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How Heroin-Addicted Offenders Experience Sobriety Upon Release From Jail

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Walden University
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Abstract

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Rebecca Foster

MBA, Columbia Southern University, 2013

BS, Columbia Southern University 2012

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Heroin addiction is a growing epidemic in the United States. The need for proper treatment programs accessible by heroin users who wish to or are mandated to participate in recovery programs is a growing need, and pathways to sobriety for ex-offenders have presented in literature as understudied. The purpose of this study was to examine heroin-addicted offenders' experiences prior to and after release on their paths to sobriety. This study followed a qualitative phenomenological approach based on the theory of personal causation, which posits that individuals see events in life as either driven by themselves or caused by others, both of which affect internal motivation. An empirical phenomenological approach was used to explore how this group of individuals perceived or experienced heroin addiction and their subsequent attempts at sobriety A purposeful sample of 15 heroin-addicted offenders were interviewed in a jail in a rural county of Wisconsin. Upon re-entry, 4 participants completed follow- up interviews. The results showed that external motivators such as social and treatment factors were separate from internal factors, although external motivators could influence the way a person makes internal choices. Results were obtained by performing coding on the semi-structured interviews both by hand and within the Atlas-ti analysis program. The theory of personal causation supports and is supported by the findings of this study. Implications for positive social change include a better understanding of the needs of heroin-addicted offenders moving from incarceration to release in treatment program development, thereby reducing harm to the heroin user, family members, and communities by decreasing relapse, recidivism, and chances of overdose and death.

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Dedication

This dissertation is dedicated to all those who live with heroin addiction.

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Chapter 1: Introduction to the Study

Introduction

As of 2013, more than 2 million Americans met the criteria for opioid abuse, with 517,000 of those identifying as heroin users (Maradiaga, Nahvi, Cunningham, Sanchez, & Fox, 2016). The National Institutes of Health (NIH; 2013) stated that more than 200,000 Americans pass through U.S. correctional systems each year, and while incarcerated, offenders can obtain treatment to help maintain a path to sobriety once released. Many studies show the correlation between heroin use and crime and recidivism and the loss of social supports, family ties, employment, and health in terms of numbers and percentages (Binswanger et al., 2012; Bukten et al., 2011; Calcaterra, Beaty, Mueller, Min & Binswanger, 2014; Evans, Huang, & Hser, 2011; Felson & Staff, 2015; Gisev et al., 2014; Gordon et al., 2015). Although that information is useful and needed when assessing individual and community needs, connections between drug interventions in jails and treatment upon release, including the effects of heroin on sobriety, relapse, and recidivism, are not well understood (Zaller et al., 2013). Heroin or the heroin addicts' experiences cannot be fully considered without taking into account the element of criminal activity, loss of normalcy and quality of life, incarceration, and recidivism, as well as the desire to be drug free and the prospect of treatment. Heroin takes over the user's life and becomes the only object of interest (Kerr, Small, Hyshka, Maher, & Shannon, 2013). In order to understand the experiences of heroin addicts' paths to sobriety upon release, a researcher must first understand how heroin use has grown in the United States, how heroin is associated with crime, incarceration, and recidivism, and how heroin addicts view and experience treatment.

Background of the Study

Heroin use has become an epidemic in the United States, and is currently one of the fasted growing public health issues (Palombi et al., 2016). One possibility for the increase in heroin is the reformulation of synthetic opioid prescriptions that decreased the ability of users to tamper with the drug and misuse it (Palombi et al., 2016). The United States has seen an influx of nonmedical use of prescription opioids, which has become a public health issue (Compton, Jones, & Baldwin, 2016); however, many nonmedical opioid users switch to heroin due to cost and ease of access (Compton et al., 2016; Novak, Bluthenthal, Wenger, Chu, & Kral, 2016). Heroin varies in color and consistency, and can be injected and snorted, heated and liquefied, depending on the user's preference (Ciccarone & Harris, 2015).

In 2013, approximately 169,000 new users emerged into the heroin market, with 517,000 persons aged 12 and older abusing heroin (Lipari & Hughes, 2015), but as of 2014 out of the 21.5 million Americans with substance abuse disorders, 586,000 were abusing heroin alone (American Society of Addiction Medicine, 2016). Heroin use leads not only to a greater chance of early death or overdose (Jones, Logan, Gladden, & Bohm, 2015) but also the possibility of incarceration (Degenhardt & Hall, 2012). According to Taxman, Perdoni, and Caudy (2013) the United States incarcerates nearly 8 million offenders, with nearly 70% of that population being individuals having substance abuse disorders.

Incarceration is just one risk individuals take when using heroin, along with the possibility of losing family, friends, careers, good health, and lifestyles (Fox et al., 2015).

Heroin users increase their chances of mortality due to the possibility of using heroin mixed with fentanyl or cocaine, both of which increase the potency of the heroin. Addicts may not realize the strength of the heroin mixed with another drug and hence overdose and possibly die. In addition to the increased possibility of an early death or incarceration, heroin addicts tend to choose injecting drugs over work or family and lose personal connections and quality of life (Lin, Chang, Wang, & Lee, 2016). Lin et al. (2016) asserted that heroin addiction has both a psychological and physical effect that endangers positive life function.

The use of heroin is not something that only affects the user during the "high"; it also affects users physically and psychologically during and after each use, in addition to putting the users in danger of contracting HIV, hepatitis, and other blood borne diseases (Ciccarone & Harris, 2015). Ciccarone and Harris (2015) also stress that when users inject heroin repeatedly, they slowly destroy their veins, which in turn can cause skin issues and abscesses. The need to find heroin and then to find an injection site can increase frustration and stress and lead to criminal behaviors to obtain heroin (Mars, Bourgois, Karandinos, Montero, & Ciccarone, 2016). Heroin use leads to health care and public health issues that then affect communities as a whole. Social harm, health care costs, law enforcement resource expenditure, and legal issues increase due to heroin use, all of which cost communities considerable amounts.

Social Perspectives and Health Care Costs

The social perspectives associated with heroin use include the damage caused to users as well as how families, individuals, and communities are negatively affected

(Cole, Logan, & Walker, 2011; Mowen & Visher, 2015). Birnbaum et al. (2011) divided group costs associated with heroin addiction into three categories: healthcare, businesses and workplaces, and criminal justice. Heroin costs were estimated to be $55.7 billion in 2009, with a breakdown for healthcare, workplace, and criminal justice at $25 billion, $25.6 billion, and $5.1 billion respectively (Birnbaum et al., 2011). Medicaid costs represent $1 out of every $6 spent on health care in the United States, and these costs are shared between the federal government and states depending on the individual needs of the healthcare, business, and criminal justice departments (Snyder & Rudowitz, 2015). Medicaid costs vary depending on the economic state of communities on all levels, from the individual, to the community, state, and country, and are limited to individuals with lower incomes and who meet specific age limits. Not all heroin abusers are eligible for Medicaid. The costs for continuing care for heroin users and abusers are excessive and growing and continue to be a burden on all of society, which is why health care and public health officials need to know how to approach heroin addiction treatment and care. Heroin addicts wishing to enter detox or recover may find barriers in place to attaining health care and treatment (Binswanger et al., 2012).

Issues with Obtaining Health Care

In order to recover from heroin addiction, professionals suggest users go through guided treatment rather than attempt to abstain on their own (Neale, Nettleton, & Pickering, 2013). Although some heroin users choose to abstain and detox on their own, many seek help from primary care providers. Two issues expressed by primary care providers is that heroin users may contact them only to obtain more prescription opioids,

and secondly that many of the providers feel that they are not properly trained in treating heroin or opioid addiction (Bowman, Eiserman, Beletsky, Stancliff, & Bruce, 2012). On the other hand, heroin addicts and treatment providers know that barriers to health care exist due to the inability to pay out-of-pocket (Kuehn, 2013; Swogger et al., 2016). For heroin-addicted offenders re-entering society after incarceration, obtaining treatment is not always easy unless they have private insurance or are eligible for and enrolled in Medicaid. For these reasons, one of the criteria for recruitment in this study was that heroin-addicted offenders had to be eligible for enrollment in Medicaid upon release. In addition, all participants in this study had the opportunity and choice to enter into immediate outpatient substance abuse treatment at the local hospital.

Understanding the background of heroin addiction is pertinent to moving forward in a positive direction towards proper treatment and paths to sobriety. Knowing how and why heroin affects health care costs as well as understanding the relationship between heroin users and health care providers was essential to the foundation of this study. This information provided the basis for the interview questions and the competence to respectfully interview the participants. In Chapter 2, I discuss further the literature on heroin addiction and treatment options, as well as what is being done to curtail heroin use.

Overview of Heroin in the United States

Opioid use for nonmedical purposes has grown in the last 50 years (Cicero, Ellis, Surratt, & Kurtz, 2014), and heroin is the fastest growing epidemic in the United States (Palombi et al., 2016). An increase in prescription opioid use has led to a rise in heroin

use and overdoses due to users transitioning to heroin because of cost (Jones, 2013), high purity (Compton, Jones, & Baldwin , 2016), and stricter regulation on synthetic opioids including tamper-proof formulas (Palombi et al., 2016). Novak et al. (2016) added that new restrictions on prescription opioid pain relievers such as OxyContin and new government programs that monitor the disbursement of prescription pain medications and therapy drugs have made it harder to abuse the drug. The correlation between prescription opioid use and heroin is the increase in morbidity and mortality rates (Compton et al., 2016). Regardless of the difficulty obtaining opiates and heroin, drug users continue to find ways and reasons to use them.

Overview of Heroin Use and Incarceration in the United States

The criminal aspect of heroin use must also be examined as heroin addicts made up approximately 70% of the 8 million offenders incarcerated as of 2013 (Taxman et al., 2013), with one-third of heroin addicts passing through prisons and jails each year (Fox et al., 2015). Every crime committed not only affects the heroin user but the community as a whole in terms of costs associated with recouping losses, criminal proceedings costs, and incarceration costs (Substance Abuse and Mental Health Services Administration, 2014). When users enter the correctional system as incarcerated offenders, they enter into a de facto health care system where they will obtain health services that provide the care they need, specifically detoxification in this case (Taxman et al., 2013, p. 71).

Overview of Drug Treatment Therapy

For the purposes of this study, the terms *opioid substitution therapy, opioid maintenance therapy, opioid replacement therapy, methadone maintenance therapy,* and

buprenorphine maintenance therapy, are used interchangeably to mean drug treatment therapy (DTT) for offenders. For the ease of reading and understanding this study, I used DDT unless otherwise specified by a specific study. For heroin-addicted offenders, the problem arises when jails do not have the resources or availability of DTTs to aid them on their paths to sobriety. Studies have shown that DTT while incarcerated increases the chances of offenders maintaining sobriety upon release and can reduce the risk of recidivism (Fox et al., 2015).

DTT is a maintenance program that allows drug users to break the habit of injecting drugs while curbing cravings and relieving pains associated with withdrawal. Methadone has been the treatment drug of choice to prevent relapse with heroin and opioid abusers and recidivism in ex-offenders (Fox et al., 2015; Zaller et al., 2013). However, buprenorphine, Suboxone (buprenorphine and naloxone), and Vivitrol (Naltrexone) are also therapeutic drugs used to help heroin and opioid abusers overcome addiction by lessening withdrawal symptoms (Fox et al., 2015; Gordon et al., 2015; Proctor, Copeland, Kopak, Herschman, & Polukhina, 2014). Studies show that heroin users prefer DTT using buprenorphine and combination drugs to Methadone (Fox et al., 2015).

Statement of the Problem

There is a lack of representation in literature of heroin-addicted offenders' experiences and perceptions regarding an path to recovery upon release from jail. Calcaterra, Beaty, Mueller, Min, & Binswanger,. (2014) pointed out that heroin-addicted offenders often lack the self-efficacy and support to carry out a successful recovery upon

release from jail. Fracturing of support systems may increase the occurrence of relapse (Calcaterra et al., 2014).

Literature shows that offenders released into society face many barriers that impede success towards integration, employment, and sobriety (Gordon et al., 2015; Harley, 2014). Pickard (2012) stated that one barrier that further deters integration, employment, and sobriety and perpetuates the cycle of substance abuse and recidivism is addiction. Pickard argued that addiction is not chronic; rather, it serves a higher purpose than other life options, and takes precedence over other barriers to overcome. Pickard's assertion was supported by Ahmed, Lenoir, and Guillem (2013) who concur that without options and positive choices, abusers will choose heroin, even if they are not addicted.

In regard to addiction, health care workers and public health officials must keep in mind the need for treatment options available to offenders prior to and upon release; the lack of opportunities for positive social change are predominant in addicted offender release situations (Calcaterra et al., 2014; Nyamathi et al., 2014). Research has shown that access to medical care and DTT immediately upon release is imperative for the success of the addicts' path to sobriety, but there is often a lack of service consistency due to financial barriers and a shortage of providers available to serve heroin-addicted offenders (Fox et al., 2014). Speer, Peterson, Armstead, & Allen (2013) believe that a lack of empowering life experiences and self-efficacy contribute to a heroin-addicted offender's difficulty in reaching and maintaining sobriety. Dannenberg, Förster, and Jostmann (2012) showed that personal barriers to sobriety upon release included a lack of personal causation and autonomy. Offering participants the option to partake in this

research, share their stories, and choose to enter into a drug treatment program upon release all contribute to building autonomy

Purpose of the Study

The purpose of this qualitative, phenomenological study was to understand the experiences of heroin-addicted offenders on their paths to sobriety upon release. In this study I focused on obtaining the personal experiences, perceptions, and perspectives that feed the cycle of drug use and recidivism, with the further intent of discovering if empowerment, self-efficacy, and positive options made a difference in heroin-addicted offenders reaching and maintaining sobriety.

Nature of the Study

This study is qualitative in nature and included incarcerated, heroin-addicted offenders as participants. I used semistructured interviews with open-ended questions, allowing participants to recall as much information as possible without guidance. Interview questions helped me to investigate heroin and treatment histories, feelings of autonomy and self-efficacy, how personal causation and internal and external motivators affected sobriety, and the offenders' desire for sobriety. I developed the interview questions as they pertained to the theory and research questions with the purpose of eliciting responses that fulfilled the study.

The research and interview questions were reviewed by an expert panel at St. Agnesian Behavioral Health that consisted of physicians, counselors, psychologists, and department heads. At the suggestion of the panel, I changed the questions to remove any driving or suggestive connotations. The panel also a suggested that I use a standard

interview questionnaire, but I needed the questions to pertain solely to heroin-addicted offenders, and therefore I designed the interviews myself. The purpose of the panel was to ensure that the research questions and interview questions linked and maintained the validity of the study as they pertained to heroin-addicted offenders. The expertise provided by the panel guided the construction of the interview questions in order that they might elicit appropriate answers that were not suggested. The expert panel was only aware of the research questions, interview questions, and that potential participants were heroin-addicted offenders. I completed this research in its entirety by myself in order to ensure anonymity of the participants and fulfill the dissertation process.

Phenomenological Research

I employed a qualitative, phenomenological approach to complete this study. Qualitative research was needed to discover how heroin-addicted offenders experienced sobriety after release from jail (Miner-Romanoff, 2012). Acquiring personal feelings and perceptions was essential to answering the research questions in-depth (O'Reilly & Parker, 2012). This approach was best suited to obtain the essence of the phenomenon, which quantitative research and data collection do not explore. Interviews conducted during incarceration and after release have shed light on what offenders believed was the path to sobriety, who and what they see as supports or barriers, and how they experienced sobriety's journey.

Research Questions

The following research question guided this study:

RQ**:** What are the internal and external motivating experiences of heroin-addicted offenders prior to and upon release from jail in maintaining sobriety?

The following subquestions further guided the focus on this study:

SQ1: What role do internal and external motivators play in regards to treatment and sobriety during incarceration and upon release?

SQ2: How do internal and external motivators and the theory of personal causation affect perceptions of social constraints to sobriety such as unemployment, loss of personal relationships, and lack of support for heroin-addicted offenders after release?

Theoretical Framework

The theoretical foundation for this study was deCharms (1968) theory of personal causation. The theory of personal causation argues that people author events as either having been done by them or to them and thus consider themselves internally as origins or pawns of the events (deCharms, 1968). The theory of personal causation posits that people cloak experiences and events with personal authorship, which sometimes leads them to accept responsibility for events they have no hand in but alsoaids individuals in realizing the events they have caused by their actions (Dannenberg et al., 2012). Hagger, Rentzelas, & Chatzisarantis (2014) further express the theory of personal causation as having a positive effect on how personal choices affect intrinsic motivation, which affirms individualism and positive perspectives.

Theory Guiding This Study

The theory of personal causation guided this study by sharpening the focus on how personal choice and external influences affect motivation. The research and interview questions and methodology allowed the theory to unfold in the data analysis and findings. Findings presented as how participants expressed and explained their experiences, real or perceived, as authored by them as origin moments or having happened to them or caused a negative event as in pawn moments. Another element of the theory of personal causation is that experiences authored by participants provide the reasoning and support for personal choices and motivations.

Theory Informing Interview Questions

I formed questions that allowed participants to openly express themselves through semistructured interviews, and I used reflexive questioning to ensure the motive to abstain or use, positive or negative, as well as the initial motivating event were expressed as well, in order to extract as much as the data as possible in each answer. Motivation to act is reflected in how the individuals perceived their personal involvement of the initial situation. Weiss et al. (2014) found that motivation to abstain from using heroin was to improve quality of life, while Wentzel (1999) stated that motivation is what causes people to do what they do. The interview questions were created to focus attention on participant experiences regarding how they relate to origin and pawn events, as well as perceived occurrences and outcomes as being authored by them or done to them.

Personal Choice and deCharms' Theory of Personal Causation

Personal choices, actions, and experiences are motivators to either succeed or fail (Wentzel, 1999). DeCharms (1968) stated that how people perceive themselves and others in relation to how experiences occurred can alter their perception of their own personal function and ability. DeCharms argued that people want a feeling of control over themselves and their lives and therefore feeling as if negative forces are working against them can be perceived as a pawn moments and a loss of empowerment, self-efficacy, and autonomy. Loss of empowerment, self-efficacy, and autonomy were elements expressed by addicts in a study by Weiss et al. (2014) in which participants believed they had the ability to become who they were prior to using heroin by achieving small personal goals. My intention was to discover how personal causation affects heroin-addicted offenders on their path to sobriety upon release from jail.

Data Analysis Informed by Theory

As noted, the theory of personal causation argues that people author events as either having been done by them or to them (deCharms, 1968). Weiss et al. (2014) found that small goals personally achieved by addicts were viewed as origin events and were reported as the way back to normalcy. Using the interview questions, I elicited descriptions of how participants viewed life events, and during data analysis, I used the theory of personal causation to determine if addiction played a role in the experiences and perceptions that occurred in the participants' lives. The theory of personal causation guided data analysis as I sought to discover how participants viewed their role in events and if there were internal or external motivators involved as well. DeCharms (1968)

stated that how individuals view an experience can be a motivator for action, either positive or negative. I discuss this theoretical framework in more depth in Chapter 2.

Definition of Terms

Abstinence: The durations in which individuals do not use heroin and are not enrolled in drug treatment or incarcerated (Nosyk, Anglin, Brecht, Dias Lima, & Hser, 2012).

Autonomy: Having the experience of choice and being able to claim one's actions as one's own. (Deci & Ryan, 2008a).

Buprenorphine: A semisynthetic opioid deterrent that is more potent than morphine, but acts as a partial agonist by blocking the effects of heroin upon use (Koyyalagunta, 2006; Wasson & Beirne, 2013).

Drug treatment therapy: Sometimes called medication-assisted treatment, it aids drug abusers in staying off illicit drugs with the use of methadone, buprenorphine, and naltrexone (Volkow, Frieden, Hyde, & Cha, 2014).

Drug user: Individuals who partake in nonmedical use of illicit drugs that are controlled by drug control treaties, such as heroin, amphetamines, cocaine, and cannabis (Degenhardt & Hall, 2012).

Heroin addicts: Individuals who are dependent on heroin and use despite impaired health (Lin et al., 2016).

Naloxone: Drug that prevents abuse of buprenorphine by creating a withdrawal limit or edge that causes withdrawal symptoms (Wasson & Beirne, 2013).

Recidivism: The term used when offenders are convicted of crimes committed after previous release from prison or jail (Raaijmakers, Loughran, Keijser, Nieuwbeerta, & Dirkzwager, 2016).

Release: The process of leaving jail and returning to society (Bender, Cobbina, & McGarrell, 2016).

Sobriety: When a previous drug user achieves one month or more of abstinence from using (McGrath-Rush, 2000).

Suboxone: A combination of buprenorphine and naloxone rendering opioids ineffective and causing withdrawal sensations upon use of heroin (Wasson & Beirne, 2013).

Significance of the Study

This research fills the gap in understanding how heroin-addicted offenders experience sobriety upon release from jail. In addition, Zarkin et al. (2015) state that the majority of research on offenders, heroin addiction, treatment, and recidivism are from prison inmate perspectives, not jail settings, thus most of the findings pertain to state prisoners and detainees. A multitude of quantitative research is available providing numbers and percentages about those incarcerated, drugs of choice, numbers on relapse and recidivism, and the desire to abstain or maintain sobriety; however, they do not provide the personal stories, desires, and perceptions of users or the meanings behind the numbers and percentages (Neale, Nettleton, & Pickering, 2011).

This study is original and unique in that it brings in the perspectives and experiences of the users themselves during a difficult transition time that poses a threat to

positive life and social changes (Nyamathi et al., 2014). The use of qualitative interviews allowed the offenders to share their needs and wants pertaining to post-release life beyond the assumed treatment needs taken on by health department officials and community leaders (Johnson et al., 2013). This research also provided insight into DTT benefits, thereby shedding light on a healthcare pathway for community and jail officials for better treatment options for heroin-addicted offenders.

This study brought information to remove assumptions about treatment, due to offenders sharing openly about what they need for help before and after release (Johnson et al., 2013). This study provideed sensitive information needed by officials to help heroin-addicted offenders through difficult transitions, towards sobriety, facilitating positive social change for communities and individuals alike. The depth of the personal experiences provided insight into perspectives that literature inadequately represents (Johnson et al., 2013).

When we consider the United States and the costs associated with heroin abuse, we can see how detrimental this drug addiction is in terms of overdose, treatment, criminal issue, and corrections expenditures. Understanding the addicted mind, and how it experiences drug use, cravings, relapse, and sobriety may be able to shed light on needed or missed steps and elements of current policies and procedures. The Wisconsin Department of Health and Human Services (DHS) (2015) state that as of 2014, heroin had been the cause of 238 out of 843 (28%) overdoses deaths, increasing from 5% of all drug deaths in 2006 to 33% in 2014. In most cases, the use of Naloxone or Narcan, counteracted the overdose, and totaled 2,072 cases of community-based individuals

trained to administer the drug, and 1,338 drug-user peers who attempted to save lives (Wisconsin Department of Health and Human Services, 2015). The development of harm reduction programs that bring in the community as a partner to prevention, is a possible outcome of this study. I discuss implications for social change further in Chapter 1.

Assumptions

As this research began, I considered my personal assumptions of heroin-addicted offenders. I assumed that participants would be eager to share their stories; however, I also believed that participants would not be totally truthful, rather elaborating, or withholding information to make themselves look better in others' eyes. I discuss self-reporting bias further in Chapter 1, along with how I countered biased reporting as well in Chapter 3. I assumed that some historical details of heroin use may be distorted due to being high or the inability to properly recall some events properly. I address recall bias further in Chapter 1. In addition, I assumed that since I was working with male offenders, I should dress down or appear less attractive in order to counter any inappropriate behaviors on participants' parts. Further, I assumed that a phenomenological study was the best way to obtain the details and stories needed to fulfill the research questions of this study.

Scope

The scope of this study involved heroin-addicted offenders set for release within one-month of initial interviews. This study only included heroin-addicted offenders, 18 and older who entered jail with a history of recent heroin use. I excluded those actively going through detoxification. I included offenders who were cognitively and emotionally

capable of completing this study, as determined by the staff nurse who identified the potential pool of participants using health and behavioral records. This researcher did not see any of the participant records.

This study took place in a Wisconsin city with a population of 42,917 as of 2014 with a breakdown of 99% urban and 1% rural, and a 1.7% increase since 2000 (City-Data, 2014). In addition, 20,958 of that population were male with a median age of 38.4 years (City-Data, 2014). Also reported was a median income of $45,804 and home values of $119,518. Demographically reported for 2014, 87.5% of the population was White, 6.5% was Hispanic, 1.8% was Black, and the rest mixed races, Asian, or American Indian. There is one jail that serves this county (CourtSystem.org, 2016), and participants were selected solely from that jail, in addition to completing initial interviews while they were incarcerated. I did not initially include homeless heroin-addicted offenders, as the participants were incarcerated; however, living status upon release included those who did not have housing and were then considered homeless.

Delimitations

This study was delimitated to heroin-addicted offenders from one jail in Wisconsin, set for release within one month of initial interviews. Those invited to partake entered jail with a recent history of heroin use marked within 30 days of incarceration. The jail staff nurse identified a potential pool of volunteers based on their status as heroin-addicted offenders who also were eligible for Medicaid upon release. The nurse did nothing more than pass out the Invitation to Participate and Consent Forms. Staff participation in this study was minimal and was not coercive in any form or manner.

Thirty heroin-addicted offenders received invitations to participate in this study. A smaller sample was appropriate for this phenomenological study, because smaller samples prevent the researcher from becoming overwhelmed with data analysis, and allow an in-depth study of a phenomenon to manifest (Roberts, 2013).

Limitations

Several factors that contributed to limiting this study as well as the results included the inability of participants to remember all the details of their experiences with heroin. Life events not mentioned may have contributed to drug use or abstinence, such as employment status, loss, or gain of a relationship, family intervention or the lack of support. In addition, telling true stories was difficult for fear of getting into trouble for crimes committed. Themes identified stemmed from the true nature and essence of each individual experience, as I could only base results on data collected. Further, I was the only coder for this study, which may have affected reliability and theme development. In addition, the sample size is small and limited to the population in a Wisconsin county jail.

Bias in Research

Researchers must be aware of and make considerations for several kinds of biases. Understanding how personal beliefs and perspectives can affect the way data is reported or interpreted can help determine how interview questions are asked and understood. Biases tend to lean towards a personal opinion or belief, and pose a prejudice for or against a group or individual viewed as an unfair perspective (Smith & Noble, 2014). Biases can also cause research participants to say what they believe others want to hear or what makes them look good in the eyes of others, which in turn negatively affects

validity and reliability (Smith & Noble, 2014). Biases affect qualitative studies just as they do quantitative studies, because data analysis bias, which is when researchers look for reported data that supports their study, and omit data that is contrary to the desired outcome (Smith & Noble, 2014).

Self-Reporting Bias

Individuals tend to desire to be socially desirable; however, due to the sensitivity of the data needed, participants may have felt threatened by disclosing information that put them in a negative light, so they provided information and answers that were socially acceptable and possibly not their true feelings, attitudes, or experiences (Feng et al., 2013; Krumpal, 2013). Krumpal goes on to assert that the main purpose and outcome of self-reporting bias is making oneself look good to others, and Freeman, Schumacher, and Coffey (2014) concur that participants may self-report a behavior, but not an actual participants' behavior. I was aware that participants of this study might employ self-reporting bias, and I acknowledged, and realized that bias during the interview and data analysis processes. I used swirling when interviewing to triangulate the participants' answers; however, some interviews were clearly testimonies of innocence. I considered the fact that heroin-addicted offenders may falsely report data to (1) look better in readers' eyes, and (2) protect themselves from reporting threatening information that may affect them personally and legally.

Recall Bias

Remembering an event, regardless of when it occurred, can be miscalculated for time, experience, and truth, in addition to incorrectly recalling if it happened at all

(Kessler et al., 2012). Kessler et al. found in their research that improper recall was equally prevalent in all periods and for all age groups; however, older participants had a harder time recalling distant memories properly. Ye et al. (2013) completed a study on alcoholism and evaluating potential bias, and found that bias was stronger in participants who drank less or over longer intervals with 15 participants reporting drinking 1-5 times in the last year, making it harder for them to remember when they drank compared to those who were habitual drinkers. The researchers compared drinkers who incurred injuries due to drinking, and the main reason for recall bias was due to the lack of recall as to when the drinking happened (Ye et al., 2013). I took into account the fact that heroin use may have distorted memories and recall, and possibly a failure to recall properly at all.

Interviewer Bias

The interviewer is the instrument used to collect data in qualitative studies. If the instrument is not rigorous, or fails to show integrity and trustworthiness in the ability to collect valid data, institutional review boards (IRBs) may not approve a study at all (Chenail, 2011). Chenail goes on to say interviewers must take the time to understand and know how to interview and analyze data transparently and reliably in order for findings to be valid. The deficit in interviewer ability can affect the entire study and that lack of confidence in ability can ultimately cause a risk and harm to participants (Chenail, 2011). If the researcher performing the interviews is uncomfortable with any of the research process, or with whom they are interviewing, that discomfort poses a problem to the truth of the data collection and analysis process. Interviewer biases against the study or

participants may affect how data is perceived and eventually analyzed, which in turn affects the research quality as a whole (Chenail, 2011). Personally, I do not have experience with incarceration or heroin; however, I practiced bracketing to ensure elimination of my own personal biases. Bracketing helps to acknowledge and remove preconceptions from a study (Tufford & Newman, 2012). Preconceptions are values, emotions, theories, assumptions, and personal interests, all of which can affect how data is interpreted (Roberts, 2013; Tufford & Newman, 2012). Another addition of knowledge I would like to add is that I provided life coaching to individuals, this being my 30th year in business. When I work with someone I know, or know of their story and life issues, I will provide disclaimers, such as, 'Before we get to this, I want to mention that I already know this about you or your life': By doing so, I put my personal thoughts and knowledge on the table. This awareness helped as I interviewed heroin-addicted offenders, because I am aware of my personal thoughts as I speak with people. I journaled my personal feelings before and throughout the study to ensure data is genuine and true to the participants rather than to meet my preconceptions.

Generalizability

This study used purposeful sampling rather than random, and therefore cannot be generalized to the whole of society (Feng et al., 2013). Although this study is not generalizable to a larger population, correctional administrations, public health, and health care personnel may find the results helpful in determining best practices for offenders with histories of heroin use. Generalizability may be limited to this community

because of particular demographics, specifying social implications to this community alone.

Implications for Social Change

Social change is how community members construct their environment as they move through it. Wanting something better for others and ourselves, seeing deficiencies and injustices, knowing there is a better way…those thoughts are the impetus for social change. However, social change does not happen overnight, rather usually requires some form of activism to get the needs and points across that change is necessary (Bashir, Lockwood, Chasteen, Nadolny, & Noyes, 2013).

Social change affects social policies and justices, and guides policy makers, administrators, and professionals on what individuals and social groups see as necessary change, nevertheless, without a noted need for the change, actual change may not occur (Ganesh & Zoller, 2012). Ganesh and Zoller point out the need for democratic processes and scholarly input to enable an increased chance of social change through the reporting of issues, and theorizing activism as the primary force behind social change. Parker et al. (2012) share the stance that activism is imperative in social change processes, and that sharing positive, collective experiences can facilitate social change inadvertently.

Social policies frame the focus on social change so there is a continuous cyclic event that needs addressing as times change (Jimenez, Pasztor, Chambers, & Fujii, 2015). Jimenez et al. go on to say policies may go unchanged for many years, so new studies that provide pertinent information and finding to perpetuate positive social changes are needed. Livingston, Milne, Fang, and Amari (2011) concur that social change takes time;

however, in relation to heroin abuse, social stigma plays a role in the need for social change, because society's perception of heroin users perpetuates negative social constraints. This falls in line with Parker et al. (2012) who argued that presenting one's perspective and experiences could contribute to the movement of social change. Sharing the experiences and perspectives of heroin-addicted offenders can offer needed information and exchange to improve how policies are written, and people are treated. Changing how social workers, correctional facilities, and public health and health care facilities treat heroin users can positively affect social change (Livingston et al., 2011).

In addition to the possible changes in perspectives, procedures, and policies, the results of this study may help reduce the burden of heroin addiction on society as a whole. According to McDonnell and Van Hout (2011), understanding what heroin addicts go through during times of cravings or relapse, including the mental stress and thought processes experienced, may help save more lives from overdose, partaking in criminal activities, and struggling through life in general. Understanding what heroin addicts perceive and believe to be the best course for sobriety can provide city officials with information that can direct resources in the proper direction and save city funds (McDonnell & Van Hout, 2011). City administrators and health officials might see expenditures caused by heroin addiction lowered by using the results of this study to keep individuals clean, protect them from harm, and promote sobriety in a way addicts see fit.

Harm prevention groups may use the findings to better focus resources through the understanding of perspectives provided anonymously, in addition to what offenders might withhold from others in group therapies due to social insecurities (Feng et al.,

2013). Public health officials can use the findings of this study to educate community members about heroin addiction and the stigma associated with being a recovering, heroin-addicted offender. Substance abuse in general is associated with crime and illegal behaviors, setting drug users apart from non-users with health and medical conditions, as socially unacceptable (Livingston, Milne, Fang, & Amari, 2011). Health care workers are not exempt from biased or prejudiced thinking, as many believe heroin users abuse the system and resources, and fail to adhere to treatment recommendations (Bowman et al., 2013; Livingston et al., 2011). Communities need social changes that pave the way to proper treatment of and understanding for addicts to move to sobriety. These potential changes to community practices may help to promote positive social changes as described by Bashir, Lockwood, Chasteen, Nadolny, and Noyes (2013), and Livingston et al. (2011), by presenting heroin-addicted offenders' perspectives and experiences in relation to their sobriety upon release, thereby providing the needed insight into understanding heroin users.

Summary

In this chapter, I presented the structure and goals of this qualitative, phenomenological study, and the research questions used to guide the research process. To fill the gap and add to the current literature, I present a study that will explore the experiences and perspectives of heroin-addicted offenders, a sample of the population that is understudied in the incarcerated setting. By examining heroin-addicted offenders' experiences, I obtained information that showed public health and health care professionals, and correctional administrations what heroin-addicted offenders believe to

be the best path to sobriety upon release from jail, in addition to enhancing the process experienced while trying to abstain and become sober.

In Chapter 2, I discuss the literature as it applies to (1) the theoretical framework of this study, (2) the history of heroin use, and its affect on the normalcy of life, (3) the research questions and how they guided this study, and (4) the research method applied. In the literature review, I built a framework using current literature explaining studies of heroin use, addiction, criminal acts, and treatment. The literature presented also provided illumination on the main ideas of heroin addiction, in addition to personal autonomy, self-efficacy, and how personal choice can positively affect life outcomes.

In Chapter 3, I provide the details of how I completed this qualitative, phenomenological study of heroin-addicted offenders' experiences of sobriety upon release from jail. I also describe why I chose empirical phenomenology over other methods, the sampling and recruitment process, data collection procedures, and how I analyzed and protected the data and participants throughout and after the study. I also explain my part as the researcher in addition to bracketing any assumptions or biases to improve transparency and rigor.

In Chapter 4, I provide the results and themes that emerged according to the participant views and statements. I explain the recruitment process as it happened, as well as details about the initial and follow-up interviews. I describe explanations of how data collection and analysis occurred, as well as providing brief participant profiles. Data quality and saturation are explained, in addition to how I achieved a rigorous and

trustworthy study. Lastly, I show the themes that emerged as well as the factors that helped developed them in tandem with participant statements and experiences.

In Chapter 5, I provide the recommendations, conclusions, and summaries developed from the findings of this study. I wrote up my interpretations of the findings in relation to DeCharms' (1968) theory of personal causation. I discuss the factors that developed the themes, as perceived and experienced by participants. I provide recommendations for health care, public health, and jail officials for future treatments and social change, and recommendations for future studies that emerged from this study. Limitations are presented to show where this study was cut off, and to provide a clear direction for any who wish to remake this study using those limitations. To complete the chapter I provide my personal experience with the participants per my beliefs and expectations, and end with the summary of the study.

Chapter 2: Literature Review

Introduction

The purpose of this qualitative, phenomenological study was to explore the experiences of heroin-addicted offenders' pathways to sobriety upon release from jail.Fisher, Manoogian, and Hoover (2016) assert that scholars recognize the critical importance of qualitative studies in understanding addiction and the addicts' experiences with sobriety. The theoretical framework of this study was deCharms (1968) theory of personal causation that deals with personal autonomy and how individuals perceive themselves in relation to the events in their lives. Specifically, I examined heroin-addicted offenders' feelings of causation and motive behind the behaviors to either relapse or maintain sobriety when released from jail. I focused on heroin-addicted offenders with injectable drug use histories and not simply incarcerated due to drug offenses. In this chapter I present literature relevant to heroin-addiction, heroin user perspectives, drug therapy while incarcerated and postrelease, and the effects of options and choices on motivation towards relapse or sobriety in relation to the theory of personal causation. I explore the listed topics for information relevant to this study and its participants. I also discuss the phenomenological approach and its use in this study, as well as its relevance as the proper approach needed to complete this study.

Literature Search

Although there is abundant literature on heroin-addiction, incarceration, and drug therapies, literature is limited regarding the experiences of heroin-addicted offenders. The literature search for this study focused on heroin addiction, incarceration, and offender

perspectives. Relevant literature dated from 2011 to 2016 was found in Google Scholar, ProQuest, ELSEVIER, Springer, PsycINFO, PsycArticles, PubMed, and APSCJournals. Literature on the theory of personal causation dates from 1968 onward in an attempt to describe classical theoretical attributes and refined positions on the theory of personal causation and motivation. I searched databases using the following key words: *qualitative, phenomenological, heroin-addicted, incarcerated, drug therapy, intrinsic motivation, extrinsic motivation, theory of personal causation, personal choice, drug-related crimes, sobriety, Vivitrol, buprenorphine and methadone treatments, deCharms, self-determination theory with relation to substance abuse, theories of substance abuse, heroin use in the U.S., barriers to treatment, readiness to quit,* and *social change for addicts.*

I located literature that matched as closely as possible to the desired needs for support of heroin-addicted offenders, drug-related crimes and incarceration, and DTT, in addition to how people see themselves in the process of motivation. DeCharms' theory of personal causation originally was based on student abilities and learning in the classroom; however, it evolved into theories on intrinsic and external motivation used in studies involving substance abusers, drug treatment, and recidivism. Although the theory expanded from educational aspects to public health and criminal justice subjects, literature is limited, particularly in the case of qualitative studies. All literature pertained to answering the research questions. The following section outlines the theoretical framework applied to this study.

Theory of Personal Causation

DeCharms (1968) proposed the theory of personal causation, explaining that people see events in their lives as either origin moments, controlled and decided by themselves, or pawn moments, happening to them without their consent. This theory explained that an origin or pawn experience may be externally or internally felt and expressed, causing people to feel in control or motivated or else pushed around, coerced or forced, respectively (deCharms, 1977). When individuals believe they have had an origin experiecne, they accept the outcome as their own, good or bad, and see themselves as the "author" of the event, knowing they made the choice to create the result (deCharms, 1968; deCharms, 1977, deCharms & Muir, 1978). For heroin-addicted offenders, perceiving treatment and sobriety as a challenge rather than a threat to their autonomy and choices is the basis of applying deCharms' theory of personal causation.

Personal causation is described as an immense drive to be capable of making changes in an environment (deCharms, 1968). It is not the same as having a motive to act; rather, it is people experiencing themselves as the cause of events (deCharms, 1992). When persons have origin experiences, they find themselves positively motivated as the cause of desired changes (deCharms, 1992). Having the confidence in one's abilities to complete a task successfully is a product of origin behaviors and events, through choosing the activities to partake in and determining one's own path and goals (deCharms, 1992).

When considering heroin-addicted offenders, pawn and origin events and actions may determine a pathway to sobriety and long-term recovery. DeCharms labels moments

when an individual perceives reality, is self-determined to accomplish goals, acts responsibly, has self-confidence, and sees the world as a challenge as origin moments. Pawn moments are defined as when persons feel a goal is imposed on them by another, when they do not consider reality, act irresponsibly, lack self-confidence, or react to situations as threats (deCharms, 1992). Many studies show that life experiences without family and social supports in addition to life disruption due to substance abuse and incarceration may be perceived as pawn moments and the absence of personal control (Fisher et al., 2016). This can lead to a circular perpetuation of self-reinforcing and determining emotions and actions that makes causality unclear. A sense of personal control promotes feelings of responsibility, thereby enhancing pursuit of social supports, which in turn enhance a sense of purpose in life and feelings of personal control (Wallace et al., 2016). As with anyone, addicts experience internal and external feelings of motivation (deCharms, 1968; deCharms, 1992). Offenders experience life differently because others make decisions for them, causing offenders to feel more externally motivated and pressured to act personally, occupationally, legally, and medically (Millere et al., 2014).

DeCharms & Muir (1978) elaborated on the theory by introducing the locus of control (LOC) and motivation by stating that once individuals recognize they have control over their lives and decisions, they are then able to set goals based on their ability to realistically achieve them, furthering their self-confidence and perception of personal control. Chaturvedi (2015) elaborated on this ideology by stating that when a person understands who they are, they then have the chance to change and create the life they

want. Individuals with a high LOC believe that their actions create their life situations and that they author their own successes. Individuals with a low LOC believe that successes happen because of fate, luck, and unpredictable forces (Chaturvedi, 2015). The theory of personal causation was developed for schoolchildren in an attempt to help them to better cope with classroom issues and feelings of loss of control (deCharms, 1968; deCharms, 1977; deCharms, 1992). However, the theory of personal causation has supported studies seeking to discover how internal and external motivation play a role in pathways from substance abuse to sobriety (Chaturvedi, 2015; Millere et al., 2014) and is well suited for the study of addiction and incarceration.

Millere et al. (2014) conducted a study on 108 substance abusers to examine treatment motivation and the factors involved in motivation to quit using. Using deCharms (1968) theory of personal causation they were able to apply the theory and focus on the influences of motivation and its origin in actions. Millere et al. discovered that the motivation to maintain treatment was greater after treatment began than before substance abusers entered treatment. Users also discovered the treatment process and the increase in self-confidence to complete treatment enlightened them, thereby encouraging them to continue (Millere et al., 2014). Chaturvedi (2015) concurred with Millere et al.'s study that improving a participant’s knowledge base increased participant LOC and perception of personal control. Chaturvedi added that by increasing personal recognition of abilities and capabilities improved participants' outlook for a healthy lifestyle, not using recreational drugs, and improved coping skills.

Ryan and Deci (2000) built on the theory of personal causation by stating that what one person finds fun and motivating may not be the same for someone else, such as attending DTT. Motivations to act under any circumstance may be internal or external, and desired either by the self (I), or by courts, family, and other forces, respectively. Wentzel (1999) completed a study on motivation and relationships in schools to understand how students were motivated to act and learn. Wentzel explained that the "I" in a statement such as, I can complete drug treatment or I can get clean, expressed a person's belief in their ability influence actions authored by them (Wentzel, 1999). A statement such as, "I am getting clean because I want to" expresses personal choice, ability, and autonomy, placing personal authorship on future events, as in deCharms theory of personal causation. In contrast, an example of a pawn moment involving motivation would be addicts attending DTT and maintaining sobriety not because they want to but because they are externally motivated or forced to do so to keep their children.

Dannenberg et al. (2012) conducted a study involving 45 participants, to discover how people attribute causation to their actions and outcomes. The study focused further on how individuals perceive authored events prior to them happening, showing that if individuals saw an outcome prior to acting, they were more likely to attribute causation to themselves as author of the event (Dannenberg et al., 2012). By considering previous authored events and outcomes, individuals reported wanting to do something different the next time in order to change the outcome (Dannenberg et al., 2012), which is supported by Chaturvedi (2015). Studies have shown that upon release, heroin-addicted offenders

have limited choices, and their social, family, financial, and employment supports are frayed (Wallace et al., 2014).

Social supports for ex-offenders are vital to their success upon release not only to rebuild their lives, but also to increase success with sobriety and recovery. The choice to maintain relationships, employment, and other obligations is removed once an individual is incarcerated, which leads to high stress and feelings of powerlessness as well as a poor view of self (Wallace et al., 2014). Increasing treatment options and positive opportunities for offenders has been shown to decrease recidivism and increase the likelihood of the offender maintaining sobriety (Fisher et al., 2016), and being able to choose allows individuals the chance to create origin experiences rather than pawn moments, thereby increasing the awareness of personal causation (deCharms, 1968).

The theory of personal causation can support the study of heroin-addicted offenders because it provides the foundation for motivation and actions, with the individual as the author of situations and life events. This study examined how heroin-addicted offenders saw themselves in the course of addiction and recovery in the context of the theory of personal causation. Next, I consider concepts related to addiction and recovery among heroin-addicted offenders.

Positive Options and Choices

Choices allow people to decide for themselves what they want and do not want. Choices give people a feeling of control over their path and destiny. Consider children who have to listen to what their parents say, throwing a tantrum whenever there is a lack of choice provided, leaving them to live with whatever their parents decide for them.

Powerlessness, a loss of autonomy, and a loss of control are the result. Having options, positive choices, and the ability to choose, increases autonomous feelings, confidence in one's own ability to make decisions, and increases motivation to do for oneself in a positive way (Savani, Stephens, & Markus, 2011).

Humans have the ability to make choices, and having access to rewarding pursuits other than drugs gives people the feeling of autonomy (Ahmed et al., 2013). Studies have shown that given choices, that individuals may make the right choice simply because they are able to do so, with no one telling them which choice to make or limiting choices for them (Savani, Stephens, & Markus, 2011). There is limited literature on heroin-addicts' perspectives of personal choice and how it affects their lives, and most data collected relates to motivation and personal control; however, having choices has been shown to provide positive outcomes when heroin abusers can choose their treatment options (Geers et al., 2013). Geers et al. state that although there is a growing body of evidence to support the outcomes associated with choice, little is of qualitative nature. Research suggests that being in control of one's life is a 'vital' human motive (deCharms, 1968; Geers et al., 2013, p.550), and having a choice allows individuals to exert control over their situations and life events (Geers et al., 2013).

Traditionally, when a person has a health problem, they see a doctor who prescribes a medication and treatment in an attempt to fix the problem. Research has shown that when a person perceives himself or herself as a decision-maker in their treatment process, they subsequently perceive more control over the health stressor, and cope better with treatment as a whole (Geers et al., 2013). For heroin-addicted offenders

who are incarcerated and later released with treatment mandates and parole contingencies, having a choice about treatment may increase the chances of sobriety maintenance as shown by previous studies (Lutman, Lynch, & Monk-Turner, 2015; Neale et al., 2013). The desire to fix unpleasant health issues extends to substance abuse, and allowing heroin addicts to choose treatment options may build the personal control needed to carry out a positive path of sobriety (Geers et al., 2013). The element of personal control falls into this study as a possible factor that increases positive treatment outcomes.

Choice allows people to live as independent, autonomous beings who are in control of their life events and outcomes (Savani, Stephens, & Markus, 2011). When given the option to choose a pathway, people are more likely to accept responsibility for their actions and outcomes, increasing personal control and feelings of self-confidence (Savani et al., 2011). Previous research supports the idea that with more options available, heroin-addicted offenders, regardless of social stressors, may take more control over their path to sobriety upon release (Savani et al., 2011). However, in contrast, Ahmed et al. (2013) found that even with choices available, addicts might still choose heroin due to the pathology of addiction rather than a lack of or presence of choices. Ahmed et al. (2013) found that not only choice options, but also a choice of positive activities and new opportunities helped to increase sobriety. Regardless of research that shows statistically positive results of drug therapy while incarcerated, offenders' perspectives show that the lack of control of one's choices is a hindrance to truly deciding what they want (Frank et al., 2015).

Many offenders enter back into society with broken social networks, difficulty obtaining employment, social stigmas, and financial barriers that work against their attempt to regain normalcy (Fox et al., 2014; Nyamathi et al., 2014). Social supports can enhance feelings of purpose and subsequently feelings of personal control in ex-offenders, which ties into the ability to make choices rather than have others make choices made for them (Wallace et al., 2016). Accepting responsibility and authorship for events in life are posited by deCharms (1968; 1992), that people feel more motivated to act in positive ways when they feel in control and are less-influenced by outside sources. The ability to make choices about family, employment, financial obligations, and treatment may increase autonomous feelings in individuals, and when coupled with personal control, increases self-confidence levels that in turn decreases the chances of relapse and recidivism (Nyamathi et al., 2014).

Heroin addicted offenders experiencing release transition through a difficult time of uncertainty about life, supports, personal abilities and control, and treatment (Fox et al., 2014). Studies show that individuals experiencing painful situations and ill health often feel hopeless and helpless (Geers et al., 2013). The introduction of treatment choices into the lives of heroin-addicted offenders upon release may bring about positive changes in what they believe to be possible in regards to sobriety. A lack of treatment options within the first two weeks of release from incarceration may pose a threat to sobriety (Fox et al., 2014). Individuals with high autonomous orientation are motivated to act according to personal desires, goals, and objectives, and people who feel autonomous may choose for themselves (Wong & Rowland, 2013). According to deCharms (1968)

when people experience themselves as the 'origin' of their life events they are then more likely to be intrinsically motivated and in control of choices. Ahmed et al. (2013) provide findings that show how positive life choices build perceptions of personal control and self-confidence in individuals, which may bode well for heroin-addicted offenders upon release. Positive life choices and options do not always amount to positive choices made, and when addiction takes over, many addicts will do what they need to do to obtain drugs and a high. In the following section, I describe the differences between quantitative and qualitative studies, in addition to qualitative methods and phenomenology.

Review of Literature Related to Methodology

Qualitative and quantitative studies differ greatly in approach, purpose, data collection and analysis, and results (Barusch, Gringeri, & George, 2011). In this section I describe the differences between approaches, and purpose for choosing a phenomenological approach, in addition for presenting the considerations for various methods that have been used to investigate heroin-addicted offenders in order to inform the approach to this dissertation study.

Qualitative Versus Quantitative Method

Qualitative research is inductive and seeks to discover the essence and phenomenon happening within a particular group (Barush, Gringeri, & George, 2011). The objective of qualitative research is to study human behaviors and experiences, thereby shedding light on the studied phenomenon, whereas quantitative research sets out to support or reject hypotheses derived prior to collecting data, using theories to base their research on (Barusch et al., 2011). Qualitative studies search for themes during data

analysis that appear because of repetition or expression by participants, and help provide answers that may have been unexplored, undiscovered, or unknown.

Another difference between qualitative and quantitative studies is that qualitative studies aim to collect spoken, visual, or recorded data that researchers are unable to quantify, measure, or total, whereas quantitative research searches for measurements, correlations, and relationships that provide percentages and comparisons, and analyzes data using mathematical methods and statistics (Barusch, Gringeri, & George, 2011; Yilmaz, 2013). Both approaches study phenomena and human behaviors and problems, however, quantitative research seeks to test a theory using variables and then explain or predict phenomena (Yilmaz, 2013). Qualitative research does not set up a study with expectations; rather it allows the processes and experiences to happen naturally (Yilmaz, 2013). Being that quantitative research would not allow the collection of in-depth descriptions of heroin-addicted offenders' lifestyles, I chose the qualitative approach to facilitate the gaining of knowledge that is socially and psychologically constructed (Yilmaz, 2013).

Lillefjell, Knudtsen, Wist, & Ihlebæk (2013) stated that public health and healthcare programs and facilities benefit from evidence-based practices derived out of statistical studies; however, qualitative studies identify strengths and barriers specific to communities, and may reveal distinctive humanistic best practices for public health and healthcare management that quantitative studies cannot due to methodology. Lillefjell et al. continued by stating that qualitative research can enhance and support quantitative statistical findings with information unattainable with scales and measures. With the

knowledge that a qualitative study enables the gathering of data related to personal experiences expressed verbally, that which a quantitative study cannot do, I discuss further in-depth qualitative methods in the next section.

Qualitative

Qualitative methods are useful in harnessing and exploring the lived experiences of participants. Qualitative studies allow the researcher to interview participants for subjective matter pertaining to the studied phenomena, thereby allowing the essence of the phenomena to be uncovered (Tufford & Newman, 2012).

Qualitative research was the best way to address the research questions asking how offenders experience sobriety upon release (Neale et al., 2013), whereas quantitative research asks for the elements of comparison or value in an offender's life regarding sobriety. Quantitative research would not capture the depth of elements of behaviors and experiences needed to answer the research questions. Quantitative research applies a deductive approach attempting to validate hypotheses, and test or prove a theory, but the best method for gaining knowledge on heroin-addicted experiences is through inductive research such as phenomenology (Roberts, 2013). Phenomenology is a philosophical approach developed by Husserl as a means of obtaining the essence of a lived experience (Roberts, 2013). Phenomenology is a non-experimental form of inquiry that allows researchers to obtain human phenomena, and gain understanding through interpretation.

Phenomenology

Phenomenology is a means of attaining insights from perspectives and experiences that happened at a particular time in an individual's life. This approach

allows researchers a chance analyze phenomena for meanings and essences without pre-configuring the possible outcomes to questions (Roberts, 2013). Researchers used phenomenology to study heroin-addicted offender's perceptions of program availability and services in a correctional setting (Houston, 2013). Houston studied seven incarcerated men 25-58 years of age, convicted of drug-related offenses. Offenders were able to share with Houston how they dealt with health issues and needs when the jail would not meet their needs.

Brunelle et al. (2015) provided a study conducted with a phenomenological approach on 127 participants consisting of drug-users to discover the motivational factors behind changing. Semi-structured interviews employed allowed the collection of data to learn about substance use and the treatments used to recover, while keeping the questioning centered on the experience of heroin (Brunelle et al., 2015). The researchers analyzed the data for themes using a coding grid of predefined codes, still allowing for growth of new themes, as phenomenology ascribes to in terms of theme evolution (Brunelle et al., 2015).

Several phenomenological studies explored treatment needs and options of offenders released from jail (Binswanger et al., 2012; Johnson et al., 2013). Researchers evaluated participant perspectives after data was collected using semi-structured interviews. Atlas-ti and NVIVO data analysis programs helped in organizing the data from both studies for coding, and theme generation. The themes that emerged from the analysis included relapse triggers caused by difficult romantic relationships, uncontrollable emotions, ranging from hurt and loneliness to boredom, mental health

problems, substance illness, and lack of housing and employment (Johnson et al., 2013). Binswanger et al. (2012) found through their research that heroin-addicted ex-offenders relapsed due to poor social supports and inadequate finances and employment. Binswanger et al. interviewed the ex-offenders two months post-release revealing the fear, threats, and dangers that many offenders experience after release. Offenders in the Johnson et al. study expressed the same fears upon release, in addition to the fear of relapse.

Neale et al. (2011) performed a phenomenological study on drug therapy treatment, performing interviews on 30 participants. Collected data was professionally transcribed, and entered into the MAXqda2 qualitative software program for data analysis. The research revealed that those detoxifying from prescription medications were apt to relapse, and none of the participants wanted to be on either heroin or drug therapy indefinitely (Neale et al., 2011).

Kerr, Small, Hyshka, Maher, and Shannon (2012) discovered in their study that heroin is such a strong addiction that users would rather find and use a deadly form of heroin than abstain. Researchers and participants reviewed a televised warning played throughout Vancouver, Canada about a high-potency heroin causing fatal overdoses. Participants consisted of active heroin addicts. Although the addicts were aware of the warnings, their main social focus was on the quality of the heroin, and the subsequent possible high. This study showed through qualitative interviews that the warnings were not working to decrease harm. The National Institute on Drug Abuse (2012) exemplifies

the desire to use a harmful dose of heroin as chronic addiction, despite potentially harmful consequences.

Lutman, Lynch, and Monk-Turner (2014) performed a study on drug-addicted ex-offenders with relation to employment opportunities upon release, and the perspectives shared by employers about their status as recovering ex-offenders. Both employers and offenders took part in interviews to obtain a paradigm perspective of obtaining employment upon release. Themes discovered from participants were the "need for self-acceptance and resilience, a perceived need for consistency in order to achieve success, a strong belief in giving men a second chance, and the need to develop employment strategies and skill to find paid work" (Lutman, Lynch, & Monk-Turner, 2014, p. 63). Themes discovered from employer interviews included the "desire to help others and give back to the community, belief in forgiveness and second chances, hiring clients as an asset to their business, and willingness to aid in clients' social reintegration and reverse social stigmas" (Lutman, Lynch, & Monk-Turner, 2014, p.66).

Phenomenology was the best approach for this study, as it allowed for personal, detailed data collection that can fill the gaps of quantitative, statistical knowledge shown in many studies on heroin addiction and incarceration (Bukten et al., 2011; Evans, Huang, Hser, 2011). I performed a qualitative study with the intention of gaining insight to a phenomenon only experienced by heroin-addicted offenders, a vulnerable group that needed understanding in order to provide the help believed or perceived to work best. I performed semi-structured interviews that allowed participants to elaborate on areas that

helped to answer the research questions rather than vague and broad areas that did not pertain to the study.

Payne and Gaffney (2012) and Larney, Zador, Sindicish, and Dolan (2016) performed similar qualitative studies that allowed incarcerated offenders to provide insights to drug use, relapse, and recidivism; however, both studies were conducted in Australia. Both studies sought to discover why and when heroin-addicted offenders used, and how drug use ended them in jail, but Payne and Gaffney specifically wanted to know which drug of choice correlated to their jail time, while Larney et al. (2016) specifically wanted to know why offenders chose to stay in or leave DTT. In this study, I explored heroin-addicted offenders' experiences regarding heroin use and incarceration, and how social stressors played a role in maintaining sobriety or relapsing, all of which affect an offender's pathway to sobriety upon release. In the following section, I describe how heroin use can lead to criminal activities and incarceration.

Heroin Addicts and Crime

Criminal activity and imprisonment are common happenings among heroin-addicted individuals (Gordon et al., 2015). Those who use heroin have a high frequency of criminal behavior, and certain crimes are commonly associated with heroin use, such as shoplifting, burglary, and robbery (Bukten et al., 2011). In an attempt to keep up with a daily heroin addiction and its expenses, users may resort to 'income-generating crimes', which tend to harm all affected, including family, friends, the legal system and the community (Bukten et al., 2011), with heroin users being more of a burden on public health than all mental disorders combined (Sutherland et al., 2015). The literature about

drug users and crime is voluminous; however, most are quantitative in nature and do not include the offenders' perspectives as to why they committed crimes or were incarcerated (Sutherland et al., 2015). In addition, literature leaves out thoughts and feelings about the best-suited treatments and interventions as perceived by addicts and offenders to prevent reincarceration and sustain sobriety (Sutherland et al., 2015).

Bukten et al. (2011) completed a study with 3,789 heroin-addicted offenders that showed a correlation between the frequency of heroin use and the frequency of crimes committed. The study showed that heroin-addicted offenders most frequently committed crimes that were acquisitive in nature including theft, fraud, and robbery, with drug offences as second most common, including selling and dealing drugs (Bukten et al., 2011; Havnes et al., 2012). According to the results, violent crimes were not associated with heroin use and incarceration; however, violence may be an element of the heroin-addicted lifestyle due to bad drug deals and exposure to illegal dealings and weapons (Bukten et al., 2011; Havnes et al., 2012). Regardless of crime being such a common factor of heroin addiction, Bukten et al. found that more than a third of their participants never received any criminal offenses. Bukten et al. marks participants without criminal charges as possible limitations, because no arrests were ever made on them, yet they could have possibly committed crimes and not been discovered.

Criminal behaviors have been strongly associated with heroin use, particularly acquisitive crimes with arrests and convictions arising from crimes committed (Marel et al., 2013). Marel et al. and Bukten et al. (2011) concur that the chances of arrest are likely if one is using heroin; however, depending on the crime, may not end in arrest. Marel et

al. posits that heroin users commit crimes to sustain their habit based on static elements and dynamic changes that occur over time and influence a user's propensity to use more and commit more crimes, and Haley et al. (2014) provide results showing the influence of static and dynamic factors on relapse upon release. Static and dynamic factors that influence individuals' lives affect if a user relapses, commits crimes, or maintains sobriety (Marel et al., 2013). Marel et al. state that age, sex, and previous life events are unchanging, static factors that may present in heroin users committing crimes, and dynamic factors are psychological, biological, and contextual in nature are changeable and may be the precursors to heroin addiction and crime. Marel et al. (2013) completed a study of 615 heroin-addicted participants and found that one way to decrease criminal activities was to participate in a treatment program or 'age out' of drug use regardless of static or dynamic factors presentation.

According to Marel et al. (2013), crimes committed by heroin addicts tend to be non-violent, in addition to being committed by younger opioid users (Evans, Huang, & Hser, 2011); however, Sutherland et al. (2015) reported that violent offenders reported being under the influence of heroin when committing crimes. Drug-users make up the majority of offenders, with offenses varying by the drug used during crime acts (Sutherland et al., 2015). Out of the 887 people who inject drugs (PWID) studied by Sutherland et al., 18 percent had committed minimal offenses, used heroin, and were younger males: Marel et al. (2013) and Bukten et al. (2011) support these findings. Financial needs, the severity of the addiction itself, and the cost of the drug attribute to crimes committed by heroin addicts (Sutherland et al., 2015). The static and dynamic

factors posited by Marel et al. (2013) also appeared in the results for Sutherland et al. as environmental factors including lower educational background, unemployment, jail time, recidivism, and mental disorders (Sutherland et al., 2015). Payne and Gaffney (2012) add that previous studies of heroin users have shown the main reason users committed a crime was they needed money to buy their drugs, which is supported by Sutherland et al. (2015). Sutherland et al. add that future studies need to include interviews uncovering the motives behind using and committing crimes.

Criminal behaviors and substance abuse are highly correlated and studies show that a large portion of drug users commit crimes to maintain their drug habit (Häkansson & Berglund, 2012). Häkansson and Berglund did a study including 4,152 incarcerated participants with substance use problems. Results showed that those who used heroin and other injectable drugs returned to jail with a 2.7-year span (Häkansson & Berglund, 2012). The study also showed that those who returned to jail had a background of violent behaviors, but were negatively associated with violent crimes. Younger males with violent behavior histories, and heroin addiction were highly associated with criminal acts and behaviors (Häkansson & Berglund, 2012), and Evans, Huang, & Hser (2011) further these findings stating that in their study of offenders, those who posed the greatest risk for reincarceration were young males with histories with law enforcement and corrections.

Although some research shows that heroin addicts have a tendency to commit crimes to fund their drug habit (Gisev et al., 2014), many heroin addicts self-reported that they committed crimes prior to starting heroin (Felson & Staff, 2015). Despite

voluminous findings on the connection between heroin and crime rates, the majority of crimes committed by heroin addicts are non-violent and associated with habit maintenance (Torok, Darke, & Kaye, 2012): Violent people regardless of the drug used while committing the crime may be more apt to commit violent crimes (Barrett, Mills, & Teesson, 2011). Heroin addicts may commit crimes to support their drug habit, albeit, the majority may be non-violent, they are crimes nonetheless against individuals, families, and communities. Recidivism is a possibility when heroin addicts resort to the same behaviors that caused them to jail time initially. Understanding why heroin-addicted offenders recidivate is an important factor in helping them on their pathway to sobriety during release.

Recidivism and Heroin Addicts

Heroin addiction and recidivism correlate, because once a heroin addict is released from incarceration the chances of them reverting back to previous behaviors and habits is possible, which include committing crimes (Hedrich et al., 2012). Offenders who inject drugs such as heroin are more likely to recidivate than addicts who do not inject drugs (McKenzie et al., 2012). Several studies document crimes committed to obtain heroin, such as thefts, shoplifting, and drug attainment or sales (Bukten et al., 2011; Gisev et al., 2014; Gordon et al., 2015). Proper treatments and interventions may prevent recidivism by allowing offenders to feel as if they can obtain normalcy upon release(Neale et al., 2011).

Heroin addicts are highly likely to commit non-violent crimes in an attempt to sustain their addiction needs through robbery, theft, and shoplifting (Coomber, 2015).

The cycle of drug addiction, criminal acts, incarceration, and relapse and recidivism is reoccurring, and happens as addicted, ex-offenders fall back into the criminal aspects of drug abuse and using (Zarkin et al., 2015). Although researchers have completed a large volume of studies to discover what elements are present in the lives of heroin-addicted offenders as part of the relapse/recidivism cycle, there is a lack of perceptions, views, and input from heroin-addicted offenders themselves (Felson & Staff, 2015). The need to understand what is going on throughout the addiction and incarceration process is pertinent to not only the needs of this vulnerable cohort, but to the communities they live within as well, because that knowledge affects success on the path to sobriety.

Approximately 70% of jail inmates are drug users and 55% use in the month prior to incarceration (Taxman et al., 2013). Inmates currently incarcerated for drug offenses or having been under the influence of drugs upon arrest have a higher criminal recidivism rate than those not under the influence (Zarkin et al., 2015). This vicious cycle of arrest and recidivism puts a burden on the criminal justice system and communities as a whole (Zarkin et al., 2015). Zarkin et al. did study which included inmates currently held in a U.S. prison amounting to 1.14 million: researchers used the Survey of Inmates in State Correctional Facilities (SISCF) from the U.S. Department of Justice to gather their data. The focus was on inmates entering a community-based treatment program upon release. Sixty-two percent of the sample had used substances just before incarceration and the remaining used illicit drugs prior to incarceration (Zarkin et al., 2015). The study showed that individuals released into treatment programs upon release were less likely to commit more crimes or relapse immediately (Zarkin et al., 2015). In addition to these findings,

Sharma et al. (2016) and Rich (2014) presented a study completed in New York City by Dole et al. (1969) showing that DTT decreased recidivism and increased treatment continuity upon release, and although this study is dated, it still holds true in 2016. Sharma et al. state that since Dole et al.'s study, little clinical research has been completed in jail settings regarding pharmacotherapy and opioid dependence.

Much research shows that offenders receiving treatment upon release are less likely to recidivate (Sharma et al., 2016; Zarkin et al. (2015); however, Taxman et al. (2013) assert that treatment received during incarceration or upon release does not reduce recidivism. Addressing offender needs in terms of substance abuse is a factor that weighs heavily on abstinence and sobriety, and studies have shown that nearly 70% of ex-offender arrests made within three years of release are for substance abusing offenders' failure to maintain sobriety (Taxman et al., 2013). Research has shown that drug use is not only a habitual behavior experienced daily in the lives of users, but it is also a factor in their criminal behavior (Taxman et al., 2013). Studies show that treatment programs for inmates while incarcerated and upon release can help reduce recidivism; however, for every eight receiving treatment, only one will be prevented from recidivating (Taxman et al., 2013). The reason behind these findings is that offenders do not always receive the needed or proper treatments while incarcerated (Taxman et al., 2013; Wakeman & Rich, 2015), and treatment is not always available upon release due to financial constraints or the choice not to be treated (Taxman et al., 2013). Matching treatments with offender needs is an expansion of the criminal justice and substance abuse treatment areas that needs adjusting and insight (Taxman et al., 2013), which can only come from drug users'

experiential input. A substance abuse program's effectiveness has a bearing on offender outcomes; therefore, quality drug programs and supports during incarceration and release may prevent relapse and recidivism (Taxman et al., 2013).

Public health and health services officials spend much time addressing the potential harm aspects of heroin addiction and criminal acts in communities (Kolind, Holm, Duff, & Frank, 2015). The cost of health care to societies each year is approximately 366 billion dollars in crime, incarceration and recidivism, and drug and law enforcement (Wakeman & Rich, 2015). Preventing relapse and recidivism is a community issue that needs focus. Another focal issue is that correctional institutions do not recognize their treatment role as a service provider, and by starting treatment within the jails, correctional centers promote better outcomes for offenders. Häkansson and Berglund (2012) add that heroin use increases the chances of recidivism, in addition to relapse upon release, and stress the importance to users and communities as a whole of treatment immediately after release.

Häkansson and Berglund (2012) state that heroin abuse and criminal behaviors are closely related, and crimes are likely to be committed due to financial needs and the cost of heroin. In their study of 4,152 prisoners in Sweden, 2,862 or 69%, recidivated and tied the return to jail with heroin and injectable drug usage. Previous research has shown that DTT and counseling together, or medically-assisted treatment (MAT), while incarcerated and upon release can decrease the chances of relapse and recidivism (Häkansson & Berglund, 2012; Substance Abuse and Mental Health Services Administration, 2015b); however, offenders are indifferent about treatments and

substitution therapies (Larney, Zador, Sindicich, & Dolan 2016). Larney et al. (2016) found in their study of 46 offenders in Australian prisons that uncertainty about starting, continuing, and leaving treatment was a difficult process. The offenders stated that entering a DTT program helped them to deal with withdrawal symptoms while incarcerated, or the possibility of injecting in prison and contracting hepatitis C (Larney et al., 2016). Regardless of the findings showing positive outcomes, other research shows that upon release, offenders chose to opt out of treatment due to possible issues when obtaining methadone or buprenorphine, such as social stigma, and reunions with other addicts (Larney et al., 2016). Larney et al. also found that offenders chose to stop methadone treatment they were receiving while incarcerated with the intent to start buprenorphine treatment upon release, because it was easier to conceal from family members, offered easier withdrawal symptoms upon abstaining altogether, and had a relative lack of stigma compared to methadone.

Offenders reported that they turned down drug therapy while incarcerated in order to be 'clean' and abstain from any type of drugs, including those considered for therapeutic purposes (Larney et al., 2016). Offenders mentioned staying on drug therapy upon release to maintain the stability they have achieved while incarcerated, including the ability to turn down drugs when faced with stressors associated with incarceration and release (Larney et al., 2016). Previous studies have concurred in volumes that stressors upon release can increase the chances of relapse, and the potential for recidivism. Communities need to plan for the possibility of relapse offenders with injectable drugs, because it may increase recidivism, and increase further when coupled with heroin

(Häkansson & Berglund, 2012). Given the cost of heroin, criminal behavior is associated and not surprising, and heroin addiction treatment has produced decreases in the possibility of future criminal acts (Häkansson & Berglund, 2012).

In an Australian study of 34,962 people, Gisev et al. (2014) found that illicit drug use is correlated to non-violent crimes; however the drug markets associated with heroin use were reported as highly violent, lending to the reason heroin addicts are prone to recidivism. Payne and Gaffney (2012) concur that heroin- addicted offenders have a higher risk of recidivism, and those who inject drugs are three times more likely to recidivate than non-injecting drug users. In their study of 1,884 Australian offenders interviewed by Payne and Gaffney, 52% of the offenders indicated that drug abuse was an element in their arrest, and heroin was the most common mentioned drug of choice in the most recent offenses. Out of that 52%, 45% attributed their recent arrests to heroin as either they (1) needed money to buy it, (2) were high on heroin, or (3) were hanging out to buy their heroin (Payne & Gaffney, 2012).

The possibility of incarceration increases when an individual uses heroin, because of the situations and circumstances evident in heroin-addicted lives: Buying and using in questionable settings, and committing crimes to sustain the heroin habit may result in reincarceration. A multitude of research provides results showing the connection between heroin use and crime, and both quantitative and qualitative studies have captured the evidence needed to show the correlations. The majority of qualitative studies located, however, occurred abroad in European, Asian, and Australian locations rather the United States (Kolind, Holm, Duff, and Frank, 2015; Payne & Gaffney, 2012; Sutherland et al.,

2015). Presenting experiences and perspectives of U.S. offenders will add to the collection of information needed in the fight against heroin use and recidivism. The following section depicts how DTT during incarceration and upon release can prevent further crimes, recidivism, and relapse.

Drug Treatment While Incarcerated and Upon Release

Drugs substituted for heroin and other opioids during treatment are methadone, buprenorphine, Vivitrol, naloxone, and naltrexone (Marel et al., 2013; Zaller et al., 2013). According to the Substance Abuse and Mental Health Services Administration (2011), each year approximately 20 million Americas with substance addiction do not receive treatment, and most heroin-addicts experience health care costs that are twice as high as individuals without substance abuse disorders (Urada, 2014). There is a plentitude of research dedicated to heroin addiction, crime, and recidivism, all of which connect through treatment provided to or the failure of provisions to offenders (Gisev el al., 2014). There is a need to apply more focus on treatment programs for incarcerated offenders as a means of decreasing recidivism and relapse, and Sharma et al. (2016) add that clinical research is lacking regarding DTT in jails. Addiction is a chronic disease that requires treatment just the same as someone with diabetes or congestive heart failure, all of which can end in an early death. Providing DTT during incarceration provides treatment during a time when drugs are usually limited, and detoxification is possible; however, releasing a heroin-addicted offender into a community without treatment lined up is setting them up for overdose, relapse, and possible reincarceration. In the following section, I discuss how DTT can help prevent future crimes and possible reincarceration.

Recidivism Prevention

Crime reduction and recidivism prevention are noted in studies where increased treatment retention was a focus (Marel et al., 2013), but keeping heroin-addicted offenders in treatment is an element that exists and may be a problem (Brorson, Arnevik, Rand-Hendriksen, & Duckert, 2013). Although there is a tremendous amount of literature showing how DTT helps prevent recidivism and crime, DTT is uncommon, and offenders rarely receive DTT upon release (Sharma et al., 2016; Wakeman & Rich, 2014). Completing treatment increases abstinence and a higher probability of gaining employment, and decreases crime rates and relapses, which altogether decrease the chance of recidivism (Brorson et al., 2013). Heroin use and crimes may occur together whether charges occur or not, because many crimes committed are non-violent thefts, shoplifting occasions, and a user's presence at a drug-buying site (Felson & Staff, 2015). DTT correlates to crime and recidivism prevention (Brorson et al., 2013).

Cepeda et al. (2015) completed a study in Russia including 269 heroin-addicted injecting participants with offending backgrounds. Results showed upon release, offenders were more likely to relapse and recidivate due to a lack of drug treatment options as well as the inability to obtain employment (Cepeda et al., 2015). Unemployment is a social stressor and barrier to sobriety, not only in Russia, but also as a finding around the world (Mowen & Visher, 2013). DTT for both incarcerated and released offenders is illegal in Russia despite clamant evidence from international sources on the benefits of treatment for both users and communities (Cepeda et al., 2015), and differences between countries' "legal, clinical, and administrative" proceedings are

constraints regarding prison DTT (Gisev et al., 2014; Hedrich et al., 2012, p.514). The participants in Cepeda et al.'s study reported relapsing in the company of a friend, while only a few relapsed alone, in addition to the influence of being unemployed thereby perpetuating the cycle of drug use, incarceration, relapse, and recidivism. This research showed that drug treatment during incarceration and upon release could reduce the risks of relapse and recidivism (Cepeda et al., 2015).

DTT is effective at treating opioid dependence (Davoli et al., 2015), and the benefits include treatment retention (Hedrich et al., 2012), reduced heroin use, incarceration and recidivism, and positive social and legal outcomes (Schwitters, 2014). An issue reported is that treatment disruption happens when an offender enters and leaves the jail setting (Hedrich et al., 2012; McDonnell, Brookes, & Lurigo, 2014). Disruption of treatment while incarcerated may be in part to administrative uncertainty about drug usage to treat heroin addiction, program costs, and inefficient staff training (Hedrich et al., 2012; McDonnell et al., 2014). Correctional institutions do not realize their healthcare impact on offender health, and therefore do not provide many of the treatments needed by drug users who are incarcerated (Kopak, Hoffmann, & Proctor, 2016); however McDonnell et al. (2014) argue that correctional institutions are ill-equipped at providing health care and 'often do so only under threat of litigation' (p.2). Schwitters (2014) and Hedrich et al. (2012) recommend the implementation of DTT in jails, because it (1) reduces injectable drug use while incarcerated, (2) provides continuity of therapy (Havnes et al., 2012), (3) decreases the chances of relapse and recidivism upon release

(Hedrich et al., 2012; Marel et al., 2013), and (4) helps keep offenders in treatment longer upon release on their path to sobriety (Marel et al., 2013).

Hedrich et al. (2012) report that DDT using buprenorphine and methadone are the most common substitutes for heroin and other opioid addictions; however, Vivitrol, naloxone and naltrexone, buprenorphine blends, have been shown to work as well if not better than methadone in terms of treatment ease , treatment retention , and sobriety maintenance (Neale et al., 2013). These substitutions not only aid in breaking the heroin habit, they work to relieve the pain associated with withdrawal (Kolind, Holm, Duff, & Frank, 2015). When offenders took part in DTT during incarceration, self-reported criminal activity decreased post-release; however, that status did not continue past six months (Hedrich et al., 2012). Hedrich et al. did find a discrepancy in DTT albeit a positive option, involving dosages, and offenders who received lower dosages of methadone were more likely to recidivate compared to those who received higher dosages. Gisev et al., 2014 add to the findings that heroin-addicted offenders who have more incarcerations and longer criminal histories are associated with shorter DTT retention.

DTT provides the support heroin-addicted offenders need to pursue a pathway to sobriety while they transition from incarceration to release. Preventing crime is one outcome associated with DTT, because it removes the pain and cravings associated with withdrawal, and hence the need to acquire drugs to end withdrawal symptoms (Bukten et al., 2011). Extensive research findings show associations between heroin addiction and crime as being common (Bukten et al., 2011; Havnes et al., 2012). A study including a

national cohort of DTT recipients totaling 3,221 participants resulted in less violent crimes associated with heroin addiction, and reduced societal costs associated with incarceration and crime (Havnes et al., 2012). Studies showed those offenders who remained in treatment throughout incarceration and release were less likely to commit crimes (Havnes et al., 2012; Marel et al., 2013); however, those who dropped out did not produce such findings, rather their criminal acts increased or reverted to pre-incarceration levels (Havnes et al., 2012). In addition to finding the differences in criminal acts of offenders who remained in DTT compared to those who dropped out, Havnes et al., also discovered that the crimes committed resulted in acts that are more violent. A limitation of this study was that those who mixed heroin with methamphetamines committed violent crimes more often than those who did not mix heroin with methamphetamines (Havnes et al., 2012), which contrasts Felson and Staff (2015) who found that heroin and methamphetamines were used least often when committing crimes. The clinical implications of DDT are that although offenders may take part in treatment, if they have a history of violent crimes, then they will continue to commit violent crimes regardless of continuation of treatment or dropping out (Havnes et al., 2012).

Gordon et al. (2015) completed a study involving 27 inmates who received drug treatment while incarcerated with follow-up injections of drug therapy occurring with only 10 of the initial sample due to attrition. Offenders who did not complete the treatment injections recidivated or were re-arrested (Gordon et al., 2015). The need for DTT upon release is explicit and officials in both jails and the community need to develop transition programs that route heroin-addicted offenders from incarceration to a

treatment provider immediately. The cost of treating this chronic disease in a casual manner is high in terms of expenses for incarceration, crimes committed, and community losses, in addition to family, relationships, and personal losses. In the following section I discuss DTT and how it is used in both jails and the community, in addition to heroin-addicts' perspectives of DTT in their lives.

Drug Treatment Therapy Defined

Providers use DTT or pharmacotherapy to treat disease. The medications function to normalize the brain's chemistry, and block euphoric feelings caused by heroin and other opiates (Substance Abuse and Mental Health Services Administration, 2015b). Methadone, buprenorphine, Vivitrol (naltrexone), Suboxone (Buprenorphine and naloxone), and Subutex are general medications used in DTT for the treatment of heroin and other opiate disorders. Some medications, such as buprenorphine, used to treat heroin addiction, are classified as controlled substances due to their high abuse potential, and government-registered providers must administer them on record. Jails may or may not use certain medications for these reasons, or they may not use any at all due to cost constraints, administrative preference, or treatment preferences. Current research establishes that DTT for incarcerated offenders is effective at aiding in detoxification, as well as maintaining sobriety upon release (Zarkin et al., 2015). Heroin addicts who have attempted DTT in the past may have preconceptions of how treatment will go and regardless of why they entered, and may not benefit from the process.

DTT provides a continual foundation that may start prior to incarceration or begin once incarcerated and carry through to release. McKenzie et al. (2012) state that DTT is a

feasible way to increase the chances of treatment and decrease relapse upon release. Despite the volume of literature showing DTT to be a positive and effective choice for heroin-addicted offenders, rarely do offenders receive DTT while incarcerated (Wakeman & Rich, 2015). There is a greater chance of cessation from heroin use if treatment is completed (Zarkin et al., 2015). The most common form of DTT is methadone (Byford et al., 2013; Zaller et al., 2013); however, buprenorphine and buprenorphine blends such as Suboxone (buprenorphine and naloxone), and Vivitrol (Naltrexone) are used as well (Neale et al., 2011). Many studies have reported the benefits of DTT on treatment retention and sobriety maintenance, and some include the disadvantages of keeping addicts on heroin substitutes (Neale et al., 2011). Some studies include addict perceptions about DTT stigma and negative outcomes, explaining they would rather abstain altogether than start or begin treatment (Neale et al., 2011). Keeping heroin addicts in treatment means finding the right treatment for each offender (Kopak et al., 2016).

Previous studies show that DTT is positive for offenders in that it provides offenders with needed treatment to quit using heroin, but also provides a safe place to be while incarcerated by removing some of the stress of incarcerated life (Frank, Dahl, Holm, & Kolind, 2015). Many heroin-addicted offenders enter jail and feel forced to go through detoxification based on the assumption that heroin is not available in jail (Miller, Griffin, & Gardner, 2016). However, even if offenders detox in jail, drug therapy is uncommon due to financial constraints, treatment beliefs, and federal laws governing controlled substance. Studies show that DTT decreases the chances of relapse and

recidivism in ex-offenders (Harris et al., 2012), but heroin addict perspectives way heavily on an addict's decision to get treatment and continue with sobriety and recovery.

Offender Perspectives Towards DTT

A perspective or perception of something, regardless if it is true or not, may have developed from experiences with a phenomena or happening that people often rely on when making decisions. Offender perspectives show in agreement with DTT benefits, even though they felt mandated in the beginning to partake (Kopak et al., 2016) many feel as though treatment will lead to a normal life (Kolind, Holm, Duff, & Frank, 2015). Perspectives collected by Frank, Dahl, Holm, and Kolind (2015), showed that offenders serving sentences wanted to enter drug therapy programs to quit or stay off drugs, because they saw sobriety as a means of living a normal life. A desire for normalcy was a theme pulled from data collection as the awareness that lifestyle changes had to happen in order for normalcy to happen (Frank et al., 2015). Also discovered was that offenders entered drug therapy while incarcerated in the hopes of gaining early release, meaning if they do something, they get something (Frank et al., 2015). However, the desire to continue using drugs upon release is there as well, and causes offenders to leave treatment upon release (Frank et al., 2015).

A factor that weighs heavily on heroin addicts is the ability to stay in treatment, and the temptation to use is always present when completing drug therapy upon release from jail, unless choices are available that give offenders the option to choose what it best for their path to sobriety. In a study of 283 heroin addicts, results showed there was no knowledge of drug therapy choice, so many felt they had to use the drug given to them

(Yarborough et al., 2016). Yarborough et al. stated that there was little literature to start with in terms of user perspectives about drug therapy and treatment experiences, therefore researchers set out to discover which drug was preferred among recovering addicts. Some addict perspectives revealed the preference to avoid methadone due to social stigmas and temptations brought on by visiting methadone clinics daily for medication (Maradiaga, Nahvi, Cunningham, Sanchez, & Fox, 2016; Yarborough et al., 2016). The possibility of running into previous consorts was too much for some to endure, however, having to get methadone every day from the clinic was a requirement. Yet, some addicts chose methadone for its structure, and the very reason some turned it down was the reason it was chosen by others; Methadone provided more structure with less ability to use drugs simultaneously (Yarborough et al., 2016). Still some addicts would have liked the results provided by methadone in terms of craving reductions, but did not want to use it due to the difficult withdrawal upon abstaining, and further did not want to be tied to a daily visit to the methadone clinic (Yarborough et al., 2016).

Yarborough et al. (2016) study presented participants who switched from buprenorphine to methadone because they wanted to relieve withdrawal pains; however, several participants stated they wished they had stuck out the buprenorphine treatment, because now they feel addicted to the methadone. There were still participants who stated they would never switch from buprenorphine to methadone, because those who did were 'hooked for life', still using while on methadone, or had a greater habit after being on methadone maintenance (p.116). Previous experiences were pivotal in decision making about drug choice, and with many holding negative views about methadone,

buprenorphine was the only choice (Yarborough et al., 2016). Participants on buprenorphine shared their experiences and perspectives as buprenorphine 'being better', working better than anything before, and better at blocking cravings than methadone (Yarborough et al., 2016). Those who chose buprenorphine did so because of the ability to take buprenorphine in the privacy of their own homes, in addition to the lack of temptation caused by visiting methadone clinics (e.g. previous drug connections, dealers, and users) (Yarborough et al., 2016). Hedrich et al. (2012) found that those taking buprenorphine were more likely to stay in treatment upon release from jail (Hedrich et al., 2012). When heroin addicts enter the correctional system, they automatically enter into a 'given' health care system that meets the needs of addicts in terms of detoxification, but not always behavioral therapy. Nonetheless, a detoxification program coupled with DTT can help heroin addicts deal with the pain of detoxification, and possibly sustained sobriety. In the following section, I considered the impact of DTT for incarcerated offenders.

DTT While Incarcerated

When heroin-addicts enter U.S. jails, they enter into an automatic health care system (Taxman et al., 2013). U.S. jail officials are in the position to treat offenders with health care options offenders may not receive upon release (Kopak et al., 2016), and jails present a vital time in an offender's life when treatment engagement can begin, thereby linking offenders to treatment upon release (Wakeman and Rich, 2015). Given that heroin users are in a position to 'get clean' in jail, jail personnel can take advantage of that element and treat heroin users with DTT while incarcerated in order to perpetuate

treatment attendance upon release (Hedrich et al., 2012). In addition to providing DTT in jails, offenders can obtain medically managed detoxification in jails with or without counseling therapy (Wakeman & Rich, 2015). Studies have shown that DTT while incarcerated provides many benefits of support to offenders that allow a smoother transition from jail to community, and path to sobriety (Byford et al., 2013; Wilson, Donald, Shattock, Wilson, & Fraser-Hurt, 2015).

Hedrich et al. (2012) show that DTT while incarcerated was strongly associated with greater treatment retention upon release, with those on buprenorphine abstaining longer than those taking methadone, in addition to remaining in treatment longer (Wakeman & Rich, 2014). Hedrich et al. show that DTT reduces relapse and the risk of recidivism in heroin addicts; nonetheless, shorter periods of incarceration were associated with higher attrition rates of DTT partakers due to less treatment time. Offenders need to be in treatment for a minimum of six months to make a difference in outcomes both while incarcerated and upon release (Hedrich et al., 2012), which is not always the case as some may be sentenced to a prison or released (McDonnell, Brookes, & Lurigo, 2014). Just because a heroin-addict is partaking in DTT with or without treatment counseling, does not mean that abstinence or sobriety is a surety (Chie, Tam, Bonn, Dang, & Khairuddin, 2016). Other factors play roles in the paths taken, including social stressors and supports, ability to find employment and housing, and insurance enrollment (Calcaterra et al., 2014; Cole et al., 2011). Different correctional facilities use different DTT medications based on the administrational beliefs and policies. In addition, jail administration and health staff may choose a different medication based on research findings and outcomes.

Different Medication, Different Outcome

Heroin addicts who start treatment take one of several drugs to aid in their recovery, and DTT, and according to McKeganey, Russell, and Cockayne (2013); it is only the first step to recovery, with removal from DTT and complete abstinence as the main objective of sobriety maintenance. McKeganey et al. (2013) completed a study in the UK involving 109 individuals using either methadone or Suboxone (buprenorphine and naloxone). The use of these drugs to maintain sobriety are commonplace and provide benefits and positive outcomes; however, there are negatives as well to using them (McKeganey et al., 2013). The following sections describe findings associated with different DTT medications, in addition to heroin-addict perceptions of the medications taken.

Methadone, buprenorphine, and suboxone compared. Positive outcomes are not always be the case when using methadone, as studies show that DTT with methadone may increase treatment time substantially; Addicts on DTT took close to 20 years for recovery compared to five for those who never entered a DTT program (McKeganey et al., 2013). Another concern about methadone is a user's ability to mix it with street heroin, thereby increasing the chances of overdose and death (McKeganey et al., 2013). Treatment options for those who do not want to deal with the issues of methadone may choose Suboxone or Vivitrol (buprenorphine blends), which counter the effects of heroin: If an addict injects heroin while taking one of these drug treatments, it voids the high normally achieved and moves the addict into a state of heroin withdrawal (McKeganey et al., 2013). Suboxone and Vivitrol also aid in decreasing heroin use and administration is

sublingually in smaller, tiered doses to suit the withdrawal needs (McKeganey et al., 2013). For instance, a user can take a dose that brings them just above the withdrawal point, enabling them to wean themselves off DTT easier. Suboxone (buprenorphine and naloxone) and Vivitrol (naltrexone) also are conducive to recovery goals, because they improve decision-making and cognitive abilities, along with improved breathing function, decrease heroin use and cravings, and provides stability needed during recovery altogether with less side effects (McKeganey et al., 2013; Zaller et al, 2013). Buprenorphine blended drugs show similar outcomes compared to methadone in ceasing heroin use (Zaller et al., 2013).

Zaller et al. (2013) completed a study comparing methadone to buprenorphine during incarceration and upon release in terms of treatment retention. Their findings supported buprenorphine as a choice for increasing treatment commitment and retention upon release, when offenders started treatment prior to release (Zaller et al., 2013). In addition to increased treatment retention upon release, buprenorphine was the choice of DTT by offenders over methadone due to the lower risk of side effects, reduced cravings, and patience preference (Zaller et al., 2013). As mentioned by McKeganey et al. (2013) regarding the possible mixing of methadone with street heroin to achieve a greater high, there is a growing concern about the same issue regarding deviation and illicit use of buprenorphine; however, the findings show it is not being mixed with street heroin, rather it is used to manage withdrawal (Zaller et al., 2013). For these reasons, the government disburses these medications through licensed entities that prescribe and document all

patients and prescription allotments. Next, I discuss the benefits and disadvantages of methadone from offender perspectives and research findings.

Research assessment of methadone. Davoli et al. (2014) presented a study of the Cochrane Reviews showing chosen treatments based on strengths and the quality of evidence offered by evidence-based research. Although researchers historically provide an abundance of quantitative information, Davoli et al. (2014) attest to the suggestion of more qualitatitive assessments and research when considering cultural and ethical factors in relation to offenders and increasing treatment retention. Findings suggest that heroin addicts should be on DTT, are advised to use methadone as the drug of choice in preference to buprenorphine, and counseling and other forms of cognitive therapies should be coupled with pharmacological treatment (Davoli et al., 2014). Miller, Griffin, & Gardner (2016) found that methadone is the most effective at treating withdrawal symptoms, yet patients who stopped treatment relapsed at a rate of 90%; these findings bring researchers to the conclusion that methadone is more of an ongoing treatment drug rather than a drug used on the path to eventual abstinence. Although Davoli et al. present compelling evidence on treatment suggestions; many studies contrast their findings and state that buprenorphine is the best option for heroin addicts on their path to sobriety and managing withdrawal, because of its pleasure minimizing effects and less potential for abuse (Miller, Griffin, & Gardner, 2016). Also noted were the patient reports of less side effects on buprenorphine compared to methadone, and even though addicts on either methadone or buprenorphine agreed to continue post-release treatment, those taking

buprenorphine continued on at a rate of 48% compared to 14% of methadone users (Miller et al., 2016).

Although there is much evidence suggesting other medications for DTT both in jails and communities, some findings suggest that using methadone will increase health and social circles, with a decreased chance of premature death and criminal acts, in addition to helping addicts to remain in treatment (McKeganey et al., 2013; Wakeman & Rich, 2015). Giving heroin-addicted offenders the ability to choose which DTT they prefer may increase treatment retention and positive outcomes. In response to issues with both methadone and buprenorphine being abuse-able, a drug called Vivitrol is being tested and used due to its ability to (1) stop heroin injection, (2) prevent a 'high' from being achieved, and (3) cause withdrawal symptoms upon heroin injection. In the following section, I considered findings on the benefits and objections towards Vivitrol (naltrexone).

Vivitrol (naltrexone). Because of concern for diversion and the need for increased treatment retention, jails may turn to Vivitrol. Vivitrol (naltrexone) is a form of buprenorphine produced to prevent diversions of buprenorphine use on the streets and in prisons (Gordon et al., 2015). In a previous study, Gordon et al. (2014) found buprenorphine/naloxone treatments to be a problem due to diversions and the ability of addicts to use it to get high both in and out of prison (Gordon et al., 2014). Although research showed that buprenorphine/naloxone was effective at treating heroin addiction, there were still great risks to using it. Vivitrol (naltrexone) blocks the intoxicating effects of heroin, yet it has no effects of its own, and administration occurs every four weeks via

gluteal injection. Gordon et al. (2015) show that Vivitrol could fulfill treatment needs in jails, because of its ease of administration, and less ability to abuse the drug in and out of prison. In their study of 27 offenders who started Vivitrol while incarcerated, ten completed six injections for a total of 24 months on the program and a 37% completion rate (Gordon et al., 2015).

Lee et al. (2016) completed a study of Vivitrol on 153 offenders and 155 assigned to a placebo treatment. Vivitrol is an extended-release formula that provides naltrexone over time to block the 'high' effects achieved when using heroin (Lee et al., 2016). Lee et al. claim that at the time of their study that no known potential for abuse or diversion, making it a drug of choice for many users and providers. Lee et al. focused on the relapse potential for those using Vivitrol, with relapse defined as 10 or more days of heroin use in a four-week period. Findings showed that 66 participants (43%) who took Vivitrol had a longer expanse of sobriety compared to those taking the placebo 99 or 64% (Lee et al., 2016). Another finding was that participants who took Vivitrol did not overdose after they discontinued treatment, compared to those on the placebo treatment who had 12 fatal or detrimental events during the 78 week study (Lee et al., 2016). Overall, for those who took extended-release Vivitrol, there was reportedly less occasions of relapse with 43% of those relapsing over the 24-week treatment period compared to 64% on the placebo (Lee et al., 2016). Lee et al. (2016) point out that there is little research on the long-term effects of Vivitrol treatment to compare to when discussing methadone or buprenorphine maintenance treatment; therefore, refrain from explaining possible long-term benefits of Vivitrol therapy.

DTT both while incarcerated and postrelease can help offenders to stay on a path to sobriety (Kopak et al., 2016; Miller, Griffin, & Gardner, 2016; Zaller et al., 2013). Although offenders may not want detoxification in jail, it happens due to the lack of drug access while incarcerated (Gordon et al., 2015), and in many cases, offenders do not receive the necessary therapies to coincide with detoxification, such as counseling and therapy (McDonnell, Brookes, & Lurigio, 2014; Miller et al., 2016). The need to continue therapy for those already on DTT such as methadone, buprenorphine, Suboxone, or Vivitrol when entering jail is shown to be conducive to treatment retention upon release, as well as maintaining positive treatment schedules (McDonnell et al., 2014; Zaller et al., 2013). Kopak et al. (2016) further this discussion by stating that there is a need for research identifying the needs and services best suited for vulnerable populations such as heroin-addicted offenders, which may in turn increase treatment retention over longer durations. Treatment retention cannot be obtained or maintained if offenders do not have a pathway to treatment upon release, however, the need for addicts to receive sobriety support should be made available with the option to join or not. Continuing DTT is imperative to sobriety success upon release, but offenders may opt out of continued treatment based on perceptions, beliefs, and fears.

DTT Continuation

Current research establishes that treatment upon release is effective in supporting offenders through detoxification and sobriety maintenance. Other factors that play into sobriety success are the ability to obtain employment, maintain social supports, and take part in positive choices and options. Nyamathi et al. (2014) concluded from their study

that post-incarceration drug treatment programs and case management is crucial for heroin addicts to prevent recidivism and homelessness. Fox et al. (2014) concur with Nyamathi et al. that homelessness and poor health outcomes are common among ex-offenders, and that there is a need for research on the connections and supports between jail and release in order to provide proper care and treatment to heroin-addicted offenders.

In addition to studying the need of ease of transition from incarceration to release, qualitative researchers need to study why heroin-addicted ex-offenders seek employment and housing before medical treatment (Fox et al., 2014). Fox et al. go on to state that there is a need for immediate-access-to-treatment studies with the expansion of studies identifying the critical steps in heroin-addiction management upon release. Martin, O'Connell, Paternoster, and Bachman (2011) assert that interviews of heroin-addicted offenders can add to the literature by providing life histories of those studied. Neale, et al. (2013) provide a caution to prompting heroin-addicted offenders into treatment post-incarceration as they found it has negative consequences of cross-addiction and relapse.

Maintaining DTT for offenders entering or exiting the correctional system is of growing importance, as evidence shows abruptly discontinued DTT is not considered best practice (Kopak et al., 2016). Treatment discontinued without medical approval is not good for anyone regardless if the disease is diabetes or addiction, and Dumont, Brockmann, Dickman, Alexander, and Rich (2012) argue that discontinuing DTT upon incarceration can cause withdrawal and a greater chance of overdose upon release. However, many correctional settings do not have the resources to care for all heroin-

addicted offenders (Lehman, Greener, Rowan-Szal, & Flynn, 2012). Although much research presents the positives of DTT, along with cautions of use and therapy, there is limited research that shows how patients experience sobriety once DTT is ceased (Dakwar & Kleber, 2015). Kopak et al. (2016) also recommended focusing on the desired end-results of recovery, reduced heroin use, and recidivism, which are the consequences of unaddressed risk factors, such as previous criminal histories and drug use.

DTT using methadone and buprenorphine represent effective solutions for jails personnel to use on incarcerated offenders due to the positive results presented in previous studies as to their effectiveness at helping heroin-addicts on their path to sobriety. The World Health Organization (WHO) called buprenorphine and methadone essential medications in the treatment of offenders with opioid addiction (Sharma et al., 2016; Wakeman and Rich, 2014). Upon release from jail, offenders must obtain employment, repair relationships, find housing, and stay clean, but those needs may remain unmet if an offender is struggling with cravings and temptations.

The transition from incarceration to release places offenders at high risk for relapse, crime, and overdose, making a crossover to community treatment critically important (McKenzie et al., 2012). Drug therapy that is started or maintained in jail and continues upon release appears to provide heroin-addicted offenders with the needed support to maintain sobriety, and this includes counseling in addition to DTT (Mohlman, Tanzman, Finison, Pinette, & Jones, 2016). Considerations regarding offenders' desires or readiness to quit, and offenders' understanding of drug choices they can use during treatment, can both affect individual sobriety maintenance, and on the other hand, jail

personnel must also consider the cost savings of DTT with counseling while offenders are incarcerated compared to simply detoxing and letting them go (Mohlman et al., 2016). When comparing maintenance treatment to DTT and a pathway focused on abstinence, the cost savings are great (Mohlman et al., 2016), and Mark, Lubran, McCance-Katz, Chalk, & Richardson (2015), add that the implications of not treating heroin addiction outweigh the costs to treat heroin addiction, with DTT paying for itself after the reductions in consequences due to heroin use. The ultimate goal is abstinence, and jail personnel potentially have the power to provide the pathway for heroin abusers to maintain sobriety upon release. DTT may not be enough for some in terms of drug maintenance and withdrawal prevention. Some, if not all heroin-addicted offenders might benefit from cognitive and behavioral therapy in addition to DTT, to help build coping skills, and self-efficacy.

DTT and Cognitive Therapy

The implementation of DTT is not the only form of therapy needed by offenders, as suggested by Davoli et al. (2014), treatment that includes cognitive reformation in conjunction with drug therapy lessens heroin withdrawal symptoms, aids in treatment retention, and together offenders are able to concentrate and engage mentally with little cravings to get high (Miller, Griffin, & Gardner, 2016). Miller et al. explain that DTT focused on relapse prevention and coupled with cognitive behavioral therapy increases the chances of post-release treatment retention. The issue that arises is that many correctional settings provide the means of a safe detoxification, but lack in behavioral therapeutic aspects even though research shows the benefit of treatment combinations

(Evans, Huang, & Hser, 2011). Cropsey, Binswanger, Clark, and Taxman (2012) concur that even though offenders' needs are great; there is a lack of services provided to them in jails, including cognitive therapy and mental health support. This lack of health care carries over for many offenders upon release, elevating their risk for relapse, recidivism, overdose, blood-borne infections, and death (Cropsey et al., 2012). Providing a transition where heroin-addicted offenders can see diminishing barriers to needed health care and treatment is a focus that all jail administrators and community officials should make. Understanding that heroin-addicts are people, complex in nature, and possibly clouded by ill perceptions, all involved in treating them should take consideration for the need for autonomy and self-efficacy as empowering elements towards sobriety. Choosing the right DTT is imperative for offender sobriety, but treatment providers must make considerations for a drug user's ability to abuse a medication, and what is preferred in terms of recovery. Treatment providers both in jails and in communities must consider the barriers to sobriety faced by offenders, as the mounting issues of treatment need, a lack of normalcy, and loss, all collide upon release. In the following section, I discuss the transitory time of incarceration to release, and the barriers heroin-addicted offenders face on their path to sobriety.

Barriers to Sobriety

As of 2011, the United States has more than 2.3 million people in prisons and jails, and nearly 1.5 million of those have substance use disorders; Approximately one-third, or 200,000 of those are heroin offenders who enter and exit the US correctional system each year (Fox et al., 2015; Josiah, Wakeman, & Dickman, 2011). Upon release,

heroin-addicted offenders must contend with barriers to sobriety that impede attempts at attaining normalcy. Having been incarcerated for heroin addiction may have negative effects such as, broken social supports, relapse and recidivism (Cole et al., 2011), finding employment and housing, reconnecting with family and friends (Mowen & Visher, 2015), sorting through broken relationships, and chronic stress (Cole et al., 2011). In addition to facing stigma and release issues, offenders must attempt to remain sober (Calcaterra et al., 2014). Social supports refer to real or perceived physical and emotional guidance received from family members, friends, and others (Wallace et al., 2014). Social supports upon release may strengthen a heroin-addicted offender's perception that they can lead a healthy life, gain personal control over events and happenings, and provide a purpose in their lives (Wallace et al., 2014).

Not all offenders are drug users, and not all drug users are offenders; however, research repeatedly documents the connection between the two (Cole et al., 2011; Gordon et al., 2015; Havnes et al., 2012), as are the failed connections for treatment continuity between incarceration and release (Calcaterra et al., 2014; Fox et al., 2015). Providing heroin-addicted offenders with what they need to transition into the community (Notley, Maskrey, & Holland, 2012), including the choice to enter into or continue DTT (Fox et al., 2015) has presented in previous research as a much needed focus for correctional and community officials alike (Cole et al., 2011; Wallace et al., 2014). Expecting an individual with a drug addiction to stay sober and cope with life stressors when coping may be the issue in addition to a substance addiction, is asking a lot when we consider the fact that people with life threatening diseases are urged to obtain and maintain treatment

in order to function properly. Diabetics do not cope with their insulin fluctuations, so why would physicians ask heroin addicts to cope with cravings and possible relapse? Heroin addicts are eligible for the same treatment options as non-drug users, but a lack of insurance can contribute to a lack of services and subsequently treatment. In the following section, I discuss insurance availability to heroin-addicted offenders, and how a lack of insurance can affect the pathway to sobriety.

Insurance and Offenders

Everyone needs healthcare during their lifetimes at least once, and with growing health care costs, having insurance can help relieve the burden of affording needed care and treatments. Clinicians and psychiatrists consider heroin addiction a chronic disease (Volkow et al., 2014) and attempting to maintain sobriety a long-term treatment need (McDonnell, Brookes, & Lurigo, 2014). Traditionally, insurances do not cover offenders once incarcerated causing offenders to move through a difficult process of attaining government-subsidized insurance once released (McDonnell et al., 2014). Offenders may have private or government insurance prior to incarceration, such as Medicare or Medicaid; however, once convicted of a crime, relinquish the right to insurance and enter a *de facto* health care system in the jail (McDonnell et al., 2014). Offenders health is protected by the U.S Supreme Court Decision Estelle v. Gamble in 1972 stating that offender health care will be provided even though they lack insurance (Venters, 2016). Once offenders are released from jail they are again eligible to enroll in Medicaid (McDonnell et al., 2014), and with the enactment of the Affordable Care Act (ACA) in

2010, offenders can get government-subsidized healthcare coverage immediately upon release from incarceration (McDonnell et al., 2014).

Continuous care is a subject considered within the ACA, because a lack of insurance for offenders may result in a lack of care, and a disruption of treatment can lead to relapse, crime, and the overuse of emergency departments (McDonnell, Brookes, & Lurigo, 2014). Although having insurance perpetuates positive health outcomes, studies show that individuals without private health insurance are more likely to try heroin because of the cost associated with obtaining prescription opioids (Jones et al., 2015). Heroin users, both uninsured or on Medicaid, comprised the highest number of overdoses (Meiman et al., 2015) and increased opioid prescribing (Mark, Lubran, McCance-Katz, Chalk, & Richardson, 2015). Jones et al. and Meiman et al. agree that the increased availability and lower cost of heroin has contributed to the rise in its use over prescription opioids; however, this is not to say that all heroin users start on prescription drugs. Regardless of insurance status, many heroin users obtain no treatment when incarcerated or in the community (Minton, 2013), and the perpetuation of crime, drug use, and recidivism may be the result of a lack of insurance (McDonnell et al., 2014; Mohlman, Tanzman, Finison, Pinette, & Jones, 2016).

The ACA has provided a near-universal healthcare program that individual states must opt into in order for Medicaid expansion to cover and fund primary health care, substance abuse, and mental health care services (McDonnell, et al., 2014). Currently 50 states allow the prescribing of buprenorphine-naloxone (Suboxone), and 51 Medicaid programs including oral naltrexone; however, only 19 and 20 Medicaid programs

approved XR-Naltrexone, and methadone, respectively (Mark, Lubran, McCance-Katz, Chalk, & Richardson, 2015). Upon release, offenders are then able to apply for Medicaid, and subsequent substance abuse treatment, covered by the ACA as of January 2014 (McDonnell et al., 2014), and the DTT used will be determined by the state treatment is conducted in Mark et al., 2015). The ACA also reimburses institutions who partake in medication-assisted treatment programs, as they are evidence-based practices, and since findings show that the new medications reduce cravings and aid heroin users on their path to sobriety, it is in an institution's best interest to incorporate these programs into their processes (McDonnell et al., 2014, SAMHSA, 2015). As of 2014 the ACA still needed to expand coverage for low-income individuals within the Federally Qualified Health Centers (FQHCs) to cover substance abuse services including outpatient and medically-assisted treatments (McDonnell et al., 2014).

The majority of offenders in jail spend a short time incarcerated until release or transfer to prison upon sentencing (McDonnell, Brookes, and Lurigio, 2014). This issue with treatment fragmentation may deter treatment objectives (McDonnell, Brookes, and Lurigio, 2014); however, jail personnel can play a critical role in treatment continuation of those entering and exiting the jail setting by providing links to treatment both in the jail and the community (McDonnell et al., 2014). Previous research shows the importance of offenders obtaining Medicaid immediately upon release in order to enter into outpatient or DTT with counseling programs is critical to sobriety success (McDonnell et al., 2014). Having insurance ahead of time coupled with the knowledge that treatment is possible upon release adds to positive perceptions that there are choices ahead for heroin-

addicted offenders. In the following section, I considered heroin addicts' perceptions of DTT, release, social stressors, and barriers to sobriety.

Perceptions as Barriers

Heroin use in itself can cause social stressors and exclusions, because users cannot completely deal with normal life events and happenings, such as maintaining employment, relationships, and positive social circles (Cole et al., 2011; Fisher et al., 2016). Heroin-addicted offenders point out perceived and recognized social stressors as being (1) bothered by problems with personal relationships (Fisher et al., 2016), (2) unemployment (Phillips & Lindsay, 2011), (3) having no home, and (4) being depressed (Calcaterra et al., 2014; Fisher et al., 2016). The perception that life elements are out of a person's control creates stress in itself (Cole et al., 2011), which leads back to the idea that personal control, autonomy (Phillips & Lindsay, 2011), and positive choices can increase the chances of heroin-addicted offenders succeeding at sobriety (Cole et al., 2011; Notley, Maskery, & Holland, 2012; Wallace et al., 2014). The need to feel as if one is making choices for themselves is a foundational basis for autonomous feelings. If one perceives themselves as being able to make correct, positive choices, having the ability to create positive outcomes, and being able to choose positive over negative options, then increased autonomy, and self-efficacy will result, along with the ability to face barriers to sobriety with resiliency.

The fact remains that the vast majority of heroin-addicted offenders will encounter barriers on their pathway to sobriety (Notley, Maskrey, & Holland, 2012; Wallace et al., 2014), with little chance or idea that they can positively influence the

stressor to their desired result (Cole et al., 2011). Notley, Maskery, & Holland (2012) add that heroin- addicts expressed that not being able to control which DTT they received meant that they may have to go to a clinic and get methadone, which meant they might run into negative social influences. With barriers in mind, Gielen, Krumeich, Tekelenburg, Nederkoorn, and Havermans (2016) bring to light through their study of 432 participants with substance use disorder (SUD) that drug users lacked the proper coping skills to deal with the social stressors experienced while attempting DTT. Gielen et al interpreted their data and labeled coping skills as 'motives for use' such as, wanting to forget or escape reality, wanting to build confidence and feel safe, and wanting to lessen disturbing and depressed thoughts and feeling. Other discovered barriers to treatment and sobriety were social pressure, loss of control, boredom, euphoria, and obsessive behaviors to name a few (Gielen et al., 2016). Perceived or real, the feelings and experiences gone through by heroin addicts create barriers to treatment and subsequently, sobriety.

Cole et al. (2011) presented a study involving 787 adult drug users, and offenders' perceptions revealing that they received little respect, and received poor treatment by others (Notley, Maskrey, and Holland, 2012), in addition to Notley et al., who found that perceptions about treatment services affected treatment continuation upon release. The participants' believed that personal treatment during treatment was partially to blame for their drug use and criminal activity, and 57.1% stated that economic hardship influenced their improprieties (Cole et al., 2011). Notley et al. (2012) support these findings stating that offenders who had previous treatment experience did not want to start back at 'square

one' (p.43), and do it all again. There is a saying that if you give me respect I will return it, and it appears to apply here, that heroin addicts want to feel like people, like humans, and treating them as anything less could create the excuse to use again, that since they are not getting respect they won't continue treatment. Perceptions as barriers may or not be real; however, not having the money to survive is a real problem and adds to the stress of maintaining sobriety. The following section discuss economic barriers encountered by heroin-addicted offenders.

Economic Barriers

Economic factors and a lack of health care access appear to add to social stress, and affect drug abuse as well (Cole et al., 2011). Binswanger et al. (2012) provide information about economic factors and barriers perceived by heroin-addicted offenders' that there is no financial help to get housing, buy clothes, pay for transportation, or ready themselves for a job. These real and perceived barriers pose a problem to sobriety, because as positive options diminish, so does the desire to remain sober. Once again, the question arises if the stressors were already there or did they manifest because of drug use and incarceration, to which Calcaterra et al. (2014) state that causality cannot be determined. The depletion of critical support elements, such as family and friends, may lead to an inability to assist an offender towards a positive release outcome (Wallace et al., 2014). Heroin-addicted offenders who have strong social supports have overall better health outcomes than those with weaker supports (Wallace et al., 2014), which provides a reason for programs to be in place to offenders through transition from incarceration to release. Economic barriers are not simply the result of a lack of employment; rather they

may be real or perceptions of a person's upbringing, demographics, or choices. Notwithstanding, the need for financial and economic stability is a focus of heroin-addicted offenders upon release, which leads to the next section discussion employment barriers and issues.

Employment Issues

It is common for offenders to enter communities with no place to live, no job, and no prospects (Calcaterra et al., 2014; Mowen & Visher, 2015; Wallace et al., 2014). Unemployed offenders are more likely to engage in drug use compared to employed individuals (Calcaterra et al., 2014). Compounding complications to employment such as lower education levels and little work experience, in addition to restrictions from working in certain fields or exclusion by employers who will not hire offenders, make it difficult for offenders to find a job (Calcaterra et al., 2014). Work release programs may provide the support needed for offenders as they work through the transition of maintaining sobriety and stability upon release (Calcaterra et al., 2014), which will increase the chances and opportunities for positive options and choices (Calcaterra et al., 2014). Employment barriers are expressed concerns for heroin-addicted offenders upon release; however, obtaining a form of income is not the only barrier faced, as social barriers pose a danger to sobriety, because they tie in together at building a person up to an autonomous entity able of achieving success in life. In the following section, I discuss how social barriers affect heroin-addicted offenders.

Social Aspects as Barriers

Having strong social supports can prevent homelessness and the potential issues that co-exist with homelessness, such as drug use and crime, with a potential then for reincarceration (Calcaterra et al., 2014; Spjeldnes, Jung, Maguire, & Yamatani, 2012; Wallace et al., 2014). Wallace et al. (2014) point out that social supports while in-prison, even if they are negative, do not have the same negative affects as supports or the lack thereof, on offenders once released (Wallace et al., 2014), exposing the need for positive support on offenders upon release from jail. In contrast, family and friends who are drug users may negatively influence offenders into relapsing, making social supports a hazard for some (Calcaterra et al., 2014). Offenders expressed the need for social support and self-awareness as critical factors for treatment success upon release in a study conducted by Fisher et al. (2016).

Fisher et al. (2016) did a study including five heroin-addicted individuals, who considered family and friends who encouraged drug use and criminal behaviors to be negative influences. On the contrary, uncovered were views of family and friends as catalysts to treatment, and one addict stated, 'nobody ever wakes up one day in their addiction and volunteers to go to treatment' (Fisher et al., 2016). Regardless of supports, heroin-addicted offenders believe the choice to be sober is only that of the drug user (Fisher et al., 2016). Also expressed by the participants was the consensus that support received by treatment peers and support groups was a great reinforcement to staying in treatment and getting or remaining sober (Fisher et al., 2016).

Additionally, Mowen and Visher (2015) point out how heroin-addicted offenders shared the fact that although family had helped them upon release, they could not wait to get out of their parent's home due to stress. The participants in Mowen and Visher's study also claimed that stress caused by family members in turn caused them to relapse and recidivate, meanwhile Phillips and Lindsay (2011) found that heroin-addicted offenders were overwhelmed with frustration at the loss of normalcy felt from drug use and incarceration, causing them to relapse and commit crimes. Findings suggest that family issues either real or perceived can eventually lead to relapse and criminal activities as a way of coping with frustrations over social stressors (Phillips & Lindsay, 2011).

When a person focuses on a distant goal, their eyes will find a faraway place and fixate to where they want to be and go; however, many times, the little things along the way take the focus, at which point the faraway goal become blurry and out of focus. Comparing this analogy to heroin addiction, one would place sobriety as the faraway focus, and all barriers strewn across the pathway, causing stumbling points, and places of defeat and falling down. When a heroin addict focuses on the barriers, the obstacles and bumps in the path, they will lose sight of their ultimate goal of sobriety and complete abstinence; family and friends can help refocus on the distant goal. Sometimes those barriers are too great, such as unemployment and the inability to find a job, inability to support a family or find housing, or maybe even running into friends and family who use and condone getting high. Heroin-addicted offenders face social barriers that make maintaining sobriety difficult, and coupled with low autonomy or self-efficacy, may sway the heroin user to relapse.

Having supports in place, both clinical and social, can aide heroin-addicted offenders from incarceration to release. There is a saying, *If you want change, then do something different*, and I believe it applies here, because if an individual is caught in a cycle of drug use, relapse, and recidivism, and they have not partaken in DTT at any point, possibly adding this support and continuation upon release could change the course of their paths and lives. Much of this is only possible if the individual has insurance or Medicaid, to ensure treatment placement, in addition to considerations regarding family and friends who provide positive support on a tough journey through treatment.

Treatment as the Barrier to Sobriety

Treatment is thought of as the best option for sobriety by providing support to abstain from heroin and addiction; however, studies show that a counter-affect is possible when treatment is not employed correctly (Koetzle, Listwan, Guastaferro, & Kobus, 2015; Kopak et al., 2016). Koetzle et al. state that although empirical evidence supports drug treatment mandated by drug courts to be a positive option for criminal offenders with drug issues, there still needs to be a focus on the target population treated, with additional focus on risk and need.

The issue considered here is the pairing of low-risk heroin-addicted offenders with high-risk offenders. Bringing low-risk offenders in contact with high-risk offenders during treatment may negatively impact the potential for sobriety of either party (Koetzle et al., 2015; Kopak et al., 2016). Torok, Darke, Shand, & Kaye (2014) concur and argue that placing drug-using offenders into a hierarchy of risk for both relapse and recidivism can aid in establishing how they should be placed into treatment that is beneficial towards

sobriety and a decrease in recidivism. Understanding heroin users' histories and predisposing factors can help policy makers and community officials to identify greater risks associated with committing crimes and relapsing (Torok et al., 2014). This information leads scholars to understand that treatment, employed incorrectly and offered to a wide range of users with low to high risks, can actually impede sobriety due to the relationships built while in treatment together. Although the pairing of low and high-risk heroin users together in therapy is an element to consider, there is still a need for future research; however, I felt it was a facet that needed to be brought up in this study.

With all of the literature, both quantitative and qualitative, regarding barriers, heroin use, and possible criminal behaviors associated with drug use, there is still a lack of information providing perceptions and experiences of heroin-addicted offenders. This gap in information can cause issues for correctional departments, communities, and addicts alike, because what is measured may not be what heroin addicts need on their paths to sobriety upon release. In the following section, I provide concepts of gaps in the literature, supporting the need for this research.

Gap in the Literature

The issue of heroin-addiction is complex and much research has attempted to discover how to curtail addiction, perfect treatment options, and provide reasons for why people use drugs. However, limited research provides the perspectives of heroin-addicted offenders transitioning from jail to life upon release (Binswanger et al., 2012; Johnson et al., 2013; Neale et al., 2011). There is a need for continued research to address the means by which an individual moves from addicted to recovering from a user's perspective,

albeit, most findings are quantitative and clinical in nature (Neale, Nettleton, & Pickering, 2013.

A gap in research involving offenders in jail is due to most research conducted at the prison level (Zarkin et al., 2015), and upon release (Brunelle et al., 2015; Gielen, Kurmeich, Tekelenburg, Nederkoorn, & Havermans, 2016; Johnson et al., 2013; Kras, 2012), consequently leaving out the transition period of incarceration to release, and the elements that affect offender response to treatment. Frank, Dahl, Holm, and Kolind (2015) conducted a study in Demark prisons to obtain inmate perspectives of drug treatment, but they did not take the study further to observe the transition from incarceration to release. In addition, the study only examined the user-perspective of experience and enrollment in treatment programs while incarcerated.

Hedrich et al. (2012) presented a study completed using inmate records and articles from Ireland and European prisons to gather evidence on the efficacy of opioid treatment programs for inmates, and how treatment while incarcerated affected treatment retention upon release. This study presented the need for future research that included community liaisons to connect offenders to treatment upon release, which I provide through the local outpatient substance abuse program at the local hospital. The focus on Hedrich et al. was to gain knowledge of in-prison drug treatment programs affects on inmates, as well as the carry-over to release.

A study completed on 960 jail inmates by Westerberg, McCrady, Owens, and Guerin (2016) aimed to discover if offenders who participated in a methadone maintenance treatment program while incarcerated had decreased rates of criminal acts

and recidivism upon release. Westerberg et al. checked on participants one year post release to assess if the methadone maintenance treatment had any positive effect on the participants' ability to remain crime-free. Analysis was conducted on medical screening forms, jail databases, and demographic information, in addition to admission and release records, recorded doses of methadone while incarcerated, criminal acts and rebooking information, and the offense committed. This study, although from incarceration to release and after, was not qualitative in nature and did not include personal experiences or perspectives, rather it was quantitative in nature using secondary data (Westerberg et al., 2016).

There are studies conducted to assess inmate and offender behaviors during incarceration and upon release, however, the gap that exists involves the personal input, feelings, thoughts, perspectives, and experiences provided from individuals directly. Senker and Green (2016) completed a qualitative study in Essex, United Kingdom that extended from incarceration to release to assess what recovery meant to heroin addicts. They research included 35 semi-structured interviews conducted both in prison and in the community. Senker and Green discovered that recovery included gaining back the feeling of normalcy lost from drug use and incarceration. The limitation of this study that contributes to the gap in literature was the study sought solely to discover the perspectives of drug treatment in the criminal justice system, and only then uncovered that recovery was much more than drug treatment (Senker & Green, 2016).

Summary

In this chapter I presented the literature relevant to heroin use, drug related crime, DTT while incarcerated, DTT continuation upon release, recidivism and relapse, and barriers to sobriety. I discussed the phenomenological methods used for this study and the reasoning behind using this approach, as well as the need for the research on heroin addicts and their experiences on their pathway to sobriety. Approaches to curtailing heroin addiction are DTT, where heroin addicts partake in drug maintenance to keep an even level of comfort while not using heroin, and sometimes jails use DTT in conjunction with counseling and psychological therapy. DTT deters heroin addicts from injecting heroin both while incarcerated as well the community (Larney, Toson, Burns, & Dolan, 2012a), and helps when continuation occurs from incarceration to release when heroin-addicted offenders need the most support (Fox et al., 2015).

In this phenomenological study, I explored the experiences of heroin-addicted offenders from incarceration to release in an attempt to discover their thoughts and feelings about what they went through, and felt should be set in place for sobriety success. The pathway to sobriety for heroin-addicted offenders is marred with stigma, lost relationships, unemployment, disease, drug use, crime, and death, and it is up to jail and community officials to remove some of these barriers faced by this vulnerable population, and create an easier and smoother path to sobriety. It is apparent that heroin addicts need both DTT and counseling therapy to learn coping skills that enable healthy choices and progress towards sobriety (Gielen, Krumeich, Tekelenburg, Nederkoorn, Remco, & Havermans, 2016).

In the following chapter, I discuss the methodology for this study. I discuss the procedures for data collection regarding thoughts, feelings, perceptions, and experiences of the participants. I also discuss the phenomenological methodology of how I analyzed and interpreted the data.

Chapter 3: Research Method

Introduction

This chapter presents the methodology of this qualitative study. I describe the design, method, approach, ethical considerations, and procedures to obtain approval in addition to sampling criteria and participant selection, the researcher's role, data collection, and data analysis. I explain why I chose a phenomenological approach to discover the experiences of heroin-addicted offenders on their paths to sobriety upon release. In this chapter I note the potential burden of conducting interviews on incarcerated individuals such gaining access into the jail including security checks, the transportation of inmates by officers, and additional security needed to conduct the interviews safely.

In the following section, I discuss the research approach and how qualitative research was better suited for this study over the quantitative method to obtain personal experiences.

Research Design and Approach

Qualitative Designs

Qualitative research is a growing area of inquiry that brings varied forms of methodology and refinement to scholarly inquiry (Neale, Nettleton, & Pickering, 2013a), and it has been gaining popularity in the field of social work as a process of acquiring knowledge of the lived experiences of participants (Tufford & Newman, 2010). Inquiring into the lives of others is a social communication aimed at gaining knowledge and information about events and experiences that may apply only to a specific group of individuals (Barush, Gringeri, & George, 2011). There are other phenomenological forms

of research such as existential and hermeneutical. The former is ontological, or concerned with being, and the latter requires interpretation of all human behaviors (Sloan & Bowe, 2014). I felt that a phenomenological study that sought to understand the human experience (Sheehan, 2014) would best shed light on the personal experiences of heroin-addicted offenders. Moustakas (1994) stated that a phenomenological study begins and ends with the lived experience being studied, coupled with the actions, perceptions, feelings, thoughts, and memories regarding the phenomenon.

Ethnographic research did not apply to this study, because ethnography involves the observation of a group of people or a certain culture within their environment and surroundings (Moustakas, 1994). The goal of ethnography is to identify social patterns for a culture-sharing group, and research questions focus on individuals and the processes of their living sites and communities (Hays & Wood, 2011). Sample size determination varies by the community, group, or culture studied and is without limits, as the group participate individually and as a whole (Hays & Wood, 2011). Both phenomenology and ethnography share the same philosophical assumption of constructivism; however, phenomenological studies recommend meaningful sampling of 5-25 participants compared to a limitless sample composing an entire community or village (Hays & Wood, 2011).

A case study methodology was unsuitable for this study as it employs a strategy of studying one case in multiple settings or multiple cases in one setting, both of which do not apply to the methodology needed for this study (Hyett, Kenny, & Dickson-Swift, 2014). Performing a study on one case would not provide the meaningful information I

was seeking in terms of community betterment, and it would not have been possible to interview multiple cases in the same settings once released from incarceration. Initial interviews occurred in the same jail; however, upon release, offenders went their own ways, and a common interview setting was unlikely.

Grounded theory studies argue the need for new theory that is applied to a greater population, in addition to validating the theory for a specific phenomenon (Hays & Wood, 2011). Grounded theory uses a purposeful sample between 20-60 participants yet still relies on interviews and observations as the means of data collection (Hays & Wood, 2011). The contrast here is that grounded theory researchers use hypotheses they test through rigorous and multiple rounds of data collection (Hays & Wood, 2011). Attaining trustworthiness in a grounded theory study aligns with that of a phenomenological study, using such techniques as triangulation, observation, and thick description (Hays & Wood, 2011). Pertaining to this study, I asked semistructured questions that allowed the participants to open up about certain times or events in their lives (Englander, 2012, p. 14), albeit soliciting direct and mindful experience recollection, whereas grounded theory seeks to identify processes and patterns in order to create a model (Hays & Wood, 2011). Phenomenology allows for the open flow of undirected and unspecified data to occur and present naturally (Hays & Wood, 2011), which excluded grounded theory as a choice for this study.

Phenomenology focuses on the lived experiences of participants, allowing for the discovery of the essence of the phenomenon shared between individuals (Sheehan, 2014), just as other qualitative approaches do. However, gaining insight into how individuals

within a specific group experience the same phenomenon or event, in this case achieving sobriety upon release, was the focus and approach of this study. The means by which data collection occurs and is presented in current living conditions without direction or bias allowed for the essential collection of an experienced phenomenon to transcend boundaries and bring light to others with the same experiences and perceptions. Another way to look at phenomenology is that it seeks the reality lived by others that excludes any assumptions or input from the one listening to the experience.

Phenomenological Approach

Qualitative research is diverse, and different approaches employ different data collection techniques that facilitate the needed responses and feedback to properly and fully report on a phenomenon, experience, or way of life, according to the worldviews and methods of each approach (Hays & Wood, 2011). Experimental scientific research cannot extract the human experiences and phenomena of life because it obstructs the ability to understand human behaviors on the emotional and spiritual levels (Roberts, 2013). Many studies provide statistical and demographic information; nonetheless, in order to understand humans on personal levels, we must research them personally as in phenomenological research.

Phenomenology requires objective data collection and analysis, with a focus on understanding and describing a certain aspect of life shared by other individuals (Yüksel & Yildirim, 2015). Researchers must make a dual consideration for the phenomenon studied from the reality of the situation as well as the way participants perceive the phenomenon. By taking data and honing concepts and descriptions down, researchers can

reduce the data and extract the essence of the phenomenon. Phenomenology must also take into account the intentionality of the participants to experience the phenomenon (Yüksel & Yildirim, 2015). In this case, that meant discovering if individuals who use heroin do so intentionally or because they are driven to do it unconsciously or without thinking about it.

I considered several qualitative approaches for this study; however, only a phenomenological approach allowed for focus on individual experiences within a group over a short period in multiple settings. In addition, studies show phenomenology is satisfactory to gain a better understanding of how disease can affect lifestyles and health behaviors (Roberts, 2013). I employed a phenomenological approach during this study, because my research required the collection of details and experiences of heroin-addicted offenders' paths to sobriety upon release, free from researcher assumptions and bias and preconceived ideas. Yüksel and Yildirim (2015) state that researchers should start data analysis with bracketing of their subjective preconceptions to remove prejudgments towards those being studied. Bracketing helps researchers openly set aside their feelings, assumptions, and biases towards the participants and phenomena studied providing the element of validity and trustworthiness of data collection and findings. In the following section, I discuss bracketing in-depth, and I show how I incorporated it into my study.

Bracketing. Bracketing is used to acknowledge any researcher preconceptions that may hinder the research and void the findings with inaccuracies (Tufford & Newman, 2010). Bracketing helps to demonstrate validity in phenomenological studies (Chan, Fung, Chien, 2013), and provides the background needed to clarify and validate

information as not being guided by the researcher (Englander, 2012). Bracketing is a conscious and deliberate attempt of repudiation of the researcher's own beliefs during and throughout the research process (Chan et al., 2013). By consciously acknowledging and setting aside beliefs and knowledge of a phenomena, the researcher will not influence the way a participant remembers, views, or understands the phenomena being studied (Chan et al., 2013). Bracketing helps to demonstrate validity with the knowledge that the researcher has set aside all preconceptions, knowledge, and assumptions about the phenomenon under study, and since I am not conducting a hermeneutical phenomenological study, which requires researcher experience as a foundational support for data collection (Chan et al., 2013), I included it in my study.

Phenomenology in public health. Researchers in the social fields are increasingly performing and relying on qualitative studies to harness and explore participants' lived experiences (Tufford & Newman, 2010, p.80). In terms of public health and health sciences, research helps in forming and shaping thoughts and behaviors by bringing to light the needs of individuals and communities (Jennings, 2015). Jennings asserted that public health goals and interventions require understanding human thinking and behavioral patterns along with the assumptions and meanings that underpin phenomena that are socially accepted by a certain group of people under certain circumstances. In this study, a phenomenological approach provided the information needed by public health officials in obtaining pertinent information about heroin-addicted offenders' needs and pathways to recovery.

Empirical phenomenology. Moustakas (1994) explained that a phenomenological approach explores how a group of individuals perceives or experiences a phenomenon. He maintained that different forms of phenomenology use intuition and self-reflection to interpret the data collected, as with transcendental phenomenology, for example. However, in light of the dubiety of qualitative research, (Neale et al., 2013), empirical phenomenological research appeared to suit this study best. Empirical phenomenology requires naïve data collection using semistructured interview questions, the admission, recognition, and removal of researcher assumptions, and interpretation of participant interviews to describe their personal experiences (Moustakas, 1994). Empirical phenomenology allows people to see what it would be like to be the participant. The purpose of this study was to shed light on heroin-addicted offenders' experiences of sobriety upon release, and the only way to accomplish that task was to acknowledge all preconceptions and notions about heroin users and incarcerated individuals (Moustakas, 1994).

Role of the Researcher

The important aspect of the researcher role in phenomenological studies is to observe epoché, as identified by Husserl as staying away from or removing presupposition or judgments about a phenomenon being studied (Yüksel & Ylidirim, 2015). I am a dissertation student, working to complete my PhD. I attempted to interview and write reports about a vulnerable population, that included disturbing information or stories of illegal activities. I am not a mandated reporter, and I assured participants of my role in this study as being a confidante, maintaining full confidentiality of who they are in

regards to what they state. I was under no obligation by law enforcement, morally, or ethically to report any of the data collected.

My role in this research was to collect data via semi-structured interview as the data collection instrument, describe the phenomenon and collect data that was free of assumptions or personal attitudes about heroin use, offenders, and sobriety. Epoché is an important aspect of phenomenology that aims to present unbiased data and findings based on external knowledge rather than internal reflection (Moustakas, 1994). This conscious decision of awareness began in data collection and extended to data analysis with bracketing in mind, which is discussed in the next section.

I was the sole researcher on this study and collected and analyzed all data, and wrote all reports. The jail staff nurse assisted in identifying potential participants, by providing inmates with the Invitation to Participate, Consent Form, and study timeline. Once inmates told the staff nurse they were interested in learning more, I scheduled a meeting to set up discussing the study, in addition to, consenting, and interviewing. Consent was done verbally and tape recorded prior to starting the interviews. We discussed any questions prior to signing to ensure understanding. During this research I interviewed participants where they were, in their current settings, in order to obtain the truest, most natural data that applied to that time in their lives, for instance as heroin-addicted offenders, or recovering heroin addicts in the communities. A focus and intention of this research was to protect all involved, including myself. Self-disclosure was an element of qualitative research that I employed by omitting myself from my research since I am dealing with heroin- addicted offenders, partially to protect my

family; my husband is a state prison warden. I stated and divulged personal assumptions, conclusions, and thoughts to insure transparency, validity, and accuracy of data collection.

My initial role was to complete a proposal that outlined my study, the theoretical framework, philosophical underpinnings, data collection and analysis, and participant considerations. After writing the proposal and obtaining committee, URR, and IRB approval (no. 04-05-17-0468747), I embarked on the process of data collection. I obtained approval from both the county jail administrator, the public health director, and the county staff nurse to recruit participants from within the jail, in addition to conduct interviews at scheduled times shown in Appendices D, E and F. Sampling the participants occurred while incarcerated. Contact continued through to 3 weeks post initial interview and post-release in order to obtain heroin-addicted offenders' experiences both when in jail and in the community; however, participants released continued to contact me with updates on their release situations. I performed interviews during both instances, transcribed the interviews verbatim, and used coding to uncover themes that presented during those interviews. This researcher gave the transcriptions to the participants for their review to check for accuracy, truth, and honesty in reporting. Upon approval by the participants, this researcher began the coding and writing process, putting the findings to paper, compiling the participants' interviews for themes. I made three attempts for each phase of contact over three days time to review transcripts, the follow-up interview, and to receive final results. If participants wished to forego a meeting for review they consented via e-mail or recorded phone call. I then proceeded with analysis, writing, and

dissemination. If I could not make contact at all after the three calls and three days I wrote it up as a limitation and moved forward.

This researcher's awareness of personal thoughts and feelings were consciously set aside in order to pull findings from information that was for and against possible theories, assumptions, and previous literature, thereby providing both pro and confounding sides of every element in this study (Barusch, Gringeri, & George, 2011).

Role of the Jail Staff

The jail staff involvement in this study was minimal. I used the staff nurse to help in identifying a potential pool of 10 to 15 participants, who were heroin-addicted, English-speaking, having used heroin within one month of incarceration, within a month of release, not actively going through detox, and were eligible for enrollment in Medicaid upon release. The staff nurse, Michelle Robbins, was thoroughly invested in the health and care of inmates at this jail, and knows their needs, programs, and times of release. Michelle Robbins was a neutral party whose daily tasks included tending to medical needs and inmate wellness. She was not in a position of authority over the inmates.

Staff involvement included using the Jail Staff Nurse Screening Guide provided in Appendix B to identify heroin-addicted offenders within the jail. The staff nurse pooled together the most appropriate participants possible, who were cognitively and emotionally competent to complete this study. Offender records, to which I did not have access, aided in the selection of the participants, and the jail staff nurse identified potential participants for the study. Once identified, the staff nurse provided the potential participant with the Invitation to Participate and Consent Form. There was no discussion

about the study between the two, nor did the nurse make any attempt to coerce or convince the inmate to partake.

The next transaction between the potential participants and the staff nurse was to state that they would like to learn more. The staff nurse contacted this researcher to set up meeting times and potential interviews. Communication for scheduling safe and available meeting times was the only further involvement the staff nurse had with this study, as there was no other reason for further involvement.

Researcher Bracketing

Barusch, Gringeri, and George (2011) state that in their study of quality qualitative article that only 14 out of 100 articles provided the role and perspective of the researcher, and that in not doing so excluded the transparency of acknowledging the author's personal lens. I provided my personal lens, beliefs, and assumptions to clarify my perspective of heroin-addicted offenders. I took on a constructivist perspective and no knowledge other than that collected from the participants made up the findings, as their reality is the knowledge this study sought (Ultanir, 2012).

As the sole researcher for this study, I was the only tool of data collection and analysis. I do not have a history of heroin-addiction or incarceration, and I do not have any connections of family or friends to heroin-addiction or incarceration either. This subject blossomed during a doctoral course on public health, and the literature, data presented, and statistics were alarming. I felt compelled to do more research and take consideration for what was happening in our country, states, counties, cities, and communities, because not enough was being done to curtail the heroin epidemic. Articles,

newspapers, magazines, e-blogs, all reported the grave issue that heroin presented, but upon looking, I found that many studies were completed outside of the United States, or were quantitative in nature, presenting statistical information alone.

As I started contemplating heroin-addicted offenders' experiences, I realized that I had a certain idea about addicts, such as they were dirty, homeless, useless, wastes, and criminals, sneaky, thieves, not to be trusted, because they all lack responsibility. These assumptions were present, because I had not considered the reasoning for addicts being in their current situations. Through research and literature reviews conducted during my doctoral studies, the discovery that heroin-addicted offenders are a growing population, led me to choose this topic. I wanted to learn what experiences happened before, during, and after incarceration in relation to heroin addiction. The exclusion of personal details in evidence-based studies is often the case; Human experiences and perceptions are pertinent to figuring out how to stop heroin addiction, and help those who are currently addicted.

In collecting the information needed to satisfy this study and the gaps in previous research, I needed to overcome a few hurdles that were naturally standing in my way. I am a White female, aged 43 years, working on my PhD dissertation. An issue affecting data collection, truth of experiences and participant behaviors centers on how the male participants may react to having a female interviewer, and if they felt the need to impress me with elaborations of the truth or falsehoods. My initial thought was to dress down, blandly, wearing my glasses, minimal make-up and hair pulled back, in order to appear less attractive. My purpose was to engage the offenders without making them think they

were getting anywhere with me personally. My intent was to follow interview suggestions that allowed for honest answers, without directing answers or making the offenders feel like I was looking for one answer or another. Careful listening, intentional questions, and open dialogue helped with trust and calm during the interviews (Miner-Romanoff, 2012).

Being reflexive with offender answers helped to ensure validity and truthfulness, by listening and returning to what was previously said causing them to draw on previous answers thereby revealing what they may not have exposed earlier (Miner-Romanoff, 2012). Miner-Romanoff also suggested asking the same question in different ways to improve triangulation and trustworthiness of answers.

Identifying and Recruiting Participants

Sampling in qualitative studies is concerned most with data richness, obtained with purposeful sampling, and an appropriate sample size providing accuracy for the approach, and research questions asked (O'Reilly & Parker, 2012). Rather than focus on sample size, phenomenological researchers must focus on the adequacy of their sample as it applies to the studied phenomena (O'Reilly & Parker, 2012). For the purpose of this study, I obtained my sample of participants from a jail setting, thereby achieving purposeful sampling as expressed as a qualitative need by Miner-Romanoff (2012). This study needed the perspectives and fresh experiences of heroin-addicts as they moved through the corrections system in order to reveal the full essence of heroin-addicted phenomena on the path to sobriety upon release. I asked the jail staff nurse to help in

identifying heroin-addicted offenders so they could be invited to participate, and provide data through interviews.

As the sole researcher and data collection instrument of the heroin-addicted offenders still incarcerated at the onset of this study, I asked the jail staff nurse to help identify potential participants in order to ensure anonymity and identities of the inmates, thereby keeping their identities unknown to this researcher. I discuss ethical considerations later in this chapter. Upon identification of potential participants, the staff nurse provided them with an Invitation to Participate, the Informed Consent Form, and the study time line. I provide the Invitation to Participate and the Informed Consent Form in Appendices A and B. Offenders who wanted to participate told the jail staff nurse they were 'interested in hearing more' at which point I scheduled a time with staff to meet the offender to review the consent form prior to conducting interviews. I accepted 15 participants who fit the sample criteria described above for heroin-addicted offenders capable of taking part in the study, who were eligible for Medicaid upon release from jail.

Inmates were given one week to consider participating, and if they chose to participate, they let the staff nurse know they are 'interested in learning more' about the study. Although the jail staff nurse identified potential participants and passed along information of interested parties to this researcher, staff in no way recruited heroin-addicted offenders or inmates to participate, nor did the staff offer any guarantees or promises for participating. The nursing staff's main purpose was to identify possible participants to maintain anonymity of the inmates from this researcher. I never learned

the real name of the inmates, because they always used a pseudonym if they decided to participate in the study.

The next section further discusses the ethical considerations for this vulnerable sample of incarcerated, heroin-addicted offenders, in addition to the data collection and analysis processes. Both the invitation to participate and consent forms clearly stated that offenders were participating in a Walden doctoral study.

Sample Saturation

Scholars define saturation as the point at which no new relevant data is being collected (Dworkin, 2012). Sample adequacy is a growing element to qualitative sampling expectations (O'Reilly & Parker, 2012). O'Reilly and Parker state that saturation was originally a grounded theory expectation, but other qualitative research approaches have adapted saturation as a sampling requirement. The authors go on to state that although sample saturation deepens findings and provides an opportunity for transferability, it is not appropriate for all qualitative studies (O'Reilly & Parker, 2012). In qualitative research, the purpose of the study is to explore perceptions and experiences, not count opinions, and so purposeful sampling is a requirement of a phenomenological study, bringing about data rich in the studied phenomenon.

Reaching saturation occurs when a researcher can sufficiently answer the research questions with both breadth and depth, and generate no new findings, themes, or ideas; however, according to O'Reilly and Parker, saturation only occurs when sampling adequate and appropriate participants. Fusch and Ness (2015) state that a failure to reach saturation has a detrimental effect on the validity of a study, because that means not

enough information was collected to support valid findings. Saturation is not about numbers rather the depth attained in answering the research questions (Fusch & Ness, 2015). Considerations to sample size include having enough participants, but not too many as this poses ethical issues on funding and wasting time and money or do not provide enough data that is transferable (Francis et al., 2010). An important factor to consider when recruiting a sample is how the methodology and epistemology apply to the sample and the ability to answer the research questions (O'Reilly & Parker, 2012). Kerr, Small, Hyshka, Maher, and Shannon (2013) performed a study on 18 active heroin users using semi-structured interviews to understand user' perceptions of warnings about heroin potency and how users responded to the warnings. The researchers assessed whether the interviews were substantial enough to gather the needed data, and they made no changes. After 16 interviews Kerr et al. found no new information, however, they completed two more interviews to ensure saturation.

Fisher et al. (2016) completed a study to understand heroin addicts' paths to sobriety. Fisher et al. interviewed five participants in recovery at the time of the interviews, to gain histories and how addiction had 'shaped' participant lives. The researchers obtained similar information from all participants for most questions, all of which were conveniently sampled, and wanted to share their stories (Fisher et al., 2016). The researchers do not mention saturation; however, immersion in the data and transparency of coding hunches are included as contributors to rigor.

Guest, Bunce, and Johnson (2006) completed an evidence-based study using quantitative measures to determine what the best sample size was needed for qualitative

researchers to achieve saturation. After an exhaustive literature and database search, the researchers found that there was no set amount for qualitative samples to recruit, leaving the ambiguous decision to chance and reason rather than evidence. Guest et al. discovered in their phenomenological study of 60 women in Ghana and Nigeria on social desirability bias and self-reported sexual behavior that saturation was achieved at 12 interviews, and data collected after only increased the depth of findings slightly. By using Cronbach's Alpha they found that at 12 interviews they had reached .70, which was considered an acceptable number. After the 12th interview, numbers improved at a slow rate and that saturation was reliable at the 12th interview (Guest, Bunce, & Johnson, 2006).

Allen, Murphy, Kiselbach, VandenBerg, and Wiebe (2015) performed a qualitative study on 11 participants using a semi-structured style with open-ended questions. One of the researcher's focuses was to verify their data and findings through a thorough literature review, identification of any researcher biases, and achieving saturation of the themes (Allen et al., 2015). These researchers estimated the needed sample size by reviewing previously completed phenomenological studies, and did not stop interviews until theme saturation had occurred. Allen et al. purposefully sampled their participants after identification made by support group staff included them as meeting research criteria. Based on the experiences of Fisher et al. (2016), Guest, Bunce, & Johnson (2006), Allen et al., and the assertions of Dworkin (2012), I needed 10 -15 participants in this study to achieve saturation. Dworkin does go on to state that many phenomenological studies using in-depth interviews have contained between 5 and 50

participants in order to obtain saturation. Marshall, Cardon, Podder, and Fontenot (2013) suggest using best practices to conduct 2-3 interviews beyond the point of redundancy to ensure saturation, but warn that too much data can take away from the delicate depth of data needed.

The methodology is phenomenological and requires purposeful recruiting in order to bring in those with the experiences needed to answer the research questions appropriately. Epistemology plays a role by bringing to the surface the knowledge carried by the participants by asking how the participants know what they know and replaces opinion with justified knowledge (Yilmaz, 2013). I considered saturation during sampling in order to ensure I answered the research questions appropriately and with regard to the epistemology, methodology, and adequacy of data collected. In the next section I discuss the ethical considerations to sample recruitment, participant consideration, data collection and analysis, and the informed consent form needed to participate in the study.

Ethical Considerations

Researchers cannot take the study of humans lightly. The risks that human research posed by conducting human research are inevitable, and regardless of the protections put in place by researchers to prevent harm, human participants may still be hurt or put at risk for participating. Different elements of research can put the participants at a greater risk of getting hurt or causing harm. Researcher bias, stereotyping participants, bringing up painful experiences, and station and status in life (Miner-Romanoff, 2012) are a few considerations made for this study that may cause undue harm. The population sampled for this study is heroin-addicted offenders set for release

in one month or less, and they are a vulnerable population because they are in the custody of the Department of Corrections (DOC) and do not have many choices given to them, and are vulnerable to coercion (Copes, Hochstetler, & Brown, 2012). Embedded in this research are assurances that participation in this study was voluntary including the Consent Form, and the Invitation to Participate.

Ethical Protection of Heroin-Addicted Offenders

The ethical protection of incarcerated offenders is of high consideration by IRB to ensure no harm comes to the offenders for participating in a research study. IRBs guide researchers to ensure all protections are in place to prevent undue harm to vulnerable research subjects such as incarcerated offenders. Although there may be social benefits as the outcome of a study, there is still the element of harm that needs addressing. Harm can come in many different forms, such as other inmates viewing the participating offenders as 'snitches', reliving painful memories, or thinking their participation will provide legal help, early release, or benefits to their case (Copes, Hochstetler, & Brown, 2012). Ethical considerations in human research, specifically those of a vulnerable population such as heroin-addicted offenders, show how the researchers will ensure no harm comes to the participants. Researchers may also provide the methodology of how they intend to prevent harm, such as the exclusion of identifiers, locations, and information.

Incarcerated individuals are not free to do as they please, rather they are subject to schedules, defined routines, meals, and events, all of which they do not decide for themselves. Incarcerated individuals are vulnerable, because they are under DOC supervision, and susceptible to possible coercion, or perceived coercion (Copes,

Hochstetler, & Brown, 2012). Coercion does not have to be a negative pressure; rather it could simply be the thought of reward or benefit that persuades incarcerated individuals to participate in research (Cislo & Trestman, 2013). Copes, Hochstetler, and Brown did a study on 40 incarcerated offenders to find out if the offenders felt coerced into taking part or if they felt harmed in any way for participating in research. The findings showed that the offenders did not experience harm or feel coerced, rather they felt better after the interviews as if they were therapeutic, as they were able to relive some moments they had not talked about to anyone (Copes, Hochstetler, & Brown, 2012). These benefits, albeit slight, were important and meaningful to the participants.

Another harm that can occur is researcher bias, because researchers may interpret interview answers through their own personal lens and misconstrue the true meanings given by the participants (Miner-Romanoff, 2012). Researcher bias is a concern that this researcher has addressed in the bracketing sections. Awareness of my assumptions, beliefs, and biases were at the forefront of the interviews to ensure the best possible interview, and allowed questions and information to happen without corruption. Stereotyping the offenders as having certain lives or ways of life is a personal awareness that I brought to this study as well. Knowing my beliefs, assumptions, and opinions ahead of time helped me to keep an open mind when interviewing and preventing directive questioning or misleading conversation that could illicit false or guarded answers, and cause invalid findings. In order to address these concerns and provide clarity to potential participants, I provided an informed consent form describing the process, benefits, potential harm, and reasons behind the study. I asked participants to read the consent

form with this researcher and discuss any questions or concerns prior to verbally accepting the form, thereby allowing an interview to occur.

Informed consent form. I wrote the form using information presented by the U.S. Department of Health and Human Services (HHS) (2016) 45 CFR Part 46.116, explaining the general requirements of an informed consent form. The informed consent form provided details of the research to potential participants, in addition to the research purpose, why I asked them to participate, what their contribution would be in the study, how the study might affect the participants, and provided the details of their participation in its entirety. The consent form was written at a fifth grade reading level, assessed by the Flesch-Kincaid Readability Scale. The participants had to read and verbally consent prior to interview initiation to ensure that participants fully understand their involvement and why, in addition to it being a voluntary choice.

Confidentiality and data collection. The process of completing interviews with a vulnerable population such as incarcerated offenders includes a proper setting, ethical protection of the population, and the safety of the participants from harm within the jail and from legal issue after interviewing. Maintaining confidentiality in research is a requirement of the study per the IRB and the organization or people in the study, such as with a correctional department and incarcerated offenders. This researcher was aware of the issues and harm that could happen during research involving vulnerable populations. This researcher made confidentiality considerations from recruitment to data collection and on to data analysis to ensure the safety of the participants, as well as the protection of their identities and the data they provided. The process of recruiting and performing the

interviews involved considerations of harm reduction and confidentiality; however, correctional officers, who knew the identities of those participating, did escort the offenders to the interview room. The correctional officers were not present in the interview room; rather I asked them to remain outside to prevent hearing the interview and information provided.

The participants of this study were considered vulnerable because of their special circumstances as incarcerated offenders, which placed them at risk for coercion and pressures either real or perceived (Wijk & Harrison, 2013). Wijk and Harrison explain that the best place to perform inquiries with vulnerable populations is in their own living space, which, at the time of initial interview, was in the jail. Apa et al. (2012) add that in order to maintain proper and rigorous research in a jail setting, researchers must accommodate jail cultures in terms of time management and schedules, providing ample time to conduct interviews and allow for any changes, and to maintain security, privacy, and confidentiality.

Even though there is no risk of medically-related harm in qualitative research as in experimental research, harm can still exist. Emotional and painful memories may cause physical harm caused by the distress of talking about painful events, and must be considered when discussing ethics and confidentiality. Ensuring that data remains anonymous and confidential can protect a participant from sharing their personal story without wanting to (Gibson, Benson, & Brand, 2012). Gibson et al. (2012) stress the importance of maintaining a proper interview relationship to prevent data distortion. Ending data collection properly, and negotiated in a way that participants are not left

thinking more of the interaction between themselves and the interviewer are important factors in ethical treatment of participants and the way data is collected (Gibson et al., 2012). This researcher did not want to behave in any way that lead the participant to believe their interview was anything more than a means of collecting data about their life experiences related to heroin addiction and incarceration. To ensure data collection was completed without harm, this researcher dressed down, was aware of body language, tone, and eye contact. Confidentiality around data collection makes the participants feel safe, and my behaviors as the sole researcher contributed to that feeling of safety as well.

This study pursued the safety of its participants above all else, maintaining confidentiality and anonymity of participants. The National Institutes of Health (NIH) (2015) states that a Certificate of Confidentiality (CoC) is needed when the study will collect personally identifiable information; and/or collect other identifiers such as social security numbers or addresses, which I did not be collect. A CoC is required when a study cannot be conducted anonymously and relies on personally identifiable information (National Institutes of Health, 2015), which I not be include in the study. Only pseudonyms were associated with transcripts, and contact information was associated with pseudonyms and kept in a separate password-protected file, away from transcripts. I now discuss the transcription and data analysis process for this study.

Data transcription and analysis. Transcription is the conversion of tape recorded data to written form, and helps to unwind the complicated experiences of qualitative study participants (Widodo, 2014). To understand better participant experiences, I transcribed all collected data myself, from recording device to computer,

and saved all transcribed data on its own password-protected flash-drive. I transcribed the recorded interviews verbatim to ensure an accurate capture of participant experiences. I used observational notes to triangulate and support participant responses at time points in the recordings, which were then scanned and saved on the flash-drive for data analysis.

In order to increase rigor and accuracy of the data collected, participants had the opportunity to review the transcripts prior to analysis. Meetings were set up once all transcripts were completed using the contact information provided by the participants during initial interviews, and participants could read the transcript associated with the number they chose upon interviewing. If participants could not remember their chosen number they could not read the transcript, and I mentioned this importance in the consent form as well. The purpose of the number was to keep the participants anonymous and protected from both any future legal actions and myself. This researcher, to further protect the participants, in addition to being a dissertation study where only one student completes the analysis, conducted transcript analysis alone.

Data Collection

Data is an element of research where researchers either collect data or use databases to complete a study. This researcher was the data collection instrument, performing semi-structured interviews using interview questions accepted by a Wisconsin State prison warden with 30 years experience, and the doctoral education psychologist at the local hospital. Semi-structured interviews are the data collection technique employed by phenomenological researchers to obtain personal experiences from participants as well as perspectives (Irvine, Drew, & Sainsbury, 2012). Data was

collected using a digital tape recorder, in addition to written notes. Being able to collect pertinent and meaningful data means knowing how to speak to and understand heroin-addicted offenders.

As the data collection instrument, I have many years of dealing with and speaking to vulnerable men, women, and children. My experience in interviewing consists of 30 years dealing with sensitive issues among hundreds of clients worldwide involving suicide, addiction, and loss. I not only work one-on-one with people, but I do private group work, and public speaking events to help guide people on their life paths, provide vision, and direction when they are lost.

Interviews were the data collection means of this study, with extra focus on trustworthiness, transparency, saturation, and validity, all of which lent to the overall quality of data collection in qualitative studies. Elo et al. (2014) state that to have a study worthy of trust is to present a study with findings are worth the effort of reading. Trustworthiness entails offering a study that accurately reports the process of data analysis, and how data is collected in the first place, how the sample is acquired, and if the analysis method aligns with the theory applied. I was more than capable of maintaining trustworthiness in this study. Trustworthiness, as it pertains to theory adhesion is explained in Chapter One, Theoretical Framework. Another facet of validity is transparency discussed in the next section.

Transparency

Transparency is a marker for a quality phenomenological study, meaning the researcher provided a detailed description of the data collection process (O'Reilly &

Parker, 2012). In addition to explicit data collection documentation, in order to produce a transparent study, researchers must explain how they reached saturation of data not just that findings are saturated (O'Reilly & Parker, 2012). Transparency of data collections also lends to study validity (O'Reilly & Parker, 2012). The steps in this study were to recruit my sample, gain consent, set up and complete interviews, and offer participants the opportunity to take part in the local hospital's outpatient substance abuse. I then transcribed the interviews, obtain approval from each participant that their interviews are correct, relevant, and accurate, analyzed the transcripts, observational notes, and recordings, reported findings, provided participants the chance to see their contribution to the study, and completed the study.

Triangulation

I employed a semi-structured guide to complete the interviews to ensure the best possible opportunity to collect data needed, without leading the participant or failing to include pertinent questions. I provided the semi-structured interview guide in Appendix F. The questions developed were to swirl and reflex around the answers provided with the intention of triangulating answers from several different points as with a triangle. Using different questions to ask about the same event or topic provided support and validity to what the participant was telling. I looked for similarities in those answers to ensure an honest answer about a topic. Interviews were the main form of data collection, with observation notes triangulating the interview data, thereby contributing to validity.

I asked questions to gain different aspects about heroin from the same participant, such as if they felt driven to use heroin, or if they chose to try it on their own. Questions

asking different accounts on the same topic helped to support and triangulate an aspect of using heroin.

Initial Interview Process

The jail staff nurse identified a pool 30 potential participants and once the inmates expressed interest in learning more to the staff nurse, interviews were scheduled and commenced, at which point I reviewed Informed Consent Forms with the participants. Upon acceptance of the consent form, data collection began using semi-structured interviews. The purpose of the semi-structured interview was to allow heroin-addicted offenders to answer openly, directed towards the needs of the study, rather than provide vague experiences. Interviews were set up in private, safe areas for both the offender and me. Although a correctional officer escorted the offender to the interview, the officer was not be in the room during the interview process, rather we were placed in safe rooms with video cameras to ensure safety; however, recording devices were not used in the rooms. We were placed in private video courtrooms away from everyone else for privacy.

I began by establishing a working relationship to build trust. A good rapport with the participants was essential to information quality; however, knowing where to stop or back off with the population I studied was essential to data collection and preventing harm (Gibson, Benson, & Brand, 2012). I introduced myself as Becky, and I treated the participants with all respect even though I did not use their names, rather I called them whatever they wanted me to call them during our time together.

Follow-up Interview Process

Upon release, all participants had the opportunity to take part in the local hospital's outpatient substance abuse program, hence the need for Medicaid upon release. The participants did not have to accept this offer of treatment, and could turn it down without issue, as described in the Consent Form. I noted in the findings if participants chose to take part or declined, and explained the reasoning for their choices in the findings following the completion of follow-up interviews. If I found upon meeting with participants for the follow-up interview that they are under the influence, or coherently unable to complete the interview, such as slurring of speech, inability to make eye contact, fidgeting, restlessness, paranoia, or other unstable behaviors, I asked if they are able to take part in the interview. I made note of the impasse, and ethically declined the interview. The purpose of a follow-up interview was to assess how heroin-addicted offenders moved from incarceration to release and experienced sobriety; however, I did not take advantage of a situation that would affect the validity of this study. Notes were taken about the issue, and that information was reported in limitations.

The follow-up interviews occurred approximately 3 weeks after the initial interview within the local public library, a McDonalds, and over the phone. Each participant provided contact information and associated it with their chosen pseudonym to maintain confidentiality and anonymity throughout the study, while at the same time providing me with the means to contact them for interviews. I used a semi-structured guide for these interviews in order to best capture participant experiences on their

pathway to sobriety upon release without leaving out pertinent information, which I provided in Appendix G.

At the 3-week mark past initial interviews, I contacted participants using the information provided to me under their pseudonyms. I also provided participants with an e-mail address specifically created for this study in order to contact me anytime at fdlstudy@hotmail.com, if they wished. Any contact information obtained for each participant was kept in a password-protected private flash-drive different than the one used for transcripts, and kept in a lockbox within my home. I discarded participant contact information once the participant viewed their transcript. Upon making contact we scheduled the interview in the local public library, where others could not overhear the interviews. Participants who took part in follow-up interviews received a $20 Visa Card as compensation for their time, useable at any chosen location. Topp, Islam, and Day (2013) showed in their study on compensating people who inject drugs (PWID), that there was a preference for a cash reimbursement over a restaurant or grocery voucher so they could buy gas or other means of transportation. Topp et al. provided a compensation of $20 per participant who completed interviews, keeping ethical considerations in mind for giving PWID cash, as did Al-Tayyib, Rice, Rhoades, and Riggs (2014) who compensated PWID and homeless youth with $20 for participating in their study on prescription and injectable drug use. With these studies in mind I chose to give the $20 Visa card to allow participants the opportunity to spend the money where and when they chose, while limiting the chances of spending any money on illicit drugs.

Ensuring participant comfort extends beyond the physical aspects of the interview environment to the interview itself, such as using the language and tones understood by the participant, moving at the speed of the participant, and listening to what the participant is saying while 'spiraling' back for more information and clarity (Nelson, Onwuegbuzie, Wines & Frels, 2013). Nelson et al. also suggest using an iterative process of moving back and forth in the process using some or all of the elements of spiraling to address participant input and feelings, and remaining flexible. This therapeutic technique allows participants to fully explain and divulge personal experiences that might go overlooked if allowed to pass without reflecting back; therefore, interviewers must be conscious of comments at all times (Nelson et al., 2013). The focus of data collection for each participant will be to saturate the interview with experiences, and then ask a question in a different manner to validate data the participant provides. The participants reviewed transcribed interviews prior to data analysis, and analysis followed, prior to writing reports. I discuss data disposition after five years later in this chapter.

Data Analysis

I analyzed the data using a phenomenological approach to discover the phenomena experienced by heroin-addicted offenders (DeFelice & Janesick, 2015) as they moved through their lives to sobriety, starting at a point of incarceration. I used the steps suggested by Moustakas (1994) for grouping, reducing, and eliminating data, in addition to searching for themes and frequencies among the participants using Atlas-ti, a qualitatitive data analysis (QDA) software program that enables the organization and analysis of qualitative data (Feldstein et al., 2013). Although researchers can analyze data

by hand, the use of a QDA program can ease the task of sorting through, categorizing data, and identifying themes and clusters (Yarborough et al., 2016). I also followed Moustakas' idea of *epoché*, which is to bracket all of my preconceived notions and ideas about the participants and heroin addiction, which enabled the discovery of the experienced phenomena rather than an assumed experience.

The data analysis included digitally tape recorded interviews, field and observational notes, in addition to the Atlas-ti QDA. In an attempt to increase trustworthiness, I strove to reduce the data to categories and concepts that honed participant experiences down to the research phenomenon. To maintain validity, a clear route of analysis and reporting was included and transparent. The first step was to listen to the recordings. I then transcribed the recorded interviews verbatim using the Atlas-ti software, and used the software to help with analyzing and organizing my data. I approached the data with an inductive manner, which is a phenomenological analysis technique, examining every sentence and statement for information that not only answered the research questions, but also possibly added a refuting perspective. I found and developed codes and set them in groups, which I then organized into categories.

I considered, categorized and coded phenomena and data until I achieved saturation to prevent misinformation or lost possibilities. At the same time, I categorized the experiences and phenomena into similar groups that shared like-thoughts and ideas, as they became the central themes studied. I pre-coded using the research questions and concepts in the study as initial means of answering the questions; however, from those new codes emerged connected, and bridged experiences and phenomena not considered

when starting the research. I provided a real, true account of heroin addiction and sobriety upon release, with the direction and focus to crossover and connect the phenomena as they unfolded. I followed Moustakas (1994) with my data analysis in terms of horizontal descriptions of perceptions and factors related to the participants' sobriety or relapse.

Limitations to obtain the truest data from this vulnerable population was real as some attempted to impress me with their stories, protect themselves, or embellish their real experiences. In addition to limitations of data collected during the initial interviews, I incurred limitations of data collection during the follow-up phase of interviewing. I discuss strategies addressing these limitations in the next section.

Strategies for Data Validation

Qualitative studies can explain and provide the means by which a researcher completed a study, however replicability is not the case with qualitative studies and is pointless in the traditional sense of reliability, rather trustworthiness and transferability make up a quality qualitative study (Yilmaz, 2013). Trustworthiness and accuracy in qualitative studies is achieved when data is truthfully and meticulously reported from both the researcher's and participants' perspectives alike (Yilmaz, 2013). Limitations in research are issues with the way data are collected, such as a participant's in ability to recall accurately an event that a research is seeking to understand (Venkatesh, Brown, & Bala, 2013). Venkatesh et al. stress the potential of limitations on data collected, and hence findings, can cause issues, because limitations can cause validity issues through a loss of data accuracy, and loss of trustworthiness. One way to ensure trustworthiness and accuracy for this study was to allow the participants the chance to approve their

transcripts prior to coding, thematic review, and publishing, thereby accurately echoing participants' viewpoints. I triangulated the interviews with observation notes taken during the interviews, and recorded physical behaviors and nuances that digital recording did not pick up (Hays & Wood, 2014).

Credibility and dependability are important facets of a quality qualitative study. The means by which data is collected can increase credibility and is one way to ensure the dependability of data analysis (Elo et al., 2014). The most suitable data collection instrument for this study was I, employing semi-structured interviews, providing structure to the interview, yet not leading the participant to inductive answers (Elo et al., 2014). Another way to help achieve credibility is by providing confounding information that expresses an opposite view of what a researcher is asking in their research questions, and by providing explicit descriptions of the researcher's presence and role in the study, as well as clearly stating research questions that are congruent with the study's design (Barusch, Gringeri, & George, 2011; Yilmaz, 2013). Rigorous data collection methods, such as triangulation, rich data collection, and external review, provide the means to credibility (Yilmaz, 2013). I included pure description from the participants about their activities, and experiences, and the settings in which I interviewed them to increase credibility (Barusch, Gringeri, & George, 2011). I also increased the chances of dependability and trustworthiness of this study by implementing a rigorous data analysis process, including how data was collected, prepared for analysis, and reported, and I included any limitations of inability to interview participants for follow-up interviews.

Data Disposition at the End of the Research Process

I will retain data collected for this study for five years securely on a locked flash-drive. I scanned and digitally saved all written notes and field notes on a secure flash-drive as well. I immediately shred all written field notes upon saving them to the flash-drive. Once tape recordings were transcribed I deleted them from the digital recording device. I deleted and destroyed all contact information upon participant review of transcriptions. After five years, I will destroy all written data saved on the flash-drive by deletion and breaking of the flash-drive. No identifiable information will be on any of the data in order to maintain participant anonymity.

Summary

In this chapter, I discussed the research design and methodology, along with my procedures for participant recruitment, and data collection and analysis. The purpose of this phenomenological study was to discover how heroin-addicted offenders experienced sobriety upon release, with the intention of shedding light on a difficult process from the perspective of the addicted user. The sample consisted of 15 incarcerated offenders who entered jail with a current history of heroin use, and who were emotionally and cognitively capable of completing this study, all of whom took part in semi-structured interviews with this researcher. I collected the data with recorded interviews, analyzed the data using the Atlas-ti QDA, and discuss the findings in Chapter 4.

Chapter 4: Results

Introduction

Heroin addiction is a growing epidemic in the United States. According to a national survey on drug use and health, 473,000 individuals ages 12 and up were addicted to heroin in 2014, with individuals ages 18-25 being the highest users in the year 2013-2014 (Substance Abuse and Mental Health Services Administration, 2015a), compared to 591,000 in 2015 (Center for Behavioral Health Statistics and Quality, 2016). Heroin-related deaths have more than tripled since 2010 from 3,036 to 10,574 in 2014 (Centers for Disease Control and Prevention, 2015).

The purpose of this qualitative study was to explore the experiences of heroin-addicted offenders paths towards sobriety upon re-entry into society and obtain new information about what is needed to help them maintain sobriety during and after incarceration. The participants in this study met me to complete semistructured interviews to address the following research questions:

RQ: What are the internal and external motivating experiences of heroin-addicted offenders prior to and upon release from jail in maintaining sobriety?

The following subquestions will further guide the focus on this study:

SQ1: What role do internal and external motivators play in regards to treatment and sobriety during incarceration and upon release?

SQ2: How do internal and external motivators and the theory of personal causation affect perceptions of social constraints to sobriety such as

unemployment, loss of personal relationships, and lack of support for heroin-addicted offenders after release?

The results of this study could facilitate positive change for heroin-addicted offenders at all levels of their lives, from personal to interpersonal to community, both while incarcerated and upon re-entry. The results could aid community leaders and professionals, treatment specialists, and medical staff to develop programs honed for heroin addiction and save resources by creating less wasteful programs that are perceived as helpful from an addict's perspective. Evidence from this study could change the way community leaders approach treatment on several levels. Users' viewpoints were obtained in this study and provide the data needed to reframe treatment programs to better suit the needs of heroin-addicted offenders in the community.

This chapter describes the means of participant selection, data collection and storage, analysis, data quality verification and saturation, and theme results. Further, this chapter discusses how Moustakas' (1994) research approach guided this study, using horizontalization, reduction and elimination of codes, categorization of meanings, and development of themes through the recognition of common phenomena. Also following Moustakas, I describe *epoch* and discrepant cases throughout the chapter.

Recruitment

I recruited participants from a county jail in the Wisconsin. All males and females who were incarcerated with a history of heroin addiction and were cognitively capable of completing the interview process were invited to participate. I provided copies of the invitation to participate (see Appendix A) as well as the informed consent form to the

staff nurse. The staff nurse reviewed 300 inmate charts and located 30 inmates who fit the criteria of having used heroin prior to incarceration, were cognitively capable of completing the interviews, were not actively going through detox, were English speaking, and were eligible for Medicaid upon re-entry.

A total of 30 incarcerated offenders were invited to participate, and 16 responded who wanted to learn more about the study. To facilitate inmate personal response, all potential participants were provided with the invitation to participate, consent form, a time line for completion, and a piece of paper that read, "Please give to the nurse. I wish to know more about the study." This piece of paper allowed the inmates to request more information without being charged to see the nurse. The nurse then knew who wanted to know more and included them in the potential participant pool. It took one week for offenders to respond as wanting to participate or know more.

Initial Interviews

Initial interviews were set up a week after consent forms had been disbursed, and offenders who wanted to know more about the study had replied. I confirmed that each offender fit the criteria for participation, reviewed all paperwork and forms, and answered all questions prior to beginning the interviews. Interviews commenced upon oral acceptance of the consent form information. I completed initial interviews with 15 of the inmates, and one decided not to participate during the initial discussion. I completed initial interviews within two weeks of invitation acceptance. Five females and 10 males participated in initial interviews lasting 45 minutes to 1 1/2 hours in length.

When transcripts of the digital recordings were completed, I went back to the jail to give participants who were still incarcerated a chance to review and approve their transcripts. In order to maintain anonymity, I asked the jail staff to bring everyone who was on the interview list and still incarcerated down to meet with me. Upon meeting with each participant, they revealed to me the number they chose as a pseudonym, and they were allowed to read their transcripts. To accept their transcripts as approved, they wrote their number at the top of the transcript. We reviewed any questions or issues at that time. All participants with the exception of #1, who had been released, and #0420 who had gone to prison, approved their transcripts.

Follow-Up Interviews

I explained to all participants that a follow-up interview would be scheduled within three weeks of re-entry, at which point I would provide them with a payment of a $20 Visa check card thanking them for their time. I explained this to all participants prior to them agreeing to participate, though some of them knew they would not be released in time due to court dates or would be transferred to a prison setting; however, they still chose to participate to contribute to the study.

Five participants were released in time for second interviews. Four of the participants provided me with their cell phone numbers and possible release dates, so I was able to call them and set up times to meet. I completed four follow-up interviews in time for this research. I conducted one interview at the local library, two over the phone due to limited time of work release, and one at a distance in a McDonalds of her choice. I recorded all follow-up interviews, transcribed them verbatim, and then coded them in

Atlas-ti. The fifth participant e-mailed me his phone number upon re-entry, and I called him to set up an appointment. The fifth participant relapsed, and we never met. His father called, thinking I was a friend, to tell me he had been rearrested and is currently in another county jail.

Participant Profiles

The participants were initially incarcerated in a city jail in rural Wisconsin. The participants were of varying ages. All 15 of the participants were white, five were female and 10 were male. Four of the participants were not married but were in relationships, while the others were all single. Table 1 provides brief profiles of each participant at the time of the initial interviews.

Table 1

Participant Profiles Initial Interviews

Participant #	Age	Gender	Yrs of heroin use	In jail	Relationship status	Treatment in jail
1050	25	Female	2	Yes	Single	AA
23	38	Female	18	Yes	Boyfriend	AA/NA
5	25	Female	8	Yes	Engaged	AA/NA
6969	52	Female	10	Yes	Married	AA/NA
2640	25	Female	3	Yes	Single	AA/NA
69	38	Male	21	Yes	Engaged	AA
14	38	Male	25	Yes	Single	AA
1	55	Male	8	Yes	Single	AA
0420	33	Male	20	Yes	Single	No
4733	34	Male	6	Yes	Girlfriend	AA
7	25	Male	11	Yes	Single	AA
2	25	Male	10	Yes	Single	No
2977	22	Male	4	Yes	Single	AA
7667	38	Male	23	Yes	Girlfriend	AA

AA = Alcoholics Anonymous, NA = Narcotics Anonymous

Table 2 shows the dispositions of the participants at the time of follow-up interviews. Although participants were all allowed a chance for member-checking of their initial interview transcripts, only follow-up interviews completed outside of the jail showed changes.

Table 2

Participant Profiles Follow-up Interviews

Participant #	Disposition	Relationship status	Post-re-entry treatment	Going to prison	Employment status	Relapse
1050	J	Single	N/A	AS	N/A	N/A
23	WR	Boyfriend	Possible	AS	Yes	Denies
5	J	Single	N/A	N/A	N/A	N/A
6969	R	Separated	AA, M	N/A	Unknown	Yes
2640	J	Single	N/A	AS	N/A	N/A
69	R	Engaged	AA, M	N/A	Yes	Denies
14	J	Single	N/A	AS	N/A	N/A
1	R	Unknown	Unknown	Unknown	Unknown	Unknown
0420	J	Single	N/A	AS	N/A	N/A
7735	J	Single	N/A	N/A	N/A	N/A
4733	J	Girlfriend	N/A	AS	N/A	N/A
7	J	Single	N/A	N/A	N/A	N/A
2	R	Single	N/A	N/A	N/A	Yes
2977	WR	Single	AA	N/A	Yes	N/A
7667	R	Girlfriend	No	No	Yes	No

AS = Awaiting sentencing, N/A = Not applicable, WR= Work Release, J= Jail, R=Released, M= Meetings, AA= Alcoholics Anonymous.

Participant 1, #1, was a 55-year-old, single, White male diagnosed with schizophrenia and bipolar with psychotic traits. He had no children, but spoke of a nephew who was very important to him. He lived with a friend whom he saved from a heroin overdose prior to this incarceration. He spent a total of 24 years in prison, and stated that he was simply "stuck on stupid" all those years. He talked about being judged all his life and this seemed to be a trigger for much of his behaviors. He stated that he came from a wonderful home with loving parents. His drug usage started with marijuana and OxyContin at the age of 15 and he had not been sober more than a year since. He stated that even when he was sober and not using, he still continued to be incarcerated due to behaviors. Treatment at the age of 19 was voluntarily completed after a finding of not guilty due to mental defect for three charges. He managed to stay sober for 2 years. Relapse was because "drugs were pulling me more than the reality of everything." He was trouble and drug-free for 5 years prior to this incarceration, which was due to a drunk and disorderly charge and issues with phone calls.

Participant 2, #23, was a 38-year-old, divorced, White female, currently in a relationship. She had two grown children, one of which was expecting a baby and getting married. Her aunt and uncle adopted her children when they were younger. Her drug use started after her father died due to alcohol, marijuana, and cocaine use. She remained clean for a year and then tried heroin out of curiosity. This incarceration was due to heroin possession and forgery to obtain heroin. She had experienced an overdose where she died and was coded before being revived and overdosed three additional times after that where Narcan was used to bring her back. She had experienced 18 years of addiction.

Her treatment experiences involved detox in jail, voluntary treatment while incarcerated, and outpatient programs when released. She stated that, "It is difficult to keep up with treatment on an outpatient level due to work."

Participant 3, #0420, was a 33-year-old, twice-divorced, White male, who was being transferred to prison within a couple weeks of the initial interview. He had a 3-year-old daughter who was born addicted to pain killers and heroin and was being adopted by another family. His history included addiction, physical abuse charges, relapse, and recidivism. He had voluntarily attempted sobriety using the methadone clinic but was concurrently taking pain killers and antidepressants. He also experienced voluntary treatment while incarcerated as an alternative to revocation, which he believed was a forced situation that he accepted voluntarily. Prior to his current incarceration he was at a treatment center and stayed clean for a month and a half. He said that there were people using heroin, methamphetamines, drinking, and taking OxyContin, but he stayed clean. He took OxyContin for pain resulting from a kidney disease. Upon release from the treatment center he relapsed after 11 months of sobriety and used heroin. He entered the methadone clinic again. One night he stated that he blacked out and awoke to his girlfriend having been beaten up. Her testimony of allegations of abuse caused him to be arrested. He had been addicted to heroin for 20 years and did not partake of treatment programs in jail. He didn’t believe the jail treatment programs were worth the time and stated, "What is that going to do? It's going to make you turn to the same thing before as you turn to it before, your drugs." He mentioned wanting medical treatment, not just a group to talk out feelings.

Participant 4, #7, is a 25-year-old, single, White male. His drug use started with marijuana, alcohol, cocaine, ecstasy, and painkillers, bridging the pathway to heroin use for the past 11 years. He has many experiences with treatment due to drug use with every incarceration due to heroin and drug use. He stated that he voluntarily entered treatment prior to incarcerations, but entered a boot camp program upon entering prison. He followed up prison release with a residential treatment program two years ago. He stated that previous treatments were to look good in the judge's eyes upon sentencing with the chance of re-entry. This current incarceration was due to drug use of meth, other opiates, and heroin. He went through detox upon entering jail this time. He states that this is the first incarceration where he is taking treatment seriously, participating in Christian AA and focusing on sobriety not socialization or future 'hook ups.' His motivations this time to stay sober are internal as he stated, "But this time around it's been a lot more me trying to fight those feelings because it's done nothing but lead back to the situation every time." He expects to get released soon.

Participant 5, #7667, is a 38-year-old White male, in a relationship. He has a three children, two older and a one year old son with his girlfriend. His current incarceration happened while he was driving to Milwaukee to buy heroin and was pulled over and arrested on a child support warrant. He has used heroin since the age of 15 for a total of 23 years off and on. He has self-treated his addiction by buying methadone off the streets, but eventually went voluntarily. The issue with continuing the methadone clinic was that it caused a vicious cycle of use, and it conflicted with his work schedule as he stated, "I like it in a way at first, ... you know, but having to go there every day really bothered me,

because I have to work and I don't know how long it's going to take. Do you have to see a counselor, have to do this or that?" He attempted to quit heroin altogether using the methadone clinic, but he said he was held at a high dose and they would not drop him any further than 90 mg dose. He stated that his leg cramps and insomnia kept him from maintaining sobriety, but found that cutting himself off did not cause withdrawal. During this current incarceration, he is taking part in AA and expects to be released in June. He plans on finding a doctor who will prescribe him pain killers upon re-entry to help with his previously sustained injuries and broken bones.

Upon our follow-up interview, #7667 was happy despite relationship tensions between he and his girlfriend, and the legal issues involving social services to get his 1-year-old son out of foster care. He is currently employed, but has not sought out treatment, because it conflicts with work; however, he plans on meeting with a physician for pain management. He commented that he would like to call and update me on his progress in the future.

Participant 6, #1050, is a 25-year-old, single, White female with no children. She has several charges of theft, all of which were due to attempting to purchase heroin with one previous incarceration in jail. Initial drug use consisted of Percocet and other painkillers from job related pains, which bridged to heroin addiction. She started using heroin in the attempt to find a common ground with a boyfriend. She found herself addicted to heroin after the loss of contact with a drug supplier. Previous attempts at sobriety were self-medicating with Gabapentin, Seroquel, and Suboxone. She wanted to quit, but did not want to go through withdrawals. Relapses were frequent because she did

not want to be sick from withdrawals, and she believed she could get sober on her own. During her current incarceration she stayed in the Huber work release program through the jail, but ended up bringing heroin into the facility, and lost that privilege. She had a previous release date of December 2016, but was caught with heroin in the jail and had given it to other inmates so was charged with several new cases. This current incarceration has been nine months in length with the hopes of being released in June or July for Huber work release rather than prison time. She believes that incarceration itself is treatment, and takes part in AA and NA group meetings. She has what she calls an 'addict mindset', her perception of what she can and cannot do has changed since her new cases have happened as she stated, "That was all before I caught this manufacturing and delivery, so it was like I felt like I could still go out and do it every once in a while. It was still in the back of my mind. Now...? It's not even there. There isn't even a question about it."

Participant 7, #2977, is a 22-year-old, single, White male with a 4-year-old daughter. He has been addicted to marijuana and opiates a total of 12 years with 4 of those being on heroin. He is currently partaking in Huber work release, and attends AA meetings in jail. His previous attempts at sobriety included the methadone clinic which he stated did not work because it was another way to get high. He also stated that he quickly turned to crack cocaine while on methadone, but never felt sober or clean, because the clinic kept raising his doses, which in turn caused him to get high. He would stop feeling those affects and smoke crack or shoot heroin. All of his incarcerations involved drugs or thefts conducted to obtain money to buy drugs. His current incarceration is for two years

with an expected release date of March 2018. During this time he will continue to perform on the work release and take part in treatment programs. He states that he detoxed when he entered jail this time, and that the programs are something, "You gotta want it in here, because there's nothing for you in here." He is concerned about the programs for men in the jail too that would help if they were better managed, "I think they need to have NA. They only have it in here for females there's just no one to do it though, it's all voluntary..there's no one to do it in here...they do the AA, but it's like no one takes it serious...I mean we're all in jail and no one takes it seriously."

Participant 8, #6969, is a 52-year-old, married, White female with three children, one of which is currently in a Wisconsin prison. Her addiction started in her 40s after her children were born. She was injured at work and started purchasing opiates for the pain as well as providing her the ability to complete her work as a CNA. She mixed that drug usage and crack cocaine with alcohol, and once cut off from her painkillers, she transitioned to heroin. Her previous incarcerations included several durations for drunk driving ranging from a weekend to a year, behavioral issues, and 30-days for drug paraphernalia. She took part in voluntary treatments with external motivations to partake, such as participation to obtain a shorter sentence or no time in prison. After a treatment alternative program (TAP) as an alternative to prison she spent at home with a GPS bracelet for one year, she took part in a one-year research study where she was provided with Suboxone to test its efficacy for heroin treatment. After that year she was cut off from the Suboxone and could not pay for treatment out-of-pocket, so she entered the methadone clinic. She stated, "It's a slippery slope with me cause I get high with

methadone..so I started abusing that." She was aware of her current incarceration happening and attempted self-detox at home, then a voluntary treatment program, and ultimately walked out. She then relapsed and returned to using heroin. She believes incarceration is an involuntary treatment program in a good way and is happy to be in a place where she knows she is safe from using. She involved herself in both NA and AA during her incarceration. She made this statement, "Well life with drugs I would end up back in jail I'm sure eventually I could end up dead, I mean I realize I'm an intelligent woman and I realize that going out of here if I decide to do dope again I'm most likely going to if not OD, die."

She was released and 2 days later relapsed and overdosed. Her neighbor found her and called for help. She received three shots of Narcan to bring her back. Her fear of overdosing caused her to see her probation officer, a doctor for anti-depressants, and a treatment program for the Vivitrol shot. She stated during her follow-up interview, "Overdosing scared me to death. I've never done it I really kind of open my eyes to what can happen."

Participant 9, #2640, is a 25-year-old, White female with two children, and a significant other. Her addiction started in 2010 with painkillers, opiates, and Percocet, and then transitioned to heroin in 2014. She has been incarcerated twice both due to drug use, and stated that her previous re-entries involved being bailed out and buying heroin immediately upon re-entry. Her last re-entry she obtained the Vivitrol shot and has stayed sober ever since, a total of 7 months. She did not detox in jail, and takes part in both AA and NA treatment programs. She talks about her supports, her desire for a college

education and degree, and the ability to take care of herself and her children. She does speak of her desire to smoke crack cocaine and use ecstasy though, as she does not see them as addictive to her or her drugs of choice. She stated, "I mean I smoke crack once in a while, but heroin is my drug of choice..so I'm not condoning any sobriety, but being faded from all day every day to smoking crack and taking some Molly, I really don't think that's a huge issue." Her current incarceration is due to paraphernalia and felony bail jumping with a bail she refuses to pay and is to be sentenced in May. She talks about needing support once she gets out in order to learn to deal with her triggers and fears.

Participant 10, #5, is a 25-year-old, White female in a relationship, with no children. Her addiction started with smoking cigarettes and marijuana as a teenager, and transitioned to heroin and other opiates. Her mother has played a huge role as a support for success, as well as an external motivation to quit using. She also carries a lot of guilt about using, and putting her mother through 8 years of heroin addiction. She stated that she had many incarcerations ranging from drunkenness to drug use to theft and burglary. She has taken part in treatment programs, one of which is the methadone clinic; however, methadone makes her high, and she has used it to get a "legal high." This current incarceration occurred after an arrest for burglary while on felony papers in addition to being high. She expresses several times that she wants treatment, wants to be sober, and knows she needs help; however, she stated that, " I have no willpower to do it on my own clearly I can't do it on my own," and also that she does not want to be forgotten simply because she is an addict. She is looking forward to a residential treatment program upon re-entry in May or June, and currently takes part in both AA and NA in jail. She also

looks forward to sharing her story and possibly doing motivational speaking to high school students.

Participant 11, #69, is a 38-year-old, engaged, White male, with two step-children. His addiction started 21 years ago with marijuana, alcohol, and crack obtained from his mother, all of which led to heroin. He stated that his family was nothing but drug addicts and alcoholics. His previous incarcerations involve drug use, assault and battery, and thefts related to drug use and funding the habit. He has made several attempts at sobriety, both in voluntary and mandated treatment programs. He spent 420 days sober while incarcerated and was sent to a work release program; however, he states that drugs were rampant through the facility and he ended up relapsing with 5 months left on his sentence. He voluntarily entered a methadone clinic at one point, except the classes for treatment were mandated. He relapsed due to appointment scheduling conflicting with work, and stated that being mandated for anything did not work for him. He reverted right back to heroin while still on methadone. He chose to leave his lifestyle and move from Chicago to Racine, Wisconsin to try and get clean. He stayed sober for 5 years by doing this. Relapse occurred when his brother was shot and killed and he went back to Chicago in search of drugs to relieve his pain. He stated, "I didn't want to feel the pain," and admitted to seeking out dealers and drugs. This relapse is why he is currently in jail. His fiancé is a support on the outside, and he hopes to get a job and treatment once released. He stated, "Continue going to AA..get a sponsor is what I really want to do . . . um . . . keep moving forward instead of backward."

He was released a couple weeks later earlier than expected and we completed our follow-up interview. .He had obtained employment as he stated he would, met with his probation officer and joined the local AA group, and met with his doctor to obtain anti-depressants and anti-anxiety meds. He also met with the hospital treatment coordinator and joined meetings there as well. He called me a week later and told me he had gotten a checking account for the first time in his life. He was very proud.

Participant 12, #14, is a 38-year-old, single, White male with three children. He states that he has been an addict since the age of 13 and locked up almost all of his life. He admits to drinking and using many various drugs throughout his life, all leading up to his heroin use. His past treatments include those completed while incarcerated, all of which are voluntary or externally motivated. His current incarceration occurred after 10 months of sobriety, due to a "few stupid things to get money to get high," and overdosing on heroin while on felony papers. The sober period was after he moved away from his normal influences to be with a girlfriend one hour away. He lost his jail time and current sentence due to the heroin use and is now looking at going to prison to finish his sentence. He claims to have overdosed around 10 times, yet continued to use. His view of treatment is that it works as long as he is engaged or it does not conflict with work. He has tried methadone and claims it worked, but is horrible to come off of, and only attempted Suboxone for a short period of time before relapsing. He is interested in the Vivitrol shot upon re-entry. His positive influences are his children, but he has more negative influences to use, including his brother and his line of work in construction. He states, "Cause last year when I got out, my brother had a business started, construction.

We had all the tools to do it, ya know..and then I get out and in December and we're doing it together." He does express the desire to be sober, but mentions that the treatment in jail is no good and does not work. He also mentions several times that his behaviors, beliefs, and physical attributes stand against him to be sober but he remains hopeful. His statement, "Oh yeah people do, I mean, I can tell an addict or a dealer, so they can also see an addict or a dealer. So you know what I mean it's like a magnet. An addict will seek out an addict to find a dealer," shows his tendency to be addicted.

Participant 13, #4733, is a 34-year-old, White male with five children. His addiction started seven years ago when he started taking painkillers from pain due to his work environment in construction. He has several incarcerations including one in prison where he completed 21 weeks of treatment for early release. He said he got a lot out of the treatment, but forgot everything the moment he was released, at which point he was supposed to go to alcohol and other drug abuse treatment (AODA), and stated, "I'm supposed to go to AODA classes, I told my PO I'm not going. So I never once tried any damn thing to stay sober." He stayed sober for a while, because he lost contact with users and dealers; however, found out that his girlfriend's brother was selling heroin, and found himself using again. His current incarceration occurred due to dealing and delivering heroin, third offense, as well as being revoked off of a previous sentence, and facing possible prison time. He partakes in AA in jail, but does not believe it is helpful, referring to appearing that treatment is helping to 'fake it until you make it' and "I talk to everybody that was in that thing I was in there for a year and it was always the same damn thing. We all did, "referring to faking it until you make it.

Participant 14, #2, is a 25-year-old, White male with one daughter. His addiction began when he was 15 with his brother dealing and his mother smoking pot. He had very little supervision. He mentioned being incarcerated many times. His last long incarceration was a two-year sentence in prison where he managed to stay clean. He took part in several voluntary treatment programs while incarcerated for two years, but they were early release programs and externally motivating. He stated that, "All the programs are a joke. All they do is teach you basic communication skills. That's only thing they do," further fueling his lack of desire to be sober. He was released from prison in November 2016 and immediately relapsed on crack and heroin. When asked about ending up back in jail he replied, "I knew I would.". He has participated in many treatment programs both voluntarily and while incarcerated. His current incarceration is due to drug usage. He believes he is his only trigger, and nothing else causes him to use. His view of sobriety upon re-entry is," I've been getting locked up since I was a kid, and I still get high . . . ya know . . . and I know I'm gonna get locked up when I get high, and I still do it, just . . . becomes like ya know, you just get used to it," and " I'd like to stay sober, but honestly I don't know . . . I don't think I'll do heroin..I always say that. I don't think I'll do heroin again, but somehow it's like a magnetic force . . . we bind to each other."

This participant e-mailed me upon re-entry and provided me with his phone number. I called him and left a message. I tried several times to reach him after that and about a week later, his father answered his phone and when I asked for him he said, "I saw him on Saturday and his lips were burned from smoking a crack pipe." I apologized

to his father and told him I was sorry for what he was going through. I asked him to let his son know that I had called, and to reach out to me when he had a chance. The participant has not responded to any further e-mails upon completing analysis or write-up. His father called a couple weeks later, thinking I am a friend of his son's, to tell me he had been re-arrested in another county and was in jail again.

Participant 15, #7735, is a 25-year-old, single, White male. He has been opiate dependent for 12 years, which started with painkillers provided to him after an accident and breaking many bones throughout his body. His doctors cut him off of painkillers and he transitioned to heroin. He is currently on probation for burglary, and although on probation has continued using the entire time. He refers to himself as a polysubstance user with a bit of arrogance and pride. Previous incarcerations include drug use and burglary. He has several spans of voluntary treatment, externally motivated by parents and law enforcement. His supports were in place, yet he chose to disregard them, "I had plenty of people who are you know you're doing good love blah blah, it's not even family it's outside sources its meetings it's people. His current incarceration involves four new felony charges for intent to distribute heroin, cocaine, and see ecstasy, as well as having paraphernalia in his vehicle. His trigger to use is overwhelming anxiety that you can see physically effects his posture and state." His outlook involving sobriety is that he has no options, needs help with pain, or help to get better in his statement, "My sense of normalcy is gone. My sense of normal is not being in pain."

Data Collection and Storage

Data collection involved digital recordings, notes, and journal memos. Data collection involved 15 interviews of participants while incarcerated, and 4 interviews of participants who were released in time for this study. Not all participants were released in time to complete follow-up interviews, and one released could not complete a follow-up, because he relapsed immediately upon re-entry.

I created a journal prior to starting data collection that included my preconceived notions and thoughts about heroin-addicted offenders, as well as how they may present in the study. By doing so I was following the step of bracketing, which sets my perceptions aside ahead of time, thereby helping me to understand what I expect and believe ahead of time (Moustakas, 1994). Bracketing allowed me to look beyond what I thought, and be aware of my ideas before sitting down with each participant. Bracketing is a form of *epoché* which is described by Moustakas as the ability to set aside preconceived notions about the participants and heroin addiction, and I did so to the best of my ability, consciously, and fully aware of my ideas.

I made every attempt to see each participant as a normal person I would see on the street, removing the reason why we were meeting, and allowing them to get comfortable and talk like to equal minds. I provided each participant with politeness, a friendly demeanor, and respect deserved by all human beings. I treated them like my teachers, and humbled myself before them to remove any feelings of superiority, by standing when they came into the room, shaking their hands, and lowering my seat so their eyes were

higher than mine. I recorded written notes about demeanors, physical behaviors not recorded digitally, and mannerisms that added feeling and emotion to the answers.

I digitally recorded the interviews, and then transferred them to my computer. I used Transcribe.com to transcribe the interviews verbatim. Upon transcribing the interviews, I deleted the digital recordings, and stored all transcripts within the Atlas-ti program for data analysis. Once data analysis was completed, the transcripts were saved on a password-protected thumb-drive and deleted from my computer. The password-protected thumb-drive is only accessible by me.

Data Analysis

Data analysis for this study included *bracketing and epoché,* member checking and transcript approval by participants, and multiple transcript reviews by this researcher for differing reasons and depth appreciation, in an attempt to feature key statements and words with compelling bearing on answering the research questions. To better organize the data, codes, and themes, I uploaded the transcripts of the digital recordings into the qualitative analysis program Atlas-ti, that I had purchased and downloaded into my computer.

Initially, I set the Atlas program aside and instead reviewed and coded the printed versions of the transcripts for internal and external motivations to quit using heroin, and internal and external motivators to continue using heroin. I also marked answers to interview questions, and spiraled back and forth to locate answers and mentions made throughout the interview regarding previously discussed questions for triangulation purposes. I highlighted questions, motivations, voluntary and mandated treatment

experiences, and perceptions, marking each instance according to research questions and interview questions. I also coded feelings, perspectives, influences, and supports expressed throughout the interviews. I then started coding the same way on the Atlas transcripts using the analysis program to code, and organize interpretations according to each participant. The third review of the transcripts was to compare my views, perceptions, codes, and interpretations of the typed transcripts against the Atlas transcripts to see how my mind experienced both forms of the same interview. I found that the comparison helped me to see different views and interpretations of the same interview and added to the complexity of the interpretations as well. I then combined all codes and interpretations in the Atlas program.

After comparisons of coding measures were made, I created a codebook according to all the codes created and entered in Atlas. I simultaneously went through the Atlas program and created code trees and connections of how each code was related to each other, which in turn helped me to develop nodes, classifications, sub-codes, and ultimately themes. This iterative process of crunching the materials also allowed me a chance to combine and remove codes that were irrelevant to the study or similar to other codes such as "No options" and "No choices," which I then combined into No Options. Building code trees while developing the codebook helped me to develop the much-needed relationships of how acts, beliefs, perceptions, treatment, motivations, and supports all affected each other in relation to treatment, incarceration, and sobriety.

The next step to understanding how heroin-addicted offenders experience sobriety upon re-entry is analyzing their feelings, perceptions, and experiences related to

treatment, incarceration, and sobriety. I focused on the internal and external motivators relating to each research question about sobriety upon re-entry, maintaining sobriety reached while incarcerated, treatment options offered while incarcerated and upon re-entry, and the personal perceptions in regards to motivators and their affects on their social constraints. By separating these elements I was able to better understand how each factor could affect sobriety upon re-entry.

I followed coding with separating the coded materials by research questions, internal and external motivators for use and to be sober, and themes. The chart allowed me the chance to review the statements and experiences related to each theme, and how to answer each research question specifically. This process of creating codebooks and charts according to the different elements and levels of depth allowed me to clarify what I was looking for and focus my attention on exactly what I needed to find at any particular moment. In the end, I compiled all my charts into one Codebook under three themes.

Data Quality

Data verification was achieved through the in-depth process of digital recording of interviews, transcription, member-checking, coding, and analyzing. I spent extensive time reviewing each transcript repeatedly to ensure all relevant data had been identified and explored. I provided thick descriptions, an audit trail, and discrepancies to ensure evidence quality, in addition to allowing each participant to approve their interview transcripts prior to analysis. Thick descriptions were supported with direct quotes from the participants in the transcribed interviews, which in turn supported the themes uncovered during analysis. I also kept in mind that this study might be replicated in the

future, and retained journal and field notes, memos, codebooks, and charts, thereby creating an audit trail.

Participants all provided differing stories and lives; however, their experiences, thoughts, and perceptions all fell in line with each other and promoted data saturation. I began to feel like each story fit into the next like a block game of missing pieces with similar shapes…each story completing the puzzle of this study. With this information in mind, I worked to identify discrepant cases, as they had minute differences from the other studies, those of which are described later in theme descriptions and Discrepant Findings.

Saturation

The data collected was repetitive in nature and saturation was achieved with the 15 participants interviewed. Data reached a saturated level during the 8th interview and I knew what the participants were going to say or how they were going to answer a question. I was amazed at the answers provided in that each participant may have had a different story and life; however, some of the events and phenomena described were the same. The occurrences shared actually made me giggle and explain how each participant fit into each other's stories like puzzle pieces.

I found that data collected provided answers and information that had already been discovered in other studies, and I was elated to find that information was supported by other researchers. This finding alone provided validity for the data collected. Reaching saturation for all interview questions, albeit, some answers were idiosyncratic, provided validity for the data collected during this study. In addition to obtaining repetitive answers from each participant that saturated each answer with like-information, I went

through a process of coding each interview four times to ensure I had not missed any information. My intention was to ensure that I had reached a position where I could not code anymore.

I found the data collected was the information needed to fulfill the gap in the literature through obtaining heroin-addicted offenders' perspectives and experiences of sobriety upon release. The data is thick in that there is much of it, and the questions were swirled and repeated throughout the conversations to provide triangulation. The data is rich, because it is validated by previous studies, and is of an honest and vulnerable quality. The data collected provided insight into previous incarcerations and relapses as well, and thoughts and beliefs about current re-entry events and post-release life. Information collected in these 15 interviews was missing from current literature, and provide insight into the lives of heroin-addicted offenders.

Themes

The purpose of this study was to explore the experiences of heroin-addicted offenders' paths to sobriety. Specifically I wanted to explore how personal causation and the perception of, experiences with, and perspectives regarding internal and external motivators affected sobriety, drug use, and recidivism. I further wanted to discover if empowerment, self-efficacy, and positive options made a difference in reaching and maintaining sobriety. The theory of personal causation guided the study by sharpening the focus on how personal choice and external influences affect personal choice and motive. The theory of personal causation guided the development of the research

questions and influenced how I developed the interview questions as they pertained to motives and influences around heroin addiction, incarceration, and sobriety.

The journey started with initial interviews occurring within the jail setting, at which time I was able to collect data pertaining to previous incarcerations, experiences, and relapses in addition to what led up to their current incarceration. During that time, I was also able to ascertain the perspectives and beliefs about treatment and sobriety during that incarceration period, views of future release and thoughts of sobriety as well. Follow-up interviews were scheduled upon re-entry for three weeks following the initial interviews. I completed 15 initial interviews within the jail, and I connected with four of the 15 participants upon re-entry, but only 3 completed follow-up interviews. One participant relapsed and did not meet up with me.

Below I describe the findings and themes that developed during analysis of the transcripts, notes, and journal. The themes developed demonstrate the individual and group experiences, perspectives, and perceptions of treatment, incarceration, heroin use, and sobriety. Provided are also individual depictions and statements directly quoted from the transcripts to express support for the themes developed. All of the participants met the initial requirements of participation in this study; however, as stated, only four were released in time to take part in the follow-up studies. Using data collected from previous incarcerations and relapses, I was able to see motivations, both internal and external, that influenced the choice to remain sober, eventually relapse, and recidivate. The themes developed are a culmination of those shared experiences.

Results

I followed Moustakas' (1994) approach to phenomenological research that states a phenomenological study is constituted of the lived experiences, actions, perceptions, feelings, thoughts, and memories regarding the phenomenon being studied. The data I present is composed of experiences and perceptions shared by all 15 participants. There are a few idiosyncratic experiences and perceptions that I share as well, and list in discrepant findings. I only included similar experiences and finding in themes if they were shared by all participants (Table 3).

Table 3

Research Themes

Themes
1. Internal factors
2. Social factors
3. Treatment factors

Theme 1: Internal Factors

All 15 participants had different stories to tell, with different events that triggered the onset of drug addiction and incarceration; however, all 15 had nuances and experiences that tied them all together like interlocking pieces. How each dealt with addiction and relationships differed in their perspectives of their situations and their abilities to see positive outcomes. Each participant dealt with issues, pain, incarceration, and genetics, and when coupled with the inability to cope and lack of direction or knowledge, created a merge of common feelings and perceptions.

Internal motivation to maintain sobriety upon re-entry. Internal motivators to maintain sobriety upon re-entry varied with each participant from wanting to take care of their families, to simply being sober for themselves. Internal motivators to stay sober were difficult to point out. The data collected did not reflect internal motivation to maintain sobriety, rather the majority of internal motivators perpetuated heroin use. Several had decided that they did not want to overdose and die and wanted to focus on a normal, drug-free life.

- #6969: Do not want to die. I want a different life.
- #5: I would love to go to school and be an AODA counselor, and I was thinking about being a motivational speaker.
- #2640: Get a job, a place to live and my kids back. Self-sufficiency. that's like motivation for me, and then I'm going to be able to do that I'll be able to get my own place, and then I'll be able to have my kids move back in
- #69: I do have kids. They're 5 and 7, and I miss the hell outta them. I don't wan tto use when I get out. I don't want to use anymore.
- #1050: I went 22 years without it and was so against it. And so 2 years out of my life I know I could go back to being that person again.
- #23: In my mind that when I get out I don't want to use again.
- #14: I want my kids back. I want to live a normal life.
- #1: I stopped blaming. I stopped going out there you know what I mean? I took responsibility and said well this has gotta stop.

- #0420: I don't want to do it no more. I don't want it. I don't want anything to do with it at all. I'm just ready.
- #7735: I'd say no for once in my life. I'm actually able to say no.
- #4733: Because now I'm going to be on my own and that's the only way I can show, whoever, social services and stuff I can restart my visitation rights. (also externally motivated).
- #7: This time around it's been a lot more me trying to fight those feelings, because it's done nothing but lead back to this situation every time. It's life or death situation now.
- #2977: My number one priority is my daughter and getting my family back. Something like that.
- #7667: I'm gonna try, because I don't wanna be bringing that stuff around my family.
- #2: My daughter. If I got her back would be the only thing to keep me sober.

Participant #7667 shared the above statement as his only internal motivation to be sober, but on the other hand he stated, in regards to his perspective on sobriety, that he may likely use again, so although he knows he doesn't want this around his family, he is ambivalent about relapsing. During our follow-up, he was more focused on getting his son back than using heroin. Participant #2 explained throughout his interview that he was going to use again, regardless of his situation, and he knew he would end up back in jail due to drug use. He stated that his daughter was the only thing that could keep him sober, but he relapsed the same day he was released from jail.

Internal motivation was difficult to identify, because much of the motivation was prompted by family, and the possibility of incarceration, loss, and death. Nowhere in the interviews did anyone say they were able to stop using because their parents were strong-willed or successful. At no time did anyone say their genetics helped them to stay clean and sober. Internal motivators are limited to personal perspectives and perceptions of experiences. Internally, participants stated that they ultimately wanted sobriety to regain normalcy, such as family, home, and employment.

Perspectives of sobriety upon re-entry. During the interviews, and regarding their potential release coming up, all of the participants were apprehensive, yet spoke of wanting to stay sober. The quotes below represent the participant perspectives regarding their upcoming re-entries.

- #2: Well..honestly I'd like to say I'd like to stay sober, but honestly I don't know..I don't think I'll do heroin..I always say that..I don't think I'll do heroin again, but somehow it' s like a magnetic force..we bind to each other.
- #5: I do want change, but I'm scared of it. I don't like it at all.
- #14: We start doing it, yea..we start doing something like that and yea know I get locked back up for heroin or..ya know? Just using basically, and I want to get my kids back. I want to live a normal life.
- #0420: And like I said today it is just at this point right now where I don't want it I don't want anything to do with it at all I'm just ready, I lost my daughter in this whole situation is so . . . She's only 3 years old.

- #1050: Now if Heron were in front of me I wouldn't even want to look at it, I would be able to walk away, it has just affected me so bad.
- #7667: I'm going to actively pursue going back on some kind of narcotic medicine when I get out of here.
- #7335: I'd say no for once in my life I'm actually able to say no.
- #7: That [getting married and having children] all sounds great. That's exactly what I want. That's what I hope happens, you know? All drugs being in that factor or not, anything can happen. That's definitely what I hope happens.
- #2977: Well I think I'm gonna have to get a sponsor type of thing or maybe just go into a sober living kind of thing.
- #6969: It scares me though because hear the stress isn't there so I know it's vital for me to get into treatment and counseling again when I walk out of here, I need that support.
- #4733: That's the plan [gaining control] for when I get out, to say the hell with that stuff. I need to get my act together, and I need to get…I mean now everything is changed.
- #23: If I decide to use again then I'm going to need… then I'm going to have to rely on Suboxone or methadone or the withdrawal from those are horrible, so then it's like what's the point and I'm about to be a grandmother.

Participant #1 did not ever express a desire to be clean; however, he spoke about what addicts need to do to be sober, how to help others, and mentioned lessons learned in treatment. He shared that he had never been sober for more than a year at any given time

for 23 years, and had spent the last five years sober. His current incarceration was due to drunken disorderly and phone calls. He was released from jail after our interview.

Internal motivation to use upon re-entry. Internal-motivators-to-use surpassed the internal motivations to abstain. Albeit, internal motivation to use was identified by the participants as a strong force, and unveils areas including the inability to cope with issues, dealing with physical and mental pains, having a lack of positive options, resignation, and making sense of personal and genetic backgrounds. All participants shared the same idea of an 'addict mindset' and believed that once they were addicts they always would be addicts. The mindset also caused them to wrestle with the fear of withdrawal and the lifestyle changes needed to maintain sobriety. The majority believed that the heroin was in charge of their life as well. They all shared the same mantra of 'It'll never work if you don't want it to,' and this also came through the data as an excuse to use based on their personal beliefs and perceptions.

- #5: Heroin is so powerful and so different that nobody's going to know what you're talking about.
- #5: I have no willpower to do it on my own clearly I can't do it on my own.
- #5: I never properly grieved, because I got high 2 days after to numb the pain that I had.
- #1: I've kind of just been alone, alone, a loner all my life and I really haven't had a chance to make a lot of friends throughout the way um cuz I never really got close to anybody, because I never felt comfortable around anybody.

- #0420: I wasn't even thinking about it truthfully. Honestly, I mean as soon as she said oh let's go get a bin, I was like, I was like I thought about it, and I was like not really, but I guess what the fuck. With everything that's happened in my life and you're going to rub this in my face, okay fuck it let's go. So that's what I did I went, got it and started shooting up the Ritalin and started shooting up heroin for 3 days we were doing nothing, but pretty much stayed awake and shooting up.
- #6969: I don't know how to deal with stress all that good. I think if I was on the outside and that [step-father's death] would have happened, I would have used.
- #23: That [genetics] makes it harder to fight it, and stress can make it harder. Triggers can make it harder, so does stress trigger that you just want to bury your feelings, and run away from things.
- #1050: I didn't really know what I wanted to do cause, yeah granted I just didn't want, I wanted help but did I want to go through withdrawals?
- #1050: Not being able to handle being sick, or work, I'd be in pain from work.
- #7667: I obviously make bad decisions but I don't know where else to go I don't know what else to do.
- #7667: I had a bunch of broken bone in my body and I had a bunch of pins in my in my body and that's why I originally got an opiates cuz I got medically prescribed them for some time.
- #7735: I don't know if it's I didn't want to quit.

- #7: I think I'm at the mercy of others.
- #14: I'm a construction guy I'm a roofer by trade so I'm so every day to. So some of it was pain some of it was not to get sick.
- #69: I didn't want to feel the pain.
- #2977: If you're willing to give up your whole lifestyle and everything, and everybody that you know, that you associated with that was involved with that.

Some participants spoke directly of their thoughts that they probably would use again. They shared the knowledge that their addiction was in control, and they had nothing waiting for them other than drugs and dealers. Even though they may have stated that they wanted to remain sober upon re-entry, they shared that triggers, both internal and external, could move them to relapse.

- #2: They can lock them up and lock them up. I've been getting locked up since I was a kid, and I still get high . . . ya know..and I know I'm gonna get locked up when I get high.and I still do . . . it just . . . becomes like ya know, you just get used to it.
- #14: You know everybody always says I'm going to move away to get away from everything. Okay it might be great for a year but then it's the same thing. You get to know people, and all the sudden you're in the same environment just a different location.

- #7667: I keep seeing myself when I get out that I'll probably use again right away or I'll go back into a clinic or I'll say screw it, but I'll end up doing something.

Participant #2640 was proud of her sobriety stating, "October is when I went to do my last charges, and then I got released from that sentence in December, so October was actually the last time I used heroin"; however, she stated that she would probably use crack cocaine again as this was not her drug of choice, and it did not make her feel good like heroin did

Only one participant was adamant that he would not use again. Participant #69 provided a full back story of incarceration, triggers, loss, and relapse, but maintained a positive outlook for sobriety upon re-entry, including getting married, getting his driver's license, and having his children returned to he and his fiancé. His plan included getting a sponsor for support, and applying with a certain company.

- #69: I don't want to use when I get out. I don't want to use any more, I even told my wife or my girlfriend I don't want to use it all.

He also stated that he was going to change his phone number so his past connections of users and dealers could not contact him, in addition to stating the knowledge that he no longer wants to get incarcerated, and that he was tired of this lifestyle.

All participants except #2, stated that they felt heroin was currently in charge of their lives. They all admitted that at one point or another, they had lived the experience of being in charge of home, family, or work. Participant #2 was the only person to say that

he was in charge of his life, with full admission that all of the events in his life were because of him and only him; however, he voiced many instances where others were the fault of his position for not making him quit using. Contradictory to his statement about being in charge, he said, "I mean I've been in jail and the prison my entire adult life. It gets hard for me to get into a routine where I go to work, and I take care of stuff and I pay my bills, and I actually pay my rent."

Internal-motivators-to-use such as anxiety, guilt, depression, a lack of positive options, and resignation were recorded as feelings and perceptions that worked as triggers. Most of the participants shared feelings of anxiety, depression, guilt, the feeling that they had no options to do better, and were resigned to the life of addiction, except for #69 who provided a positive outlook and plan for sobriety upon re-entry. He was the only participant being released without the fear of prison time, yet he made the personal choice to live a sober life prior to re-entry. Internal-motivators-to-use were profound and plentiful. Many participants stated that they needed to leave the lifestyle, which involves external motivators; however, the data shows they are unable to leave behind or ignore their personal knowledge and beliefs. In order to change how they are affected by internal negative motivators, they express the need for proper, caring treatment, which will be discussed in great detail in Themes 2 and 3.

Relapse. All participants spoke of previous incarcerations and releases, at which point they all relapsed at least one time. Data shows that relapse is caused by the internal inability to cope, regardless of the trigger being internal or external. The quotes below represent relapse experiences from previous incarcerations and re-entries.

- #2: The same day I got out of prison, I started getting high again.
- #5: They talked to me 'til I was blue in the face and I still went out on Huber and used even though I swore I wouldn't.
- #14: I had got out in August and we were working together, but we were both clean. I was going to the methadone clinic and then just poof, he [his brother] started using a little bit of time, and it was his business, so I was working for him. He gave me the job when I got out, and he was using, and I sort of pushed it away, and I was staying with my father, you know? And then working with him every day, I started going out to the bar after work with him have a couple of beers.
- #0420: I was clean for a like 11 months before I used again, and then my dad died.
- #1050: I can withdrawal on my own and get through it, it's just me sticking with it. And But I would always like relapsing.
- #7667: There's always something the back of my mind give me anxiety all the time and that's a lot of time where I do drugs to help me with release.
- #7735: I left there [treatment facility], ...uh probably within 2 weeks I was using again.
- #7: I got put on probation and I couldn't smoke weed anymore and someone said do you still want to get high? These pills are out of your system in a couple of days, and next thing I know I'm just doing, I'm getting high. I went without 'em one day and I was sick.

- #2977: So instead of pursuing anything with the legal part of it [losing his daughter], I said fuck this and I went and used.
- #2977: And it's weird, because I don't really remember who I was, cause it just kinda takes that part of you away and you just...it's gone really.
- #6969: I sat there [voluntary treatment] for 4 days and was still just so sick, that I checked myself out and went and got high.
- #4733: So I did a 21 week program which was SBISA. Well I got a lot out of it I really did, but as soon as I walked out the door, I forgot every damn thing I was in treatment for. I mean I started.
- #1: I never made it more than a year on the street
- #69: It was like easy to get, didn't even have to leave the building [work release]. So I started up again.
- #2640: When I got released I was . . . I had bail one time, and I got bailed out for three weeks, and went back to court. And then got bailed out like a month later, but um . . . each time that I get bailed out of jail—like my first instinct is to go to the bank, withdraw my money, go to Milwaukee and get high.
- #23: My 11 years sobriety that [being fired] is what triggered that to end.

Theme 2: Social Factors

Social motivators involve relationships and the ways we relate to society. How we see ourselves and interact in society is the focus of this section. Each participant described social factors that played a role in how sobriety was either perceived or

anticipated upon re-entry. Social factors presented either as external motivators to pursue sobriety or as triggers or stressors to use.

External social motivation to maintain sobriety upon re-entry. Participants described positive supports, such as family and significant others, and employability as the only social factors that played a role in externally motivating participants to stay sober. Participant statements regarding external social motivation to maintain sobriety are provided in the following section.

- #14: Yeah it's like work and my kids and I'll be fine.
- #14: I've always maintained leadership roles at my job. I've always been a foreman.
- #0420: My mom is like my rock.
- #0420: I'll probably start doing tattoos and piercings when I get out but I got to find a real job at the same point.
- #1050: I have my friends [non-users] and family.
- #1050: I want to [pursue her degree].
- #7667: I have my father, He's, he lives and Waupun.
- #7667: If I could find a way to dig myself out of this…if I could get my license back I could making $35 bucks an hour somewhere. I got like 20 years experience in my field.
- #23: I will still have D and L too.
- #23: I enjoy, actually industrial work. I have been a term press operator. I have done assembly work.

- #5: I mean I have my family. And my dad but I don't talk to them nearly as much as I do with my mom.
- #7735: I really want to go get high you know what I'm going to go hang out with my mom. Cuz that would pull me out of it in a heartbeat.
- #7735: I'm not worried about a job. Even with having felonies, I've always managed to find a decent job. My resume speaks for itself, and it's not like I'm tooting my own horn or anything, but I've managed to excel at multiple different jobs.
- #7: My fiancé's best friend she's been supportive throughout everything.
- #7: I was a maintenance engineer technician for an apartment complex company before I was incarcerated, I would go to apartment complexes all over the fox family and essentially take a building that was had stud and turn it into a full furnished apartment. It was awesome. I learned how to do Electrical Plumbing all sorts of carpentry.
- #2977: She's [mom] really stuck with me and I've done a lot of bad things.
- #2977: Yea, like right now I'm doing some sort of construction, I'm using a nail gun, all day making pallets.
- #6969: My daughter "J" who got out of prison 2 years ago is my biggest supporter and my biggest critic.
- #6969: I've been doing retail and that works out okay for me it's a paycheck.
- #4733: I have 2 sisters and my brother and my mom and then obviously I'm going to get to contact Amy Johannes and get into treatment.

- #4733: I'm very skilled in both [carpentry and HVAC] of those Departments and done em my whole life.
- #1: I have my sponsor and I have my AODA.
- #1: My daddy always told me, 'Why don't you be a cook or something,' but I never took it seriously. Now I'm older and I can't move crates and boxes like I used to, but I'll do it. I didn't even know it was for 4 years, to get your masters is 6 years.
- #69: She [fiancé] is a support.
- #69: I'm going to go to Mastersons' staffing or Seek staffing and find some types of temporary work until I can find something permanently
- #2640: I feel like the relationship that I have with my so, he motivates me to stay sober, because there wasn't a day where he's like 'oh you're doing Big Shit I'm proud of you for being sober from heroin.' He is like 'You're an addict and you've been a heroin addict for how many years so the fact that you're just clean from heroin like, it's super great."
- #2640: I want to go and do that. I want to go waitress at Applebee's or something. I just want to do something, and have my own money and I want to start paying my own bills.

Participant #2 was the only one stated that he did not have any positive supports. He described a release that was full of nothing, no options, no home, no sober friends, no job, no family, and nowhere to go except back to using. He mentioned painting houses or selling drugs as his employment choices, neither of which were a drive for him to stay

sober. Participant #5 stated that she had not been employed in five years, and prior employment was terminated due to criminal activities. She did state that she would like to become an AODA and motivational speaker.

The majority of data collected about positive supports, relationships, and employment brought hope to the discussions. The majority of participants sat up straighter and acted proud when they spoke of their accomplishments, as well as hopeful for the future. The following data collected represents the negative social aspects and stressors experienced and perceived by the participants as deterrents to sobriety.

External social motivation to use upon re-entry. Social data presented was made up of negative influences, such as friends and family who use and dealers, stressors, and perceptions. Social stressors that externally motivated participants to use were negative and broken relationships, a lack of education and supports, both personally and professionally, homelessness, criminal pasts, unemployment, and reliance on others. The following participant statements represent experiences and perspectives of negative social factors that play a role in using upon re-entry.

- #14: You know there is stress and then you get that euphoria feeling when you're high.
- #14: Every time it's like I have to explain to her I'm locked up again, I used heroin . . . overdosed. You know, I just can't . . . I'm getting yelled at by family it just don't work. That makes you wanna use again, like screw you.
- #0420: She knows about my, about my addiction. She told me to clean up. And then there is the possibility that my mom told me just the other day that I

think "A" wants to be with me and I was like why with all my headaches? What do I have for her?

- #1050: It broke my heart. We're not going to get back together or toxic for each other blah blah blah. I went through extreme heartache, because this whole… even though we were weren't together, like he was the love of my life. It was huge. It was bad.
- #1050: Some gave up,, you know some family have give up.
- #7667: I was just using it that time I was going through a stressful time I will be with hospitalized I gave my son to my sister-in-law.
- #7667: When I went with my best friends and I left my wife, my kids went with her and moved out of town. I like pretty much annihilated all of my friends, pissed off my family, lost my kids.
- #7735: I have a phobia of normal people I mean I can't stand being around normal people.
- #7: That's [bad childhood] not going to be my excuse or my reason, but when I think back on it that was always something big.
- #7: There are always issues at home and heroin to me could always give me this warm feeling all the time when I used it. When I used it, it was always there. When I wanted it and it was always good and always got me high no matter what, so it never let me down, it never let me down.
- #6969: I'm coming out to him and this is like our last Rodeo to see if we can make it work.

- #4733: I have got no place to go I gotta get my house on my own.
- #23: Another setback is financially. Um, especially since I committed` forgery to get the drunks that I wanted, so now I mean ,in the long run, it's going to cost me that restitution, all that, I don't have a home right now, if it weren't for my boyfriend, I wouldn't have a place to stay and whatever.
- #5: And every boyfriend I've had has went to prison, just got out of prison, or is going to prison.
- #1: Because I'm a convicted felon and there's nobody going to hire me or there's nobody going to hire me cuz I'm have tattoos.
- #4733: I'm a high school dropout.
- #69: I have to get my license straightened out first.

Although participant #69 stated that he did not have his driver's license, it did not deter him from being positive and describing his plan for success upon re-entry during his interview.

Participant #2640 did not share or describe negative social aspects that might trigger her to use. She described a positive support, a desire to work, and a hopefulness to be self-reliant for herself and her daughter. She stated that her sobriety was important, and she was proud of herself for maintaining sobriety upon re-entry.

Participant #2 shared and described many negative influences and stressors awaiting him upon re-entry. He hoped to repair a relationship with his ex-girlfriend and mother to his child; however, he believed that there was nothing else waiting for him to

build a life on. He relapsed the day of re-entry and is currently in another county jail. his statements are as follows.

- #2: I don't know how, I don't know what I'm going to do exactly I don't even know how I'm going to get to work.
- #2: I have nowhere to go really anymore.
- #2: I can't go back to my mom's house. Her landlord won't let me there. My dad won't let me go there, he thinks I'll be a bad influence on my little brother like my older brother was for me. And he's like 13 now, so he's like probably just starting to see pot and everything.
- #2: I couldn't go and get her [his daughter] and I lost it and I went and got high and gave up.
- #2: I don't even know how I'm going to get to work.
- #2: just feels like life started right where I left it off at. When I left prison, it feels like right when I got out I was back to my life again.
- #2: No . . I was going to do it [commit suicide] on purpose.

Theme 3: Treatment Factors

All 15 participants described the intense need for treatment before and during incarceration, and upon re-entry. Surprisingly, many of the participants expressed a desire to receive exit counseling prior to re-entry that would help them to create a plan for success regarding treatment, living conditions, contacting a probation officer, and employment. One-on-one counseling was the first choice of counseling prior to re-entry to remove the fear of speaking in front of a group, as well as allow participants to work

through their issues without sharing problems with other offenders. They all believed that behavioral counseling would have been beneficial both while incarcerated, as well as upon re-entry, because they all described the need to change their thinking and habits. Below you will find participant quotes regarding detox in jail, AA and NA, no exit counseling, handholding, methadone, Suboxone, Vivitrol, mandatory vs. voluntary treatment, and advice to professionals.

Detox in jail. Participants expressed many opinions of the jail's treatment of offenders who enter jail when coming down from drugs. Although nurses within the jail monitor all offenders detoxing, offenders are limited on comforts and pain medications. The point of the detox program is to safely get the offenders through withdrawals, and sometimes admit them to the hospital if the need arises. Those participants who experienced detox upon entering the jail preferred solitary confinement for the initial 3 days, but believed an assessment for the ability to be moved into general population soon afterwards, rather than keeping them locked up alone for 10 days, as the program currently calls for. Participants all say they know themselves well enough. Most liked the peace and quiet of detoxing in solitary. Participants described upset at the lack of compassion by staff, the inability to continue DTT upon incarceration, and the lack of comforts such as pillows and blankets. Some participants mentioned that incarceration is a treatment in and of itself due to the mandatory detox, and it saved their lives.

- #2: They just to lock you in a cell. They take your underwear and your white T-shirt and your socks away from you, and give you a suicide blanket, no sheets, no pillowcase, and they don't give you anything for it.

- #14: The treatment here sucks. There is no treatment really.
- #0420: I know that I'm going to go out there at the end of it and I'm going to go through withdrawals again everything like that and I've done 10 days here and I still have two weeks after you know that I was withdrawing so, I was gone for 24 days I almost a month of withdrawing.
- #1050: When you withdrawal...the first 3 days you literally only have um... the first 3 days are the worst. They wouldn't give me medication to help my withdrawal until after those 3 days.
- #7667: They need to offer some kind of help in here...I mean they got the methadone clinic in FDL and like a lot of ppl need it, and I mean, if I would have come in here on heroin detox, I would I would have definitely needed to go to the clinic.
- #7735: You're going through detox, the only thing you want.. give me some Imodium. They won't give you Imodium, Tylenol, nothing.. all the aches and pains are there.
- #7: I was at my worst for heroin addiction. The physical withdrawal symptoms was like 3 to 5 and even after and some days light by the grace of God, 3 days into it, I'd be okay enough to where I'm stable, I might still feel crappy, but I definitely don't need to be locked away for everybody else.
- #2977: The only treatment there is really in here…you gotta want it in here, because there's nothing for you in here.

- #6969: You're in a room, you don't have a TV, you don't have a book, you don't… I was so sick I couldn't even get up, so I didn't even know I had to ask to take a shower, so maybe it… and I was made to feel like a real asshole when I came in here.
- #4733: You know the code here fake it to make it. That's the truth.
- #1: The better plan of action then is now, a lot of these guys coming in here are dead and they're like here's some Gatorade, can't give you any meds.

Participant #5 and #23 did not talk exclusively about detoxing in the jail, rather they talked about going through withdrawals in general as being difficult, and needing drug treatment if they ever felt the desire to use again. However, they both described the knowledge that withdrawal from a drug treatment would be just as difficult as heroin, and figured what was the point of using then.

Participant #69 did not describe any experiences with detox during his current incarceration. When asked, he did mention the need for better programs and treatment. Participant #2640 did not detox when she was incarcerated. She was sober and was thankful that she did not have to withdrawal in jail. Participant #1 was the only one who stated that pods set up for offenders who were detoxing would be best, so one did not have to go through withdrawals in general population with others who did not understand the process. He expressed fear about being in jail, and thought that being placed with like-minded individuals would make detox and withdrawal easier. Jail treatment programs often accompany detox in jail; however, they are limited according to the participants' interviews. All participants expressed a want and desire for better treatment;

although, most of them attend the AA and NA meetings. Below are a few perspectives and beliefs regarding the AA and NA programs in jail.

Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). All participants expressed the feelings that AA and NA are a joke. They state that they are socialization platforms to meet up with friends and find new connections for drugs upon re-entry. not only is this a problem and a wasted resource, it does not reach the participants. AA is a 12-step program that follows a reckoning with God, self, and others. Several participants expressed an upset with the religious aspect of AA, as they do not believe in God or have a relationship with Him. Cognition and behavioral treatment is the first step to understanding their needs, abilities, and opportunities for improvement, all of which come from within. they all expressed a need for better programs in the jail.

- #5: Yea, but that's a joke . . . it really is that's why I don't even go.
- #7735: There is no positives. There is no positives in this place. They don't do anything for you. They're not even an NA meeting that the men can go to. Women can go to NA, so the women can go to Na and AA, but we can only go to AA. And most of the time you go to these meetings and all it is an excuse so that I can go see Joe who I haven't seen.
- #0420: No the jail here doesn't do shit for you very much. they need to offer some kind of a program, yeah they offer Na and AA, but what is that going to do?
- #2977: I think they need to have NA, they only have it in here for females there's just no one to do it though, it's all voluntary. There's no one to do it in

here. They do the AA, but it's like no one takes it serious...I mean we're all in jail and no one takes it seriously...they're only there just to see other ppl in jail.

- #2: I think ya know...people doing meetings, going to AA, working a 12-step program, works for a lot of ppl.
- #14: You go to groups like that too and people just go there to find a new connection.
- #7: I thought it was all a joke, a lot of people were there just exchanging numbers and for hookups.
- #23: I've been doing AA meetings and NA meetings and there are some people, as long as you find a group that you're comfortable with...meetings, for outpatient can be helpful.
- #4733: In here they don't do shit for me...I go to AA meetings. In the past people would always just come here, that was the, you know, that was one thing, and today you just want to come to see who's there so you could talk to somebody or get out of the dorm for an hour that's it. You don't get nothing out of it.
- #1: They'll start talking amongst themselves about not, just kind of, not deliberately but maybe hey there heroin addicts, hey I got opiates blah blah blah.
- #69: Right now they have AA program but that's more for alcoholics, and they only have NA for females--they need it for males.

- #6969: I will say one thing about here, I mean they offer a lot of, they offer NA, they offer AA, they offer Christian AA. That's what the group thing is all about. And I will say that I just I'm really leery, because I know a lot of people who've been in and out and everybody wants to be sober and everybody believes in God when you're locked up. It depends on what you do when you walk out of here that really matters.
- #7667: AA meetings an NA meetings in that kind of stuff never really help to me, it's kind of like I just got to get the mindset to just say no. From my experience either make you crave, ya know . . . or help you out with more hook ups when you're really need it. I mean . . . it's about the way it is. Every time I come to jail, I got more hook ups when I come out, it gets easy and easier to get drugs when you come out.

Participant #1 did not speak directly about taking part in AA while incarcerated; however, he spoke about treatment in general that is provided. The four participants with whom I completed follow-up interviews all stated that treatment within the jail had no bearing on their sobriety upon re-entry, including the AA and NA programs. They laughed and could not express more how the AA and NA programs provided in jail were worthless. Participant #69 described his treatment upon re-entry as to include both mental health care and AA meetings, in addition to hospital outpatient programs. He is currently using as many resources as he can to remain sober. Participant #6969 stated that the AA and NA programs were both a place of socialization and a place of belonging. When completing her follow-up interview, #6969 stated that the jail programs did not help her

prepare for re-entry, or help prevent relapse. Participant #7667 stated during his follow-up interview that he did not have the time or mindset to take part in AA or NA programs at the moment. Participant #23 is currently in the H dorm work release program, and did not yet meet up with an AA or NA provider. She mentioned that she was going to meet up with her probation officer and find out about the best treatment options for her at this time.

Participants described the need for better treatment in the jail that was less social and more rehabilitative. One means of achieving this was expressed as one-on-one rather than group settings as groups were described as social times that perpetuated drug use upon re-entry. Several of the participants had no vision of life upon release that did not include heroin, some of which claimed they had nothing and no one. The need for exit counseling became apparent through the quotes of several participants, which I provide below.

No exit counseling. All but three of the participants expressed and described worry and fear about re-entry. Their stresses stemmed from a lack of direction and supports to a need for better supervision. Prior to re-entry would be the time to help identify internal motivation to quit using as well as providing offenders with literature apart from the methadone clinic, advising them on different DTTs. All of the participants expressed a desire and need for a plan of action upon re-entry, with several also mentioning their fear of what re-entry would bring. The participants described the fact that they do not have options or supports when they faced re-entry, and their focus was solely on what they did not have waiting for them rather than what they could do for

themselves. All of the participants described a want and need to know more about treatment options, but did not know where or to whom to turn for more information. The lack of direction, lack of self-efficacy, and lack of self-confidence in their own potential success, is observed in their described need for exit counseling.

- #7667: What did you say about that Amy lady? Even about the study and the outpatient stuff, I need to know like with a pain management program. [Participant #7667 stated that three weeks prior to re-entry, he sent a message that he needed to speak to a psychologist to straighten out his thoughts and issues. He said that no one responded, so he sent another note a week later requesting a visit with a psychologist, and again, no one responded. He stated that he needed help and no one ever came.]
- #0420: Well I've got the food stamp and I've got Medicare so . . I got the badger care for the state of Wisconsin, it just depends on if I can get or find out [about treatment] you know?
- #7735: I did well there, but I pretty much got out and was in another foreign town no friends, no one I knew.
- #2977: From what they do now [help with transition]? No
- #6969: I'm like please don't send me out there on nothing...I'm terrified, I just know I'm gonna start using again.
- #14: A lot of the stress is a big thing if you just have a counselor you know like I said to transition would be a lot easier.

- #23: I would like to know where that [needle exchange] is for when I do get out.
- #2: I was like how do I get sober what do I do…what should I do? I get to get out and then I'm just stuck back out on the streets in the same situation where I was. I have nowhere to go...and with the same friends and I get high…cause that's what I know how to do...and they don't have anything for me to go anywhere else.
- #1: I don't know, I don't know, because I don't think I'm going to use [in response to asking if he needed treatment upon re-entry].
- #6969: What would have been ideal as if I would have been a little more active in setting up my release. I just didn't know any other way to deal with it so I went and got some heroin.

Participants #1050 and #69 did not talk about treatment or support upon re-entry. They did not describe any desire for exit-counseling, rather they stated several times that they were completely done with heroin, because it had ruined their lives. Participant #7 did not speak about treatment or exit-counseling upon re-entry; however, he described his situation as letting go of control and allowing God to take over. He stated that he was scared to death of re-entry and what could possibly happen. His fear showed the need for direction and exit-counseling, as he also stated during his interview that if he had had direction and positive options, then he would have taken a different pathway rather than using heroin. He expressed his desires for normalcy upon re-entry, yet ambivalence carried his tone. Participant #7 said, “That all sounds great. That's exactly what I want.

That's what I hope happens, you know? All drugs being in that factor or not anything can happen. That's definitely what I hope happens.” Participant #69 had a plan before re-entry. He stated in his initial interview his intentions for treatment and employment. He followed through with all of his intentions as he explained them initially.

Handholding. All participants expressed the need of handholding. All 15 participants describe the need to build a new reality by having someone hold their hand due to their inability to cope combined with temptation to use. The participants described themselves as ill-equipped to deal with normal life, and they begged for help, treatment, and guidance to relearn life sober.

They all want someone to supervise them, watch them, walk with them, and keep them accountable. They wanted more urinalysis (UA) tested weekly, if not every other day. They want to be restricted from drug use in a home or treatment facility, both of which are more conducive and desired for sobriety. They believe that someone outside of their family, who understands drug addiction, and is not a probation officer of the law, would be best to help them get through re-entry and prevent relapse. Regardless of their appearance to be in control or in charge, they all wanted to know someone cared about their well-being. Examples of handholding are presented below.

- #7735: I wish someone would have supervised me more when I first got on probation.
- #6969: It scares me though because hear the stress isn't there so I know it's vital for me to get into treatment and counseling again when I walk out of

here, I need that support. I'm like please don't send me out there on nothing...I'm terrified, I just know I'm gonna start using again.

- #2977: Well, I think I'm gonna have to get a sponsor type of thing or maybe just go into a sober living kind of thing.
- #2: They should have something or maybe even where they force you to get your fuckin' life together...cause that's what we need....that's what I need.
- #5: Don't give up on me help me. I need help don't send me and throw away the key and send me to prison I'm trying to tell you honestly I need help.
- #14: To be honest, you know the counseling I think I could do it after a while, but right away do you know cuz, I'm just, I'm going to fall back into the same thing.
- #7667: If somebody could pin point my dumb stupidity and figure out a way for me to dig myself out...then ya know.
- #4733: Do you know just like my probation officer, she didn't drop me. She didn't even piss test me or do nothing for 7 to 8 months. That kills me be, because I knew she didn't care if she's not going to drop me.
- #4733: Because here's the thing in the past with me. My probation officer, once I knew, I see my PO today, I always thought that I could be clean by the next PO visit, but I would always gamble with the piss test. So for me… it's gotta be, cuz when I went to POP classes at the mental Center I did that-- I knew that every day I could get dropped I didn't do shit. If I knew that I could get dropped every day, I didn't do nothing.

- #69: Like a sponsor, cause that's what I'm going to do when I get out is get a sponsor.
- #2640: I think it's really important to have a support person, a real support person. Someone who keeps order and to do an inpatient, I mean, I wouldn't mind doing that so I can learn how to handle things.
- #23: I think that would be ...the first couple months of recovery...especially if you don't have a strong mind or the will power, some people struggle more than others...some people...it's important.
- #1: Someone who indulged in that chemical frame of mind that's doing three or four syringes everyday is not going to be in the right frame of mind to say hey I want to go to treatment.
- #0420: No they pretty much just released you to your entire life. pretty much [clap] have a good life.

Participant #1050 did not describe a need for handholding or supervision as her focus was on getting back into the work release program and possibly going to prison. Her main objective of her interview was to plead her innocence and case. Her lawyer was aware of the study and approved her participation before she spoke with me. Much of her interview was testimony. She claimed that she was done with heroin and never going to use it again. When asked about possible treatment, she stated that she did not want to even think about heroin as it was her only reason for being in jail. Participant #7 did not describe any need for handholding; rather he shared an indifferent perspective about sobriety and how he would achieve it. He used the word 'hope' a lot, that he hoped all

would work out for him in a positive way. He also shared that he would have to do a lot of footwork this time to win the support of his family.

Each participant expressed an issue with mental health that triggered them to use heroin for pain relief from anxiety, depression, and other mental anguishes, such as loss. Mental health is not addiction though, and needs to be addressed separately. Below are participant statements about their mental health, and what they have experienced and need for help.

Mental health. All 15 participants described mental health issues such as anxiety and depression that they needed addressed, because those stressors triggered them to use for pain relief. All were concerned with physical and mental anguish, with pain, both physical and mental, being a top cause to use. All participants expressed pain as a reason to use or relapse. The ability to cope, a behavioral and cognitive expression, is described by participants as something they cannot do or have trouble doing. Mental health treatment is a care beyond addiction maintenance and treatment programs that is expressed as a need by all participants.

- #2: Probably that's probably like my biggest problem is anxiety. I don't know if that makes me used. I just know that when I am anxious I need something to get that anxiety to go away to call me down.
- #7667: I can't sleep for more than 2 hours at a time besides the fact that I'm going through all this you know kind of anxiety and stuff like that going on right now.

- #7735: Like right now it's not hot in here but I'm sweating like a pig. Always because my anxiety. And it makes me 10 times more self-conscious, which makes the anxiety ten times worse.
- #2977: And it made me feel good...like, I felt like I could talk to people..I have bad anxiety, so like it helped me feel like I could talk to anybody.
- #23: My anxiety is what I started with it marijuana and then I started selling it though.
- #69: No, for anxiety and depression and bipolar [on meds upon re-entry].
- #2640: I think it's really important to have a support person, a real support person. Someone who keeps order and to do an inpatient, I mean, I wouldn't mind doing that [behavioral counseling] so I can learn how to handle things.
- #5: Maybe a sponsor somebody you know somebody I could call.
- #0420: I got put on all kinds of medication, because I got a bad back, and I got put on Oxycodone. I was on Opana. Opana is an oxymorphone and the medication for pain.
- #1050: Not being able to handle being sick, or work, I'd be in pain from work.
- #6969: You don't have to deal with the mental stuff in here like if I'm at home and I'm withdrawing I am going to do whatever I have to do to get that fix. Just the mental game that if you're as sick as you can get and you're shitting all over yourself and you're feeling that crappy that you know what's going to make you feel better, you're going to do what you have to do to get that fix.

- #6969: I really want to know about the Vivitrol shot...and get into behavioral treatment...get help to stop. I don't want to overdose.
- #23: The cocaine at first was more for numbness and things like that, and when I started that [heroin] it was more for the pain, but it also helped with the depression as well.
- #14: I'm getting yelled at by family it's just don't work that makes you want to use again like screw you. You know what I mean? Especially family that use this too. So you need outside help outside of your circle. That's the big thing for me.
- #4733: Of course. That's the plan for when I get out, to say the hell with that stuff. I need to get my act together and I need to get… I mean now everything is changed. I have got no place to go. I gotta get my house on my own. I gotta get all that stuff. I don't have somebody there I can rely on now. So everything has changed for me and I mean it's going to help me.
- #1: I've been diagnosed with schizophrenia and bipolar disorder a personality with psychotic traits, but I don't know I don't see myself as a violent controlling person but it's just the way I had to be.

Follow- up interviews uncovered personal visions to success for sobriety. Participants #69 and #6969 both expressed the need to differentiate their anxiety, depression, and mental health from their addictive triggers and behaviors. Participants #69 and #6969 both sought out mental health care in addition to their other treatments. Participant #6969 obtained drug treatment therapy to help support her sobriety on top of

anti-depressants and anti-anxiety meds. Participant #69 involved himself with AA and outpatient treatment programs, but avoided drug treatment therapy as he described a good feeling of being clean and sober. Participant #23 mentioned contacting her probation officer to find out about treatment programs and DTT; however, she did not mention contacting a doctor about mental health care. Participant #7667 mentioned taking painkillers three days before he got out of work release, and stated that he had not yet looked into treatment, because he was dealing with so many personal issues. He did state that he would not use methadone, and that he wanted to contact a primary care physician for pain killers.

Mental health care is different than addiction care and the drugs differ in purpose and outcome, and several participants talked about DTT as a requirement for sobriety upon re-entry. All talked about anxiety and depression and how heroin subdued those attacks and calmed them down. Participant #7735 stated that on heroin, he never had panic attacks. Several expressed a personal knowledge of methadone and Suboxone treatment, as well as the knowledge that they did not want to use it again as a treatment due to the difficult withdrawals. The following section presents participant views of methadone and clinics that disburse the drug.

Methadone. Nine of the participants describe experiences with the methadone clinic as a problem conflicting with work and as an evil process, that causes a vicious cycle of drug use and relapse. Participants who claimed to like the methadone treatment stated that it was, because they initially got high off the low doses; however, they had to increase doses to obtain the high, which put them at precarious levels for withdrawal.

Participants were adamant about their dislike of the methadone clinic, believing it locked people into a cycle of legal drug use, high doses, and impossible withdrawals. They believed that drug treatment was necessary, but people needed another option other than methadone, as many use it to get high and then get stuck on it. Provided below are the direct quotes from participants showing how methadone affected their lives.

- #2977: I was like getting treatment at the methadone program, to be honest, I don't really think it helped me at all, because it really just another high, I mean it feels like..it's a legal high.
- #2977: Yea, and it really didn't help me to stay away from anything. I started smoking crack cocaine, like after being on that, so I mean it was I was really never clean while I was there. And you just keep feeding me and keep raising my doses, ya know so I can barely function...I'm falling asleep at dinner table and stuff like that.
- #14: That methadone clinic thing, I did it for a few months and it's just, it's just going everyday that's the issue. If you have a job it's almost… it sucks you have to go there at 5:30 in the morning you know?
- #0420: I got tired of giving her money for heroin and I was using it to, but I was also on methadone at the same time.
- #7667: You know, and that [methadone] was keeping me on my sobriety going for a long time. I was on it for like 18 months, and I was working on you know, getting off the stuff, cuz I don't…I think it's kind of an evil situation to she gets stuck in it you get stuck in it.

- #7667: It's not convenient at all, and I didn't like the fact that you keep going up and up. And honestly, I was hoping so I'd be able to get high off of it, which never happened and I kept going up and up and up, and I felt okay, but it never did what I wanted it to do for me and eventually I was stuck.
- #5: I got sober that time, but right when I got out I went back to the methadone clinic and that was just a crutch for me to get high because I'm and felony probation I can't do legal drugs. Every day I would have to ask them you know can I go up I need to go up and need to go up, and they put you up 10 milligrams every time you ask them.
- #6969: He [the doctor] decided methadone be a good option for me, not through the clinic, but through him, so that was working, but then...it's a slippery slope with me cause I get high with methadone. So I started abusing that, and have had that on and off ever since.
- #6969: I would say 75% of the people that I am aware of that use the clinic it's not helping them. They are selling their dope. They're selling their extra doses. They're still getting high, because there's no blocker or anything in that. I just don't think the methadone clinic. I think it's a waste of money in this country really.
- #69: I actually went to the methadone clinic. Actually the methadone...and methadone was messing me up worse than the heroin.
- #23: I would have gone to the methadone clinic...I would have struggled. If I decide to use again then I'm going to need… then I'm going to have to rely on

Suboxone or methadone and the withdrawal from that are horrible, so then it's like what's the point?

Participant #2 and #14 believed methadone worked if a person wanted it to, and that it was helpful for a maintenance program, but withdrawals were bad.

- #2: I think, ya know, people doing meetings, going to AA, working a 12-step program, works for a lot of people, but I'm also a firm believer in Suboxone and Methadone. Other than that...like unless somebody like...wants to change, they're not going to.
- #14: Like the methadone thing I did and it did work, but the withdrawal is horrible.

Participant #7735 stated that he considered going to the methadone clinic, but he believed his addict mindset would be to spit out the methadone and sell it to someone else. In addition, when he tried to sign up for the clinic, he stated that his insurance would not cover the methadone, and he would not pay the $16 a day for the program. Participants #7, #1, #4733, #2640, and #1050 did not describe any instances of methadone treatment in the past nor did they mention considering it for future treatment options.

Drug treatment programs that offenders are involved in prior to incarceration are not continued once they enter jail. All offenders go through detox if they are incarcerated when actively using substances as well as when they are coming off drug treatment therapies. Several participants mentioned using Suboxone as a DTT for withdrawals. The following section presents participant perceptions and experiences with Suboxone.

Suboxone. Suboxone is the brand name of buprenorphine and naloxone combined to treat opiate disorders. Suboxone blocks the receptors from heroin and painkillers, disallowing users to obtain a high. The following quotes describe how participants view Suboxone as a drug that gets them high, or a means of dealing with withdrawal. The data that unveiled here is that even though the participants could take Suboxone to help stay off of heroin, they could stop taking it and get high if they chose.

- #1050: I would attempt to get clean. I would just find Suboxone from somebody else and I would take Suboxone, I would take Gabapentin, I would take Gabapentin. So I would take…now I take Seroquel to sleep, so within like a week I'd be done withdrawing, so I knew I could do it on my own.
- #14: I've done the bupe and Suboxone on the street not to be sick.
- #2: I don't know. I think, ya know, people doing meetings, going to AA, working a 12-step program, works for a lot of people, but I'm also a firm believer in Suboxone and Methadone.
- #2: I really don't know how it happened where I got back on heroin. Well if I just buy a Suboxone and take that you know, whatever. And then, I was like if I just buy some morphine I'm not doing heroin, and the next thing you know I'm shooting up heroin again.
- #2977: I mean when I was out there I was going to meetings and I'd get my token for being sober, and I was on the treatment programs for Suboxone or methadone, and it's really...to me it's not even sober.

- #2977: I think maybe the suboxone thing would help a little bit for people to wean off of it…and they gotta have some...the methadone is different than the Suboxone...I think a lot, because there's an opiate blocker, and naloxone, and it's in the Suboxone and um..so you're not able to get high.
- #6969: I was on Suboxone, so I was doing a little better, like after that 3 months, and I was on Suboxone, and I was doing okay, but I had to do my time here, cause my charges were here, cause Dane county wouldn't take me because of my charges...so..I do what an addict does...I thought okay screw it, I'm just going to get messed up cause I thought I was going to come out to no job, no treatment, no apartment, cause I was going to lose all that I'm homeless, and came here messed up.
- #7667: So when they go back out there even Suboxone or whatever and that will help them to stop you from...they block it out for you can immediately get high because a lot of time when you get out of here you want to go get high really bad. If you're in here for a while and you go out and you kill yourself, right when you get out, because you need to have at least a good system with that.
- #7735: I was supposed to be detoxing actually 2 days after I got arrested, but got caught with a bunch of Suboxone and I was supposed to detox when she got out...in three weeks I'd be clean...but here I am.
- #23: Suboxone Clinic... it became like with a suboxone clinic, for example, it became overwhelming with my daily life and with working.

Participant #1 mentioned the need for more medications for treatment; however, when I asked him to define what he meant by better drugs, he explained that he meant drugs to help with withdrawal, because 'withdrawing from heroin and opiates is nasty.' He described a better treatment as taking place in a hospital.

Suboxone is a DTT that is described as some to work for withdrawals, but at the same time is described as a drug to get high on by others. It is also described as a hindrance to work schedules as is the methadone clinic. The following section is a collection of quotes from the participants about their desire to know more about Vivitrol.

Vivitrol. Vivitrol is the brand name for naltrexone, and is a DTT that consists of one shot a month; which removes the need for daily visits to a clinic. Vivitrol blocks the opioid receptors and prevents users from getting high. The Vivitrol shot stays in their system, preventing users from stopping a dose to get high. Below are the statements made by participants about Vivitrol, all of which either show as the desire to know more about Vivitrol, or the personal knowledge of its efficacy.

- #6969: Had I contacted people about treatment and what I was going to do and ultimately if they would have just given me something like a Vivitrol shot before I left the day off and I think that maybe I would have been better off.
- #6969: I don't know very much about the Vivitrol shot but it I want to find out.

Participant #6969 overdosed a couple days after re-entry. She was taken to the hospital at which point she met with her probation officer about DTT. She was allowed to go home, and she contacted a doctor and treatment facility for both anti-depressants, anti-

anxiety meds, and the Vivitrol shot. I called her a week after the follow-up and she said she had in fact obtained the meds needed to treat her mental health, and her Vivitrol shot. She said, "I feel like I can do this now. It's good, because you just never know what you're dealing with, depression or addiction," and she sounded great.

- #14: But the Vivitrol, I don't know about that they were just talking about that it MSDFwhen I got out last time.
- #14: The Vivitrol that we were talking about...that could work. What does it last?..a month..a shot a month?
- #14: Like the methadone thing I did, and it did work with withdrawal is horrible. Suboxone I've never done full time, I've done it to where I know maybe a week at a time or something you know.. the Vivitrol thing I'd have to read more upon that.
- #2640: When I got out I um was put on probation so then I in December...I was like I need the Vivitrol shot, because I really need to get my shit together.
- #2640: I didn't mind it. I actually liked it, I didn't withdraw from it, I didn't go and redose, because a couple days after I got released, they put a warrant out for my arrest, for some hearsay stuff..so I didn't go and redose. The first is that I didn't realize I could go and get high until the end of January...so the Vivitrol shot was way out of my system.
- #23: They should also do the Vivitrol shot for people...they're only doing it from my understanding due to grants for a few select people.

Participant #23 stated during her follow up interview that she was going to talk to her probation officer about the Vivitrol shot as a DTT.

Mandatory versus voluntary. All 15 participants shared experiences about treatment either being voluntary or mandated. The difference in the two treatments is that one is internally motivated and the other is externally motivated. From the data collected, regardless of the type of treatment, the desire to quit must be present for treatment to succeed; however, data shows that mandated treatment always fails due to the lack of internal motivation, and the external requirements placed on the participants being perceived as mandated or told what to do. Voluntary treatment can be internally or externally motivated, but mandated treatment is always externally motivated.

Voluntary treatment. Participants describe as having done on their own, without outside influence, this internally motivated treatment. There are other factors recounted as having had an effect on the choice to complete treatment, such as the possibility of withdrawal, or the simple desire to get high. The participants describe thoughts about and experiences with treatment, and display the strength of their internal motivation, as well as personal choice in the below statements.

- #2: It went good. I left there and I went to ROOTS...in Milwaukee--it's a sober living, called ROOTS Counseling Services, like a halfway house sober living house that I was in. I was there for about 3 months. I had like 100 days clean and I just left..I got sick of it, because they're really hard on you. It's like military sobriety, ya know, it's like boot camp sobriety in a house on the east side of Milwaukee. And like, it was fun, yea, but like...it wasn't worth it. I got

like… got to the point where I left, I came up with the decision that I'd rather be getting high than be going through...it's a lot funner getting high than living here doing this stuff that they want me to do every day. Like, I literally have no time for anything at all, but working on my sobriety and working. And barely be able to sleep at night.

- #5: I'm scared. Cuz in treatment, obviously there is people that are there for drug and alcohol problems, so there is two people in treatment that people that have to be there, and people that want to be there. I know I'm kind of on both as a prisoner, I've got to go there, but I want it as well, because this is enough already. It's been this vicious cycle for so long.
- #14: I've done outpatient I've done POP, I tried one on one counseling. The counseling thing was the best thing I did but I just I didn't follow up on any of the appointments was the thing. I was working too much you know but the pop thing works. I don't like that.
- #0420: I wanted something [methadone]. I wanted treatment. I wanted to get clean and everything like that, and I was clean for a like 11 months before I used again.

Participant #1050 spoke of voluntary treatment and not enough internal motivation to quit using, and she spoke of treatment with external motivators as well.

- #1050: Yes, I went to the doctor and he's like inpatient Suboxone treatment or outpatient? And I didn't really know what I wanted to do cause yeah granted I

just didn't want, I wanted help but did I want to go through withdrawals? No. So that made me not want to quit.

- #1050: I wanted to be clean for him, I wanted to live that sober life with him.
- #7667: So, eventually I came to this clinic in FDL. I went to pry a couple of months after it opened. I like it in a way at first, you know, but having to go there every day really bothered me, because I have to work and I don't know how long it's going to take, and do you have to see a counselor, have to do this or that. I was hoping I'd be able to get high off of it which never happened and I kept going up and up and up, and I felt okay but it never did what I wanted it to do for me and eventually I was stuck.
- #7735: Did outpatient, I got kicked out. So, when I got kicked out my drug use skyrocketed. So, then I voluntarily went to my probation officer and said hey I need help. Stay in Illinois then and I'll pay for your rehab, so they paid for me to go to rehab I did my 90 days, within 12 hours of being out I was using again.

Participant #7 stated several times that he chose to voluntarily enter treatment programs, but there was always an underlying reason to participate.

- #7: My first time it was I guess it really my choice but it was more so to reflect good and eyes of the judge when I went. And then always after then.
- #7: Yes there was always an underlying reason.

- #2977: It did, um...I was like getting treatment at the methadone program, to be honest, I don't really think it helped me at all, because it really just another high, I mean it feels like..it's a legal high.
- #6969: I was using. I was using. And I uhh, went into Talerian to detox voluntarily before I came here…about 3 months before I had to check myself in, because I was trying to get clean and do it at home and it just wasn't working. And uh...I sat there for 4 days and was still just so sick, that I checked myself out and went and got high.
- #6969: So she's like you come over and we're going to figure this out and she talked me into going into detox even though it didn't work out mostly because it was like being in jail, it was a horrible place to detox, they did not make me comfortable. I'm not even talking about like they have to give you Suboxone but they did not make me comfortable and I was so miserable.
- #4733: Yeah I've never did any treatment on my own. I never even ever since I went to prison and came out I'm supposed to go to AODA classes, I told my PO I'm not going. So I never once tried any damn thing to stay sober.

Participant #1 described his attempt with voluntary treatment, as well as his belief that sometimes voluntary treatment can be coerced externally.

- #1: My last 3 two convictions were NGI's, not guilty by reason of mental defect or disease. I have went through a treatment program in DePaul Treatment Center in Milwaukee. That's when I was young, I was like 19 and I

managed to stay straight for maybe 2 years, but I never refrain from being incarcerated.

- #1: Well I think a lot of it has to do with people, they're forced into treatment, because of some kind of agreement like, I got a five-year s sentence that if you go into treatment and do this faithfully, well then you're not going to get 5 years we'll give you probation. And a lot of times that sounds like a great deal and yeah it it's a deal.

Participant #69 stated that he voluntarily entered the methadone treatment program, but was mandated to attend classes so he left the program and relapsed.

- #69: Yes..I actually went to the methadone clinic. Actually, the methadone...and methadone was messing me up worse than the heroin. I just started using it again...It's like screw this, I don't want to go through those classes...5 hour classes and they talked about nothing.
- #2640: I just have never really been in a treatment facility ever. I've never been in an inpatient. I have done outpatient, but I wasn't successful, because I didn't get along with the counselor.
- #23: I grew up around Alcoholics Anonymous, Alanon Anomynous Teen. My mom used to have me in Al-Ateen, my parents had me seeing a counseling, because of their addictions since I was 10 years old, but yet here I sit an addict.

Follow-up interviews showed that #6969 and #69 both initiated voluntary treatment on their own. Both obtained DTT, mental health treatment, and programs to aid

with their sobriety. Participant #7667 was caught up in stressors such as dealing with a broken relationship and trying to get his son out of social services. Participant #23 was dealing with finding a home. Both #7667 and #23 stated that treatment was conflicting with their work situations and they could not find the time to commit to a program.

- #69: I'm doing meetings. I went to AA. And I talked to Mike at AA about going into meetings, so I am doing that now, and then I went to the hospital, and talked to them, so I'm going to be doing meetings once a week with the hospital.
- #6969: I really want to know about the Vivitrol shot...and get into behavioral treatment...get help to stop. I don't want to overdose.
- #23: Actually, I am going to ask her about the Vivitrol shot. I've been sober 6 months and don't want to start that cycle again.
- #7667: I have not looked into treatment as of yet, because of all the issues I am dealing with right now.

Mandatory treatment. All 15 participants agreed that mandatory treatment does not work, because the addict has to want to change on the inside. The statement about having to have their own motivation to quit was shared by all participants, and the need to change was a required element of successful treatment. However, the data shows that externally motivated treatment is easily manipulated by stressors or perceived failures in relationships, defiance and behavioral issues, and if the external motivation is to achieve an optimal result, such as early release or less sentencing. Below are the participant statements regarding mandatory treatment.

- #2: I was like how was it intense I was in prison, I'm going to say and do whatever I gotta do to get out of there you know?
- #5: I'm going to rehab to inpatient treatment, so I'm waiting for my PO to come with my alternative to revocation papers.
- #14: Well then, me and my brother get caught up and I overdose numerous times. You know this time I got out of treatment and she said, 'I'm done. You're clean or I'm done.' I've talked to her a few times on the phone but she won't come to see me.
- #0420: Forced, a forced situation like a forced hand . . . and then I was using at the center and stuff like . . it was like, whether or not do I want to do this or do I not want to do this or no?
- #7735: The Gateway program was sort of an ultimatum. Either do this or get out of the house and I was young then said yeah I'll do it whatever. Screwed it up within 14 days.
- #2977: A couple of them I was forced by my parents, and I've been three party's petitioned, just because I . . . everybody I've met really said that you've just gotta want it . . . um . . . so..like all those other times, I tried it I just wasn't ready to quit.
- #6969: Went through the TAP program, which is the Treatment Alternative Program in Dane county, and that was actually fabulous for me, because that was my only year of sobriety.
- #6969: It's kind of like involuntary rehab but in the best way.

- #4733: I said the first 14 months straight, then I did another year on the other one and then got treatment got released early. So I did a 21 week program which was SBISA. Well, I got a lot out of it. I really did, but as soon as I walked out the door, I forgot every damn thing I was in treatment for.
- #4733: The truth? I knew I'd get out early if I went.
- #69: When I was in the joint they sent me to a . . . drug treatment..I forgot their facility name...Sheridan...in Illinois...I did, 420 that time...420 days in their rehab.
- #69: When you're mandated to do things, you don't want to do them. It makes you screw up faster. You screw up. You relapse.
- #7: Yeah, so motivation together, jail not so much to stay clean. So all for the wrong reasons, as I look back. And in prison I did boot camp, because I got to go home early.
- #1: I need to go, because if I don't, I'm going to get sent to prison. That little incentive on the back [points to his back] that says I will do that kind of in a way, but I think if you make it more of a choice.

Participants #2640 and #23 did not explicitly describe any mandated treatment; rather they discussed incarceration, relapse, and overdose experiences. Both women described their belief that incarceration is a form of treatment in and of itself, as a mandated detox and treatment program.

- #23: Out on the streets...if I weren't incarcerated, I would have struggled to quit and I would have gone to the methadone clinic...I would have struggled.

- #2640: It's easy to remain sober in jail, it's so easy to remain sober.

Participants #1050 and #7667 shared the fact that they had never felt mandated to complete any treatment, and #7667 did not describe any instances where he entered treatment due to external motivation.

Discrepant Findings

All of the participants' stories provided enough information and saturation to develop three common themes; however, discrepancies appeared as individual and idiosyncratic data either was reviewed or was not apparent. I discussed those discrepancies in each section above, pointing out differences and variances between participants regarding each theme. Participant interviews provided depth and range to answer the questions, and in the next section I describe the level of saturation reached.

Advice to Professionals

All 15 participants were excited to take part in this study. I treated them as a source of information and asked them to teach me about their addiction, their life, their experiences. I took a back seat to them, and allowed them to lift themselves up as the senior knowledge bank. When asked what their thoughts and feelings were about better treatment options and better release programs, as if they were sitting in a room of professionals, they lit up and wanted to make sure I relayed their advice. They all felt their input could make a difference and they were adamant that I take their advice verbatim. The desires are for a person to help them who knows addiction, who can guide them, hold their hands, and walk them through their issues until they grasp the ability to cope with triggers. The data shows they would prefer a sobriety officer if you will, rather

than a probation officer, because the majority of crimes are related to heroin use and addiction. Stop the addiction and the crimes will stop too. Below are the participant quotes sharing what these 'professionals' believe is important change for heroin-addicted offenders.

- #2: They need to help people get their lives in order before they get out of jail. Maybe some kind of program where you work, where you can save money in here and get your own place before you get out. They should have something or maybe even where they force you to get your fuckin' life together...cause that's what we need. . . . That's what I need.
- #5: Maybe a sponsor. Somebody, you know, somebody I could call. My mom always tells me when I'm not with her, if you're around people and you want to use just call me. If you feel like something is in your head or you're sad and you want to use call me talk to me, I'll talk to you through it. And I never did and I've always used and I've never called her.
- #14: The counseling thing was the best thing I did but I just I didn't follow up on any of the appointments was the thing. I was working too much you know but the pop thing works. I don't like that.
- #14: Obviously we all need to be punished. . . Tf you lock us up and then you just send us back, treatment is way better. I swear by it. That MSDF thing, I would probably still be clean if I just would have stayed away from my brother.

- #14: I want to do treatment when I get out again. I'd rather do the counseling one-on-one counseling I don't like the group thing, a lot of people like me I don't like it in front of a group and telling everybody my problems. We all got the same problems why has my problem on to somebody else? You know what I mean?
- #14: The one on one thing like this...they got the group things in here that half the time it's stuff out of a bible and shit like that..the higher power thing..I don't believe in that..you've got to do it for yourself. if you really want to be clean you're going to be clean..and the one on one thing is just for me..it works better.
- #0420: They need to offer some kind of a program, yeah they offer Na and AA, but what is that going to do you need an on-site nurse you need to be in the hospital you need to be in something like where you know you can have fluids and stuff like that.
- #1050: Yes and they give you one blanket, no pillowcase, and you… so even if you're freezing, you have one blanket, and then you're hot and cold… and you're on a leather mattress dude the worst way ever to withdrawal. And then you know you can't eat, like you really can't, because you're throwing up and your senses are so, they're just so….
- #7667: They need to be able to...other counties like Milwaukee and others like OshKosh, lately umm… that they take people...it's a maintenance program, and they take people there every day, ya know? Through jail or whatever..let

them walk or however they get there..FDL County does not offer that. And granted I said the clinic is evil, which it is, but i think there should be a maintenance program of some kind.

- #7667: That the County's need to understand this is an epidemic and it's killing people and you've gotta help umm when they come in here otherwise they're just going to go right back out and do this right away.
- #7667: Yeah well, so when they go back out there even Suboxone or whateve,r and that will help them to stop you from . . . Then block it out so you can't immediately get high, because a lot of time when you get out of here you want to go get high really bad. If you're in here for a while and you go out and you kill yourself, right when you get out, because you need to have at least a good system.
- #7735: Not being thrown in a single cell with no sheets. I guess it's very different a lot of people, I mean, like me, I don't withdraw all that hard I don't shoot up. I've never injected. I don't go through a terrible withdrawal, but when you come in it depends on which jail you're in, cuz when you come to every jail I've been to in Wisconsin they lock you into a freakin room for 3 days. You eat there are you sitting there alone.
- #7: Listen to what we say. To talk to a doctor we can't wait hours or a day, we need to have them come in. If you know we're cold, give us a blanket or an extra something, cuz you're going between cold and freezing. And you know if there are certain foods that the kitchen can accommodate, let us have it,

because say it's sometimes, even a week at a time that you're throwing up all the time, so you can't take what their giving to you. People still come in with problems and issues like drugs addiction and they still need to be taken care of.

- #7: I do and I don't. I mean they offer the really limited very limited on what they offer here for support group or a class. I mean and in order for you to go to AA or Christian AA you have to make sure that you're up at 7 in the morning to sign up for it so it's not something that you can just call.
- #2977: The only treatment there is really in here..you gotta want it in here, because there's nothing for you in here, and you're around a lot of different types of ppl, so one day you'll be like I want to be like the person I want to be, and the next day you're like . . . awww fuck this . . . I don't want to do it anymore. But ya know, there's a lot of ups and downs, because of the environment you're in. There's no treatment really.
- #6969: I also came in with meds that were specifically for drug withdrawal and I talked to my doctor and he said you know this is going to be really rough you're going off Suboxone, but I didn't want him to cut my Suboxone down. I really didn't want to be weaned off of it, cuz I thought I would use it while I was out there anyway. So he gave me withdrawal meds and they wouldn't give those to me in here. He gave me Gabapentin and clonidine and they wouldn't give me them either. Well they gave me clonidine, but only at half a dose and that was a third of the time that doctors sad.

- #4733: If you give me room to hang myself I'm going to hang myself.
- #1: Mainly it's the medications um you know if they would have a better medication list.
- #2640: It's a step process, you can't just throw somebody out there in the street and be like okay you're sober now and then expect them not to go and touch something else.
- #2640: Exactly that's the problem. And honestly, if they really cared about addicts they would do an in-depth treatment. Because I don't think . . . it's going to take an addict sometime to get their shit together. It's going to take an addict some time to change their mind. You know so if they screw up and the program one, and then you bring them back to jail because they broke a rule, and then send them off to prison, that's not going to help them either, because they need to take time mentally. They need to have a few chances, not just one and then off to prison right away. Not just jail and sit here for a long period of time.
- #2640: And this county, there is no group home for females here. There is no temporary living places here in this County for females.
- #23: Um....okay can I say to you, I 'd rather say...what I think now, rather than then, because when you first come in you're still in that user state of mind, and if you really want to get clean, um, one thing I would have to say is behavioral. If they had programs in the jail to help those change their behavior. Do you know what I mean? To change the way you think . . . um . . .

because like here they have NA, they have AA, yea that's great. You go to probation and parole, and they have Connnn . . . behavioral [cognitive behavioral] changing..?

- #69: Add more programs. Right now they have AA programs, but that's more for alcoholics, and they only have NA for females. They need it for males. Um . . . less bible studies. They got too many bible studies.

All of the participants were open, sharing their stories and experiences the best they could with as much recall as possible. Only #2977 stated that his recall had diminished during the years he used heroin and had lost a piece of himself, stating that he could not remember life before heroin.

Summary

In this chapter I discussed how I recruited participants, participants' profiles, the data collection process and storage, data analysis, data verification, and theme development. The results of this study show that heroin-addicted offenders lack the direction and knowledge, as well as coping skills upon re-entry to succeed at sobriety. All participants expressed a strong desire for handholding and guidance towards and throughout treatment completion. The participants all shared common stories and experiences even though their life situations varied. The unique lives and experiences of the 15 participants were connected by three common themes. Differences were reported in the perception of and belief in drug treatment therapy programs, as well as plans to achieve sobriety upon re-entry. I present an interpretation of the findings and results in Chapter 5.

Chapter 5 Summary, Conclusions, & Recommendations

Introduction

This study addressed a gap in the literature regarding what factors and experiences heroin-addicted offenders felt were important for sobriety upon re-entry. This phenomenological study was created to discover the experiences, thoughts, and perceptions of heroin-addicted offenders on their paths to sobriety. I completed 15 semistructured initial interviews in the local jail and four follow-up interviews with participants who were released during this study. The interviews were digitally recorded, and I transcribed them verbatim. I used the Atlas-ti qualitative analysis software to organize my transcripts and code the interviews.

The participants provided rich and deep descriptions of living their lives with addiction and incarceration, and although each participant provided a vastly different story and perspective, three themes developed out of the findings. The participants expressed physical, mental, and emotional pain and difficulty in their attempts to be sober, sharing losses, rejection, and failures, all of which affected their self-confidence, self-efficacy, and perception of life events. In their interviews, they described the need for caring support from people outside of family and friends. They stated that they felt they were in charge at one point in their lives, but that heroin was in control of every financial, emotional, and physical move they made once they started using. All participants felt that better care was needed for those actively going through detox in jail, not just drug treatment, but personal care and treatment by staff. The passion that these participants shared for heroin on one level was matched by their desire to quit and not

understanding how to do it. The contradictions were apparent, as although they felt in control of their lives they still felt that heroin was in control, and although they wanted to be sober, the euphoric feeling that heroin gave them was like nothing they could describe. There was a love for the heroin, a depth that could be seen in their facial expressions and heard in their voices as they talked about it, an abusive love/hate relationship relationship that they could not find the means or strength to leave. In this chapter, I interpret the participants' stories in the context of other studies and the theoretical framework.

I also discuss the internal, social, and treatment factors that made up the emerging themes as presented by the participants. The internal factors that played a role in motivating participants to use were anxiety and depression and the addict mindset, as described by participants. Internal motivators to abstain were idiosyncratic involving children and the desire to live a normal life. Also discussed were the perceptions of events in life as being origin or pawn experiences as described in the theory of personal causation by deCharms (1968), and reasons for relapse, all with internal motivations.

The social motivators interpreted in this chapter are personal loss, drug using peers, and broken relationships with family and children and their influences on participants to use. Treatment factors discussed are the external desires to quit, experiences of detox in jail, and perceptions of AA, NA, methadone, Vivitrol, Suboxone, exit counseling, mental health, and handholding, as interpreted by this researcher from the data collected. The next section provides the interpretations of the findings in relation to the theoretical framework and other study context.

Interpretation of the Findings

The results of this study related to the theory of personal causation and added to the body of literature on heroin addiction and offender experiences with sobriety upon re-entry. This study provides perspectives and beliefs shared by heroin-addicted offenders as they transitioned from jail to re-entry. The knowledge gained through this study adds information to the body of literature about what is believed to be the needed steps and processes for heroin-addicted offenders to reach and maintain sobriety upon release.

The theory of personal causation guided this study by providing a focus on personal choice and motivational influences and how they affect personal actions. There is much literature on the theory of personal causation dealing with how people perceive events as either controlled by themselves or decided by others and imposed on them without consent (DeCharms, 1968). DeCharms (1992) explains the origin aspect in his research, that persons who have confidence in their own abilities have the potential to determine their own paths and goals. DeCharms goes on to state that the opposite position is called pawn expereicnes, when persons feel as if their actions and movements are imposed on them by another person, they hold a deluded perception of reality, they act irresponsibility, and they lack self-confidence.

Wallace et al. (2016) stated that a sense of purpose along with a feeling of personal control are achieved when persons make their own choices and take responsibility for their actions. Individuals also pursue positive social supports when they take on a sense of control (Wallace et al., 2016). The issues revealed in this study regarding the theory of personal causation were that addicts, like all people, experience

internal motivations; however, being offenders means that they have also experienced life where they are told what to do by lawyers, jail staff, treatment specialists, and public health professionals, causing them to feel more like pawns rather than in charge of their personal choices. These findings of origin and pawn are seen in other studies where offenders have expressed feelings of external motivation and pressure from others (Millere et al., 2014). Below I discuss how the data collected and results of this study support the theory of personal causation.

Internal Factors

Participants all described intrinsic motivators that moved them to first try and continue using heroin. Mental illnesses such as anxiety and depression were expressed as pains that went away when heroin was used, and it brought relief from the feelings and pressures they were experiencing. Jones (2013) showed that heroin use for pain stemmed from the initial use of opioid pain relievers, and Schmidt et al. (2014) stated that heroin helped relieve anxiety and feelings of stress, both of which support the participants' statements of using heroin for anxiety and pain. Anxiety and depression are discussed below in-depth to show how the theory of personal causation relates to the data collected. Another internal motivator discussed was the thought patterns perpetuating heroin use; participants called it the addict mindset. The addict mindset caused participants to continue to use, warped perceptions of events and who controlled the outcomes, and drove participants to relapse. Descriptions of the addict mindset provided insight into how participants viewed themselves as capable or incapable. These internal factors are discussed below.

Anxiety and depression. Several of the participants explained that they used heroin to end the pain of anxiety and depression; however, studies show that heroin use increases the occurrence of anxiety attacks because it impairs the brain's ability to ascertain situations for what they are, rather than what they appear to be (Xin et al., 2014). Xin et al. (2014) stated that heroin, because of its ability to cross membranes faster than morphine, causes a euphoric feeling and addictive process; however, heroin use has been found to inhibit the ability to properly reappraise emotional situations and contributes to anxiety when sober. Ball, Ramsawh, Campbell-Sills, Paulus, & Stein (2013) supported this finding in that anxiety and depression can result in maladaptive emotional dysfunction when emotional quality and function are compromised. In other words, the participants believe the heroin is helping them by relieving the anxiety and depression, but studies show it is actually increasing the likelihood that an anxiety or depressive attack will occur. The issue is that anxiety tells the individual that it needs heroin to stop the attack, and so they continue to use. If the issues causing the anxiety are not dealt with, the possibility of relapse increases.

Anxiety and depression were triggers that all participants spoke of during their interviews. Their demeanor was shy, more hunched over, quieter, and more aware of their personal space. As described by Laufer, Israeli, & Paz (2016), anxiety is an internal situation affecting self-confidence and self-efficacy. Participants explained that events that caused them anxiety ranged from sitting with me in the interview room to being in public in normal situations. A few participants sat relaxed and confident as they told their stories, while others sat with their arms around themselves, rocking while they sat or

biting their nails. The anxiety they felt was apparent, and it showed in one participant as I shook his hand and felt cold, clammy palms. He stated throughout the interview that he had horrible anxiety, chest pressure, and self-confidence issues. I told him to relax around me and not worry, and he stated that it was everywhere and everyone, not just the interview process. Anxiety is an internal situation affecting self-confidence and self-efficacy (Laufer et al., 2016). Participants described being out in public as an event that caused anxiety or that they knew they had anxiety and did not know why.

The results showed that anxiety and depression played a significant role in internally motivating the participants to use and relapse. At no point did the participants state that anyone else had caused them depression or anxiety; rather, they claimed the emotions and feelings as their own. This acceptance of responsibility caused the participants to suffer low self-esteem, self-confidence, and self-efficacy. Albeit internal, the anxiety seemed to stem from fears related to unemployment upon re-entry, loss of family and normalcy, and the possibility of relapse; as if their uncertainty of their potential actions scared them. Several participants mentioned being afraid of re-entry and the path to sobriety; they were afraid that they would not make it, especially alone and under current circumstances. One participant was anxious the entire interview and described anxiety as a catalyst to using; however, he claimed to be in charge of his life and drug use. He believed there was nothing anyone could do for him, but he also begged to just go home to his mom.

The theory of personal causation supports these findings in that people develop goals based on their perception of self-efficacy, and those beliefs determine what a

person does or does not do to achieve those goals (Wentzel, 1999). A person's beliefs about causality and personal control also play a role in how they act and pursue goals, such as heroin-addicted offenders pursuing sobriety. If they lack self-efficacy and improperly reappraise situations due to emotional dysfunction that has worsened from chronic heroin use, then anxiety and depression will worsen, and a cycle of emotional disturbances and heroin use will result. The participants see themselves as the problem, creating a negative internal origin experience perspective within themselves, destroying self-esteem and confidence. The self-initiation to act comes from within, as anxiety and depression are internal, and participants saw the anxiety and depression as themselves—who they were—throughout the interviews. Participants expressed in connection with the mental disturbances that the addict mindset seemed to control their desires and actions. They blamed this internal force as the reason to continue to use and relapse.

Addict mindset. Several of the participants spoke of the addict mindset that kept taking over even when they wanted to quit using heroin. The mindset was to continue on the path of using and selling drugs. Kreek et al. (2012) state that the addict mindset is a neuraladaptation caused by drug use, where actual changes occur in the brain, hence supporting findings that drug addiction is a disease of the brain. The addict mindset becomes an internal motivator and factor to continue using drugs (Kreek et al., 2012). This internal drive to continue using was expressed as seeming to be out of their control and a true voice in their heads to walk away from treatment and sobriety. Almost all of the participants mentioned that 'an addict will only quit if they want to quit', and that statement seemed to take on a life of its own, as if more of an excuse or reason to

continue using. Several of the participants explained that although they knew quitting heroin was the best path for them, that they would hear people talking about buying and selling, and realize they too could make money this way, which caused them to fall back into selling and using heroin. One participant spoke of sneaking heroin into the jail, and instead of flushing it down the toilet, she used some and shared it with her cell block mate, based on the 'addict mindset.'

One participant expressed the addict mindset in a way that cries simple addiction. He stated that he was clean at one point, and decided to try heroin again to see what would happen. He immediately fell into the addiction again, and said that his mind reverted to addict-mode and he could not function without a fix. There is reason to believe that addict mindset is a means of describing and glorifying addiction. What participants believe is a mindset brought on by genetics, external support, and heroin use, is simply addiction. The theory of personal causation labels events that happen to a person perceived to be out of their control as pawn events. The internal motivation to act is inhibited by an external force, the addict mindset; however, the mind is within, and once again we see people labeling origin events as pawns, which destroy self-confidence and self-efficacy, autonomy and self-determination (Ryan & Grolnick, 1986). The theory of personal causation supports these findings, because although the participants' actions are autonomous and self-determined, they still have an effect on self-esteem and self-efficacy, albeit negative.

Another form of addict mindset that participants described was the daily routine of addiction. This habitual behavior compounds the addiction, because participants

believed they could not function without their daily fix of heroin. Many participants explained the daily routine of getting up, finding the money to buy the heroin, however that may be achieved, driving to get the heroin, sometimes every day to and from Milwaukee, and using, all so they could take care of themselves and go to work. The described this routine as exhausting and tiresome. One even stated that it got boring to do, so he abstained for a while.

It is apparent that cognitive and behavioral treatment is needed to help heroin-addicted offenders to understand the mind and how it works. The psychological factors that play a role in addiction and how the brain functions may help them understand what is happening each time they snort or shoot up heroin. Understanding now how to cope with internal desires to use, and move past them would be beneficial to their recovery. Also suggested would be spiritual guidance, not religion, but spiritual guidance to explain the different forces at work in our lives every day as well. Spiritual guidance is something that everyone understands and can relate to, because spirituality comes from within. Religion is something people have to understand and relate to themselves, which they may not.

Internal motivators to abstain were limited, as explained above, the participants had a lot of internal emotion, all of which is a part of them, motivating them to use. Motivators to abstain are explained in the next section.

Motivators to abstain. The theory of personal causation explains that when a person takes responsibility for their actions, and sees themselves as the locus of control rather than events happening due to chance, luck, or other external forces, individuals see

themselves as origins of their actions (DeCharms, 1974). When an individual says I want this or that, they are taking an active role in deciding their outcomes and stating their belief in self (Wentzel, 1999). Several participants in this study simply stated that they wanted to be sober because they were afraid of dying. Their internally motivated statements to abstain all contained 'I' in them, as for what they wanted, not someone else. I want to get a job. I want to go to school. I want my family back, I don't want to use again…all are autonomous reasons to stay sober and help them facilitate and create expectations for their futures.

One participant stated her fear of overdosing and dying, while six participants described a life with normalcy as their reasoning for wanting sobriety, with their children back in their lives. One participant stated that education was a reason for sobriety, as they wanted to go back to school, and seven participants stated that they simply were ready to be clean. This internal motivation they spoke of was a vulnerable mention about themselves and their knowledge of what it would take for them to quit, painfully stated as they also expressed the difficulty in quitting. The events in our lives are personally viewed as either origin or pawn, we either control it or we do not, and the next section discusses how those moments have affected and are affecting the participants pursuit of sobriety upon re-entry.

Pawn versus origin. The theory of personal causation by DeCharms (1968) names intrinsic and extrinsic motivation as origin and pawn events, and two major elements of the theory. The motivation itself must be examined for its determinants and not simply what drives the behavior (DeCharms & Muir, 1978). This means that

individuals must discern what determines their motivation rather than what drives it. For instance, when the participants decide to quit using, they must view it as a challenge rather than a threat, determining how they will approach sobriety on their own, rather than be driven to it by an external force, such as in pawn-identified events (DeCharms & Muir, 1978).

Participants described events when incarcerated, as pawn moments decided by jail staff, lawyers, and judges. They did not feel autonomous, and stated that they were not currently in charge of their lives. However, four of the participants made mention of having lived without heroin for so long they knew they could do it again, or that they were done using, because all bad things in their lives had happened due to heroin use. Pawn moments, externally driven or caused, made up the majority of perceived events in the participants' lives. Examples of mentioned pawn events were losing their children, beginning drug use because of a friend, genetics, or pain caused by work or an accident, being arrested because someone called them in, catching a case because someone talked, put in jail because of location or address, arrested because a probation officer was being mean, using again because a probation officer would not test them regularly, leaving treatment because it was too hard, and the list goes on and on. It was very seldom expressed that an act was intentional or a participant's responsibility. The pawn moments are internally decided by an individual's perspective of their ability to complete a difficult task or goal (DeCharms, 1968). The low self-esteem and low-confidence levels described by the participants' supports their descriptions of pawn moments and why they do not accept responsibility for their actions.

One participant stated that he had been clean for a couple of weeks, based on his desire to be with his girlfriend and daughter. He went out hiking with a few friends and was tempted to drink some whiskey, so he did. Upon drinking he said, Fuck it, I already drank," and proceeded to do some crack and then when it was gone he asked for the heroin, but his friends declined him and the last thing he remembers is passing out. He did not blame anyone for that relapse event, rather he accepted it as his own; he chose to drink and get high, making this a negative origin experience. He fully blamed himself for his weakness. This drinking, crack, and eventually heroin binge led to a full-blown overdose that his friends said killed him. They dragged him to his apartment and left him for dead. He accepts all of this as his own actions. This participant shared many origin moments all ending in negative outcomes, or representing poor choices. These negative events added to his belief that he was incapable of being sober, because of his low self-esteem, low self-efficacy, and lack of self-confidence, even though all the moments were claimed to be autonomous in nature.

Positive origin moments that a participant spoke of several times began with "I", and continued into his re-entry on a positive note, because he had accepted his outcomes as his own, and decided that he was capable of obtaining the goal of sobriety on his own. This intrinsic motivation and origin-based events he described were choices of personal acceptance that no external influences were driving, and he followed through with his initial decision to remain sober upon re-entry. Ryan and Deci (2000) explain this phenomena in that motivation level and orientation both play a role in how a person perceives and moves through a task such as sobriety. The level of motivation being how

motivated a person is, and the orientation or what or who is motivating a person can affect the outcome of the situation. This study adds to the theory of personal causation as it was seen in this study and explained earlier, in that origin moments can be internally motivated, but a pawn moment can be both internally or externally motivated. The desire to quit using drugs can be internally motivated, but how much? Quitting using heroin can be externally motivated, but what does it mean to the user? Does it mean freedom sooner than later? Does it mean getting their family back? How much are those events appraised for in the eyes of the heron-addicted offenders?

This leads us to see that regardless of the pawn or origin moment, what one individual sees as motivating to be sober, another individual may not, such as attending an inpatient treatment program. One participant claimed that inpatient treatment was not fun and much harder than he had expected so he quit to get high, and another participant stated that she had never tried inpatient treatment before and wanted to experience it upon re-entry. Motivations are different, perspectives are different, and desired outcomes are different. How a heroin-addicted offender perceives a moment or event, can affect their motivation to achieve the desired goal. An example of this is how the participants expressed opinions of the AA and NA meetings in the jail. They all believed the groups were a joke and a time to meet new people and get drug dealer information for when they got out. Even if a participant spoke of wanting to be sober and attended AA and NA meetings in the jail, their motivation to actually get something out of that time may have been hindered by their perspective of the groups due to hearsay and others' opinions. I want to get clean and attend the AA meetings for sobriety, but everyone says they are a

joke. This perception going into treatment may affect the belief in what the group could do for them, and ultimately be ineffective. Pawn and origin identified events play roles in relapse as well, as presented in the following section.

Relapse. The focus of this study was on heroin-addicted offenders and their experiences of sobriety upon re-entry. Relapse experiences can and do happen, and were a part of this study. Li et al. (2015) show that relapse is a function that occurs in the brain, physiologically, and not simply as a decision to use again. Li et al. go on to state that cues or triggers are perceived in the brain, and brain responses to certain cues and triggers were greater in heroin-addicted persons than non-users. The research conducted by Li et al. also showed that heroin-addicted offenders and substance abusers alike need cognitive and behavioral therapy to help distinguish and determine cues and triggers to aid in the curtailing of relapse.

Xin et al. (2014) supported these findings in that their research showed that the brain can dysfunction and cause people the inability to appraise similar situations properly. For instance, if a person suffers a hypoglycemic attack, their symptoms may be increased heart rate, dizziness, shaking, and weakness. This reaction causes that person to panic at the thought of passing out in public or while driving. The person then likens any physical activity that causes a raised heart rate and weakness to passing out and that fear causes panic. Now any time that person experiences hypoglycemic attacks they also have a panic attack. When heroin addicts are coming down from a high, they get sick, and that sickness causes anxiety, which is caused by the fear of withdrawal and the addict uses

again to stave off the withdrawal. Any situation that causes feelings that are likened with withdrawal make them anxious and they use again.

Participants shared stories of previous incarcerations and relapse, as well as current re-entries during this study. The need for treatment to increase self-perception and self-efficacy is needed if heroin-addicted offenders are going to determine their triggers and their abilities to be sober. The personal views shared by the participants of this study show that many entered into treatment involuntarily or believe the treatment does not work for them. As we will discuss later in this chapter, involuntary or mandated treatment is perceived as a forced act and does not work, according to the participants' statements. One participant upon re-entry from her current incarceration felt that she was okay without treatment and insisted that treatment interfered with her work release schedule. During her initial interview she stated that she would need methadone or Vivitrol to help her, as some just needed help. Her boyfriend contacted me while I was completing the research using her phone to tell me that she had lost her work release due to a relapse and would not be out until the fall. He stated that she was very upset with herself for messing up and losing her job on the outside. I thanked him for contacting me and left it at that.

The fear of relapse is real in every participant in this study. Even the confident participants who believe in themselves fear the unknown. A participant explained in her initial interview that she was afraid of re-entry, because she did not trust herself or what she would do once released. She said she could overdose and feared dying. She expressed fear, and talked about her triggers openly, one of which was her step-father passing while she was incarcerated. During her follow-up interview upon re-entry, she stated that she

was hit with the pain of losing her step-dad, and realized she had not dealt with his death. She went and obtained some heroin and used all of it, causing herself to overdose. At no time did she claim anyone else was in control of her relapse, and she took full responsibility for her actions, stating that she never wanted to use again for fear of dying. Her ambivalence almost cost her her life, and not once did she name any events as pawns. In a conversation a week after her follow-up interview, she stated that she felt she could finally handle sobriety after having obtained a Vivitrol shot and treatment. She took control of her situation, gained a bit of self-confidence, and finally a bit of autonomy, all supported by what DeCharms (1968) described as an internally perceived locus of causality. The locus of causality is concerned with why a person does what he or she does, which is different than the locus of control which describes what controls a person's outcomes (Deci & Ryan, 1985).

Another participant decided while he was incarcerated that he was not going to use again. His locus of control was the participant himself, as he saw that he was in charge of his future and the outcome of his sobriety. The locus of causality was that he wanted to be sober, and was tired of living the same addicted life and routine. With this information known, it was apparent that not all participants had the same perceptions of their control and causality that DeCharms' (1968) theory of personal causation described. This one participant was the only one who held to his convictions of wanting to quit and realizing what he needed to do to maintain sobriety. One participant talked about using upon re-entry as a certainty, even though he wanted to remain sober. He admitted that he was not willing to maintain sobriety if he could not have his daughter in his life. He

relapsed the day he was released and was reincarcerated less than two weeks later. His locus of causality was that he wanted to get high, and the locus of control was that he saw all of his social stressors such as homelessness, loss of his daughter, and un-employability as threats against himself, as a pawn sees himself.

Social Factors

The social motivators that participants described were the loss of family, home, employment, and normalcy. Social factors and influences described in this study happened regardless of the participants' wants, such as knowing they would lose a relationship if they used heroin again, or recidivate if caught in the wrong place with the wrong people. The reward of using heroin trumped any consequences they might incur. These findings are supported by Volkow, Baler, and Goldstein (2011) that social factors play dual roles in addiction; one being the reason to use, and the other being the consequence of use. One participant spoke of her desire to be self-sufficient again as she described her longing to work again, get her daughter back, and take care of herself and her little girl. When participants shared that they had no family and friends to turn to, they described the open arms of drug using peers to run into upon re-entry. One participant stated that he could not go home with his father, his mother had passed, and his girlfriend was moving back in with her parents and they would not allow him around. He said that he would go to the drug dealer's home, sleep there, and pay rent by selling drugs. He had it in his mind to use even before his release. The lifestyle lived by heroin-addicted addicts is the cause of broken relationships between parents, siblings, children, and employers, all of which weighed heavily on the participants' minds as they answered

interview questions. Below I discuss social factors more in-depth in relation to the theory of personal causation and how they support each other.

Personal loss. The theory of personal causation asserts that personal causation involves experiences that build on the healthy functioning of individuals' perceptions by helping to identify events and outcomes people have caused by their own actions (Nahab et al., 2011). For instance, when a person turns a handle to open a door, they expect from previous experience that the door will open. Upon turning the door-knob, the door opens and fulfills the person's expectations. They know they are the only one who turned the knob and therefore the door opened because of them, and they apply their signature of origin to this event. The same applies to all events, and if a person believes their actions will cause an outcome one way or another, they will automatically assign it as an origin or pawn event, based on previous experience. Personal loss is an event that can be perceived as origin or pawn based on the theory of causation, and according to the participants of this study, the losses experienced were based on their personal actions. Although the personal loss described in this section is origin in nature, it carries guilt and sadness with it, which undermines positive self-confidence, and caused the participants to foresee more loss in the future. Based on their perceptions of inabilities to cope, the participants are stuck in a cycle of perceived loss and experienced loss assigned as origin and having their signatures on them.

The fact that we assign our signatures to all events we experience as our own or having been caused by others, aligns itself with the theory of personal causation in that people also assign themselves or others as the cause of their losses. This study supports

those assertions in that the participants accepted blame for their losses in most cases. The participant statements I include in this chapter express the pain and guilt of their personal losses, as well as their lack of coping skills and self-efficacy, as they turn to heroin for emotional support. These "I" moments are origin in nature, claimed by the participants as outcomes of their own actions, and self-reflected, causing a deeper pain and guilt, as they accept the outcomes as their own. The inability to cope with these feelings causes a stronger need to use. Guilt, shame, and a lack of coping skills are found in studies regarding prostitution (Clarke, Clarke, Roe-Sepowitz, & Fey, 2012), crack-cocaine use (Daniulaityte & Carlson, 2011), and minorities (Lewis, Milletich, Kelley, & Woody, 2012). There is a lack of literature pertaining to guilt, shame, and a lack of coping skills regarding heroin users and social loss, that is perceived to come from within, filling a gap in the literature. The point being that literature often shows recovering addicts to be the only ones who accept responsibility for their lives and actions (Neale et al., 2014). In the same way, other studies state that heroin users blame others for their drug use, rarely accepting their responsibility for their lives (Neale et al., 2013). The participants of this study counter those findings by showing awareness of their contribution to their current situations, even while still addicted by using 'I' statements that direct responsibility inward. These findings counter mainstream ideas that addicts cannot accept blame while in denial or when using, because they lack the self-efficacy to do so. Although these participants experienced loss, which was the cause of or result of heroin use, they still maintain the ability to choose, and regardless of the positive or negative outcome, accept

those outcomes as authored by themselves, hence the possibility of negatively reinforced origin moments as well as pawn moments that they feel to be externally motivated.

Participants described personal loss as a trigger to use heroin. Some explained that if they had experienced the loss while released they would have immediately turned to heroin to cope with the pain. One describes how she was sober and got a case of the 'fuck its' and decided to use, because she was dealing with loss while released and simply didn't want to maintain sobriety. Still others describe how loss happened while they were incarcerated and once released they realized they had not dealt with the pain of the loss and relapsed. One participant spoke of losing her step-father while incarcerated, and when she was released, she found herself dealing with his death alone, and she turned to heroin for comfort; however she overdosed and received three shots of Narcan to bring her back.

Death is not the only loss that participants described as triggers. The loss of a normal life was another factor mentioned by several participants. One participant wanted to work and take care of his kids, pay his bills, make amends with his sister and mother. Another participant also spoke of working towards repairing relationships with family in order to help with their sobriety. The guilt and shame carried by the participants exposed how deeply the felt anguish for ruining their lives and comforts for heroin. They explained that there was no way they could fix all their relationships and losses at once, and that it would take a long time to recuperate from heroin use. Rebuilding their lives was a desire by all; however, almost all lacked the knowledge and direction to stay the sober course. They knew it would take a long time to regain the trust of family and non-

using friends, and then faced with social stressors of unemployment and homelessness, the issues seemed insurmountable and their lacks of self-confidence and self-efficacy showed. For example, all stated in one way or another that once you are an addict you are always an addict, and it seemed as if this internal factor played a role in how they attempted to overcome social factors that worked against them.

Another element of social factors is when users attempt to take on more than they can bear upon re-entry. One participant explained during his interview that he was in a relationship and had a one-year-old son. He stated that he would probably use again once released,, but he did not want to bring heroin around his family. He described a tumultuous relationship with a girlfriend who has a drinking problem. He was released without a probation officer. Upon speaking with him during his follow-up interview he stated that he was working as a roofer, and trying to get his son back from social services; however, an issue lied in the fact that his girlfriend is an alcoholic and cannot be around their one-year-old. He called me again after our follow-up to share his perspective and status. He was having trouble working, because he had gotten his son back from social services and could not leave him alone with his girlfriend [the boy's mom], because of her drinking problem. He also could not go to treatment, because it was conflicting with work. He stated that his social life was making him feel crazy and insane, unable to deal with everything. His next contact with me was to send his girlfriend to an alcohol treatment program so his son would be safe. These social factors are just a few mentioned, and to someone who has trouble coping with problems, and finds comfort in getting high, this situation upon re-entry is a catalyst to relapse.

The issue of sobriety upon re-entry is that participants know they have a lot to deal with in terms of straightening out their lives. Five of the participants spoke of life upon re-entry as having no one to turn to in the way of positive supports. They spoke of how family had turned on them, or that they were alone to begin with. One participant stated that he had not been home in three years, away from parents and siblings, and this pain was apparent in his statement that he just wanted to go home and be with his mom. He carried himself in a strong, defensive way, but when speaking of broken relationships and the pain he had caused them, you could see his demeanor changed and he appeared more hurt than strong. His crossed arms clenched around him when speaking of his mom and family. He tilted his head sideways, and adjusted his posture away from me, crossing his leg and bouncing his knee. Talking about his family made him anxious and it was apparent that he needed help dealing with those hurts and issues. He was not the only one who carried pain and guilt from broken relationships though.

A female participant described her addiction experience as having hurt her mother repeatedly by using heroin, but that she also carried a great guilt for hurting herself so badly. Although her mother was a positive support for this participant, she failed to use her support until she was fully engulfed in addiction and the lifestyle it entails. She spoke of her inability to cope with addiction or her lack of will power, knowing that she was likely to use again regardless of her supports. She mentioned during a time of sobriety, when she was happy with her relationships and life, that she lost a pregnancy at 6 months and relapsed two days later due to the loss. She said she never dealt with the pain of losing her baby girl and that it was still a worry for her today that it would cause her to

relapse. She is not the only participant who dealt with loss that caused her to use heroin or relapse, and another commonality is that none of the participants shared experiences of dealing with the losses immediately via coping skills or working through the pain of the loss, rather they all immediately turned to getting high. It is apparent that heroin-addicted offenders need to talk out their losses, regardless of when they happened, and discuss how they coped with the loss or if they did not deal at all with the loss. This discussion leads to exit counseling, which I review later in this chapter.

This study shows that pain and guilt are triggers to use heroin, and it is apparent that all heroin-addicted offenders need help working through those social stressors and factors to help them develop coping skills to deal with the pain and guilt they carry.

Drug using peers. All 15 participants describe the beginning of their heroin addiction had involved drug using peers and family. All explained that family and friends introduced them to drugs and recreational drinking, as well as, painkillers and other opiates. Not one participant attributed the start of their addiction to themselves, rather the pressure and environments they grew up and hung out in. The theory of personal causation supports these moments as pawn, because the participants felt outside forces created outcomes in their lives. The study results show that participants felt others caused their addiction; however, the participants acted autonomously and of free choice, which means they blame others for their own actions. This is supported by several participant statements that they would have stayed sober if their friend or parent had not introduced them to heroin, and also when it was stated that if the probation officers had been more vigilant in keeping track of the participants, they would have had the chance to relapse.

The act of accepting responsibility for one's actions creates an origin of the individual, allowing that person to discern and define themselves and their actions, thereby building a healthier way of mental functioning (Nahad et al., 2011; Xin et al., 2014). It is unclear if these participants are aware of the fact that they are the reason for their addiction and do not want to accept that responsibility, or if they truly believe someone else controlled that event in their lives.

Notwithstanding, none of the participants stated that someone put the drugs in their mouth, nose or arm, rather they did so out of curiosity, compliance with a significant other, or to relieve pain. The belief that a person can be externally motivated to behave autonomously is real in the way that people make voluntary choices based on external motivation; however, the participants did not claim their actions for their own regarding starting using. For example, in this study, participants were able to see how they chose to partake in treatment while being externally motivated to do so, but unable to see the similarity about drug use. Two participants blamed others for their drug use, but stated throughout their interviews that their drug use was all on them, that they were in control of when they abstained and when they relapsed. It almost seems as if accepting responsibility or blaming others becomes a choice as well, depending on how much pain may be associated with an act. For instance, both of these participants shared their extreme anxiety in their interviews, and owning up to the fact that they created the current mess in their lives and allowed drug addiction to take over is too much to bear. The more these two participants talked about family, the more anxious they became, as I observed during the interviews in their movements and bodily reactions of cold sweats,

hot flashes, arm movements, and nail biting. Most of participants in this study do not claim personal authorship for the start of their addictions.

One participant stated that he was originally on painkillers to treat pain associated with a bad accident he was in when he was 13. He blamed his doctors for his turning to heroin, because they stopped providing him with painkillers at the age of 19, and he was addicted to the painkillers by that time. However, when asked, he stated that if the accident had not happened that he would have turned to heroin anyway, because he was an anxious redhead with no friends growing up. He described himself as a reject of society because of his red hair, that he had no friends until he started dealing drugs, and finally became popular. He claimed that after that, his social life became his only life of being a polysubstance user and drug dealer, all of which he believes he authored; however, he continued to want to blame those around him for continuing on the heroin-addicted lifestyle. He went on to say that if he had his family he would turn away from heroin, but since his incarceration and sentence would not allow that, then he would continue to use. His perception was more defiant for the reason that he was going to choose, and claim authorship of using heroin if he could not be with family, but ultimately blaming family and law enforcement for his drug use. He is currently facing prison time if he cannot get into an alternative to revocation program for treatment at the Milwaukee Secure Detention Facility (MSDF).

Socially, nine of the 15 participants did not believe they had positive supports from family or significant others. They explained that heroin and the addict lifestyle was always dependable and reliable in that an addict can always recognize another addict, and

drug dealers are always open to providing for their customers. It is very easy to fall back into the addict lifestyle as peer-using friends will not stop you from using. One participant shared his story of losing his parents, his brother ostracizing him, and having lived with a woman who was now incarcerated. He described his life as that of a loner, with an inability to get close to anyone. He stated that at this point in his life he was clean and had not used drugs, rather he turned to drinking with his girlfriend. He did not worry about a lack of supports, but he was still saddened by the loss of his parents, as they were all he had. He was clear during his interview that he had no desire to use again, rather he wanted to help others who were addicted. His stance as a young man was more pawn in nature, as he allowed others to influence his decisions. He had a very low self-esteem due to being overweight, and he kept away from relationships and people in general. As he grew older, he lost the weight, got hurt and was given painkillers to deal with the injury. He realized he was addicted to the painkillers and turned to heroin. As an adult, he took responsibility for his affairs, incarcerations, and addiction. He stopped blaming others for his problems, and chose to author current events as well as those previously perceived as pawn events, and changed his perspective on life. His motivation turned from external to internal, and he became more autonomous in his decision making, which in turn caused him to gain self-confidence, which was apparent in his interview. He made it clear that with his new-found self-confidence that no one could influence him to use again, when he stated that everyone has to pick themselves up when they fall.

One participant explained that family was full had turned their backs on him, and he had nowhere to go upon re-entry other than to drug-using friends and dealers. He

explained that he had a girlfriend and daughter, but she did not want to get back together with him due to his drug use. His father would not let him live with him, because he believed this participant was a bad influence on his little brother. His mother's landlord would not let this participant move into her apartment due to his drug usage either. He believed his only alternative to jail was living with dealers and selling drugs while using. Even though the peer-using friends and dealers knew this individual had just been released from jail, they contributed to his relapse and recidivism by providing him with drugs. Regardless of this participant's situations and drug use, he always claimed the relapse events as his own. He stated during his interview that the same day after his last re-entry in November 2016, he relapsed with meth and heroin. He also stated during his interview that he was going to relapse after his release again, even though he wants to be sober and stay clean, he is drawn to heroin and meth like magnetic forces draw to each other. In regards to the theory of personal causation, this participant claims authorship of the events, and acts as an origin, to all negative outcomes. His previous experiences are that he will relapse and recidivate, and so when he act upon re-entry, it is his perception that all things lead to relapse and recidivism, and so he does not try change the outcome. The congruence between his similar situations means that he perceives that he did something and it ended in this same outcome producing the feeling of authorship (Dannenberg et al., 2012). His perceptions of his outcomes, such as relapsing, finding drug users and dealers, and ultimately being reincarcerated only reinforces his feeling of authorship. The other issue here is that personal causation deals with intrinsic and extrinsic motivation; although this participant claims to be intrinsically motivated to use

heroin, his personal choice to do so does not produce positive outcomes. His actions reinforce his lack of self-efficacy, self-sabotage, and drive towards failure, leading him to believe that he himself can only produce negative outcomes.

It is apparent that social factors such as personal loss and drug-using peers are negative motivators in the participants' lives. The inability to cope with loss in environments where they are exposed to heroin, increase the potential for relapse. These participants shared their experiences in relation to social aspects, and the data shows that social factors and external motivators play a role in heroin use and relapse. The need for treatment that addresses the lack of coping skills and cognitive behaviors is needed for these participants, in addition to the programs that they are already exposed to such as AA and NA. Treatment needs and factors are discussed in detail in the next section.

Treatment Factors

The inability to cope with stressors is a factor mentioned by all participants. The participants described their dislike of being in jail; however, several stated that being in jail was a good thing, because if they were on the outside when certain events happened, they probably would have relapsed. Also, several explained that being in jail was a treatment on its own, and were grateful for being in a safe place. They did express their disdain for the AA and NA programs the jail offers due to their platform for socialization and acquiring new drug contacts. In partial agreement, Pickard (2012) states that AA perpetuates the addict mindset that addiction is what it is, and once an addict, always an addict, thereby believing that AA is not an effective treatment for heroin addiction.

All the participants expressed a desire to quit using heroin, but they also expressed a desire and need for treatment and guidance, as most do not believe they can stay on a path to sobriety without it. This section describes the participant experiences and perceptions of treatment while incarcerated and upon re-entry, their desire to quit, detox experiences in jail, perceptions of AA, NA, methadone, Vivitrol and Suboxone, exit-counseling, mental health care, and handholding.

Desire to quit. All participants expressed a desire to quit using heroin and live normal lives. At the same time, all but two participants expressed a need for treatment upon re-entry. The desire to quit using heroin in internal, yet still influenced by both internal and external factors that may or may not be known to the participants. Stressors such as family, financial, and residence issues discovered upon re-entry, the possibility of a partner being unfaithful while incarcerated, losing a child to social services, or finding that a partner no longer wants to be in a relationship can all affect the desire to quit. The theory of personal causation states that origin events are determined by the individuals themselves, as actions perceived to be authored by individuals. This study aligns the theory of personal causation with findings, thereby allowing community and public health officials, as well as correctional administrators to understand the motivations associated with heroin use in order to develop proper treatment and re-entry programs that facilitate sobriety for heroin-addicted offenders.

Wong and Rowland (2013) state that individuals with high autonomous perspectives of themselves are better equipped to set goals and achieve them. This assertion aligns with the theory of personal causation in that individuals who experience

themselves as the origins of their behaviors and actions are more likely to be intrinsically motivated to achieve their goals (DeCharms, 1992). In this study we can see that at least one participant had a high level of autonomy and had decided for himself that sobriety was the goal for re-entry. His internal motivation to be sober and change his life for the better strengthened his chances of sobriety, because he saw himself getting a job and taking care of his family, and he was driven to achieve those goals. However, as we have seen in the results of this study, that people can be origins of their behaviors and actions and turn the goal into more of a wish that they do not believe is possible, and end up believing in themselves more as a failure, resulting in exactly what they thought would happen…relapse.

One participant shared another factor involving the desire to quit as she was facing the possibility of prison or an alternative to revocation and work release. Her probation officer advised her that upon re-entry, she should not go to treatment, because she had been sober for so long, and finally in a good place. The probation officer's reasoning was that she was a low-risk user, and putting her with high-risk users might add negative influences to her sobriety path. She discussed using for the past two years and how it had ruined her life. She went on to state that she did not even want to look at heroin again, and would rather pursue her education upon re-entry. However, her interview was a case log, and approved by her lawyer to partake in, so I was not sure of her honesty as to her true desire to stay sober, or never doing or selling heroin again. Her interview was more like a testimony in case her identity was divulged, and read more like a recount of her arrests than honesty.

The results of this study show that regardless of the personal desires of the participants to want to quit using, they still have to contend with their internal motivators, external motivators, and inabilities to cope with stressors on the outside. Binswanger et al. (2012) state that social inequities played a role in relapse of offenders upon release; however, the authors do not mention motivation as the reason for relapse, rather they state the lack of social supports are the reasons for relapse, nor do they discuss the desire of offenders to quit using.

The participants in this study made it clear that being in jail was easy, and that staying sober was also easy in jail, but life on the outside was real and difficult, and once released, more difficult to deal with than imagined. All participants described a life without heroin while in interviews and that they were aware of and afraid of what would happen upon re-entry. This knowledge opens the door for jail, public health, and treatment officials to develop better detox and treatment programs while heroin-addicted offenders are incarcerated, as well as provide appropriate treatment upon re-entry, all of which I discuss in the following sections.

Detox in Jail. There are currently no studies, which include heroin-addicted offender perspectives of detox or heroin withdrawal in a jail setting, while incarcerated. The interviews obtained for this study provide insight into the basic thinking of heroin-addicted offenders, and what they believe they need to recover. The participants expressed both positivity and upset over the programs they are currently providing within the jail for withdrawing offenders. They stepped out of their comfort zones and shared their fears of being alone while sick, their anger of being monitored, and for some, their

belief that it will not help. These findings fill a gap in the literature where offender perspectives can help develop better jail and re-entry programs.

Entering jail when actively using or on a DTT is unnerving for heroin-addicted offenders. Some participants explained that they were sober, but knew they were going to get locked up so the 'addict mindset' told them to go get high one last time before going to jail, so they did. Yet, others were going through DTT or treatment and chose to stop treatment and get high before incarceration, because they knew their DTT would be taken from them and detoxing from methadone is worse than heroin. The fear of going through detox is real for heroin addicts, and that fear of the pain associated with detoxing is what keeps many using. The participants also expressed self-medicating until they were incarcerated to help detox before jail. This study shows that participants know they are going to go through detox in jail, so they use prior to incarceration.

One participant entered jail and on the advice of her boyfriend told the jail staff that she was not detoxing, because he told her that the staff will lock her in solitary confinement for two weeks and she will be alone that whole time with no blanket or pillow. She did not want those discomforts so she stayed in general population while detoxing and said she felt horrible. Detox is experienced as your senses magnified one hundred times. Everything is amplified, from smells to noises, the addict experiences every detail of events around them. This participant explained that she could smell the disinfectant on the food trays and it made her throw up. Her second incarceration she knew she would be detoxing and she told them right away that she was going to detox in jail. She spent two weeks in solitary, just as her boyfriend had told her, without a pillow

and a suicide blanket, neither of which kept her comfortable. She also stated that she went from freezing to sweating and a steel bed is not a good place to do that.

A female participant shared that this incarceration was new for her, because she had gotten the Vivitrol shot last re-entry and did not realize it had worn off, and had not used at all. She entered jail this time clean and sober and rejoiced in the fact that she was not going to detox in jail. Two other female participants described the after-period of detox, seeing new people come into the jail with the knowledge that they were going to detox, and thankful it wasn't them. They mentioned the fact that those detoxing were hard to ignore as they were across the hall from their dorm. Another female participant explained that she knew she was going to jail this time, so she tried to detox at home, but could not because she was getting so sick. She put herself into an in-patient treatment program, but they did nothing to make her comfortable so she checked herself out and got high. One participant stated that she was made to feel like 'a real asshole' when she entered the jail, as jail staff made fun of her going through detox and withdrawal, calling her a heroin addict. Another participant shared that jail staff made fun of him, because he hallucinated when detoxing and they had remembered him from several other incarcerations prior.

The initial detox is difficult for all heroin-addicted offenders and they all agree it is a nasty time to go through. They asked for more compassion from the jail staff, as they already feel like garbage physically and mentally. One participant said, We're still people." The participants described a more comfortable situation with an option to get out sooner from solitary if they are physically and mentally able to enter general population.

They also stated that books would be good to work through the time. They all stated that sleep was important, because some had not slept in days, and sleep was a time when they were not in pain. One participant expressed anger that staff check on them all the time and wake them up, when all they want to do is sleep. Compassion from the jail staff was what all asked for as it is a tough time to go through. The understanding of what a person goes through during withdrawal and detox is something all staff should understand so that maybe they can be more compassionate and sympathetic; albeit they are in jail for a reason, most of the time it is due to drug use and crimes associated with funding the habit. If their addiction were under control, the crimes would not occur. Knowledge of jail staff could also help them to recognize who could leave solitary and enter general population sooner, as many expressed a feeling of anxiety while being alone.

All but two of the participants believed that solitary was a good place to be while going through initial withdrawals and detox, as other people around, noises, and smells can aggravate them more. Two participants believed that a Pod set up solely of detoxing individuals would be optimal so they could support each other and understand what the others were going through. Both participants suffer from self-reported acute anxiety disorder. One slept under his cot to feel safer, and the other said he would rather puke in front of 19 other people than sit in a cell with a camera on him all day. When I asked participants about this idea they said it was horrible, because there would be a Pod full of withdrawing individuals getting sick all over each other. Solitary confinement while detoxing was the chosen form of incarceration for detoxing, but participants also suggested a shorter time alone.

This study shows that participants are more likely to enter jail with the expectations of withdrawing and detoxing in a cell than entering sober. Some enter jail while on DTT and have to detox from Suboxone, methadone, or Naloxone, all of which are just as hard if not harder to withdraw from than heroin. The participants suggested that adding DTT to detox in jail would lessen withdraw symptoms and make detoxing easier, as well as help support them upon re-entry to prevent relapse. Although the participants understand that they are in jail due to illegal activities, they described their withdrawal in jail as needing to be more sympathetic to their physical and mental needs. Providing them with books and distractions while in solitary confinement would help with the boredom and anxiety associated with being alone and in pain. Two participants also discussed the need for medical treatment and intravenous fluids rather than Gatorade to keep them hydrated; however, they also knew that being treated in such a way was not feasible. The only other discussions were for better treatment by staff that exacerbated what appeared to be shame or embarrassment by participants for being addicted to heroin. Participants expressed shame and embarrassment about physical issues occurring when going through detox and withdrawal, such as illness, hallucinations, and anxiety. The jail supplements the detox treatment with optional and voluntary programs such as AA and NA that heroin-addicted offenders must sign up for on their own. I discuss the perceptions and experiences of AA and NA as described by participants in the next section.

Perceptions of NA and AA. All of the participants described the jail programs as a joke. They stated that the jail programs such as NA and AA were socialization times to

see people they had not seen in a while or to find out numbers and connections for drug dealers once released. Most concurred that the programs did nothing for them in the way of treatment or figuring out how to cope with issues and addiction. Krentzman et al. (2011) state that AA is a 12-step program that has a high efficacy rate for those individuals who continuously attend meetings on a weekly basis for three or more years. The issue here is that many offenders do not spend 3 years in jails, rather they are moved to a prison or released. Krentzman et al. go on to state that individuals have a better chance of recovery and sobriety when they read AA literature, get a sponsor, and meet with other recovering addicts when not in meetings. Although these findings showed a higher rate of sobriety, the participants of this study do not believe the program provides the needed structure or help they need.

One participant stated that stated that in order for the NA or AA to work, a person has to be comfortable with their counselor, and have to have the mindset to quit, which all participants described in their own words. She added that the jail needed to provide behavioral counseling as well to address cognitive issues. Three participants mentioned that the jail does not offer NA for men, only women, and appeared a little upset by this omission. Two participants explained that they went to the Christian AA offered, but it is all about God, as is AA, and a third participant added that they need less religion in their programs concurring with the other two. One participant said it was too hard to wake up early to sign up for AA, and blamed himself for a lack of meetings, and another said that he did not believe in a higher power, rather himself to get through his sobriety and added that if you want to be clean you are going to be clean. He described his discomfort of

talking in groups and said AA and NA are just another way for people to get high in the end. He wanted one-on-one counseling rather than groups, treatment in the jail sucked, and if you don't want it [help], it won't happen in jail.

Five participants stated that they do not go to the AA or NA programs, because they do no good, and are simply times to socialize. They almost seemed angry that more structure was not built into the programs, along with help and guidance for when they are released. The described the meetings as role-playing different situations, but as they spoke, it seemed like they wanted more. One participant said to me that just sitting here talking to me about his issues was helping him; that he wanted more of this [talk time], because it made him feel better. Two of the participants made no mention of the AA or NA programs in their interviews, one stated that he did not believe in them, and two believed it might work for others, but not for them. An idiosyncratic answer from one participant was stated enthusiastically that she had been locked up a lot, and that this jail offered a lot of programs to help heroin-addicted addicts, yet in her follow-up she stated that none of them helped her.

The jail is apparently doing what they believe will help heroin-addicted addicts once they re-enter society; however, from the perspective of the participants, the AA, NA and Christian AA programs need more structure and reworking to actually benefit them. It is apparent that talk time and socialization must be kept to a minimum, as well as any exchange of information between the offenders. The participants are looking for something to make a difference in how they see and deal with addiction, but what is offered right now seems to be a waste of resources such as money, man-power and time.

Several of the participants expressed a desire for actual counseling, not group work, to help them cognitively and behaviorally, which might be a direction the jail would like to test out on a few to see where it goes.

The theory of personal causation supports these findings as the participants are acting autonomously as they choose to take part or not in treatment. They are the deciding factor in how the treatment plays out, yet they state that the treatment is the problem. This conflict of autonomy being infiltrated by an external force causing failure must have an effect on what these participants believe they can do. For example, they set their minds to do something they believe is positive and it is crushed by a controlling force that does not follow through and do what it is supposed to do. The outlook is that even if I set my mind to do good, and control that action, someone else can still mess it up for me. The question is if these participants have the coping skills and cognitive ability to recognize that they made good choices that someone else might have unintentionally screwed up for them, or if they believe it was done intentionally to mess up their choice to get sober. They have gone from origins to pawns in one event, depending on how they perceive the event. DeCharms (1977) stated that the difference between an origin and a pawn is how they see things and perceive them. The origin experiences the outcomes of their actions in accordance with what they want, while the pawn sees their experiences and outcomes determined by others. These participants explain partaking in treatment, but having it thwarted by poor program development, and ultimately as deciding their outcomes. What would produce more origin moments would be to help heroin-addicted offenders who are serious about sobriety achieve that sobriety with programs that work.

Although the programs do not currently allow for DTT, it is a discussion had by all the participants as pre-treatment for re-entry, as well as upon re-entry. In the next section I will discuss participant perceptions and experiences of methadone, Vivitrol, and Suboxone.

Perceptions of methadone, Vivitrol, and Suboxone. Participant perspectives of DTT varied greatly from liking what it did for them, to hating the cycle of addiction it kept them in. All of the participants describe their experiences of using methadone and suboxone to get high, and many express the desire to learn about Vivitrol and its potential to help maintain sobriety.

The common experience for participants using methadone is that they initially got high from using it. They describe obtaining methadone as a legal high. When they are no longer high from the dose they are on, they simply go to the clinic and ask for a higher dose, to which they oblige. The participants explain that they are increased daily in order to maintain the high, and reach levels above 100mg; however, they can still get high while on methadone. The participants explained that the issue is that once they get to such a high level of methadone that they are stuck, and the clinic will not bring them down; their ultimate desire is to abstain, but find that if they don't go get their doses, then they are sick and withdrawing.

One participant explained that she finally felt good and did not want to get back on methadone and feel numb all over. She went on to say that she could finally feel again, and methadone numbed her feelings. This cycle of addiction she and other participants spoke about is something she did not want to experience any more. This

cycle they all describe causes them to turn to heroin, because not only do they not want to maintain the high methadone doses, but the daily visits to the clinic interfere with work schedules. One participant also added that the treatment was voluntary, but the classes and meetings were mandatory and he could not make them at their scheduled times so he turned back to heroin. The consensus on methadone is that it is a legal high, creates a vicious cycle of addiction, and is difficult to maintain as it currently is.

One participant described his thoughts of methadone as it would probably help him if he used it, but his mindset would be to spit it out and sell it on the streets. He said that before his current incarceration, he attempted to get on methadone, but the clinic had a waiting list. Once they allowed him into the program, they would not take his private insurance and told him he would have to pay for the methadone out-of-pocket, so he turned it down. He goes on to explain that he could not afford the $16 a day, but would spend more on heroin, so he understood what he was doing and what he wanted. He behaved autonomously, and made choices based on his own interests and goals making him an origin of his actions (Wong & Rowland, 2013); however, his actions produced negative results, reinforcing his belief that he is the reason for his poor outcomes. The problem here is that theory supports autonomous people as being highly and positively, intrinsically motivated (DeCharms, 1992); however, the findings in this study show that heroin-addicted offenders can be origins of their behaviors, act autonomously, and still produce negative outcomes repeatedly. How these participants see themselves and who they place responsibility on in the end is what matters to the theory. For instance, although this participant produced a negative outcome through his own actions, he stated

that he was the one who could not deal with the cost and time needed to obtain the methadone, yet he went on to state that he would have done it if they didn't charge him out-of-pocket. He still wanted to blame the clinic for not being able to be on methadone when all options were within his ability to choose. He makes a pawn out of himself in this situation, almost a victim, and then sees the situation as whatever he does for himself, someone will always ruin it. This perspective is something these participants need to deal with in counseling and behavioral therapy, so they can see that they are the determinants of their actions and outcomes, as well as how to deal with the choices available to them.

Personal choice and preference play a role in sobriety as described by participants that they are either internally or externally motivated to abstain. The way each participant explains their addiction and path to sobriety varies in perceptions of treatment, addiction, and motivators. The same pertains to preferences for DTT, of which several participants describe their experiences with Suboxone. Suboxone is a combination of buprenorphine and naloxone. The intent of the drug is to decrease withdrawal symptoms and create a threshold that disallows users to abuse the drug.

Seven participants made no mention of Suboxone use or treatment. Four participants described using Suboxone on the streets to self-medicate and prevent getting sick from heroin withdrawal. Four participants stated that they believe in Suboxone and its ability to stave off withdrawal symptoms. However, one participant said that the Suboxone eventually led to morphine and then heroin again. Another participant stated that she was voluntarily entered a Suboxone study for one year and then was cut off after the research ended. Her doctor felt sorry for her and prescribed her the Suboxone to

prevent using heroin, but when she entered jail she could not bring it in with her and ended up withdrawing in jail. One participant stated that he entered jail each time withdrawing from either methadone or Suboxone, but does not believe using either means a person is sober. He also preferred Suboxone over methadone, because a person cannot get high on Suboxone. One participant stated that he wanted to find out about Suboxone for re-entry, but did not know where to go for it. He also said it had worked for him in the past, but it was better than methadone, because it did not interfere with his work schedule. The complaints from these participants who wanted to use Suboxone were simply that it is difficult to withdraw from, and it interferes with work schedules. One DTT that several participants brought up interest in is Vivitrol.

Vivitrol is the brand name for naltrexone, an opioid blocker that prevents drugs like heroin from being received by opioid receptors in the brain. it is a non-addictive drug that can be given to individuals who have detoxed and have cleared opioids from their system. It is a once monthly shot that when combined with behavior counseling was shown to prevent relapse 90% of the time compared to 35% prevented in participants who took placebos (Vivitrol, 2017). The study also showed that those who took Vivitrol were 17 times less likely to relapse and stayed in treatment 72 days longer than those who took the placebos (Vivitrol, 2017). Lee et al. (2016) found in their study of incarcerated offenders that Vivitrol was more likely to prevent relapse upon re-entry than the usual treatments using methadone and buprenorphine, and that participants in their study requested Vivitrol over those treatments as well.

During initial interviews, four participants expressed the desire to know more about Vivitrol shots, because they had already used methadone, Suboxone, or buprenorphine and did not like the results or were willing to try something new. One participant expressed knowledge of Vivitrol from a previous treatment program, and wanted to find out about it for treatment on re-entry. He expressed this desire several times throughout his interview. Another participant stated that she had heard about the Vivitrol shot and wanted to know more for treatment upon re-entry, because it could allow her to use DTT and not conflict with her work schedule. This same participant during her follow-up interview stated that she had not pursued treatment as she was still in the jail's work release program. Another participant stated during her initial interview that she wanted to know more about the Vivitrol shot, because she was afraid of overdosing upon re-entry. She stated that she wanted to couple it with behavioral counseling as well. Upon re-entry she did in fact overdose, and after speaking with her probation officer, met with a physician and treatment specialist. She was given the Vivitrol shot and stated that she felt like she could finally handle sobriety. She stated during her follow-up interview that she wished she would have been given the shot prior to re-entry to prevent her almost fatal overdose. The fourth participant described her experience with Vivitrol as awesome. She stated that she got the Vivitrol shot in December of 2016 when she was released from jail the last time and felt like she needed to get her life together. She did not redose at the end of December, because she found out another warrant had been issued for her. She was re-arrested February 6th and realized at that point that the Vivitrol was out of her system and she had remained sober with no

withdrawal. She was excited to have had that experience and thanked Vivitrol and a positive support person for her success.

The three DTT drugs discussed here represent common and rising stars in the war against heroin and opiate addiction; however, using the drugs for treatment is not enough to be efficacious. The perspectives of these participants show that much work is needed to hone the programs to suitable workability for normal lives and sobriety to be achieved. From increasing clinic afterhours and counseling, to adding behavioral counseling and care. Care givers need to consider the fact that methadone is seen by users as a means to a legal high, and that Suboxone may work, but it is popular on the streets for self-medicating. Vivitrol is newer and many of the users did not speak of it, and those who did wanted more information about how it worked. It shows in studies that it has high efficacy rates and may prove to be the next DTT coupled with counseling that provides a smoother path to sobriety for heroin-addicted offenders.

Exit counseling. Exit counseling is not something participants could name on their own in their interviews. They talked of treatment, and needing to speak with psychologists and therapists prior to re-entry. They expressed a desire to know more about treatment options, where they were going to live, who they were going to see upon re-entry, and where they were or were not going to live. Participants generally showed a lack of direction when asked about re-entry, and a lack of knowledge when it came to treatment options and professionals to help them. This general lack of provisions seems to be the norm for care, as offenders are released at midnight with nothing and nowhere to go. This leads to the need for exit counseling. In support of these findings, Garland,

Wodahl, and Mayfield (2011) completed a study showing the needs of heroin-addicted offenders upon re-entry, but the need for exit counseling was not discussed.

Also discussed were the social stressors experienced by heroin-addicted offenders, and the need for treatment upon re-entry; however, the transition period from incarceration to re-entry was not covered; however, in Garland and Wodahl (2014) stress the importance of re-entry programs and the social movement of correcting behaviors during and after incarceration. White, Saunders, and Fisher (2012) asserted that there are very little studies pertaining to exit counseling that continues into re-entry, and that more information is needed on how to develop and implement new plans and programs. White et al. go on to say that programs that start during incarceration and extend into re-entry, coupled with counseling have shown positive outcomes in decreasing recidivism, revocations and new convictions. Participants of this study provided personal insight, thought, and perspective on what they believed was needed to be successful at reaching sobriety, and exit counseling was one of the issues discussed.

One participant upon completing his follow-up interview stated that a month before his release he requested time with a psychologist to work through his issues of getting his son back, and dealing with his girlfriend who he found out had been unfaithful during his incarceration, as well as his addiction needs and treatment. He stated that no one came to see him. He said that he then requested psychologist meetings two weeks prior to release and again, did not hear back from anyone. This situation angered him as well as left him feeling very out of sorts, because he knew what he was facing upon re-entry. He called several times after his follow-up to share how much he was struggling,

that he had got his one-year-old son back from social services, but was struggling with keeping his job, caring for his son, and taking care of his girlfriend who is an alcoholic, in addition to not being under any treatment of his own. I contacted the Director of Public Health in the area who was able to provide him with a number for childcare that accepted his insurance to help relieve some of his pressures and worries. I have not heard back from him a week later. He is just one example from this study showing that working through issues prior to release would be a positive support for heroin-addicted offenders.

A majority of the participants spoke of wanting to speak with someone about what their plans were, if any, upon re-entry. They described a lack of knowledge and direction of who to contact for treatment, wanting numbers of physicians and treatment facilities. They described past situations of re-entry into the hands of someone who was intoxicated. They described having nowhere to sleep upon re-entry, having to turn to drug dealers' homes for a bed. The participants expressed a desire for counseling that could help them organize their resources, as well as work through a few issues that could be triggers for relapse. An example would be one participant shared that she lost her baby at 6 months gestation, and two days later she relapsed before she dealt with the pain of that loss. During her interview, she cried openly and said that it was a big loss for her. She stated that it was a situation she needed to work through before she was released on her own.

Another participant expressed his knowledge of relapse as inevitable as he had done it every time he was released in the past. He knew he would relapse and shared that he had nowhere to go but to stay with drug dealers upon re-entry. He did relapse the day

he was released from this current incarceration and is currently in another county jail. The question arises to ask if these people had exit counseling that provided an outline of phone numbers to important treatment connections, family contacts for support, and different treatment option information such as a list of DTT and how they work, would these heroin-addicted offenders be better off? If someone sat down with every one of these participants and walked them through their re-entry details, as well as talked to them about current issues and situations that might trigger them, would they have a better chance at sobriety? These questions evolved with this study's findings, and are important enough to be a focus of discussion among health care and public health officials. Exit counseling is a desire and need of heroin-addicted offenders and their perceptions discussed bring this inner need to light. When participants discussed exit counseling and issues and possible triggers upon re-entry, they also brought up the need for mental health care and what was available to them for treatment in addition to the DTT upon re-entry. In the next section, I discuss how participants perceived their mental health needs and desires.

Mental health. Throughout the study participants expressed a need for mental health care. As I discussed earlier, anxiety and depression plays a role as an internal motivator to use heroin; however, treatment will be discussed here. Addiction is different from mental health, albeit, both need to be treated with medications, they are different medications with different purposes. The question here that might be up for more research is what comes first, the anxiety and depression or the heroin addiction? The reason I pose this question is because 10 out of the 15 participants described debilitating

anxiety that ruined them socially, and depression that made them want to die. They stated that heroin made the depression and anxiety go away; however, it studies it has been shown that heroin use increases anxiety levels, because it cripples the brain's means of appraising new situations from previously painful situations, and so all are appraised as anxiety causing or depressing (Xin et al., 2014). One participant described a life full of severe anxiety that stemmed from feeling like an outcast due to his red hair. He had no friends growing up and was teased incessantly. He could not identify nor was he accepted by a peer group growing up and he developed a phobia of 'normal' people and situations. In high school he started selling drugs and he says it changed everything for him, because he finally became the popular kid. He used weed and painkillers and decided that that was how he wanted to live the rest of his life...selling drugs and getting high, because they both contributed to diminished anxiety and depression. He also stated that he needed to be on a non-narcotic painkiller upon re-entry to prevent relapsing. The situations described are different and show that heroin-addicted offenders are dealing with both mental health issues and addiction. Ten of the participants described how anxiety has played a role in their heroin use; therefore it seems only plausible that mental health care be set in motion upon re-entry as an inclusion of treatment.

A female participant upon re-entry relapsed due to some pains and issues she had not yet dealt with. She overdosed and was brought back with three shots of Narcan. We discussed how lucky she was at her follow-up interview to be sitting with me to talk about that experience. We followed up a week after her overdose and she stated that she contacted both a treatment specialist for her addiction and obtained the Vivitrol shot, and

her physician for anti-anxiety and depression medications. We spoke again three months later and she stated that she is doing very well, has planned a trip to Tennessee, and upon my prodding, will be working with the public health director to develop a re-entry program for heroin-addicted offenders. She also spends a lot of time babysitting her grandson, which never would have happened had she not taken care of both her physical and mental issues.

A male participant who shared his positive outlook despite his situation, re-entered and immediately found a job, entered AA and an outpatient program with the hospital, but also went to a physician for medications to treat anxiety, depression, and bipolar. He felt proud of himself for handling all of his issues as he did, and stated that he would tell others that they too could do it if they took one day at a time. Two other participants who were released during this study did not enter into treatment of any kind and put it off stating that all of it [treatment] interfered with work schedules. Both of these participants expressed a need for treatment during their initial interviews when they were released, ergo one would think obtaining treatment would have been a priority for both. This is where exit counseling would come in handy, to help heroin-addicted offenders visualize their release, and plan their time and treatment.

The need for mental health treatment was not a focus of this study, nor did I intend to discuss it; however, the participants described it as an aspect of who they are and have been for a long time. It also seemed as if it was difficult for the participants to separate mental health needs from addiction and had melded the two into the same issue, which would compound the perception of inability to cope with life and issues. Here we

see how these participants are origins with the desire to get help. They know and want help for their anxiety, depression, and whatever other mental help they require. If the anxiety and depression were treated, would these participants refrain from using heroin? This matter should be of concern to all public health, health care, and law enforcement officials, as it could curtail the use and harm of heroin. The interesting point here is that the participants view mental health as internal and a part of the individual, while addiction is viewed as external, even though participants felt internally motivated to use, heroin is injected or snorted, hence external to the participant. The point being, if a physician gives a participant medication to treat anxiety, depression, and bipolar, they readily accept it as they are treating themselves and their personal health, but if a specialist gives a participant treatment for heroin, it is viewed as being imposed on them and they may turn it down. The theory of personal causation supports these findings that choice is the foundation of personal influence and autonomy. Making the choice to obtain treatment is a commitment and responsibility to oneself, both of which are viewed as origin behaviors. Making treatment a choice on any account benefits heroin-addicted offenders, because it bolsters their self-confidence and self-efficacy, little by little increasing the ability to make positive origin choices. Supporting the mental health and treatment needs of heroin-addicted offenders is a need that should be addressed during every re-entry. Releasing heroin-addicted offenders with exit counseling and guidance towards treatment is a movement in the right direction, but still some participants expressed a need for handholding during and after re-entry to keep them on the right track. In the next section, I discuss handholding with loving support.

Handholding. The participants of this study described their experiences with heroin as having control of their lives prior to using heroin, and losing control of all facets of their lives once addicted. Several of the participants expressed the fear that they could not control their addiction upon re-entry and that they did not have the will power to refrain from relapsing. These admissions provide data that show how the self-confidence and self-efficacy of heroin-addicted offenders is destroyed through the cycle of use and inability to control oneself. Losing self-confidence in one's ability to make personal choices that positively affect their lives, causes individuals to lose their perception of self-efficacy as well, and they see themselves as the origin of all their negative outcomes.

Although the participants described some events in their lives as having failed due to the influences of others and external forces, the fear of not being able to control their own addictions and relapse subscribed to the idea that the participants know they personally are the origins of their addiction. This little window into all of the blame and distortion of perception described by the participants shows that ultimately, heroin-addicted offenders know deep down that they are the reason for all their problems and cannot control themselves, which leads to the need for handholding upon re-entry. In a 2006 poll of U.S. Voters, 70% believed at that time that states should provide rehabilitation services to offenders both incarcerated and released, and nine out of ten people polled believed that planning a re-entry program with guidance extending into re-entry was imperative, and be set up starting at sentencing. Handholding as a concept is not discussed in literature, and although sponsors and probation officers are mentioned

throughout literature, the participants of this study are more apt to ask for Sobriety Officers, who keep them in line. This is not discussed in current literature. Participants describe their need for intense observation and guidance.

One participant described heroin in a loving way. When I asked her if the thought of heroin was a trigger for her and if she still loved it she replied, "Yesssssss, I do. Once you know that feeling, you'll never ever find it again." Her reaction was that of a young girl thinking of a boy she loved and dreamt about. She even smiled and looked up in a daydreaming manner. and went on to say that she had no will power, and that she needed help in jail and upon re-entry or she knew she would relapse. Her appeal for help was heart wrenching as she sat there and looked inwardly stating, "I tell my PO, everybody…don't give up on me. Don't give up on me, help me. I need help don't send me and throw away the key and send me to prison I'm trying to tell you honestly I need help." She stated that she felt in charge in jail, because the structure provided to her helped her control her addictions; however, once released, she knew the structure and rules would be gone, and she would have to depend on herself to stay sober. She knows she does not have the strength or ability to stay sober with all the external influences. Her struggle is real and intense, and she was begging for help. She added that if drugs were around her, she knew she would use them or take them or steal them. She expressed the need for the constant help of someone who knew her plight and could monitor her closer than a probation officer would.

This participant's desires are not uncommon, as all of the participants stated that closer monitoring, such as frequent drop testing UAs, ensuring they are going to

treatment programs, and keeping them away from known drug dealers was something they wanted. The do not believe that probation officers were properly suited to their situations, because their crimes were all related to funding their heroin habits. Some suggested what we will call Sobriety Officers whose main purpose is to monitor the individual for sobriety rather than criminal activities. This is all well and good; however, setting up a program such as this may not be feasible, as the costs related such a program might be too much.

Participants expressed the desire for 'sobriety officers' to force them to attend treatment, because that is what they need, because they cannot do it on their own. Here we see the theory of personal causation supported in that this participant knows he is the origin of his negative outcomes, but he goes on to state that since there is no exit counseling or help to set up life upon re-entry, that it is the fault of the 'system' that he relapses. He believes that if the 'system' had more control over his release that he would finally be able to get sober. He puts all possible positive outcomes on the 'system' making himself a pawn of all outcomes, which does not improve self-confidence or self-efficacy. This outlook of handholding may not be the best treatment possibility given the theory, because the participants would see themselves as the pawns of all positive outcomes and not the authors themselves. It is a slippery slope to consider handholding and close monitoring of heroin-addicted offenders upon release, as they need it, and want it; however, it may not improve the outcomes, because autonomy and authorship of positive outcomes is not personally identified. This leads us to how heroin-addicted offenders perceive themselves during and after treatment. In the next section, I describe the

participant experiences and perceptions of voluntary and mandatory treatment and the motivational factors they perceive to affect them.

Voluntary versus Mandatory Treatment

The theory of personal causation asserts that personal choice and motivation plays a role in how individuals perceive themselves in the outcomes, as either the origin or the pawn depending on who is in control of a decision (DeCharms, 1968; DeCharms, 1992). Origins see themselves as the authors of their actions, and high autonomy gives them the confidence to make decisions on their own. Pawns perceive outcomes as the result of external forces beset upon them involuntarily. Pawns have low-autonomy, and low self-confidence in their actions and abilities; therefore, they believe they will fail at goals and achievements. When you give heroin-addicted offenders the choice to participate in treatment, they take it; however depending on the situation, may accept treatment not because they want to, but because an external force is compelling them to. Voluntary treatment with internal motivators is the best form of treatment, because the desire to quit comes from within, and personal choice and autonomy play a role in the decision process to get treatment.

All participants shared treatment experiences, with some stating that they had never pursued any form of betterment program on their own. All of the participants described mandatory treatment as a personal choice to obtain a beneficial outcome, such as early release from jail or prison, the ability to remain home with family, or to repair broken relationships. They even describe AA and NA programs in jail as voluntary and up to them even though they are incarcerated and at the mercy of the jail administration,

judges, and the law. Some do not even partake in jail programs, because they do not believe they work. Not one of the participants expressed a time when they felt compelled and mandated to take part in treatment, but said that even though it was their choice to complete some treatment, it was because of another reason that they did it. The theory of personal causation supports these findings in that these participants lose their autonomy when coerced to do treatment, and the internal motivation is lacking. The treatment outcomes are not viewed as personal choices regardless if the treatment was effective or not, the participants feel like pawns. Three participants spoke about attending treatment for personal reasons, not suggested by any outside source, and their self-confidence to complete treatment successfully was apparent. Two of which were released and completed follow-up interviews shared their confidence to be sober. A third participant who was released but did not complete a follow-up, spoke during his initial interview about removing blame from others, accepting that he is the origin of his problems, and living a sober life helping others. I believed him when he stated that he was going to do it, and that a $20 Visa card was not why he was taking part in this study.

The participants shared their perceptions of mandated treatment as still leaving them with the want to get high, or disgruntled that they completed treatment and it did not succeed. Mark the word the *treatment* did not succeed, not that they did not succeed in abstaining. They portrayed no perception of self as having control of addiction or sobriety at all. Every participant in this study has undergone treatment that they were not internally motivated to partake in, and every one of them relapsed upon ending the programs as well. The participants will tell you that they have to want it. They have to

want sobriety. They have to have a goal. They have to want to make the lifestyle changes. It appeared that all of the participants had been in one treatment or another and could recite what they had learned, such as once an addict, always an addict, and you have to want it if you want to quit using. These statements appeared to be lines to fall back on in case they relapsed or could not find the internal motivation to quit.

The opportunity for heroin-addicted offenders to take part in exit counseling and one-on-one counseling during incarceration and prior to re-entry could be a time of finding out and discovering what issues were still unresolved that could possibly trigger a relapse. In addition, that time could be used to help offenders uncover internal motivators that may not be apparent, and aid in the success of treatment. Having the personal option to voluntarily participate in treatment, coupled with internal motivators to remain sober presents the best options for personal success. Making the choice to achieve a goal and then subsequently achieve it is origin behavior, high autonomy, self-confidence, and self-efficacy. Not only do the participants determine their own outcomes, they do so in positive ways and empower themselves to act alone in the future as the author of their outcomes (DeCharms, 1968). This study shows that all of the participants have experienced mandated treatment or voluntary treatment with external motivators, and all ended in relapse and reincarceration. The participants agree that any treatment that is completed for the sake of others or other reasons does not work. Below are my recommendations for social implications and growth.

Recommendations

I designed this study to uncover the perceptions and experiences of heroin-addicted offenders as they enter back into society after incarceration stemming from heroin use. The findings of this study determined that heroin-addicted offenders want personalized treatment throughout their incarceration continuing into re-entry where they face stressors and issues with the inability to cope. Notwithstanding, each participant was offered the option to meet with Amy Johannes of the local hospital substance abuse outpatient treatment program, but none who were released contacted her; rather, they either did not obtain treatment, or they pursued treatment on their own.

The participants in this study described relapse situations based on varying stressors and triggers from lost relationships and children, to simply smelling a one-dollar bill. The experiences described are supported by the theory of personal causation and how people see themselves as the cause of their situations. The participants illustrated their experiences by explaining who and what were the reasons for, excuses for, and perceptions of events that happened, both good and bad in their lives. The statements made by participants to explain their reasoning for addiction, relapse, loss, and sobriety are all either origin or pawn events supported by the theory of personal causation, and validate how pawn and origin moments are perceived.

I will disseminate this study in journals to public health community professionals, the local hospitals, treatment facilities, and the correctional system, as well as any other interested parties wishing to read the results. My efforts to ensure this study is properly understood will depend on the parties to whom it is disseminated, depending on if the

readers need novice terms or if they prefer scholarly writing. This study has the potential to change treatment options for heroin-addicted offenders both while incarcerated and upon re-entry. Recommendations to public health departments, treatment specialists, and correctional administrators would be to offer these individuals a more compassionate detoxification period where they are treated like sick humans should be treated, rather than like they are less than human or drug-seeking, as one participant stated, which made her feel very badly about herself.

I would also recommend that detoxification in jail would last in 3-day increments, with offenders offered the option to enter general population after each third day of incarceration. Some heroin-addicted offenders are offered the chance to enter HUBER work release within the jail, which allows the offenders to leave jail on a daily basis and go to work, and make a paycheck. In my opinion, with the data presented from this study, I would recommend that all offenders be a part of the work release program prior to final release in order to get them established with an employer and save money to pay for a home upon re-entry. Several participants stated that they wished the system would provide them with the means of making money and finding a home upon release. This small change in sentencing could change the way heroin-addicted offenders experience and perceive re-entry. Knowing that there is money in the bank, and the means to buy food, and pay rent could potentially increase the feeling of self-efficacy and confidence.

Another recommendation would be to spend the final 2-3 weeks of incarceration drawing up an exit contract. This contract would help each offender figure out and clarify who their positive supports are, what their triggers are, and what problems they have to

work through. In addition, they could decide where they are going to live, name their probation officer and treatment supports, as well as receive phone numbers to the local outpatient programs, and Medicaid and physicians' offices. This exit-counseling can help each offender to work through and identify their positive connections and supports as well as where they need work, and when a better time to do it than when they are in the care of the jail and have time to consider their plans.

My last recommendation involves DTT and I suggest at the behest of all the participants that the county jail provide offenders who have detoxed in jail or who have a history of heroin use, be given the Vivitrol shot prior to re-entry. Several participants wanted the Vivitrol shot, but of course did not get it, and wished they had to support their sobriety and help prevent relapse. The one thing that most of the participants were most afraid of upon release was themselves and their potential for relapse, prompting the mention of DTT before re-entry. The Vivitrol shot is a once-a-month treatment that does not interfere with work schedules, and sets heroin-addicted offenders up for success on their paths to sobriety. Jail staff could administer Vivitrol shots when offenders enter the work release portion of their sentences, providing the beginning stages of DTT and support requested by the participants. With these recommendations stated, it brings to light future studies researchers could complete to determine if heroin-addicted offenders experienced greater success towards sobriety. Recommendations for future studies are discussed in the next section.

Recommendations for Future Studies

This study included heroin-addicted men and women, currently incarcerated, and sampled randomly yet purposefully while in jail. All participants were White, and from the same jail in a city in Wisconsin. Data was collected using semi-structured interviews for both initial and follow-up interviews. This design, albeit a complete phenomenological qualitative study, could be redesigned as a mixed methods or a sole quantitative study using surveys and scales to measure data rather than interpretive analysis. A quantitative design and anonymous data collection might have recruited more offenders, as some may have declined simply because they did not feel comfortable speaking with an interviewer or want to divulge their stories and secrets to anyone.

Another recommendation for more research is to continue beyond two to three weeks past re-entry, to determine if treatment is adhered to, and if choices are made to stay sober long-term. Participants described the need for proper treatment that did not conflict with life and work schedules, so a study on DTTs such as Vivitrol would prove essential to discovering if a once-a-month shot is the key to sobriety for heroin-addicted offenders. A study on Vivitrol should take place prior to participants being released and extend at least five to six months to determine if participants re-dosed and stayed sober. Another study that might prove beneficial would be to see if heroin-addicted offenders actually fared better with a 'sobriety officer' rather than a probation officer, since most of the crimes committed are to fund the addiction.

Another option of completing this study would be to take a sociological approach and use the theoretical framework called the social ecological model (SEM), that focuses

on the micro, meso, and macro levels of influence in a heroin addicts life. A sociological approach to addiction would bring attention to how addicts perceive themselves within social structures as to how they function and view conflicts.

A study that includes more participants might also prove beneficial to not only increase the diversity of the participant sample, but increase follow-up responses, thereby enabling a higher rate of perspective of choices and outcomes as they relate to sobriety, relapse, and recidivism. Cultural diversity might provide different outcomes and perspectives based on upbringing, religion, and relationships.

Implications for Social Change

The results of this study may produce implications for social change. Heroin currently affects individuals, families, communities, states, and the United States as a whole. Increasing rates of use and morbidity are reported across the world; however, this study focused on a small area in Midwestern United States, Wisconsin. The negative effects of heroin use touch lives of those around users from family and friends and co-workers, to local businesses, and law enforcement. The harm done is not just to the individual, but also to all those they meet. On a social level, heroin-addicted offenders may be kicked out of their homes and have to live on the streets or in dealer homes where they sell drugs to survive. Their drug use may include thefts and burglaries to fund their habits. Because of social rejection, heroin-addicted offenders may lose self- confidence, suffer from anxiety or depression disorders, or relapse and recidivate.

The information obtained from this study adds to the theory of personal causation, and how heroin-addicted offenders experience pawn and origin moments, with focus on

how extrinsic and intrinsic motivators support sobriety or relapse. The information from this study could assist public health directors in developing better programs both in the jails and for heroin-addicted offenders upon re-entry. That assistance could include allotting resources more appropriately to programs and treatment that offenders believe is more helpful, such as one-on-one counseling rather than group discussions. The information from this study could also provide law enforcement and judicial systems with a better form of re-entry care since most crimes are related to addiction rather than violent criminal acts. Treating the cause of the problem rather than the object used to commit the crime sounds like a better focus than sentencing time that is viewed as a joke or opportunities to increase drug connections. The participants expressed the need for treatment and programs that work, laughed at the jail time, and wished for someone to listen to their wants; this study provides the information needed to make those subtle yet powerful changes, as long as the results reach the right hands.

The knowledge acquired from this study is helpful in advising community leaders in how to change programs and make them meaningful to heroin-addicted offenders, yet ensure they are secure enough that participants cannot take advantage of the programs in a negative way. For instance, rather than jail sentences, heroin addicts spend their time in drug treatment facilities for their entire sentence. During their sentence, they receive counseling such as behavioral or cognitive therapy; they participate in speaking events at local schools, sharing their stories, and include them in program development within their communities, thereby empowering them with opportunity and positive experiences that give them self-worth. Instead of making them felons, or offenders, simply heroin-

addicted individuals should be given the chance to change with the help of positive options.

Limitations

This study has several limitations. The sample consisted of 15 White men and women ages 18 and older, from a single jail in Wisconsin. Although this study was open to all heroin-addicted offenders within in the jail at the time of this study, no non-Whites accepted the invitation to participate. Given the range of the sample and this study being qualitative in nature, it cannot be applied to the general population. Future studies might include a more diverse sample of races. Recall bias and failure to recall are considerations that may have distorted data, or caused a failure of proper recall. One participant stated that heroin use had messed up the ability to remember life before drug use and he could not remember well.

Initial interviews were conducted while participants were still incarcerated, and three participants appeared to use their interview time to re-tell their stories, and possibly help their cases, either to prevent prison time, or to gain early release. This possibility means that the participants were not forthcoming with their stories, and could have tainted the data collected, making some of their testimony invalid.

Follow-up interviews were limited, because only a few participants were released in time to complete this study. One participant was released and never contacted me, one was transferred to prison, eight had not completed their sentences in time, leaving five open to follow-up; however, I only completed four follow-up interviews. One of the five released in time for follow-up interviews relapsed the same day and I could not reach him

for a meeting. This information limited the amount of data collected that pertained to sobriety upon release for this current incarceration; however, I was able to collect data about previous incarcerations and relapse, and recidivism experiences from all participants though, and reasoning and motivators as to why the ended up back in jail. The limitations to this study show that future studies might choose to increase the sample size to ensure a larger follow-up rate.

Researcher's Experience

As the sole researcher of this study, I had to be very aware of my own biases and beliefs. In order to provide a transparent study, I journaled my feelings and thoughts prior to beginning interviews, and continued my journaling and field notes throughout each interview and during data analysis. I entered this study as an ignorant party. I humbled myself and prevented my behavior from seeming hypocritical. I have learned in life that when you judge someone about something you do not understand, God has a way of teaching you that lesson. Out of fear of this happening to me as it had in the past, I refrained from passing judgment or asking questions internally about why they acted a certain way or continued to use at all. I am not an addict. I am not an offender. I have not walked in their shoes and I have not experienced their lives. I do know that life happens and sometimes those things are bad. I am in no way able to decide what kind of people these participants are, and truthfully, I really enjoyed each of them.

My experience as a researcher enacting epoché', I wanted to make sure that pre-coding did not include any of my beliefs or biases. I went through the iterative coding process with an open mind, removing codes that did not apply or were conceived prior to

the coding process and did not apply to the research or interview questions. I made sure my focus was on the motivation behind the statements, the meanings of the statements as they were made, and the actual words of the statements themselves. I kept my research questions and theory notes close by as a reference to stay on course and not mentally verge based on my personal thoughts. I wanted to make sure that each interview provided authentic, high quality, and truthful codes.

I have read the interviews so many times during the iterative process. I relived their interviews as I read my field notes, remembering their cold, clammy hands upon shaking, or bouncing legs, sitting Indian style, how they leaned forward to share a sacred or painful moment, or sitting with arms crossed to protect themselves as they shared their deepest, darkest secrets, or most intimate moments. These participants have my email and phone number, and continue to call and update me on their progress and positive moments. I feel obligated to these 15 participants to share their stories. I feel obligated to the participants to ensure their story is heard.

Summary

The process of answering the research questions, what are the internal and external motivating experiences of heroin-addicted offenders prior to and upon release from jail in maintaining sobriety, what role do internal and external motivators play in regards to treatment and sobriety during incarceration and upon release, and how do the theory of personal causation and internal and external motivators affect perceptions of social constraints, such as unemployment, loss of personal relationships, and lack of support, in heroin-addicted offenders towards sobriety once released, produced three

themes. The results show that all 15 participants have an overwhelming drive both internally and externally to continue to use heroin and other substances. The personal knowledge gained from years of using has engrained in them the knowledge of who can provide drugs, and where they can get them, which is not easily forgotten. Seeing the world through the eyes of an addict is much different than from a non-users perspective. The inability to cope with issues, pains, and injuries, both physical and mental, make every day problems seem insurmountable, causing them to turn to the only thing that has ever been dependable, from their perspective, and that is heroin or a combination of that and other substances.

Internal motivation to abstain from heroin and live a sober life was entirely found to be intrinsic, as a purposeful and deliberate act of change. Sobriety required origin moments and events to be initiated by the participant to facilitate change, as well as self-determination to be sober, understanding that reality is full of triggers, taking responsibility for personal actions, and having the confidence to approach challenges openly. The participants provided in-depth and rich stories based on their experiences as heroin-addicted offenders on paths to sobriety. They shared their hardships, hopes and dreams of sober lives and desires for normalcy. This study is a testament to the participants' courage in sharing their stories and it will hopefully help communities to create social change that benefits heroin-addicted offenders and substance users alike in the future.

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Appendix A: Invitation to Participate

Invitation to Participate in a Walden University Doctoral Study
Conducted by Becky. PhD student.

You are invited to participate in a PhD doctoral study entitled, *How heroin-addicted offenders experience sobriety upon release from jail*. We will complete this study in two interviews, one while incarcerated, and a follow-up interview at 3 weeks after the initial interview to take place at the local public library. I will not name you or the jail in the study at any time. I will name you with a number for the entire study. The first interview will not result in any payment; however, I will give you a $20 Visa Card as payment for partaking in the follow-up interview. There will be no financial benefits during the initial interview occurring while incarcerated.

This study is not connected to the Department of Corrections (DOC) rehabilitation programs. There will be no benefits regarding a parole board or early release, and no rewards for good behavior for participating. There are no risks to you if you do not participate. No punishments will occur, and no one will treat you differently if you do or do not participate, nor will your choice to participate affect your jail time, probation, or parole.

This research may not personally help you, but it may help others in the future who are incarcerated and addicted to heroin. Your personal experiences may help correctional and community programs to better aid those who are attempting detoxification, sobriety, and abstinence. Your input may be beneficial to many, as your personal experiences are critical to helping officials understand the changes needed to help heroin-addicted offenders on their paths to sobriety**.**

In addition to this invitation you have been given the Informed Consent Form and approximate time line for the study. If you choose to partake in this study, please let the staff nurse know "you are interested in learning more." The nurse will not come to you about participating. It is up to you to bring your interest to the staff nurse.

This researcher does not work for the DOC, or any of its affiliates. This researcher will not receive any financial award for conducting this research. The researcher's personal benefit of completing this study will be to fulfill the requirements of a PhD doctoral program with Walden University.

I suggest that you speak with your counselor or drug treatment specialist prior to consenting to participation to ensure you are ready to tell your story. I do not want to do you any harm by asking you to tell me about situations in your life that have caused you pain.

Thank you for your consideration.

Appendix B: Jail Staff Nurse Screening Guide

Jail Staff Nurse Screening Guide

These are the guidelines and parameters of the sample needed for the study conducted by Becky, doctoral student and PhD candidate with Walden University.

1. Inmate used heroin within one month of incarceration.
2. Inmate is cognitively and emotionally capable of partaking in this study.
3. Inmate is eligible for Medicaid upon release.
4. Inmate to be released to society possibly between March and April 2017, depending on proposal approval.
6. Inmate is English-speaking.
7. Inmate is not actively going through detoxification.

Appendix C: Data Collection Approval Letter

23 Feb 2017

Rebecca [redacted]
Doctoral Student with Walden University

To Whom It May Concern,

Rebecca [redacted] has requested permission to collect research data from inmates incarcerated in [redacted] jail through a project entitled *How heroin-addicted offenders in Fond du Lac County experience sobriety upon release from jail: A study to complete a doctoral degree with Walden University.*

Walden University has policies in place to protect the participants from harm including:

A. The right to inspect the consent form, transcripts, and final project prior to submission.
B. The right to privacy, confidentiality, and anonymity, where nothing said in the interviews can be used against them.
C. The right to refuse taking part at any point in the study without affecting their life.

As a representative of [redacted] *County Public Health Department*, I am authorized to grant permission to have the researcher recruit research participants from the [redacted] *County jail, with help from staff. Rebecca* [redacted] is also permitted to collect research data *at designated times that fit the jail's and inmates' schedules.* The researcher has agreed to the following restrictions: *No contact with offenders unless permitted by health department officials and staff within the county jail.* This permission is authorized by me Michelle [redacted], and permits Rebecca [redacted] to perform research in this setting.

If you have any questions, please contact me at [redacted]

Sincerely,

[redacted]
Public Health Nurse
[redacted] *County Health Department*
Sr.
, WI 54935

Appendix D: Jail Administrator Approval

23 February 2017

Rebecca [redacted]
Doctoral Student with Walden University

Re: IRB approval

Walden IRB,

As [redacted] County Jail Administrator, I am approving the study to be conducted by Rebecca [redacted] within the [redacted] County Jail entitled *How heroin-addicted offenders experience sobriety upon release from jail* . The potential participants for this study are assigned case-workers who follow their well-being and compliance with release requirements. There is no IRB within the jail that needs to take further action or approval. I authorize Rebecca [redacted] to enter the [redacted] County Jail to perform interviews on selected inmates, which will include audio-recordings and observational notes.

Sincerely,

[redacted]

[redacted] *County Jail Administrator*

Appendix E: Waiver of Right to Review

23 February 2017

Rebecca [redacted]
Doctoral Student with Walden University

Re: Waiver of Right to Review

Walden IRB,

I am writing to provide a Waiver of Right to Review the materials, audio-recorded, written or transcribed, by Rebecca [redacted] during her interviews of inmates at [redacted] County Jail. The reason for the waiver would (1) protect the inmates depending on their admissions and information, and (2) it would allow the inmates to provide full disclosure of their experiences, which will better fulfill the purpose of this study, and without which will not have truthful findings.

I understand the purpose of this study is to obtain the most open and honest information in order to better the county and community programs set in place to help prevent relapse and recidivism. With a Waiver of Right to Review, Rebecca will be able to assure inmates that what they are reporting is protected, and their honesty will not be used against them in the future. This letter does not pertain to actions, behaviors, or admissions outside of the recorded or written data collected. This letter does not protect inmates from actions, behaviors, or admissions made outside of the interview process with this researcher. My signature ensures that no jail staff member or law enforcement entity will have the right to review the interview materials collected by Rebecca [redacted] during her study on How heroin addicted offenders experience sobriety upon release from jail.

Sincerely,

[redacted]

Health Officer/Director

[redacted] *County Health Department*

[redacted] *Street*

[redacted] *WI 54935*

Appendix F: Semi-Structured Interview Guide

Semi-Structured Interview Guide

This guide will provide the questions, not in any particular order, needed to answer the research questions and provide triangulation of one topic from several different 'takes.'

Hello. I am Becky and I am conducting an interview on heroin addiction and sobriety upon release from jail. I am going to ask questions and record your answers, all of which will remain confidential. I ask that you answer each question as if you are telling your story, as open and honest as you can. Your information may help others, by contributing to a better understanding of heroin addiction and what individuals go through while using, are incarcerated, and trying to achieve sobriety. Just do your best to answer the questions and tell us about your experience.

 Tell me about yourself. Age, married, single?

To address RQ1: What are the internal and external motivating experiences of heroin-addicted offenders prior to and upon release from jail in maintaining sobriety?

Theory

 Did you ever think you would end up in jail?

- What role did heroin play in being incarcerated?
- How long have you been incarcerated? How many times? What role did heroin play in those experiences?

 Tell me about your first experience with law enforcement.(*Triangulation question)*

- What role did heroin play in that experience?

 Tell me what you think of treatment options?

- Did you feel forced into treatment or was it your choice?

Motivation

 Tell me why you first used heroin (origin events).

- How often have you used? What were your triggers for using?
- How did others influence your usage (pawn events)?
- How easy or difficult is it to obtain heroin?
  - While incarcerated?
  - Outside of jail?

 How is heroin currently affecting your life in jail? upon release?

Theory/Motivation

 What is your current view of sobriety upon release?

 What is your perception of sobriety?

- Life with drugs? Life without drugs?

Tell me about a setback you experienced where you either turned to heroin or maintained sobriety.

Motivation/Empowerment

What is your experience with abstaining?

Theory/Empowerment/Autonomy/Self-Efficacy

What programs or treatments would make heroin withdrawal while in jail easier to deal with?

How do you think treatments and programs while in jail would affect your sobriety upon release?

To address Subquestion 1: What role do internal and external motivators play in regards to treatment and sobriety during incarceration and upon release?

Theory

How will you achieve sobriety? Abstinence *(origin or pawn feeling that may influence internal motivation and self-efficacy)?*

Motivation

Tell me about your experience with detox/treatment/support *(Triangulates RQ1).*

Self-Efficacy/Motivation

What are your thoughts about treatment once you are released. *(Triangulates RQ1)?*

To address Subquestion 2: How do the theory of personal causation and internal and external motivators affect perceptions of social constraints, such as unemployment, loss of personal relationships, and lack of support, in heroin-addicted offenders towards sobriety once released?

Theory

What kind of situation was so stressful that you felt compelled to use heroin?

How will you address triggers to use? *(Here I will also bring up other users, stressful events, dealers, or losses if not brought up in other answers)*

Motivation

What are your plans to obtain employment when you are released from jail?

Tell me about your support system.

Wife/girlfriend/child/parents/employer/friend/dealers/Other users?

Tell me about one person who believed in you and lifted you up in your life (This question will ascertain if the participant has any external motivator affecting internal motivation).

Is there anything you would like to add?

Appendix G: Follow-Up Interview Guide

Follow-up Interview Guide

Hello and thank you for making this communication possible. Your participation and experience are appreciated more than you know. We will not be long, and I simply as that at this time, you be honest and frank. All your input is still confidential and protected.

 What has life been like, in relation to sobriety from heroin, since you were released from jail?.

Theory

 Tell me about your experience with treatment since release.

  Or have you lost because you relapsed? Why?

 What choices have you made towards sobriety

 What would you say to the You I interviewed 3 weeks ago about life, sobriety, and treatment?

Motivation

 Tell me about your supports for sobriety since release.

 What opportunities has sobriety opened up to you since release?

Theory/Motivation

 Tell me about the treatment options that interest you or that you feel would be better for you?

 Is there anything else you would like to add?

Appendix H: Human Research Protections Training Completion Certificate

Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that
Rebecca Foster successfully completed the NIH Web-based training course
"Protecting Human Research Participants".
Date of completion: 11/13/2016.
Certification Number: 2235344.

Appendix I: Codebook

To use			The day I got out of prison, I traded my...I had no money, I had no money at all..all I had was my car that I had bought before I went to prison so I sold my car and traded it for $1000 and an ounce of meth.
To use			When I get out of jail? It's kind of a scary feeling
To use			I lost my daughter 6 months pregnant. it was bad me and my boyfriend now. Yeah that is something to do with it. We both relapse right away like 2 days after it happened.
To use			I'll be getting high...I just don't....sometimes that feels like that's my only option
To use			I'm a high school dropout
To use			Heroin has been in control. heroin is control for ever its power made every move financially emotionally, physically, everything of my life for the last six to seven years
To use			I think I'm at the mercy of others
To use			I can't stand being around normal people
To use			I came here with three pairs of clothes not knowing a single soul in Wisconsin, and I went out of my way to search and find heroin
			Just feels like life started right where I left it off at. When I left prison…it feels like right when I got out I was back to my life again.
To use		Trigger	That's probably like my biggest problem is anxiety
To use			I have terrible anxiety. Terrible depression..everything
To be sober			I was like how do I get sober what do I do
To use			I have anxiety attacks
To use			Oh yeah really bad anxiety I have anxiety disorder anyway, but it gets horrible when you're coming down off of crack
To use			Guilt and shame will bring you down every time.
To use			So that's what's messed up, that I do all of that and then now they're still helping me.
To use			I'll be getting high...I just don't....sometimes that feels like that's my only option
To use			I've been in jail and the prison my entire adult life..it gets hard for me to get into a routine where I go to work, and I take care of stuff, and I pay my bills, and I actually pay my rent.
To use			I obviously make bad decisions but I don't know where else to go I don't know what else to do
To use		Behavior/ Attitude	It could just be that I'm bored
To use			I thought I had everything going for me with my addiction. I could sell

To use			The day I got out of prison, I traded my...I had no money, I had no money at all..all I had was my car that I had bought before I went to prison so I sold my car and traded it for $1000 and an ounce of meth.
To use			When I get out of jail? It's kind of a scary feeling
To use			I lost my daughter 6 months pregnant. it was bad me and my boyfriend now. Yeah that is something to do with it. We both relapse right away like 2 days after it happened.
To use			I'll be getting high...I just don't....sometimes that feels like that's my only option
To use			I'm a high school dropout
To use			Heroin has been in control. heroin is control for ever its power made every move financially emotionally, physically, everything of my life for the last six to seven years
To use			I think I'm at the mercy of others
To use			I can't stand being around normal people
To use			I came here with three pairs of clothes not knowing a single soul in Wisconsin, and I went out of my way to search and find heroin
			Just feels like life started right where I left it off at. When I left prison…it feels like right when I got out I was back to my life again.
To use		Trigger	That's probably like my biggest problem is anxiety
To use			I have terrible anxiety. Terrible depression..everything
To be sober			I was like how do I get sober what do I do
To use			I have anxiety attacks
To use			Oh yeah really bad anxiety I have anxiety disorder anyway, but it gets horrible when you're coming down off of crack
To use			Guilt and shame will bring you down every time.
To use			So that's what's messed up, that I do all of that and then now they're still helping me.
To use			I'll be getting high...I just don't....sometimes that feels like that's my only option
To use			I've been in jail and the prison my entire adult life..it gets hard for me to get into a routine where I go to work, and I take care of stuff, and I pay my bills, and I actually pay my rent.
To use			I obviously make bad decisions but I don't know where else to go I don't know what else to do
To use		Behavior/ Attitude	It could just be that I'm bored
To use			I thought I had everything going for me with my addiction. I could sell

To use			Guilt and shame will bring you down every time
To use			I had a lot of resentment towards what my mom did I Grudge for a long time
To use			I've been locked up just about my whole life. Been an addict my whole life. Since 13 pretty much.
To use			I've always kind of had this depression about me
To use			My addictive behavior is what is always going to set me back to using drugs
To use		Perspective	I do want change, but I'm scared of it. I don't like it at all
To use			So until I found that out I was doing just fine, everything was great
To use			It's physical and mental. It's one hundred percent emotional but I think about it every night and how I lied to my dad before he died
To use			I was just so bad, I was a hundred pounds I was sick I was living with my dealer in Manitowoc, I was sick and I was skinny and my arms were just terrible from shooting up.
To use			You know you get in front of a group and all of a sudden you're gun-shy or you open up too much
To use			Being heavier-set person the emotions and the depression and everything that you got it
To use			My sense of normal is not being in pain
To use			Now if I don't got it I'm really sick
To use			It' s like a magnetic force..we bind to each other
To use			I'm still a hopeless freaking drug addict don't get me wrong,
To use			We thought it was a stupid rule..riding your bike in the skate park? Why can't we? Ya know...okay..now they can
To use			I was mooning the cars as they went by. My brother talked me into. The cops brought me home
To use			I'm at the mercy of the world right now where I'm at with all the stuff that's been happening wrong
To be sober			I know I'm in charge of my life
To be sober			I'm in charge of my life
To use		Incarceration	Pretty much I think it had to do with every one, because in some way a drug had something
To use			To be honest no. At first no, but after A while of the lifestyle I was living, ya know, you just kind of expect it to happen at some point
			I can't sleep for more than 2 hours at a time besides the fact that I'm going through all this you know kind of anxiety and stuff like that going on right
To use		Mandated Treatment	I want to get high

To use		Frustration	How do i have the reassurance
To use	**Social**	Stressor	I don't have somebody there I can rely on now
To use			I have to rely on like my kids mom for a lot of stuff
To use			My daughter's mom..me and her are kinda iffy
To use			I have nowhere to go really anymore
To use			I can't go back to my mom's house..her landlord won't let me there
To use			a lot of ppl don't want to hire ppl like me, because I have numerous, numerous thefts
To be sober			What would I do? If they weren't there? If my mom hung up the phone what would I do? Nothing.
To be sober			It took my mother 4 months to even talk to me or come and see me yeah I mean and I don't blame her
To use		Trigger	They left me alone
To use			I mean my mom came to pick me up from prison, but she gets high
To use		Perspective	I need some way to do it, but everybody's wrecked it for me, because all these people chasing around pills, and selling stuff to everybody
To be sober		Positive Supports	I actually have a girl who supportive
To use			I mean I have my family. And my dad but I don't talk to them nearly as much as I do with my mom
To be sober			My mom…
To use		Friends	It was a bad crowd it's how it all started a heroin thing because of my ex boyfriends
To use			Tt first it started just because everybody else was doing
To use	**Treatment**	Bridges	I have an injury, so my doctor gave me Vicodin
To use			I walk out the door I don't care what anyone says about it's hard to get pain pills from a doctor, not for me I walk in I'm going to walk out of there with Percocet, Vicodin, one of those two guaranteed
To use			I was taking pain killers upwards of 60 mg of Oxycodone a day
To use			They [physicians] pulled me off my pain meds and said we don't want you opiate dependent the rest of your life..at which point I changed to heroin
To use			I guess a setback for me was when I was unable to continue with the suboxin. It ended up being where I, the methadone was myself back
To use		Frustration	You just got me on all this medication you got me fucking addicted to it and now you're going to tell me that I got to find a different doctor now I'm going to go through withdrawals what are going to do for me? There's nothing I can

			do for you is what he told me
To use			If he wasn't retiring I would never have used heroin
To use			Is there is nothing they can give me.
To use			They need to help ppl get their lives in order before they get out of jail
To use		Perspective	I don't think there should be fear of calling for help when you're in that situation
To use			Honestly there's nothing they can do. There's nothing you can do in prison
To use			All the programs are a joke. All they do is teach you basic communication skills. That's only thing they do
To be sober		Early Release Programs	I did Sabesa, and Thinking for a Change..did this Epatedis group, did a bunch of groups in the ERP
To use		Voluntary Treatment	I don't really think it helped me at all, because it really is just another high. It is a legal high.
To be sober			I've chosen. I've gone to treatment I went to ANOVA
To be sober			I want to do treatment when I get out again. I'd rather do the counseling one-on-one counseling
To use		Mandated Treatment	They just feed me medicine and maybe I see a counselor, once a month. And I come there and I take my medicine and I go back home. And that place is a joke there's people selling weed in the parking lot, they're doing this and that I'm like really this is just not a good place. It's just a crutch to get high legally cuz I'm on probation
To use			A couple of them I was forced by my parents, and I've been three party's petitioned, just because I…
To use		Detox in Jail	They don't do anything for you
To use			It makes me more agitated that I'm in there
To be sober		Incarceration	Being here sucked at first and now it's totally you know I need this and this is the only thing that's going to help me this is what I need right now
To be sober		Sobriety	This is the longest time ever...7 months
To be sober			I've been clean from heroin since October
RQ2 Internal/external motivators treatment			
To use	**Internal**	Relapse	Probably within 2 weeks I was using again
To be sober			The Gateway program was sort of an ultimatum
To be sober	**Social**	Positive Support	I'm still in my parent's insurance so I have good insurance
To be sober	**Treatment**	Voluntary Treatment	I've been doin' a lot of treatments
To be sober			If I were back home I wouldn't have the option to go buy a dope period for one if I did my dad would beat the hell out of me

To use			I got on suboxone, for a year..they would pay for it for a year...which I did..my only year sober in a whole year
To be sober		Early Release Programs	I did Sabesa, and Thinking for a Change..did this Epatedis group, did a bunch of groups in the ERP
To be sober		Mandated Treatment	I can go to a treatment program there in lieu of going to prison
To be sober			If you drop me at a halfway house right now yeah there's enough people who would keep an eye on me, but no one who's going to step on your neck
To be sober			From there they had sent me to an outpatient program in Rodgers in Kenosha. I left there
To use			The tap program was something I was made to do
To use		Frustration	I need to get my life together and they make it impossible for me to get my life together
To be sober		Behavioral Counseling	If they had programs in the jail to help those change their behavior..do you know what I mean, to change the way you think
To use			It's going to take an addict sometime to get their shit together it's going to take an addict some time to change their mind.
To be sober		Sobriety	The goal right now is to get an Institutional alternative to revocation at Milwaukee secure Detention Facility
To be sober		Sobriety	I need help so don't leave me here to burn
To use			I, I don't even know where to start with that.
To be sober		Handholding	I wish someone would have supervised me more when I first got on probation.
To be sober			It keeps people accountable.
To be sober			If you're getting out of jail you go out on bond you're going to WCS. You're going to go 3 times a week and pee in a cup.
To be sober			Right then and there she should have been like pee in this cup for me, and she didn't.
To be sober			I need help when I get out there those drop me off at the corner and expect me to go where I'm supposed to go. Hold my hand until I get there
RQ 3 Theory/motivators affect perceptions			
To use	**Internal**	Behavior/ Attitude	I'd probably still have, because I had plenty of people who are, you know, you're doing good blah blah blah
To use			I've always been a drug dealer, it's all I know.
			I never gave myself a chance.
To be sober		Positive Support	I have two college degrees.
To use		Trigger	Always because my anxiety. It makes me 10 times more self-conscious, which makes the anxiety ten times worse.

To use			I'm still anxious all the time…is there nothing they can give me?
To use			It's more than just a physical anxiety of being in a situation. Constant pressure in my chest, always.
			Oh yeah really bad anxiety I have anxiety disorder anyway, but it gets horrible when you're coming down off of crack
To use		Stressor	I'll got back to my old life cause I'm forced to. No other choices when I get out.
			I don't know how, I don't know what I'm going to do exactly I don't even know how I'm going to get to work
To be sober		Perspective	If I could find a way to dig myself out of this..if I could get my license back i could making $35 bucks an hour somewhere. I got like 2o years experience in my field
To use	**Social**	Stressor	Most of my family has alienated me
To use			If I go to prison honestly, I don't think she's going to stay.
To use			People don't want to hire people like me, because I have numerous, numerous thefts..ya know? Maybe have places where they hire addicts..ya know? Stuff like that makes it easier to get a job like you're forced to have a job or something. Cause I get high pretty much...well...I'll get back to my old life cause I'm forced to. No other choices when I get out.
To use			Her lease is up May 30th and that's the day I get up and she's moving back in with her mom's house so I can't even go stay there. Her mom and her dad don't like me.
To use			A lot of ppl don't want to hire ppl like me, because I have numerous, numerous thefts
To use			I ain't got a job I can't get a job I have a record that's like a mile long, what's 17 felonies on my record so.... I mean it is what it is
To use			I'm never going to get a job cuz they're never going to they're not going to hire me
To be sober			Maybe have places where they hire addicts..ya know?
To be sober			That is how I am..I'll work 7 days a week usually
To be sober			I'm thinking about going back to cook it when I get out so.
To use		Trigger	The drinking will trigger me only because he's not, he's a very mean drunk he's not a pleasant drunk. If he was a happy drunk I might be able to deal with it but he's an a****** when he drinks so yeah it's going to trigger me
To be sober		Positive Supports	My daughter J who got out of prison 2 years ago is my biggest supporter and my biggest critic, she will put me in line and do it mom quit bullshittin' me
To be sober			I have 2 sisters and my brother and my mom
To be sober			My mom…
To use		Lack of Supports	uhh... No. No
Extra information / Triangulating			
	Treatment	Advice to Professionals	They should have something or maybe even where they force you to get your fuckin' life together...cause that's what we need....that's what I need
			One-on-one counseling just makes it easier you
			The treatment here sucks
			Here they give you Gatorade they give you like 5 different medications, to stop you from feeling the withdrawals and stuff like that. What is that going to do? it's going to make you turn to the same thing before as you turn to it before. Your drugs.
			Right now they have AA program but that's more for alcoholics..and they only have NA for females..they need it for males. Um...less bible studies..they got too many bible studies
			They need to help ppl get their lives in order before they get out of jail