

ENVIRONMENT MATTERS: EXPLORING WOMEN-ONLY SUBSTANCE ABUSE
TREATMENT PROGRAMS AS “THERAPEUTIC LANDSCAPES”

ENVIRONMENT MATTERS: EXPLORING WOMEN-ONLY SUBSTANCE ABUSE
TREATMENT PROGRAMS AS “THERAPEUTIC LANDSCAPES”

By

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ABSTRACT

This thesis explores the character of women-only substance abuse treatment programs as ‘therapeutic landscapes’ using qualitative interview and observation methods at two women-only treatment programs. The thesis explores the character of these programs from the perspective of both staff and clients. Not surprisingly, treatment clients had both positive and negative views about various elements of their treatment experience. As such, identifying these sites as ‘therapeutic landscapes’ requires us to consider how they maintain a structured environment (their core objective) on an ongoing basis, while also being influenced by a wide range of factors. The individual characteristics of staff and clients, staff/client and peer social relations, the surrounding neighbourhood, and the internal and external program environment are factors that shape the ongoing operation of treatment facilities. Further, through them, key tensions arise in the facilitation of the treatment program, which staff needs to consistently try to balance. These tensions arise as programs try to strike a balance between (1) structure and dependence, (2) retreat and reality, (3) individual and collective needs, and (4) homogeneity and diversity. Maintaining a healthy atmosphere and a positive group dynamic therefore requires a wide range of considerations. By studying the core objective of addiction treatment and the factors that influence whether programs achieve this objective we can better understand the ways that environment matters when exploring women-only substance abuse treatment programs as ‘therapeutic landscapes’.

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CHAPTER 1

INTRODUCTION

While Westernized understanding of substance abuse and treatment primarily formed around knowledge of male experience increased efforts have been made more recently to improve our understanding of how this knowledge can be applied to the experience of women. Since the 1980s, greater attention has been placed on more efficiently meeting the treatment needs of women. Women-centered programming has been added to the urban landscape with the recognition that many women experience their addictions and access to treatment differently than men. They are often challenged by eating disorders, trauma history, stigma (associated with female drinking), shame and guilt (associated with being a ‘good mother’), safety issues, parenting/custody issues, and/or a lack of worth/confidence/esteem. Women-centered/client-centered programming is better able to assist women with these hurdles, while also helping them work through their substance abuse concerns. Even still women are quite often restricted by their choice when seeking formal treatment help, since despite current efforts a lack of programming still exists for them in Canada. As such it is imperative that we gain a better sense of how women are using and/or are limited

by the treatment options that currently exist for them, as well as how they perceive these environments based on the characteristics that they possess. This can be approached using the 'therapeutic landscape' concept, which is becoming increasingly popular amongst the studies of health geographers.

1.1 The Research Questions

The aim of my research is to (1) explore the characteristics of addiction treatment environments using the concept of therapeutic landscapes, and (2) to build a stronger understanding of the various approaches used in addiction treatment for women and the extent that these are shaped by geographical and environmental considerations. This contributes to literature associated with addictions. It also responds to three gaps related to the use of the therapeutic landscape concept that have been ongoing since its adoption. The first – that more micro-scale analysis needs to be conducted to better understand individual experiences and constructions of these environments (see Wilson 2003; Andrews 2004). The second – that greater consideration needs to be paid to the potential for these landscapes to produce negative results (see Wilson 2003; Conradson 2005; Wakefield & McMullan 2005; Wilton & DeVerteuil 2006; Lea 2008). Lastly – Wilson (2001) emphasized the lack of attention that health geographers have given to social and cultural difference in relation to therapeutic landscapes, whereby insufficient attention to gender remains. These critiques have guided my

analysis and support its purpose. More detail of Gesler's therapeutic landscape concept and its applicability to my research will be provided in Chapter 2 in my literature review.

1.2 Thesis Outline

Following the introduction my thesis is organized into five chapters. In Chapter 2 I provide a thorough review of academic literature that pertains to my topic. This discussion is broken up into two key sections. The first discusses the shift from medical geography to geographies of health and then outlines (1) the construction of the 'therapeutic landscapes' concept, (2) its growth and application, and (3) current criticisms related to its ongoing adoption and opportunities for future research. The second section demonstrates an understanding of alcohol/drug consumption and treatment in the Canadian context. The discussion focuses on (1) alcohol consumption in early settlement, (2) temperance and prohibition efforts in Canada, (3) the modern alcoholism movement, (4) alcoholics anonymous and treatment for addictions, (5) contemporary treatment in the Canadian context, (6) women and addiction, (7) barriers to treatment for women, and (8) women-only treatment. Chapter 3 then outlines the methodological approach that I have adopted. In this chapter I discuss the context of my research, the approach I have used for data collection

purposes, and provide an overview of my research participants. I conclude this chapter by providing a brief explanation as to how I proceeded with my analysis.

In the second half of my thesis I present my analysis and concluding remarks. My analysis focuses on how treatment programs operate as therapeutic environments and has been separated into two portions. In Chapter 4 I outline the core objective of addiction treatment; elaborate on the individual characteristics of treatment clients, and the similarities and differences that exist amongst them; and reveal the types of staff/client and peer social relations that can be expected within the two residential substance abuse treatment facilities studied, as well as how tensions amongst them are negotiated. In Chapter 5 I have focused more on how substance abuse treatment programs can be considered therapeutic based on their physical characteristics, internally and externally, and by their physical location and the influence of the local neighbourhood. In this discussion clients and directors have provided their opinions on what they like and don't like, and would like to see changed in relation to the treatment environment. They also provide an indication as to how the local neighbourhood influences their treatment experience, based on managerial strategies that are used to control their access to the neighbourhood as well as places they choose to go when off-site, while also considering how its characteristics influence their perception of it.

I conclude my discussion by presenting a summary of my findings and expanding on key tensions present in the addiction treatment landscape. I then

provide a discussion on the strengths and limitations of my project and an argument for future research opportunities that I feel would be useful additions to my work.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

Addiction treatment facilities aim to improve the overall health and well-being of their clients in part by creating environments that are conducive to recovery. The facilities vary in terms of their specific treatment philosophies. They also vary in terms of the specific contexts they work with (building environment and neighbourhood context). In fact, some operate in locations that are arguably less than ideal for treatment and recovery. This thesis is concerned with understanding how these facilities work as therapeutic landscapes (Gesler, 1992). The concept of the 'therapeutic landscape' has evolved since its inception in the early 1990's through an increased interest amongst geographers to evaluate the complex relationship between geographical setting and health and well-being. The popularity of the therapeutic landscape concept reflects a broader shift from a traditional medical geography grounded in a bio-medical model to a geography of health with a broader socio-ecological conception of health and illness.

This literature review will briefly consider the broader conceptual shift from medical geography to geographies of health. It will then outline in some detail Gesler's early work on the concept of therapeutic landscape. Next, it will consider how the concept has been applied and further refined over the past

decade or more. Next, the review will consider critiques and limitations of the concept identified to date and the potential that it has to support future research interests. To conclude, I will suggest how the therapeutic landscape concept can be used to understand the recovery environment found in addiction treatment programs and the neighbourhood settings of which they are a part.

2.2 FROM MEDICAL GEOGRAPHY TO GEOGRAPHIES OF HEALTH

Medical geography has a long history, both within and beyond the discipline of geography (Curtis and Tacket 1996). Mohan (2000, 494) defines medical geography as comprising “geographical analyses of health, disease, mortality and health care”. Traditionally, medical geography comprised two main strands of research. The first was concerned with understanding the spatial patterning of disease as well as its diffusion over time and space, while the second strand was focused on the spatial patterning of health care services, as well as their availability to and use by patients (Jones and Moon 1987). Significantly, these strands were informed by a positivist philosophy with an almost complete reliance on quantitative methods to measure and test empirical data (Curtis and Tacket, 1996). They also relied on a biomedical model. As Milligan (2001, 11) notes, this model

...views disease as generic; that is, it is believed to display the same symptoms and processes over time and space. Such a conventional view of biomedicine has tended to resist any encroachment of social models of

health and ill-health, with the emphasis being on science, technology and rationalism – cure rather than prevention.

Beginning in the early 1990s, a number of geographers began to advance a critique of medical geography, arguing for the development of a broader geography of health and health care (Kearns 1993; Litva and Eyles 1996; Kearns and Gesler 1998; Smyth 2005). They expressed a number of key concerns with medical geography. First, they argued that geographers needed to engage with a variety of social theories rather than rely on a Positivist philosophy (Kearns 1993; Dorn and Laws 1994). This shift also encouraged an exploration of other models of health that challenged assumptions contained in biomedical model (Curtis and Tackett 1996; Gatrell 2002). Emphasis has been placed on conceptions of health as more than the absence of disease, instead emphasizing a socio-ecological model that understands health in terms of an: “interactive set of relationships between a population and its social, cultural and physical environment” (Mohan 2000, 330). Criticisms of the reliance on the biomedical model also emphasized that this model could exert considerable power over people by labelling their bodies and defining their problems and the appropriate responses (Dorn and Laws 1994; Brown 1995). Kearns (1993) and others also emphasized the importance of ‘place’ as a setting for lived experiences of health over more abstract notions of ‘space’ as backdrop for disease patterns. Moreover, there was a call for the use of qualitative methods that would allow for the exploration of meaning in relation to

people's experiences of health and ill-health (Kearns and Gesler 1998; Wilton 1999). Curtis and Taket (1996) suggested that these developments led to three new conceptual approaches to research (alongside the spatial patterning of disease and health care) in a 'new' geography of health. These were humanistic, materialist and cultural approaches.

Humanistic work focuses on experiences and meanings of health, and the complexity of health related behaviour. This work questions universal assumptions about the meaning of health, ill-health and disease characteristic of the biomedical model (Milligan 2001), asking instead how individuals and groups come to understand their health. Not surprisingly, humanistic studies encouraged the use of qualitative methods to gather information about people's experiences of health and ill health, and their contacts with health care systems (Eyles and Donovan 1986). As Curtis and Taket (1996) make clear, materialist research places emphasis on the *social causes* of differences in health and difference in access to and quality of care received by individuals and groups within societies. This work focuses attention on socio-economic contexts, and the ways in which material constraints and social inequality underlie inequalities in health and healthcare. Finally, culturally-informed research places emphasis on the importance of culture as a *system of meaning* for making sense of health, illness and health care. This emphasis also fit with the interest in the meanings associated with place, and the ways in which cultural meanings vary

geographically. As I show in the next section, the therapeutic landscape concept is strongly linked to the cultural theme. This theme also reflects broader developments within cultural geography, and new ways of thinking about landscapes (Gesler 1992).

2.2.1 The Therapeutic Landscape Concept

Wilbert Gesler first introduced the ‘therapeutic landscape’ concept in 1992 in an effort to provide a conceptual structure through which geographers could better identify how “the healing process works itself out in places” (Gesler 1992, 743). He explained that: “[m]ost social scientists who study health would agree that environment and health play extremely complicated, interacting roles in health”, yet no framework existed to support this recognition at the time (Gesler 1992, 737). His work encouraged geographers to adapt their perceptions of the relationship between health and place by inserting the notion of a therapeutic landscape as a: “geographical metaphor for aiding in the understanding of how the healing process works itself out in places” (1992, 743).

In this initial paper, Gesler set out four different ways of engaging with the therapeutic landscape concept. The first drew from more traditional themes in cultural geography to examine landscape in terms of the interactions between physical environment and human health. For example, Gesler explored the enduring connections between water and healing in many cultures. He also noted

the common perception of the countryside as a healthy landscape, notwithstanding factual data pointing to poorer health in rural areas. In addition to this traditional theme, Gesler suggested ways of thinking about therapeutic landscapes from humanistic, materialist and cultural materialist perspectives. As suggested above, these perspectives reflect broader shifts occurring within medical/health geography.

A humanistic perspective foregrounds the role of people's beliefs about health and illness. One implication of this is the recognition that while diseases are biological realities, these realities are understood by people through cultural lenses, provoking different reactions and health-seeking behaviours. For geographers, a humanistic perspective is strongly tied to the idea of 'sense of place'.¹ Gesler argues that there is significant potential for health geographers to use this concept to evaluate the 'therapeutic-ness' of health care settings. The humanistic perspective also includes a focus on the symbolic character of landscape. This suggests that components of the environment, whether natural or built, express meaning and can be interpreted or 'read' for insight.

A materialist perspective focuses attention on the ways that structural forces in society create certain types of environments, which in turn help to perpetuate an existing social order. Particular concern in this perspective is directed at issues of inequality, the ways that some groups within society

¹ Sense of place can be understood as "the meaning, intention, felt value, and significance that individuals and groups give to places"

dominate, and other groups try to resist such domination (Gesler 1992). In health terms, for example, Gesler talks about the power of medical professions and the extent to which this power has led to the marginalization of other perspectives on health. Other examples include the geographical differences in people's access to health care, where these unequal landscapes reflect significant inequalities on bases, such as class and gender.

Finally, the cultural materialist perspective Gesler sees as an attempt to bring together the other two perspectives. This perspective recognizes the role of belief systems, culture and human agency, while also acknowledging "the constraints of underlying structures" (1992, 741). Gesler notes that such a perspective may be useful in considering how more or less therapeutic landscapes are created by both human agency and social structure. Examples include the landscape of deinstitutionalization, which can be understood as a product of both structural change (e.g., welfare state cutbacks) and agency (caregivers, patients, neighbours) occurring within an urban setting.

In a subsequent paper, Gesler (1993, 171) argued that health geographers could make a significant contribution to thinking about the effective design of health care environments by (1) contributing to theory on the nature of therapeutic landscapes, (2) applying this theory to concrete examples of "places with enduring reputations for healing", and (3) deriving lessons from these examples for the design of modern environments. He suggested that his own case study of

the sanctuary at Epidauros, Greece, for example, demonstrated the importance of a variety of factors including the proximity of nature, seclusion from everyday stresses, and attachment to place to health and healing. More broadly, he argued that a lesson for modern health care from the Epidauros case is that:

[health care] costs would be substantially lowered if less attention were paid to using expensive equipment and employing high paid personnel and if more attention were paid to creating caring and comfortable environment for the ill (1993, 185).

As I show below, Gesler's call for work using the therapeutic landscape concept has met with considerable response.

2.2.2 Growth and Application of the Therapeutic Landscape Concept

The therapeutic landscape concept has been successfully applied to the study of various population groups within a variety of different geographical contexts. In addition to two edited collections, (Williams 1999, 2007), there has been a proliferation of journal articles using the concept (see Smyth 2005; Gesler 2005). In a comprehensive review, Smyth (2005) usefully argued that health geographers' work on therapeutic landscapes could be organized into three major themes: (1) therapeutic places, (2) therapeutic spaces and, more recently, (3) therapeutic networks. I use Smyth's classification here as a means to summarize these developments.

Much of the early work drawing from Gesler was concerned with the extent to which certain *places* could be considered to be inherently therapeutic because of the perceived healing qualities they possessed. As I suggested earlier, Gesler identified these places as sites that had sustained their reputation as healing sites over a long period of time. As Milligan (2001, 25) notes, a focus on these sites: “draws attention to alternative modes of healing, illustrating how it might be possible to develop environments conducive to healing in contemporary society”. Much of this work also focused on sites that were extraordinary in the sense that they were well-known for their healing qualities (in a number of instances because of their association with water). These included: Epidauros, Greece (Gesler 1993); Denali National Park, Alaska (Palka 1999), the Hot Springs, South Dakota (Geores 1998); the Basilica of Lourdes, France (Gesler 1996); and the Hot Springs of Bath, England (Gesler 1998). Smyth (2005, 489) points out that most often these places were significant historically in connection to their geographical location and physical attributes, and were “marketed as places of healing and recovery” and would otherwise not necessarily have been characterized as therapeutic (see for example Geores 1998).

Gesler’s work encouraged geographers to consider how these extraordinary places came to develop positive psychological associations for people, and the ways that places “provide meanings and attachments” with sometimes significant consequence for health (Andrews 2004, 307). At the same

time, the extraordinary nature of the sites under investigation limited the broader relevance of the work (Wilson 2003). As a result, a second phase of study emerged. Geographers began to look at therapeutic landscapes more generally as *spaces* within which health manifests itself (Smyth 2005). They also started to consider the ways that “cultural beliefs and practices structure the sites of health experience and health care provision” (Gesler and Kearns 2002, 1). This more recent body of work places less significance on specific geographic location and instead highlights how space accomplishes its therapeutic function through its “physical, social and symbolic organization” (Smyth 2005, 488). Attention has also been paid to both the therapeutic and un-therapeutic characteristics existing within many of the environments being discussed. This is partly in response to Williams’ call in her edited collection (1999) for geographers to recognize “places that promoted well-being and maintained health” as therapeutic alongside those “that had achieved a [lasting] reputation for healing” (Gesler 2005, 295).

In these studies the therapeutic landscape concept has been used to examine the design and identity of various contemporary institutions that both formally and informally provide healthcare services. These include the discussion of hospitals as potential therapeutic spaces through not only the design tactics used to create them, but also through the language used to market certain ones as superior in relation to others (Kearns and Barnett 1997, 1999, 2000; Gesler et al. 2004). Elsewhere Fannin (2003) discusses how some birthing rooms in the

United States now strive to be more 'therapeutic' by creating "home-like" settings for those in labour by downplaying the necessary technology used by physicians. The therapeutic landscape concept has also been connected to the discussion of other spaces that offer healing functions, such as; prison (Stoller 2003), schools (Holt 2003), fitness centers (Andrews et al. 2005) and health camps for sick children (Kearns and Collins 2000).

Most recently, Smyth (2005) argues that research has begun to explore health and healing in relation to landscapes as therapeutic *networks*. These are: "less formalized arrangements of support and care that often exist outside (or in parallel to) the traditions of biomedicine." As she notes, these networks extend well beyond spaces associated with biomedicine and often encompass a variety of complementary approaches to health maintenance. She also argues that people support and care for one another through these 'networks' by building relationships with family, friends, as well as therapists and/or other related service providers (Williams 1998; Wiles and Rosenberg 2001; Andrews 2004).

Since forms of healthcare are taking place beyond the formal institutional setting much more often than in the past, one implication is that these therapeutic networks may take a variety of different forms (Smyth 2005). Not only can they be established through the creation and acceptance of alternative forms of healthcare, such as yoga and massage retreats (Lea 2008; Hoyez 2007), places of stillness and retreat (Conradson 2007), substance abuse recovery programs

(Wilton and DeVerteuil 2006; DeVerteuil et al. 2007), the home space (Williams 2002; Donovan and Williams 2007), and public or community gardens (Twiss et al. 2003; Milligan et al. 2004), but geographers are also considering the concept in relation to landscapes used for family entertainment purposes as well, such as the zoo (Hallman 2007). Significantly, the idea of 'networks' suggests an understanding of therapeutic effects that is not necessarily tied to a specific place or setting (see, for example, Andrews' (2003) work on complementary medicine and imagined landscapes).

The therapeutic landscape concept has also been used to depict how networks of care are provided in relation to the everyday social realities that certain populations experience, as well as how they are created and negotiated. These include networks created by marginalized groups, such as on-reserve First Nations peoples and their healthcare providers in Northern Ontario (Dobbs 1997 in Gesler and Kearns 2002; Wilson 2003); those living with mental health issues (Parr 1999; Pinfold 2000); women's empowerment through media initiatives in Uganda (MacKian 2008); and the experiences of street homeless people in Toronto (Bridgman 1999).

2.2.3 Criticisms and opportunities for further research

Although popular, the concept of the therapeutic landscape and the research it has prompted have been met with some criticism. Some people have

pointed to the ‘western’ bias of research (Wilson 2003; MacKian 2008). Others have raised concerns about the theoretical depth of the literature (see, for example, Andrews 2004). Recently, English et al (2008) argued that the concept could be usefully linked to the growing literature on ‘emotional geographies’ to better understand the link between well-being and place.

Three themes can be identified with particular relevance for this research project. First, there has been some concern about the geographical scale of analysis. Wilson (2003) and Andrews (2004) both argue that much work to date has been at the “macro-scale”, on the collective production of therapeutic places and their consumption. Less attention has been paid to the micro-scale, “the ways in which therapeutic places are constructed and experienced by individuals” (Andrews 2004, 309). This study, drawing on qualitative methods and extended observation, allows for some of that micro-scale analysis.

Second, a number of authors have noted that it is problematic to assume that therapeutic landscapes produce entirely positive effects (see, for example Wilson 2003; Conradson 2005; Wakefield and McMullan 2005; Wilton and DeVerteuil 2006; Lea 2008). Along these lines, Baer and Gesler (2004, 412) argued that it made sense for researchers to apply the therapeutic landscape concept to “more difficult and contestable examples”. Drug and alcohol treatment programs provide the kind of difficult and contestable setting that can provide better understanding of positive and negative outcomes associated with

therapeutic landscapes. As Wilton and DeVerteuil (2006) have argued, these programs function with two motivations; to provide care to individuals but also to manage the behaviour of individuals who are seen as being out of control. It makes sense then that people may experience these environments differently, with varying opinions as to whether they are therapeutic settings. Interestingly, MacKian (2008) has suggested that there is often a sense that therapeutic landscapes are always places that we *chose* to go to. For her, this is problematic assumption and we need to devote more attention to the nature of environments people inhabit whether they like it or not. Given the nature of addiction and the fact that some people are made to seek treatment, recovery programs provide an interesting example of this type of setting.

Third, there has been a recognition that social/cultural difference in people's experiences of therapeutic settings has not been adequately explored. Wilson (2001) talked specifically about gender difference and cultural difference on the basis of ethnicity. The latter topic is addressed somewhat in her own work on everyday landscapes of aboriginal communities (Wilson 2003), but there is still more to be written with reference to gender and therapeutic landscapes. Given the insufficient attention that has been placed on gender in the 'therapeutic landscapes' literature future research could more explicitly identify the gendered elements present within environments such as addiction treatment facilities and

perhaps also attempt to provide some comparison of the different realities that women and men face in treatment.

2.3 UNDERSTANDING ALCOHOL/DRUG CONSUMPTION and TREATMENT

In this section of the literature review, I examine research on historical and contemporary approaches to the consumption and regulation of alcohol, and the treatment of people considered to have problems with alcohol and other drugs. The discussion is broken into eight sections. First, I consider the history of alcohol consumption in North America and the rise of temperance and, ultimately, prohibition. Then I examine work that documents the liberalization of attitudes to alcohol and the growth of the alcoholism movement that focused attention on a specific problem group within the population. This is followed by consideration of the Alcoholics Anonymous fellowship, which developed in the same historical period. I then turn to the contemporary treatment landscape, exploring what options are available. Particular attention is given to the options for women, as well as the barriers they face in accessing treatment. Finally, I examine literature on the design and operation of women-only treatment programs.

The focus of the early sections of this review is primarily on *alcohol* consumption, regulation and treatment here because the history of temperance, prohibition and the rise of the modern alcohol movement and the *Alcoholics*

Anonymous fellowship provide an important backdrop to the contemporary treatment landscape. I recognize that there are important differences in the history of other drugs' consumption and regulation, in particular the legal nature of alcohol consumption in contrast to the illegal nature of many other mind-altering drugs (see, for example, Tracy and Acker 2004). In addition, public perceptions of the illegal and immoral nature of drug use have had very negative implications for how society views female drug users (Boyd 2004). At the same time, given the specific focus of this thesis on the nature of treatment environments, limiting the scope of the review seemed appropriate.

2.3.1 Alcohol Consumption in Early Settlement

European settlers brought a “well-established taste for alcohol” with them when they arrived in Canada. It was so prominent in every day pre-industrial, colonial life that the French, English and Irish all dubbed it the “water of life” (Heron 2003, 17). After British Conquest of Canada (1759) alcohol was recognized for its financial potential and its consumption initially went unquestioned (Smart and Ogborne 1996). Early regulations prioritized the issuing and collection of licensing fees over controlling drunkenness and/or rates of consumption (Popham 1976 in Smart and Ogborne 1996; Heron 2003). There was also no real attempt made by the government to interfere in the use or distribution of alcohol; instead it was given attention for its trade potential (Heron

2003). The only time that the Canadian government attempted prohibition was when farmers were called to fight in the War of 1812 and there was concern over the availability of wheat and the government wanted it to be preserved for making flour rather than whisky. This attempt lasted for only about a year, as soldiers complained that they could not fight without liquor; special provisions were made for them and the legislation was removed shortly after (Smart and Ogborne 1996).

Despite its regular use amongst European settlers, drinking was a social custom unknown to Native people in both Canada and the United States prior to European arrival. Studies suggest that they lacked an understanding of the potential physical and social affects of excessive consumption, which led to many problems for this population (Tracy and Acker 2004). Beyond the challenges experienced by Native Canadians, consumption of alcohol was not held in negative regard prior to the temperance movement. Moderate social drinking was accepted amongst all religious denominations and it wasn't until 1830 that any shifted their perspective on drinking and/or supported its prohibition. Even when the opinions of certain religious denominations changed other denominations persevered certain behaviours that clearly supported consumption. For example, as late as the 1840s alcoholic beverages were still being advertised in church newspapers (Smart and Ogborne 1996; Heron 2003). The same was true in the everyday social life of Canadians. Because they traveled by horse and carriage prior to the construction of the railroad Canadians were quite limited by how far

they could travel each day. This meant that there were a large number of Inns and Taverns along commuting routes, so that travelers had somewhere to eat and sleep before moving on. A large amount of drinking took place in these buildings because, for many years, inns in Upper Canada charged for room and board, but not for whisky (Smart and Ogborne 1996). Smart and Ogborne (1996, 9) note that: “[t]he first official census for Upper Canada in 1851 counted 1,990 taverns, or one for every 478 people”.

2.3.2 Temperance and Prohibition in Canada

Some studies suggest that Temperance, as a social movement, formed in response to arguments made as early as 1790 by Benjamin Rush (a physician and statesman), who stressed “that drinking alcohol could induce a disease manifesting itself as a progressive loss of control”, whereby abstinence was the only appropriate treatment (Chavigny 2004, 109). Rush emphasized that while people started drinking of their own free will over time drinking habitually would result in the evaporation of that same willpower that had been used by the individual when choosing to take a drink in the first place (Valverde 1998).

In Canada, the Temperance movement began in the 1820s and roughly modeled developments taking place in the U.S. and Britain in an attempt to eliminate problem drinking amongst Canadian men (Smart and Ogborne 1996; Heron 2003; Blocker 2006). While it is unclear as to when the first temperance

meeting took place, respect for social drinking in Upper Canada was starting to disappear by the 1830s and by “1832 there were 100 [temperance] societies in Upper Canada with 10,000 members, and they were served by 12 temperance newspapers” (Smart and Ogborne 1996, 16). By 1842 the number of temperance members had increased six times leading to more than one of every ten people being recognized as members in Upper Canada (Smart and Ogborne 1996). By 1837 there were also eighty societies with approximately 30,000 members in Nova Scotia as well (Heron 2003).

In some respects its success can be attributed to the fact that many Canadian churches got their clergy from the United States, where the movement was in full force and had consolidated to create a national organization (known as the American Temperance Society) in 1826 (Heron 2003). Many of the clergy coming from the United States were already supporters of the movement (i.e. Presbyterian, Methodist, Episcopal and Baptist) and were able to further influence the social shift that was starting to take place in Canada (Smart and Ogborne 1996). Unlike the U.S. however, temperance efforts present in Canada were more decentralized, so it was not until the 1840s that it became a much more prominent driving force in the everyday lives of Canadians (Heron 2003).

While the Anglican Church showed little interest in the movement, Fundamentalist Christians were quite active in their support, even bringing the movement to the Canadian west through their evangelical efforts. As a result of

their dedication they were often thought to have “ownership” over drinking problems in Canada (Smart and Ogborne 1996). This became especially apparent when Methodist and Baptist leaders decided to define “problem drinking”, and what should be done about it (Smart and Ogborne 1996). Nearly a century passed before their ‘ownership’ was questioned by the government and the medical profession.

The way that the movement brought together the public and motivated their collective action is quite impressive when we consider that it took place despite varying degrees of public opposition and a complete lack of government funding (Smart and Ogborne 1996). Interestingly it was successful primarily by offering alternative ‘social opportunities’ to its members, while also changing the way they viewed personal and public alcohol consumption. Smart and Ogborne (1996, 36) also argue that the movement provided “the first real treatment for alcoholics”. This is interesting in light of how treatment is approached in the Canadian context currently. Unlike today, instead of focusing on the individual behaviour of those who chose to drink regularly and/or excessively, temperance society members focused on imposing environmental controls. Not only did this approach contribute to a shift in how social life was constructed for Canadians over the next century, but it also adjusted the nature of the built landscape and the public’s use of it.

Because drinking was so readily accepted in all social spheres during this period (including festivals, elections, marriages, funerals, and pioneer ‘bees’) early temperance societies “allowed the use of wine, beer, and cider and were essentially ‘anti-liquor’ societies” (Smart and Ogborne 1996, 17). They saw beer, cider and wine as healthy if consumed in moderation, and only tried to control the consumption of distilled spirits, such as whisky (Heron 2003). In many ways initial efforts within the movement seemed to strive to decrease the social impacts of excessive consumption rather than to rid Canadian society of drinking all together.

Smart and Ogborne (1996, 8) explain that “[o]ne of the first roles undertaken by the temperance societies was to sponsor bees at which there was no drinking” and that “[t]emperance society members [made it clear that they] would only go to bees of that type”. This was a strong statement since a ‘pioneer bee’ was not just a social event, but also an essential part of rural life since the purpose of the bee was to complete large work projects (i.e. logging, barn raising, land clearing through the assistance of others). Because bees were so central to rural existence temperance members saw them as an opportunity to promote social change, since Canadian men typically drank a large amount of whisky while working and socializing with one another at them (Noel 1994). This was just one of many impacts that early temperance societies had on social life, since they also sponsored bands, sports teams, and concerts; nature walks; constructed libraries

and reading rooms; hosted parties, educational evenings, and public speaking contests; and controlled the functioning of taverns (Smart and Ogborne 1996; Heron 2003). In order to compete with social events that involved drinking, temperance supporters used alternative recreational programming to prevent communities from returning to drinking after the temperance campaign had moved on to another area (Heron 2003).

Numerous exclusions were imposed on membership in temperance societies in early years on the basis of racial, political and social difference. Temperance members initially excluded African American and Native peoples; Irish Orangemen, in an effort to counter their potential influence on a political level as increased immigration took place; and women were excluded because speaking about drinking and drunkenness was thought to be unladylike in the early 1800s (Smart and Ogborne 1996). Over time, as the movement grew, many of these exclusions were lifted. Women were eventually admitted as visitors and over time developed “an active, even dominant, role in the temperance movement, chiefly through their own organizations such as the Women’s Christian Temperance Union (WCTU)²” (Smart and Ogborne 1996, 18). While the WCTU placed emphasis on woman’s suffrage and getting the vote for women in Canada

² WCTU was founded in 1874 in Chatauqua, NY. By the end of the year meetings were also taking place in Ontario, Canada (Picton, Owen Sound) and by 1885 WCTU chapters existed in all Canadian provinces (Smart and Ogborne 1996).

it also saw drinking as a social problem that led to increased poverty, family breakdown, infidelity, and hardship for women and children (Cook 1995). As such, the organization was at “the forefront of defining the nature of drink and the possible solutions” (Smart and Ogborne 1996, 26). Members focused on eliminating drinking in Canada using numerous strategies, including the reduction of taverns, the teaching of temperance in public schools, and eventually prohibition (see, for example, Sheehan 1984).

Over time, some members of temperance societies began to dispute whether all alcoholic beverages should be banned (Smart and Ogborne 1996). This early opposition came from several sources including church groups who favoured moderation over abstinence (e.g., Anglicans); and the upper classes (Smart and Ogborne 1996). However, the leaders of the movement (especially Methodists), continued to insist on complete abstinence. As Heron (2003, 55) argues, the temperance forces were convinced that alcohol: “released destructive impulses that would normally be kept under control, impulses that prompted the drinker to commit immoral and anti-social acts. Drunks became paupers, criminals, and threats to the well-being of their families”. Their strong stance on eliminating all drinking ultimately cost the support of more moderate members (including some of the more wealthy supporters). Despite these setbacks, the pressure to abstain from all alcohol did yield significant results. By 1855,

between one quarter and one third of the population had committed to abstain from drinking entirely (Heron 2003).

At the beginning of the 20th century the temperance movement was still strong; however it experienced obvious decline after the World War I, and the decline accelerated after Prohibition disappeared (Smart and Ogborne 1996). There was a changing social climate amongst members at this time, which resulted in declining participation. Members began to feel that there was less purpose in the movement and developed a decreasing sense of control, which caused them to question their support (Smart and Ogborne 1996). This stemmed largely from their efforts to achieve Prohibition countrywide, which was successful in all provinces except Quebec, however did not last very long before it was voted out (Smart and Ogborne 1996). This was disheartening since its major goal was to obtain and uphold this legislation (Smart and Ogborne 1996).

By the 1920s government monopoly systems had largely replaced Prohibition in Canada, and who could drink, what they could drink, and under what circumstances they could drink was redefined by the State (Smart and Ogborne 1996). 'Moderate' consumption became much more socially acceptable than it had been over the previous century during the mid to late 1920s and with the 'collapse' of Prohibition the purpose of temperance essentially disappeared. By the 1930s, at the onset of the Great Depression, Canadians developed the sense that there were other things they needed to focus their energy on instead of

temperance and/or Prohibition (Smart and Ogborne 1996). There was also a shift in the demographic makeup within Canada during this time, which also contributed to its decline. For example, there were greater numbers of Anglican and Catholics; an increase in Eastern European immigrants (most of whom were unfamiliar with Protestant ideologies and temperance); and urbanization led to a smaller proportion of rural Canadians who had provided a base of support for temperance (Smart and Ogborne 1996).

2.3.3 The Modern Alcoholism Movement

Much of our initial understanding in regards to excessive consumption and temperance derives from how it was constructed by the religious groups that initially characterized its use and informed the public about it. Reviewing the formation and existence of the temperance movement through this lens helps us to better understand “the historical roots of Alcoholics Anonymous and subsequent confessional treatments of addiction and addictive behaviour, in particular their peculiar mix of disease concept and spirituality” (Chavigny 2004, 109). While reformed drinkers had previously relied on experience-telling to encourage other drinkers to abstain from future consumption, throughout the temperance movement they began to embrace religious support as well and tied it to their approach (Chavigny 2004). Members emphasized their ability to maintain their sobriety through the enforced abstinence that they gained through the assistance

of the pledge, the sympathetic fellowship of other temperance followers, and through the grace of God (Chavigny 2004). This overshadowed efforts being made by medical professionals to categorize excessive consumption as a disease at the time, which changed when Prohibition was deemed an unsuccessful approach to controlling consumption amongst Canadians (Smart and Ogborne 1996).

The Canadian government, in partnership with the medical profession, took control over the drinking issue in the 1920s and over the next few decades readjusted how the public viewed consumption (Heron 2003). Instead of continuing to identify drinking as a threat to the public as a whole the government strived to normalize its use; thereby removing environmental controls associated with consumption and replacing them with an expectation of individual responsibility amongst certain groups of Canadians (Blocker 2006). During the three decades following Prohibition drinking amongst women, although historically and in some respects still viewed as unacceptable, increased dramatically and many began to participate in social drinking in a wide variety of settings (McClellan 2004). Notwithstanding these changes “the woman alcoholic was viewed as more deviant and disturbing than the male because of a persistent association between drinking and masculinity” and so many did not approve of their consumption (McClellan 2004, 268). In fact, many viewed drinking amongst women as a threat to conventional gender roles and a breakdown of their

femininity (McClellan 2004). Interestingly, these ongoing cultural perceptions of drinking contributed to how the Modern Alcoholism Movement unfolded when it formed in the early 1940s (White 2004).

The Modern Alcoholism Movement developed through the work of “several groups of research scientists, including the Research Council on Problems of Alcohol and the Yale Center for Alcohol Studies, along with clinicians and educational and self-help groups, such as the National Committee for Education on Alcoholism and Alcoholics Anonymous” who identified alcoholism as a disease, rather than “a vice or simple bad habit resulting from a lack of willpower” (McClellan 2004, 269). Valverde (1998) emphasizes that classifying drinking as a disease meant that one was required to consider its implications physically or mentally, and sometimes in relation to a mixture of both. She identifies as well that “the question of the will was largely abandoned” towards the end of the 19th century (Valverde 1998, 3).

This paradigm emphasized that alcohol-related problems stemmed from internal issues rather than from the substance itself, based on the aim of “support[ing] therapy rather than censor[ing] for ‘alcoholics’”, which “implicitly opened the door to moderate drinking in the population at large” (Blocker 2006, 233). No longer was there the concern that drinking would lead to addiction in all cases. Instead Canadians recognized that most people could drink socially and/or

recreationally, although for others consumption would most likely lead to alcoholism (McClellan 2004; Blocker 2006).

While the disease model of alcoholism gained momentum and social acceptance very quickly, the construction of a formal definition for alcoholism and explanations for its causes developed over time (McClellan 2004). E.M. Jellinek, a physiologist at the Yale Center for Alcohol Studies, is generally considered the modern father of the disease model of alcoholism, because of his work defining the concept (White 2004; McClellan 2004). He defined alcoholism “as a chronic, progressive disease with distinct stages” (McClellan 2004, 270). Key to his explanation was emphasis on the fact that there are many different types of alcoholics and that only those who have the disease suffer from a ‘loss of control’ and therefore possessed a true addiction (Valverde 1998; Wilton and DeVerteuil 2006).

Unfortunately constructions of this definition and work geared towards developing a better understanding of the disease focused entirely on the experiences of men. For, example, while Jellinek was successful in developing a better understanding of male drinking patterns and its impact on their ability to function at work and/or in regular social situations, his work does not take into account the amount of alcohol his subjects were actually consuming or include female subjects in his data collection and/or reflections (McClellan 2004). While his model was progressive at the time his research emphasizes the impact that

drinking has on men and their ability to function effectively at work, connecting its relevance to how their consumption might jeopardize their ability to adequately provide for their families (McClellan 2004).

Social discomfort with female drinking, based on its characterization as a predominantly masculine activity, was likely part of the reason for female exclusion in Jellinek's work and his construction of the disease concept of alcoholism, and has "shaped views of female alcoholics in a variety of ways" (McClellan 2004, 268). For instance, in early years, "the distinction between the "normal" social drinker and the pathological drinker, a central element of the modern definition of alcoholism, was more difficult to draw in the case of women, for whom anything more than an occasional cocktail might be considered suspect" (McClennan 2004, 268). By drinking excessively female alcoholics were thought to be challenging the longstanding stereotypes attached to their gender role (i.e. their continued lack of involvement in male work and social environments, and their responsibility towards all domestic necessities of the home) and as such were automatically considered more pathological than men displaying similar behaviours (McClellan 2004). These early assumptions, when defining the nature of the alcoholic, have had extremely negative impacts on women who experiences problems in relation to their consumption of alcohol (and other drugs). For instance, failure to understand the treatment needs of women has largely resulted from early addiction studies, whereby physicians and

scientists largely “interpreted women’s drinking primarily as a *gender* transgression” resulting in a lack of knowledge with regards to the various ways that class, race and ethnicity contribute to and/or affect their drinking patterns (McClellan 2004, 278). These early opinions also informed the development of Alcoholic Anonymous, which constructed its understanding of recovery largely through male experience. As I show below, the popularity of Alcoholics Anonymous has strongly influenced contemporary treatment approaches/options.

2.3.4 Alcoholics Anonymous and treatment for addictions

Once Prohibition was lifted and alcohol became more socially acceptable and commonly consumed amongst Canadians they were faced with new challenges. Rather than having legislation which controlled public consumption the public was free to drink however much they liked. For many this meant a return to moderate drinking and for others it meant excessive indulgence. Because no workable clinical definition was offered by Jellinek problem drinking and ‘normal’ drinking were often culturally defined (Wilton and DeVerteuil 2006). As well, very few treatment programs existed at the time though and so drunkards were often left to their own devices, which for the most severe alcoholics meant the occasional jail sentence (Heron 2003). “[H]ospitals generally refused to deal with drunks” and in most cases so did general practitioners, despite that it had been labeled as a disease (Heron, 2003, 352).

“E]xcessive drinking was [still] generally regarded as a symptom of moral weakness rather than a condition requiring state supported treatment” at the end of the 19th century (Smart and Ogborne 1996, 195). As a result, even private treatment sanatoriums that accepted alcoholism as a disease still focused their energy on helping alcoholics deal with their withdrawal symptoms and avoid relapse (Smart and Ogborne 1996). There were a limited number of these private sanatoriums and they catered only to certain social classes, and so many heavy drinkers seeking sobriety continued to seek out alternative recovery options (Smart and Ogborne 1996).

Alcoholics Anonymous (AA) formed in 1935 through the efforts of two men who were seeking to find an incentive to put their own serious drinking problems to an end (Blocker 2006; Heron 2003; Smart and Ogborne 1996). Bill Wilson, a New York stockbroker, and Robert Smith, an Akron medical doctor, formed Alcoholics Anonymous by first attending non-denominational, evangelical meetings that promoted spiritual revival (Heron 2003). Over time they began to recruit other alcoholics to join the meetings and then eventually branched off to form their own group, because they recognized the increased benefit of only meeting with other alcoholics, but also maintained the spiritual element present in their former group (Heron 2003).

In Canada the first AA group was launched in Downtown Toronto in January 1943 through the United Church of Canada (Heron 2003). Since that

time it has been widely adopted by a large number of Canadians. Wilton and DeVerteuil (2006, 653) encourage us to recognize that while its continued adoption of the disease concept of alcoholism “might be seen as contributing to a medicalization of problem drinking... the organization also mounts a fundamental challenge to the medical authority, arguing that only an alcoholic is able to diagnose and treat alcoholism”. It also counteracts medical emphasis on curing individual addictive behaviour by emphasizing that alcoholics cannot be ‘cured’ and will remain alcoholics even through their sobriety, because they will still be battling compulsions (Wilton and DeVerteuil 2006).

During the 1940s and 1950s the lobbying efforts of AA members “profoundly shaped the recovery landscape” as they rapidly diffused and encouraged the establishment of new treatment options for alcoholism (Wilton and DeVerteuil 2006, 653; Smart and Ogborne 1996; Heron 2003). As a result, many new approaches to recovery were developed during this time, especially when people began to recognize that alcoholism results not just from excessive drinking, but also individual susceptibility (Smart and Ogborne 1996). This recognition caused a shift which supported the collective efforts of some physicians and community leaders, and AA members to lobby the Canadian government for funding to support programs geared towards the education and treatment for addictions (Smart and Ogborne 1996). These early programs varied in terms of their specific approaches to recovery, however were similar on the

basis that they followed the 12-Step model of AA and were mostly run by recovering alcoholics (Wilton and DeVerteuil 2006). The 12 Steps of the AA fellowship are presented in Appendix 1.

Valverde (1998, 11) points out that despite its position on the lack of a cure for alcoholism “an overwhelming majority of North Americans consider AA to be a more appropriate referral for drinking problems than any medical institution”. Interestingly this has resulted in the 12-steps of Alcoholic Anonymous also being adopted by a number of medical institutions despite that the program lacks any form of medical accreditation. Valverde (1998, 19) explains that “[w]hether or not it works to cure alcoholism, AA has certainly succeeded in developing a whole array of non-professionalized, low-cultural capital techniques for action on oneself that have profoundly shaped our present”. Not only does AA encourage people to define themselves based on their addiction to alcohol, but it also requires them to take accountability in relation to the choices that they make in their daily lives, which have the potential to impact their recovery.

Over time, this perspective led to a second wave of residential social model programs that began to take into consideration whether certain physical and social arrangements were either conducive to recovery and abstinence, or not. While slightly removed from the AA model, in the late 1970s and early 1980s these programs attempted to establish ideal recovery environments by taking into

account both the internal and external space on site and the community environment surrounding their programs, so that clients would have a greater opportunity for success (Wilton and DeVerteuil 2006). While they vary in terms of their specific approaches to treatment, these programs constitute the majority of treatment options available to people who find that AA membership alone does not provide a basis for recovery from addiction. In addition, the AA/12 Step approach to addiction has spawned a variety of fellowships dealing with other drugs and addictions. The two best known of these are Narcotics Anonymous (est. 1953) and Cocaine Anonymous (est. 1982). Again, the popularity of these approaches has made them a central part of drug addiction treatment in North America (Valverde 1998). During the 1970s and 1980s, treatment programs that had originally been established for alcohol problems expanded their mandate to include other drugs such as heroin and cocaine (Wilton and DeVerteuil 2006)

Since the 1980s addiction services have been expanded through federal and provincial initiatives to improve accommodation for specific populations (especially native people, women, youth and those in the correctional system). The Canadian government is however also quite conscious about controlling its health and social service expenditures, and so has also focused attention on: “increasing emphasis on non-medical, community-based services and the need for early intervention” (Smart and Ogborne 1996, 199).

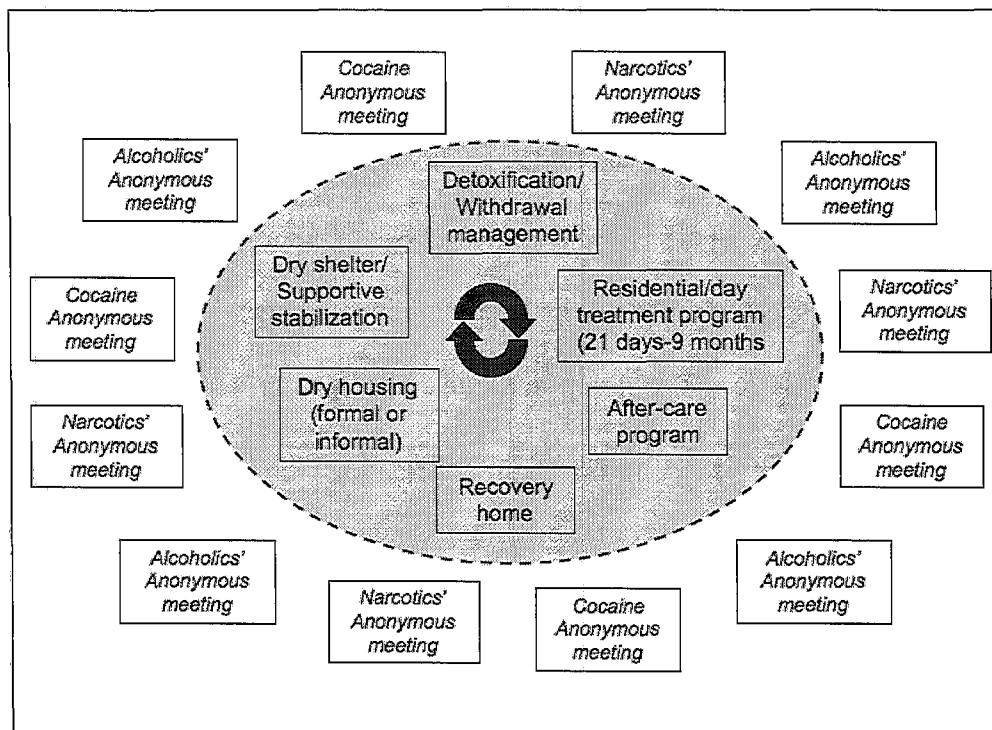
2.3.5 Contemporary Treatment in the Canadian Context

Treatment for drug/alcohol addiction is found in variety of settings that accommodate clients through both non-residential and residential programming. Smart and Ogborne (1996, 206) suggest that many programs can be understood as “broad spectrum”, in the sense that:

A typical broad spectrum program would routinely provide alcohol education, relaxation therapy, assertiveness training, leisure counselling, and group and individual therapy and referral to Alcoholics Anonymous. Many programs also provide nutritional counselling that aims to help clients to develop healthy eating habits. Residential programs also sometimes have daily exercise programs based on the “healthy body/healthy mind” principle”

Rush and Ogborne (1992) emphasize however that unlike traditional alcohol treatment programs, many addiction treatment programs now serve multiple forms of addiction within the same facility. This has resulted from the correlation between drug and alcohol use amongst alcoholics. For instance, some alcoholics medicate with drugs, others are drug users who drink only when their drug of choice isn’t available, and still others are poly-drug users, who use a variety of drugs in combination with their drinking with some knowledge of how they interact with one another (Smart and Ogborne 1996). This has changed the nature of these facilities and has contributed to a shift in respect to how addiction is understood (Smart and Ogborne 1996).

As was noted earlier, Canadian addiction treatment programs quite often exist in the form of non-medical, community-based services rather than through hospital-based medical services. This reflects not only an interest in implementing the most cost effective strategies possible, but also a growing appreciation with respect to the ways that addiction is influenced by social context (Smart and Ogborne 1996). The structure of the contemporary treatment system is represented in figure 2.3. This diagram is a simplification by necessity and does not account for geographic variation in service, but it does give some sense of the basic structure. The centre of the diagram represents the formal treatment system. Someone seeking treatment might enter the system through an initial stay in withdrawal management, and then seek a period of residential treatment at a formal service provider. He or she may then attend an aftercare program, with weekly meetings. They may also elect to move into shared accommodation with other recovering addicts, since this provides a 'dry' living environment. At the same time, given the influence of the 12-Step fellowships, they are likely also attending AA/CA/NA meetings during their time in formal treatment.



**Figure 2.3: The structure of the contemporary treatment system
(from Wilton and DeVerteuil, 2007)**

2.3.6 Women and Addiction

In addition to geographic variation, the diagram in Figure 2.3 does not address differences between women and men's access to treatment. Westermeyer and Boedicker (2000) have suggested that there are many similarities between men and women, and their substance abuse. These include; their demographic characteristics, their use patterns of legal substances (i.e. alcohol, caffeine, inhalants, tobacco), and the length of time spent abstinent in between their illegal drug use. Their research also supports previous findings (Brown et al. 1995;

Blume 1986; Beckman 1981) that show that while rates of familial substance abuse is similar amongst men and women that, if married, women are “more apt to have a spouse with substance abuse compared to men” (Westermeyer and Boedicker 2000, 526). Westermeyer and Boedicker (2000) have also established that women, while showing similar rates of self help activities and use of treatment modalities, differ from men in that they have fewer admissions into treatment and fewer total days in all types of treatment. While their research is based on American data, their results are similar to other studies (Mondanaro 1989; Weisner and Schmidt 1992; Hodgins et al. 1997; Swift and Copeland 1998) that identify women as being less likely than men to enter substance abuse treatment and more likely to approach a health care professional (Westermeyer and Boedicker 2000). This will be discussed in more detail below when I outline the barriers that women experience when considering their treatment options.

The work of Westermeyer and Boedicker (2000) is also important in that it emphasizes important differences between men and women in relation to substance abuse. Of specific relevance, according to Westermeyer and Boedicker (2000), is the fact that while women start using later in life they become addicted more quickly and severely than men, and their use has a greater impact on their health far sooner. Ashley et al. (2003) have identified as well that women differ from men with regards to their substance abuse in that it is often initiated as a result of a traumatic life experience or through the substance abuse of a partner.

They are also “more likely than men to have poor self-concepts (low self-esteem, guilt, self-blame) and high rates of mental health problems, such as depression, anxiety, bipolar affective disorder, suicidal ideation, psychosexual disorders, eating disorders, and posttraumatic stress disorder” (Ashley et al. 2003, 21).

Women are also more vulnerable to HIV infection through drug use since they “are more likely than men to inject drugs, use drugs with many partners, share paraphernalia after an injection partner, exchange sex for money or drugs, and have difficulty negotiating condom use with their sex partners” (Ashley et al. 2003, 22).

Interestingly, although women constitute a diverse population, studies indicate that service providers attempt to form homogeneous groups of women for treatment (i.e. through similarities in their symptoms, crisis experience, and/or demography) with the belief that it speeds their ability to trust and relate to one another (Hodgins et al. 1997). Rutan and Stone (1984, 97-98) explain that this is based on “[t]he fact that individuals begin with the knowledge that in some fundamental ways they are similar to others hasten the initial, trustbuilding stage” and improves the overall group dynamic (in Hodgins et al., 1997). Group construction helps to further support the one similarity that exists amongst all clients – their struggle with addiction - regardless of differences in regards to the demographic characteristics they possess and/or other life experiences that they have had. In Ontario and other jurisdictions, assessment/referral systems have

been established, partly to match women and men with appropriate resources in the community (Ogborne and Rush, 1990 in Smart and Ogborne 1996, 213).

However, there is a problem here in that the ideal of trying to match women to the most appropriate services is constrained by the limited number of programs available to women.

Other research has also noted differences in women and men's experiences of addiction treatment. Ellis et al. (2004, 214), for example, argue that supportive social relationships may be more important to the recovery of women than to men's recovery "[since] female substance abusers may be more vulnerable to family dysfunction, depression, and feelings of shame and guilt over their addiction". For this reason, it is important that women feel supported in their social lives, whether through peer relationships in the treatment setting or through relationships with friends and family outside of treatment. These supports, whether real or perceived, have the potential to improve the psychological well-being of women, by creating a defence against relapse (Ellis et al. 2004). The search for supportive relationships might also lead some women to seek out single gender programs rather than mixed-gender programs (Niv and Hser 2007).

2.3.7 Barriers to Treatment for Women

There is good evidence that women face more barriers when seeking out treatment than men do (Addiction Research Foundation 1996). Swift and Copeland (1998), for example, surveyed staff and female clients at treatment programs, identifying a wide variety of constraints including lack of knowledge about resources, fear, childcare and time constraints, transportation problems, and poor previous experience in treatment. The Addiction Research Foundation (1996) has suggested that barriers can be organized into two categories: structurally imposed barriers present either in the woman's social environment or characteristic of the treatment program environment; or psychosocial barriers related to how women's sense of how seeking treatment will impact her life and the current relationships that she has. Because there are fewer programs available to women over men in Canada structurally imposed barriers that exist can have a much greater impact on the access that women have to treatment. These take the form of access for people with disabilities, the availability of child care facilities on site, location of the program in relation to one's home environment and/or access to transportation services, and whether withdrawal management is offered on-site for those who need a structured detoxification period rather than doing it on their own, for example (Addiction Research Foundation 1996; Ashley et al. 2003).

Psychosocial issues also impact women differently than men in some cases. One major barrier for women is that they often receive less support from family and friends even when making the effort to go to treatment. Quite often women hide their use from their family to the maximum degree that is possible, and even when family members find evidence of their use they quite often deny that the behaviour is reflective of an addiction (Cook et al. 2005). As a result, in many cases women avoid seeking help until they are in a crisis situation (Addiction Research Foundation 1996). Even in these instances however women are still more likely to approach generalist health care providers (i.e. their family doctor) and as a result are less likely to recognize their problems than if they sought help through addiction treatment facilities (Mondanaro 1989; Weisner and Schmidt 1992; Swift and Copeland 1998; Hodgins et al. 1997; Westermeyer and Boedicker 2000). In this respect social stigma, labelling and guilt act as sizeable obstacles for women seeking to potentially access substance abuse treatment (Ashley et al. 2003)

Other psychosocial issues exist for women though as well. For example women are also more susceptible to financial barriers, since they are more likely to “have part time jobs, receive less pay, and have fewer benefits and less job security” than men (Addiction Research Foundation 1996, 43). Many women then factor in affordability when deciding whether to access treatment. This is especially true of women with childcare responsibilities, who may lack access to

child care services and/or the ability to pay for them, and those who have lower education and employment levels (Ashley et al. 2003). In some cases, women who are older or younger might also be concerned that their age-specific issues (i.e. hearing or sight impairments in older clients) will not be addressed properly in treatment. There are still others as well that struggle with the availability of programming that is culturally-sensitive and can overcome their language barriers, since many women who do not speak fluent English will have difficulty explaining their problem (Addiction Research Foundation 1996). Women might also experience insensitivity through referral networks, which should be connecting them to women sensitive programming when requested, since these are not always available (Hodgins et al. 1997). Gender, and the availability of appropriate dedicated resources for women, is an important consideration since “programs that treat men and women clients together are less able to attract and retain especially vulnerable women, such as lesbian women, women with a history of physical or sexual violence, and those who have worked as prostitutes” (Ashley et al. 2003). More broadly, there has been an increased recognition in recent years that “men and women arrive at treatment with different problems and different motives for treatment”, which has the potential to impact their post-treatment outcome (Hodgins et al. 1997, 807). Women, Hodgins et al. (1997) explain, have substance abuse issues that are more socially embedded, which means that they enter treatment when they are having problems associated with

their health or their families, while men tend to seek out treatment in connection to employment issues or legal concerns. Recognizing these differences has led to greater awareness of the need for women-only treatment.

2.3.8 Women-Only Treatment

Recognition on the part of governments that women have specific treatment needs has encouraged research into gender differences in addiction/addiction treatment in recent years (Cook et al. 2005). This recognition has also encouraged the improvement of services for women, in both Canada and the United States, supplementing those existing treatment “programs that had been developed by and for middle-class white males” (Cook et al. 2005). At the same time, there have also been efforts to create approaches to treatment that recognize the specific needs of women clients. For example, the 12-Step program has been revised to create both a Feminist-informed program, and a ‘Women For Sobriety’ program (see Appendix 2). Collectively, these developments constitute a shift in the right direction, but Swift and Copeland (1998) argue that there were some major challenges associated with the initial delivery of women-only programming. They explain that early efforts to provide women-only programs were faced with gaps in service delivery, such as; a lack of availability of female counsellors and staff who possessed specialized knowledge of women’s needs, and gender specific barriers to treatment that were not given proper consideration

(i.e. the availability of on-site child-care, stigma attached to the female addict restricting their ability/choice to access treatment).

Typically men have been more likely than women to access treatment regardless of the format that it is being offered (hospital-based, residential, outpatient), which often produces treatment environment's that are highly male-dominated and geared more towards their cultural ideals (Reed 1985; Saunders et al. 1993; Hodgins et al. 1997). According to Hodgins et al (2007) this is part of the reason why single-gendered treatment programming for women is so strongly advocated for. Smart and Ogborne (1996, 207) explain that "[m]any women with alcohol problems have been abused by drunken males and may thus be reluctant to discuss their problems in male-dominated settings", therefore without providing a women-only treatment alternative these women might shy away from considering a formal treatment option when striving for their sobriety. Further, Hodgins et al (1997) explain that without single-gender programming women are often limited to entering programs that have been developed to best meet the needs of male users, because men represent the largest proportion of their clientele.

In recent years, there have been more women seeking help through the treatment system. This is partially due to "[c]hanging attitudes to treatment and efforts to involve people in treatment before they become severely alcohol dependent" (Smart and Ogborne 1996, 202). However, the provision of women-

only treatment programs has also contributed to this shift, since women's needs are better met in these environments (Smart and Ogborne, 1996; Hodgins et al. 1997). The Addiction Research Foundation (1996, 47) identifies that women-oriented treatment programs can be distinguished by a number of characteristics.

Typically, they:

- *offer a broad range of services (e.g., family and children's services, health services) in-house or in coordination with other programs*
- *take a holistic approach to a woman's treatment and recovery*
- *make the physical and emotional environment as comfortable and safe as possible (e.g. furniture, culture of the program, interactions between clients and staff)*
- *have women on staff as counsellors and in leadership positions*
- *have sexual harassment policies*
- *recognize that women's issues around substance use are different from men's*
- *recognize that women's treatment needs are different from men's*
- *recognize that women's treatment needs are not all the same*
- *educate women about substance use and its effects on their bodies, relationships, and coping skills*
- *understand the importance of relationships in women's lives*
- *empower women (e.g., increase self-esteem, develop coping skills, offer job training)*
- *stress wellness and ways that women can nurture themselves*
- *work together with women to plan goals for change*
- *offer women-only groups*
- *are sensitive to all women regardless of sexual orientation, culture, race, age, socioeconomic status, etc.*

These changes to better meet the needs of female substance abusers have led to a wide array of benefits connected to their perception of addiction treatment and its potential as a therapeutic approach to their recovery process, as well as a small number of perceived disadvantages.

Swift and Copeland (1998) identified five major benefits connected to women-only treatment programs that have evolved since their implementation. These include; (1) greater potential for physical and emotional safety and trust, (2) greater opportunity to develop honesty and openness amongst female clients, (3) increased support gained amongst women since they identify better with one another, (4) increased provision made for necessary child-care, and (5) potential for improved treatment outcome. These findings are supported by earlier work (Houston, 1986; Sirkin et al., 1988; Butler and Wintram 1991), which emphasize that there are certain issues that women feel more comfortable discussing together, rather than with men, which contributes to their ability to be open and honest with each other. These include discussions over elements such as; how their bodies work and alcohol affects them, eating issues that plague them, violence that has been inflicted on them, issues related to their reproductive systems (pregnancy, PMS, menopause), feelings associated with their qualities as a parent, and aspects of their sexuality and how it plays out while they are drinking and/or using drugs (Addiction Research Foundation 1996). It is also easier to eliminate sexist language, provide one another with physical and emotional support, improve self esteem as women role model for one another, develop greater assertiveness, and focus on oneself rather than trying to take care of or please men in the group (Addiction Research Foundation 1996).

Interestingly, some authors have suggested that the absence of men negatively impacts a program's ability to create a 'realistic' social environment in which to learn coping skills (Swift and Copeland 1998). Hodgins et al. (1997) have suggested that female clients' wholly positive views of women-only programming might come in part from their dissatisfaction with other earlier treatment programs, or because they have been unwilling or unable to enter alternative programming. The authors suggest that more research is needed to explore the nature of single-gender treatment environments. Other works suggests that women with fewer resources and with histories of being sexually abused do benefit greatly from women-only programs and use them more readily than mixed-gender programming (Niv and Hser 2007).

Work on women's access to, and experiences of, addiction treatment has been ongoing for two decades, but there is still work to be done to more effectively understand the gender specific needs of women in relation to addiction treatment. For example, one major criticism that has emerged is that "investigators [have] generally fail[ed] to view women as important subjects for study separate from their reproductive functions" (Hughes 1990, 37 in Cook et al., 2005). This is a criticism that is still current, since much research continues to focus on addiction treatment for pregnant women (e.g., Moylan et al. 2001; Hohman et al. 2003; Burgdorf et al. 2004a; Porowski et al. 2004) and women with children (e.g., Marsh et al. 2000; Green et al. 2007). While it is true that

addressing the childcare and pregnancy needs of women may be critical for program retention (see Chen et al. 2000), there are a number of other questions about the diverse characteristics and needs of women seeking treatment that can be asked. For example, in this thesis I am interested in understanding how treatment spaces can be modified to better meet the therapeutic needs of women, with potential implications for retention rates and recovery. As DeVerteuil et al. (2007) emphasize, there has been little written on the connection between the operation of treatment facilities and the built/social environments that they occupy. At the same time, existing research (see, for example, Timko 1996; Grosenick and Hatmaker 2000) does indicate that aspects of the environment (e.g., architectural style; neighbourhood amenities) may have some bearing on a program's operation. Similarly, while existing research has pointed to the importance of women-only social environments for treatment, there has been no exploration of the ways in which the organization of the *spatial* environment may relate to, and impact, the *social* dynamic of women-only programs.

The therapeutic landscape concept can provide a useful way of beginning to answer some of these questions about the environment of addiction treatment. In addition, the connection to therapeutic landscape research helps to address the absence of work by health geographers on the nature of addiction treatment (Wilton and DeVerteuil 2006). Significantly, this absence exists despite the fact that Gesler used alcoholism and addiction recovery as one example of the

potential significance of sense of place to health and healing. Drawing on earlier work by Godkin (1980), he suggested that because familiar places represent failure, threats, or feelings of not being wanted:

...therapy for alcoholics might usefully include establishment of refuges, places with positive images where identity could be established (Gesler 1992, 738).

In my analysis, I attempt to show exactly how these types of places operate and provide an understanding of how women dealing with addictions experience these 'refuges'.

CHAPTER 3

METHODOLOGY

3.1 INTRODUCTION AND OBJECTIVES

As was suggested in the previous chapter, therapeutic landscapes in general vary widely across space with regards to their structure and function, as well as both their internal and external characteristics, and physical location. Similarly, if we think of addiction programs as one kind of therapeutic landscape or environment, they also provide treatment to a wide variety of clients with various substance abuse issues in a number of different geographical settings. With the exception of private fee-for-service organizations, programs typically operate with limited resources and so may be constrained in terms of the locations and treatment environments they are able to occupy or construct. Understanding treatment programs as therapeutic settings requires one to be open to the diversity of these distinctive places, while also attentive to potential similarities between them.

My objective in this thesis is to (1) examine women-only substance abuse treatment programs as “therapeutic landscapes” and to (2) consider what factors influence their capacity to act as healing sites. My research is part of a larger study that examines the strategies and spaces used by addiction treatment programs to assist clients in recovery from drinking and/or drug using. While the

larger project is concerned with a diverse group of facilities (in terms of geographic location, treatment philosophy, length of stay, etc), my thesis research is concerned with a detailed analysis of two women-only programs. As was suggested earlier, therapeutic landscape literature has been criticized for lack of attention to gender and the experiences of women as distinct from men. The focus on these programs in the thesis provides one opportunity to respond to this criticism.

My research design follows the lead of other health geographers, who recognize the importance of using qualitative research methods when attempting to identify a particular location as a “therapeutic landscape”. The preference for qualitative methods comes from recognition that understanding therapeutic landscapes requires an appreciation for the perception, experience and uniqueness of individual places. As such, studies have primarily been approached using intensive, qualitative or mixed methodologies, including small-scale surveys of agencies (Kearns & Collins 2000), interviews with key informants (Kearns & Collins 2000; Williams 2002), detailed visits of single sites (Madge 1998; Pinfold 2000), in-depth, unstructured interviews with small samples (Weinberg & Koegel 1995; Pinfold 2000; Wilson 2003), and the observation of specific facilities over long periods of time (Weinberg & Koegel 1995).

3.2 RESEARCH CONTEXT

To gain insight on the characteristics of women-only addiction treatment programs as therapeutic landscapes I selected two facilities as study sites. The selection of two sites allowed for a comparative analysis, exploring differences and similarities between the sites. These sites were selected from a larger sample of programs involved in the broader research project. One was located in the City of Hamilton, and another in the City of Toronto. In consultation with my thesis supervisor, these two sites were deemed suitable for the study as they exhibited some similarities but also a number of differences that would make a comparison potentially interesting. For example, the two sites varied based on location (affluent urban single family neighborhood vs. mixed income apartment dominated setting), length of stay (5 weeks vs. 10 weeks), and programmatic ‘sense of place’³ (converted single family home vs. institutional setting). In keeping with the research ethics protocol for the project, I provide discussion of the programs’ neighbourhood settings and some photographs of the treatment environments, but the names of the programs and their exact locations are withheld for confidentiality purposes.

³ Sense of Place – “the meaning, intention, felt value, and significance that individuals and groups give to places” (Pred, 1983 in Gesler, 1992, 738). It “is an interactive relationship between daily experience of a (local) place and perceptions of one’s place-in-the-world. This conceptualization sees place as simultaneously center of living meaning and social position. Place involves an interactive link between social status and material conditions and can be used to interpret a range of situated health effects that imply a link between mind, body, and society (Kearns and Gesler, 1998, 6).

3.2.1 Program “B”



Program B is a multi-purpose, women-only substance abuse treatment facility. The program is provincially funded through a regional healthcare provider and is the only service provider in Hamilton offering withdrawal management and residential addiction treatment services to women. The current program exists as an amalgamation of two formerly separate programs (a woman’s detox and a woman’s only residential treatment facility) that were sited in two separate locations. This amalgamation took place in response to a suggestion by the Ministry of Health for consolidation and has benefited both

programs, since they were both previously confronting financial difficulties and the risk of closure. The amalgamation of the two programs occurred in November 2004. Significantly, the residential treatment program had been located in a lower-income neighbourhood nearer the downtown core and the director commented on the challenges that this location had presented to the daily operation of the program (i.e. drug dealers, observation of drug use, prostitution).

Program B's primary function is the operation of a five week addiction treatment program that can be completed by women as residential clients or day clients depending on their personal living situation and the severity of their addiction(s). Like many women-only programs Program B strives to be as client-centered or woman- centered as possible, incorporating elements of multiple approaches to addiction recovery (see Figure 3.2). These typically include cognitive-behavioural therapy focused on lifestyle change, as well as elements of a bio-psychosocial approach that recognizes the specific challenges that confront women. Programs vary in terms of the extent to which they embrace harm reduction, and there can be a tension between the abstinence requirement of residential programs and the principles of harm reduction philosophy.

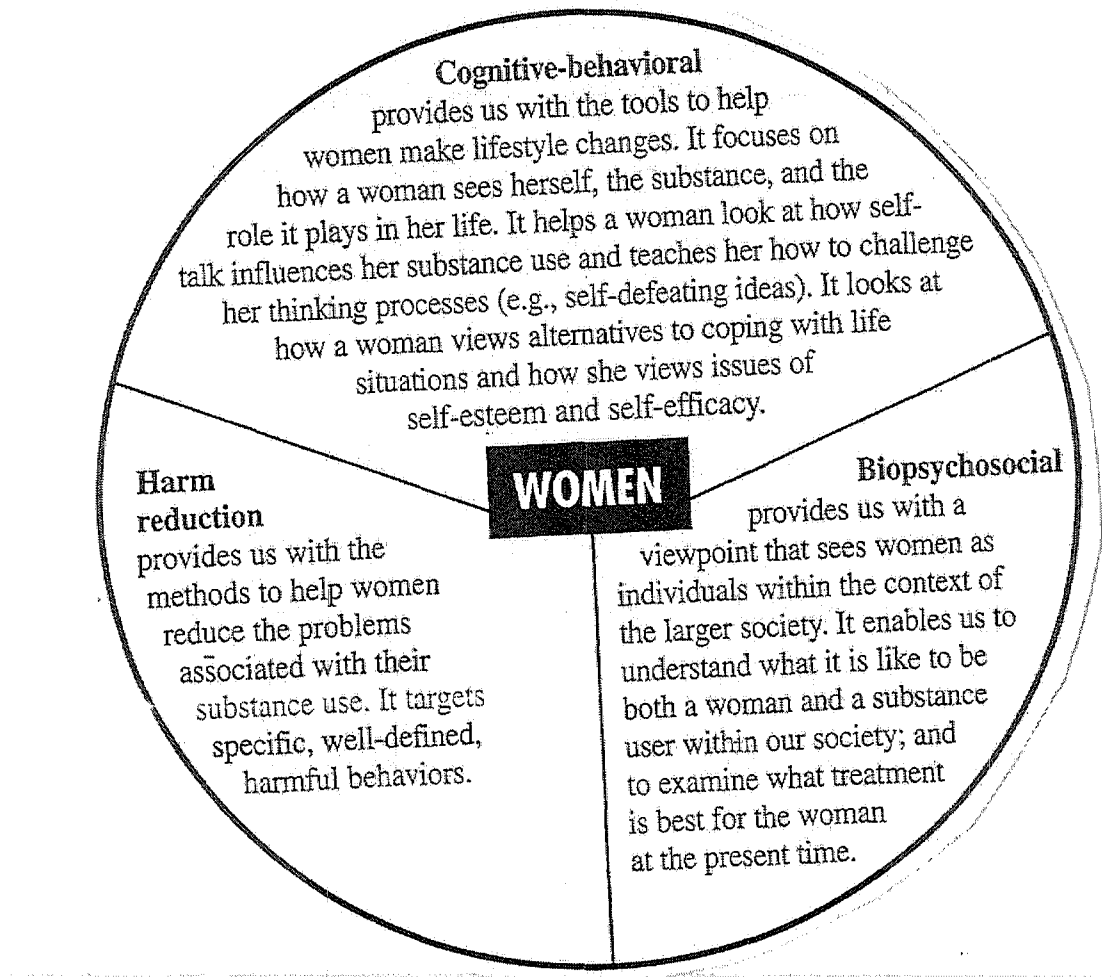


Figure 3.2: Characteristics of Women-centered Substance Abuse Treatment Programs

Based on the physical capacity of the building the program is able to accommodate eight residential and four day treatment clients per treatment cycle. Because the program operates on a fixed intake system, clients start and finish the program together, without newer clients continuously being introduced and added to the program. This is different from most treatment centers within the province

where new clients are continuously accepted into the program, in some cases even daily, in an effort to maximize the affect of available program funding. Both the staff and the director at Program B considered this difference to be one of its greatest strengths, since it allows the women to get to know each other, build trust in one another, and to go through the program as a group, supporting one another along the way.

Program B currently services clients within a large, relatively modern building that was formerly used as a residential centre for children with developmental disabilities, but was retrofitted by Program B to create a custom-designed, semi institutional setting capable of meeting its many needs. The two-storey building has been re-organized primarily in an effort to provide as many services as possible in the same location. The main floor has been retrofitted to accommodate out-patient treatment programming. These services include Withdrawal Management (formerly recognized in many programs as detox), New Choices (a program that has been specifically designed to meet the needs of women with children), Taking Steps (a pre-treatment program for women who are considering treatment or who are looking for harm reduction strategies, without necessarily committing fully to abstinence in their recovery), and After-care (a two year program for women who have completed a formal treatment program). The center also facilitates the operation of a number of AA, CA and NA meetings

in the evenings, which are open to the public and that residential clients are required to attend.

The withdrawal management (previously known as detoxification or 'detox') program is a ten-bed unit that offers space to women who are dealing with an unsafe living situation that they feel they need to remove themselves from, who are concerned about relapse and need a space which will prevent them from any negative choices that they are considering, are on a waiting list to enter a treatment program but are currently without housing, or have completed a residential treatment program, but who were unable to secure adequate housing prior to completion of their program.

Geographically, Program B is located in West Hamilton, just below the escarpment in a mixed-income neighbourhood with a mixture of high rise apartment buildings (which are presumably rental properties), small shops and single family homes. The property provides space for staff and visitor parking; a rock garden (which clients contribute to from time to time by spelling out words of encouragement, or by placing rocks in it which they have painted in program); a covered smoking area with space for a number of women to sit; and a fenced off green space for client use. The property is backed by a large cemetery. It is also well situated for use of public transportation with a bus stop right in front of the site, as well as across the street.

3.2.2 Program “A”



Program A is a residential treatment facility that has been offering programming to women struggling with substance abuse, since 1955. In its early years it provided clients with a longer term stay of up to one year in a “recovery home” environment. It was not until November 1964 that it moved into its current location and the program evolved into the more structured women-only addiction treatment program that it is today. The Executive Director explained that this occurred in response to advancements in Canadian understandings of addictions.

The current Program A site was originally donated to the Canadian National Institute of the Blind (CNIB) and was used for the rehabilitation of members of the military injured during WWII. It was subsequently used for the

training of blind teachers. The CNIB sold it to the organization that operates the addiction treatment program in the early 1960s, and it has operated as treatment program for women with addictions since the late 1960s. Unlike Program B, the site of Program A has undergone very few physical changes, despite its changing function over time. An addition was added to the rear of the building to provide a larger dining area of clients, however otherwise has been left in its original form. It has been painted inside and out, and landscaped to improve/maintain its physical appearance. The facility has been challenged by its original design for many years and plans are in place to completely remodel the entire internal design of the building in the very near future, although the program is unclear as to when exactly that will be. It will however be continuously challenged by its external treatment space, since the site exists on a corner lot on a very small plot of land.

The program is located in an affluent residential neighbourhood in central Toronto. The housing stock of the neighbourhood is primarily large single family houses, some of which have been converted to apartments. On the periphery of the neighbourhood, there are a number of large multi-story apartment buildings. The program is very close to subway and streetcar lines, making it easily accessible to women. The fact that it is an attractive old Victorian home in an affluent residential neighbourhood is cited by the director as a major advantage since it provides women with a safe and pleasant environment.

Clients can begin treatment at Program A at any time they wish provided that there is not currently a waiting list. There was not a waiting list during the time of my observations, since they took place during summer months when, according to the program director, treatment is not as actively sought out. Apart from this however the program accepts women immediately once they have completed the initial assessment stage and have completed a 72 hour 'dry' period, either on their own or through a Withdrawal Management program. It is able to have this flexibility because it operates on a ten week, continuous intake cycle. The site does not offer Withdrawal Management services however, so clients must be referred to the program or contact the site themselves to verify available space and determine their eligibility for admittance. There are no costs involved for the client, since the program is funded through a non-profit organization and supported by the provincial government.

Like Program B, Program A also operates as a client/woman-centered program (see Figure 3.2), which draws in part on the 12-steps of Alcoholics Anonymous but also adopts a holistic perspective to treatment for women. Its slogan is 'Reclaim you Body, Retrain your Mind, Revive your Spirit'. Clients are therefore encouraged to attend CA, NA, and AA meetings out in the community in the evenings (during their free time) when formal programming is not being offered. These meetings are also offered on-site on a weekly basis within the structured program time, so clients are required to attend. Former clients who are

participating in the after-care program are also encouraged to attend these. In an attempt to offer holistic programming clients also participate in relapse prevention sessions, learn skills to assist in healthy living, are taught the 12-step model, and are encouraged in their spiritual growth. Physical fitness, nutrition and recreation elements are also aspects of the program and further encourage clients to build skills for healthy living. Program A also offers an optional anger management program in the evenings, which is a three hour session and lead by the program facilitator at Program A.

3.3 DATA COLLECTION

Ethics clearance for the research was covered under an application submitted for the larger project. Once a decision had been made about program selection, letters of intent were sent to the directors of each site to explain the purpose of my research goals and ask for their participation in the project. The letters were followed by a phone call to address any questions the directors may have had about the project. At this point I presented each director with the opportunity to schedule an interview to speak further about my intentions. During the meeting with the director at each site I asked how I could best my conduct research. Specifically, I requested an opportunity to conduct participant observation at each site, and to have an opportunity to interview clients about their experiences in the program. While both directors were willing for the

research to proceed, data collection varied between the sites with more opportunity for observation at one than at the other.

Ideally, a qualitative approach permits researchers: “to understand lived experiences and to reflect on and interpret the understandings and shared meanings of people’s everyday social worlds and realities” (Limb and Dwyer 2002, 6). Such an approach was deemed to be most appropriate for this project since I was interested in people’s (clients, staff) understandings of addiction treatment programs as therapeutic environments. The project combined participant observation and in-depth interviews.

3.3.1 Interviews

Semi-structured, open-ended interviews provide respondents with an opportunity to speak at length in their own words about their feelings and experiences of a specific phenomenon (Bryman and Teevan 2005). In the context of this research, interviews with clients were organized around a semi-structured interview guide (see Appendix 3). The interview guide was divided into five main sections. The first consisted of introductory questions relating to how they found out about the program and how long they had been there. The second section asked them to describe their addiction history/experience, while the third section dealt with their experiences in the treatment program and surrounding neighbourhood. The fourth

section asked them about their living arrangements before and after treatment, and the final section collected some basic demographic information.

The format of interviews at the two programs was similar although the process of recruitment differed significantly. At Program A the director encouraged me to ask clients right away if they were interested in being interviewed and create a sign-up list so that I could get as many interviews as possible. At Program B the director was more hesitant about allowing client interviews. She asked that I wait until the women were further along in the treatment cycle for one-on-one interviews. As a result the number of people available for interviews was significantly reduced because several women were discharged from the program. This issue is discussed in more detail in the analysis. At Program A I had much better access to women clients and was able to interview a larger sample of the women. At both sites the directors were interviewed (see Appendix 4; format of Director Interview). In both cases, there was also an initial attempt to recruit staff members for interviews but it quickly became clear that they were too busy for interviews and it seemed more appropriate to include their perspectives in the field notes taken during observation.

In both locations clients were offered an incentive in the form of a gift card for participation. This was negotiated with program directors, and obviously influenced clients' decision to participate, albeit in different ways. At Program B

clients were not explicitly encouraged by staff to participate in interviews. Instead, as they got to know me and became increasingly comfortable with my presence on site they expressed interest in sharing their experiences. In this respect the gift card seemed like an added bonus to many of them, who were happy to share and be helpful. At Program A I was introduced to the treatment group, and staff members pointed out that I would be conducting clients interviews, with an incentive provided for participants. A sign-up list was created before I had really had a chance to even break the ice with clients. Everyone in the group signed up and this seemed to be principally because of the gift card since I was asked several times about the specifics of the gift card.

At both sites clients were read the consent statement and signed a written statement of consent. Respondents generally seemed comfortable and reasonably open about their experiences, especially once it was made clear that our conversations were confidential. One limitation arose when attempting to gain clients' perspectives. In an effort to maintain their personal safety and privacy clients have been instructed not to gossip about one another and are technically not allowed to talk about the experiences of others or mention names in conversation unless given permission by the individual in question. This meant that some women felt uncomfortable sharing stories that included others, while others chose to ignore this rule in the context of the interview.

In an effort to maintain client privacy and avoid any unnecessary distractions interviews took place one-on-one in private office spaces. At Program B all interviews were conducted in the conference room on the second floor, which is a part of the staff office space. Clients generally didn't seem to mind this; however a few would speak more quietly when it was something that they definitely didn't want others to hear, or questioned whether others could hear them or were listening. Despite proximity to the staff the space was very private. At Program A all interviews were conducted in the Chaplain's office, because it was the farthest away from both the staff office space and client meeting rooms. One problem was that the room was next to an open space that contained a phone used by clients to make private phone calls. As a result several respondents were distracted and/or asked if others could hear them, when they heard other clients talking outside the room.

3.3.2 Fieldwork

Participant observation focuses on the *immersion* of the researcher into a social setting to provide insight into people's experience of place (Kearns, 2000). Like the interviews, the nature and length of participant observation varied between sites based on the access I was able to negotiate with program directors. At Program B I was able to spend many weeks with the women and essentially participated in all aspects of the program. I was not limited in any way with

regards to the time that I spent with the women during program time, although I was not able to make observations during their free time in the early morning or into the evening, with the exception of the after-care and creative writing sessions that I attended. In most cases I sat in on group discussions as a client, without sharing my feelings or perspectives. I did this, because when I attempted to sit inside the room, but away from the conference table on my own clients expressed discomfort and were distracted whenever they noticed me taking notes. When I sat at the table they seemed comfortable with me regardless of what I was writing. However, this integration made note taking somewhat more challenging, especially when clients really expected me to come along with them all day long. I wanted to be able to observe them during their breaks when they went outside or into the communal living areas, which meant that often I would have to take quick notes and revise them later in the day.

At Program A it was slightly different. The program director seemed to want to limit my participation in the program to the time needed to complete the interviews with clients. Once interviews were completed, she seemed to anxious to have the program return to its regular routines. This meant that my observations there took place in longer stretches over a shorter time span. In general, clients seemed fine with my sitting separately in program, which I think was largely due to how I was introduced there. When they learned that I was a student their concern for me making observations on their behaviour seemed to

diminish greatly. They were quite comfortable speaking openly around me. This might be due in part to the fact that Program A has new clients continuously added to the program, so they are more comfortable with changing elements within it. Whatever the case, I had much greater opportunity to take notes as I went along, and my role here was more as a passive observer rather than an active participant, as was the case at Program B.

At both sites I stayed during meal times as well to gain insight on clients' social interactions and activities outside of the structure of the classroom. I was however not given the opportunity to spend time with them off-site, which would have enhanced my observations. Extensive field notes were taken throughout the period of participant observation, with emphasis placed on comparing and contrasting the objectives of the organizations, the daily activities of the women at both programs, interactions between staff and clients, and the experiences and opinions of individual clients and staff members at each site. I also recorded my own impressions of the two sites, and my interpretations of the daily events of staff and clients as they occurred. Where possible, photographs were also used to document elements of the program environments.

3.4. RESEARCH PARTICIPANTS

My interview sample was made up of the 2 Program Directors and 16 treatment clients. Of these women 11 were interviewed at Program A, 1 being a day client and 10 being residential clients, and 5 were interviewed at Program B, 3 of which were day clients and 2 of which were residential (reasons for this difference between the number of clients at the two sites discussed above). These women ranged in age from 22 years to 60 years old, and with the exception of one day client at Program B all were currently unemployed, on disability, or on leave from work. The two women who were on leave had been asked by their employer to do so to seek treatment as a condition of their continued employment. Of the 13 women who were currently unemployed, 3 admitted that they had lost their jobs as a result of their addictions. Only one client was on disability, although a number of women mentioned throughout the program that it was something that they were trying to get since it paid better than their unemployment or welfare currently did. Three of the five women interviewed at Program B identified themselves as alcoholics and two of these women recognized that it was the only substance that they used. On the other hand, at Program A many women recognized themselves as alcoholics, but only one woman said that it was the only substance that she used (or had ever tried in her case).

While some women seemed to not to talk about whether they had children at least half of the women did acknowledge having children. In many cases those

women with children were in treatment, because they had lost custody of their child(ren) to Children's Aid Society and/or had been threatened that they would lose them permanently if unsuccessful in their treatment efforts. Interestingly, Program B is a five week program and all clients interviewed still possess custody over their children, whereas Program A is a ten week program and only one woman still had custody over her children while many others were on the verge of losing custody of them all together. At both facilities alcohol and marijuana were used by most clients; however client drug of choice varied considerably. There were a large number of women using crack cocaine and/or alcohol and a smaller number addicted to crystal methamphetamine or prescription painkillers. As well, two women at Program A were mandated to attend treatment as an alternative to jail time.

3.5. ANALYSIS

Interviews with the directors and clients were transcribed verbatim, while all field notes were typed up for analysis. Analysis began with repeated reading of the individual transcripts to gain an understanding of the different perspectives of clients. After repeated reading, I began to develop a coding structure in consultation with my thesis supervisor. The process of coding involved both inductive and deductive thinking. Inductively, the approach used was similar to grounded theory in that an effort was made to identify a central or core category

that described the basic goals of the program environments (Bryman and Teevan 2005). At the same time, a deductive logic was used to identify, and code for, a number of factors that appeared to influence the programs' ability to meet their core goals. Part of this logic came from the structure of the interview guide. For example, sets of questions in the guide related specifically to internal and external program spaces and surrounding neighbourhood since I was specifically interested in how these characteristics influenced the operation of the programs. Once the coding structure had been drafted, interview data and field notes were coded using QSR N6 software. The coding structure is presented in Appendix 5. In the next chapter, I present the results of the analysis based on these codes.

CHAPTER 4

TREATMENT PROGRAMS AS THERAPEUTIC ENVIRONMENTS I

4.1 INTRODUCTION

A program's ability to construct itself as therapeutic for substance abuse clients is determined by both the physical environment, internally and externally (on-site and within the neighbourhood), and through the social relations that take place within it. Since clients are guests within these spaces we must evaluate how their general presence, and interactions with one another and staff members, impacts the ongoing character that these spaces possess and their ability to achieve their core objectives.

With regards to the social construction of the treatment space I will first discuss the strategies these programs use to offer and maintain a structured environment. I will then establish connections between the maintenance of structure and the implementation of discipline, and how these objectives are influenced by group dynamics (through staff/client and peer relations) and the individual characteristics of staff and clients on a socio-cultural level. Space also plays an active role in shaping everyday social life and so in the second portion of my analysis I will discuss how the internal and external physical environment, and the surrounding neighbourhood, influence client behaviours and the ability of treatment programs to function as therapeutic landscapes. The diagram below

highlights four key objectives within the treatment context and how they both influence and are influenced by external variables.

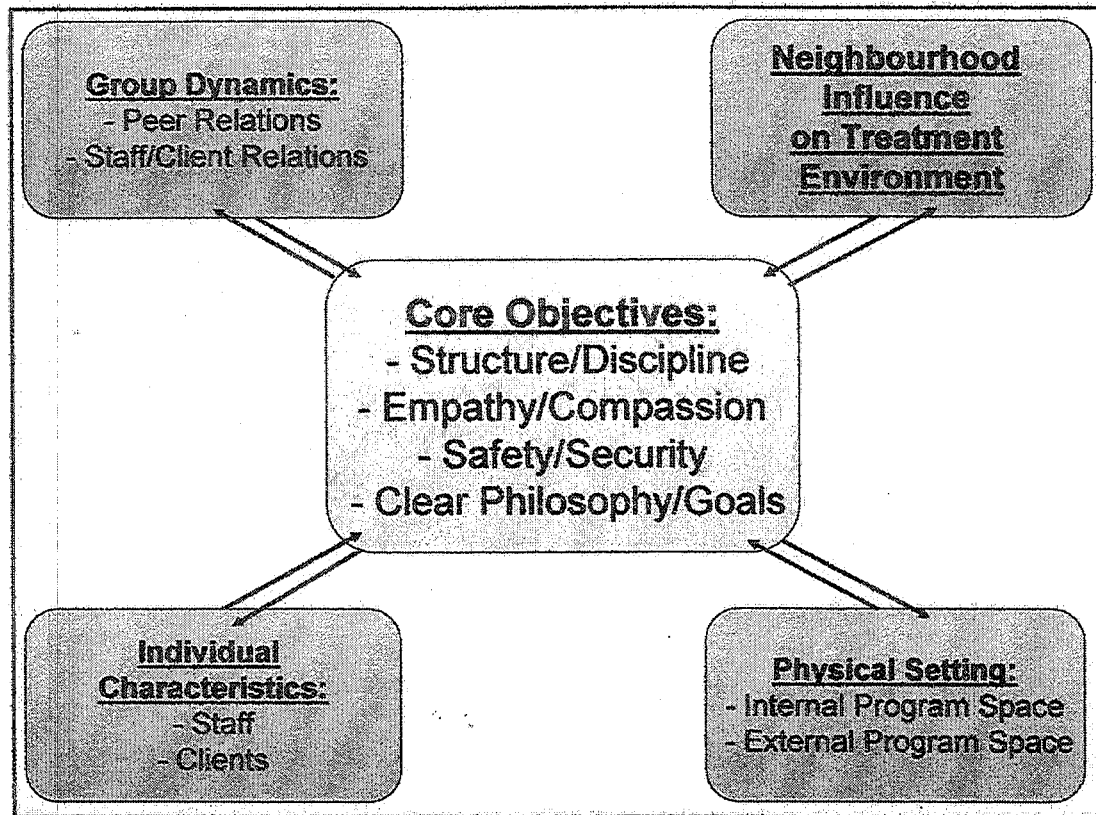


Figure 4.1: Factors influencing and influenced by Core Objectives of Addiction Treatment

4.2 THE CORE OBJECTIVE OF ADDICTION TREATMENT

The core objective of addiction treatment is to create a structured environment within which clients will be prevented from drinking and/or using, and at the same time teach clients the skills necessary to help them maintain their sobriety when they leave the program. In many ways, the structured program

environment can be understood to ‘stand in’ for clients’ own diminished capacity to control their use. This makes the successful functioning of the treatment environment an essential element in maintaining individual control for each client. Structure and discipline are implemented and geared towards consistently motivating ‘the self’ towards personal growth and understanding, and help clients to build relapse prevention and life skills. What is taught and how structure exists varies at any given site depending on the philosophy being used. While it is obvious that the fundamental rule is that there is to be no use amongst clients while in treatment there are a variety of other rules designed to achieve therapeutic ends. These include rules focused on creating structure in connection to everyday activities and routines, social interactions amongst clients and staff, and the daily movement of clients within and beyond the program setting. Because treatment philosophies and approaches vary, staff and clients often possess differing perspectives on how structure and discipline should play out within the treatment atmosphere.

At both Program “A” and Program “B”, structure and discipline are implemented within to provide clients with a clear sense of what is and will be expected of them while in treatment and when they leave the program. Many clients find the rules quite difficult to follow; therefore staff members strive to show clients the reason behind a rule whenever possible, but do so with varying degrees of success. This discussion will highlight how structure and discipline

are created and maintained – first to meet the needs of the group and secondly to protect the needs of the individual client. This is despite the fact that both facilities aim to be as client-centered as possible. As well, rules are implemented to protect the overall goals and reputation of the facility at times over the needs and wants of individual clients. While there are various reasons for this it does weigh on how the program functions and at certain points interferes with its core objectives.

4.2.1 Philosophy, Daily Routine & Structure at Program “A”

One of the main objectives of creating a structured program and disciplining clients who do not follow the rules is to help them re-build and re-learn many essential skills used in daily living that they have forgotten or let go of during their period of drinking and/or use. The purpose of this is to educate them with regards to the skills they will need to live independently without feeling the need to use. The director at Program “A” identified that from the perspective of the client or an outside observer that,

It may seem pretty juvenile but if you have any hope of going out of here and having sort of an ordinary life, then you need to learn those things. If you don't learn them or you don't practice them appropriately, there are going to be costs involved and those costs could be pretty significant (Director, Program “A”).

She explained that the rules are guided by what will be expected of clients when they leave. The Program Coordinator at Program “A” provided an example of

how the structure and discipline used in program will provide guidance to clients when they leave.

They are expected to be on time for meals and if they aren't there is a consequence. We tell them that when they get out of here and get a job people expect you to be on time. So we are trying to help them build those habits about being conscious of time and showing up on time. If they don't do their chore properly – you know, there are going to be people who are going to have expectations on you that things are going to be done properly and we are trying to help you work towards that. Rather than 18 people are living here so you have to do it (Program Coordinator, Program “A”).

Her statement reminds us that while some of the chores the women do need to be done because it is a large group, that the goal is to encourage clients to build positive habits and skills that they can continue to apply to their lives when they leave. In connection to this there are also rules that are imposed to ensure that all clients feel safe, secure and comfortable within the group atmosphere, while showing and receiving respect from staff and peers. During my observations at Program “A” a new client joined the group and another client, who had been at Program “A” for quite some time, was asked to share the rules and guidelines.

She explained that in group:

...what is said in this room stays in this room. Therefore no one is supposed to approach another about subject matter that was brought up, unless they were invited to do so. There was to be no ‘sexism’, or ‘drug-ism’. Also, you must ask permission of an individual if you want to give them a hug, and there was also the rule that you are not supposed to offer Kleenex to someone unless they gesture that they want some. The Kleenex rule was also enforced at Program “B”, for the fact that a person should be allowed to freely process through the way they are feeling without being interrupted, or made to feel that they should not be crying. Finally,

we were told that there were to be no 'we' statements, that could end up categorizing people. That is, you are not to speak on the behalf of others, and therefore you should only communicate utilizing 'I' statements (Program "A" field-notes, 5).

These rules encourage the women to build positive relationships with their peers and accountability for their own actions. They are especially important since all of the women come from different social backgrounds and have varying degrees of skills guiding them in their communication with others. This means that the rules are easier to follow for some than they are for others. Anita points out as well that at times it is difficult to understand why some rules are in place, especially when you feel like doing something other than what is required of you.

The rules are kind of hard. It's often challenging, but really worth it. The rules are kind of hard. Its hard to obey and be told, you know, for instance – tonight I would much rather go outdoors and spend the evening than go to a CA meeting when my problem isn't with coke, but them is the rules (Anita, Program "A").

Unlike Program "B", which aims to be as client-centered as possible while also integrating elements from a wide range of treatment philosophies, Program "A" aims to be client-centered while striving to also adhere to the 12-steps of Alcoholics Anonymous as closely as possible as well. This means that one of their expectations is that clients participate in on-site AA, CA, and NA meetings regardless of their drug of choice, because they feel there are similarities amongst users that clients will learn from.

Given the focus on maintaining a structured environment, emphasis is placed on regulating clients' movements beyond the program. At Program "A" clients are not given limitations as to where they spend their time off-site as long as they are back by curfew and have signed out. There is much more flexibility at Program "A" in this respect than there is at Program "B". Karen explains that:

When we go for our walks we only have a half an hour, so you don't have a lot of time. We usually walk up to Tim Horton's to grab a coffee or something. You can go around the block... There are not really boundaries; you just have to be back within a half an hour, so you don't really want to go too far. When you have your evenings and on the weekends when we are off you can go basically anywhere. Some girls have gone to Scarborough, Mississauga, you know what I mean, so we don't really have boundaries in that sense neither. You just need to make sure you are back by curfew, which they have pretty good curfews too, so... During the week it's 10:30, Friday nights its 12:30 and Saturday nights it's 12:00, so that's pretty good (Karen, Program "A").

This difference between the two sites is likely due to the fact that Program "A" operates a ten-week program, rather than a five-week program like Program "B", so clients are given a chance to apply the life skills that they are learning in the neighbourhood to a larger degree. Also Program "A" is located in a neighbourhood where obvious triggers do not exist as readily as they do within the Program "B" neighbourhood. Further women are encouraged to search for housing and jobs, and to go to AA, CA, and NA meetings in their free time, which requires that they be off-site for longer periods of time. The women are monitored only through urine testing and breathalysers when they have been off-site for half hour or more. Ronda, a client at Program "A", explained that there

are only consequences if you leave the program without signing out and back when you return. She explained that there are consequences for other things as well, which are often tied to losing your off-site privileges.

I have got a consequence. I'm lying. I've got a few consequences only in the time that I've been here, only because I didn't wake on time for breakfast. If you don't get up on time for breakfast you get a consequence for the whole day – you have to stay on property for that whole day. It's kind of like being on assessment and no phone privileges. It's pretty strict here actually for that, so I think that's what makes people move their butt around here too. The consequences are pretty severe when you just do something little, which I think is good, because it motivates you more to work your program better and be on time for stuff, which is why you are here right?! ... I think the most serious one is they take away a free night and if you have a weekend coming up they will take away that (Ronda, Program "A").

Consequences obviously vary depending on client behaviour and the severity of the rule that is broken. During observation I learned that some client behaviours provoke more severe reactions from staff than others. This is especially true of aggressive behaviour, which results in immediate discharge, because it impacts the potential safety of the whole group.

Program "A" has zero tolerance for physical violence, or even reported threats of physical violence. For example, I was told that if staff overheard one of the women say 'let's take it outside', than that would be grounds for their dismissal. Under such circumstances, the staff will often try to point a woman towards other resources that they could utilize while they 'cool off'. However, I was told that such women are usually extremely agitated during such confrontations, and are too unwilling to listen to alternative options. However, many eventually calm down after their dismissal, and call the Program "A" back, crying and apologizing for their behaviour, promising never to do it again if they are allowed to return. Regardless, if someone is dismissed on the grounds of violent behaviour, they are not banned forever, but they must wait a period of 6-8

weeks before they are potentially eligible to return. If the matter was of a more serious nature, they may be expelled from the program for even longer periods of time (Program “A” field-notes, 4).

Clients also are immediately discharged if they are found in someone else’s room; however staff do not always find out about these transgressions because clients are reluctant to tell staff for fear of being known as a ‘rat’ by others. This survival/street mentality is an interesting social element present amongst clients because while they are concerned with having their things stolen by others, they are often more concerned with how others will treat them if they find out that they are telling on others for things that they aren’t supposed to be doing. This is an issue that was present at both Program “A” and Program “B” that impacted the degree that some rules could be enforced, because staff are not able to see everything all of the time. Despite the variance amongst clients perspectives on rules and how they should be enforced there is little to no variance at all with respect to their behaviour when another client breaks a rule – they will not tell on another client for fear of how revenge will be paid to them by others.

Clients generally accept rules that are enforced by staff as long as they perceive them to be applied evenly and fairly towards all clients. However, when clients feel that some are being favoured over others and/or are not being given the consequences that they deserve resentment quickly builds. In a client-centered program like Program “A”, where responses to individual clients are based on staff’s sense of their individual’s needs and progress in the program, this

makes enforcing rules and discipline in what clients perceive as a 'fair' manner especially hard. What is permitted for one client is not always the same for others, which is something that clients quite often have difficulty understanding. In this type of environment it can be difficult for clients to accept the rules, especially when they don't understand the personal needs of other clients and/or don't understand why their personal requests are being accepted by staff when others are being denied. Clients talk to one another when they think that this is taking place, which results in suspicion about whether the staff are making appropriate and/or fair decisions or not. Julia comments on this in her interview, saying;

Sometimes I think that some rules are put in place for some. I've some seen one girl here get railroaded every time she asks for something and I don't get it one bit. I don't understand why and I see other people asking and getting their needs met and this particular person just gets shut down every single time and I just don't get it... Everything that she has asked for so far she has been declined on. You know her daughter wanted to come and visit here, she wanted to see the birth of her granddaughter, she had to come back early when her daughter was in labour – her daughter. Like what the hell, you know what I mean?! That was crazy, that was nuts. ...But then I think I only have three weeks left, so I would probably just bite my tongue and just abide by the rules, but nevertheless I just don't understand why okay you can get a pass and okay you can't. It just doesn't make sense to me. Or, for that matter, I'm not feeling well, may I go lay down, no. And then other people can, you know?! (Julia, Program "A").

Interestingly Julia's statement points to the fact that clients often will not stand up for each other against staff when they think that another client is being treated unfairly, because they are afraid that it will impact their own situation. Julia was

referring to Tiffany, who identified her own feelings on her experiences by explaining that the rules can be unfair, because the counsellors do not all enforce the rules the same way, so depending on the counsellor that you are assigned you might be treated very differently.

I think that the rules should go across the board. I came here and I thought my fifth weekend, because I started on a Thursday, so it wasn't explained to me that my fifth weekend was going to be before I thought it was. I come in to her office that day and lay down my sheet and she goes – you've got a weekend off and I said nobody has told me. Then she says no, no this is the way we count it, so it wasn't explained to me, so they took my weekend away from me. So then I only got – instead of getting two single overnights I only got one. Well then I find out later on that other people – she told me that the reason we are taking them away is because you can't have two in a row, but then I find out other people's clients get them like that. So there has to be some kind of unity, because that really bothered me, disturbed me. And then like somebody can leave during the middle of the week to go to their kids graduation and stay overnight, but I can't my daughter, who is just down the street, can't watch my granddaughter be born?! She's 17 years old, she's got no one here. It still bothers me... That was one of the hardest things I've ever had to do... and then I felt like I was abandoning her again and I explained that to them, but they arbitrarily made their decision. Then to watch other people be allowed to go – to leave and stay overnight to pack their house or watch their kid graduate. Well what was the difference between my situation?... It really bothers me. I think there has to be a lot more continuity. (Tiffany, Program "A").

Clearly this is an issue that can become quite complicated depending on how clients perceive the choices made by the staff. As well it highlights the importance of making sure that staff are managed in such a way that they will respond to situations consistently. When clients recognize differences amongst the staff they will either try to use these differences to benefit themselves and/or

they will lose faith in the structure of the program, causing them to perceive the program negatively; therefore impacting their potential for success. At the same time however in a client-centered program staff are expected to respond to situations in their own way, since there is no black and white response to each situation that arises. Depending on the approach used by staff and the perspective of clients this can act as either a positive or negative influence on programming; a fact also reflected in my analysis of structure at Program “B”.

4.2.2 Philosophy, Daily Routine and Structure at Program “B”

At Program “B” rules and discipline are structured around creating clear expectations for group living, so that a safe and respectful environment can be established and preserved over the five-week treatment cycle. In an interview, I asked Donna, a client, what rules were strongly enforced by program staff. She explained:

The biggies – no food outside, no going into anybody else’s room, no bringing food from downstairs back upstairs, which really sucks because I’m pretty much force feeding myself at dinner time, because I’m not hungry. (Donna pauses for a moment to think) I should know them eh?! (Smiling as she is saying this) You are actually not allowed to lie on the couch, but I think that’s just a question of hogging and apart from that there are only three chairs. What else?! You have to do you chores, you’ve got to get up at 7:00, you can’t go out past quarter to 10:00 no sorry quarter to 11:00, 15 minutes and you have to be back on premises, you always have to sign out and sign in. I think those are the biggies. I don’t really find their rules unreasonable with the exception of the walk. Maybe I’m just getting immune to rules – I’m going to go wild when I get home and break them all!!! (said enthusiastically, but also sarcastically), (Donna, Program “B”).

Donna's statement highlights how the rules at Program "B" are modeled to provide clients with structure in their lives. This is accomplished within treatment, with staff encouraging clients to follow a clearly defined daily routine. Some rules, such as only allowing clients off-site for fifteen minutes at a time, are also structured around maintaining client safety on and off-site. Donna emphasized that this is a rule that a number of clients have an issue with, because they don't feel that it is enough time to accomplish anything away from the program. She explained how she spent her 15-minute walk:

We boot it to the store, get our coffee... talk with Odet (a local store owner). She actually got into making us a boiled egg, so we can have an egg and I have a banana there and a coffee and then we get back in 15 minutes... That is a big thing that I'm definitely going to recommend as a change here. 15 minutes in the mornings, which I don't count because you are on a coffee mission, and 15 minutes in the evening is not enough, because there is the cemetery where you can see the escarpment and there is a pond back there. 10 minutes is just kind of getting there and you take a few steps and then you have to get back again and you are under pressure, so I think that as the program progresses they should be decreasing the cocooning. I feel really strongly about that... That's not preparing me for anything. (Donna, Program "B").

She feels strongly that as clients progress through the program they should be given more time outside to gain some independence and facilitate their transition out of the program. This time limitation for off-site exercise was put in place to ensure greater safety because there are a lot of triggers within the neighbourhood, yet many clients shared Donna's view that more time should be given to women later in the program.

Clients are also involved in setting rules themselves. At the beginning of the five-week cycle clients worked with the session facilitator to create a list of rules that they would agree to follow during their time during group sessions.

These rules were concerned with personal growth and included;

- *Confidentiality = what is said here stays here – anonymity – respect other people for concern and shame around addiction and others knowing about it. Share your own experiences only.*
- *Respect others = no gossip, interrupting, one person talks at a time*
- *Participation = expected on a continuous basis*
- *No physical/verbal abuse*
- *Punctuality (comment made by client about own inability to be on time. Ex- doctor says to come at 10am because knows she won't show up until 1pm)*
- *Attend all group meetings*
(Field-notes, Program "B")

From the perspective of the program director, the rules are quite straightforward and most clients do not have an overly difficult time following them unless they do not truly want to be in treatment:

You know, usually they alienate or break a rule on purpose or you know, they want to blame us for the reason that they had to leave. And that goes with the territory - that is going to happen. And then they'll come back (Director, Program "B").

She explained that they do this when they get more than they think they can handle; however while this may be the case to a certain degree it is clear from my observations that when rules are not enforced consistently clients will adjust their behaviour in response and often try to get away with whatever they think they can.

At the beginning of this afternoon's session there were a number of women (3-4) who did not show up on time. They were at least fifteen minutes late. The other women attending and the facilitators were clearly irritated about this. Once the women finally arrived they claimed that since the morning's session ran a little late, that they thought that Laurel had said that the afternoon session would start fifteen minutes later. It is true that the morning's session did run late, however Laurel never explicitly stated that the afternoon would begin late as well. It did appear that there was a genuine misunderstanding, for Laurel was somewhat unclear when we had departed from the morning's session. However, as opposed to taking the stance of 'when in doubt, show up on time', these particular women chose 'when in doubt, milk the situation for a little extra free time'. Laurel appeared to be trying hard to contain her frustration. Generally it has been stated that if you show up late to a session, that you revoke your privilege for being there, as coming in late is disruptive to others. However, Laurel did decide to let them all stay (Field-notes, Program "B").

When staff members do not enforce the rules consistently it impacts the perspectives of other clients as well, causing them to question the abilities of the staff in certain instances.

During the afternoon break I was speaking with some of the women who had been in the room on time, and a few of them were definitely annoyed and even angry about the lack of retribution that the late women faced for not showing up on time. These women viewed that situation as a lack of 'assertiveness' on Laurel's part, which is interesting because assertiveness is a primary focus in this treatment program, and a skill that all of the women are to be actively working on (field-notes, Program "B")

At times, staff members contribute to the frustration amongst clients when they themselves do not arrive to program on time and/or place enough priority on modeling the rules themselves.

While in afternoon session on feelings things began to unravel quite quickly. We started approximately 30 minutes late, because Sylvia said that she was dealing with some issues upstairs, so immediately the women knew that

something was going on. This seems to be the case quite often though, where the staff comes in to group quite late, because they are dealing with other aspects of the program. The clients are either left waiting without any communication as to when the staff member will arrive or in certain cases simply go outside or stay outside for a longer than usual smoke break. I don't think that session has started on time once with the exception of the introductory session (Field-notes, Program "B").

Clients do not care what the reason is for this. In most cases they simply think that if they are expected to arrive to session on time that staff members should be as well. This was an issue that was ongoing during my observations at Program "B".

The staff members adjust their rules from one treatment cycle to the next in an effort to foster what they perceive to be the proper amount of structure necessary to maintain the delicate social dynamic present amongst clients, while also providing an overall sense of safety. One way that safety of the group is maintained is by searching clients to check if they are carrying any drugs, alcohol or other materials that may jeopardize the safety of others. At the same time, staff members are careful not to search clients too much for fear that clients might start to resent the intrusion. A discussion with one staff member during fieldwork made this clear:

I had a brief conversation with Laurel at lunch about discipline in the facility. I asked specifically if the women are subject to searches upon arrival, or during their stay. She mentioned that only their bags and belongings are searched after they have been out of the facility for an extended period (or upon arrival). Their person is not searched unless there are extenuating circumstances. For the most part they are given the benefit of the doubt. However, the women can be forced to take a random urine test

if there is suspicion that they have been using drugs. If this proves that they have, or if any paraphernalia is found on them, this results in immediate discharge (Program "B" field-notes, 3).

Significantly, some clients at Program "B" felt that they weren't being searched enough and that it actually was putting their safety in jeopardy.

During one of the breaks I was speaking to a couple of the residents. One topic that came up was the lack of searching that occurs within Program "B". One of the women indicated that she has been in another treatment facility before and mentioned that they were much stricter there in terms of searching the women for drugs. Her attitude was that they were actually a little too lax about this at Program "B", which she felt jeopardizes the safety of some residents. She mentioned that one of the women that were down in detox was just recently discharged for bringing substances on to the premises (Program "B" field-notes, 3).

There are clearly numerous perspectives on this issue, therefore maintaining a balance can be difficult for staff. Their philosophy on this issue is reflective of the respect for personal and private space that they are trying to show clients.

One client explained that she liked the searches, because it acted as another motivator to stay in check. While staff realize that some clients may need this at first they also discourage clients from developing a dependence on repercussions. Instead they display their trust in the women, which often makes them feel proud of themselves. This encourages clients to stay sober independently, rather than because they are concerned that they will be caught and removed from the program. It does show us though that some clients have a strong need and/or want for structure while working through their recovery. The question of dependence in relation to searches is part of a larger tension characteristic of both

programs. While Program "A" and Program "B" attempt to provide structure for women who are unable to control their addictions, this structure is only temporary. While women may feel safe within the program because of this structure, they cannot rely too heavily on this external restraint. Instead they are encouraged to learn new strategies of self-monitoring and control.

At Program "B", the director recognized that regardless of their background the women have had difficult lives. For this reason, it is important to structure the program in such a way that empathy, compassion and respect are characteristic of the relationships between staff and clients, and among clients. This expectation is also linked to the creation of a safe and secure treatment setting that will facilitate client recovery. As the following statement makes clear, considerable emphasis is placed on clients moderating "street behaviours":

There is an expectation that this will be a safe place, no matter where you have come from, that if you are from the street, that if you are from one of the most affluent homes in Hamilton, or surrounding area, that this is the common language that we speak, which is respectful and equitable, and we are not using our street behaviour, or you're going to be called on it, because it is not acceptable. And you may know somebody from the street, and you've got a bad rap with them, but that is not going to happen in here... The reality is, is that these are vulnerable women who have little to lose, and don't have a lot of assets and skills and confidence that they're bringing when they walk in through our door, and it doesn't matter what their income or education level is. They've been pretty beaten up out there by the time that they get here... emotionally, spiritually, physically... and what I think works, and what we're trying to demonstrate works, is clear expectations right from the get-go, and enforcing those. We are a women-centered program. We make lots of exceptions... But we have some expectations of them, while they are here. Which have to do with communal living, and safety, a safe place for everyone who walks through that door...

We have zero tolerance for violence; we have zero tolerance for street behaviour. (Director, Program "B").

There were many instances when staff displayed their lack of tolerance for street behaviour and aggression amongst clients. For example, during fieldwork three women were discharged for behaviour that the staff believed to be compromising the safety and comfort level of the rest of the treatment group. Decisions regarding client discharge are given a lot of consideration before being made, since staff strive to give the women every opportunity possible to be successful in treatment and in their recovery, despite the impact it can have on other clients and the treatment atmosphere until these decisions are made. In these instances the staff attempt to respect remaining clients by being as discrete about another clients' discharge as is possible, although there are many arrangements that need to be made and so this can be hard, if not – at times – near impossible. When Val, LJ and Tanya were discharged from the residential program there was some inconsistency amongst the staff as to when and how their discharge and removal of their belongings should take place.

Katherine (a staff member at Program "B") knocked on the door of the group session and told Sylvia, the group facilitator, that Val and LJ, two residential clients, needed their binders. LJ had already come in to grab hers. The way that Katherine dealt with this was very disruptive. Once Sylvia had let her in the room she hurried through to grab Val's things, muttering under her breath that she had to get the binders. She smacked one binder on top of another then looked up at the wall and decided that she was going to tear down their posters so that they could take them with them, complained about trying to find their names and stormed out. It was very unprofessional and disturbed the flow that had existed in the morning in a

matter of minutes. Afterwards it took the women a while to settle down again. They were all quite worked up. One client even commented that there was an 'elephant in the room' after Katherine left; however there was no further discussion used to resolve client feelings and/or concerns about what had just happened (Field-notes, Program "B"; 07/24/2007).

Katherine's behaviour clearly upset the rest of the treatment group. A number of other staff members were also bothered by the approach that Katherine used to remove the materials and felt that it should have been handled differently. This instance also points to the way in which the effective maintenance of the structured environment at the program is dependent on the skill of staff members. Donna, a client, commented that there had been a number of problems with staffing during her time in the program and that this had really impacted the environment:

They don't have their act together in a lot of ways – and I think its because of the newness. I didn't know that Karima, the supervisor, just came in March. That's pretty new. Second of all, the senior counsellor whose in charge of intake, Laurel, she's only been back from maternity leave for two months. The staff, and again you are going to get that anywhere, but it's a little bit more obvious and the occurrences of it happening I find are a little bit more frequent (Donna, Program "B").

Her interpretation of events is quite insightful as there had been significant staff turnover at Program "B" prior to her arrival and so the program was in something of a transition, with staff getting used to the expectations and approach of their new manager. While Donna understood the cause of recent problems and inconsistencies, not all women were as understanding or aware of what was taking place. Moreover, some women attempted to use the staffing

inconsistencies to get away with behaviours that would otherwise have been unacceptable.

4.2.3 The ‘Character’ of Addiction Treatment Facilities

During interviews clients were encouraged to think about how they would define the character of each program. Many made reference to their overall perception of the program; combining their opinions of program philosophy, structure and discipline, and daily routines, as well as their recent experiences on-site and within the neighbourhood. To facilitate discussion, respondents were encouraged to think of the program as a person and were asked how they would describe that person. Reflecting the diversity of the women, there were a variety of responses. At the same time, there were numerous similarities within and between respondents at the two sites. These responses are presented in tables 4.1 and 4.2.

In part, these responses reflect the focus of both programs on creating a structured and safe environment, while maintaining a balance between overt discipline and empathy with clients’ needs. The majority⁴ of responses from clients at both sites were positive. Of the fifteen positive words used in association with the Program “A” program the word *helpful* was used by three

⁴ Fifteen of the twenty-five words used at Program “A” (3:5) and twelve of the eighteen words used at Program “B” (2:3) characterized the program as positive.

different clients, and of the ten negative words used the word *militant* was used twice.

Table 4.1: Characterizations of Program “A”

| Positive Characterizations | Negative Characterizations |
|----------------------------|----------------------------|
| Successful | Really Unorganized |
| Informative | Militant (x2) |
| Honest | Exhausting |
| Very Happy | “Holier than Thou” |
| Determined | Really, Really Hard |
| Not Strict, but Regimented | Confusing |
| Structured | Not a lot of Harmony |
| Fun | Strange |
| Comfortable | Suspicious |
| Friendly | Not Very Healthy |
| Lenient | |
| Helpful (x3) | |
| Giving | |
| Generous | |
| Religious | |

Table 4.2 Characterizations of Program “B”

| Positive Characterizations | Negative Characterizations |
|--------------------------------------|---|
| Very Smart | Sometimes Forgetful |
| Very Open | Sometimes Impersonal |
| Somewhat Disciplined | “they don’t have their act together in a lot of ways” |
| Flexible | Inconsistent |
| Patient | Mysterious |
| Non-Judgemental | Challenging |
| “A Definite Necessity for Addiction” | |
| Successful | |
| Honest | |
| Caring | |
| Comforting | |
| Very Rule Based, Very Rule Oriented | |

While there was no overlap in words used by clients at Program “B” their statements seemed to recognize the shifting dynamics that exist within residential addiction treatment facilities in a manner similar to clients at Program “A”. For example, one client said that Program “B” is “*somewhat disciplined, sometimes forgetful*” (emphasis added). Another described it as “[s]*ometimes impersonal*” explaining that if you thought of Program “B” as a person then “they are someone

who [you] have to open up to in order to get them to talk to [you]" (emphasis added). These statements refer not only to the particular program experiences of clients, but also to the character of the program overall. Further, they also serve to point towards the day to day variability that clients observe and experience within these programs.

Notwithstanding the official rules of each organization, the clients make clear that the environments at the programs are dynamic, shifting over time in response to a number of factors (see figure 4.1). Both of sites have a variety of programs to deliver, which are continuously being altered and improved. They also employ multiple staff members, each with their own unique personalities, perspectives and approaches to treatment. Moreover, no matter how effective a staff member, they are not always aware of what is going on within the facility, what rules may have been transgressed and what tensions may have arisen. As a result clients, at times, view these programs and their staff as inconsistent. For example, Donna explained;

You will get a different answer depending on who you ask on certain. Some of the answers go right across the board, like immediate discharge if you're seen going into someone else's room. You will get that consistently though, but there are other things that if you want the answer you want, you will be selective about who you ask.

Joanne, who described Program "B" as "somewhat disciplined, sometimes forgetful" was also referring to her experience with the staff at this site when characterizing the program in this way. While she recognized in her statement

that staff members are busy, she said that she asked for one of her journal entries that was missing, but explained that she “will probably not see it again, because they will forget to look for it”. While these statements are made by clients at Program “B”, statements made by clients at Program “A” suggest that adequate staffing and programming challenges are equal, but likely also more complex at the Program “A” facility.

Program “A” operates using a continuous client intake system and so there are a wider range of factors to take into consideration. For example, there is an indication by one client at Program “A” that because clients do not all start the program on the same day that there is a less structured, less formal intake procedure. When asked to describe the character of the program, she states that it is;

[u]n-organized right now. But I know that they have people away, counsellors away. It's really unorganized. I came in here and no one told me anything. Yesterday I walked around like a lost puppy dog” (emphasis added).

As a new client to the program, this experience was quite vivid in the woman’s mind. Her intake experience left her viewing the program as un-therapeutic⁵ and identifying herself “like a lost puppy dog”; however key to her statement is her recognition that it is “[u]n-organized *right now*”, which she connects to a temporary lack of adequate staffing (emphasis added). This statement suggests

⁵ Which is suggested through her description of the program as unorganized.

that staffing issues and client/staff relations (see below) are more complex in a facility that operates using a continuous intake system. By contrast, using a fixed⁶ intake system would ensure that clients enter into treatment in a more therapeutic manner, since the facility would be more adequately prepared to meet initial client needs and concerns.

Connected to recognition relating to the variability within these programs another client at Program “A” identified the program as “confusing *right now*” (emphasis added). She explained that “[t]here has been a shift again” in the facility; that there was “not a lot of harmony” amongst the women (staff and clients alike) in the house at that point. Interestingly, she recognizes that there is not one factor alone that negatively impacts the atmosphere, but that “it’s the house as a whole” and all of the people and elements within it that produce her perception of it. In this way then for her the therapeutic character of the environment shifts in connection to the evolving attitudes, behaviours and actions of both the staff and clients at any particular point in time. Her statement suggests that from moment to moment the program can shift from un-therapeutic to therapeutic depending on who is present and/or what is taking place. Supporting this perception another client at Program “B” notes that both staff and clients shape the character of the program:

⁶ Fixed means that all clients enter the program at the same time.

I find that it's a very happy environment, very happy. It has its certain days where it has its downs, where some people's moods can change the environment, but most days it's happy (Samantha)

Samantha seems to be mirroring how she feels through her explanation of the program's character. By her definition then, central to the character of the program is the people that utilize it (the clients) and the people who support its operation (the staff) to equal degrees. She is emphasizing how her own feelings are impacted by the moods of others, which suggests as well that in order for residential addiction treatment facilities to function as therapeutic environments constant attention must be paid to group dynamics and ensuring that the women are positively impacting one another whenever possible.

Structure is a fundamental component in the operation of a residential addiction treatment facility; however it is not always the easiest thing to consistently maintain. As Julia explains, "[i]t's almost scary to think what a difference a day can bring, like how the dynamics can change so quickly and you say for what and you don't know". It is through daily routines, rules and regulations, monitoring by staff members, as well as social interactions amongst both staff and clients that treatment clients interpret the character of these spaces both as therapeutic and un-therapeutic. Clients express feeling that being in a treatment program is "really, really hard" (Anita, Program "A"), and "informative, but it is also exhausting" (Tiffany, Program "A"). Their connections to identifying these programs as being challenging were often related

to how they were structured. Jade explained that the program is “[n]ot strict..., because strict sounds too negative”, but that “[i]t has really good structure”. For her structure is effective because she “thrive[s] in it” (Jade, Program “A”).

For others structure within these programs is not viewed quite the same way. Donna said that she felt that the program was “very rule based, very rule oriented”, however seemed to be placing a negative connotation on her words. She felt that there was a “little bit too much discussion around consequences” and that more information should be given up front, so that clients would know what they were getting into before starting the program. Rather than say that the program was well structured or organized, Donna said that “they don’t have their act together in a lot of ways” and so for her they were “a little bit mysterious”. In this sense the problem with the structure and discipline used by Program “B” was that staff had failed to make them explicitly known. Because Program “B” is client-centered the overall sense that I gained from clients was that the structure that they experienced was very situational and so on some levels difficult too understand, especially when they applied to one person and not another.

More often than not when the women were describing the structure of these programs as un-therapeutic or ineffective they were making reference to negative experiences with, or perceptions of staff members in specific. For example, at Program “A” two clients used the word *militant* to characterize the program. Tabitha described the program not only as *militant*, but also “[h]olier

than thou”, which gave the impression that she was making reference to the staff as a collective entity. When asked what made her feel this way she elaborated by saying that “it looks like they are looking down over at me and that their way is the right way. That’s the way it is, and I know that’s the way it is, but you could say it a different way” (Tabitha, Program “A”). There were also significant variations amongst clients as well. For example, Tanya identified it as *lenient*, since she had noticed that there were no consequences for clients coming in late to group. Her description seems to suggest that the staff are not quite as militant as was previously described. It is therefore important to identify the similarities and differences amongst the women, so that we can gain a greater appreciation for what their needs might be and/or why they feel certain ways with regards to particular things.

4.3 INDIVIDUAL CHARACTERISTICS OF TREATMENT CLIENTS

The first of the four factors to shape the therapeutic character of the program and its capacity to achieve core objectives is the diversity of the clients who use the program. In this section I provide a sense of the diverse characteristics of women at both programs. While every woman has a complex and compelling story, space restrictions mean that I cannot share them all here. Instead I would like to provide four ‘portraits’ of women who represent the range of experiences that exist amongst clients. The women I had the opportunity to

interview and observe in program differed from one another in a number of ways: their demographic characteristics (including age, social class, income/employment, geographic origins, ethnicity, marital status, etcetera), their addiction histories, experience with formal treatment and their experience with loss resulting from their addictions.

4.3.1 Joanne (Day Client at Program “B”)

Joanne is a middle class woman, who is married without any children. She has been living in the Hamilton area for the past 25 years. She works alongside of her husband as a real-estate agent. Because she is a day client at Program “B” and her job is so flexible, her home life and ability to work has been largely unaffected by entering treatment. Perhaps her biggest challenge is that she lives and works in the local area, while also striving to maintain a high degree of anonymity in association to her addiction to alcohol and her enrolment in a recovery program.

I think when I first came here I was probably a little bit paranoid just because I felt exposed and didn't want anybody to know I was here... It's not something that I am going to go around advertising nor am I going to share with a lot of people, but if somebody saw me walking in here there could be a million and one reasons why I could be here, so I am not quite as paranoid as I probably was when I first got here (Joanne, Program “B”).

The primary addiction issue that Joanne has is that she likes to drink wine and feels that when she does she always drinks too much. Prior to getting into treatment she felt it was starting to get out of control.

Her statements about treatment and recovery seem to suggest that she believes more in harm reduction and self monitoring than she does in abstinence. She went to one other three-week residential treatment program ten years ago. Since that time she said she's controlled her use by focusing her energy on her work, exercising and maintaining a good relationship with her husband. She also attends meetings (at another location) based on a modified AA program to more effectively address the needs of women (*Woman for Sobriety*).

Joanne is unlike many other clients in that she does not have any other addictions that accompany her alcohol addiction. She feels that she has experienced next to no loss due to her addictive behaviours and took part in the Program "B" program to "nip it (her drinking) in the bud before it started to get too out of control". During the interview Joanne explained that a high degree of self-awareness is central to her approach to maintaining her sobriety. She connected this not only to herself, but understanding where others are at as well by stating that;

When I came in here my whole thing that I said to myself is that I would do what was expected of me and that I would keep an open mind and that I would try and learn from everybody – including people that I didn't necessarily like or want to even talk to... There is always something to be gained from meeting just about everybody here. And I think my

experience here has taught me about maybe being a little bit more open and honest and that kind of stuff, and just figuring out what I'm thinking. Sometimes it's not easy to figure out what you are thinking even when you are thinking about it sometimes you don't realize what it is.

She enjoys Program "B", because it takes a client-centered approach rather than adhering strictly to the AA mantra, which she has a difficult time identifying with.

4.3.2 Donna (Residential Client at Program "B")

Donna is similar to Joanne in some ways, but also quite different. She is a 54 year old, middle class woman from the Greater Toronto Area, who has been living in Southern Ontario for the past 23 years and is married with one teenage daughter. She previously also had a son, but lost him to suicide, which is something that she struggles a great deal with.

Donna had a career as a behaviour consultant for young children but was on long-term disability as a result of her alcohol addiction when she entered treatment. She is unable to work, because she recently received a DUI charge. Donna's identity was grounded in her education and her career helping young children, so this temporary loss in employment has had a tremendous impact on both her sense of self and her day-to-day life. The biggest challenge for her now, she says, is that she is often left at home alone and bored while the rest of her family is working and going to school. She is also hesitant to go out on her own, because she feels triggered by so many things in her life.

Unlike Joanne, Donna strives for abstinence in her recovery. She has been to treatment a number of times over many years and recognizes that for her sobriety takes place one-hundred percent or not at all. She identified that she can no longer just have one or two drinks – that once she starts drinking that it is very difficult for her to regain her control and stop.

While Donna is similar to Joanne in terms of her social class, her housing situation, and her ongoing relationship with her family, her addiction history is more complex. This is why (along with the fact that she doesn't live in the Hamilton area) she was enrolled as a residential treatment client, rather than a day client like Joanne. While her primary addiction is alcohol, she uses marijuana and has used a wide range of other drugs on a more recreational/occasional basis.

When asked to describe her addictions, Donna explained:

I'm an alcoholic, I also smoke marijuana, so it is safe to say I am addicted to that. I have been an alcoholic for probably 25 years I would say and probably more. It started when I was in university and I was an older than average student so that's when it sort of snuck up on me. You know, meeting friends early at the end of the day and I was a single mother at that time, so you know my son was in care until five and I could go have a couple of beers before getting home. And then you get your friends to come home and they bring beer, etcetera. I have used a lot of other drugs but have not become addicted to them and people generally don't get addicted to hallucinogens like LSD so... I've done LSD, I've done mushrooms, I've done MDA, I've done Mescaline, I've done peyote, I've done speed, what else??? I haven't done heroine. I've done coke. I haven't done crack. So, the big one is alcohol.

And when asked what kept her from continuing to use the other drugs that she had tried, Donna said that they were not practical. Instead she said,

They were a treat. They were viewed as a treat. My friends and I used to have very planned highs. You know when we were going camping May 24th, so we'd plan it and we didn't do it at parties and that kind of thing. It was always outside be it winter or whatever, that was our thing to get high and go tripping outside. And again I'm sure a lot of it had to do with being a single mother, but if you've ever experienced those kinds of hallucinogens they are not the type of thing that someone would tend to get addicted to, because you would probably end up fairly psychotic and likely hospitalized. I mean I had a job, I was a student, I was a mom. It was never an option. It was a treat.

Interestingly she connects her use to what she considered to be manageable at various stages in her life given her responsibilities as a single mother, a student and someone who had a job. She indicates not considering her drinking as a problem initially, but instead as an addiction that “snuck up on her” over time. Because much of her drinking took place when she was socializing with friends she did not identify it as an addiction until it became a more obvious problem in her day-to-day life. Reflecting back, she now believes that she has been fighting her urge to drink for over 25 years now.

4.3.3 Ronda (Residential Client at Program “A”)

Ronda is a residential treatment client at Program “A”, whose life experiences and addiction story are quite different from Joanne and Donna. She is a 38 year old single mother of two children, who have been removed from her care as a result of her addictions. Prior to entering treatment she was living in subsidized housing for aboriginal people in Toronto, where she plans to return

after treatment. While she was born on a reserve in Northern, Ontario, Ronda has lived in Southern Ontario since she was adopted, through Native Child and Family Services, at the age of 15 months. She is addicted to both alcohol and crack cocaine, although identifies crack as her primary addiction.

Ronda relies on social assistance to support herself and her two children and identified that apart from the seven times she has been in treatment⁷ she has continued to use consistently since she was 19 years old. She also explained that she did not complete many of these programs, leaving as little as 4 days into the program on one occasion. It was not clear whether she has contact with, or support from, her adoptive family. When asked to share her addiction story, Ronda said;

I started doing cocaine when I was 19. So, I'm 38 now, so I've been doing it for 19 years. And I started smoking crack when I was about 25. I was doing just like powder from age 19 – I did my first line on my 19th birthday. Did lines until about 25 and then somebody introduced me to crack already cooked from the street, then I got started on that... continued using steadily until just recently.... [T]he only times that I really stopped was when I was in the programs... [The problem is that...] I know people EVERYWHERE. I can't go anywhere in this frigging city without knowing somebody, so this is also what I am afraid of when I leave here too. So, yeah what happened was I just meet somebody and I get talked into something even though I know I shouldn't be doing it, but I end up doing it anyways right?! So, that's what happened last time and I was so close to having my kids come home and I screwed it up. So, that's what made me want to go into a residential program, because you know, I was coming up to the two year

⁷ Treatment experience includes; withdrawal management, formal day treatment (three times, including one mother and child program) and residential treatment, which she also went to three times. She also identified that during one of the residential programs she swapped her urine sample to remain in program, because she was using throughout the program; however needed to complete it to regain custody of her children.

mark of my kids being in care and they can't be in care any longer than two years or I lose them. So they'll be crown wards right?!

Through her description of her drug and alcohol use she identifies how ingrained it is in her everyday life and how difficult it is to maintain sobriety when there are triggers surrounding her practically everywhere she goes. She also draws our attention to the consequences she will face if she chooses to use and/or is unable to complete the program.

Perhaps the only obvious similarity between the experiences of Ronda to that of Joanne and Donna is that over time her addictions have escalated, now impacting many aspects of her life. While Ronda said that she did not try to control her drug use and drinking prior to entering Program "A" this time, she now recognizes that she is cannot drink or use crack cocaine at all, because the use of one almost always results in her use of the other.

Basically, because if I don't intend to use and I'm drinking they might as well – they go hand in hand now, so I can't even drink now at all. I used to be able to drink and not use and then somehow it just started, they just started going together. I can't even do either one now.

Her story also highlights the increased progression of use that often takes place over time and how much more complicated addiction becomes when there is more than one substance involved. It also points to the pressures women face when attempting to regain custody over their children. Successful completion of a treatment program is an important step toward winning custody, and many women saw regaining children as a prime motivator for recovery.

4.3.4 Tabitha (Residential client at Program “A”)

Tabitha is a residential treatment client at Program “A” who, at 50 years of age, is now homeless. Her story illustrates a greater degree of social and material loss than those of Joanne, Donna and Ronda. She also shared a number of personal experiences that are quite troubling for her. Interestingly, Tabitha begins her story by describing two key elements in her life – her education as a nurse and her negative sense of self, which translated into being self-conscious about her weight. She explains that she chose to go into nursing, because it was “right up [her] alley”. She explains that she enjoyed,

Learning about the body and how it all worked and then know how to get things [drugs], but I didn’t really get too wrapped up in it, because I really loved my job and because I liked to help people and be of support and seeing them be sick and then well again – being a part of that.

At first this choice was made, because it supported her interest in helping others. Her statement also identifies though that she was also aware of the fact that her job also gave her greater access to prescription medications. Tabitha enjoyed this job for some time, but as other elements in her personal life began to weigh on her the two spheres collided, making her unfit to continue working as a nurse.

The choices Tabitha made in her personal life were guided heavily by her negative self-image. In her interview she described marrying her first husband, who was abusive even while they were dating, because no one else had shown any interest in her. After a few years of marriage and the birth of her daughter she

left her husband, becoming a single mother. Two years later Tabitha met her second husband. After her first marriage ended she was determined to have the perfect wedding with her second husband and thought that all of her dreams were coming true – “the white picket fence and having all kinds of money – just everything was perfect”. Unfortunately with all of this change Tabitha became more self-conscious about her weight. She had just given birth to her son and wanted to look perfect in her wedding dress, so started to abuse prescription diet pills. This was not something that she viewed negatively however. She felt that the excessive use was justified because it was being done for a reason. Tabitha remained happy in her marriage, not using the diet pills after her wedding and only drinking on occasion with her husband for many years without showing any obvious addictive behaviour until her daughter was 10 years old.

Tabitha explained that problems in association with her drug and alcohol use did not really begin to surface for her until her daughter told her that she was being sexually abused by Tabitha’s second husband. Tabitha was torn. She did not know whether to believe her daughter and in turn leave her husband or think she was lying about it and stay. She waited for the court’s decision before deciding what to do. It was during this time that she used heroine for the first time, then cocaine. She explained that while she was initially attempting to distract herself from the potential truth in her daughter’s story that over time she ended up developed addictions to the drugs that she was using. As she explains,

We went to court, but they threw it out for lack of evidence, so I still didn't get an answer. Well during that time while that court case was going on I went to my aunt's house and her husband's family is from Niagara Falls. I lived in St. Catharine's. And they were drug people. And I said to my aunt Lori – what are they doing in and out of the bathroom? Because it seemed like they couldn't wait to get in there, so she said ah I have got to tell you something, they are doing Heroine. Each one would take a turn going in right. And I said what is that all about? Like I kind of knew a little bit about it from my nursing, but I wasn't street smart, you know?! She said well ask them. So they said that it takes away their pain, their worries, their fears and you don't feel anything. I said – GIVE some of THAT to me! I want to try it... I used with my daughter and her boyfriend – heroine – and then after that came the crack with my son... My son – used with him – he didn't really finish school, got himself in trouble with the law. This is his second time in federal prison. He's only 23. I have a lot of guilt around that. Well about using and not being there for my kids. My son is more accepting than my daughter. My daughter still got some resentment

As she acknowledged, Tabitha's drug use has had a tremendously negative impact on her life. In addition, she experiences a significant amount of guilt about the impact of her life on the lives of her children, both of whom are also addicted to drugs.

Significantly, Tabitha's interview also shows how she changed her perception of her addiction over time as drinking and using began to have a greater impact on her life. Initially she thought she could quit using drugs but still drink as she did not feel that she was an alcoholic. During this stage of her thinking she was like many other clients who felt that a 'harm reduction' approach to use was enough to keep their lives in order:

I was off and on in AA meetings and stuff throughout the years and treatment and whatnot and I don't know. I knew I was an addict, but I could never say I was an alcoholic, because it never caused me any

problems. And I have always had in the back of my mind, 'well, I can still drink, I just won't do drugs' right?! (Tabitha, Program "A").

Today however, after experiencing so many losses in association with her use and having gone through a combination of both day and residential treatment programs seven times she believes that abstinence is the only approach that will work for her. She now refers to herself as an alcoholic, even though it is not her primary addiction. As a result Tabitha adheres closely to the AA program, explaining that she is willing to go to any length for her sobriety now, because she has been "at death's door a couple of times" and sees this as her last chance.

4.3.5 Similarities and differences amongst clients

These four profiles display some of the variation that exists among women at both programs. While their stories are all different, they also collectively illustrate both the factors that contributed to the women's addictions as well as the resulting costs of drug and alcohol use on the women and those around them. The impact of drug and alcohol use on each of their lives is often connected to the length of time that they have been struggling with their addictions and their associated choices. Further, while each woman is similar when we consider that they are struggling with addictions and many associated issues, they are also quite different from one another in a number of ways as well. These include, but are not limited to; their social class, housing situation, marital status and existence of

family support/relationships, as well as their drug(s) of choice and the experiences that have taken place in their lives in general and as a result of their use over time.

This discussion has also brought our attention to the variety of ways that clients view their addictions and addictive behaviours, and how their personal philosophies impact their approach towards their recovery and their perception of treatment overall. It also displays how challenging sobriety can be to maintain when considering that most of the women interviewed and all of the women profiled have been to treatment two or more times and are still working at finding ways to maintain their sobriety. As well, as their addiction issues become more complex and have a greater impact on their lives, some women are cycling through programs to meet not only their addiction needs; some are also using these programs to find safety and shelter from street life, and to regain custody of their children. These variations amongst the women pose a variety of challenges when trying to maintain a therapeutic atmosphere within the program environment. Clients' differences can impact how they interact with one another, leading to harmony amongst the group or causing opposition and conflict, depending on the overall make-up of the group and the individual characteristics present at any given time. The women's individual characteristics also impact how they interact with program staff and counsellors.

4.4 SOCIAL RELATIONS AMONGST STAFF AND CLIENTS

Whether a treatment center is able to achieve its core objective is also strongly influenced by a second factor, the social relationships that exist between staff and clients. Given the philosophies of the programs, staff members strive to be as client-centered as possible in their interactions with women clients. They do this by trying to maintain a balance between empathy/compassion and structure/discipline in their dealings with clients. At the same time, individual staff members have their own approaches to treatment, which sometimes differ from the official line of the program. Clients quickly become aware of the different perspectives of workers, and make decisions about who to approach with specific needs and requests. As I illustrate below, this ongoing negotiation can both hinder and/or facilitate a program's operation. I also show that a key issue shaping clients' perspectives on individual staff members is whether the latter have personal experience with addictions. For some clients, staff members in recovery are seen as more legitimate counsellors.

In addition to the staff, clients approach their peers for support while in program. Here again, they often seek out those who are the most similar to themselves and/or the ones that will most likely be able to respect and understand the experiences they have had. How these peer relationships are negotiated and managed also influences the overall dynamic within the program. The benefit to strong and successful peer relations is that they have the ability to supplement the

work of staff in positive ways (i.e. through help/support, learning, friendship). At the same time there are potential challenges associated with peer relations that need to be managed to maintain the therapeutic potential of a particular program. For example, staff may try to limit how close clients get with one another. Their concern is that if clients form too close of a friendship with one another it could put them in a more vulnerable position. For example, should one client relapse or quit the program, her friend may feel unable to stay. As well, when some clients get too close it has the potential to change the dynamic of the whole group – creating a feeling of cliqueness where others inevitably feel left out. This section highlights how the staff-client and peer relationships play out in the two programs, and the consequences of these relationships for the treatment setting.

4.4.1 Staff-client relations at Program “A”

Relationships between counsellors and clients have the ability to impact the therapeutic potential of the addiction treatment environment in a variety of ways. The presence of staff is essential for a well-structured and safe atmosphere. This fact is recognized by clients, who are often quick to scrutinize the actions and abilities of individual workers based on the extent to which workers meet their perceived needs. Given the range of personalities that both utilize and are employed by addiction treatment facilities there are many perspectives on what works and does not work. Often clients will evaluate particular counsellors on the

basis of their ability to show empathy and compassion towards them, while also maintaining a 'reasonable' amount of structure.

Because individual clients enter Program "A" through continuous intake it can take time for them to develop confidence and earn the support of their peers. As a result, the initial support offered by staff strongly influences how clients interpret the program space. Christine, a new arrival at Program "A", provided an example of how staff support and encouragement impacted her first group session:

I was just trying to say my piece this morning, because the counsellor said, 'Christine just who cares what everyone else thinks! When it's group therapy talk... say how you feel'. So this morning in group therapy I tried to talk and say how I felt. And I felt that... people didn't understand... I'm trying to express myself the best I can, but [right now] people just don't understand where I'm at or something. I don't understand myself. (Christine, Program "A")

In this situation the counsellor encouraged Christine to speak up for herself, although she was clearly intimidated in the group setting. Over time, as she builds relationships with her peers this support will more likely come from other clients rather than a staff member. As clients build trust in one another they increase the level of support that they show one another and decrease the demands that they place on the staff.

While staff support is crucial, the women interviewed did not always see their relationships with staff members in positive terms. Julia, for example, drew

a distinction between her relationship with Vicky, the intake worker, and the counsellor she was assigned in program:

She meets my needs. You know what I'm saying?! It's like, what do you need today? – Okay it's as good as done. Or, I don't need anything. – Okay that's as good as done... I probably feel more connected with Vicky, who I never see on a regular basis, than I do Donna, who is now my counsellor. And I don't know why! (Julia, Program "A")

Many women commented on what they would like to see staff do differently. For example, Tanya, thought staff should be better at enforcing proper etiquette by reminding clients of the behaviours that are appropriate and inappropriate in a group setting, rather than just ignoring rude behaviours. While some clients would view this as overly controlling and unnecessary, Tanya felt the group atmosphere would be more therapeutic if such elements were in place. She continued:

[H]ere clients are allowed to slouch and sleep in their chairs in group, and I feel that is very disrespectful. It makes me feel that I am uninteresting, and that people don't care what I have to say. And then I tend to keep looking at them, like I mean – come on! It's distracting. So I feel the counsellor should say 'sit up straight, like your falling asleep!' (Tanya, Program "A")

Tanya may hold such strong feelings about this because she had previously attended another more structured program with more stringent expectations about behaviour. This experience also reminded her of past experiences that depleted her sense of self-worth and therefore she recognizes it as important to her

recovery. Julia offered a similar statement about the acceptability of behaviours by certain clients at mealtimes:

Even belching at the tables is okay, so I don't get that. I don't get [how] some of the behaviour [is] acceptable and then [how] some of it [is] not. I don't understand, but maybe they expect more from some people and less from others? Maybe I guess. Maybe that's how this place is run – more on an individual basis. What your needs are on an individual basis versus [the needs of the group as a whole]. It has been made clear in the treatment centers before this one that here are the rules man and you will follow them and if you EVER belched like a pig at the table in [the other facility] you'd be out. It just wouldn't be tolerated.

The issue raised by Tanya and Julia is undoubtedly one that staff face at all treatment programs. The majority of treatment clients have experienced more than one treatment center. As each facility has its own philosophy, clients – especially veterans of many programs – bring in strong opinions about what works best and are sometimes willing to challenge practices that they do not fit with their own sense of 'best practice'. For example, Julia identifies how the philosophies held at different facilities guides their day-to-day practice.

[The other facility I went to] is based on the 12 step, big book. That's what they believe will get you sober, keep you sober, die sober. Like you live the big book of Alcoholics Anonymous and the 12 steps and that's the answer for sobriety. Because they are a 21 day program they are very regimented. Because I cam from there, like [my counsellor] said – here is not as strict and I have to understand and accept that. But it's not about being strict. It's very black and white there (Julia, Program "A").

This statement identifies how clients need to adjust to various programs depending on the philosophies that guide their practice and not expect each one to be the same as the last. It also suggests that the rules specific to programs are

influenced by the length of time women spend in treatment. Longer programs may be more tolerant of behaviours – at least initially – that are grounds for dismissal in short-stay facilities. This was certainly the case at Program “A” where there was an expectation that clients would work through and improve behaviour as they gain more time in recovery.

Notwithstanding variations between programs, staff members face the constant challenge of determining when a client breaking a rule should be disciplined immediately, spoken with after the fact, or simply given a pass. This can be particularly challenging when clients are in counselling sessions with staff. In her interview Samantha said that she felt like her counsellor dismissed or rejected her during one-on-one sessions. She said: “it’s like she’s pushing me away because she has something better to do”. While this situation may be an outcome of the limited time that counsellors have, Samantha saw the sessions as unhelpful and un-therapeutic because she was not given the opportunity to open up about issues troubling her. She responded to the situation by approaching other clients for the support she felt was lacking in the counselling sessions.

I find that they (other treatment clients) are more helpful actually than the counsellors. Because my counsellor, I don’t find that she is very helpful for me. I am in and out of there (her office) in twenty minutes and she’s just pushing everything to the next week, so I don’t even bother opening up, because there is no point, because she’ll just say – let’s talk about it next week! (Samantha, Program “A”)

Interestingly, this use of peer supports is something staff want and expect clients to take advantage of. They are aware of the needs of their clients overall, but also recognize that they alone cannot meet client needs. Instead they help clients build relationships with one another so that they gain the additional support from their peers, a point I return to in the peer-relations section below.

As they get to know staff, clients begin to assess their credibility individually and collectively. A key issue here was the extent to which staff members had personal experience with addiction. This is an issue that many clients consider to be an important element in relation to how they build relationships with and relate to particular staff members. It was a recurring theme in my field notes. For example, while attending a group session at Program “A”, Tabitha wanted someone to explain:

...the worth of learning from people who haven't been in her shoes, who only understand addiction through what they have been taught in school, because she is not sure whether they can understand where she is coming from or help her through this stage of her recovery. (Field notes, Program “A”)

I was surprised to hear her be so frank about this issue in the presence of the staff and felt that they might be equally surprised, however they didn't seem to be. I also expected them to become defensive; however that did not occur either. Instead something very different happened.

[O]ne of the counsellors pointed out that one of the greatest strengths of the program is not necessarily what you (the clients) will get from the counsellors, but what you (the clients) will learn from each other.

The staff member responded to Tabitha by attempting to emphasize the importance of the relationships that clients will build with their peers rather than trying to justify her position as an effective counsellor based on her personal history. Tabitha's question was one that was raised by many women. Some felt that only another addict could possibly understand where they were coming from, know when they were lying or telling the truth, and/or show them the empathy and compassion that they need, because these counsellors have a grounded knowledge of addictions. Many also accepted rules and discipline more readily from staff members who were recovering addicts because they thought that these individuals must know what works and what doesn't. This perspective underlies the practice of the Alcoholics Anonymous organization, which argues that only other alcoholics and addicts can mentor people in their journey towards recovery.

Julia also believed that there was a major difference between counsellors who are ex-addicts versus counsellors whose understanding comes from academic knowledge on the subject. She felt that at Program "A" "[t]here is a very distinct division between staff and clients", which she seemed to think existed because staff were not ex-addicts themselves and as a result set themselves apart from the clients. Other women made similar comments about Program "A" staff, although it was never explicitly made clear that staff members were not in recovery themselves. During fieldwork, they simply did not speak of their own past

experiences with addictions if they had any. In any case, Julia's feelings stemmed in part from her experience at another program, where the counsellors identified themselves as recovering addicts. As a result, Julia felt that they identified with her and in turn treated her like she deserved better for herself despite the negative things she had done as a result of her drinking.

[W]hen I went in there (the other program) I felt so disgusted with myself. I had so much shame and guilt and hurt, because of my kids and they (the staff) were like, 'let us love you until you can love yourself'. You would never get that here (at Program "A"). (Julia, Program "A").

By contrast, she believed that Susanna, the 'professional' counsellor she had been assigned at Program "A", was not able to fully or immediately understand the feelings of an addict/alcoholic:

Susanna said something to me one time. She said, 'you know you put yourself into such a box of negativity'. I said, 'you don't understand – that box had me and I couldn't get out. YOU couldn't get out of that box'. So the fact that I put myself in there... See that's the whole thing, I don't have to describe to [the counsellor at the other program] how bad it was. All they had to do was look at me and they felt it (Julia, Program "A")

Tabitha had also recently completed treatment at the program referred to by Julia, and she expected the counsellors at Program "A" to be recovering addicts or alcoholics. She emphasizes that before choosing to enter into a program, women should find out what type of experience the staff has in relation to addictions, whether experiential or academic.

I would honestly say to anybody who was going to treatment to enquire about their counsellors, because I really honestly feel that the best

counsellors are the ones with the addictions themselves. (Tabitha, Program “A”)

Initially, Tabitha felt strongly that people with addiction experience made the best counsellors; a stance that was linked to her belief that the 12 steps of Alcoholics Anonymous was the only way to obtain long-term recovery. However, over time she expressed greater acceptance of other approaches to treatment, a shift in opinion that was a direct result of conversations with Program “A” staff. She was encouraged by staff to try to consider more than one route to a successful recovery, although remained fearful that trying other things could lead to relapse. She had only known/had sobriety in her life for a short period of time, which she believed had come through the support of recovering counsellors at another 12-Step treatment program and through the Alcoholics Anonymous fellowship. It makes sense then that at this point in her recovery she has reservations about taking advice from counsellors who do not appear to have personal experience with addiction.

4.4.2 Staff-Client Relations at Program “B”

The way that clients feel when they arrive at Program “B” is somewhat different from the experience of clients at Program “A”, because the intake system is fixed rather than continuous. Clients at Program “B” enter the program together as a cohort. While many of the same feelings of vulnerability exist -

especially if women are entering treatment for the first time – they are given the opportunity to get to know each other as a group with a shared objective.

Irregardless, until clients have the opportunity to get to know one another and to develop a sense of place/comfort in their new surroundings they often feel somewhat anxious. And at times other factors may heighten that anxiety. For example, when Donna first came to Program “B” she had a difficult time arranging her medications with the pharmacy which was an un-therapeutic experience for her.

Another woman (Donna) was having issues with her meds during session and so left the session for quite some time. After lunch when it was time for everyone to get their meds she was clearly having an anxiety attack around hers not being ready yet, but the staff were very patient with her and helped to diffuse the situation. She complained that they shouldn't recommend that out of town clients use that particular pharmacy if it takes them so long to get organized properly. (My Field Notes, Program “B”)

In this scenario the staff at Program “B” showed that they are very capable of dealing with client needs in a professional manner. They calmly explained the process that they were going through to get her medications properly organized and told her that they would remove her from group session when they arrived, which she accepted. Again, it is during the intake process and early days in the program that staff support of new clients is especially important.

It is important for staff to work at making a positive first impression on clients and to maintain a good ongoing relationship with them. At the same time, as in any relationship, effort is required from both parties involved – staff and

clients in this case. Sarah recognized that in program clients have to adjust to the different personalities amongst the staff, along with trying to absorb what they are being taught if they want to make the most of their treatment experience.

But then you also learned about each counsellor and the way that they wanted to teach and conduct their classes. They are all so very different too. So you kind of put yourself in a different way of thinking when they are teaching too (Sarah, Program “B”).

Adapting to the variations amongst the counsellors might be more difficult for some clients than for others. This can potentially impact the therapeutic objectives of the program, since it can result in these clients refusing to learn from particular staff member and/or being unable to understand what is being taught. This might also be considered a ‘therapeutic’ strategy used by clients in some senses since they are choosing what they *think* is best for their recovery. This could however work to their disadvantage if they are not able maintain an open frame of mind with regards to various aspects of the programs they utilize given their limited availability

In her interview, Donna describes finding one counsellor particularly challenging to relate to and learn from. The therapeutic nature of the program was limited for her during her first few days in treatment because she did not feel safe with this counsellor. As she explains, during a session “a counsellor completely lost it and screamed at two of the residents”. This experience had a profoundly negative impact on her.

I was afraid and had a panic attack. I did end up sleeping downstairs in detox, because I did not feel safe up here (on the treatment floor) with her... [I]t did cross my mind that I needed to be hospitalized, that I wouldn't be able to pull it together, so that was a biggie. (Donna, Program "B")

She explained that this situation took place because there were two clients who were repeatedly interrupting the counsellor. While counsellors regularly face unnecessary interruptions, on this particular day the counsellor responded quite strongly to the situation. For Donna this response was inappropriate, because clients are re-building their social skills and learning to wait can be a challenge not only in this scenario, but also in life in general.

You have to remember that these people are starting to get a voice and maybe its like learning to ride a bike – they are trying it and they're falling off and they try it and they don't get it right and they haven't learned any diplomacy and their first reaction is aggression. It's a dog eat dog world (Donna, Program "B").

While Donna was able to remain in program despite her anxiety, she retained a very vivid memory of this incident. In her opinion this counsellor reacted too strongly to the situation that was presented, which she felt was unnecessary for her. She explained that she is more likely to relate to staff members who take a softer approach towards her.

I think that the ones that are good are the ones that for me are the more gentle women. The other ones are kind of hard, self admitted recovery. [They] are a little bit more sergeant major like and I can see, given the clientele, why they may have to be like that, but they don't need o be like that with me. It's not necessary. I don't need it. There may have been a time in my life when I did need that, but I don't need that now. I need direction. I need understanding (Donna, Program "B").

Interestingly she identifies that her needs are different from what they were years ago. Her statement also draws our attention to how clients build connections with certain staff members based on whether they have a personal addiction history or have learned about addictions through an academic setting. Donna is unlike many clients who identify more strongly with staff who have a “self admitted recovery” story to share, as was also the case at Program “A”.

This discussion has highlighted the various ways that relations between staff and clients take place. While in some cases actions by staff are viewed negatively by clients, Joanne explained that from her perspective counsellors react in ways that are unintended and/or not ideal at times, because they “have a lot on their plates”. It is important to remember that the response provided by staff might also be connected to the client-centered approach used by Program “B”, whereby counsellors are able to decide how to deal with particular situations on their own based on their interpretation of what has taken place and what they think will be best for the client. This is the alternative to following a set of rules and guidelines that are black and white, and that may or may not meet client needs. Unfortunately, depending on the situation, this can lead to clients questioning the actions and/or decisions of the staff. This was observed at both sites especially in cases where the situation and/or outcome involved what clients perceived as preferential treatment.

4.4.3 Peer Relations at Program “A”

As with staff-client relations, the relationships that clients build with one another are complex and multi-faceted. This discussion will highlight the ways that peer relationships help to support women in some instances, while constraining their recovery efforts in others. One of the main areas that clients are able to supplement the objectives of staff is through their support for one another. All clients are vulnerable in their own way with respect to particular challenges that they are working through. While counsellors strive to support clients' progress as much as possible, the one-on-one time they have available for each woman is quite limited. Other clients are ideally able to pick up where staff have left off. For example, Ronda explained that relations with her peers in treatment helped to improve her confidence and self-esteem:

I am one of the ones in the group that has been here for a while and I do not like sharing in group, because I get really nervous like talking in front of a lot of people. And I think that part of the reason is that I wasn't confident enough and just recently, in the past – just this past week, I started talking. And I like my feedback! And the girls are starting to tell me when we are on our walks how much they enjoy listening to me talk and that I should be talking more often, because they think that I speak really well when I do say something. And they're all telling me how proud they are of me that I'm sharing now and that maybe I should have done it sooner! So feedback does actually, it helps a persons – what do you call it – self esteem?

Obtaining feedback in group therapy was healing for Ronda. Moreover, the experience she had in group gave her the confidence to go to an AA meeting and

share her story, despite the fact that she was nervous and didn't know everyone there.

Samantha also felt that the relationships that she had built with her peers had definitely improved her treatment experience, not least because the support helped her to feel comfortable at Program "A".

When I came – like my first day or you could say my first week – it was nothing like what I expected it to be. It was so much more positive! And it was just very welcoming... Everyone was like, 'hi, I'm this person, I'm that person, - you know – welcome. If you have any questions or you need anything just ask me!' You know?! So I just found that the clients were really helpful, really nice, so I felt comfortable right away (Samantha, Program "A").

This was especially important since it was her first time in treatment. She was completely unsure what to expect and these initial experiences had an obvious impact on her perception as she transitioned into the program. She explained that these relationships were more helpful for her than the relationship that she had developed with her counsellor. Again, this was because of the limited one-on-one time that was available to her. While she did not feel like this should be the case (getting more support from other clients than she felt she was getting from staff) she was appreciative of the suggestions that other clients provided her with and how helpful they were whenever she needed someone to talk to. As noted earlier, the staff recognized that some clients felt that they were not adequately available to them. However they also deliberately limit their availability because they do not want clients to build a dependence on them. Instead they strive to maintain an

atmosphere amongst the clients where they are continuously trying to support others in the group. From this perspective it is more important for clients to network with and learn from one another than to network with the staff, since these women have the potential to continue to be part of their support network when they leave the program.

In program clients who have been to treatment numerous times and who have been struggling with their addictions over a long period of time have the opportunity to help others, because of their deeper knowledge of the challenges that others could face in recovery. Tabitha talks about being in this position and her feeling that clients who are new to treatment and recovery are often naïve as to how hard it is going to be.

I find I can pretty much get along with anybody. My patience and stuff like that is tested, but I turn it around with younger people, because I was there. 'I don't have a problem with alcohol, its only drugs or vice versa, right?!' Or 'I haven't gone that far, poor you, but that won't happen to me! I've got all of these things in place' (speaking for the other clients). Well I used to too – now they are all gone, you know?! So I try to give as much encouragement to them as possible, because I can relate to where they are (Tabitha, Program "A").

She describes being able to provide encouragement to newer clients and give them some warnings as to what to avoid. In doing this she takes on a mentorship role, characteristic of the 12-step program, while also trying to emphasize her views. She does this in an effort to steer other women away from the harms she has experienced in her life, yet I noticed that at times this is not the way that it

came across. Instead, it sometimes seemed like she was suggesting that very few people go through treatment only once – almost providing a sense of hopelessness to the process – when in actuality she was just trying to suggest what to avoid so that they are more successful in their recovery than she was at their age. This example highlights a major challenge associated with client communication.

While it is great that clients are willing to share and try to help one another, many are still learning how to do so effectively. Tabitha has the best of intentions but expressed frustration at being misunderstood by others. Irregardless, being willing to try to help one another is a central element to why social relations amongst peers is crucial; however at times it is helpful if staff are there to mediate what is being said so that the point being made is understood properly.

Staff are unable to mediate communication amongst clients at all times, however strive to support them to improve their approach towards one another in program, especially during group therapy. This is a forum where women are encouraged to share their thoughts and feelings with the rest of the group, and receive feedback. This is meant to help them to work through some of the issues affecting their lives. Clients quite often share their concerns over strained relationships with family and friends that are the result of drinking and/or using. They also express concerns about what the next phase of their life is going to look like and how they are going to approach sobriety on their own after leaving treatment.

Sharing not only releases some of the tension that they are feeling, but also encourages others to do the same. Through this process clients gain support from one another not only by realizing that others are going through similar things that they have gone through or are continuing to go through, but also through feedback that is provided to them. I sat in on many group sessions and was able to capture an example of how this process takes place:

One of the first women to speak disclosed that she had not had any contact with her mother and sisters since Mother's Day. On that particular day she had confided that she had experienced another relapse and was using again. They became very upset with this information, and a conflict broke out, resulting in the woman and her family 'mutually disowning each other'. The woman explained that very recently she had written a birthday card to her mother, whose birthday was quickly approaching, however she was having trouble mailing it, for she feared further rejection. Consequently she was feeling very lonely and full of anxiety.

When the woman was finished speaking she said that she would be open to any feedback that the others may have. Quite a few of the women spoke up and said that they too have (or have had) estranged loved ones, and therefore understand her pain. As a group they tried to reassure the woman that a mother/daughter bond is enduring, and that no matter what deep down her mother still loves her. They encouraged her to go ahead and mail the letter, so that she would know that she had at least tried to rekindle contact. It seemed as though the woman was reassured and felt better by getting this off of her chest.

The slogan that the facility takes is one from Alcoholics Anonymous, which is that 'secrets keep us sick'. This woman clearly felt much better about this particular situation after sharing it with the group and realizing that they were not going to judge her negatively for it.

Staff members facilitate the discussion to ensure that it stays on track and clients remain supportive of one another. They encouraged clients to share and also reminded them to be active listeners who provide their peers with supportive feedback without passing judgement. Further, clients are not allowed to provide each other with feedback unless the person who shared indicates that they are comfortable enough to receive it. In this way, clients who are concerned still with what others might think or say in response to what they have shared do not have to accept feedback, but are still able to express themselves. This is an important daily exercise for many of the women, because very often they lack confidence in their ability to effectively communicate with others and this provides them with a relatively safe space to do so.

Group therapy also helps clients to work through and figure out how to avoid future risks associated with drug and alcohol use. Very often clients express feelings associated with wanting to use or having been triggered to use. Their stories remind others of how easy it is to relapse. As clients share situations where they felt particularly challenged, others are reminded not to take unnecessary risks that could jeopardize their recovery, no matter how resilient they think they might be. For example, in group,

Another woman spoke of a risky experience that she had undergone the previous day. This woman explained that she had been clean for nearly eight months, however she had to deal with some unfinished business with one of the doctors that she used to visit regularly. This required her to go down to the doctor's office. Unfortunately, the doctor's office was located

at an old 'drop-in' location that she used to frequent when she was hooking and using. She had been experiencing great anxiety over having to return to a place that was so closely connected with her life as an addict. She had discussed this risk with her counsellor who had advised her that perhaps this was not the best thing to do, when she was still in a relatively early stage of her recovery. However, the woman insisted that this business must be taken care of, and assured her counsellor that she felt strong enough to go back there without giving in to temptation.

She was now recapping her experience of returning there. She said that she underestimated how difficult it was going to be for her. When she was coming out of the doctor's she ran into a woman that she used to work the streets with. She relayed how the woman was obviously still actively using, and was twitching and very nervous. The woman mentioned to the group that she had tried to keep her conversation brief with this other woman, however while they were talking the addict dropped her crack-pipe on the ground right in front of her. She said this scared her because she experienced the strongest physical temptation that she has ever felt since the time that she stopped using. Apparently, the user asked her if she wanted to accompany her while she went to get high, at which point she ended up vacating the scene. The woman then relayed to the group, that if she had not had the Program "A" to return to, she very likely would have made another poor choice, which would have 'been the end of her'. She went on to explain that when she did finally make it back to the Program "A", that she actually envisioned it as a haven, and compared it to a scene that you would see in a movie when the heavens opened up with bright, showering lights and music. She felt so fortunate that she had this location and a routine to return to.

Her story emphasizes how important it is that clients are able to return to the treatment center after experiencing a difficult situation associated with their use, given their vulnerability. It also provides staff with a platform to highlight what clients can learn from their peers.

4.4.4 Peer relations at Program “B”

Program “A” struggled with the dynamic of the treatment group because new clients were entering the program just as regularly as others were leaving. The continuous intake system added an extra dimension to social relations that was not present at Program “B”. Because the latter operates a five-week program using a fixed intake system there is no initial division of clients, where some are ‘new’ and some have been there for a number of days or weeks. Instead clients go through program as a group. The director emphasized the advantages of this, stating:

One of the things that needs to happen for a closed program is that these women are working towards their journey as a group. There’s strength in the group, there’s recognition that I have common issues as my peers, there’s problem solving, there’s new ideas, there’s different approaches that happen with a group. So they need to build that group and we need to facilitate that happening. I don’t believe that we want them to connect with only one or two people. I think we want to help them build a network. Having secrets with one other person who can let you down is very unhealthy, so I would like to have them work with all of our team.

Ideally the women build a network of support rather than relying on just one other person. They also problem solve within the smaller group; working out any personal issues that they have with other clients as they arise. As Gabrielle, a client at Program “B”, explains, it is also easier to open up in the group setting, because there is a greater opportunity to build trust in the group when the people in it remain unchanged and they are also comfortable sharing with you.

Being a small group I found it very easy to come out of your shell and to share experiences and I found a lot of the other women were very forthcoming with their ideas and experiences. That made it a lot easier to be honest and to bring things out front (Gabrielle, Program "B").

She identified that this group was also easier to open up in, because it was small. This was the result of a number of women withdrawing and/or being discharged from program early on in the treatment cycle. While this is not ideal in a general sense, it made some remaining clients feel more comfortable, providing them the ability to more intimately share their experiences and build closer friendships with those around them.

Like women at Program "A", many clients at Program "B" enjoyed sharing in group therapy. This time affords an opportunity to discover that other people are going through situations that are quite similar to themselves, or in some cases have had much more complex experiences.

The group therapy is a wonderful healing process. Within the group the women are suffering from the same disease, so it's helpful. And to see what their lives have been, what they have experienced in their lives too. It's been quite an education for me. I feel like I am on the higher side of the fence when I hear what has happened to them and [learn about] their lifestyles, what they are doing with themselves. [It has been] quite an education (Sarah, Program "B").

Learning about the experiences of others, as Sarah identified, can help clients to feel better about their own experiences and actions, although this is not a wholly positive phenomena since she seems to be judging others by what they have done in their lives in comparison to herself. There are many instances however where

clients feel better in group therapy simply because they realize that they are not alone. Other women have similar experiences and can relate to where the person's situation. Donna believes that alcoholics and drug users all have something in common because: "*our common denominator is that we are addicts and a drug is a drug, regardless of what we do.*" Over time, clients' relations with one another also extend beyond their addictions. In group session, for instance, they learned many other positive similarities they had with peers.

They did an 'autographs' activity where they learned small ways that they were similar to one another by getting the autograph of peers who possessed certain traits. They also did a 'my facts' activity where they told the class three things about themselves, one of which was supposed to be a lie, and have the class guess which was the lie. This got all of the women laughing and chatting with one another, which was awesome to observe. They all seemed very willing to participate – some opening themselves up right away, while others sharing somewhat less personal truths.

While it seemed that initially it was important for clients to remind themselves that their common denominator was addiction, as they became more familiar and comfortable with one another, reminding themselves of their 'common denominator' became less and less important. As they worked through more team building activities, the level of support that they displayed towards one another increased as well. Here is an example from my field notes:

The next thing we did was gather in a circle, the main difference being that we did this beside the group table so that it no longer sat within the middle of everyone. Without the physical barrier of the table separating all of us, immediately I sensed a greater deal of unity, which provided a nice setting for this upcoming exercise. One of the facilitators presented one of the women with a gift. This gift was wrapped in multiple layers of wrapping

paper. On each layer of wrapping paper there was a statement written. The person who held the gift then had to pass the present onto another woman whom they felt best fit the description (and the process continued). The gift was intended to be the positive affirmation, or validation that each woman received through the written description. With each layer, the descriptions appeared to get slightly more personal and required more thought.

Examples of statements included:

'Give this to someone who has demonstrated patience'

'Give this to someone who possesses a talent you admire'

'Give this to someone who you feel has heard you'

Give this to someone you feel that you could confide in'

With each passing of the gift, the receiver was only allowed to say 'thank-you'. Laurel mentioned that this was the rule because many women tend to try to refute the compliment in some way. This ended up being a beautiful and emotional exercise, that all of the women were actively and attentively participating in. It was very interactive. I will admit that at first I had some reservations, for I was concerned that the quiet, older woman would receive the gift last, because she has probably established the least amount of contact with the other women. I was afraid that this would only isolate her more. This did end up occurring, however when she was given the gift the affirmation was a nice one, and perhaps more fitting to her character than some of the other descriptions, and therefore more sincere. Since this quiet woman appears to be very intelligent, overall I think this was best, for she would have been able to quickly identify whether a woman gave her the gift out of pity. The statements that applied to her included:

'Give this to someone whom you admire' and 'Give this to someone whom you would like to get to know better'.

After this portion was over, we started with one woman, and went around the circle and everyone had to give a compliment to that woman. This was done for each of the women... This was a very powerful moment for all of the women in the room. A few were moved to tears both when they were receiving and giving the compliments. It is clear that accepting positive qualities about one's self can be very emotional for many of these scarred women. Some were visibly uncomfortable with hearing these good things about themselves, spoken aloud. However, all expressed that they enjoyed being able to make positive comments about the others, and making others

feel good. Some also commented on how useful it was to hear some of the perceptions that others had towards them, and they were often surprised by the nice things that some had to say (qualities that they would not have otherwise recognized within themselves).

It is clear that the group sessions provide an opportunity for the women to build positive relationships with one another, and to express themselves while learning to identify with and listen to the experiences of others. The group setting helps clients to improve their ability to show empathy towards others, which is especially useful, since many are so entrenched in what has been taking place in their own lives. Over time taking part in this group therapy assists clients in being able to better identify their own feelings and emotions – improving their ability to work through them. Further, clients benefit greatly from the feedback of their peers. The level of isolation that clients feel is often minimized when others identify that they are able to relate to their experiences and/or have gone through the same thing.

As clients advance in the treatment process they also benefit from the positive changes that they see in their peers. While they might not immediately identify with the changes that have taken place within themselves their observations of others can often act as an additional motivator for them.

As part of session we discussed how affirmations can manifest themselves and become tangible elements of our lives. Together the women discussed that you can actually see visible changes in a person as they begin to feel better about themselves. Some signs include; women taking more time and putting more effort into their physical appearance, they exhibit less negative talk both towards themselves and towards others, and have more

self-confidence, which is demonstrated by greater eye contact etcetera. This is another area where group treatment seems to be very beneficial. Sometimes it can be difficult to observe changes within oneself. Therefore seeing the progress of another woman both physically, mentally, and spiritually can serve to remind oneself of how far they too have come. Also, it can serve as a motivator for further change. I have heard on more than one occasion, different women referring to another client who is further along in their treatment, saying things like 'I want that happiness, or confidence for myself'. Seeing others make the transition serves as a constant reminder that healthy change is possible.

However, the opposite can also be true. When a client leaves the program early, it can have profoundly negative impact on those still in treatment. For example, they expressed concerns and thoughts around the potential relapse of former clients, and where these women were returning to and whether they would be safe spaces for them. While constructing concerns over the challenges of others clients not only redirected their attention away from themselves temporarily, but also sparked feelings of jealousy in relation to the progress that these women had made and self-doubt in relation to whether they would also be able to get to the same point.

4.4.5 Negotiating tensions at Program “A”

The benefits associated with peer relations are not automatic and need to be managed by staff and clients to maintain a positive dynamic within the treatment group. When this fails to occur clients interactions become strained and many challenges arise. These include but are not limited to; an increased level of

judgement over one another; hostility when explaining/trying to enforce program rules, and segregation within the group/the formation of cliques. In turn, these developments can cause clients to become uncomfortable in the treatment setting, making it difficult for them to open up and trust others, ultimately disrupting the therapeutic character of the program.

Christine's interview suggests that not everyone has a good first impression of Program "A". She explained that her experience was actually quite negative.

There's been negativity as soon as I walked through the doors for me. One lady said to me – I came out for a cigarette and I was stressed out and she said – 'there's only allowed three people out here, eh?! You're going to have to go!!' And I'm like, 'what? Okay, I don't know the rules. I'm new here'. I wasn't given a briefing, so right away people were yelling at me and I didn't know the rules (Christine, Program "A").

In this instance, other clients were quick to put the newcomer in her place rather than mentoring her into the program in a friendly manner. This was difficult for Christine, making her feel immediately uncomfortable with her peers and colouring her perception of the facility as a whole.

Clients are not always immediately friendly with one another for a variety of reasons. Often existing clients want to determine the motivations of new clients when they first arrive. They do this in order to protect themselves against building relationships with clients who don't want to be there and/or don't want recovery as much as they do. As Tiffany explains,

You can tell right from when somebody walks in here what reason they are here for – if it's because they are forced in here, because they want to come in here, or they just don't know yet – and I just basically try to avoid the ones that don't want to be here, because you get sidetracked so... For the first couple of weeks that I was in here it was really hard. There was a lot of back biting and gossiping and talking and I just tried to really ignore that.

She specifically avoids going to AA meetings with others, for example, because she argued that a large number of clients go to them to meet men (a practice known by clients as '13 stepping').

I don't go to meetings yet. I've made that personal choice, because I find in the house a lot of the things that go on in meetings have to do with 13 stepping and I don't like that. They (the other clients) are not focusing on what they are supposed to be focusing on and so I avoid going to meetings with them (Tiffany, Program "A").

She feels that this distraction could be quite dangerous, potentially threatening her focus and therefore her recovery.

For some clients the relationships that they build with their peers is part of what they enjoy most in treatment. Ronda explains however that staff members prefer that clients don't get too close with one another, and may actively intervene to limit relationships. She talked about a recent situation that revolved around her close friendship with another client, Samantha:

That's where I was going (the basement) and then when Samantha came in the house that's where she became my best buddy and that's where she hangs with me, because we like quiet, you know?! Me and her are inseparable, even though they have found a way to separate us. We were in the same room together, now we are separated, because I think that the rule here is that they don't like people getting too buddy, buddy. It makes the other clients feel uncomfortable, so they separated us during program time

and separated us from being roommates. Because too if we are getting too involved in each other then we are not going to concentrate on our program and plus the other clients might not feel too comfortable – like new ones that like, you know – because a lot of people have a lot of problems, deep problems that come in here and maybe that's not the type of atmosphere that they want (Ronda, Program "A").

Staff are concerned not just that close friendship could disrupt the dynamic of groups sessions but also that if one person were to leave the program and/or relapse that it might be hard for the other one to deal with – precipitating their own departure. Not all clients are as understanding as Ronda has been when staff attempts to manage their behaviour and the social relationships that they construct. While in conversation amongst a group of clients at Program "A" I learned that some clients actually left the program when a room switch took place or when they were told that they shouldn't be spending all of their time with one or two other people.

As clients get to know one another and spend their days in program together tension can also arise if they have trouble communicating effectively with one another. This might mean that at times clients say things that they don't mean and/or say things that hurt others with or without intending to do so. For instance, Anita described the damage to her sense of self when another client cast judgement on her for having Cerebral Palsy (CP).

We had a girl in here, probably five or six weeks ago for two or three days and she kept saying that my CP was the devil's work. That was challenging to be told that time and time again, but she didn't stick around too long.

And you know, that's something that will pop out in my mind ten years from now (Anita, Program "A").

Her statement draws attention to how some statements can have lasting impacts on others – long after treatment is finished or the other client has withdrawn from the program. This is just one example of how easily the delicate balance present when clients are interacting with one another can disappear. Other similar situations to this took place in group therapy as newer clients were learning to communicate in the group setting.

I identified one scenario in my field notes where 'older' Program "A" clients seemed to show an extreme lack of compassion towards a 'newer' client in group. While situations similar to this took place on a number of occasions, during this particular incident the counsellor had briefly stepped out of the room – leaving only one facilitator there to manage the dynamics and conversation of the group.

A new client was the next to speak up and indicated that she was feeling very frustrated with her life. She was very scattered and was rambling on a mile a minute trying to clarify things in her own head while explaining to the others where she was coming from. She provided a not-so-brief background of herself. She kept referring to the fact, that she was here for herself and nobody else, and made the comment a couple times: 'No offence to all of you guys, but we all have our issues'. I took her as reaching out to the group to find some common ground, however during her narrative she used the words crack and pot and alcohol on a few occasions. One of the other girls snapped at her at this point, and said that 'as explained there is to be no drug-ism', which means you are not supposed to use the names of drugs or paraphernalia when speaking. This girl explained that when she hears such terms they act as a trigger for her, and she actually begins to taste and smell the drugs, and breaks out into a

sweat. She basically insinuated that she resented this new girl for making her feel uncomfortable. At this point, the new girl got fairly defensive and apologized and said that she did not understand what drug-ism meant, and therefore did not know that she was breaking a rule.

Another woman then jumped in and in a somewhat hostile tone, objected to the new girl making comments like 'we all have our issues'. She explained that she does not appreciate being lumped in with everybody else, and explained that she has her own individual set of circumstances, that differ from everyone else in this room. She said that if she herself wants to identify the fact that she has issues, than that's fine, but she should not be speaking on behalf of anyone else's experience. Again, the new girl apologized and said that she would try better to conform to the rules, and that she was not trying to offend anyone.

At this point, she clearly looked intimidated. Although it is important for her to be familiarized with the rules, I felt that this could have been done in a more delicate way, and with more understanding particularly since she had just joined the group and was therefore already likely feeling very vulnerable. In addition, no one bothered to offer her any positive feedback on what she had said, and instead chose to focus on all of the rules that she had broken. The primary counsellor was actually called out of the room while all of this went down, and therefore she was not present to help smooth things over (Personal Observations).

The clients who responded to this woman left her feeling more vulnerable, intimidated and insecure than she already was. While rules are ideally put in place to enhance the comfort of all clients, they can also be used to strengthen social alliances and increase power amongst certain clients.⁸ Unfortunately this behaviour can strongly impact the way that new clients perceive the program and its therapeutic capacity. In this instance, the woman informed me later that she had decided she was not going to stay at Program "A" because she did not feel

⁸ Interestingly, clients mutually decided later that the "drug-ism" rule should be waved, because there are so many rules that it can be overwhelming to try to remember them all on a day-to-day basis.

that it was a supportive environment. Because women are in such a fragile state as new clients very small challenges can sometimes seem incredibly overwhelming. This experience demonstrates the essential nature of supportive client relations that work towards with the core objectives of the program, as well as the practical difficulties involved in maintaining such relationships.

4.4.6 Negotiating tensions at Program “B”

Unlike Program “A”, because of the fixed intake system at Program “B”, there is the potential that a negative dynamic amongst the treatment group could go unchanged over a treatment cycle if issues go unresolved. While clients are encouraged to work through disagreements with others on their own, conflicts can strongly impact the frame of mind and comfort of all women in the group. Donna described a group of women who were in program with her as “extremely volatile” and felt that many lacked the skills necessary to “live in a community living situation”. She supported her assessment of the group by outlining how many women are remaining in the treatment program at the time of her interview⁹

Apparently this group has been the most difficult group in a long time and as you know there is only three of us left in residence and there were eight, and there were three doing the day program and there are only two now, so that sort of speaks volumes. One person in residence left on her own, the others were discharged and the person who left the day program left on her own as well (Donna, Program “B”).

⁹ Donna’s interview took place two and a half weeks into the five week program.

Her statement draws attention to the difficulties involved in building peer relationships in this type of setting, especially given the diversity of the women and the challenges they face. This is especially true when the dynamics amongst some of them are poor and/or when so many leave over such a short period of time. It also suggests a major issue with the fixed intake system in terms of using resources to their full potential when a large number of women withdraw or are discharged from the program so early on. The staff suggested to clients that the volatility in their group is not the norm either. Nevertheless, the behaviour of even a small number of clients obviously has the ability to impact the safety and comfort level perceived by others. Donna described a confrontation she had with another particularly hostile client before she (Alma-Marie) was discharged later that day.

Alma-Marie, because she is a prostitute, is used to staying up all night and I think that it was a pretty big challenge for her to get up at 7 o'clock in the morning here. I mistakenly woke her up to get the coffee, because she was in charge of our caffeine coffee that we were allowed to have and she lost it. She was extremely verbally abusive, she was threatening and she was discharged as a result of her behaviour. I was intimidated to a certain extent, but I have to admit that I was certainly prepared to defend myself in an altercation if was necessary. Just the fact though that you have to have those considerations in your head that you would have to physically defend yourself is not good. It is not good. I felt bad that she was discharged. I went through a period of feeling extremely guilty because if I hadn't woken her up, but then commonsense told me that that was bound to happen (Donna, Program "B").

Interestingly, while clients may not get along while in program together Donna's statement suggests that they still feel empathy and compassion towards one another.

Donna also identified another challenge that exists amongst clients in the treatment setting, which is that very few clients have any money. This was the case at Program "A" as well and results in an atmosphere where some clients are constantly asking for money and/or borrowing things from others, who have more resources available to them.

That's another thing that gets very problematic around here. No body's got any money, so you've got to be really careful with that, because it won't stop. There was a lady in detox that came up here and she was really broke and I bought her a pack of smokes and I bought her a coffee, because she was only going to be here a couple of days, but I made it very clear with her that she could not let anyone else know that. So you have the people that are really broke so you have to be careful (Donna, Program "B").

I also commented on this after observations made on a group outing;

Often poorer women in the center will bum cigarettes off of other women, ask for change for laundry or ask them to share other personal items with them. Amanda actually went as far as to hand another client a ten dollar bill and ask her to get a roll of quarters for her, because she didn't want the other clients to see. She knew that Donna was trustworthy because she has resources of her own and constantly has other clients asking her for things or to pay for items at the store. Deborah also told me that the lady at the store will give her cash back on her visa card, but lets her come behind the counter to put it in her wallet so that the other women would not see. Clearly this is an ongoing issue that presents itself on a daily basis (Personal Observations, Program "B").

While some clients are very generous with one another, others become uncomfortable with being asked for money and adjust their spending behaviour. This is a challenging scenario, especially when this distinction amongst clients results in a social environment where clients are suspicious of one another. For example, in some instances clients start to steal from one another when they cannot find anyone who is willing to share with them, which makes building a trusting and safe feeling within the environment very challenging. When I came into the group room for session one day I noticed a very obvious shift – everyone had their purse with them, whereas they hadn't previously. I recorded these observations in my field notes noticing that clients were behaving as though they were suspicious of a particular client whenever she went somewhere on her own.

During session Tanya looked as though she wasn't feeling well and so asked to go lie down. She left group. Alma-Marie was also given permission to leave to go make a phone call that had to take place at a certain time. At break the tensions taking place in the house started to become quite clear. A number of the women were concerned with Tanya leaving session when everyone else was in group because they were starting to notice things going missing in their rooms (Personal Observations, Program "B").

It is challenging when theft takes place, because clients start focusing on the behaviour of one another – studying each others actions to determine who the thief might be. This heightens issues associated with existing personality conflicts to a degree that feels almost unbearable, because clients begin to

intentionally avoid certain people, breaking down any possibility of cohesion amongst the group.

As issues arise clients can also become even more judgemental of one another. For example, Donna was not getting along with Sharon, because she demanded her own way all of the time. Sharon consistently took control of what the women were able to watch on TV when she was in the room and expected to be excused from program whenever she did not feel up to being in the group.

In the evening I watch a movie, again that is a touchy thing, because we will refer to her as the "B" client – and no "B" doesn't stand for bitch, but hahaha – I think she is only used to watching TV so she kind of tends to take ownership of it. And when she is in the down, which is most often, because when she is up it's the manic. I'm not sure if you are familiar with bi-polar, but it's not a comfortable atmosphere, so sometimes I don't feel comfortable there and that may change. I don't hesitate though to watch a movie, because it helps to make time go by fast (Donna, Program "B").

Donna started to question whether it made sense for Sharon to be accepted into treatment in the first place, which she connected to Sharon's mental ill health (she was diagnosed bi-polar and had also suffered brain injuries due to her addictions).

There is a woman here who went from – and this is certainly questionable in my mind – went from 5 weeks in a psychiatric floor as a result of an attempted suicide and didn't have any stabilization time and came here. She's quite psychotic, severe bi-polar and she has had brain injury twice. So, initially I thought that would be ok, but I am really struggling with that now... It's like sandpaper on wood – I'm letting her get to me.

Her statement suggests that she attempted to keep an open mind initially, but that as time progressed it became very clear to her that a residential treatment centre

was perhaps not the most appropriate place for her given the degree of help that she needed. The daily interaction with this client was also challenging the therapeutic nature of the program for her, since every day her patience towards this client seems to diminish even more.

Clients also struggle in building relationships with their peers simply because each of them is trying to work through many difficult issues in program and has finite energy to devote to others. As they get close to one another they open up and share their experiences, asking for support and advice from each other. The challenge is that often they can only provide so much support before it begins to take away from the energy they need for themselves. During fieldwork, I recorded the following about Donna's decision that she could no longer convince Amanda to stay in program:

After our walk on Friday Amanda decided to leave the program... Donna said that Amanda came outside and told her that she was going home. Donna said that Amanda has done this a number of times, so she told her "I'm not going to try to talk you out of it this time, if that's what you feel is best for you then I guess that's what you need to do". And that was that, she left

While she might have just needed the verbal reassurance that she was strong enough to continue, Donna felt that she could not keep convincing her to stay. This type of situation relates to the staff's concerns that clients not get too close to one another in program. On the one hand, clients must focus most of their energy on themselves. On the other, too much support can lead to one client's over-

dependence on another. Several staff members commented that it is not uncommon for clients to relapse and have to repeat treatment because they were too focused on the needs and problems of other women in their group and did not learn how to care for themselves.

Lastly, client behaviour seems to shift as women near the end of treatment and become increasingly anxious about leaving the program. Sarah identifies this as a challenge during her interview by saying;

They are all getting anxious to leave, and their behaviour patterns are changing. It's probably like 'yeah, I only have one week to go, so I don't need to adhere to the strict rules and regulations anymore. I've only got one more week and they can't punish me for doing anything anymore'. And there have been problems with individuals on a one-on-one basis with each other. I can't let any of their problems affect me [though]. I don't care about any of that. I just step outside of it.

As she identifies through her own behaviour clients might distance themselves from others during this time in an effort to remain in a healthy frame of mind that will continue to facilitate their recovery. How clients adjust their interactions with others is often strongly impacted by available space, both internally and externally. The treatment space imposes certain limitations on its clientele, especially given the high volume of women that are frequently utilizing them.

CHAPTER 5

TREATMENT PROGRAMS AS THERAPEUTIC ENVIRONMENTS II

5.1 INTERNAL TREATMENT ENVIRONMENTS

5.1.1 Introduction

There are various aspects of the physical environment, both internally and externally, that can impact a program's ability to provide a therapeutic setting for clients. As clients spend the majority of their time inside, the internal treatment space will be discussed in first, followed by an analysis of the external neighbourhood environment. With regards to the internal structure I will first provide a description of the physical layout of each center. Through these descriptions it will become evident that each facility is designed to encourage particular behaviours; most notably that clients act as active participants in their recovery, and that they refrain from isolating themselves from others. The majority of this discussion will be focused on highlighting how program spaces function as therapeutic and have been deliberately created to aid clients in their recovery.

5.1.2 The Internal Space at Program "A"

Program "A" operates in a three storey residential home that has been retrofitted several times to meet the needs of the program. When you enter the

house there is a cozy foyer that provides entrance directly into the rest of the facility. Directly to the left is the director's office and to the right a sitting room with space for clients to meet visitors. In front there is a staircase that provides access to the second and third floor. Further down the hall is the 'chapel' - which essentially functions as a second group room. Despite its name it does not have a strong religious appearance. Beyond that is a large living room and behind that the exercise room, which is linked to the kitchen and the dining room. Also on the main floor is the secretaries' office, the prescription closet (which will be explained in more detail below), and a staff area. The layout of the main floor is somewhat convoluted and takes getting used to, but is also quite large and provides clients with quite a bit of room to roam around.

The living room is quite large and is where a number of the women choose to spend their free time. The couches are organized in concentric circles around the fireplace, which has a TV stuffed into it. There is also a fish tank to provide the women with some relaxation. The exercise room just behind the living room is very small and cluttered. There are a number of machines that have been donated to the facilities that are arranged in a long line with little space for clients to actually use the machines. Beyond the exercise room, the dining room is part of a recent addition to the building. It has a number of round tables that comfortably sit four to five people. It is set up with a diner feel to it – with plastic flowers on the tables, and red and white chequered plastic tablecloths. It is very neat and

tidy, and private despite the fact that there are apartment buildings right behind it. When the addition was put onto the building the windows were placed high up to provide ample light without neighbours being able to see in. The walls in this area are exposed brick, which gives the area an institutional feel that conflicts with the diner theme. From the side of the dining room, a door leads out to a bricked patio area. There is seating beside the door where clients wait in line to go outside to smoke. The challenges associated with smoking are discussed in more detail below.



(Picture of the Dining Room at Program “A”)

The second floor contains some of the clients' bedrooms, a staff washroom, a client washroom, staff office space and the main classroom. On the third floor there is another client washroom as well as more bedrooms. Clients typically share their room with one other person; however there are a few rooms that are larger to accommodate a third person when needed and one single room. Clients are only allowed on the floor where their bedroom is located and if they are on the other floor it can result in immediate discharge. There are no locks on bedroom doors, so if a client has any valuables they are supposed to give them to staff to be placed in the safe. Each of the bedrooms, while simple, has single beds, a desk and a wardrobe for each client. The only bedroom space that is different is the assessment room where clients spend their first week. This room has three beds in it, but has a more clinical feel to it, since there are dividers between the individual sleeping spaces.

The classroom on the second floor is designed very much like a typical school room. There is row seating and the counsellor stands at the front of the room with a blackboard behind her. There are also health related posters placed around the room which show images of the body and the physical effects of alcohol, smoking, cocaine, marijuana and HIV/AIDS. These gave the room a very clinical feel. Supporting this was a row of health related pamphlets on the back wall that are in a location that does not seem very conducive to the women actually accessing them, since one would have to squeeze between the furniture to

reach any one of them. One wall in this room has windows from wall to wall, providing plenty of light and a pleasant view of the neighbourhood; however the windows might also be distracting, a fact that one client demonstrated during my fieldwork. About halfway through class she crossed her arms, put her head down and started peering out the window at the street.

Clients at Program “A” are also able to spend their time in the basement if they choose. In this area, there is an additional seating area with a TV, fridge and half bathroom. It is neatly done, but has a very dark and dingy feel to it as there is no natural light. There is also a cold storage area in the basement for food, and a number of washers and dryers that clients are able to use to clean their clothing while there. It doesn’t initially seem like a therapeutic space, however some clients used it as an alternative space to busier areas of the house, as will be discussed below.

5.1.3 The Internal Space at Program “B”

Unlike Program “A”, the internal treatment space at Program “B” has been customized to meet the needs of the program. The building was previously home to a service provider for children with development disabilities. When Program “B” moved in, the internal space was gutted and retrofitted so that a wide range of programs could successfully take place there. While it does have a very

institutional feel it is also very logically organized. Once buzzed in at the main entrance there is a large foyer. In my personal observations I wrote that,

It is minimally furnished with two blue sofa seats and a small shallow cabinet that has two clipboards on it – one for volunteers and the other for clients. There was a picture across from where I was sitting that would make one feel that they were in a resort; in a private room with the French doors wide open, breeze flowing through as you are able to look at an undisturbed ocean view.

I enjoyed that picture, because it took me away from where I was for a split second. Having never visited a treatment facility before, I found myself feeling nervous as I waited for the director to meet with me.

To the left of the foyer is the withdrawal management (detox) space, which takes up one half of the main floor. Directly in front of the main entrance is another door, which leads into the area used for the New Choices program. This program services mothers with young children. To the right is a solid door that leads you into a stairwell and brings you up to the area used by the staff. The staff area is an open concept cubicle design with a lunch room, a conference room, private phone/sitting room (used by clients and staff to arrange housing, work and medical visits), and three private offices for the director, assistant director and principle counsellor. My footnotes contained the following comment on this space:

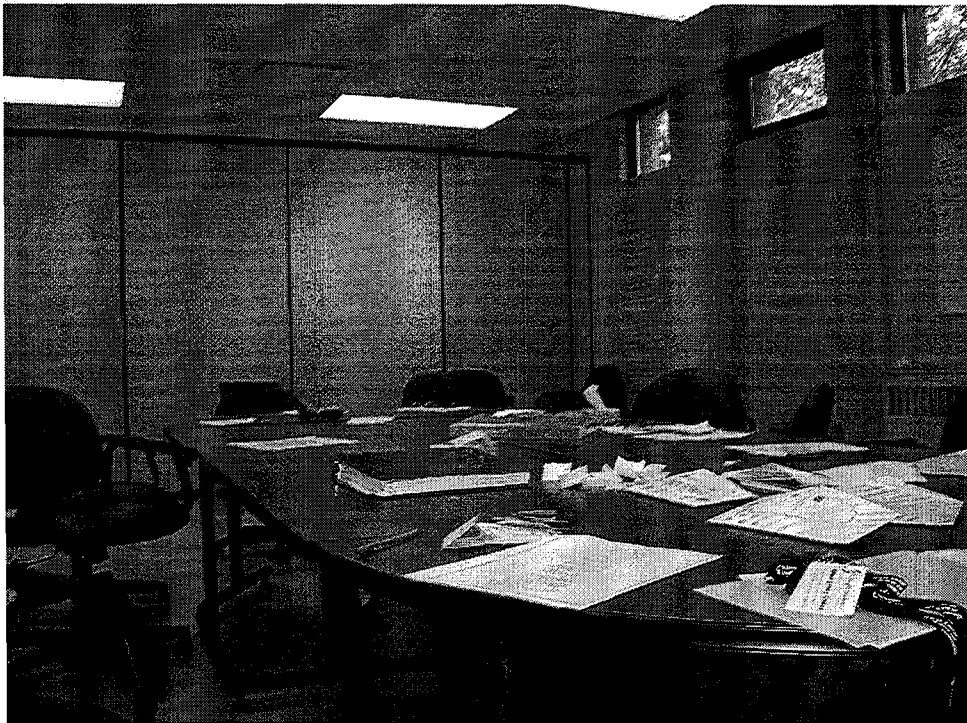
The upstairs area and even lobby have a very professional feeling to them despite their trying to warm up the space with client artwork, plants, throw pillows, and etcetera.



(Staff Lunch Room at Program “B”)

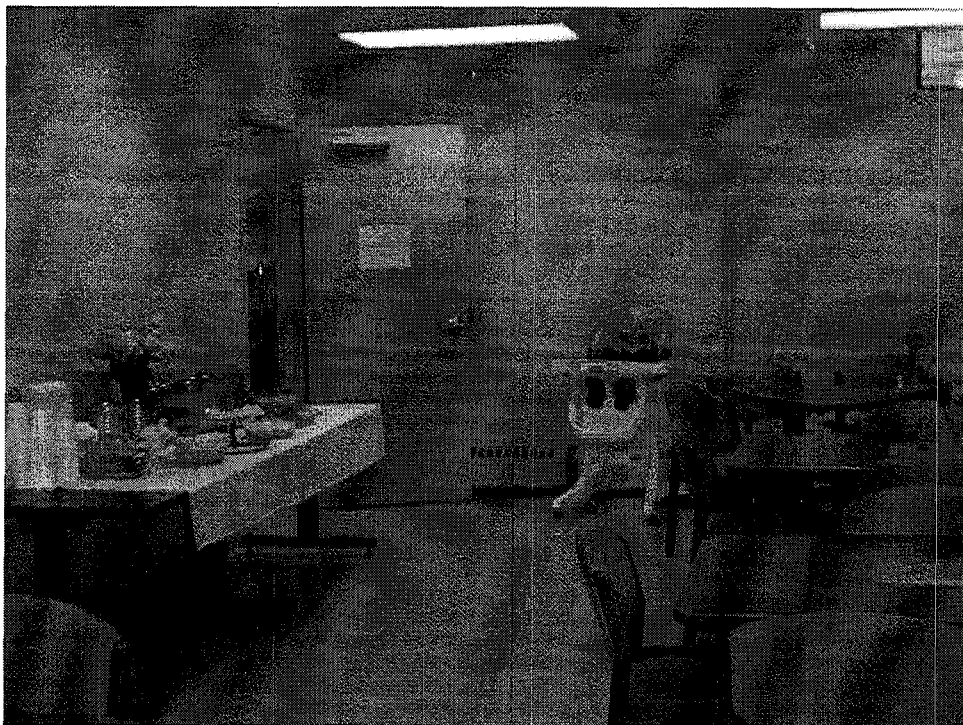
At the end of the staff area is a door that leads into the living area for residential treatment clients. This contains a living room and kitchenette combined at the center, a large washroom, and client bedrooms arrayed around the perimeter. The bedrooms generally accommodate two women however there is one large room that accommodates three, as well as a room set aside for non-smokers. Beside the staircase is an elevator for clients with disabilities. Although no clients were using it during fieldwork, several staff members used it regularly to avoid the stairs.

All programming for residential and day treatment clients at Program “B” takes place in the basement. In this area there are two group rooms that look like typical conference rooms. They each have a large oval table with numerous chairs around them.



(Program “B” Group Room)

In the basement there are washrooms, as well as the dining room and kitchen. The dining room is a very sterile room – more hospital-like than any of the other rooms in the facility. Like the rest of the facility the dining room’s walls are painted in a neutral beige colour. There is also minimal artwork or decoration on the walls, although the director envisions the walls filling up as clients’ writing and artwork is displayed.



(Program “B” Dining Room)

All clients who use the facility at Program “B” share this dining space; withdrawal management, residential and day treatment, and new choices (mother and child). Clients are served in a buffet style. There is a long table running along one side of the wall with the food placed on it and then four tables running in the opposite direction that can seat five to six people comfortably. Given the shared use of this space with clients from other programs there is a different dynamic present when compared with Program “A” where all the women are familiar with one another. Nevertheless, at both programs the choices clients make about where and with whom to sit in the dining area provide a good indication of the ups and downs in peer relations. During fieldwork, I noticed that

clients would scan the room as they left the buffet line before choosing where to sit. Tensions were especially evident when clients chose seating at a table by themselves or at the opposite end of the room from others in their group.

At both facilities staff generally did not eat lunch with clients. Rather it was a time for both to get a break from one another. The only difference was that at Program “B” one staff member would sit in with the group for the first fifteen minutes of lunch to monitor how clients were behaving with one another. This was seen as a necessary strategy because the dining area contained so many women at very different stages of their recovery.

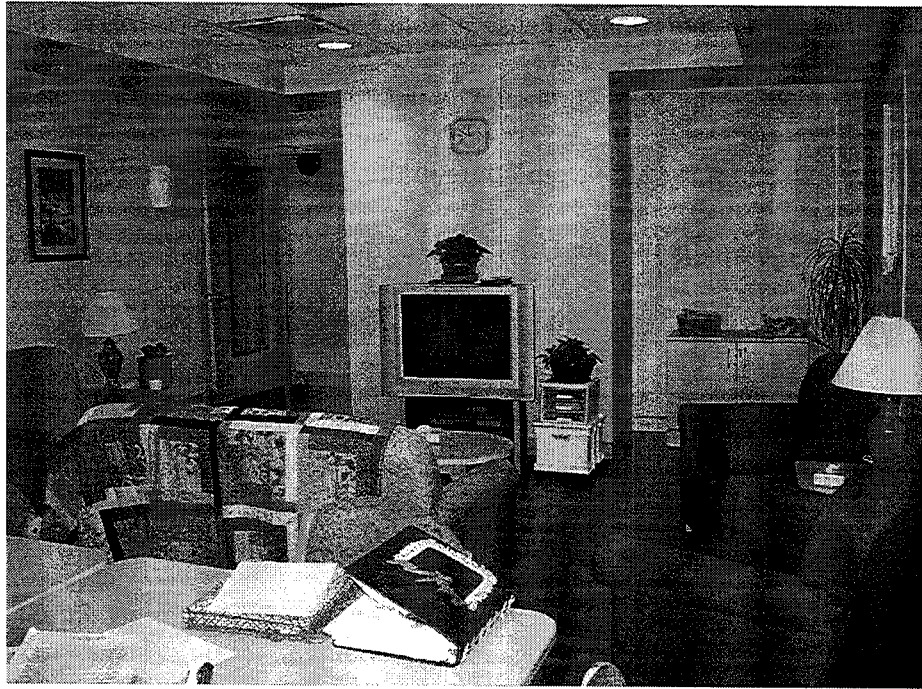
5.1.4 Comparing popular spaces at Program “A” and Program “B”

In the course of the broader research project of which this study is a part, it was realized that respondents often had trouble answering direct questions about the character of program space. This difficulty may reflect people’s unfamiliarity with concepts and ideas from human geography, particularly the idea that space plays an active role in shaping everyday social life. As an alternative, I asked respondents to talk about places within the program that they liked and disliked, and to think about why this was the case.

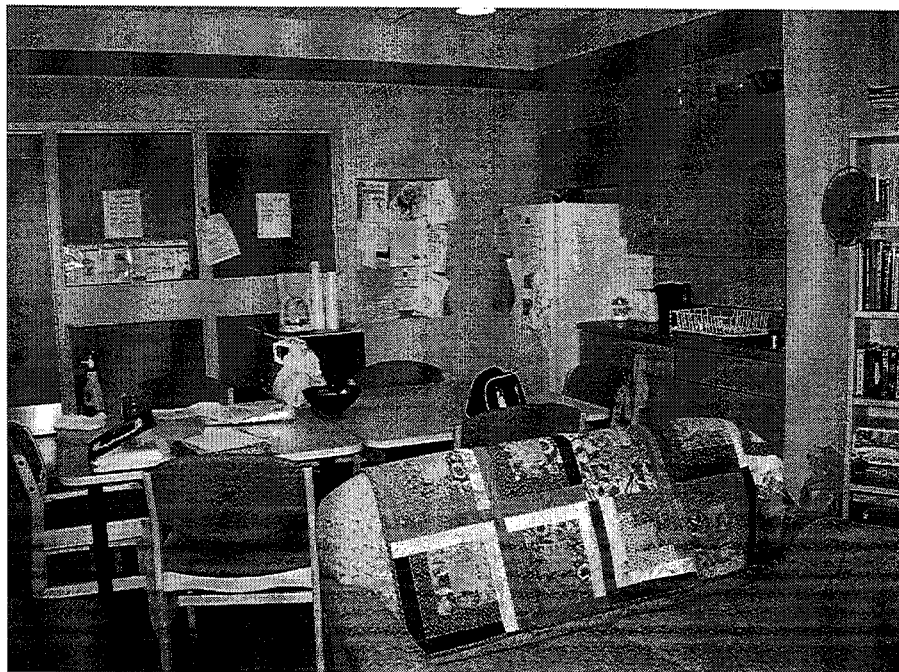
Significantly, favourite spaces for clients were often the smoking areas, because almost all clients smoke, and the living room/communal area, because clients enjoy socializing with one another while not in program. At Program “A”

clients also enjoy the living room because it is so comfortable, which is supported by the director at Program “A”, who believed that “if they could do anything they wanted in the house they would be curled up in the living room”. At Program “B”, on the other hand, clients spent much more time outside than they did in the common area. This seemed to be due to the fact that there is no rule about the number of women who can be outside at one time at Program “B”, and because the communal living area is much smaller and less comfortable than the one at Program “A”. During fieldwork at Program “B” I noted that:

While waiting for a few of the women to get organized, change and go to the bathroom and such I went into their communal living area. At first glance I thought it looked quite nice. It has a couch and a few arm chairs, a fair sized TV, a kitchenette, dining room table, some books and a range of movies to watch. I decided to plunk myself down on one of the arm chairs, which I dropped myself into and practically bounced right back off of. They are quite firm and actually somewhat uncomfortable, and are made of a plastic like fabric which I would imagine was chosen because it is easy to clean, but is not very welcoming or ideal. One of the women watched my facial expression as I sat down and said “not very comfortable eh?! I suppose we could go to our rooms and sit on our beds, but they don’t want us to isolate ourselves either, so that’s what we’ve got!” I couldn’t help but think that it doesn’t really encourage use of the space. Further, it is placed in the center of the building and so there is no natural light.



(Communal Living Area at Program "B" – View of Living Space)



(Communal Living Area at Program "B" – View of Kitchenette/Dining Space)

Comparing the two sites, the living room/communal space at Program “A” seemed to be much more conducive for daily use by a large group of women than the same space at Program “B”. Although the furnishings at Program “B” are new and well organized, the cluttered and worn couches in the living room at Program “A” are more comfortable and far more inviting. Also, while the physical sizes of the facilities are comparable there is more space for clients at Program “A”, because it is strictly a treatment facility, whereas Program “B” is a multi-purpose treatment facility.

A few clients at each site prefer quieter spaces and so seek out locations where people don’t tend to go as often. At Program “B”, clients would need to either go to their room or go outside in the available green space, weather permitting, because they only have one communal living area available. They might also choose to go to the group room (classroom), but this did not seem to be something that they chose to do, since they spend much of their time there during program. At Program “A” some clients also went to their rooms for peace and quiet, while a few often went to the basement. While it is more run down than the rest of the house and does not have any windows some clients find it appealing because it is quiet and a space away from others. Ronda commented:

I like it down there. Me and my buddy (Samantha) go down there... [W]e’ve got a fridge down there, we’ve got a bathroom down there, we’ve got a sink down there, we’ve got cable down there – we are SET down there! It’s like our own little living room. Nobody in the whole house goes down there, just us... [W]e like it quiet, you know?!

Ronda's comments point to the ways in which clients negotiate their use of the internal treatment space to meet their social needs. She and her friend use the basement to isolate themselves from the larger group when they needed time to themselves. While the staff and director at Program "A" had little to say about the basement, they saw Ronda and Samantha's frequent use of the space as part of a larger issue of interdependence. I later discovered that they had been initially assigned as roommates, but were reassigned when the staff felt that they were getting too 'buddy-buddy'.

Some women, Ronda included, found the intensity of the large group interaction too much at times and so used the basement space as a break from that. Since the basement had an extra television, they were also able to exercise some choice over the evening programming, even if the larger group upstairs chose what they did not like. Tanya, for example, commented:

I like to spend time in the basement for a few different reasons. One, it's quieter – not too many people go there. And it's not that I want to isolate, but it's really hard when you have thirteen to fifteen different woman watching TV upstairs. And everyone seems to like 'Law and Order' and I don't like 'Law and Order' and 'Special Victims Unit'. They watch all of these people getting raped and abused and it's like 'my gosh, I've been raped and abused since I was five and I don't want to see this here', so I go downstairs (Tanya, Program "A").

Clients seem to be aware that spending time alone or with a buddy in the basement might be perceived as attempting to isolate oneself; however clearly at

times it is preferable for them for a variety of reasons that might not initially be obvious.

5.1.5 Comparing unpopular spaces at Program “A” and Program “B”

When speaking about the places that they chose to avoid while in treatment the responses of clients at Program “A” and Program “B” were quite different from one another. While Program “B” had less communal living space available to clients there seemed to be less on-site tension when considered in connection to places that clients chose to avoid. They thought of very few examples of places that they would avoid in comparison to the clients at Program “A”, who had strong responses to this question.

Clients at Program “A” pointed not only to physical attributes of the facility that they did not particularly enjoy, but also to places where the social setting was not quite what they were looking for. With regards to physical attributes clients described not enjoying the basement because of the way it smells (Karen and Tiffany) and just simply because they don’t like basements (Julia).

I don’t like the basement – it smells. There is a water problem down there and they haven’t fixed it. The water drips from the ceiling and it makes the carpet and that smell funny (Tiffany, Program “A”).

The director at Program “A” also felt that the basement lacked natural light and saw it as an area that needed to be changed; however this has not yet taken place, most likely due to a lack of resources.

Some clients also explained that they avoided using the dining room (Karen) and the classroom (Jade) because both rooms had a lack of comfortable seating. Others described settings, such as their bedrooms, that they avoided, because they felt more isolated – leaving them to reflect on their lives. In her interview Samantha explains why she does not like to spend time in her bedroom.

I don't like being isolated. There are some times that I would like to go to my room and chill for a little bit, but I think that being by myself would just bring stuff up that I don't really want to think about – like my mom and stuff. So, I find when I am out and talking with people and stuff it keeps me happy, it keeps my day bright.

The bedrooms at Program “A” would likely have this effect, because they are more out of the way than the bedrooms at Program “B”. Clients sleep on the second and third floor at Program “A”, and unless someone else was going to their bedroom no one else would pass by a bedroom to go anywhere else.

At Program “B” the bedrooms are on the outer perimeter of the building on the second floor with the communal living area at the center. Staff offices are also on this floor, separated by a single door. Further, the group washrooms are on this floor, which are the only washrooms available to the women unless they are in group in the basement. The way that Program “B” has been designed and laid out means that if clients were to spend time in their rooms to catch a break from everything they would not have as much opportunity to feel isolated, because it would be much more likely that numerous people would pass by their room while they were in there. Regardless of the physical layout and design of a

particular treatment facility Samantha has touched on something important here. Her own sentiments mirror the staff's sense that there is a danger of isolation in the bedroom space, yet at the same time there might be some benefit to clients being able to access some time alone.

With regard to spaces that clients choose to avoid as a result of the social dynamics that are present within them at Program "A" most women pointed to the living room. This is likely due to the fact that it is where most of the clients congregate to socialize and relax most frequently when not in program and not outside smoking. Both Anita and Tanya explained that they avoid it because they can't watch the shows that they want, while Leanne didn't want to hear the TV all the time. There seems to be a struggle for space and control within this room, both with regards to TV programming and where clients can or cannot sit while using the space. Tanya points to this in her interview:

I so much want to lie back on the couch and watch TV there, but there's not enough couches. Yeah, there's not enough room. And it seems if I have a couch and I leave for a minute and come back, 'well – you snooze, you lose'. But then, if I come in and sit somewhere, and someone comes in and says, "I was sitting there, can you move?" I move right away. So the people who are not as assertive lose out in treatment.

Since Program "A" operates on a continuous intake system, tensions over spaces like the living area may increase and diminish as the dynamic of the group changes over time.

For the most part clients at Program “B” could not think of anywhere *on-site* that they actively avoided (Gabrielle, Joanne, Sarah, Hilda). This is likely due to the fact that my fieldwork took place in the summer when a number of the women spent as much time outside as they could. There was only one instance where a client described avoiding the communal living area when another particular client was there. As Donna explains:

Well I mentioned the common room if Sharon is in there and she is on a roll, which is most of the time. Yeah, I'll avoid going in there.

I suspect that during winter months clients at Program “B” would have more to say about perceived problems with the living environment.

5.1.6 Perceptions of Things to Change at Program “A”

The director at Program “A” identified a few physical changes she would make to the site if she could that differed from comments made by clients. She explained that the organization is hoping to renovate the chapel, which also functions as a second group room.

We haven't been really pleased with it (the chapel). It feels cluttered and not spiritual. It just feels too much like just a spare room. Mostly it's just decorating – the room itself is okay.

Interestingly, many clients described this room as one where they found they could relax. Despite the clutter, clients liked the dark green colour of the walls and the view of the garden from the window. Perhaps the least comfortable

aspect of this room is the chairs, but that seemed to be the case throughout the centre.

The director at Program “A” also explained that she would like to see the space used for the dispensary changed, which was a converted closet. Based on what she said I recorded some particularly concerning observations about this space.

Relatively recent changes to ministry regulations meant that homes are now required to dispense medication in a way that allows individual clients to maintain confidentiality. This was the only spare space, so has had a little counter and locked cupboard added. The director says that it is not ideal, particularly since it means that a staff member is in there by herself. She says that they have put an air horn in there for people to signal for help should any problem arise.

A key issue for many clients was the design of the classroom. As mentioned above, it is structured in such a way that makes it feel like a traditional school room, however is too small to function the way the centre wants it to.

Clients find it disorganized and uncomfortable. For example, Julia said:

If they do renovations they should renovate the classroom first! Even the tables - like everything about it seems half-ass thrown together. I don't know, it just seems like the worst room possible to have us sit in the most and have us try to absorb and open up our minds in the most. It looks like a Goodwill room, dishevelled, convoluted, confused. ... I find that messed up because we spend the most time in there. The configurations – some people are sideways, some people are uncomfortable. It's uncomfortable for the most part. If they want a classroom setting the room is far too small for it. I don't know, it's almost very institutionalized, but in a dirty way. ... It just doesn't seem to fit its purpose.

Given the amount of time spent in the classroom, clients' feelings about the environment may have a significant influence on the day-to-day operation of the group sessions. While Jeanette was perhaps the most articulate about these issues, she was not alone in her negative perceptions of the classroom. Many women felt it needed to be a lot bigger if it was going to function properly. Tabitha felt that the classroom needed to be arranged differently to make it feel more inclusive. This would also require it to be much larger than it is.

In the classroom I would prefer a circle so that you can see everybody. I think that it would be beneficial for the client and the teacher. You can't hide behind anybody.

This is true of the way that the classroom is laid out. While I was observing use of the classroom I noticed that clients who were not interested in participating, for whatever reason, tended to sit towards the back and separate themselves from what was being taught. Jade, like Julia, emphasized the amount of time that is spent in the classroom when she explained why it needed to be changed.

The most uncomfortable is the classroom. The chairs aren't comfortable. It's kind of hard when we are sitting there for an hour for Life Skills and then we have Step Class right after, and there's no break. So for an hour and a half we are sitting on those hard chairs. So comfort wise that room definitely [needs to be changed]!

It seems by her statement that if small changes were made to the room and to the daily schedule that the room could feel a lot more therapeutic than it currently does. Beyond the size of the classroom though there are many structural changes that clients felt needed to take place.

A number of clients at Program “A” also noted that the building was entirely inaccessible. As an old three storey house, with floors split into multiple levels connected by stairs, it is a problematic environment for people with physical disabilities. Anita, for example, uses a walker and explained that there are a lot of ups and downs in a day and the number of stairs often makes her feel quite tired.

I often joke about the steps in terms of the architects must have had a lottery to see who could come up with putting the most stairs in there, because there are stupid, dinky one or two stairs everywhere in the house. Mind you, I have lost weight – go figure.

Jade felt the same way. She thought that while the space seems alright that the design could be a lot more open concept. Tabitha also pointed out that aside from needing an elevator to accommodate clients with disabilities, the stairs going down to the basement needed urgent attention:

They should have an elevator, especially for handicap people! It’s pretty dangerous going down to the basement for someone who is disabled and walking down those stairs, because it is really small (Tabitha).

When I inquired about accessibility with the staff, I was told that the program simply cannot accommodate someone in a wheelchair. As such, an individual with such a disability would be told to seek treatment elsewhere.

Both the director and many clients felt that the basement at Program “A” needed to be changed as well. It is very dark and dreary looking. As the director explained, there is “no natural light down there at all”, which poses not only a

challenge in terms of its therapeutic potential, but also a major safety concern in the case that there were ever a fire. Other clients commented on needing more space, especially in the exercise room where there is both a lack of room and a large amount of clutter. It is definitely not big enough to accommodate the number of clients at the centre. A few clients also felt that the bedrooms could be bigger as well, since the beds are often close together. Considering the program space overall one client said she would like to see the colours on the walls updated:

I find the colours of this place are pretty drab. Like I know it's old, but it doesn't have to look it (Tabitha).

This is an interesting comment given that colour is often believed to impact the therapeutic potential of a space. Because of the number of comments regarding what should be changed at Program “A” there are plans set in place to gut the building and renovate it entirely. While the director was not clear on exactly when that would be taking place both herself and the assistant director seemed to be aware of many of the current issues and concerns surrounding it.

5.1.7 Perceptions of Things to Change at Program “B”

As mentioned the communal living area at Program “B” is not nearly as comfortable as the living room at Program “A” due to institutional furniture that lends itself more to form than enjoyable function. One client at Program “B” also

described the room as depressing, because it lacks any source of natural light. This seemed to be a major challenge at the facility, since a number of clients commented on lighting and location when speaking about structural changes that they felt needed to take place.

When asked what she would change Gabrielle explained that she would “just [like] more windows” and that if that was not possible then “more time outside would be nice”. Interestingly, despite the fact that the building was gutted and renovated for the centre, most of the spaces that clients use are quite dark. The only exception to this is their bedrooms, which are on the second floor and where they spend very little time during the day. While on tour of the facility the director explained that the set up provides clients with privacy, since the area surrounding the facility is densely populated; however, in practice it seems that the provision of privacy conflicts with clients’ need for a lighter, and potentially more therapeutic, treatment setting.

The group room, where clients spend the majority of their time, is located in the basement and also has very little natural light. Clients often complained that the basement was too cold. With regards to lighting, Joanne felt that the group room needed to be brighter, while Donna found fluorescent lights really un-therapeutic because they bothered her eyes. She makes an interesting observation about the difference in lighting between the group room that is used for clients

and the lighting in the conference room that is used by staff (where I conducted our interview).

In terms of the group room, ditching the fluorescent lights would be nice, because that's hard on your eyes. Some pot lights would be nice – actually like they have here in this room!! So lighting.

Significantly, clients could be excused for thinking that the staff's space had been given more priority than their own program space. Staff offices are located upstairs in an area that is brightly lit and are placed along an outside wall where there are a number of windows. The staff area was also well decorated with artwork providing a more welcoming feel. For Donna, a client at Program "B", this was what was lacking in areas for clients. She felt that the centre had an institutional feel to it.

Its just hospital floors, everywhere we are there is just hospital flooring and the absence of pictures. So that would be one thing. What else?! I think that's really the biggie... There is no cozy place here... Yeah, I guess warmth really describes it for me. This place lacks warmth and cozy-ness.

5.2 EXTERNAL TREATMENT ENVIRONMENTS

5.2.1 External Treatment Space at Program "A"

Upon initial inspection one would not guess that the Program "A" property is being used as a residential treatment facility. It has quite an elaborate garden at the front and side of the property, which is very well maintained, and - unlike Program "B" – no signage to make its purpose obvious to others. The exterior of the building is beautiful and its architectural style matches other

houses in the area. The only place where its function becomes obvious is in the backyard, which is essentially just an extension of the driveway. It is mainly cement and very small. An addition was needed on the house and a larger dining room was added. Unfortunately this takes away from the external space available to clients since it has eaten up a lot of the backyard space. As well, because of the large number of clients there are garbage and recycling bins along the right side of the property that further impede on their use of the space. There is more privacy for clients at Program “A” than Program “B” though, since Program “A” has only one apartment building behind it and is on a corner lot, so has residential neighbours only on one side of them. Staff and clients outline their perceptions of the Program “A” property and shed light on the challenges associated with it below.

When I first arrived at Program “A” and was given a tour of the site I made some quick observations about the exterior of the building and the property itself.

My initial impression was that the exterior of the building is beautiful, however could use some sprucing up since some paint was chipping and that sort of thing. It has a quite elaborate garden that makes the property seem like it would be a single family dwelling, except for the number of vehicles on the driveway, which sort of gave it away to me.... There is not very much outdoor space at all and by the looks of it no where to sit and relax and find peace at all. The outside area seems only to be used for a quick smoke break; otherwise it looks as though the only time the women would spend time outside is when they go on a walk. I was told that they are not allowed to use the front lawn for any reason. The backyard space itself is not overly inviting. One of the women in the house who has a disability

leaves her walker outside so that the women have somewhere to sit – which seems problematic to me since I would think that she would need it. Also, there is a wooden planter box surrounding a tree that some of the women sit on, but nothing that would be overly comfortable or inviting.

I was struck by how well maintained the property was, but also surprised at the lack of outdoor space. The director explained that this was one thing that she would love to change about the site:

One thing that would be nice is if we had a bigger footprint of land because we have to really limit outside activities for the women, because of the noise level... We are here essentially at the pleasure of our neighbours. If they raised enough of a ruckus we would have to relocate. We have the support of our neighbours, but as you can see outside, we have a very lovely home on this side and apartments in very close proximity to us on the back.

Staff members at Program “A” are very aware of this challenge and explained that the limited space can be quite problematic when trying to accommodate so many women. One staff member took me outside with her when she went on her smoke break. While we were out there she described the situation to me from her vantage point.

While we were out there she explained that only three women are allowed to be outside at any one time to smoke, because otherwise it gets too loud and they don't want to upset the neighbours, even though there haven't been any complaints that she is aware of. She said that there is a family with three young girls next door and when there are more women outside sometimes the language and discussion gets to be inappropriate, so they avoid that by only letting three out at a time (Personal Observations).

She seemed to have quite a good rapport with the women and her tone suggested that she found it unfortunate that the centre needed to do this.

Given the opportunity many of the clients would change the external treatment space entirely. When asked about it a few commented that there is a beautiful garden at the front of the house but clients are not allowed to spend time there for any purpose whatsoever. As Tanya said:

The front part is so beautiful! The flowers, the nature, the plants – I've never seen so many flowers in my life in front of a house. I think it's gorgeous, but we're not allowed to sit out there, we have to say in the back where there are no flowers. It would be nice if we could see and enjoy the nature.

This limitation raises the question as to whether the aesthetically pleasing garden has been created and maintained to contribute to the therapeutic nature of the centre primarily for clients, or whether its upkeep is primarily intended to appease the neighbours. While clients find the garden beautiful they are unable to fully enjoy what it has to offer, which impacts the therapeutic character of the program environment. Other clients felt that they would benefit greatly if the backyard space was more like the front yard. When asked what she thought about the outside space Tabitha said,

I would have the landscape where there would be seating areas out amongst the garden or whatever. Tables, chairs, lots of flowers, a tree swing – just a peaceful, serene garden.

Jade first jokes about how it would be nice to have a pool, but seems to realize that it is not a change that is likely to take place and so settles on saying that she would like some grass to sit on and a little bit more space:

I would put in a pool (laughing)! Forget the YMCA we can just swim! Maybe make the back bigger. They've got some nice gardens on the side and the front, but I think I would make more space and put in some grass. It's nice to sit on the grass. We've got the pavement there and there are no chairs, so I don't know, that's probably pretty much what I would change about the outside (Jade).

As these statements indicate, clients had many frustrations about the external space not only in relation to its layout and design, but also with respect to how they are able to use it due to its physical size and location. Poor appearance and a lack of comfortable seating were topics noted by staff and clients.

In addition to these concerns, major tensions were caused by rules limiting the use of the outdoor space. The footprint of the site is very small relative to the overall size of the house and, as mentioned, the centre is in a wealthy residential neighbourhood and is concerned that if they don't maintain a positive relationship with their neighbours that they will be forced to relocate. This concern led the director to impose limits on the use of the backyard to reduce neighbours' exposure to noise, smoke and inappropriate 'street' language. While understandable, this action interferes with the therapeutic capacity of the program. Significantly, limiting the use of the outdoor space has caused the internal treatment space to become less therapeutic, impacting daily routines and disrupting social relations amongst clients. Clients rush out of group, fighting their way downstairs to be able to get outside for a smoke first. They also argue and glare at one another when they feel that someone has taken more time than

they deserve while smoking. Further, clients who do not smoke make no attempt to go outside during break for fear of how other clients who do smoke will respond.

This is clearly a point of tension because many clients identified that their need to relax and have a smoke break was one of the main reasons they would like to see the size of the backyard increased. Christine said that having to rush to smoke because of the three person rule made her feel stressed out. When I asked Anita what she would change about the backyard she shouted: *“I would make one flipping big smoking area, OKAY!!”* In her mind the use limitation due to the lack of space was a major frustration not just in terms of wanting to smoke. When she wanted to sit outside and read a book she couldn’t, because other people would be waiting their turn to go smoke. Anita had a difficult time accepting this rule, and felt that if she wanted to read quietly outside this should not be subject to the three-person smoking rule.

At Program “A”, clients are constantly fighting their way to get outside to smoke and staff is continuously trying to find ways to minimize the tension surrounding the issue. At the same time, clients do recognize that the way that they are behaving about smoking and going outside is a product of the environment. As Tiffany explains,

Having three people out there is very, very hard. I just have my smoke and I go, because I am trying not to smoke more than I do. I normally don’t smoke four cigarettes a day, but I find that this atmosphere creates a

want to. You can't really finish your cigarette – you're out there, there's nowhere to sit, there's nothing to do, so you just have your smoke and run in and ten minutes later you want another one. There is no comfort out there at all. The minute I stop smoking I feel forced to go inside, because there is a person waiting at the door to get outside and is watching you!

The staff at Program “A” might be aware of this dynamic among certain clients, but did not comment on it directly. The lack of outdoor space is not something that Program “A” is likely going to be able to change. It does seem though that modifying the way that clients are able to interact in connection to this space will be the determining factor as to whether the majority of future clients at Program “A” would have positive perceptions of the space rather than identifying a list of changes they would make to it like the majority of clients seem to be doing currently.

5.2.2 External Treatment Space at Program “B”

The building that houses the Program “B” program is located front and center on the property and has a very institutional look to it. It is separated from the street by a public sidewalk and a small lawn that exists for aesthetic purposes rather than use by clients, given its size. Also, centered directly in front of the building is a bus stop, which is extremely useful given that the facility services many different women in the area by offering a wide range of programs.

A driveway and parking lot surrounds the building in a u-shape – going out to the street on both sides. Across the street and to both sides are rental

apartments and behind the building and parking lot is a chain link fence, which separates the grounds from a local cemetery. There is an opening/right of way on the left side of the fence with a trail leading into the cemetery. Clients who enjoyed walking through the cemetery used this as a shortcut rather than walking around the block. Also, numerous people from the neighbourhood use this passageway, which the director at Program “B” identified as a challenge when sharing her perceptions of the space.

To the left side of the building is space for staff and client parking with a fence, which separates the property from the neighbouring apartment building. At the back of the building there is a smoking area for clients and a rock garden which separates the parking lot from the cemetery. To the right of the building is a green space with a small shed, picnic table, water fountain, and grassy area for clients to go spend time to relax while on break or at the end of the day. Each of these areas are discussed in greater detail below.

While this setting is far more institutional than Program “A”, staff and clients at Program “B” seemed to be much more satisfied with the external space available to them. Being in a relatively low-income, high density area they experience less pressure from neighbours than the Program “A” site. They also have more space available to them and so less concern that client behaviour, while outside, will be heard by neighbours or impact the center’s reputation. In fact, the

centre has to concern itself with how the behaviour of certain neighbours may impact clients on-site. As the director explains:

In some of the earlier days I actually had to get drive-by security to keep an eye on things. We use cameras and that gives our women the security, because there is a safety issue.

Because the site was vacant for some time prior to the arrival of Program “B” many of the neighbours used the left side of the parking lot as a shortcut between the street and the cemetery. While Program “B” staff would prefer this not to be the case, some members of the local community feel that they have a right of passage in this location. Some local residents, youth especially, used the green space on the opposite side of the building to hang out with friends and engage in illicit activities, including drinking and using drugs. As the director commented:

We have a couple of people that we really don't want on the property. Um, that bring marijuana and/or crack and smoke it while they are here. We've individually spoken with them and we have not had to go to the next step to get them barred, but we found out how to do that if we need to.

The external space at Program “B” is distinct from Program “A”, because the centre has explicitly tried to create an outdoor environment that contributes to the program’s goals and therefore acts as a therapeutic space. The external space was still in transition during fieldwork - most of the physical elements were in place but it was not functioning quite as the centre envisioned. When asked whether she was aware of any spaces that clients particularly liked the director

spoke about what she thinks they *will* like when the grounds are completed rather than what they currently like about the space.

I think that they are really going to love the green space. They're not out there enough yet, because we're not quite finished. We have visions of birdfeeders and hanging baskets, and there's going to be a sandbox out there for the children. They're going to be able to ride their tricycles and pull their wagons and chase each other around there. So there's going to be that piece that occurs.

Our plan for the very back is that women will plant there and/or do some weeding. For some of our women who have actually moved on at this point, that was a wonderful project for them. They did our spring cleaning, they organized it and were out there for days working away at that. And they felt such joy in doing that. So, you've got a variety of ways to appeal to people's needs. Some like that community nature – being a part of it. Even if nothing else it is quieter – it's a safe place to bring their kids.

The green space that the director is referring to is quite beautiful. There is a lot of shade from the tall trees and a pond with a small waterfall, which unfortunately was not running properly during the time that I was there. Regardless, the space itself is actually quite relaxing despite that plans for it are not yet complete.



(Green Space at Program "B")

During fieldwork I saw the women make very limited use of this space, although some clients explained that they get up early in the morning and go there to both exercise and meditate before program begins. I also observed one client spend her free time trying to clean up the space by pulling weeds and working in the garden. The challenge with this space though is that because the centre is a multi-purpose facility attempts are being made to allow the green space to function for mothers with children, treatment clients and withdrawal management clients. This means that, unlike the rest of the property, clients are not allowed to smoke in the green space. Clients saw the green space as a “perk” but also explained that it was underutilized because of the no smoking rule. Donna, for example, said:

They do have – and this is a perk – I mean you can’t smoke there, but that’s okay – they do have a green area where there is grass and there is a shady tree and a picnic table. It’s not used much, because they have day program where parents come with their kids and they don’t want kids eating cigarette butts and for sure there would be clients who threw their cigarette butts down and for sure that would be trashed, so I totally respect that and get that.

Her statement displays the complexity of implementing “therapeutic” design within an addiction treatment facility serving multiple populations. What is therapeutic for one group may not be for another. For many of the women in treatment, smoking was an integral part of everyday life and not something that could be set aside easily.

On a few rare occasions when clients were given the opportunity to take part in program outside the green space was used. As Gabrielle explained, clients

really enjoyed the change of scenery and saw having program take place outside as a treat.

We did enjoy the times that we got to do programs outside. It was nice weather and the circulation was better. The air sort of woke us up a bit and we could get up and move around to do activities. We learned a lot of space and boundary lessons that way.

The challenge with having program outside is maintaining the privacy and comfort of clients. Interestingly some clients avoided going outside as much as possible when they first got to the program. This was especially apparent amongst day program clients who lived in the Hamilton area. Joanne explains that she initially spent the majority of her free time inside because:

I think when I first came here I was probably a little bit paranoid just because I felt exposed and didn't want anybody to know I was here, so that was probably part of it.

She lives and works in the area, and while she identified her behaviour as temporary I noticed no change in the amount of time she spent outside as she moved through the program. For her, public awareness of her time in program was a major concern. The external treatment space at Program "B" is quite visible from the street so maintaining privacy while outside was a challenge for her. She was clearly concerned about the potential stigma that would result if anyone she knew saw her there.

With these concerns in mind staff members were very selective in the types of sessions that took place outside. Yet when they were able to utilize the

green space for program it provided clients with a very obvious benefit. The women seemed to be much more relaxed and more enthusiastic about what they were learning.

[At] this morning's session on forgiveness and acceptance, one of the exercises was definitely enhanced by the physical surroundings. As mentioned, the women wrote the things that they felt guilty about, along with the things that had been done to them that needed forgiveness / acceptance on a series of scrap papers. The things were kept private and were folded up so that only the 'writer' knew what was on those papers. Together we then went outside to the side yard by the pond. It was an absolutely beautiful day with a soft breeze. Our objective was to burn these pieces of paper in order to release all of the negative feelings that were associated with the things that were written on the papers. Laurel mentioned that this was a cleansing exercise and meant to lift some of the weight that these buried feelings require us to carry.

We used something as simple as a lighter and an empty coffee can to do the 'burning'. We took turns with each woman burning all of their papers, one at a time. With each paper the women were expected to pause and reflect, and to actually imagine themselves releasing this from deep within themselves. It really was a powerful 'ritual'. All of the women appeared to enjoy this process. One of them had been shivering prior to her turn and associated this with the negative feelings that she had been carrying in regards to the items that she had written down. She had confessed that she actually felt 'nervous' about letting some of these things go, because they had become such a part of her. After her turn was finished she came back up to me and was amazed by the sense of peace that she felt. She mentioned that her 'goose bumps' were now gone and no longer felt nervous for this was replaced with a sense of relief.

The soft sound of the moving water in the pond, the deep green foliage and trees that surrounded us, the bright sun, and soft wind definitely enhanced this experience, and contributed to the tranquil atmosphere that resulted. The women were all in fabulous moods by the end of this exercise and literally appeared to be filled with new energy (at least for the remainder of the day). I don't know if this exercise would have been quite as powerful if it had taken place in the rain, or on a dark and cloudy day.

One staff member explained that while it is quite enjoyable to use the green space for program there are only a few portions of the program that can practically take place outside. The workshops for the most part must take place inside due to the materials and supplies that are often required (e.g. flipchart, markers, the need for a table, etc). As well the staff needs to be careful not to conduct sessions outside where client privacy and confidentiality could be put at risk. It is up to the discretion of the staff to determine when it is and/or is not appropriate to hold session outside, which would likely be influenced by both content and the dynamic of the group at any given time.

The green space seems therapeutic, because it is well-kept and aesthetically pleasing but clients do not seem to use it as often as one would expect, since they are not allowed to smoke there. Often clients choose to spend their time together smoking on a bench at the back of the building. There are two stone benches and a couple of metal ash trays, which are covered by a wooden overhang that provides the women with shelter from inclement weather while smoking. This area is on the edge of the parking lot behind the building.



(Client Smoking Area at Program “B”)

Given the importance of smoking in daily life, it could be argued that the smoking pit provides them with more ‘therapeutic’ setting than the green space! It is likely, however, that they would choose to spend more of their time in the green space if there were no use limitations there.

Aside from the director’s concerns about neighbours’ use of the property, there were very few comments made by clients connected to wanting to change the external treatment space. In this sense, it functioned in a more therapeutic manner than the Program “A” property, although it is interesting that in both sites

smoking played such a significant role in dictating the character of, and clients' relations to, the external environment.

5.3 UNDERSTANDING THE INFLUENCE OF LOCAL NEIGHBOURHOODS

5.3.1 Introduction

A fourth factor influencing the dynamic character of the treatment programs is the surrounding neighbourhood. While separate from the formal structure of the program environment, the neighbourhood has the capacity to shape clients' experiences and their sense of safety and security within the program. In interviews, clients described the surrounding neighbourhood from their vantage point, providing insight into what they liked about the neighbourhood setting at particular sites and what they saw as problematic. These collective perceptions help us to gain a better sense of the external atmosphere that these centers are a part of, while also providing a greater understanding of how they add to the therapeutic potential of a particular location in certain instances and can take away from it in others. This section is organized in the following way. For each program, I reflect first on clients' perceptions of the local neighbourhood. I then focus more specifically on the ways in which the neighbourhood influenced treatment experiences. Third, I talk about the strategies used by each program to moderate unwanted neighbourhood influence.

These often included time limitations and boundary restrictions, which shape how clients interact with the neighbourhood. They also impact how clients perceive the neighbourhoods surrounding each site and the level of awareness that they possess with regards to what takes place within them on a day-to-day basis.

5.3.2 Perceptions of the Program “A” Neighbourhood

Clients at Program “A” described the immediate neighbourhood surrounding the program primarily as *affluent* and *well-maintained, clean* and *respectable*. In connection to the affluence of the neighbourhood Tiffany described it as *very Rosedale-ish*, making reference to another well-known wealthy Toronto neighbourhood. Many women commented that they appreciated being able to look at the old homes while on their walks and found the architecture of many of them quite fascinating. Others explained that they enjoyed the elaborate landscaping and *the vegetation - the flowers and the trees*, and thought that they were *very beautiful to look at - very serene (Tiffany)*.

Given the affluence of the neighbourhood, Program “A” is in a location that one might not initially expect for treatment center. In my field-notes I wrote that;

Program “A” is in an interesting location... This is a very affluent, upper-class neighbourhood. I was told that the homes range in value from seven hundred and fifty thousand to one million dollars each.

It is in an *interesting* location for treatment not only because of the value of the properties in the area, but also because I thought that the NIMBY opposition of

home-owners would prevent the siting of a treatment center in this neighbourhood at all (Wilton 2000). In fact, Program “A” has been a part of this neighbourhood for over thirty years – first as a woman’s shelter and for the past twenty years as an addiction recovery program. In this sense, it predates the gentrification that has transformed the neighbourhood in recent decades. The director explained that, while there has been pressure from neighbours at certain times (i.e. trying to have the program removed from the neighbourhood), for many years residents were unaware that it was a recovery home at all. Currently, staff members deal with neighbours’ concerns as they arise and do what they can to avoid conflict whenever possible. Upon initial inspection this opposition seems to have minimal impacts on the nature of the treatment experience; however as I showed in the previous section the restriction of clients’ use of outside space – a product of neighbours’ complaints – has added tension to the day-to-day operation of the program.

Interestingly very few clients were able to say a negative thing about the neighbourhood or the neighbours, aside from their complaints about not being able to go outside to smoke freely. Many described the neighbours as friendly and explained that quite often they wave at each other when taking their daily walks and sometimes visit with the neighbours’ dogs. Ronda’s statement suggests an appreciation for the familiarity in her daily routine, and a sense of community and comfort with the neighbours. She says,

I look at the type of people that are walking down the street... we go for a walk and we see the same people walking their dogs almost at the exact same spot at the exact same time every morning... and they all seem like very nice people. They all say hi and everything. They are friendly.

In Jade's interview she explained that she was concerned about the neighbours having an awareness of the treatment center and treating clients differently because of it. She felt relieved though when she realized that this was not the case.

I'm pretty sure that people in the neighbourhood know we are from the treatment center, but nobody gives us bad looks about it, because I was a little concerned about that.

As a result, she was more comfortable spending time in the neighbourhood and described it as having a non-intrusive atmosphere. The director supports Jade's statement by pointing out that,

They (clients) are not ostracized. Nobody crosses the street when they see our women walking down the road. It's like being a real neighbour. It's not like there is an attitude.

The positive relationship that clients feel they have with neighbours seems to suggest that the neighbourhood has a positive influence on the program's therapeutic function. Ironically, some clients speculated as to whether they would be as tolerant as neighbours. Samantha, for example, commented:

I don't think that there is anything that you can really complain about in this neighbourhood... I feel bad for the neighbours [though]. I wouldn't want some rehab place in my neighbourhood!

Of the eleven clients interviewed at this site seven could not describe anything that they disliked about the neighbourhood at the time of their interview; three did not comment on their dislikes when asked what they liked and/or disliked about the neighbourhood; and one said that she thought that the street lights should be brighter after pausing for quite some time to think about the question.

When considering what they liked about the neighbourhood many women pointed to things that weren't present in the local environment. For example, Tanya explained that it was 'awesome', because 'there's no triggers'. She felt this was connected to the area's affluence:

It's in a nice neighbourhood, there's no prostitution on the corners, no drug dealers. It's in a higher class neighbourhood – that definitely helps!

Jade made a similar comment, which she connected to feeling a greater sense of personal safety and security, and views the neighbourhood as a safe haven.

You don't see a lot of trouble here, you know?! You don't have to worry about walking down the street! ... It's almost like a little hideaway almost.

Feeling an overall sense of safety in the neighbourhood is especially important for women. While men in treatment also benefit from a lack of drug dealers and other external triggers in the immediate neighbourhood, women experience greater limitations to use of public spaces in general due to patriarchal norms (see, for example, Valentine 1989; McDowell 1999). Being in a location where they feel less susceptible to external threats means these women are able to utilize the

neighbourhood space to a larger degree than they potentially would in other areas, and experience fewer threats to their recovery.

The perception that clients have of the neighbourhood as lacking these negative elements is crucial to them feeling safe at Program “A” and being able to establish daily routines in a secure location. While going through treatment and early in their recovery they are extremely vulnerable to negative external influences. Samantha explained:

There are no drug houses or anything around – or that I have noticed – I don’t think that there are. So that’s really good, because I think that would be really difficult. I probably wouldn’t want to go outside knowing I have to pass all of these places, so I think that is a real advantage that there is nothing like that around here.

Tiffany said that: *it’s an area where you can go for a walk and not be triggered, because there isn’t those things around here.”* At the same time however the women are not so far removed from external influences that they cannot escape needing to control their urges. They have to want to stay in the neighbourhood and not actively seek out drugs and/or alcohol. Jade explains that there are triggers out there, but you have to be able to deal with them no matter where you are, whether in treatment or not. She describes a particular situation where she was triggered, saying;

The only time that I got kind of triggered was walking along Bloor Street seeing people on the patio with their beers, but you are going to see that. It’s still nicer though. So that was the only time that I was kind of triggered. I was walking by and I wanted to grab his beer off of him and take a sip, you know (laughing)?! And I was on my way to a [AA] meeting!

You are going to have to deal with those temptations anytime, anywhere though, right?

Because her primary addiction is to alcohol this is true, she will have to deal with those temptations anytime, anywhere. Tanya had a similar experience when she first got to Program “A”. She described being hyper-vigilant over the presence and display of alcohol in the area. She explained:

That’s the first thing I noticed when we went for a walk. That was tough, seeing the LCBO. And then over there, the other way, was a billboard of beer. But I mean you’re going to get that anywhere when you first show up.

She had been to treatment in a rural setting previously and so found the proximity of alcohol especially difficult on arrival. Although rural settings might be seen to provide greater safety, clients recognized that these settings might be more difficult to leave. Julia argued that a rural treatment setting could not give clients the opportunity to face their challenges while in treatment, whereas an urban area provides more of a “testing ground” while still offering the treatment centre as a safety net.

For me being stuck in a rural area would be very difficult, because I think that there comes a point where you have to integrate into society, be with people, know how to handle walking past liquor stores. Because I’m alcohol based you know those are the things that I have to get used to. So, I think that this kind of gives you the opportunity where you can go out, then you know you have to come back and deal with it.

The director echoed this sentiment, suggesting that the program is in an ideal location – a safe neighbourhood, but one that is very close to the rest of the city’s amenities.

I think in some ways you have to learn how to work at your recovery in the environment where you are going to be returning to. I feel that we kind of have the best of both worlds here, because we are in a nice, safe neighbourhood with a low crime rate and there is not much street traffic around here [but] it's steps from Bloor Street and it's steps from transit. It is in the heart of the city. It approximates more of what the women are going to have to return to (Director, Program "A").

However, Tanya argued that some clients needed an initial withdrawal depending on the degree to which their addictions had been controlling their lives. She says:

For me, at that time, that is what I needed (the treatment center out in the country). I never regret going there, because you can't just go down the street and go to the store, you know?! You are stuck there, and for hardcore people and hardcore users that is the perfect place.

For a drug user, such as Tanya, this may or may not be the case depending on their drug of choice and their personal experience. It does raise the question however as to whether alcoholics and drug addicts should be placed in treatment together or if their "testing grounds" need to be slightly different from one another. It also begs the question as to whether more vulnerable users need to begin treatment in a more secluded setting until they are in a point in their recovery where they feel they are able to take on external challenges and triggers with more success.

Regardless, the center is able to benefit from being in a neighbourhood that is close to the downtown core, in an area that the women feel is quiet, peaceful and safe, but at the same time is also accessible to other parts of the city and local services. Of particular relevance is the fact that women are able to access a

variety of different AA, NA, and CA meetings in the immediate vicinity with no need for use of public transit. Julia stresses this in her interview by saying;

There are so many meetings in Toronto. There is no excuse if you are interested in 12-step work or learning – there are more than ample opportunities to get you to a meeting!

When I asked another client (Jade) about going to meetings she agreed with Julia and said,

They are all over the place. There's NA, CA, AA. They are pretty good. Usually you can find one within walking distance... For the most part I walk to meetings. I think I have only taken the bus to one.

Clearly the centre is in an excellent location when considering client access to external treatment options and support. Further, if they live in the area or are planning on settling there, by participating in meetings within the neighbourhood they are building support systems that will assist them in their recovery once they leave. With that said it is important to note that remaining in the immediate neighbourhood will not be an option for many of the women, because its affluence will preclude them from being able to find affordable housing.

While the program's location was not chosen specifically for its therapeutic potential, the reality is that this neighbourhood provides a largely positive setting for treatment. Although the 12-Step philosophy focuses principally on the workings of the individual addict and not their environment, my analysis provides some recognition that the environment can play a role in helping people to control themselves against their urges.

5.3.3 Neighbourhood Influence on Treatment Experience at Program “A”

When asked directly about how the neighbourhood influences their experience in treatment clients at Program “A” generally indicated that it contributed to the quality of their stay. As mentioned, safety is extremely important to these women on many levels. This is evident in how Tiffany portrays the neighbourhoods’ ability to impact the time she is spending in treatment. She responds to being asked about whether the neighbourhood makes a difference to her progress by stating that,

I think it does, because it keeps me from being distracted. It’s so different from my [home] environment that it doesn’t trigger me and I think that it gives me a sense of safety, because I know that I can walk out the door and that I’m not going to walk into my dealer or be walking into some guy in an alley or something like that. So it is a good choice for location.

Location is an extremely important element to consider when determining one’s sense of safety. Clients are going to be more comfortable in areas where little to no threat to personal safety exists. Moreover, Tiffany’s statement encourages us to think about safety not only in general terms, but also how safety is perceived from a women’s perspective and from the perspective of a drug user or alcoholic. At the same time, as I suggested in the previous section, there is a tension between providing safety and giving women a realistic environment in which they can learn how to stay and sober. Although some women talked about the advantages of a rural setting, many felt that treatment should take place in a setting that can act as a testing ground; a setting not dissimilar from what they

will experience when they return home after leaving treatment. At the same time, they also recognize that too many triggers and too much street activity can make an environment un-therapeutic, leaving clients feeling unsafe and at risk of relapse. Jade offered a clear example of this. She describes staying at a woman's shelter and clean house, as she called it, which was in an area that made her feel very uncomfortable:

Every time I walked out until I got close to Eaton's Centre I was on pins and needles – literally. You walk down the street and see people using and see... I don't know. I heard stories and you see things there and you know it just has a higher rate of violence and drug use. It's just a scummy neighbourhood, you know?! You could literally walk out the door and couldn't even get down the street and people are down the alley way smoking crack and you can see them doing it, right?! So it was so close (Jade).

The proximity of drug use and other triggers clearly caused considerable stress for Jade and stand in stark contrast to the Program "A" neighbourhood. Similarly, Samantha explained that being in a healthy and "normal" neighbourhood helped her stay on track and keep a positive frame of mind. She said:

It seems like a normal – whatever normal is – but normal environment. It's good. Just knowing that I [would] have to pass those places [somewhere else] would probably screw up my day.

While clients agree that Program "A" is in an excellent neighbourhood and had very few complaints, there were some who perceived it as less friendly than Samantha did. This is because of public opposition towards the program. Tiffany

explains that she feels that the neighbours don't want the women there and that some give them dirty looks when they are going for their walks. As she explains,

Nobody's ever said anything – to me anyways – but I've noticed some of the looks of the little old ladies and stuff and you can tell that they don't like us here. Plus counsellors have said that the people around here have complained and had meetings and have tried to get rid of us!

Clearly thinking that the neighbours don't like having the treatment centre in the area influences the therapeutic potential that the neighbourhood has for her. Her perception of the area was also coloured by the counsellors' warnings about the potential for neighbourhood opposition. Here again, program staff have to balance their desire to avoid conflict with neighbours with the need to present the local area as a welcoming environment for women clients.

5.3.4 Managerial Strategies at Program "A"

One important strategy used by staff at Program "A" is to limit clients' movement off site during their first week of treatment.¹⁰ As the director explained, this is a deliberate strategy to try to limit vulnerable women's exposure to potential threats and triggers. She commented:

It helps them get grounded and to make a bit of a break between where they are coming from and where they are going. After that whenever there is free time they can go off.

¹⁰ They are only permitted to leave the program with a staff member.

After the first week, the women are actually given much more free time to spend off site than clients at Program "B". As a result they face testing for drug and alcohol use much more frequently. Whenever they leave the site for more than 30 minutes, clients must do a breathalyser or a urine sample on return. They are also given random bag checks. At Program "B", urine samples are only done consistently after clients have taken an overnight or weekend pass. The Program "A" director explained that testing is done with clients' safety and security in mind, since if one person is using it could dramatically impact the progress of many others.

Clients are expected to use their off-site time to attend AA, CA, or NA meetings in the evening and to look for work and/or new housing arrangements if necessary, although their off-site activities did not seem to be closely monitored by staff. This lack of attention to off-site activities by staff may be explained in part by the program's reliance on testing. For staff, the off-site time was seen as an important part of the treatment experience, with women learning to confront the outside world and go about their everyday business. The director commented:

Even in our rules we try to show them that it is not just a rule for community living, but it is to help them down the road... that our expectations parallel what they would encounter in an 'ordinary' lifestyle (Director, Program "A").

Providing clients with free time in the evening to go to meetings and run errands is similar to how one would live outside of the program. If a client is caught

using while in treatment the staff make a joint decision about how to respond and try to be as client-centred as possible.

If we have found that someone has used they are not kicked out on the street. What they need to do is go somewhere safe, like a detox facility or counselling. Then what they are expected to do is write a 'relapse story', which is to say why what happened, happened and how they will ensure that those circumstances do not happen again to put them in that position. Then the story is read to the counsellor and we make a team decision and more often than not, if they take accountability for what they have done, they will come back (Program "A" Director).

The challenge here is that treatment space and detox space in the city is quite limited for women. Program "A" relies on working in connection and partnership with other service providers, whose resources are similarly limited. If there is not available space some of these women may need to go back home or to the streets until they have completed another 72 hours sober. Clients benefit from the continuous intake system that Program "A" operates, because as soon as they have completed their dry period they are able to re-enter the treatment program, unlike Program "B" where they would have to wait for another five week cycle to begin. Staff at Program "A" explained that clients would then essentially re-start their time in program by being placed in an assessment week again. In this sense clients benefit by being given a second chance, because of the flexibility that Program "A" is able to offer – as long as space is available at a local detox or shelter. However, it seems that the program would be better able to meet client's needs if it were a multi-purpose facility like Program "B", because an emergency

bed could be provided in their own detox program for situations such as this.

With that said, while Program “B” is a multi-purpose facility it is not necessarily able to respond to a client ‘relapse story’ by placing them in detox and then move them directly back into the treatment program, because it operates on a fixed intake system and so depending on the point in the treatment cycle space may not be available in detox for that length of time.

One client explained how the system for breathalysers and urine testing works at Program “A”. She expressed frustrations about this system, in part because of the equipment used:

They can do it (breathalyser or urine testing) up to three times a day, every day if they want. I’ve never seen anyone get it more than once a day, but you have to do it every Saturday and Sunday and every other day at least during the week. Sometimes they will double up on you – it just depends, but the breathalyser isn’t working properly, because I’ve blown and shown when I haven’t done anything and a couple of other people have too. And it’s always blinking this warning light on it... So it bugs me that it isn’t working properly, because if I blow over it could get me in a lot of trouble, especially if it’s someone from CAS or for somebody who has probation orders or things like that (Tiffany, Program “A”).

While Tiffany’s statement focuses more on the repercussions of the breathalyser not working rather than how it has the potential to impact her treatment experience and/or safety these are important elements to consider. Not only could a false positive lead to her discharge from the program, it could also threaten her recovery and personal safety if another client’s use went unnoticed by staff, because of their unawareness of the breathalyser not working. As well, knowing

that this machine is continuing to be used despite staff awareness could lead to some clients feeling vulnerable unnecessarily, while others potentially take advantage of being able to use and stay in program.

Notwithstanding concerns about the reliability of testing, other clients expressed appreciation for the regular drug testing. An excerpt from my field notes captures this sentiment:

One client expressed that she needs this type of monitoring, because it helps her to avoid giving into temptations. I asked two other clients how they felt about the matter and both appeared to have no problem with being regularly tested. One stated 'if you have nothing to hide, then why should it bother you'? The other added that women involved with the Children's Aid Society are particularly happy about being tested, because it helps them to prove that they have remained consistently clean, which can help them to re-obtain custody of their children. One remarked that it is funny to see that some women who have been using still try to get away with it. Even though they should know that they are going to fail their test, they will pretend like everything is normal and continue going to classes as if nothing happened until the results come in.

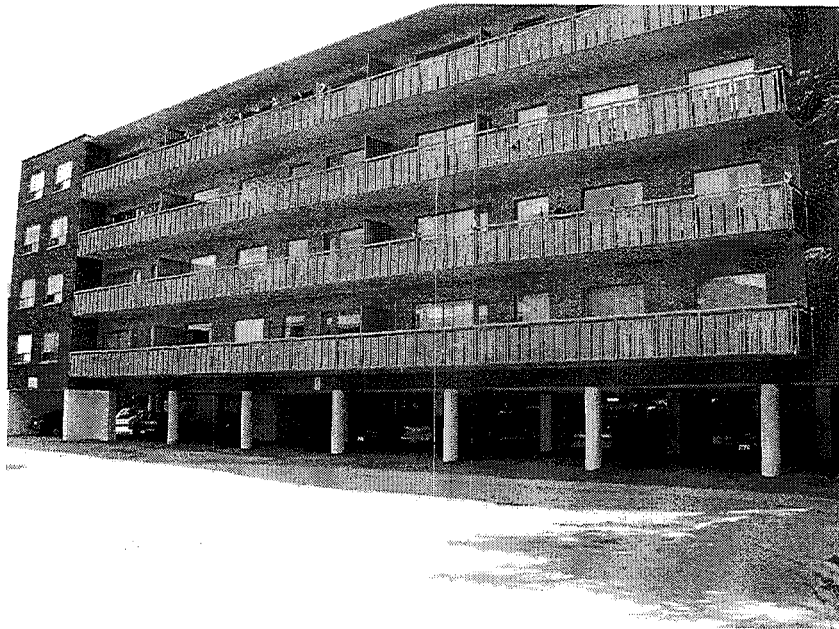
It is significant to consider that clients might use this type of monitoring as an incentive to avoid giving into temptations, as the one client identified, and while this would not be ideal over the long term it may be beneficial for some who are particularly vulnerable, especially during the early stages of their sobriety, as long as they gained their own strength against temptations over time. Also interesting is that client use does not necessarily result in an automatic discharge. They are actually handled on an individual basis with consideration for extenuating circumstances.

5.3.5 Perceptions of the Program “B” Neighbourhood

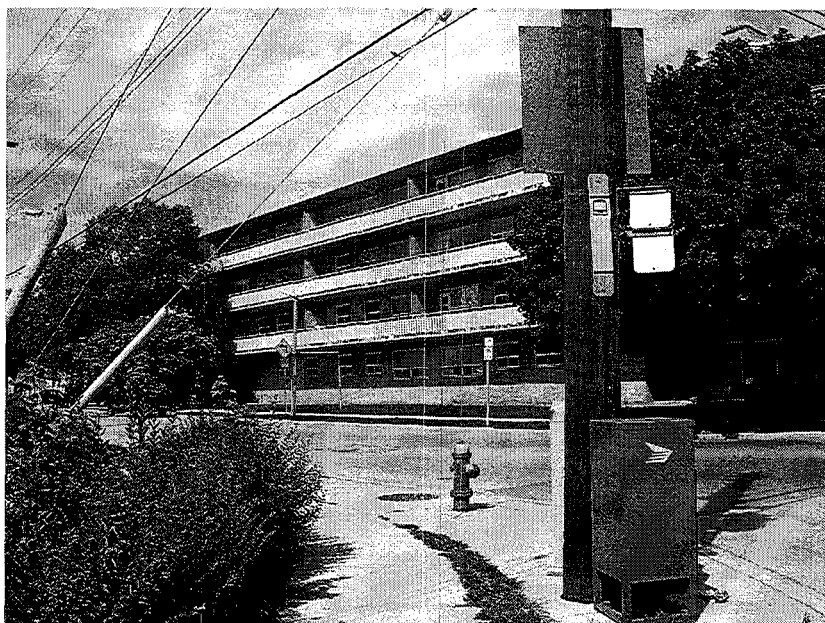
Unlike Program “A”, Program “B” is situated in a relatively low income area. The director at Program “B” referred to the area as a ‘white ghetto’, which she clarified by stating that,

It is considered kind of a white, not poor white slum, but a white lower income [area], because there is less diversity than there is in some other places, but it is NOT an upper class community... There are smaller homes and they have been here for a long time in some of the areas. It is [also] a highly concentrated area, because of the apartment dwellings, which means that there are more people.

The program is surrounded by a number of large apartment buildings, many of which are in need of some repair. At the end of the street there are a number of stores (a variety store, a Laundromat, etc). There is also a bar and a pool hall that have negative reputations. The pharmacy around the corner dispenses methadone, which is helpful as well as problematic, since the facility itself is unlicensed to do so for those clients needing this service.



(Apartment Building Located to the Left of Program “B” Facility)



(Apartment Building Located Across the Street from Program “B” Facility)

Notwithstanding these characteristics, some clients saw the neighbourhood in relatively positive terms. Gabrielle, for example, commented:

I see no problems with it. It seems like a nice neighbourhood, like a family neighbourhood. There's restaurants and variety stores and the bank is close by and there's nice houses if you want to walk around during break (Gabrielle).

At the same time, she explained that because it was summer she spent very minimal time outside walking around during break, so likely did not have the same awareness of what was taking place in the neighbourhood as some of the other women.

By contrast, other clients had significant reservations about the local area. Some of these concerns had to do with the general appearance of the neighbourhood.

For example, Joanne commented that:

There is some high density, not particularly glamorous apartments and some middle class houses... There are a lot of students around, which is good – well, can be good anyways depending on whether they are having their parties or not... so yeah it's a nice neighbourhood actually... I [just] dislike the apartment buildings, because they are kind of drab.

People's opinions were shaped in part by the individual characteristics. Joanne was a middle-class realtor from the Hamilton area, who had a particular knowledge of the more and less desirable sections of the city.

In addition, both Gabrielle and Joanne were struggling with alcohol addictions and had little sense of the local neighbourhood's reputation for drug use and the

potential triggers that might exist as a result. Joanne recognized this when she commented:

I don't have a problem with this neighbourhood. I have heard some of the ladies say that there are dealers and things like that around here, but I don't know that to be true. I've never seen anything, so I couldn't speculate on that...

The presence or absence of drug use in the area is not a primary concern for these women and does not have any impact on the ability of the program to meet their needs. Their statements however do highlight how a client's drug of choice may influence whether a particular neighbourhood setting is more or less therapeutic.

Donna, a residential client at Program "B" also felt that it is *not a heavy drug area*. She identified it as being *a funny little neighbourhood* that would be *difficult to class*, despite feeling that it likely consists of a lower-middle class demographic. This is similar to how the director at Program "B" identified the area. Hilda seemed to have a comparable, but slightly dissimilar perception of the neighbourhood. She identified it as *suburban welfare*, connecting her feelings on the neighbourhood to her overall perception of what Hamilton neighbourhoods generally are characterized by. She explains that,

It's nice, but it's Hamilton. [In] Hamilton every other street is a bad street. It's all scattered. So I mean it's nice, but there's a lot of issues around this neighbourhood... It's a nice neighbourhood though, but you know there's a lot of crack heads around here.

Hilda seemed to have a greater awareness of the presence of drug use in the neighbourhood, due in part to the fact that she is from the Hamilton area. Here

again, we are reminded that the individual characteristics and background of the women influence their sense of the neighbourhood setting as more or less therapeutic. Hilda has a greater connection to the area and more knowledge about what is taking place. She indicated in her interview that she knew people in the area surrounding the treatment center who used drugs. This raises the question as to whether there is a greater therapeutic potential for clients who go to treatment in an unfamiliar area, perhaps simply in a different neighbourhood or city than one where they have negative associations. While they would need to reinsert themselves back into their home neighbourhoods, they might benefit from minimizing distractions while in the early stages of their recovery. This is connected to the earlier tension around environment. While leaving an environment for treatment offers a temporary relief from immediate pressures, the challenge of returning to that environment still exists once clients have completed the program. This challenge will be returned to in the conclusion.

Although opinions about the neighbourhood setting were mixed, there was some consensus that it was a significantly better environment for treatment than the downtown core or the east end of the city. These areas had much more negative connotations in the minds of many women. Sarah, for example, felt that the neighbourhood was comfortable and described it as being within her *comfort zone*.

I was pleased to find out that it was in an area like this. Comfortable neighbourhood as opposed to being in the east end of Hamilton or right downtown. You know, busy James Street or whatever is not as accessible with a car and I wouldn't want to travel there in that busy area downtown. I enjoy this area... the neighbourhood is very quiet (Sarah).

Laura, a residential client at Program “B”, also expressed concern about entering the “downtown area”, because she felt unsafe in that area. In my field notes I was able to capture some of the reasons she did not want to go there on our afternoon outing.

While on break the women began to discuss where they would go for their afternoon outing. There was some debate about this because they were thinking about going down to Bayfront Park, but Laura quickly threw that idea away. She said that she wouldn't go because she didn't feel safe. She said that park is right near her old apartment where she was raped. She also expressed feeling unsafe going anywhere near the core because there are drug dealers everywhere, as she explained. We all accepted her reasoning, which she repeated a number of times until I told her that it was fine, that we understood where she was coming from and that we would not bring her somewhere where she felt unsafe. She said thank you and then any time any other suggestion was made her first question was whether it was close to downtown or not – clearly concerned about her safety in proximity to that area. I suggested that we go for a walk down the rail trail, since it is so close to the facility and has a wide walking path and is nicely treed. The women seemed happy about this idea once I explained that it is in the opposite direction of downtown. Also, Joanne – one of the day clients – had also made this suggestion, so they felt comfortable with the idea of it.

Laura's reasoning for not wanting to go downtown raises an interesting consideration that should be factored into determining what areas are appropriate to use to treat women with addictions. For her, a treatment facility downtown would not be a therapeutic environment because she feels a heightened level of

vulnerability there. Many women who are trying to recover from their addictions are also coping with traumas from their past that have taken place in numerous different settings. This raises the question as to how a center can possibly choose a suitable neighbourhood setting that will meet the needs of all clients. Moreover, if we consider the limited availability of treatment facilities for women in comparison to men then it is vital that this be given some serious consideration. As mentioned in my discussion about the Program “A” neighbourhood, women experience greater limitations to their use of public space. As such, determining what areas are potentially the most comfortable for women in recovery may help organizations to design more therapeutic treatment settings.

5.3.6 Neighbourhood Influence on Treatment Experience

There were both similarities and differences amongst clients at Program “A” and Program “B” with respect to how they felt the neighbourhood influenced their treatment experience. First many clients at Program “B” didn’t seem to feel that the neighbourhood added to or took away from their program experience. Many seemed to have relatively little to say about direct influences. A key distinction here is that the Program “B” clients had very little time for activity in the surrounding neighbourhood, and this likely restricted its influence.¹¹ Like women at Program “A”, the majority of clients viewed their safety as the key

¹¹ Clients only have two fifteen minute intervals where they are allowed to spend their time off-site.

issue when considering how the neighbourhood could potentially impact their treatment experience. Sarah explains that in order to be successful within the program – or any program - that she needs to feel comfortable in the surrounding neighbourhood as well.

To me I look to my own success here in the building itself, but I need to have that [same] comfort outside of the building as well. The neighbourhood itself must be a safe place to walk, to be in. It doesn't have to be a wealthy neighbourhood, just a comfort zone (Sarah).

Her statement highlights the insignificance of location in terms of neighbourhood wealth. Rather it emphasizes comfort and perceived safety as being essential. I say *perceived* safety, because the director did mention challenges that Program “B” faces because of some local residents, an issue that I return to below. In general, although several respondents had reservations about the overall appearance of the neighbourhood clients at Program “B” did not offer any examples of ways that the neighbourhood threatened or negatively impacted their treatment experience.

Lastly, while public opposition existed when Program “B” was first establishing itself, it seems that it is not an issue that continues to plague the site. This is different from Program “A” where public opposition did not exist initially, but now does as a result of changes within the neighbourhood over time. Program “B” approached these challenges as they arose, which is likely part of the reason why they have dissipated as much as they have. This will be discussed in more

detail below; however it is important to consider as well that Program “B” has a larger tract of land than the Program “A” site does and rather than having high end, single dwelling homes next door the Program “B” site has low end apartment buildings. Either way the impact that the neighbourhood has on clients at Program “A” due to its location does not exist for clients at Program “B”. And because they are not limited to their use of the external treatment space clients at Program “B” have not developed any reason to resent their relationship with their neighbours as it seems some clients at Program “A” might.

5.3.7 Managerial Strategies at Program “B”

Significantly, while clients at Program “B” spent little time in the surrounding neighbourhood, certain aspects of the neighbourhood had encroached onto program space, raising concerns among staff. During her interview, the program director explained that there were a number of unhealthy influences in the local neighbourhood.

There are some things about the neighbourhood that are concerning to me... This [neighbourhood] has a higher percentage of pedophiles than some other places in Hamilton... [Also] I know that we have crack houses in the neighbourhood. I mean that's our reality. We have somebody across the street who is a dealer and we know about that.

Not surprisingly, she has a greater awareness of these negative influences than some of the women enrolled in the program. She is also attempting to minimize the potential harms that such influences may have on the therapeutic environment

of the program and women in treatment. For example, she had spoken with the local police department in order to gain some insight as to how to approach and deal with some of the safety issues that exist within the neighbourhood. They had made suggestions with regards to use of appropriate cameras and lighting for the site. The director also indicated that the police had been willing to spend a little more time around the property.

They (the local police) sometimes come and sit and do their reports in our parking lot late at night (Director, Program "B").

Unfortunately while there had been improvements to site safety as a result of discussions with the police, some staff also felt that there were negative aspects to the use of surveillance cameras. One person suggested that the withdrawal management staff spent too much time buzzing people in and out of the building, and that the residential staff spend too much time watching the surveillance camera. She felt that both groups of staff could be spending their time more efficiently elsewhere given that staffing is already minimal and that the focus is supposed to be on interacting with the clients and assisting in their recovery. This is a major frustration for some staff, although the director feels that time allocation to the surveillance cameras is necessary to ensure client safety.

Staff members also work to make the property safer for clients by intervening with local residents who attempt to use the property for illegal or inappropriate purposes.

We have a couple of people that we really don't want on the property that bring marijuana and or crack and smoke it while they are here. So we've individually spoken with them and we haven't had to go to the next step to have them barred. We have found out how to do that though if we need to.

This was initially a major challenge for the site because the property had been vacant for over four years prior to their arrival. As such many people in the neighbourhood had developed patterns of usage there and until Program "B" adopted the site there was no one blocking them from doing that.

In instances where staff is unable to deal with situations on their own they actively seek help from local authorities. The director pointed to client use of the methadone pharmacy as one issue where clients faced danger in the form of local drug dealers loitering in the area. Because it is off site and there is not enough staff to support someone escorting clients each time they need to go the center approached the police for help. The director explains:

What was happening was that the dealers were doing their work at the payphone right beside the Laundromat (which is in the same complex as the methadone pharmacy). So we pointed that out to the police and they were able to move those people on.

She goes on to explain that while the women need to be able to say 'no' themselves, they are also very vulnerable. Helping to make the neighbourhood safer for them therefore assists them as they transition through treatment and their recovery. She supports her position by stating that,

Part of our role is to help to try to make that a safer place... You just, you help them to build the skills to help them [the women] be strong and those

who are not going to [be strong] this time, are not going to this time, so we can just hope we get them next time.

While recognizing that not everyone will be able to stay strong and be successful the first time through treatment, she also feels that Program “B” should do everything in its power to minimize dangers in the local environment. From her perspective using these managerial strategies improves the level of safety and support that the women can expect the centre to provide.

Beyond concerns for client safety within the local neighbourhood Program “B” also needs to maintain a conscious awareness of how the neighbours feel about what they are doing. The site experienced a fair amount of public opposition in connection to their presence within the neighbourhood initially. The director at Program “B” explained that neighbours made their feelings known, making sure that staff and clients felt unwelcome there.

Initially there was some stigma. We had people that would ride by on bikes and scream out ‘junkies’ and ‘druggies’ and I mean that’s people (Program “B” Director).

Although difficult initially, she explained that opposition had largely disappeared, which she feels is at least partially due to the fact that they have been good neighbours. Interestingly Program “B” took a very similar approach to Program “A” in its effort to curb public opposition. They held an open house, so that neighbours could gain a greater appreciation for what they offer and are attempting to accomplish by being there. Neighbourhood understanding is central

to their acceptance of treatment facilities being present within the local area. Both sites greatly decreased public opposition and concern by being open to sharing how they planned to use the treatment space and answering the questions of neighbours.

CHAPTER 6

CONCLUDING REMARKS

6.1 Introduction

In this final chapter, I first summarize the key findings from the analysis presented in chapters four and five. The summary focuses on the core objectives and those factors influencing the core objectives outlined in figure 4.1. After the summary, I present a discussion of key tensions that characterize the operation of treatment programs, connecting these tensions to some of the existing research outlined in chapter 2. Finally, I discuss the strengths and limitations of this study, before suggesting possible directions for future research.

6.2 Summary of findings

The intent of this thesis was to understand the character of women's addiction treatment programs as therapeutic environments, and to consider the extent that various approaches used in addiction treatment for women are shaped by geographical and environmental considerations. Analysis suggested that a central theme of both programs was the emphasis on structure. Having a structured program environment is an essential element in the successful functioning of addiction treatment. Clients' rely on this structure, especially early on in the treatment process, as a temporary replacement for their own diminished capacity to control their use. While structure and discipline vary from one facility to another rules are implemented in an effort to assist clients towards personal

growth while also helping them to build relapse prevention and life skills. A clear set of rules provides clients with a strong understanding of what is and will be expected of them while in treatment and when they leave the program. Structure and discipline achieve therapeutic results within the treatment setting by prioritizing; protecting the needs of the overall group first, then the needs of the individual client, while simultaneously ensuring the operation and reputation of the facility.

Accepting the rules in a client-centered atmosphere can be quite difficult for some clients. This is especially true since staff members apply a client-centered approach when responding to clients, making different decisions based on what their perception of individual client's needs. This causes some women to question whether they are being treated fairly, especially when the needs of others are unknown or not properly understood, or they feel that others are getting preferential treatment. At times this can cause clients to become suspicious of staff, which impacts how successfully structure can be implemented. When clients think staff are interacting with other clients in a way that they deem unfair they may refrain from expressing their opinions for fear of how it may impact their own treatment experience. This highlights the importance of making sure that staff operate in such a way that clients perceive their treatment as consistent and fair, despite differences among them.

Conscious awareness of the potential impact of how rules are enforced has the potential to improve a program's therapeutic capacity. Staff members reflect on their actions to assess whether they have made the most appropriate choices, and in doing so often modify the approaches they use based on how effective they feel they have been. With that said, while they recognize structure as being an important element in the treatment process they also want to avoid causing clients to become dependent on the discipline that they receive when they break the rules. They would rather clients' make positive choices on their own within the treatment setting so they can continue to on their own when they leave.

Alongside an emphasis on structure, staff members also strive to provide empathy and compassion, so that clients are given the opportunity to construct more positive and secure identities. In all instances however, regardless of their backgrounds, clients are held accountable for their behaviour. Longer programs may initially be more tolerant of behaviours that are grounds for dismissal in short-stay facilities; however regardless of program length staff demonstrate limited tolerance for street behaviour, since it is considered unpredictable and has the potential to jeopardize the safety and security of others. Interestingly clients often continue to use a survival/street mentality and do not tell staff members when others have broken the rules for fear of being known as the 'rat' and the social implications that it will have for them. Clients often adopt this position

despite the fact that the behaviour of others could impact their progress and the overall safety of the treatment environments.

In instances where clients push the limits decisions regarding discharge were taken very seriously. Staff members are reluctant to discharge clients because such events placed tremendous strain on the social environments of treatment programs. Even after a discharge, remaining clients continue to feel the effects of the upheaval. It is at these times that the effective maintenance of the structured program environment is dependent on the skill of the staff, since any weaknesses the client population displays (i.e. as a result of turnover or lack of cohesion) have considerable potential to impact the delicate balance of the group at this time.

Clients at both sites perceive the character of the treatment environment in a variety of different, but overlapping, ways. While most were positive their responses seemed to represent the juxtaposition of feelings they had relating to the presence of both structure and discipline to promote client safety, and empathy and compassion to promote client wellbeing. In many ways, the variation that they expressed is representative of the treatment setting. On a day-to-day basis there is tremendous variation in the dynamics present within these facilities, which is something that clients both observe and experience. Comments made by clients identified that this was in response to a number of contributing factors, which include; variation in lessons being delivered and how they are taught,

dissimilarities in perspectives and approaches used by different staff members, and perceived inconsistencies within the program based on how staff behave. As experiences at Program “B” demonstrate, these factors are amplified in treatment settings where a continuous intake system exists. Programs operating a continuous intake process can also be initially more daunting for new clients, especially if the social balance is temporarily upset.

As suggested in figure 4.1, the overall environment of the treatment programs is influenced by four sets of factors: the individual characteristics of women; social relationships within the program; the character of the program environment; and the neighbourhood setting. While structure is fundamental it is also a very difficult thing to maintain in part because of the diversity of the clients. Each client comes from a different social background and has a variety of different life experiences. As a result each perceives structure differently, which makes implementation and enforcement challenging. The women I had the opportunity to interview and observe in program differed from one another in a number of ways: their demographic characteristics, their addiction histories, experience with formal treatment and their experience with loss resulting from their addictions. While there was variation amongst their stories both similarities and differences can be observed between them. These women were similar in regards to the fact that the degree that their drug and/or alcohol use had impacted each of their lives was often connected to the length of time that they have been

struggling with their addictions and their associated choices. Their experiences also suggest that recovery does not come easily to most, since many have been to more than one treatment facility. Clients differ though in terms of how they think about their use. Many have specific beliefs about their addictions, which guide their approach to recovery and perception of treatment. These differences pose challenges when trying to maintain a therapeutic atmosphere and impact how clients interact with one another, as well as how they interact with program staff and counsellors.

Social relationships between staff and clients and amongst peers also have a significant influence on the overall functioning of a treatment center. Because each staff member possesses their own approach to treatment in the client-centered atmosphere when trying to maintain a balance between empathy/compassion and structure/discipline clients often become aware of their differences and attempt to use these differences to their advantage. Because staff presence is essential for a well-structured and safe atmosphere this can both hinder and/or facilitate a program's operation. There are many perspectives on what does work, especially since many clients have experience with multiple treatment centres. A key consideration for many clients is whether staff members are themselves in recovery. Some feel that only another addict could possibly understand where they are coming from and provide the empathy and compassion they need. Their reasoning is based on an assumption linked to the 12-Steps that

only recovering alcoholics have the ‘grounded’ knowledge necessary to help others with their recovery. Some clients also feel that counsellors who were not in recovery set themselves apart from clients and had greater difficulty understanding their feelings. Staff members tackle this attitude, by encouraging clients to consider that there may be more than one route to a successful recovery, although some clients remain fearful of new approaches.

Clients seek support from their peers in a comparable fashion as they do with staff; they try to form relationships with other clients who share similar experiences and/or social characteristics. These relationships can both positively enforce and/or negatively challenge program goals, and influence the overall dynamic of the program. As such, staff members attempt to manage social interactions amongst clients whenever they deem it to be necessary, since the benefits associated with peer relations are not automatic and cannot be assumed. In programs that operate on a continuous intake basis new clients may find it difficult to developing peer relations with existing clients. This means that the initial support offered by staff is imperative to integrate a client into the social environment. While this is also true in a fixed intake system, clients may have an easier time gaining the support and confidence of their peers. However, these clients may have greater difficulty maintaining positive relationships with one another if the dynamic of the group deteriorates over a long period of time. In instances where issues go unresolved – as was the case at Program “B” – a

negative dynamic amongst the treatment group can potentially impact an entire treatment cycle.

As clients build trust in one another, they increase the level of support that they show one another and decrease the needs that they have of the staff. This is something staff members expect and encourage, since they alone cannot meet the wide array of clients needs. For example, clients who have been struggling with addiction for a longer period of time can help others, for example, by highlighting potential challenges along the road to recovery. However, an ongoing challenge associated with peer relations is that many clients are still learning to communicate effectively, so others may misunderstand their intentions at times. Nevertheless, learning about others' experiences can help clients to feel better about their own experiences and actions and helps them to realize that they are not alone. In all cases clients may struggle while building peer relations simply because they are in treatment to work through difficult issues in their own lives and can only offer so much support to others. Like their relationships with staff, clients must also be careful not to become overly dependent on one another.

The physical design of the treatment setting was of particular interest when approaching this research. Both programs attempted to use the organization of space within and around their facilities to encourage clients in their recovery. For example, both programs implemented rules to prevent clients from isolating themselves (shared bedrooms, limited access to private space). In addition, the

directors of both programs recognized that program environments had the potential to support or detract from the therapeutic aims of their organizations.

Although both programs recognized the role of the environment, there were significant differences between them in terms of the character of program space. These differences reflect a number of factors, including the spaces that programs inherit to begin with, the limited resources available to modify or renovate, and the potential problems posed by neighbours. Program “A” exists within a large residential home that has been modified gradually over several decades to meet programs needs. The layout is somewhat convoluted, yet the space itself is quite large so attention has been paid to the layout and design of each individual room through the use of existing furniture and accessories. The site responds to spatial limitations by making strategic choices when constructing physical change. While some spaces have a more clinical feel than others, clients generally see the internal treatment setting as ‘very homey’. The space offers clients a lived in, welcoming and comfortable environment to work through their treatment. By contrast, the building used for Program “B” possesses a much more of a formal institutional setting. The physical layout was designed specifically to meet the multi-faceted needs of its program. The building is highly organized both in relation to its physical layout and design, yet also projects an institutional feel throughout. While some effort has been made to moderate the institutional feel (paint colours, wall coverings), these changes have only been partially

successful. Interestingly, the director believed that the program space would develop more of a 'lived in' character over time as more women used its resources, leaving behind artwork and other evidence of their stays.

Clients also had opinions on the extent to which treatment spaces were well suited to the objectives of the program. Asking about spaces that were liked and disliked by clients provided an opportunity to better understand the active role that space plays in shaping the everyday social life present within the addiction treatment atmosphere. Most often they enjoyed those environments that were the most comfortable and where they could enjoy socializing with one another, while some sought out quieter, more removed settings. Clients also talked about the need for change in rooms where they spent considerable time, especially when these spaces were cluttered and/or disorganized, and/or had uncomfortable seating. Others identified 'upbeat' paint colours and more natural light as key to a more therapeutic feel for treatment space.

The environments surrounding the facilities also differ from one another on a number of levels. At Program "A", limited backyard space and an ongoing concern about neighbours combined to significantly constrain clients' use of the external environment. This, in turn, had a number of negative impacts on the internal social dynamic at the program. At Program "B", a newly completed green space had been designed specifically for the benefit of clients. Although some women enjoyed the space, rules governing smoking and the needs of

different client populations limited its use. This provides an interesting example of the difference between the therapeutic aims of the program, and the perceived needs of women clients.

Finally, the neighbourhood around to the treatment environment is also a factor that shapes a program's therapeutic capacity, although the magnitude of its influence is limited by how much time clients have to spend off-site. Clients' knowledge and perceptions of the surrounding area is also influenced by whether they live locally. Neighbourhood spaces can either enhance or diminish the sense of safety and security that clients build within the program environment. For this reason programs moderate client use of the surrounding environment when clients are perceived to be particularly vulnerable and/or when the setting is thought to contain one or more 'threats' to recovery. To a great extent, the content of the local neighbourhood is beyond the control of the program, so staff members must maintain a keen awareness of what is taking place in the surrounding neighbourhood, and keep in regular contact with local police enforcement officers and store owners to minimize the negative effect that the neighbourhood can have on a clients' treatment experience. In addition, there are some managerial strategies that programs use to minimize the negative effects of local environments. These include; restrictions from leaving the program space for certain lengths of time and during certain points each day, using breathalyser and urine sample testing when clients have spent longer periods of time off site, and

random bag checks. Clients are also encouraged to use their time off-site to accomplish tasks relevant to their recovery and leaving the program.

6.3 Key Tensions in the Addiction Treatment Landscape

My analysis helps to shed light on a number of key tensions that characterize the therapeutic landscapes of addiction treatment programs (see figure 6.1). A brief discussion of each of these related tensions also helps to connect my findings with the literatures outlined in Chapter Two.

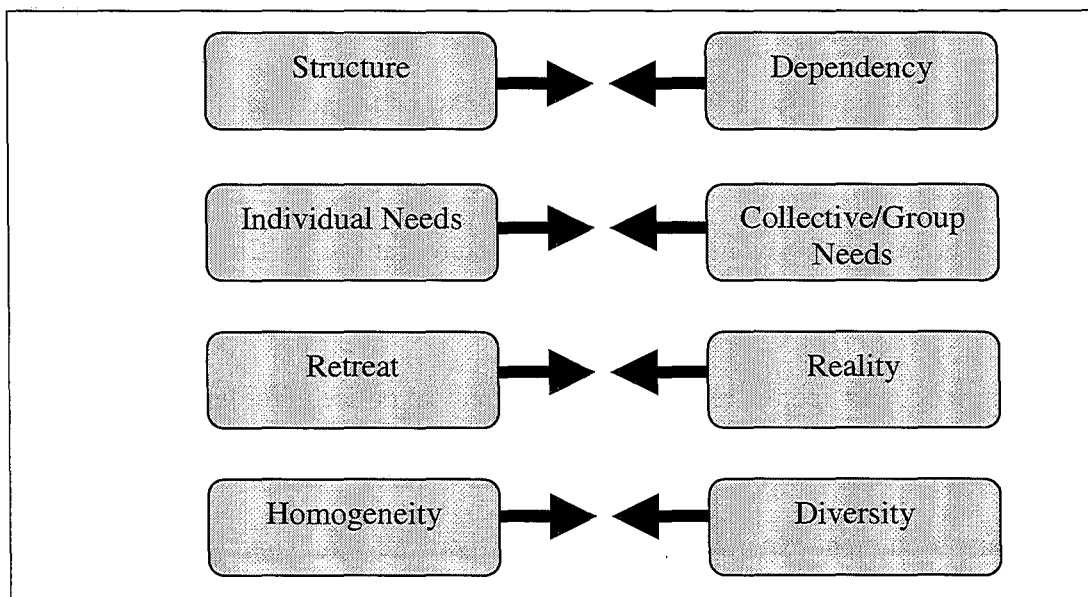


Figure 6.1: Key tensions influencing the operation of substance abuse treatment programs

6.3.1 Structure versus Dependency

As has been suggested throughout the analysis, the core objective of both treatment programs is to maintain a structured environment. For women attempting to recover from addictions, the programs provide a proxy for their own diminished self-control. However, staff members are also mindful to ensure that the program's structure does not encourage clients to develop dependency on the program, particularly because their stay is only temporary. Maintaining a balance between these two poles is not easy, and the staff must work to consistently shift the balance over time as women move through the program. In this sense, the analysis shows that a great deal of work is involved in producing and sustaining a "difficult and contestable" therapeutic environment within an addiction treatment setting (Baer and Gesler 2004, 412). It also indicates that program staff have the potential to produce a variety of outcomes, some intended and some unintended, some positive and some negative, as they attempt to manage these environments to the best of their abilities (see, for example, Wilson 2003; Conradson 2005; Lea 2008).

6.3.2 The Individual versus the Collective

At both programs considerable emphasis was placed on recognizing the individual needs and starting points of different women as they entered and progressed through the program. While this is a key aspect of client-centered programming,

my analysis demonstrates that it is very difficult in practice to implement a structured environment where collective existence and cooperation are dependent on the perception of fair and equal treatment among the women. This is also made more difficult if there is turnover amongst the staff and/or staff resources are stretched too thin. Some studies (see, for example, Ellis et al. 2004) have argued that supportive relationships may be more important to women's recovery than men's. To the extent that this is true, the tension between individual needs and collective satisfaction may have a greater impact on the operation of programs catering to women. This issue is also connected to recent discussions of therapeutic environments as it points to the ways in which the same environment might be experienced in very different ways by women based on their interactions with staff and decisions made about their treatment.

6.3.3 Retreat versus Reality

A third tension concerns the extent to which programs should act as refuges from the threat of alcohol and drug use. On the one hand, staff and clients both see the treatment program as a space where women can feel safe from people and places capable of triggering a relapse. As Gesler (1992, 738) suggested in his initial discussion of therapeutic landscapes, addicts' problematic relationships with other familiar places suggest that: "therapy for alcoholics might usefully include establishment of refuges, places with positive images where identity could be

established”. This idea of refuge or retreat certainly also fits with popular perceptions of better-known private treatment centres such as the Betty Ford Clinic as a space away from stresses in people’s daily lives. On the other hand, there is a sense that, since women have to eventually leave the program, they should be exposed to ‘some’ risk in the course of treatment so that they are able to practice what they have learned in counselling and group sessions. This raises an interesting question about what really constitutes a ‘therapeutic’ environment for people attempting to recover from addiction. Is it an environment completely free from risk or is this environment so unlike the real world that it actually does more harm than good (linking back to the question of dependency – see 6.3.1)? Again, this connects to Baer and Gesler’s (2004) question about the complexity of such ‘difficult and contestable’ examples. It also responds to earlier calls to try to understand the differences between ‘extraordinary’ sites such as spas and retreats, and the therapeutic character of more mundane or everyday spaces (Wilson 2003; Smyth 2005). In addition, this tension suggests an important temporal dimension to therapeutic environments; what is therapeutic for these women (and other people in recovery) changes over time as their resistance to drugs and alcohol is built up through participation in the program.

There is also a connection here to the literature on addiction treatment. While some studies support the creation of women-only treatment spaces, others have suggested that the absence of men negatively reduces a program’s ability to

create a 'realistic' social environment in which to learn coping skills (see, for example, Swift and Copeland 1998). My research reiterates the importance of women-only spaces. As Smart and Ogborne (1996, 2007) have noted, many women in treatment for addiction are also dealing with abuse from male partners, and this was certainly the case for some women in the programs I studied. It is difficult to imagine the sharing of experiences and positive interactions that I documented during observation taking place in a co-ed environment (see also Ashley et al 2003; Niv and Hser 2007). At the same time, the conflicts and tensions I observed remind us that women-only spaces are not intrinsically or necessarily therapeutic. Staff and clients must work together to create and sustain a supportive environment.

6.3.4 Homogeneity vs. Diversity

Some studies in the addiction treatment literature have suggested that treatment may be more successful if providers can work with relatively small groups of women who are fairly homogenous (in terms of their addiction histories, crisis experiences, and/or demography) (see Rutan and Stone 1984; Hodgins et al. 1997). While this may be the case in theory, limited resources for women's treatment may make this difficult to accomplish in practice. Moreover, the search for homogeneity may be undesirable if it meant greater selectivity on the part of treatment providers and potentially longer wait times. In Hamilton, for example,

Program B was the only residential treatment program for women. While women are not technically restricted to local programs, those wanting to access treatment as day clients have few other choices. At same time, great diversity amongst women may increase the likelihood of misunderstanding and conflict among the clients of a program, making the balance between individual and collective needs more difficult to maintain (see, for example, Section 6.3.2).

This larger question of access also connects to recent discussion in the therapeutic landscape literature. MacKian (2008), for example, has argued that the notion that people *chose* to go to specific therapeutic sites is a problematic assumption. This is certainly the case in the context of women's addiction treatment. Choice is often limited and women needing help may end up in programs with philosophies and routines that do not entirely fit with their own ideas about how to approach recovery. This returns us to the recognition that therapeutic environments are complex phenomena capable of producing multiple outcomes for different people, some more positive than others. The analysis also demonstrates that 'therapeutic effects' of settings such as treatment programs are worked out on an ongoing basis by those individuals and groups who inhabit these spaces at any particular point in time.

6.4 Strengths and Limitations

Reflection on data collection and analysis is an important part of the research process and I recognize that this project has both strengths and weaknesses. In terms of strengths, the use of qualitative methods in this thesis research did allow for an in-depth exploration of the two programs. As such, the thesis contributes to the existing body of knowledge on therapeutic landscapes by providing a detailed micro-scale analysis of staff and clients' experiences within a specific type of setting. The combination of methods (interviews and observation) also helps to strengthen the analysis since I was able to compare and contrast respondents' opinions with my own observations of the daily routines of the two programs.

In recent decades, feminist researchers have emphasized the advantages of qualitative research methods as a way of gathering women's stories about their lives in ways that quantitative methods could not (Moss 2002). Some work has suggested that qualitative interviews may serve a cathartic or potentially empowering purpose in the sense that women are able to talk through issues with someone who is genuinely interested in their experience (see, for example, Opie 1992). While the benefits of such interviews are not automatic, my encounters at the treatment centers did suggest that the women appreciated my interest in their struggles with addiction. By sharing their experiences with me clients were able to express their opinions about how best to approach treatment. Donna, a client at

Program “B”, emphasized these sentiments in her creative writing class. In one session she chose to write about our interview:

*I will write about the interview with Michelle (McMaster Research Student)
Thoughts and words are valued, opinions and perspectives needed
Information yields knowledge of the unknown
Never to be experienced by those who are not addicts
Addicts experiences are removed from those who are free
Should they blunder, spiral down, they will know
Experiences evolve into thesis, for all to know, those who care
Changes emerge to improve the path and the surroundings we share
Comfort and caring is what is deserved and earned
Physical, emotional and mental warmth
Envelop me – I am an addict.*

Her writing indicates that sharing with me encouraged her to feel valued – that her perspectives of the treatment center and experiences as a client were worthwhile.

In terms of weaknesses, two deserve specific mention. First, my research took place with the permission of the program directors with the consequence that access to the programs (where I could observe and at what times) was negotiated at the outset of the fieldwork. Not surprisingly, at both programs I was not given access to all aspects of the program and was not able to be there on a continuous basis as clients worked through the treatment process. As such my observations represent only a partial picture what takes place within these facilities that, although supplemented by one-on-one interviews with clients, would be more complete if I had the opportunity to observe activities around the clock. One alternative approach would have been to ask permission to enter the programs as a ‘client’ and stay within the residential environment. While this may have

provided more opportunity for observation, it also raises ethical questions about whether this type of role is justifiable if it takes up a place in treatment that could be used by someone else in need.

In connection to this first issue, the access negotiated at the two programs differed. At Program “B”, I was provided with a great deal more access to the program of a 5-week treatment cycle. As a result, my fieldwork was more extensive and I was able to get to know the women better there. At the same time I was unable to interview as many women at Program “B”, because the director asked me to delay interviewing while tensions within the group were resolved by staff. By the time permission was granted, several women had been discharged, leaving far fewer remaining in the program. At Program “A”, limited opportunity for fieldwork and fewer visits to the site negatively impacted my observational data, but I was able to conduct a significant number of interviews with women clients.

6.5 Future Research Opportunities

Future research opportunities exist in relation to critiques mentioned above, as well as in relation to how the therapeutic landscape concept applies to addiction treatment programs. While I have explored how environment matters when constructing women-only addiction treatment programs as therapeutic many other avenues exist. For example, given the insufficient attention that has been

placed on gender in the 'therapeutic landscapes' literature future research could more explicitly identify the gendered elements present within environments, such as addiction treatment facilities, and perhaps also attempt to provide some comparison of the different realities that women and men face in treatment. For example, a gender analysis could successfully take place by considering my own data in connection to the broader research project of which this study is a part. One might also consider how the experiences of women vary when they are clients at a women-only program versus a co-ed program, and/or how their experiences differ from one another based on where they are situated geographically (whether local, provincial, or worldwide). Further, it would be useful to consider the ways that women-only and mixed-gender programs may be considered as 'gendered' spaces.

In continuation with my own project it might also be interesting to follow the movement of the clients I observed to gain a better understanding of their experiences upon program completion. Presumably there would be a fair deal of variation amongst their experiences in relation to whether they maintain their sobriety, or return to drinking and/or using; how they work at applying the life skills that they learned while in treatment; the social networks that they maintain and/or disconnect from; and to the changes that they make in the living arrangements that they possessed prior to treatment. By following the lives of these women we might also gain a better sense of the presence or lack of

continuity that exists throughout the treatment system. Very few programs exist to specifically meet the substance abuse needs of women. It would be useful therefore to observe the approaches that they take to access programs that currently exist; what these programs offer and where they are located; what happens when women aren't able to find the services that they are looking for, and how the system is currently meeting or failing to meet their individual needs as a result. This would provide us with a better sense of their lived experiences both in relation to their drug and/or alcohol use, and how it is affecting their lives, as well as how they develop connections with treatment services.

My research has strived to establish that environment matters when exploring women-only substance abuse treatment programs as 'therapeutic landscapes'. In doing so however it has not established a method of determining how success can be characterized when classifying one program as a therapeutic landscape and another not. While we know that these sites are going to be perceived differently by each client depending on a wide range of personal factors, it would be helpful if future research considered developing a system that is able to measure program success, so that 'best practices' can be more adequately determined.

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Appendix 1: 12 steps of “Alcoholics Anonymous”

THE TWELVE STEPS OF ALCOHOLICS ANONYMOUS

1. We admitted we were powerless over alcohol – that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God *as we understood Him*.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Make a list of all persons we have harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God, *as we understood him*, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

Source: Addiction Research Foundation 1996

Appendix 2: 13 steps of “Women for Sobriety”

WOMEN FOR SOBRIETY (WFS)

New Life Program

1. I have a drinking problem that once had me.
2. Negative emotions destroy only myself.
3. Happiness is a habit I will develop.
4. Problems bother me only to the degree I permit them to.
5. I am what I think.
6. Life can be ordinary or it can be great.
7. Love can change the course of my world.
8. The fundamental object of life is emotional and spiritual growth.
9. The past is gone forever.
10. All love given returns two-fold.
11. Enthusiasm is my daily exercise.
12. I am a competent woman and have much to give life.
13. I am responsible for myself and my actions.

Source: Addiction Research Foundation 1996.

Appendix 3: Client Interview Guide

CLIENT INTERVIEW GUIDE

Introduction

1. Can you tell me how long you've been a client at this program?
2. How did you come to choose this program?
3. Did you get a referral to the program? If so, where from?
4. Was there a waiting period to get in?

Addiction issues

1. Would you mind telling me a little about the addiction issues you're dealing with?
2. If you were explaining the challenge of recovery/treatment to someone who hadn't dealt with addiction, what would you say?

Experiences at the program

1. Can you tell me about your experiences here since you arrived? (e.g., what kinds of activities/programs have you been involved in?)
2. What was your reaction to the program initially? What about now?
3. Can you describe the program in terms of its physical layout and design?
4. Where do you spend your time during a typical day (e.g., counselling, group sessions, eating, socializing, smoking, resting, etc)?
5. Are there particular places that you like spending time?
6. Are there other places you'd choose to avoid?
7. What about your bedroom, how do you feel about that?

8. If you had to describe the character of the program, what words would you use?
9. What would you change about the layout and design of the space if you could?
10. Have you been to any other treatment program?
11. If yes, can you tell me about your past experiences with other treatment providers?
12. How did they compare with this one in terms of some of the issues we've just been talking about?
13. How do you feel about the space outside the program, in the immediate neighbourhood?
14. Do you spend much time outside the program?
15. Where do you go?
16. Can you describe the neighbourhood here?
17. What things about the neighbourhood do you like/dislike?
18. Do you think the neighbourhood makes any difference to your progress here?

Living arrangements before/after treatment

1. Where were you living before you entered the treatment system?
2. Was it important to leave that environment in order to start treatment?
3. How long can you stay at this program?
4. Is that long enough for you?
5. Where do you think you'll go when you leave here?
6. Ideally, what kind of living arrangement would you like?

7. What difference would that make to your recovery?

Demographics

1. How old are you?
2. Where are you from originally?
3. Were you working before you entered the treatment system?
4. If not, what was your primary source of income?
5. What about after you leave here? What are your plans?
6. Do you have any questions for me?

Appendix 4: Director Interview Guide

DIRECTOR INTERVIEW GUIDE

Section 1 – Overview of program & client population

1. How long has your program been operating?
2. Describe the programs you offer here, and a sense of how many people are here at any one time, and how many are served over the course of the year
3. Can you outline the recovery/treatment philosophy that underlies your program(s)?
4. Can you give me a sense of the demographic profile of your clients (socio-economic status; ethnicity; gender; age; homeless/housed; place of origin)

Have these characteristics changed much in recent years? (how so; what are the reasons for these changes)

5. What are the most common substance abuse issues that your clients face?

Has that changed much in recent years?

6. What is the residential /outpatient split?

Have these characteristics changed much in recent years? (how so; what are the reasons for these changes)

7. How are people referred to you? What are the typical paths through which clients arrive at the facility?
8. Can you describe the experience of typical client(s) here in terms of how long they would spend in the program (residential inpatient → outpatient, sober living, etc?)

Section 2 – Program & neighbourhood environment

1. Can you describe your facility in terms of its physical layout and design?
2. How long have you been based here?
3. Do you have a sense of why the program located here?
4. Was this a custom-built facility for you?
5. If yes, what kinds of spaces/environments were important to you as you were planning out the design?
6. If no, have you made changes to the building to accommodate your program (what were they?)
7. What are some of the aspects of this environment that you think work well for the program? What about aspects that don't work so well?
8. Are there things that you would change about the program environment if you could? What?
9. Are there particular parts of the facility that clients like to occupy? Conversely, are there spaces they don't use? What about outside the program, in the immediate vicinity? Are there places people like to hang out and smoke, for example?
10. Where do clients spend most of their time at the program?
11. Can you describe surrounding neighbourhood, in both physical and socio-cultural terms?
12. How would you characterize the relationship between the facility and the neighbourhood? Is it positive or negative?
13. To what extent have you had to deal with community opposition to your program since you've been here?
14. Do your clients spend much time in the neighbourhood around the

program?

15. Are there features of the neighbourhood that are positive for clients (places to go, things to do?)
16. Are there aspects of the neighbourhood that are less conducive to clients' well-being? What are they?
17. Are there things you'd change about the neighbourhood to make it more conducive to recovery? What would those be?
16. What do you see as the primary challenges in helping clients towards recovery?
17. Do these relate in any way to the kind of environment clients are in (either the internal program environment or the neighbourhood)?
18. What about when people leave the program... what kind of difference does being here make? Where do they go? If they don't want to return home, are there alternatives?

Appendix 5: Coding Structure

- 1= Index Tree
- 2= /Program
- 3= /Program/Program A
- 4= /Program/Program B
- 5= /Type of Treatment
- 6= /Type of Treatment/Residential
- 7= /Type of Treatment/Day
- 8= /Type of Treatment/Day vs. Residential Treatment
- 9= /Type of Treatment/Fixed vs. Continuous
- 10= /Treatment Space
- 11= /Treatment Space/Internal
- 12= /Treatment Space/Internal/Physical Layout and Design
- 13= /Treatment Space/Internal/Physical Layout and Design/Things to Change
- 14= /Treatment Space/Internal/Time Spent on Typical Day
- 15= /Treatment Space/Internal/Time Spent on Typical Day/Favourite Spaces
- 16= /Treatment Space/Internal/Time Spent on Typical Day/Avoid Spaces
- 17= /Treatment Space/Internal/Structural Accommodations
- 18= /Treatment Space/Internal/Structural Accommodations/Bedroom Space
- 19= /Treatment Space/Internal/Structural Accommodations/Bathroom Space
- 20= /Treatment Space/Internal/Structural Accommodations/Shared Spaces
- 21= /Treatment Space/Internal/Structural Accommodations/Quiet/Private Space
- 22= /Treatment Space/Internal/Structural Accommodations/Family Spaces
- 23= /Treatment Space/Internal/Structural Accommodations/Quality of Furnishings
- 24= /Treatment Space/Internal/Structural Accommodations/Classroom Space
- 25= /Treatment Space/Internal/Structural Accommodations/Dining Area
- 26= /Treatment Space/Internal/Privacy
- 27= /Treatment Space/Internal/Privacy/Medications/Testing
- 28= /Treatment Space/Internal/Privacy/Pay Phone
- 29= /Treatment Space/Internal/Use Limitations
- 30= /Treatment Space/External (Property)
- 31= /Treatment Space/External (Off Site)
- 32= /Treatment Space/External (Off Site)/Perception of Neighbourhood
- 33= /Treatment Space/External (Off Site)/Off Site Destinations/Time Spent
- 34= /Treatment Space/External (Off Site)/Description of Neighbourhood
- 35= /Treatment Space/External (Off Site)/Neighbourhood Influence on Treatment Experience
- 36= /Treatment Space/External (Off Site)/Transit Availability/Access

37= /Treatment Space/Therapeutic Features
 38= /Treatment Space/Non-Therapeutic Features
 39= /Program Description (Site Specific)
 40= /Program Description (Site Specific)/Length of Program/Opinion
 41= /Program Description (Site Specific)/Philosophy
 42= /Program Description (Site Specific)/Structure
 43= /Program Description (Site Specific)/Structure/Daily Routines
 44= /Program Description (Site Specific)/Structure/Monitoring
 45= /Program Description (Site Specific)/Structure/Rules/Discipline
 46= /Program Description (Site Specific)/Structure/Intake Process
 47= /Program Description (Site Specific)/Structure/Education/Life lessons
 48= /Program Description (Site Specific)/Structure/History/Evolution
 49= /Program Description (Site Specific)/Structure/Capacity/Programs/Resources
 50= /Program Description (Site Specific)/Structure/Program Content
 51= /Program Description (Site Specific)/Structure/Client Profile
 52= /Program Description (Site Specific)/Character
 53= /Demographic Characteristics
 54= /Demographic Characteristics/Age
 55= /Demographic Characteristics/Birth Place
 56= /Demographic Characteristics/Job Status/Type
 57= /Demographic Characteristics/Disability Benefits/Social Assistance
 58= /Demographic Characteristics/Living Arrangement After Treatment/Current
 59= /Demographic Characteristics/Living Arrangement Prior to Treatment
 60= /Demographic Characteristics/Living Arrangement Prior to
 Treatment/Importance of Leaving that Environment to Start Treatment
 61= /Demographic Characteristics/Living Arrangement Ideal
 62= /Social Relations
 63= /Social Relations/Peer Support/Relationships
 64= /Social Relations/Peer Support/Relationships/Program B Interviews
 65= /Social Relations/Peer Support/Relationships/Program A
 66= /Social Relations/Peer Support/Relationships/Program B Fieldnotes
 67= /Social Relations/Peer Support/Relationships/Program B Fieldnotes 2
 68= /Social Relations/Peer Support/Relationships/Program B Fieldnotes 3
 69= /Social Relations/Peer Support/Relationships/Program B Fieldnotes 4
 70= /Social Relations/Client/Staff Relationships
 71= /Social Relations/Client/Staff Relationships/Program A Interviews
 72= /Social Relations/Client/Staff Relationships/Program A Interviews/Fieldnotes
 73= /Social Relations/Client/Staff Relationships/Program B Interviews
 74= /Social Relations/Client/Staff Relationships/Program B Interviews/Fieldnotes
 75= /Distinctions between Women
 76= /Distinctions between Women/Class/Social Status

77= /Distinctions between Women/Personal/Addiction History
 78= /Distinctions between Women/Smoking
 79= /Distinctions between Women/Opinions relating to Self/Others
 80= /Distinctions between Women/Treatment History
 81= /Program Experience (Site Specific)
 82= /Program Experience (Site Specific)/Length of Time in Current Program
 83= /Program Experience (Site Specific)/Initial Reaction to the Program
 84= /Program Experience (Site Specific)/Program Experiences/Involvement
 85= /Program Experience (Site Specific)/Program Experiences/Involvement/Exercise
 86= /Program Experience (Site Specific)/Program Experiences/Involvement/Use of Buddy System
 87= /Program Experience (Site Specific)/Program Experiences/Involvement/Responsibilities
 88= /Program Experience (Site Specific)/Client Perception of Counsellors
 89= /Program Experience (Site Specific)/Client Perception of Counsellors/Counsellor versus Addict Debate
 90= /Program Experience (Site Specific)/Overall/Current Perception of the Program
 91= /Self Through Treatment (General)
 92= /Self Through Treatment (General)/Self Monitoring/Awareness
 93= /Self Through Treatment (General)/Life Losses through Addiction
 94= /Self Through Treatment (General)/Motivation for Treatment/Recovery
 95= /Self Through Treatment (General)/Relapse Experiences/Obstacles
 96= /Self Through Treatment (General)/Transition into Treatment
 97= /Self Through Treatment (General)/Experience with and Perceptions of Treatment
 98= /Self Through Treatment (General)/Experience with and Perceptions of Treatment/Challenge of Treatment/Recovery
 99= /Self Through Treatment (General)/Post Treatment Goals/Reality
 100= /Self Through Treatment (General)/Environmental Awareness

