinin & Connelly, 2000) of the research. Using this approach, it became necessary to reflect upon my understanding of coerced and voluntary treatment. Further, it was necessary to understand how my perception of these topics has developed by considering influences of

where, when, who, and how my ideas on this topic have been formed. Finally, it was necessary to recognize that my perception of the topic would influence the interpretation of the research data.

The topic of coerced versus voluntary treatment is an area that has emerged as a common topic of discussion throughout my career in the youth mental health and addictions field. At the beginning of my work in the addictions treatment field over ten years ago, it became evident that both the professionals and the clients I worked with assisted in forming my opinion on coerced and voluntary treatment. Many of my colleagues who work in the addictions field tend to hold to the notion that if a person does not want to change, then change is not likely to occur. Hence, clients that are considered resistant to the treatment process are not referred to or accepted into programs that could benefit them. Along with my colleagues' opinion on this topic, the clients who I work with also seemed to hold to this belief about motivation.

It has been difficult for me to determine the source of this belief or how this perception is reinforced in society but I have heard, on countless occasions, from clientele and clinicians that, "if you don't want the help then treatment just won't work." This perception is neither entirely correct nor incorrect. While working in the mental health and addictions field for the past ten years, I have noticed that resistant clients can derive benefit from taking part in treatment services. Furthermore, the level of resistance presented by a client can change once they are able to reconsider a new relationship with their substance use. My main contention with the notion of coerced approaches is that forcing a client to remain involved in a program they are not suited to, or prepared to be in, is fraught with

practice and ethical implications. The negative effects of forcing a client to remain in this situation and how it can outweigh the positive intentions of the service have been witnessed. From a social worker's perspective, the tension between coerced and voluntary approaches needs to be further considered. This conflict between standard practice approaches and the client's lived experience of being in treatment has spurred on my interest in this topic. Therefore, by focussing on this topic in my research, I intended to assist in clarifying the client's perception of their experiences in treatment as well as my own. Furthermore, the research gave a voice to the youth who took part in residential treatment and allowed them to express what their experiences are like and how coerced or voluntary treatment effected them.

In summary, my perceptions and beliefs on the topic of coercion have been shaped by several influences. First, I have been working in a youth residential treatment centre for the past ten years. This explains the where and when of the formation of my beliefs on the topic of coerced and voluntary treatment. Second, I would estimate that during this time I have met and assisted over a thousand adolescents with their addiction issues. In addition, I have met and worked with dozens of professionals who shared with me their opinion on the notion of treatment readiness and coercion. These people represent the who and how of the development of my opinion on the topic of coerced and voluntary treatment. Therefore, it is difficult for me to determine whether my opinion on this topic would have changed based on working with a different group of professionals or clientele. This reflection is necessary to the discourse on this topic because it demonstrates how interpretation and perception is a product of a complex interplay of time, place, and person. Further, this reflection identifies

my position on this issue and how my perception had an impact on the interpretation and analysis of the research data. Therefore, throughout my analysis of the research data, I have attempted to remain mindful of how my perception and biases effect my interpretation of the data.

Autoethnography and Narrative Research

The primary methodological approach used in this research involved the use of a narrative research approach. However, a second aspect of the research design involved the use of an autoethnographic lens. Thus, the overriding approach is narrative, with a recognition that a personal or autoethnographic account of the role coercion or voluntariness has in the treatment of substance use problems is also present throughout the research process.

Autoethnography, as a research method, provides a platform from which to conduct qualitative research. It embraces the personal and provides a format to intersperse the researcher's experience throughout the research design and analysis (Davis & Ellis, 2008). Recognizing that personal bias and perception unavoidably influences the research process is a critical aspect of autoethnography. Getting to know the "forces" that shape human understanding are important components of autoethnography (Chang, 2008). Inserting knowledge of these "forces" into the research process is unavoidable and should be embraced by the researcher because this process of knowing is part of developing a greater awareness of self and the influence the self has on the research findings and outcome (Chang, 2008; Davis & Ellis, 2008).

Using the notion of self-reflection and interpretation formed a critical part of understanding the research findings. As discussed in the previous section, I had to reflect upon the who, where, why, and the how of my research. Knowing how my personal beliefs and attitudes about the subject were formed, forced me to recognize that I might interpret the data and the stories told by the participant using my lens -- a lens tainted by years of experiences working with people and professionals who have all shared an opinion on the topic of coercion. To this extent, I employed an autoethnographic reflexive process to understanding and recognizing my beliefs about the research topic.

The methodological framework for this research employed a qualitative research design (Patton, 2002). As discussed throughout the review of the literature, most of the research on coerced treatment has involved the use of quantitative designs. Hence, the intention of employing a qualitative design was to provide a greater depth of understanding into the experiences of coerced and voluntary treatment. The method of qualitative inquiry employed during this research flowed from a narrative research paradigm. Narrative research is concerned with gathering the story of a person's experience and using this data to develop interpretations of their experiences. Several stories can be analyzed simultaneously to help identify the critical themes that emerge from the lived experience of coerced or voluntary attendance (Patton, 2002). Using a narrative research approach can provide a spectrum of data to convey some form of meaning about the person's experience through analyzing the themes that emerge from the stories told (Ospina & Dodge, 2005).

The search for meaning is an important aspect of narrative inquiry (Bruner, 2004). The telling of stories not only shapes other's perceptions of reality but also the storyteller

themselves. This notion is summed up by Bruner (2004) in the statement, "a life is not "how it was" but how it is inter-preted and reinterpreted, told and retold: Freud's *psychic reality"* (p. 708). The focus of this research is to attempt to determine the meaning that participants associated with being voluntary or coerced. The meaning the participants portrayed of this experience assisted in providing a better understanding of this subject.

Text data is central to using a narrative approach. Narrative data is gathered from the stories or accounts told by the research participants. These stories are known as field texts (Creswell, 2005) and provide the elements to be analyzed during the research process. I believe following a narrative approach with autoethnographic undertones provided a critical missing link to the current body of research that has generally failed to examine the issues related to coerced treatment by employing a qualitative approach. Narrative inquiry has been used in a range of areas to identify the meaning associated with lived experiences (Kelly & Howie, 2007; Overcash, 2004). Using narrative approaches has widespread application and has assisted in understanding the story and the meaning of specific human experiences, such as receiving cancer treatment (Overcash, 2004) or nurses learning new treatment interventions for assisting mental health patients (Kelly & Howie, 2007). The use of narrative research approaches is varied and seems only limited by the researcher's capacity to listen, identify, and interpret the stories being told.

Although the term "lived experience" is typically associated with the phenomenological paradigm of qualitative research, a narrative approach will be used (Patton, 2002). Narrative research is suitable for analyzing social and individual experiences (Ospina & Dodge, 2005). Essentially, for the purposes of this study, the participant's story or

lived experience of attending residential treatment will be gathered and analyzed for common themes to provide a deeper understanding of what it has been like to take part in treatment on a voluntarily or coerced basis.

Sample

The subjects for this study were selected using a non-probability convenience sampling method (Rubin & Babbie, 2005). Essentially, clients who met the qualifying criteria and entered into the treatment program were asked if they would be willing to participate in the study. Eight participants were selected to take part in this research. This sample size is within acceptable sample sizes for studies using a qualitative design (Patton, 2002). The smaller sample size allowed me to gain an in depth understanding of their treatment experiences.

The youth who took part in the study had accessed the treatment services available at a residential treatment centre in Northern B.C.. This program is offered through Youth Mental Health and Addiction Services of the Northern Health Authority. The participants in the study were male and female adolescents between the ages of 16-18. Although the program offers services to adolescents from the ages of 13-18, it was felt that it would be difficult to determine whether those between the ages 13-15 would be able to provide informed consent. Therefore, to protect their integrity, the decision was made to not include them in the research project.

Subjects were recruited by asking each youth individually if they would like to take part in this study. They were approached by the counsellors working within the program and

asked if they would be interested in taking part in the research process. Participants who expressed interest in taking part in the research met with me to discuss their participation in the study in more detail. If they agreed to take part, they were required to sign an informed consent form. When available, their parent or guardian were also asked to sign an informed consent waiver. Some of the youth were estranged from their parents and therefore parental consent was not able to be attained. Since parental consent could not be attained in some cases, it was necessary to discuss this problem with the participant to ensure they understood why parental consent was preferable. However, because of their circumstances, gaining parental consent was not possible. In these cases, I decided to only interview youth who seemed to have a solid understanding of the notion of informed consent. In addition, some of the parents were not able to sign the informed consent form in person. In these cases, I spoke to the parent over the phone and obtained their verbal consent and noted this on the parental consent form.

Instrumentation and Data Collection

The narrative data or field text (Creswell, 2005) was collected during two audio recorded one on one interviews. Each interview lasted approximately twenty to thirty minutes and focussed specifically upon their treatment experiences. The interviews were semi-structured. An interview schedule (Appendix D) provided me with a framework to begin asking questions about the participant's experiences in treatment. However, based upon the direction of the interview, not all questions listed in the interview schedule were asked. The interviews were based upon participant's experiences and therefore did not

always fit with the questions provided in the interview schedule. Therefore, throughout the research, the interview schedule was used as a starting point to meaningful conversations with the participants about their experiences in treatment. The interviews provided an opportunity for the participant to tell their story of coming to treatment and what it was like being in treatment.

The first interview occurred within the first few days of the participant's arrival at the treatment program. The focus of the first interview was to identify the circumstances that led to them coming to treatment. The collection of this narrative data was critical to interpreting how this experience had affected them. During the initial interview, the client was asked to identify and discuss whether they viewed themselves as volunteering to attend treatment or whether they felt coerced to attend.

The second interview typically occurred during the final week of the participant's stay in the program. The purpose of the second interview was to discuss the ongoing story of their experience in treatment. The second interview also provided a deeper context of the experience of being coerced or voluntarily attending a treatment program.

Not all the youth who took part in the study completed their course of treatment. As a result, they were not able to take part in the second interview. In total, four of the eight participants interviewed were not able to take part in the second interview. In these cases, the information gathered during the first and only interview was incorporated into the study because this information revealed important themes about their experience of coming to treatment and what they thought of their experiences since arriving in treatment. I noticed

that the information gathered during the first interview was the most telling. The experiences early on in treatment seemed to set the tone and course for the remainder of their stay. Therefore, the information that was gathered from those who did not take part in a second interview is viewed as critical to the findings about understanding their experiences of voluntary or coerced attendance and have been included in the findings.

Treatment of the Data

Narrative analysis does not have a standard methodological approach (Kelly & Howie, 2007). The use of a specific set of narrative and ethnographic procedures were employed throughout the research process. Following a set of narrative and ethnographic procedures provided an opportunity to achieve a better understanding of the experiences being considered within the research (Kelly & Howie, 2007). The treatment of the narrative data gathered during the research interviews primarily flowed from a collection of narrative research methods.

As part of developing a meaningful account or story of the participant's experience of coerced or voluntary treatment, four specific procedures were undertaken to portray the field text in a meaningful way. The four procedures were transcription, retranscription, development of a final story, and emplotment to identify themes that emerge from the final story (Creswell, 2005, Kelly & Howie, 2007). According to Creswell (2005), it is important to transcribe the participant interviews. Next, the transcribed data can be retranscribed into categories that use a key to represent the setting (environment, place, time or locale), characters (individuals in the story), actions (individual movements or behaviours in the story), problem (questions to be answered or phenomena to be described), and resolution

(explanations about change). The retranscribed data can be organized into a chronological sequence to form a final story. The final story discusses the major influences and events that occurred during the story (Creswell, 2005). Last, the final story should be analyzed for themes using a narrative approach called emplotment. Emplotment involves identifying events and actions within the story that contribute to the outcome of the story (Kelly & Howie, 2007).

To begin the narrative analysis, all data collected was audio recorded, transcribed, and saved in a computer file. The data was kept strictly confidential and will be destroyed upon completion of my thesis research. The data was stored in a locked file cabinet in a locked office. Any information that could be used to identify a respondent, such as name, was erased from the data and each participant was assigned a pseudo name during the analysis phase of the research.

In keeping with the tradition of narrative research, the field text data gathered from one or both the interviews was retranscribed. Retranscription involved sorting the data into a context of time and place while identifying the major characters, actions, problems, and resolutions that arose during the telling of the story (Creswell, 2005; Kelly & Howie, 2007). During this process, it became evident that the information presented by the participants during the interviews could be sorted in categories. Generally the categories identified experiences before and at the beginning of treatment, during treatment, and near the end of treatment. Separating the data based upon time and place was a valuable part of establishing the "when" and "where" of these experiences. However, the most telling aspects of the narrative data emerged when it was viewed from an inside (internal) and outside (external)

perspective (Clandinin & Connelly, 2000). The participant's internal thoughts, feelings and emotions experienced throughout the treatment process, for me, brought forth the greatest level of understanding about what it is like to be coerced or to volunteer to attend treatment. From my perspective, the internal and external components of the participants' stories were the most critical to understanding and representing their experiences in residential treatment. Sorting the data in this manner provided a more detailed account of the participant's larger story of entering and beginning treatment through to completion.

Initially, I had planned to use the retranscribed data to develop a final story or account of the participant's experience in treatment. The purpose of the final story was to provide a context to analyze the data for plots and subplots about the experience of being coerced or volunteering to attend treatment (Kelly & Howie, 2007). In addition, the final story would have provided an account of the person's experience from the beginning of treatment through to the end and could be shared with the participant to ensure they agreed with the portrayal of the events they described in the interviews. Unfortunately, based on my own limitations as a researcher and the timing between interviews, it was not possible to develop these stories on time and share them with the participants before their departure. The participants were interviewed near the end of their stay and therefore had left the treatment program before the development of a final story. In response to this problem, I decided to develop a process of analyzing the data based upon my interpretation of what the participant said during the interview(s). The process I developed involved sorting the data into themes that flowed from the temporal aspects of the data. Thus, the data and themes

that emerged could be placed into categories that represented experiences that occurred during pre-treatment, treatment, and near the end of treatment.

Once the data was sorted based on time, as well as internal and external experiences, an emplotment process was used to identify significant themes that emerged from the sorted data (Kelly & Howie, 2007). The common themes that arose from the sorted data identified what participants were saying about their experiences throughout the treatment process. During emplotment, themes were developed by examining three points of reference: recurrence of ideas repeated throughout the stories using various terms, repetition of ideas repeated in the stories using the same terms, and the forcefulness of verbal or nonverbal cues that highlight a thought such as tone or volume (Overcash, 2004). Isolating concepts using these three points of reference allowed for the development of themes that spoke specifically to what participants were saying about the experience of being coerced or to voluntarily participate in a residential substance abuse program.

Credibility and Transferability

In qualitative research, the terms credibility and transferability have been developed as a means of paralleling the interpretivist paradigm with the positivist paradigm (Patton, 2002). In the qualitative research paradigm, credibility is typically used to describe the congruence between the portrayal of the participant's experience and what was represented within the research (Bradbury-Jones, 2007). Credibility is generally associated with the notion of internal validity within the quantitative research tradition. The ability of the research to reflect the participant's lived experience in an accurate fashion increases the

credibility of the research (Dodge, Ospina, & Foldy, 2005). Transferability, within the qualitative paradigm, has been discussed in the literature as being akin to external validity, which arises from the positivist and quantitative framework (Patton, 2002). Transferability refers to the degree to which the results of the study can be generalized beyond the findings to other similar contexts.

Within the context of this research, credibility was affected by variables that lead to misinterpretations of the participant's experience of treatment. As a means of increasing the credibility of this research, it would have been ideal to share reflections of participant interviews with the participants shortly after the interviews were complete. This form of member checking (Bradbury-Jones, 2007) would allow participants in the study to reflect on whether their information that was shared had been interpreted accurately. Although I was not able to share my final interpretation of the interviews with the participants, I thought it was necessary to take a moment after each interview to reflect on what was said during the interview with the participant. This allowed me to move on from the interview stage with the knowledge that the participant had at least agreed that I had understood what they had intended to portray in the interviews. This is a critical step within narrative research because it is necessary that the participant agrees with how their story was interpreted and presented within the research.

As an alternate means of increasing the level of credibility of this study, the researcher shared tentative findings with other counsellors working in the program and within the addictions field. Sharing preliminary findings with these professionals assisted in determining if what was being found throughout the interviews was an accurate

representation of what is typically noticed by those working within the treatment program. In the opinion of professionals in the field, it appeared the preliminary findings represented themes of experiences of other adolescents whom they had encountered throughout their careers.

Additionally, as part of an ongoing reflexive process and as a means of increasing the reliability of the research, I kept a journal that summarized some of my thoughts and concerns that arose throughout the research process. Keeping a reflexive journal is considered an important tool to examine personal reactions to the research process as well as reflect on assumptions that arise during research (Ortlipp, 2008). Although the journal is not extensive, it provided me with a forum to reflect upon my experiences during research process. The purpose of the journal was to reflect upon issues that arose during the data collection phase, interviews, dialogue with the other counsellors within the program, as well as personal effects the interviews had on myself as the researcher. All of these processes assisted in increasing the credibility of the research.

Despite employing the above noted techniques, it is not likely the findings of the proposed research will have a high level of transferability. The nature of narrative research methods is that they lead towards unique outcomes concerning the stories and experiences shared about voluntary or coerced attendance. Hence, the findings of this research will remain specific to this particular research project. However, it is possible that the results of the study could leave one to ponder what the experiences of coerced or voluntary treatment might mean to the larger population. More specifically, the findings of this research may have special applicability to Northern and remote regions. The location of the treatment

centre is in a northern community and accepts clients living in vast Northern and remote areas. Therefore these findings may be particularly valuable to others working and living in these areas.

Dependability, Rigor, and Relevance

The notions of dependability, rigor and relevance are interconnected. Rigor is defined as the accurate and systematic link between theory and method. Relevance is viewed as the degree to which the findings of the research apply to the experience of practice and whether the findings resonate with those working within the area being researched (Dodge, Ospina, & Foldy, 2005). Dependability is typically concerned with the degree the study is able to represent the findings in a consistent fashion (Patton, 2002). These terms should be considered simultaneously but at the same time must remain separate in their meaning and how they affect the narrative research process.

As part of increasing the level of rigor within this research project, it was necessary to locate myself within the context of the research. Within the qualitative paradigm, this is known as reflexivity (Dodge, Ospina, & Foldy, 2005). By revealing personal traits and potential biases, the participants and the readers of the research are able to evaluate how the researcher's personal influence may have contributed to the research findings. The reflexive process is critical because it assists in increasing rigor and credibility (Ortlipp, 2008). Furthermore, as discussed above, the stories that emerged from the field text were shared with those working within the addictions field. Allowing the counsellors to review the stories that emerged from the research was another method used to increase the rigor and relevance of the research findings.

In answer to the notions of dependability and rigor, the autoethnographic approach (Chang, 2008) that is embedded in this research speaks to the concept of how my role as the researcher enmeshed with my experiences as an addictions professional. Recognizing that interpretation of research findings is influenced by ones understanding of the topic area is critical to autoethnography (Chang, 2008). Hence, it is necessary to include this thought about how my interpretation of the data was unavoidably influenced by my experiences and opinions on the topic of coerced and voluntary treatment formed over the course of my professional career.

Chapter 4: Research Findings

The following chapter highlights the findings of qualitative interviews I had with eight youth participants at a residential youth treatment program in north central British Columbia. The participants were males and females between the ages of 16 and 18. The adolescents interviewed were asked to describe their experiences of coming into and attending the program. Specifically, for the purposes of this research, the adolescents were asked to describe their perception of whether they viewed themselves as being coerced to attend or as voluntarily entering treatment. The interviews were open ended and were intended to provide the interviewee with the opportunity to describe their opinion and experiences concerning the topic of coerced and voluntary treatment.

Introduction

For the most part, youth participants were interviewed twice, once near the beginning of their stay and once near the end of their stay. Not all participants were interviewed twice due to leaving early or unexpectedly from the program and an interview could not be arranged before their departure. In total four out of the eight participants left the program before completing a second interview. This was anticipated before beginning the research and the decision was made that their information would be included regardless of completing a second interview. Interviews were conducted at the treatment centre in a private room. The interviews were audio recorded and took approximately twenty minutes each. The participant's names were exchanged with pseudonym names during the transcription process.

Demographics

The participants who took part in the study ranged between the ages of 16 and 18. There were five female participants and three male participants. The participants came to the treatment centre located in a medium sized city in the central interior of the province. The participants lived in areas from all over British Columbia. Generally, the participants were referred to the program to address some form of problem alcohol or drug using behaviour.

Findings

As part of analyzing the narrative data gathered during the research process, it was necessary to examine the transcribed interviews using a three dimensional approach (Clandinin & Connelly, 2000). The three dimensions included internal processes, external processes, and temporality. Examining narrative data from an internal, external, and temporal context provides a means to analyze narrative data in a thicker and richer context (Clandinin & Connelly, 2000; Creswell, 2005; Lieblich, Tuval-Mashiach, & Zilber, 1998). Therefore, in the analysis of the data gathered during the interviews, I examined the text for statements that fit into one of three categories: 1) External: statements that described external events, people, places, or behaviours; 2) Internal: statements that described thoughts, feelings, emotions, or internal conflicts and; 3) Temporality: statements that located the internal and external occurrences in a timeframe of beginning, middle, and end.

Out of the three pronged emplotment process, I noticed the emergence of eight themes or categories. These themes are as follows:

1. Triggering events.

2. Thoughts and feelings before treatment.

3. Having connection with a professional support.

4. Relationships with family and friends.

5. Self reported level of coercion and voluntary.

6. Reported value of being coerced or voluntary to attend treatment.

7. Experiences in treatment.

8. Thoughts about remaining or leaving treatment.

Typically, the eight themes could be sorted into three main categories: pre-treatment, treatment, and post-treatment. The three categories included the temporal location of past, present, and future. In addition, internal or external processes, or a combination of both, tended to resonate across all the themes. For example, an individual might find themselves experiencing some pressure from family to go to treatment (external) while also having significant thoughts about being afraid to go (internal). All of these external and internal experiences could also be located in a temporal context of pre-treatment, treatment, and post-treatment. This example illustrates how the themes in the following sections arose from a complex interplay between an individual, the people in their life, as well as other sources of influence.

Before examining the eight themes, it is necessary to recognize two main interrelated concepts that resonate across them. The first concept is the notion of what I came to view as the coercion/voluntary continuum. The second concept relates to self-determination theory (Rush & Wild, 2003; Wild, 2006; Wild, Newton-Taylor, & Alletto, 1998) and its interplay with being coerced to attend substance abuse treatment.

The notion of the coercion/voluntary continuum emerged as the research progressed. It became evident that the participants could not be neatly grouped into two distinct categories of either being voluntary or coerced. Rather than two categories, the participants described (through statements in their narratives) feeling as though they were partially coerced as well as attending voluntarily and therefore viewed themselves as being located somewhere in the middle of the continuum. The majority of the participants, in subtle ways, leaned more towards either side of centre on the coercion/voluntary continuum.

Self-determination theory relates specifically to many of the themes that arose from the research interviews. Since the focus of the research was to examine the lived experience of coerced or voluntary attendance, much of the data collected relates specifically to the notion of free will and personal choice. Thus, the literature on self-determination theory emerged as having a significant relationship to the findings. The underlying premise of self-determination theory is that an individual's motivation is enhanced by the degree to which they are able to exercise free will and control over decisions they make (Wild, Newton-Taylor, & Alletto, 1998). The connection between self-determination theory and the research findings will be discussed in greater detail later in the analysis section.

Triggering Events

> *I didn't get to make the choice because I had gotten hit by the semi and they thought I was suicidal so they put me in here...*
>
> *Tanya*

All the research participants agreed there was some form of triggering event that spurred on their referral to treatment. The event seemed to trigger a series of experiences that led to external and internal influences pushing them towards entering into a treatment

program. In Tanya's case, she had once been forced to attend treatment because her family and professional supports were worried about her. She described how the professionals working with her at the time had thought she was suicidal. She indicated that being struck by a tractor trailer truck had caused a great deal of concern about how her use of substances was impacting her mental health. She indicated that once the decision was made that residential treatment was necessary, she was ordered to go as part of a certification under the Mental Health Act. The interview with Tanya occurred during her second stay in the residential program and that this time around she had decided to come into the program. She was able to contrast how the first time around she felt pressured and bullied into attending and that this was not something she wanted to take part in at that point. However, during her second stay she discussed entering treatment under her "free will" and that she felt more comfortable with this choice.

Overall, the respondents were able to identify some form of event that led to them entering into treatment. The notion of internal and external pressure is a significant theme that arose from examining triggering events as a theme. Some discussed that they were told to go to treatment or they were no longer be welcome to stay in the family home (Jack and Mary discussed this as being a critical factor in deciding to come to treatment). This form of pressure speaks to the notion of coercion beyond traditional views of the concept such as being forced by the court system or some other forms of legal imposition (Mental Health Act) to attend treatment.

Other participants discussed making the decision to attend treatment in conjunction with their family (Alice, Beth, Jim, and John). Collaborating with family led to the

adolescent experiencing both internal and external pressure to attend. The external pressure came from family wanting them to go and the internal pressure arose from the debate within the individual's mind of whether they should go or face the possibility of rejecting their family's request. However, collaboration with family led to a sense that the participant had a say in what happened to them. For example, John said, "me and my grandmother thought about it and sat on it for a couple of weeks and we came to an agreement and said you know what I think I need this rehab." Alice also stated that she went to treatment for "me and my family." The triggering events varied between the participants but the reasons to attend arose from combinations of internal or external pressure. For example, threats of personal harm and safety led Alice to decide to go to the treatment program. She said that, "getting stuck in a lot of bad situations" like "these two guys, the guys I had been drinking with had...I was just in a really bad place." It seemed that the family pressure arising from these kinds of negative experiences led to a combination of internal and external pressure to seek assistance through treatment.

Thoughts and Feelings Before Treatment

Once the decision to go to treatment had been made, a series of thoughts and feelings were experienced leading up to the day they left home to attend the residential treatment program. Unlike the triggering events theme, the experiences leading up to leaving for treatment were primarily internal. Generally, all participants, except one, discussed experiencing some form of internal conflict or debate leading up to their admission date. The thoughts and feelings ranged from being "nervous" to "freaking out." Most participants described the thoughts and feelings leading up to their admission date as being an ongoing

internal debate about their decision. Examination of statements related to this theme reveal that five of the participants thought that their decision to enter into treatment was a difficult decision and another two described the decision as an easy decision. For example Alice stated, "I had to think about it over and over in my head" and "I was freaking out." Alice also stated that she did not know what to expect upon arriving at the program; "I had this vision of 30 or more people in here, like a big cafeteria where you got trays, I don't know where I was getting that picture." In contrast, Tanya seemed more comfortable with her decision as this was her second time in treatment -- "making that choice (coming to treatment) was very simple for me because I got to choose for myself and I knew what I was getting into." These two experiences demonstrates the contrast that arose in the thoughts and feelings experienced by the participants before entering into the treatment program.

Other participants described emotions such as fear and hope leading up to their admission into the program. For example,

> *I was scared that after I have my baby I would, you know be a teenager and not a mother and go out and party and that pressure was on me you know, I was not doing it for myself, a big part of it was for me, and a big part of it was for my future family. I just didn't start drinking for no reason, I didn't get addicted to it for no reason there are things that push you to addiction and I felt pressure that I had to get those things out of me before so I'd be ready to have a good future and to give my baby a happy life not a guilt one or not one like I had when I was growing up.*
>
> *Beth*

On the other hand, others discussed having a sense that going to treatment represented a fresh start for them and that coming to treatment might "make my life a little better" (Jack). The feelings that are experienced are wide sweeping and can sometimes be polar opposites

to one another. The findings that resonate from this theme demonstrate how internal debate is a significant part of attending treatment.

Having a Connection with a Professional Support

This theme arose from examining the data for external factors that played a role in the decision to enter into treatment. The concept of having a connection to a professional was focussed upon during the research interviews because according to the literature, coercion has a negative impact on the professional/client relationship (Skeem et al., 2007). This information is concerning because having a strong working relationship with a counsellor is an important part to increasing treatment outcomes (Hepworth et al., 2006). The information gathered during the interviews revealed that all the youth had some form of connection to a professional before entering into treatment. The information collected during the interviews indicates that the relationship between the participant and their counsellor was not negatively impacted by the referral to treatment. The participants spoke about having a good relationship with their counsellor and that they played a significant part in the decision to come to treatment. Mary described her counsellor as being "one of my best friends." She also spoke about how she thought her counsellor was proud of her decision to go to treatment. Other participants spoke about how the counsellor worked with them and their family in the decision to come to treatment.

It appears the counsellors working with the youth were not the primary driving force in spurring on the referral to treatment. Hence, they were not viewed as being part of the coercion process. The youth and their family seemed to have a greater influence in the decision making process. Thus, the counsellor seemed to take on a supportive role in the

decision process. Jane indicated that her counsellor did not push her to attend but she strongly encouraged her. A professional encouraging the adolescent to attend was a consistent occurrence across all interviews.

Relationships with Family and Friends

Besides relationships with professionals, relationships with family and friends were also an external motivating factor that played a role in the decision to enter into treatment. All the participants discussed how their decision to come to treatment was influenced by their family. The kind of influence from family varied from collaborating in deciding to come to a more adversarial or directive process. For example, this involved the parent telling their son or daughter to either go to treatment or they would be asked to leave the family home. Mary spoke about having an adversarial relationship with her mother and how she was told by her mother "either go to treatment or find another place to live." However, at the same time, Mary also spoke about how she valued her relationship with her mother. Mary agreed that if it was not for her strong connection with her mother that she would have left treatment and accepted the consequence of no longer living in the family home.

In contrast, other participants spoke about having made the decision to come to treatment as improving their relationship with their family members. John spoke about "having the confidence from my grandma." John also spoke about having the support of his girlfriend as well as his grandmother to attend; "my grandma and girlfriend are really proud of me." Jack also affirmed the connection with friends and family playing a role in his decision to come and remain in treatment; "most of my friends and influences on the outside are pretty happy for me for making decisions like this."

Another finding that arose from this section, is that if the family favoured the participant attending treatment this added a level of pressure for them to attend. Alice stated that she "did not want to disappoint her family." Jim also spoke about feeling like coming to treatment improved his relationship with his family and that because he came they appreciated him more. When discussing the perceived benefits of improving his relationship with his family by choosing to attend treatment Jim stated that:

> *Jim: Ya, and appreciate me too.*
> *Interviewer: Appreciate you...?*
> *Jim: Coming here and actually trying to quit drinking and stay away from all those problems.*

Jim also discussed the notion of collaborating with his family to decide to enter into treatment. Jim made the following statement in describing the dialogue he had with his mother before deciding to come to treatment:

> *Well she knew I didn't really want to come for a while but then I told her if she doesn't put any pressure on me for coming or not that I'll go. Just to get away from Rupert for awhile.*

Overall, it appears there are two aspects to the interaction with family members in the decision making process to attend treatment. On one hand, there is the notion of collaborating with family in the decision making process to attend treatment. On the other hand, there is a process of family exerting pressure either directly or indirectly on the individual to attend treatment. Generally, the collaboration with family approach led to a level of self-imposed pressure to attend treatment as means of avoiding conflict or disappointing family who wanted them to take part in residential treatment. Family pressure to attend had varied outcomes. There were some who resented the pressure to attend and

those who felt comfortable with the pressure and realized that coming to treatment improved their relationship with their family.

Self Reported Level of Coercion and Voluntariness

The self reported level of coercion/voluntariness was a major theme that resonated from the research interviews. Essentially, this theme was the primary focus of the research because the experience of coerced or voluntary residential treatment seems to be reflected by the level of coercion/voluntariness perceived by each participant.

Overall, the self reported level of coercion seemed to fall on a scale or continuum of voluntary or coerced. On one end of the scale is the perception of feeling fully coerced and on the other end is the self reported level of feeling their attendance was voluntary. The interview data provided enough information to locate all the participants at some point on this scale.

Considering the collected data, I was able to locate one participant completely on the coerced end of the scale based upon statements that reflected he/she did not want to be in treatment. Three others reported experiencing a moderate level of coercion from outside sources (i.e. friends and family) combined with a level of self-determination. The remaining five participants reported feeling a lower level of coercion reflected by statements that demonstrated they made the decision to go to treatment and that they made the decision to remain in treatment.

Out of all the participants interviewed, Mary made the most definitive statements about how she felt about being coerced to attend treatment. For example:

> *I don't know if she* (mother) *realizes it but it's like this is really hard for me like being here, it's like this is punishing for me. And the kids, like when I say*

> *that, this is suffering for me, they're like what no, but really like I'm not like one of those kids that says like I'm so happy to be here, I'd definitely come back, but if it got to the point where I thought that I needed to come back then there would be serious problems and I would go to one of those six month rehabs but I don't know this is definitely like...it has taught me a lesson in a way that if I don't want to be taken out of my comfort zone then I have to earn that, like I have to earn those things and stuff like....being comfortable at your house and all that stuff like that should be a privilege so this is really, I know I keep saying that but this really feels like punishment to me.*

Mary's statements about feeling coerced demonstrate why she was located on the coerced end of the coercion/voluntary continuum and why I viewed Mary as being coerced. Of the participants interviewed, she made the most definitive statements about how she viewed her level of coercion. Mary's interview was important to the research as it provided me with an opportunity to begin comparing and contrasting other participant statements about how they viewed their level of voluntariness compared to hers.

As discussed above, three other participants seemed to fall somewhere in the middle of the voluntary/coerced continuum. John, Jane, and Alice made statements during their interviews that led me to believe they were experiencing a moderate level of coercion to attend treatment. The sources of coercion seemed to differ between the participants but they all made similar statements about how they felt about their level of voluntariness.

For example, John discussed feeling as though he was both forced and had volunteered to attend treatment. He spoke about feeling pressure to attend to demonstrate to the courts that he was trying to make some positive changes in his life. On the other hand, he realized that he should go to treatment on a personal level because his substance use was leading his life in the wrong direction.

> *I was sort of forced to go here because I got court ordered and it was the*

> *only way the charges would go over well if I was here in treatment. My court date is on the 16th so if they hear that I am here in treatment I may not get sentenced to time or anything like that. But then again I volunteered myself to at the same time because I want to quit drinking and using drugs.*

As demonstrated by the above quotation, John recognized feeling as though he was coerced but had also volunteered to attend treatment. Experiencing aspects of voluntary attendance and feeling pressure to attend treatment by the court system seemed to make a difference in how John perceived his experience of treatment. For example,

> *I personally think it was the voluntary part because before I came here I really started doing drugs and I started to get myself into a lot of trouble and then my grandma just started getting sick of me and she said you need help and I said grandma I do too and we both said what do I do so we went and talked to my social worker and she said I should do rehab and me and my grandmother thought about it and sat on it for a couple of weeks and we both came to an agreement and said you know what I think I need this rehab.*

John's statement is an example of how collaboration with professional and personal supports is an important component of how an individual can experience treatment. Even though John was experiencing pressure to attend due to a pending court date, he felt positive about the decision he made.

Jane was another participant who reported feeling some level of pressure to attend treatment. During her interview she was asked to rate her level of coercion on a subjective scale from one (feeling fully forced to attend) to ten (freely made the decision to attend). Jane's reply to this question was that she felt she was an eight. However, as the conversation progress she spoke about feeling some level of pressure to attend. For example, Jane indicated that, "there was some pressure from some other people but other than that it was mostly my decision." She identified the source of the pressure as being family and friends. Of interesting note, Jane had previously attended treatment and during that time she had felt

even more pressure to attend and because of that she felt resentful about attending. Considering her previous experiences of being forced to attend, Jane felt positive about her decision to attend treatment this time around. She described her decision to attend treatment as a "good choice" and a "smart healthy decision." Considering the information gathered during the interview, Jane seemed to view herself somewhere between moderately coerced and voluntary on the continuum.

The third participant who fell somewhere in the middle of the coerced/voluntary continuum was Alice. During the interview, Alice made statements about how she wound up deciding to attend treatment. Using the same scale question as the one asked of Jane, Alice placed herself on the scale as a four. Overall, Alice did not add a great deal of information about how coerced she felt, she tended to speak about her experiences leading up to treatment and how her family (twin sister and father) wanted her to attend.

The remaining participants all made statements about having made the decision to attend. For example, Jack stated that, "I made the choice to come." Other participants such as Jim, Beth, and Tanya all reported similar statements about having made the decision to attend treatment. Overall, the participants that spoke of feeling as though they had volunteered seemed to view their decision in a positive light and seemed comfortable with being in the treatment program.

It should be noted that Tanya and Jack also spoke about having been previously forced to attend treatment and that this time around they made the decision to come. Tanya indicated she felt better about her decision to attend treatment this time around as opposed to her previous experience of being coerced to attend. Jack indicated, "this time around...I

want something better." My interpretation of these kinds of statements is that they were spoken with a conviction that demonstrated empowerment and pride. This personal interpretation resonates from the inflection heard in their voices as well as the body language and nonverbal cues that indicated they were proud of their decision to attend treatment.

Reported Value of Being Coerced or Voluntary to Attend Treatment

The reported value of coerced or voluntary attendance in treatment was a theme that emerged from the discussions with participants about whether they viewed themselves as coerced or voluntary. As discussed above, all participants made statements that led me to believe they could be placed on some point on the coerced/voluntary continuum. However, another theme that arose from this discussion is the participant's opinion on the practice of coercing someone to attend residential addictions treatment. Overall, the participants had a negative perception and opinion of the practice of coercing someone to attend treatment. For example, Alice provided the following thoughts about the practice of coercing a person to attend treatment:

> *If you're forced to come then you might not be happy, if you didn't want to... you cannot get help if you don't want it. No one can help you then.*
>
> *If I was forced to stay here I wouldn't be so willing to do all the worksheets and stuff.*

These statements reflect Alice's overall perception that coercion is not the most viable option when it comes to providing treatment to those with substance use problems. Beth also provided comment about the practice of coercion:

> *I think if I had to stay like if I'd been forced to stay then I'd be more like pissed off and you know feel more like pressure and that and I wouldn't share as much because it would just be like you know I'm not here to share, I had to come here I have to stay I'm not here to let this stuff go.*

Jack used the following metaphor in describing the practice of coercing a person to attend treatment:

> *Well I don't, I'd have to say if you stick, you know...If someone is hooked on donuts you know, someone's munching down on donuts you know and you don't want them to eat a donut you know, so you force them to go to a place where they can leave at will and go eat that donut well you know that if they do something bad will happen if they leave that place, then that person just hates you because they see it as you know you don't want them to be happy right but you know if you kinda just let them wait and realize then sooner or later that person is just not going to want that donut anymore because that donut is just going to clog their arteries and they are going to realize that through the media or whatever is around them that that donut is going to make them fatter and fatter until they die. So that person is going to come to you and ask help to not grab that donut, you know. I don't know that's just my little metaphor.*

Jack also provided the following insight about learning through personal experience rather than being forced to attend treatment. He also added his thoughts about being previously forced to attend treatment:

> *If a person is at the stage where you have to forced them, then they definitely don't realize that quite yet why they need to stop doing that thing and sometimes it just takes time for that person to go down that path to the point where, you know sometimes it takes time for that person to learn that, sometimes people have to learn the heard way, they just can't be told they need to change.*
>
> *When I was forced into it, it was because somebody else...when you're forced into something or when you are forced into treatment I should say it seems like somebody else wants to deprive you of what you want.*

I view Jack's thoughts on this topic to be of particular interest because he had been previously been coerced to attend treatment and was voluntarily attending treatment at the time of the interview. Jane also provided insight into being coerced to attend treatment based upon her previous experience of being forced to attend:

> *I've been forced to seek treatment and it sucks because for me I feel like I just want to rebel, I feel like if I have to be here I'm just going to make everyone's life miserable. If I come here willingly I seek the help and I am willing to take the suggestions and listen and ya just willing to get along with everybody.*

John shared both positive and negative views on the concept of coerced treatment:

> *I personally say they should be pressured to come here and like I'm thinking I'm thanking everybody who sent me here. It does everything it says it will do, it will help you stay clean and stay away from drugs. Volunteering it's just like I got volunteered to be here and I got nothing else to do so I'm here.*

> *You can't force someone to come because I don't want my friends to come here and then run off or something. I want them to actually come here and take in the advice the one on one, I'd like them to meet all you guys and I'm going to go back and tell them how nice you guys are and the might not even probably believe me on this how nice you guys are and all I've got to say is if they came here they'd be sitting here doing the exact same thing with you talking about the exact same thing telling their friends. I personally think they need it too. And I'm happy I came here too though because I get to look at all the new outlooks on life and I really do want to bring some of my friends here because I've got friends who have problems too but I can't just be like go, because they might not listen.*

Mary shared her thoughts about her plans upon returning home after being coerced to attend treatment. Her statement reflected a rebellious attitude towards her family who she viewed as the sources of her coercion:

> *I'm going to go out and I'm going to party it's that I'm going to go out and I'm going to spend so much time with my friends that I'm never going home again anyways because of how unconnected I was, you have to make those connections again, like I have like a best friend an ultimate friend that it's really important for me and her to have a good connection.*

> *It's hard to sleep here, it's hard to live here, like I'm living here right now and don't like it.*

Tanya described that it was important that people make an informed decision when coming to treatment. She thought if a person understood the treatment process better they could

make an informed decision about there attendance. She also described how volunteering to attend treatment is a positive idea because it contributes to a person's free will:

> *I also think that if you are going to be voluntary alot of people are scared to come here because they haven't informed themselves...I don't know being voluntary not having been here before, forced into here maybe maybe I wouldn't have come because I didn't know about it. I didn't really know what it was like before I came here I didn't even know about rehab before I came here, well like I knew there was rehab but I didn't know it was at the hospital or whatever you know.*
>
> *Being voluntary is always a good thing because the person is making the choice to come here and nobody else. Being forced is, it can be a good thing if your about to die or something but other than that I don't really see the point of being forced into anything really because I believe in free will.*

The above quotations, demonstrate how participants agreed that voluntary attendance was an important aspect of having a positive outcome after treatment. This finding is congruent with the discourse about self-determination theory. Self-determination theory posits that an individual's motivation is enhanced by the degree to which they are able to exercise free will and control over decisions they make (Wild, Newton-Taylor, & Alletto, 1998).

However, some discrepancies did emerge about the practice of coercing people to attend treatment. John made several comments about him being forced to go to treatment and how this was a positive decision that was made for him. He indicated that had he not felt pressured to attend, he likely would not have come. Once he arrived he described having a positive and uplifting experience that quickly changed his view about being forced to go. Once he felt comfortable in the program he realized that this was a good place for him to be and that treatment provided him with the necessary skills and enhanced his motivation to move forward in his life. However, John also recognized how forcing someone to go to

treatment may not work because they could choose to leave upon arriving; a statement congruent with self-determination theory.

Experiences in Treatment

The focus of this research centres around the experience of coerced or voluntary residential treatment. Interestingly, experiences in treatment emerged as a theme that identified the participant's internal and external experiences while in treatment. As previously noted, most participants fell somewhere in the middle, or on the voluntary end of the coerced/voluntary continuum. Despite being located on different points of the continuum, most participants described having mixed experiences in treatment. Most indicated that they thought coming to treatment was a good idea and that they had some positive experiences during their stay. However, most of the participants seemed to recognize that being in treatment is difficult, the reasons for the difficulties tended to vary.

Tanya found attending treatment in her home community to be difficult because sometimes while on outings in the community with the treatment group, they would walk past "a person's house that I knew or areas that I had visited alot you know or areas that were like my hangout grounds." However, she also found treatment to be an empowering experience because:

> *it makes me feel good, it makes me feel like I have some integrity and well and actually that just a different subject, that was just about coming back I have integrity because before I left I said that I would come back and I did...it makes me feel really confident I guess in my activities that I partake in here because I'm not being forced to be here I can put in my 100 percent in because it's my choice to be here.*

Other participants recognized that being in treatment is difficult. However, they also maintained a belief that remaining in the program may lead to some form of personal

transformation. Jim indicated that he "decided to stick it out as long as I could." Others recognized that coming back to treatment for second time was a good decision. Jack indicated that he felt different about being in treatment his second time:

> *I'm realizing that I don't want to kill myself anymore...not in a suicidal sense but I don't want to kill myself by using chemical drugs or whatever anymore I just want to get that whole part of my life over and done with so I can move on.*

As mentioned in previous sections, of the participants interviewed, Mary seemed to identify herself as being the most coerced to attend treatment. Interestingly, she seemed to have the most negative things to say about her experiences in treatment. Most of the comments she made about her experience in treatment focused on being away from family and friends and an overall frustration with not feeling like the process was working for her. Mary's experience seems to be summed up best by the following two excepts from her interview:

> *I'm not going to follow and obey the rules, this is like, this really is like a punishment to me this is the ultimate punishment for me.*
> *It's hard to sleep here, it's hard to live here, like I'm living here right now and I don't like it.*

These statements underscore the perceptions of who I considered the most coerced participant interviewed for this research. None of the other participants seemed as adverse to the treatment process than Mary. Hence, her comments reflected a generally negative experience in treatment. Unfortunately, Mary left the program two days before the scheduled final follow-up interview date. Therefore, I was not able to determine whether her opinion about treatment had changed since the initial interview. Mary's reported experience in treatment lends credence to the notion of self-determination. Mary had a low level of self-

determination and correspondingly had a high level of resentment towards the treatment process.

Thoughts About Remaining In or Leaving Treatment

Another theme that emerged from the interviews revolved around the thoughts that participants had about their decision to remain in or leave the program. As discussed in the previous section, completing a residential treatment program was described as difficult. During the interviews, most of the participants referred to their decision to remain or leave the program. Therefore, it seemed necessary to include these comments as a theme arising from the research. This theme is interesting because it reflects the often difficult personal journey of the participants during treatment.

In addition, it should be noted that of the eight participants interviewed, only four took part in the second follow up interview. Generally, the participants who did not take part in the follow-up interview chose to leave the program early. On one occasion, I had to reschedule the final interview and the youth left before another interview could take place. It was anticipated prior to commencing the research that some participants may not take part in the final interview; it is not uncommon for youth to end their treatment unexpectedly. Nevertheless, the information provided during the initial interview was telling and formed a significant part of the research findings.

Of the eight participants, seven reflected back on their decision to come and remain in the program in a positive light. The eighth participant (Mary) presented her experience of remaining in the program as being frustrating and bordering on useless. Some of the

following comments made by the participants illustrates the rewarding and sometimes difficult experiences during treatment:

> *I was able to get a whole new outlook on myself that was a big thing just on life in general I guess, I think that's what I have gained from it. It was really, it was great, I didn't understand how I could do that or get a lot out of it...*
> *Alice*

> *I just didn't start drinking for no reason, I didn't get addicted to it for no reason, there are things that push you to addiction and I felt pressure that I had to get those things out of me before so I'd be ready to have a good future and to give my baby a happy life not a guilt one or not one like I had when I was growing up.*
> *Beth*

Jack, on describing how sometimes he wanted to leave the program but did not:

> *you just get that feeling like fuck it I wish I was with my friends or out going for a walk.*
> *Jack*

> *At first I didn't really like it..my decision because you don't know who's going to be here and stuff like that. Then as time went by I guess I started liking it.*
> *Jim*

> *I come here like I said it is like the groundhog coming out of the snow and seeing his shadow again man, because before I didn't know who I was or what I liked or anything but now that I come here it is like...I'm starting to realize that I've only been here for six days and I've got 22 more to go, and in those 22 days I'm pretty sure I'm going to figure out who I am and what my real personality is like because before it was all about the drinking and the drugs but now in the 6 days that I've been here I've got a whole new outlook on life, I've got a whole new set of goals and a whole new set of life changes.*
> *John*

> *I knew it wasn't horribly bad and it was easier because I knew I could leave if I wanted. I could make the decision to leave and it was in my hands and no power was being taken away from me. I like the people that were here already so that made it easier to just come in general.*
> *Tanya*

> *If I'm feeling like this how much longer can I really last if I feel like this for the whole three weeks, like the whole three weeks that I have to be here for I'm*

going to feel even more miserable
Mary

These comments demonstrate how the participant's opinions about being in the program influenced their perception of the treatment experience. For some, deciding to remain in treatment made sense and in other cases remaining in treatment was a difficult yet rewarding choice. In some cases, even though treatment was viewed in a positive light, the decision was made to leave the program early. Regardless of how coming to treatment was perceived, the participants were able to recognize value in coming to treatment if the individual was motivated to be there. This theme resonates with the notion of self-determination theory and coerced substance abuse treatment (Wild, Newton-Taylor, & Alletto, 1998).

Discussion and Limitations

Eight themes emerged from analyzing and emploting the data gathered through interviews with adolescents attending the residential treatment centre. Themes arose from using a narrative analysis and emplotment process which involved examining the data from inside/outside (internal/external), and temporal (past, present, and future) perspectives (Clandinin & Connelly, 2000). Examining the data through these perspectives led to the emergence of three categories that contained themes that centered around the participants' experiences of coming to, being in, and leaving treatment. The treatment experiences described by the participants followed their story from the decision to enter treatment to the final days of their stay in the program. Not only did participants describe this notion of temporality, they also associated a range of internal experiences (thoughts and feelings) that accompanied each stage of their stay in the program. Furthermore, the participants were

able to describe the role external factors (friends, family, and professionals) had in their experience of coming to treatment and remaining in the program. Hence, the themes that emerged tended to follow a temporal flow from pre-treatment (experiences before treatment), treatment (experiences during treatment), and post-treatment (thoughts about life after treatment). The themes that arose combined temporal, internal, and external factors together as a means of communicating and explaining the experience of being coerced or voluntarily attending treatment.

As identified above, the use of a temporal lens led to the emergence of themes that could be placed in pre-treatment, treatment, and post-treatment categories. The first four themes 1) triggering events, 2) thoughts and feelings before treatment, 3) having connection with a professional support, and 4) relationships with family and friends tended to include data that reflected pre-treatment experiences. The experiences during treatment were reflected by themes 5) self reported level of coercion and voluntary, 6) reported value of being coerced or voluntary to attend treatment, and 7) experiences in treatment. The final group of experiences fell into a post-treatment category and include theme 8) thoughts about remaining or leaving treatment.

Internal and external factors are contained within the pre-treatment category. As discussed above, feeling pressured to attend was influenced by an interplay of a range of internal and external factors. The pre-treatment category led to the emergence of the coerced/voluntary continuum because this was when the participants began to describe the processes that led them towards attending treatment. Often the decision to attend treatment involved the presence of pressure which came from a range of sources such as the

individual, family and friends, or the criminal justice system. The presence of multiple sources of pressure or coercion on those who attend treatment is confirmed throughout the literature (Currie, 2001; Klag, O'Callaghan, & Creed, 2005; Wild, 2006; Wild, Newton-Taylor, & Alletto, 1998).

Some form of triggering event played a significant role in spurring on a referral to the treatment program. Hence, the *triggering events* theme emerged as being one of the critical factors in determining whether an adolescent came to residential treatment. The participants spoke about experiencing a triggering event that made them or others realize they needed to come to treatment. Triggering events ranged from not wanting to experience the negative and unhealthy consequences of substance use, wanting to stop due to being pregnant, to facing criminal charges related to substance use and wanting to demonstrate to the courts that they were trying to make a change to their substance use patterns. This finding is congruent with the notion that people experience a range of pressures from multiple sources before entering treatment (Wild, 2006).

The second theme of *thoughts and feelings before treatment* revealed valuable insight into what the participants were thinking and feeling before coming to the treatment program. Many of the youth experienced mixed emotions about going to treatment. The thoughts and feelings experienced before going to treatment relate to the notion of motivation for treatment. Research examining the experiences prior to attending treatment demonstrates how internal and external motivational forces play a significant role in the decision to attend treatment (Wild, Cunningham, & Ryan, 2006). The participants spoke of both internal and external experiences that occurred prior to entering the program. This theme, brought forth

important information about how the participant was feeling and what they were thinking about before coming to the treatment program. For the most part, research into the pre-treatment motivation has failed to capture specific emotions and thoughts that occur to those about to enter treatment. The experiences leading up to the decision to enter treatment is an area that requires further exploration using similar qualitative approaches used in this research.

The theme of *having a connection with a professional support* also fell into the pre-treatment temporal category. This theme focusses on the impact a person's choice to attend treatment has on their relationship with their professional supports. Generally, this theme highlights that most youth value their relationships with professional supports before entering the program, while others came to appreciate the support offered by the treatment counsellors at the centre. This finding is unique because according to the literature on this topic the dual role relationship of a professional being both the coercer and the counsellor can negatively impact the therapeutic relationship (Skeem et al., 2007). It is important to note that the counsellors working with the youth in the treatment program are not necessarily the coercer but they do have the capacity to enact sanctions by reporting failure to complete treatment or abide by the rules of the treatment program. Overall, the participants reported having a positive connection with the counsellors in the treatment program as well as with their home community.

The final theme within the pre-treatment category was *relationship with family and friends*. This highlighted two roles family and peer involvement have in the participant's decision making process. Family could either pressure the youth to attend through an

interplay of threat or some form of sanction for failing to go, or they could take on a concerned ally role and collaborate with the adolescent in the decision making process. Familial pressure to attend treatment is discussed within the literature (Wild, Cunningham, & Ryan, 2006). However, most of the research on this topic has used a quantitative approach to examine family pressure and seems to have missed some of the subtleties identified by the participants in this research. Even though family may have played a role in pressuring the adolescent to attend treatment, participants still seemed to view the parent in a positive light and spoke about having a level of understanding about why their parents and peers were concerned.

The second category contained themes that describe experiences that occurred during treatment. Themes that make up the "treatment stage" revealed the most telling experiences of the treatment process. For example, the participants described how after they came to treatment many of their preconceptions about treatment were dispelled. Once they spent a few days in the program, many of the participants recalled changing their perception of what treatment would be like. Further, some of the participants who had previously been in treatment (at the same program or another program) reported feeling different about coming to treatment a second, or even third time. The explanations about the differences between their current experience in treatment and previous experiences were illuminating. The references to previous attempts at treatment were not expected and could form the basis for future research. However, for the purposes of this research, youth who had previously attended some form of residential treatment seemed to use that experience as a reference point for assessing their current progress in treatment.

The second category contained themes related to the crux of this research project. The first theme in this category was the reported level of feeling coerced or voluntary, the perceived value of being coerced or voluntary, and the experience of being in treatment. These three themes intersect on a range of levels but the over-ridding premise of the themes resonates most with the notion of self-determination theory. Self-determination theory posits that people have an underlying need for autonomy. Further, self-determination theory recognizes that if a person views themselves as having choice and free will in a decision, a corresponding increase in their level of motivation and interest is realized (Wild, Newton-Taylor, & Alletto, 1998). Considering the themes in this category, I argue that self-determination theory also applies to adolescents because the themes arising from this research demonstrate support for the central tenets of self-determination theory.

The theme of *self reported level of coercion* was important because it identified the participant's perceived level of coercion. This theme assisted in developing my understanding of the coercion/voluntary continuum. By analyzing the interview data, I was able to locate them as being somewhere on a scale between being coerced or voluntary. The majority of the participants fell somewhere in the middle of this scale because they identified experiencing external pressure to attend as well as recognizing they wanted to come to treatment.

The level of perceived coercion has been examined in previous research. The level of coercion was identified by using a likert scale that identified external, interjected, and identified reasons for attending treatment. Previous research in this area has found that making a personal choice to attend treatment corresponded with a positive outlook of taking

part in the treatment process (Wild, Cunningham, & Ryan, 2006). This research finding resonates with the data from the *self reported level of coercion* theme. The participants seemed to balance external and internal factors influencing their decision to attend and consequently viewed themselves as being only moderately coerced to attend.

All the participants were asked to add their opinion about the value they associated with coerced or voluntary treatment. Hence, the theme *reported value of being coerced or voluntary to attend* emerged and provided valuable insight into the perception of coerced treatment practices by those attending treatment. Participants identified that the practice of coercing people to attend residential treatment was not viewed as being a fair and worthwhile practice. Several of the participants described how they had previously experienced being coerced to attend treatment. The consensus was that being coerced was a frustrating experience and reinforced a resistant stance by the client during their stay in the program. This finding is congruent with research in the area of self-determination theory because it corresponds with the value of free will. The interplay between motivation and positive outcomes in treatment is largely dependent upon the type of motivation. Intrinsic and internal factors associated with motivation lead to better outcomes versus external motivating factors such as the courts or parental influence (Vallerand, Pelletier, & Koestner, 2008). The participants seemed to confirm this account when they spoke about their internal thought processes leading up to their decision to attend the program. The thoughts and emotions experienced by the participants before attending treatment seemed to stand out as a noteworthy experience leading into treatment.

The final theme in the treatment category highlighted the participant's *experiences in treatment*. My initial thoughts before beginning the research were that people's experiences in treatment would vary based upon whether they viewed themselves as volunteering or as being coerced. However, what emerged was that people typically viewed being in treatment in a positive light. The main variation in this finding came from Mary, who viewed herself as being coerced and expressed significant resentment about being in the program. Although most participants reflected on their experience in treatment in a positive light, they also agreed that taking part in a residential treatment program is difficult. This theme leads me to ponder the notion how forcing people to remain in a situation they do not want to be in is laden with important ethical considerations. Hence, literature examining the effects of coercion on the therapeutic relationship adds an important component to this discussion. This theme is congruent with the findings within the literature examining the dual role relationship that emerges when the coercer is also the counsellor (Skeem et al., 2007). However, the experience the participant has in treatment is an important factor to consider. Best practice research in the area of youth treatment speaks to this finding because youth do not necessarily have to complete treatment to experience positive outcomes (Currie, 2001). The participants who did not finish treatment and did not take part in the final research interview noted in their initial interview that they viewed themselves as having a positive treatment experience. I think these findings may reflect the presence of a client-centered philosophy in the treatment program; moreover it speaks to the skill and experience of the counsellors working in the treatment program.

The post-treatment category contains one central theme, *thoughts about remaining and leaving treatment*. This theme highlights the participant's concluding thoughts about coming to treatment and the self-evaluation of the changes they made during the process. The overall finding of this category was that the participants associated treatment as being a positive experience. For the most part, the youth who had initially reported feeling pressured to come to treatment tended to view their decision to come to treatment and remain in the program positively. This finding is supported by the literature that discusses the value of building positive rapport with clients (Lishman, 1994). This finding also supports the notion that even though clients may be coerced to attend treatment, having a positive experience during their stay can alter their perception of the negative aspects of being coerced to attend (Currie, 2001). Having previously worked with coerced clients in residential treatment, this finding is not surprising to me. It reaffirms the tenets of client-centered therapy and the notion of treating clients with unconditional positive regard (Zimring, 1994).

This research represents a small step into the exploration of coerced and voluntary treatment using a qualitative approach. As discussed in the literature review, very few studies have examined the experiences of those who are coerced to or who voluntarily attend residential treatment for substance use. The lack of literature on this topic represented a significant challenge for myself as a developing researcher. However, the experiences described in this research could be used by future researchers on this topic as a means to develop more extensive look into the topic. In addition, the Northern Health Authority could

examine the findings and themes to inform future treatment practice concerning coerced clientele.

Eight adolescents were interviewed for the purposes of completing this research. As the interviews with the youth progressed many of their experiences overlapped. The interview data from the eight participants provided significant insight into the experiences of coerced or voluntary attendance. However, it is possible that increasing the number of interviews could have revealed further unknown factors about this topic. Due to the relatively small sample size, the outcomes of this research will not be transferable to the larger population.

This study used convenience sampling to identify research participants. Essentially, those who attended the residential treatment program and were within the 16 to 18 year old age category were recruited to take part in the study. This sampling method may have excluded adolescents who may have reported different experiences of coercion than those who participated. Regardless, I am grateful for having heard the experiences of the youth who volunteered to take part in this research.

It is possible that certain types of participants may have chosen to take part in the study versus those who did not. Those who took part may have been more apt to answer questions in a specific way which could potentially skew the results. This kind of uncertainty is found within many studies that involve human subjects. Related to this limitation, only those who volunteered to take part in the study were interviewed. Therefore, this group of individuals presented their views on the topic and therefore the findings of the research may not be generalizable to a broader population.

A final limitation of this research arises from my employment as a counsellor at the treatment program where the study took place. This raises an important ethical consideration about a dual role relationship emerging as both counsellor and researcher. Before beginning this research, this topic was discussed with my thesis committee as well as those working at the treatment centre. Upon close consideration, this dual role was considered unavoidable. Therefore, to address this dual role relationship, I discussed the significance of this with each research participant in a respectful and ethical manner. I was able to minimize the impacts of this dual role relationship by only preforming research tasks, such as interviews, on days that I was not working at the treatment centre. As part of decreasing the impact of the dual role, I was not involved in the recruitment of research participants. The counsellors working in the program approached the prospective participants and ask them whether they would be interested in taking part in this research project. These counsellors were never advised whether the participant had finally agreed to take part in the research; this assured a level of confidentiality for the participants. In addition, research participants were made aware that they did not have to participate and did not face any negative consequence or positive benefit by choosing to participate in the research.

Chapter 5: Summary and Recommendations

When I set out to research the topic of adolescent experiences of coerced and voluntary treatment, I thought I would be able to predict many of the outcomes due to my previous experience of working in the area. However, as the research progressed it became evident these biases were unfounded. Keeping the focus of the research on the experiences of the participants quickly revealed that personal experience cannot be defined by others. The narrative process of examining stories about specific experiences leads to unique outcomes because every individual has their own story and interpretation of their reality. This thought reminds me that each day people, including youth, are told what is best for them. Experts working in the addictions field are often placed in a position that provides them with significant control and power over the peoples lives they are charged with helping. It is important to remain mindful of these power differences and how they interact with another's experience of the same situation.

Considering the outcome of this research, evidently individuals who face serious substance abuse issues find themselves exercising significant self-assessment of the problems associated with their use. The notion of free will and the tenets of self-determination theory (Wild, Cunningham, & Ryan, 2006; Wild, 2006; Vallerand, Pelletier, & Koestner, 2008) emerged as defining concepts in the participants' assessments of their experiences in treatment. The voice of the adolescent is lost when people determine what is best for them without considering their thoughts on the issue.

The main recommendation arising from the findings of this research is that listening to the opinions and thoughts of those who enter treatment is critical. Although some may experience a significant amount of uncertainty about entering treatment, encouraging adolescents to at least try to attend treatment is a useful strategy. By attempting residential treatment the individual is provided with the opportunity to experience it first hand and make the decision whether this intervention is what they want. Helping people based upon their needs is a tenet of client-centered therapy (Zimring, 1994). This critical component of the therapeutic experience can be lost when people are forced to take part in intervention strategies that go against their free will.

If people are forced to attend treatment they should be provided with an opportunity to determine whether they want to continue the process after they have attempted being in the program for a few days. It is important to recognize that residential addictions treatment is not for everyone. However, until a person has attempted this form of intervention they cannot assess whether this kind of approach would be helpful. Therefore, coercing people to attend treatment but allowing them to self-determine when they leave treatment seems to strike a reasonable compromise to satisfy the needs of criminal justice system, or appease the worry of a concerned parent or friend.

My main goal is that this research adds to the discourse on the topic of coerced treatment. Consideration of the lived experiences of those who are coerced to attend treatment is an area that has been largely overlooked in the literature. Understanding the lived experience of coerced or voluntary attendance could assist researchers in determining

the factors that improves or diminishes treatment experiences. More research in this area using a qualitative approach could add to the discourse on this topic by further identifying the factors that contribute to and influence an individual's story of attending residential substance abuse treatment.

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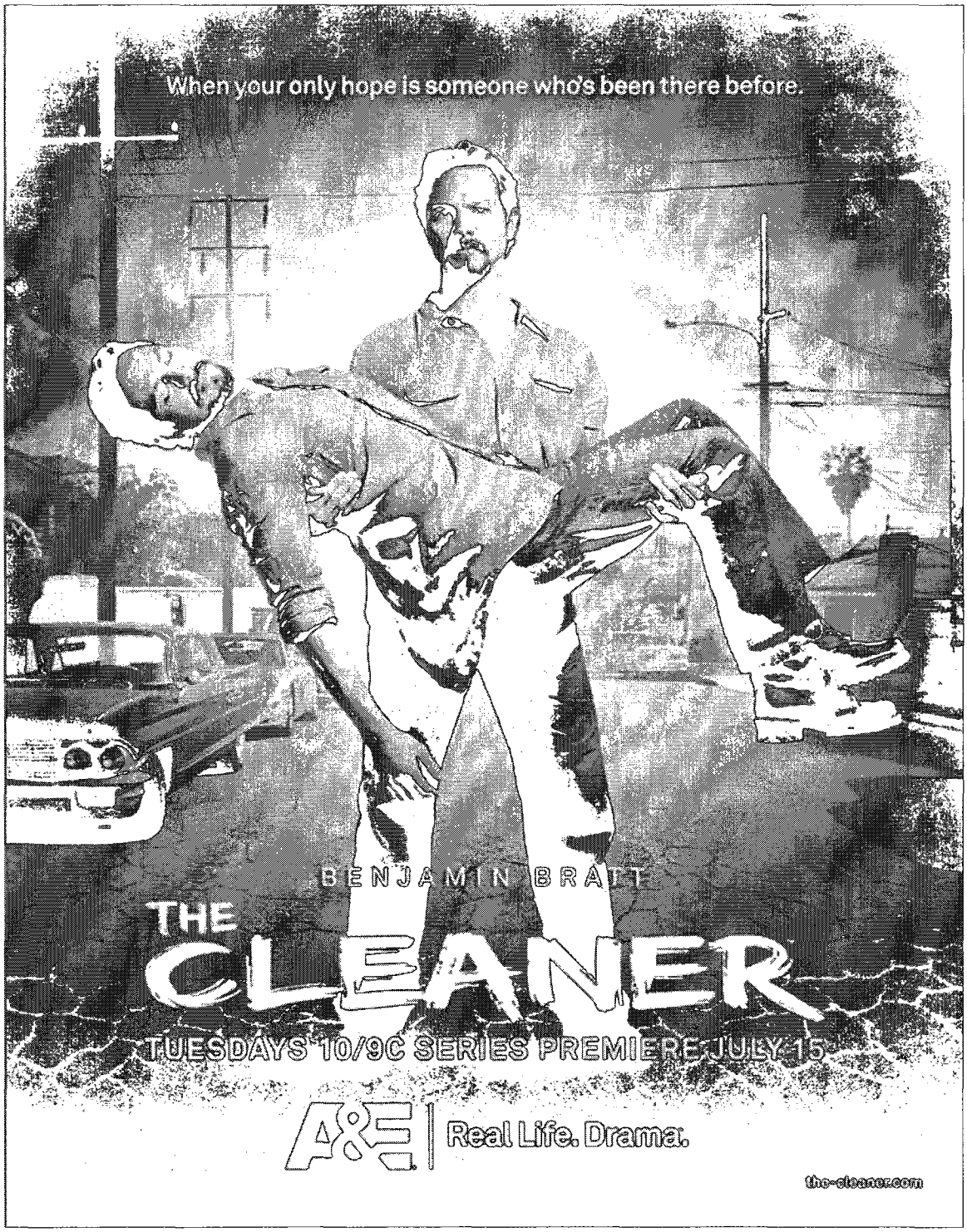
Appendix A


When your only hope is someone who's been there before.
BENJAMIN BRATT
THE CLEANER
TUESDAYS 10/9C SERIES PREMIERE JULY 15
A&E
Real Life. Drama.
the-cleaner.com

Appendix B


JACK NICHOLSON
ONE FLEW OVER
THE CUCKOO'S NEST

Appendix C

Amy Winhouse--Rehab lyrics

They tried to make me go to rehab but I said 'no, no, no'
Yes I've been black but when I come back you'll know know know
I ain't got the time and if my daddy thinks I'm fine
He's tried to make me go to rehab but I won't go go go

I'd rather be at home with Ray
I ain't got seventy days
Cause there's nothing
There's nothing you can teach me
That I can't learn from Mr Hathaway

I didn't get a lot in class
But I know it don't come in a shot glass

They tried to make me go to rehab but I said 'no, no, no'
Yes I've been black but when I come back you'll know know know
I ain't got the time and if my daddy thinks I'm fine
He's tried to make me go to rehab but I won't go go go

The man said 'why do you think you here'
I said 'I got no idea
I'm gonna, I'm gonna lose my baby
so I always keep a bottle near'
He said 'I just think your depressed,
kiss me here baby and go rest'

They tried to make me go to rehab but I said 'no, no, no'
Yes I've been black but when I come back you'll know know know
I ain't got the time and if my daddy thinks I'm fine
He's tried to make me go to rehab but I won't go go go

I don't ever wanna drink again
I just ooh I just need a friend
I'm not gonna spend ten weeks
have everyone think I'm on the mend

It's not just my pride
It's just 'til these tears have dried

They tried to make me go to rehab but I said 'no, no, no'
Yes I've been black but when I come back you'll know know know
I ain't got the time and if my daddy thinks I'm fine
He's tried to make me go to rehab but I won't go go go

Appendix D

List of Potential Supplemental Questions Participants Could be Asked

The narrative method asks participants to tell their story. The following lists are examples of questions participants were asked during the interviews. This is not a complete list of questions asked, as other questions arose as the interviews progressed.

First Interview:

Why was it important/not important for you to come to this program?
Why did you come to this program?
How would you describe how you made the decision to come to this program?
Did you experience pressure of force to attend? From where?
How would you describe the professional supports you have in your life?
How would you describe your family and peer supports in your life?
What motivated you to come to this program?
What could change your motivation to stay or leave the program?

Second Interview:

What goals or motivations did you initially have in attending?
What kept you in the program?
Do you think being forced or voluntary changed your relationship with the counsellors in some way?
Having completed the program, what is your opinion of how being forced/voluntary impacted your stay in the program?
Do you have any other thoughts on whether being forced/voluntary to attend treatment was the right decision for you?