AN EXPLORATION OF SOCIAL SUPPORT CONSIDERATIONS FOR SUBSTANCE USE AFFECTED ONTARIO WORKS RECIPIENTS : STARTING TO DEFINE THE BACKDROP

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ABSTRACT

Social support is generally viewed in the addiction field as an important consideration in assessment and a potentially valuable component of a comprehensive treatment plan. The literature would suggest that strong social support can benefit individuals during many stages of the recovery process, including both active recovery and longer term maintenance. Less is known about social considerations in the initial stages of seeking support to begin recovery.

This report seeks to explore social support considerations for a specific population, Ontario Works recipients who have identified substance use as a barrier to employment, and to do so in a hopefully reciprocal manner which values understanding context from those with lived experience. This qualitative study is informed by the principles of grounded theory in a general manner, began with no specific hypothesis, and allowed participants flexibility in their responses. Previously documented barriers facing this population were generally reflected by the circumstances revealed by this study's participants.

The principle findings outlined the lack of social supports currently in place for participants and their struggle to seek help. Seeking help appeared to require an emotional low point and a recognition that overcoming the substance use concern would not be realistic without additional help. Support seeking appears to be encouraged by specific nurturing characteristics of supporters. From a practice perspective the findings illustrated the need for increased focus on clinician/client engagement and a greater focus on

practitioner's appreciating the unique challenges facing this population and utilizing creative approaches to address them.

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INTRODUCTION

Individuals receiving social assistance experience a complex set of daily choices and challenges. In addition to coping with financial resources that are insufficient by any standard, many must manage circumstances that serve only to heighten the marginalization they face daily and which, in real terms, represent both practical barriers and constant emotional turmoil. Often, drug or alcohol abuse is a factor, one which integrates uniquely with individual coping for each individual and adds an additional layer of stigma. Overcoming a substance abuse issue is a complex process - even when resources are comprehensive and accessible. For those with multiple barriers the challenge can seem insurmountable. Regrettably, this challenge is often faced with few social supports. The development of a better understanding and appreciation of the struggle of individuals living in this circumstance was the motivation for this study.

The overarching focus of the research was to explore the components, relative importance, and nuances of social support that clients receiving social assistance through the provincial program [1]*Ontario Works,* view as useful in enhancing their ability to make changes with respect to alcohol and drug use. In the writer's experience working with this population as an addictions counselor, social support is certainly not equally distributed, but it appears a lack of individual social support resources can be identified and supplemented.

[1] **Ontario Works** provides income and employment assistance for people who are in temporary financial need. www.hamilton.ca/HealthandSocialServices/.../**OntarioWorks**

Better appreciating the elements of social support through the voices of clients may be clinically useful within the addiction community and within the program discussed in this thesis.

For the purposes of this study social support is defined as that group of individuals, either informal (typically family and friends, peers) or formal (typically professionals) who provide moral support (encouragement), emotional support through discussion of feelings, instrumental assistance, mentoring support (guidance) and recreational support (Herie and Watkin-Merek, 2006). Ideally, this support is provided in such a way that the recipient can discuss his or her feelings within a safe and trusted environment.

The research premise was intentionally positioned as exploratory. The study's intent was to add to the knowledge base an element of individual and perhaps collective group lived experience regarding the social support factors which underlay the challenge of addressing a substance abuse issue for individuals receiving social assistance. Secondarily, participant insights were seen as potentially informing program components. In this thesis I will provide the reader with some background information regarding the research setting; provide a summary of the pertinent literature; discuss the ethical considerations that were important to the study; describe the methods used and participant characteristics; provide an analysis of the findings (including participant quotations); and, finally, discuss the study's implications for program enhancements and social work practice and it's potential to encourage future research.

First, let me situate myself in this research and explain why, in my view, an understanding of the relationship between social support and successful substance use change may be useful. Based on my practice experience, clients engaged in addiction counseling often exhibit inconsistent motivation and can struggle with social stigma, shame and guilt. These factors appear to have an impact on attendance. Having said that, clients typically have a lot at stake. I have seen evidence that successful treatment can mend broken family relationships, improve physical and emotional health, and create a foundation for improved employment and financial outcomes. Melnick, De Leon, Hawke, Jainchill and Kressel (1997) citing Deleon (1984), Simpson and Sells (1982) and Hubbard and Collins (1988) indicated there is a well-established evidence that successful treatment outcomes correlate with time in treatment. "Drop out"of treatment is associated with lower levels of client/counselor congruency (Pulford, Adams, and Sheridan, 2007). Both of these factors would be consistent with my experience. As well, my observation would be that *who* the client spends time with and *who* s/he avoids, can impact substance use change. Certainly this is not a startling revelation, particularly for those in the addiction field, but it does serve as a backdrop to understanding the potential usefulness of this study. If new insights on social support factors relating to client/counselor interactions can potentially improve attendance theoretically more consistent treatment could improve outcomes. Further, participant views on supportive versus non supportive social networks may assist in treatment planning.

I am a social worker and addictions counselor employed by Alcohol, Drug and Gambling Services (ADGS) within the department of Public Health in the City of Hamilton, Ontario. ADGS is a key partner in the Ontario Works (OW) Addictions Services Initiative (ASI), a program intended to assist Ontario Works recipients who have identified substance abuse as a barrier in obtaining employment. Positioned as an employment program as opposed to an additional social assistance benefit, the aim is to provide intensive case management for voluntary participants in a manner that addresses foundational deficits (such as housing and access to primary health care), combined with addiction services – all delivered in a manner suited to the client (Ontario Works, 2013). The program, from the writer's perspective, appears well funded, and is grounded, both formally and informally in guiding principles which support social work values and a client centered approach. The program recognizes the individual "pace" and the often inconsistent nature of client motivation by providing a flexible time frame and an accessible re-entry process should a client hesitate through the change process or experience a relapse. The program attempts to be responsive to the multiple barriers that participants face by providing such services as trauma counseling, specific employment development resources, acquired brain injury assessment and links to related services, art and music therapy facilitated by registered therapists, transportation funding, and individual counseling (outside of addictions counseling). In my experience, it has the ability to "tailor" services for each client. This is accomplished through the provision to clients of an OW case facilitator with a much smaller caseload than held by a conventional worker (the caseload in 50 clients in ASI, it is the writer's understanding the caseload is 100-

150 clients for a typical case manager) . In the program's 2013 evaluation clients reported that their experience in the program involved a level of individual attention and caring that appears distinctly differentiated from the typical OW experience (Ontario Works ASI program 2012 Evaluation). From a personal (albeit potentially biased) standpoint, I can attest that the program's intentions are aligned with its day by day delivery.

Importantly however, the program cannot escape its immediate institutional surroundings: it is located in an Ontario Works office. This location, while convenient for clients, appears to simultaneously present challenges in terms of client comfort. There remains however, a real opportunity for valuable client support and treatment within a program that appears to have provincially-based funding stability and that has consistently been supported by the City of Hamilton. The program's framework appears sound and generally well appreciated by clients (Ontario Works ASI 2013 evaluation) but gaps remain. Missing are opportunities for the inclusion of client voices in several aspects of substance use change, including social support factors (in my experience a subject those with substance use concerns often find difficult to talk about). It should be noted that the Hamilton ASI program leadership consistently look for comfortable avenues to seek client feedback through a participant advisory committee and ongoing informal opportunities. To date, however, client input regarding social support has been minimal and has primarily been provided by only long-time program participants within an OW setting. The voices of new clients are absent. Interestingly, one of the most pronounced items of feedback from clients is the request for ongoing peer support, a consideration that has relevance to this

study. This research is seen as a beginning effort to contextualize and better understand an extremely marginalized population – social assistance recipients with drug and alcohol problems and how social support considerations could inform the ASI program's responsiveness to client needs. If the findings can advance client voice within the addiction field or ideally be incorporated into the ASI program specifically, locally or provincially, they can be viewed as useful and reciprocal.

While social supports is the chief interest of this thesis it should be noted that this research was done within an institutional context with an employment mandate and within a program designed to support employment readiness. This focus does influence the components of the ASI program to a large degree (Ontario Works, 2013). Interestingly, clients within the program generally speak of personal objectives that are more abstract than obtaining employment; "functioning normally", "gaining control" and "working on me" are commonly expressed client goals. These goals, at least initially for most clients, seem to precede work as a priority.

It is important to point out that completing this research was difficult. Defining the study focus without presupposing the outcome, navigating the ethical concerns, recruiting participants and, ultimately, deciphering if and how the qualitative data was somehow correlated was challenging. It was not, however the toughest part. The real difficulty was the process of: listening to and hearing six stories; attempting to appreciate the absolute uniqueness of each one; recognizing how rich each story was in the story's demands on the

story-teller; and the "matter of fact" way that these difficult stories were told. Then, after thanking the participant at the close of each interview, assuming the responsibility of ensuring that the final product represented something that is useful, reciprocal, respectful, and does not neglect the human component within compiled data.

In the end, I hope this thesis will be viewed as having achieved these goals; that after all the conversations were sorted, themed and interpreted, the cumulative story respects individual experience and can provide for both professional and program development through the offering of a broader understanding of both the shortcomings and needs for social support for this group of participants and the narrative of hope and dignity that emerges.

LITERATURE REVIEW

The components of the literature review reflect the initial background information needed to substantiate the study's relevance and methodology, an appreciation of the existing related research, and consideration for the themes which ultimately surfaced. This involved providing a glimpse of the bio-psychosocial characteristics of client populations similar to the one involved in this study, a broad review of the impact of levels of social support generally and specifically within the realm of substance abuse treatment, social support as it relates to drop out rates and client retention, valued components and supporter characteristics, an exploratory review of the potential value of qualitative studies involving lived experience, client willingness to seek support/help, and peer support considerations.

Setting the Stage

Let me begin this literature review with some background information. A factor underlying the potential value of the my research project to improving practice with Ontario Works recipients addressing substance use concerns, involved consideration of the general characteristics and life circumstances of the population group at the heart of this inquiry , and how these characteristics might integrate with the construct of social support. The ASI program's premise is that this population generally faces numerous obstacles that may impact upon their ability to make substance use changes and to obtain employment. A

study conducted in the United States (Chandler, Meisel, Jordan, Rienzi and Goodwin, 2004) involving Temporary Assistance for Needy Families (TANF) recipients found that participants reported "serious health problems (24%), impaired psychiatric functioning (17%), very low self esteem (16%) and learning disabilities (21%), limited work skills (30%) and not graduating high school" (41%)" (Chandler et al, 2004, pg. 12, 13). Another study (Morgenstern, McGrady, Blanchard, McVeigh, Riordan and Irwin, 2002), collected data which compared female welfare recipients considered "substance dependant" with female welfare recipients deemed to be "nonaffected" along a number of parameters. The authors found significantly lower levels of education and job skills, longer time spent in receipt of welfare, greater housing concerns, and less previous employment consistency in the substance dependant group. From a health perspective, the authors reported finding that this group of women faced significantly higher levels of physical health limitations affecting the ability to work, including depression (45% vs 9%), and post- traumatic stress disorder diagnosis (20% vs 3%). Experiences of domestic violence (38% vs 13%), child welfare involvement (84% vs 48%), arrests and incarceration (56% vs 15%, 25% vs 5% respectively), and of having children identified with special problems (17% vs 9%), were similarly considerably higher among the women identified as substance dependant. Overall, the barriers to change faced by to this group of women were more than double those of women considered non-affected. Danzinger & Seefeldt, (2002) citing the U.S. based Women's Employment study, reported problem rates for welfare recipients above the general population in high school education

rates, depression, having children with health problems, experiences of domestic violence and transportation problems.

The concerns discussed above regarding U.S. welfare recipients appear to be similar in Canada/Ontario. The recent Review of Social Assistance in Ontario (Lankin and Sheikh, 2012), in providing an overview of Ontario Works recipients indicates that OW recipients make up 3.6% of the Ontario population, 94% of which live in Southern Ontario. Sole support parents make up 30% of Ontario Works cases, 93% of which are women. About 75% of children in families benefiting from Ontario Works live in sole support families. 33% of primary applicants have completed Grade 12-13, about 24% have university educations, 43% have Grade 11 or lower. 13% of primary applicants are newcomers, living in Canada 5 years or less. The average case at Ontario Works lasts about 21 months, 29 months for sole support parents.

Of more specific relevance are the health concerns associated with welfare recipients. In "Precarious Lives – Work, Health and Hunger amoung Current and Former Welfare Recipients in Toronto", Lightman, Herd and Mitchell (2008) outlined broader health concerns reported by those living on social welfare benefits. The authors, reporting on a previous study (Hamelin, Habicht, & Beaudry, 1999) emphasized the impact of inadequate diet as it relates to reports of "hunger pangs, depletion of energy, fatigue, and illness related to access of adequate food" (pg. 3). Lightman et al (2008) also referred to Vozoris and Tarasuk (2004) who reported welfare recipients in Canada had higher rates of reporting poor

health, depression, distress, functional health, and heart disease when compared to those not receiving social assistance.

Although concrete statistics are not available for people engaged with the ASI program, my experience would certainly support the unique presence of multiple barriers confronting this population, in addition to the substance use concern. Additional barriers such as these can potentially undermine the impact of useful social support and complicate the process of developing appropriate social supports.

The Relevance of Social Support to Treatment

Kim, Davis, Jason and Ferrari, (2006) summarize a number of general findings with respect to social support. Citing Burman and Margolin (1992) they indicated that the availability and receipt of adequate social support is seen as contributing to improved physical and mental health and a lack of social support is connected to problems such as substance abuse citing McGrady (1986). Kim et al reported that such factors as being married to an individual not dealing with substance abuse referring to a study by Moos, Bromet, Tsu & Moos (1979) and support from at least one person as studied by McGrady (2002) may both contribute to improved treatment outcomes. Time in treatment is a reliable predictor of post treatment outcomes with longer time in treatment leading to better outcomes (Melnick et al, 1997): presumably, treatment programs incorporate formal and possibly informal supports which may link to this finding.

While having support from others is believed to improve treatment, importantly, the research does suggest that decisions around types of support and who to include as a supporter is important. For example, some supporters can simultaneously have both positive and negative effects. Kim, Davis, Jason & Ferrari (2006) determined that parents, children, friends, co-workers and significant others all positively impacted recovery attempts for the men in their study but, with the exception of children, could also be negative influences on substance use. Kim et al (2006) posit that some relationships appear to motivate attempts at recovery but may simultaneously influence substance use negatively given the stress they can generate. Children, on the other hand, were seen as motivating recovery (Kim et al, pg. 92) thereby reducing use. Another study explored the inclusion of children in a residential substance treatment program with their mothers and concluded that "the children's presence in the program was experienced as a major support and played a critical role in coming to the program" (Wong, 2006, pg. 131).

Social Support and Dropout and Retention Rates

Given that time in treatment correlates positively with improved outcomes in substance abuse (as previously indicated) the relationship between levels and characteristics of support may be important in increasing client retention. Clients reporting higher social support levels at the point of intake have been shown to remain in treatment longer (Dobkin, De Civita, Paraherakis & Gill, 2001). Treatment drop out has been linked positively to spousal separation and to poor social function (Sayre, Schmidtz, Stotts, Averill,

Rhoades & Grabowski, 2002). In one study, clients listed the primary reasons for dropout to be "social support and staff connection issues" (Palmer, Murphy, Piselli & Ball, 2009, pg. 1021) indicating that social support is an aid to retention ; interestingly, in the same study, clinicians also understood staff connection issues as important but did not rank social support as highly as clients.

In terms of obtaining future employment, whether one stays in treatment or prematurely discontinues treatment appears to matter. In a broad longitudinal study in the United States, Ginexi, Foss & Scott (2003) found that continued illicit drug use was "by far the greatest barrier to labour force participation" (pg, 513), whereas continued treatment for drug abuse was a positive predictor of labour force participation. Anecdotally, these findings would mirror ASI outcomes.

Social support seems not only to facilitate seeking treatment, but also to be a factor post treatment. Higher levels of social support appear to be associated with greater psychosocial wellbeing prior to treatment (Beattie, Longabaugh, Elliott, Stout, Fava and Noel, 1993), and lower alcohol consumption following treatment after 2 years (Finney, Moos and Mewborn, 1980) as cited by Dobkin, De Civita, Paraherakis and Gill, 2002. One study determined that among substance abusers in outpatient treatment, clients receiving only low levels of support showed greater symptoms of depression and psychological distress and, 6 months after intake, higher levels of drug and alcohol use (Dobkin et al, 2001). Simpson, Joe, Greener and Rowan-Szal (2000) studied the effect of re-socialization processes that

actively and deliberately involved family and peers and found that the process, along with further treatment, correlated with reduced future substance use (and criminality) after treatment. The authors concluded that, "the influences of post treatment peer and family relations on outcomes show why drug treatment programs should indeed place high importance on social support issues in counseling their clients" (Simpson, pg. 1925).

Valued Components and Supporter Characteristics

One particularly useful study with participants in a residential substance abuse treatment setting, utilized grounded theory to explore female substance users' views of specific supportive and unsupportive behaviors on the part of people providing support (Tracy, Munson, Peterson, Floersch, 2010). Data was categorized into 2 major themes, "Positive Support Helpful to Recovery" and "Negative Support Harmful to Recovery". In terms of Positive Support," an axial code, Emotional Support, emerged as a prominent factor. The code included "encouragement, caring and concern, communication, being there (related to consistency), making sure (related to appointment keeping etc), praise, and recognition of success for hard work, and positivity" (Tracy et al. pg. 264-267). A second code was termed "Tangible Help" and included "bringing personal items", "keeping in touch through treatment", "doing for and doing with", and "helping to get me into services" (Tracy, et al 2010, pg. 267-269). A third code, "Informational Support", identified "teaching specific to disease, teaching coping skills, sobriety support, advice and educating" (Tracy et al, 2010, pg. 269-270) as key components. The Negative Supports Harmful to Recovery" code

included “excessive worry about others, tangible supports harmful to recovery (e.g. managing kids while the participant used), unsupportive messages and information, and community of use” (Tracy et al, 2010, pg. 271-273). Researchers drew a number of conclusions: 1) the discussions confirmed previously documented categories in social support, namely emotional, instrumental and informational, 2) some behaviors encompass more than one type of support (ie., “being there” is both instrumental and emotional support) and 3) components of social networks can be both positive and negative (ie. friends took care of children while mothers used, but also while they attended treatment) (Tracy pg. 273-274). Regrettably, the literature review did not uncover research that was able to corroborate or augment the findings of this study; the authors (Tracy et al, 2010) indicated that previous studies of specific social support components were limited particularly as they related to women with substance use concerns. This study involved participants from the general population rather than the population studied in this thesis.

The study does however appear to connect to what clients report as favourable supporter characteristics. Prior research would indicate that, not only the support behaviors, but also the quality of the support connection matter, in both client retention and treatment outcomes. In summarizing the research literature regarding the nature of the emotional responses of an “ideal clinician” to persons with substance use disorders, Najavits, Crits-Christoph and Dierberger (2000) citing numerous sources, identified that such ideal clinicians would exhibit “a high degree of charisma, optimism, and enjoyment working with substance use disorder patients, and a low degree of cynicism, blame, boredom, hostility and control”.

Schorer (1965) determined that treatment retention has been shown in clinicians with a "higher need for nurturing but less need for aggression, achievement and abasement" as outlined by Najavits et al, (pg. 2000). Perhaps not surprisingly, the display of "friendship qualities" as discussed by Kim et al, 2006 (pg. 87) have been associated with better outcomes in recovery referring to prior research. (Humphreys, Mankowski, Moos and Finney, 1999; Mohr, Averna, Kenny and Del Boca, 2001).

Importantly, a study conducted by Comfort, Loverro & Kaltenbach et al (2000) examined the impact of supportive pre intake involvement with clients engaged in substance abuse treatment and the degree to which clients became involved in tangible services when offered or not offered in the initial screening discussion. In this study, services offered included transportation, client escort to appointments, child care during intake, reminder calls, briefing calls regarding what to expect in counseling, and follow up on missed appointments. The services, although tangible, appear to the writer to represent a level of case management consistent with the "nurturing" theme articulated above. The results, however, were somewhat inconclusive. Those offered these additional services were no more likely to attend an admission appointment, but they did utilize the services offered more often than the control group during the treatment period.

Lived Experience/Client Voice

It proved difficult to obtain specific information about the effectiveness and value of social support that came from the perspective of service users among welfare recipients

identifying substance use as an employment barrier. The absence of client voice in this literature was interesting, given there are numerous studies pertaining to similarly stigmatized groups which suggest that service user feedback can provide valuable insights when sought. For example, Pulford, Adams and Sheridan (2007) determined that clients reported significantly greater problem improvement than did clinicians. In a qualitative study involving interviews with 6 "dually diagnosed" (substance use and mental health concerns) individuals (Jones, 2010), participants reported that peer support was particularly valuable in substance abuse treatment and, in fact, service users ought to be involved in counsellor training. This study further spoke to service users' reports that staff attitudes in service delivery impact stigma, and that training to improve awareness and client confidence of staff is important. Participants also suggested that the provision of peer support through "drop in" would be a useful service enhancement. As discussed previously, this type of service user feedback is routinely heard in the ASI setting. The authors of the Jones (2010) study suggest that lived experience as a source of knowledge is undervalued and potentially important for both practitioners and researchers, an approach which is consistent with the regard for client voice that will be discussed in the methods and methodology section of this paper. This position has been echoed in additional studies, one of which (Miewald 2003) outlined that marginalization of welfare recipients' views was a result of their lack of political power. Findings such as these encouraged the (hopefully) reciprocal nature of this study.

Client willingness to seek support/help.

Client willingness to seek support emerged as a primary participant focus throughout the discussions and data assimilation. A review of the literature on this topic revealed some related research findings and a number of theories which attempted to explain the help seeking process. Little research was uncovered which supported the theoretical constructs but the theory often connected well with participant comments. One article in particular, Cohen (1999) seemed to best reflect the content of participant discussion in his comments on the concept of seeking help. (pg. 67):

> For some persons, asking for help is the dominant mode of coping with problem situations; they seem to have no difficulty requesting assistance when they consider the circumstances, the setting and the potential helper appropriate for such behavior. On the other hand, for may persons in need, asking for help involves suffering, soul searching, and a major emotional effort to overcome a wide range of social and psychological obstacles that may, in the end, preclude the articulation of the request and the subsequent receipt of assistance.

This tension seemed to be at the heart of the issue for our participants.

The above literature will be explained later in this section and linkages will be reflected upon in the discussion section.

The literature did address 3 concepts related to willingness to seek support/help; readiness, motivation and willingness to change. While these concepts are viewed as peripheral to the primary theme, they are related and worthy of consideration with respect to our participant's circumstances.

Client readiness generally refers to an individual's "perception of the necessity for treatment" (Melnick et al, 1997, pg. 489). Motivation speaks to "intrinsic factors referring to the desire for change" (Melnick et al, 1997, pg. 488). Ekendal (2007) described "willingness to change" as an attitudinal characteristic (pg. 247). All three concepts link to portions of the client discussions. The research regarding client readiness and motivation to change, although extensive, was not found to include reports specific to the population studied here. This factor, and the distinction drawn between these concepts and willingness to seek support/help, determined the brevity of the comments here. Both client readiness and client motivation generally appear to be positively correlated to age, that is adults are more motivated/ready than adolescents, and readiness and motivation are seen as a dynamic rather than static characteristic within individuals (Melnick et al, 1997). High motivation among substance users has been linked to "pursuing goals that were likely to succeed" and "emotional satisfaction if succeeding" (Cox, Blount, Bair and Hosier, 2000, pg. 127). High motivation has been negatively correlated with problem denial (Cox et al, 2000). A willingness to change has been shown to be linked to negative consequences and to problem severity (Tucker, 2001) as cited by Ekendahl (2007) and appears "context dependent" (Ekendahl, 2007, pg. 257).

Ekendahl (2007) explained this further:

> "It seems as if something happens with the individual that enhances his/her willingness to change and prospects to achieve it while situated in a social context, where optimism and engagement is expected and encouraged."

The remaining review of the literature in this section speaks more specifically to willingness to seek support/help. Fischer and Turner (1970) as reported by Cohen (1999) identified several attitudinal dimensions which contributed to the process of seeking psychiatric help for those with mental health concerns including 1) recognition of need, 2) stigma tolerance, 3) interpersonal openness, 4) confidence in mental health professionals. One study, however, provided a valuable overview of this topic. Cohen (1999) created an instrument to measure client willingness to seek help. To do so he first summarized the research that had been done up to that point in time. Broadly, the research indicated that women were more likely to seek help than men (see for example, Boldero & Fallon, 1994 amoung others); stress levels are a reliable predictor of help seeking behavior (Florentine and Anglin, 1994 amoung others); although stress severity is not a reliable predictor of help seeking behavior (Pahl, 1985); and one's social situation/isolation is a meaningful factor in deciding to seek help (Goldberg and Huxley, 1980 amoung others) In the article, Cohen discusses help seeking models (pg. 69) including:

1) The equity model (Walster, Walster & Berscheid, 1978) which focuses on the need for reciprocity influencing asking for help.

2) Reactance theory (Brehm, 1966) which considers loss of freedom (removal of choice) in asking for help.

3) Attribution Theory (Kelley, 1967) which posits that people tend to seek causal explanations for events and view help seeking as being easier when the need is attributable to external factors versus internal factors.

4) Threat to Self Esteem Model (Fisher, Nadler & Whitcher-Alagna, 1982) which indicates that individuals weigh the pros and cons in relation to self esteem being gained or lost when asking for help; accepting help can be negatively received.

None of the models above relate specifically to substance abuse and in my experience are not used in the addiction field. They nonetheless appeared to have connections to the participant discussion and will be addressed within the discussions section of this paper. In developing his instrument Cohen referred primarily to the Keith-Lucas model (1972) which incorporated opposing models to create the following conditions that were crucial to seeking help. (Cohen, pg. 70):

1) The individual must admit need

2) The individual must be prepared for self disclosure

3) The individual must be prepared to allow another person some measure of control over his or her life.

4) The individual must be willing to change.

Cohen's article describes the testing of the instrument for validity and reliability and reports the results to be promising within his sample. One related study, which challenged

the validity of Cohen's work as it relates to help seeking for different problem types, identified the General Help Seeking Questionnaire (GSHQ) as a useful measure in identifying whether seeking help is desirable with respect to a specific problem (Wilson, Deane & Ciarrochi, 2005). For the purposes of this paper it should be noted that help seeking behavior in both studies was assessed in a general sense, not specific to a particular population, did not involve participants with a substance use concern, and made no reference to social support factors that might influence the process. Secondly, the literature search revealed little additional complimentary articles and Cohen's work, while relevant to this study, is now somewhat dated. Nonetheless, the concepts discussed do have application to the participant remarks in this study and will be further addressed in the discussion section.

Some research did emerge relating to emotional factors and help seeking intentions. Deane and Ciarrochi , (2001) determined that those with high "emotional management competence" (pg. 241) were more willing to seek help from family, friends and professional sources for suicidal ideation but with respect to emotional problems they were more likely to seek help from family and friends, but not professional sources. In other words those with lesser emotional management skills were less likely to seek help.

Although not a primary literature review focus in the context of this theme some interesting research on coerced treatment is worthy of mention here. Coerced treatment is substance abuse treatment as a substitute for jail, probation, loss of child custody or any

other condition of the legal system. Coercion has been shown to be a useful means by which to create an opportunity for the substance abuser to reflect on the consequences of their addiction before the denial can be broken down and the motivation can be generated (Miller & Flaherty, 2000). Legally coerced treatment has in fact been shown to have a beneficial effect on substance use levels (Burke and Gregoire, 2007), possibly as a result of a forced change motivation as described above. Certainly these selected findings have potential implications for treatment as the client has no choice to seek help, a circumstance that potentially reduces the challenge of reaching out.

Peer support

The literature consistently acknowledges the benefit of peer support in substance use treatment although the language used may vary and contextualize the notion of peer support somewhat differently. The Stage of Change model (Prochaska, Diclemente and Norcross, 1992) outlines a sequential process individuals progress through when making personal changes. The process, one which is widely used to inform treatment and motivational interviewing in the addiction field includes 5 stages. Clients are seen proceed through pre-contemplation (non- recognition of the concern)contemplation (a consideration of pros and cons of making the change), preparation (the decision to move forward and initial planning), action (concrete steps to support change and initial change behaviors) and maintenance (sustaining change). Prochaska et al (1992) identify processes which can support a client moving through the model's stages. One such process is termed "helping

relationships" and is defined as "being open and trusting about problems with someone who cares", which appears to reflect the peer support premise of self-help groups (Prochaska et al, 1992, pg. 1108). "Recovery capital" literature includes peer involvement within the social capital seen as beneficial in processes of recovery (Best and Laudet, 2010), indicating that mutual help groups allow for recovery "champions" which allow for the "viral spread" of recovery capital (Best and Laudet, 2010, pg. 5).

Direct peer support within substance abuse treatment has also shown promise in several forms. One unique approach, "Peers Reach Out Supporting Peers to Embrace Recovery" (PROSPER), has been utilized successfully with clients identified as having substance use concerns who have been incarcerated in Los Angeles. The program seeks to provide a safe and trusting environment and reinforce family/significant others' relationships (Andreas, Davis and Wilson, 2010). Peer support is seen as "counteracting negative forces" (Andreas et al, 2010, pg. 329), and increasing motivation through support groups, peer coaching, role models and numerous social activities, including a peer led café. Gains have been seen in participant self-efficacy , perceived social support, reduced stress, and general measures of quality of life. A similar program, "Support Network Intervention Team" (SNIT,) has been used North Carolina, United States to assist families addressing issues stemming from substance abuse (Winek, Dome, Gardner, Sackett, Zimmerman and Davis, 2010). Stakeholders assisting families include family, friends, and all types of formal supports such as social workers and anyone with a strong tie to the family. Viewed as a systemic approach to substance abuse, the program platform values collaboration, which

appears to engender accountability from the participants. While not designed specifically as a peer support vehicle, the program builds on the theme of counteracting negative supports.

Summary

My review of the existing research literature demonstrated social support to be a foundational element in substance use treatment. The literature, however, provided very little information with respect to the client population, social assistance recipients identifying substance use as a barrier to employment, that was the focus of my thesis research. Further, the research literature tends to prioritize voices of professionals and others; missing are the perspectives of this population. Given the lack of relevant literature and the unique barriers that exist for this population, accounts of lived experience may assist in augmenting our current understanding of social support and inform possible additions to the clinical process in the addictions field and, specifically, to that of the ASI program. For me, the review of the literature provided sufficient background to support the use of research methods that would promote open dialogue with participants from this population, and encourage flexibility in the interviews, making room for participants to direct the discussions to make plain the issues around social support that were important to them.

METHODOLOGY AND METHODS

This study utilized a qualitative interpretive approach designed to allow exploration of a broad research question. In the interpretive tradition, it was intended to recognize that "social reality is based on people's definitions of it" (Newman, 1997, pg. 69) and that it this explored " by revealing the meanings, values, interpretive schemes and rules of living used by people in their daily lives" (Newman, 1997, pg. 71). The approach places value on the service user as "expert" concept, one which enables the researcher to appreciate the contextual nature of experience for a specific population. As indicated previously, the population researched here appears to be confronted with a unique and broad set of challenges, a circumstance in which qualitative, interpretive processes could best capture the participant experience.

Secondly, it was also intended to provide a critical lens, that is, the collective views of the participants would hopefully uncover a perspective that could be integrated in to practice in the field with this select population.

My experience within the addiction field with this population would indicate that substance abuse has social, cultural and structural influences and that the participant population's voice has been undervalued. My concern, which prompted the study, was that the voice of this population group is rarely sought, particularly within an open setting. The lack of research in this area leaves open the possibility that the social reality we are seeking to impact has not been fully articulated by those in a position of expert. Research regarding

similarly "voiceless" populations such as violent crime perpetrators (Smith, Ferguson, 2005), homeless youth (Ferguson, Au-Kim and McCoy, 2011), rural men and sexual identity (Kennedy, 2010) and individuals with severe mental health (Singer Solway 2011) have elicited dialogue that represents knowledge contributions either not previously uncovered or not sufficiently appreciated. In summary, the research emphasis emerged as an opportunity to explore an ethically important "gap" with the potential to inform practice.

To explore people's experiences and meanings of social support, the principles of grounded theory were drawn on to underpin the framing and process of this research. It should be noted, however, that grounded theory has not been used fully. The study utilized only some components of grounded theory. The approach contained no hypothesis, de-emphasized theoretical frameworks, and valued contexts as described by the client. While formal coding processes were not strictly followed, the data was synthesized to identify themes. It was not thought to be practical within the scope of this thesis to utilize grounded theory in a full manner. In utilizing grounded theory components the research aim was two-fold; to provide a rich, contextualized description of the experience of the participants, and to begin to explore causal connections towards – ideally – the generation of theory. Importantly, grounded theory is designed to permit theory to emerge from the data rather than being influenced by a specific theoretical lens. A core objective in traditional grounded theory is to deliberately avoid starting from a particular theoretical framework in positioning the research question and in initial data collection in an effort to avoid bias in interpretation (Charmaz, 1995).

That being said, given that the research was conducted in an institutional setting, it was understood that consideration of structural components impacting participants' experience may emerge. A grounded theory approach lends itself to framing participant themes in a context that appreciates broader structures, which may or may not be apparent to them (Solway, 2011) and is, thus, consistent with an interpretive methodology. Grounded theory principles acknowledge that theory development within such a setting may not be "purely" inductive, that the researcher "can seek new information to examine questions concerning equality, fairness, rights and legitimacy" (Charmaz, 2005, pg. 512) by designing data collection in a manner that encourages their examination. The interview process utilized in this study sought to allow sufficient flexibility such that social justice issues could be explored. The process deliberately reflected "constructivist" grounded theory, a framework that acknowledges the perspective of the researcher as being neither detached nor objective, and attempts to leverage that perspective to accomplish critical analysis. Charmaz (2005) postulates the following:

> "Constructivist grounded theorists take a reflexive stance on modes of knowing and representing studied life. That means giving close attention to empirical realities and our collected renderings of them – and locating oneself in these realities. It does not assume that data simply await discovery in an external world or that methodological procedures will correct limited views on the studied world. Nor does it assume that impartial observers enter the research scene without an interpretive frame of reference."(pg. 509)

Clearly, I was somewhat imbedded in the research and was cognizant of my inability to eliminate or fully know the ways participants perceived my connection to the ASI program and to OW specifically. Understanding the secondary purpose of the research – to

potentially impact program components – my position was less than objective. I acknowledge this factor may have coloured the interpretation component of data analysis. While this research proceeded without an existing hypothesis, it provided a forum to enrich the understanding of social support factors for OW recipients in concert with substance abuse issues. The research was designed and interpreted to explore individual participant experience and to then reflect upon treatment objectives, processes, goal setting, priorities and gaps within the service provision as they relate to social support. As this researcher values reciprocity in the study's obligation to the participants, I was hopeful the outcome would produce insights that would move beyond being descriptive and would begin to explain causal connections as effective grounded theory can often accomplish (Larossa, 2005).

Ethical Considerations

Given my direct involvement in the program, considerable care was given to demonstrate a high level of transparency and to ensure client comfort was maximized. Both the recruitment letter (appendix A) and the client consent letter (appendix A) were clear in identifying my role within the program. Similarly, all recruitment strategies made this information explicit. Also, the recruitment process followed a self- selection method which facilitated respect for participants' privacy and confidentiality – at no point did I know who was approached to participate in the study, coming to know only the identity of those who contacted me regarding participation. Confidentiality precautions also included the use of

pseudonyms in transcripts, strict adherence to formal data security requirements as identified in the client consent (appendix A); and eliminating any formal or informal discussion with OW staff members regarding participants. Initially, the research was to be conducted using focus groups, an idea that was amended to individual interviews at the request of the McMaster University Research Ethics Board in an effort to further minimize confidentiality risks. Clients were offered the opportunity to review the final report prior to finalizing it as a means of further checking that they could not be identified, again to bolster confidentiality.

Three specific risks were identified and addressed within the McMaster University Research Ethics Board application regarding potential participant expectations/uncertainty. First, I sought to ensure participants were aware that addiction counseling service or service wait time was unrelated to participation in, or withdrawal from, the program. This was deemed a potential concern if participants viewed involvement as improving their service priority within the program. Secondly, there was a potential risk that a participant may, at some point in the future, become involved in counseling with myself. I was able to mitigate both risks through carefully prepared information letters and consent forms, which included a separate introduction provided by Ontario Works (appendix D). This introduction positioned the program as individual research rather than as linked to the program. The consent form included clear and open provisions for withdrawal from the study and a pre-prepared form outlining a proactive process should the participant, in the future, find himself/herself in a position of counseling (individual or group) with the writer (appendix E).

There was also an additional consideration regarding the interview process itself. Appreciating the potentially sensitive topics of social support or lack thereof and the substance abuse (often current) factor at play with all participants, steps were taken to provide counseling resources should a client feel triggered or in some way unsafe (appendix F). My experience in addictions and individual counseling was seen as a further protective factor in this regard.

Recruitment

Recruitment was designed to adhere to the principle of self-selection and to position the research as being distant from the broader ASI and OW programs. Involvement in the study was ultimately open to all program participants who had not had a previous connection with the ADGS counselors. Initially, the process of recruitment was intended to be introduced through ASI orientation sessions, in which neither I, nor a colleague from ADGS, were present. These sessions were designed for those individuals who were considering entering the program and were on a waitlist. At these sessions case facilitators would have spent some time informing those in attendance of the research and sharing contact information for those who were interested. This process proved unsuccessful. The sessions were poorly attended and, through a change in program entrance eligibility criteria (consistent with the often fluid nature of programs within large institutions), the wait lists were effectively eliminated and program entrance moved to an individual screening process. This prompted exploration of different recruitment strategies, several amendments to the ethics

application and, eventually, a recruitment script being designed (appendix G) for presentation to potential clients by OW case facilitators. Case facilitators were ultimately offered a small incentive (a $5 gift card) for successful referrals. Slowly participants came forward, however non-attendance at interview sessions became an additional factor. Less than 50% of interview appointments were kept. No follow up was done on those not attending to ensure interviews were seen as clearly voluntary. Low attendance may have reflected typical hesitation related to the dynamics of volunteering for a program within the OW environment, and is generally consistent with the 50 – 60% attendance at addiction counseling and OW appointments within the program. Nonetheless, it was disappointing. Given the population involved in this program, pressing issues that appear to be part of generally stressful and often chaotic lives, and other practical considerations such as transportation costs, may have interfered with good intentions. It would, however, be useful to explore reasons for non-attendance generally; the findings in this study would suggest emotional challenges may have contributed to it as much as instrumental ones.

Participant Characteristics

Ultimately, six individuals were interviewed, five identified as male and one as female. In two cases the substance concern involved alcohol, two cases opiates, and there was one case each of crack cocaine and cannabis. One participant was in the age group 21-30 years, two were between 31 and 40 years, another two were between 41-50 years, and one fell within the 51-60 years age range. While the substance use mix is quite representative of the

client base the program generally works with, and the age range showed some representation, ideally it would have been preferable to have more gender diversity in the study. Although it was not specifically reported, the sample contained primarily individuals with some "clean" time, up to about a year, although in one case the participant was still actively using. In one case the participant was involved with the methadone maintenance program in an effort to eliminate use and moderate the impact of opiate withdrawal. I had hoped for more participants, although the pace of recruitment and the restrictions imposed by this being a Masters' level thesis did not support additional efforts to expand the sample. The study then, is limited in its ability to generalize findings given the sample size.

Following completion of their interview, participants were compensated with a $20 gift card from Tim Horton's.

Data Collection and Analysis

Semi-structured interviews were conducted with each participant in a private office outside of the OW building in an effort to add to client comfort and reinforce distance from the OW program. Participants had no comment on the location of the interviews. Each interview was audio taped with participants' permission, and then transcribed by an independent transcriber (Confidentiality Oath, Appendix C). Transcribed interviews totaled 46 pages, averaging eight pages per interview. The interview questions totaling eight, were deliberately non- specific and generally open ended (appendix B) in keeping with grounded theory principles. The process was designed to be non- threatening; time was spent

acclimatizing each participant through informal non study related discussion, and re-explaining the voluntary nature of the process and participants' right to withdraw at any time as outlined in the information form/consent letter (Appendix A). It appeared clients found the process comfortable as evidenced by their general appreciation for the opportunity to contribute, their lack of indication of emotional upset, and their candid discussion. Before asking the interview questions, I provided participants with a brief description of social support, outlining the variance among individuals in terms of the amount and need of each type of support. This was done to position the first interview question as a smooth transition and to alleviate apprehension should a participant identify little social support. The description was consistent with the first question however in hindsight it may have led the conversation unnecessarily. Participants were also given the opportunity to review the interview questions prior to the interview, again in an effort to increase comfort. Participants generally indicated no concern regarding the questions. Each client was asked to provide brief background Information regarding their substance use and stage of recovery prior to answering the questions. Interviews lasted between 30 and 60 minutes.

The process utilized an approach which is consistent with a number of principles of "appreciative enquiry" (Wikipedia, 2013). Appreciative enquiry places value on participants experience and does not attempt to uncover a "pre-existing truth" (Bellinger and Elliott, 2011, pg. 711). Participants were reminded that this was an opportunity for the writer to receive direct information and advice, and that the results of the research would hopefully

inform program enhancements. I stressed that I was open to clarifying any question and, in fact, was often asked for further explanation. My observation was that participants responded positively to the interview setting ; viewed it as safe, and that the questions were both broad enough to capture their experience and respectful of their individual circumstances. There were no instances in which a participant declined to respond to a question.

From my perspective, the experience was overwhelmingly positive. Participants appeared candid, seemed to appreciate the opportunity and, based on the dialogue generated, appeared willing to share. There were no reservations identified regarding the writer being a potential counselor for them in the future. In fact, that concern appeared largely unfounded as clients reported viewing it as an advantage, indicating they would feel more comfortable in a situation in which they did not have to "re-tell" their story. Participants were uniformly polite and appreciative and appeared to value the opportunity to add to the knowledge base in this area.

Following transcription, I reviewed the dialogue for consistent themes through systematic coding. Each transcript was read at least three times. Key quotations which appeared to have particular relevance or resonance with the participant were highlighted. Those quotations were then grouped based on common sentiments. When the themes were identified it became evident that they could be grouped in to two primary categories that appeared to reflect broad considerations.

FINDINGS

Consistent with the tenets of grounded theory this study was intended to be explorative. In the interviews, I made a conscious effort to allow participants to "drift" in an effort to explore useful directions and clarify meaning. Having said that, all participants answered the same questions in the same order.

Upon reviewing the transcripts, it was clear the dialogue was not organized or sequential, nor did it consistently remain on topic. It did however seem to reveal honesty, rich life experience and the beginnings of an alternative dialogue. The principal themes that emerged were 1) Factors involved in seeking help/support and 2) Support Considerations. Within each theme several sub themes were identified.

These themes represent my understanding of the aspects of social support that were important to participants, their experience in asking for it or not, receiving it or not, and ways in which it could be enhanced. My general sense, throughout the interviews, was that social support was not well defined in the clients' minds, quite possibly because their stories did not reflect much experience of social support in their lives. This created some awkwardness in terms of interviewing but an invaluable experience professionally for this writer. On numerous occasions I found myself explaining the question again and often receiving an answer that was off point. When confronted with such misunderstandings or inconsistencies, I was flexible with the answer's clarity, logic and adherence to the topic, and maintained a clear respect for the participant. This faith seemed to be justified when the

transcripts were reviewed; while the accumulation of data was messy, it contained considerable substance to facilitate my understanding of social support for this group of participants. In summary, the themes below were sorted and thus presented on the basis of number of occurrences discussed, importance as indicated by the client, relevance to social support, and potential for program or social work implications. I will present these themes principally through the words of the participants and my connecting commentary and analysis.

THEMES

Factors Involved in Seeking Help/Support

This theme appears first as it appeared to be a dominant client direction. None of the questions directly asked about what I have termed "Factors involved in Seeking Support" but it was remarked upon by every participant. The themes discussed here, for the participants in this study, represent those factors which led not only to motivation to change, but more importantly, actually seeking help from others, formally or informally. Within this theme a number of sub-themes became evident as discussed below.

1. Precipitating Events

One of the areas that was explored in some detail, given that clients often moved the conversation in this direction, was the significance of impactful events (often followed by emotional crisis) that often prompted participants to seek support. In many cases there appeared to be a level of desperation clients spoke of after such an event or experience that had to precede the difficult

decision to ask for help. Participants spoke in a manner that described succumbing to the problem. For Participant 1, it was an emotional low point that seemed to build over time, and appeared to have been accelerated by legal problems:

> Before I went to the treatment centre I went to, I struggled for about 2-3 years trying AA and such and they would say, "you got to admit you are powerless and your life has become unmanageable now." I could not admit that for a long time because maybe I did not want to admit I was weak, or maybe like I did not want to belittle myself, I wanted to think I was stronger and bigger than that, but after it broke me down so much so hard it came, like, it was obvious my life had become unmanageable you know, so I knew what I had to do, I knew where I had to go.

He/she was prompted to this reflection as a result of jail time. Similarly, participant 2 discussed a visit from the police, which ultimately led to his/her daughter being taken by Children's Aid. This participant spoke to how the abrupt presence of the police and then child welfare moved her concern to a new level, in his/her words :

> I had a boot up the butt, yah. because the cop came in, search my house, tools everything and they could not find it because, yes, I was a user, but like the cop said to me, "I am a crack head with a conscience".

Likewise Participant 3 described a marital separation, in which two children were involved. For this participant, this was a very difficult situation and one which s/he understands to have directly impacted the decision to seek support:

> My wife and I split for whatever anybody's perception of me, I am just too tired and I just know better now that I am ready for some reason.

Other participants identified other types of events that seemed to precipitate seeking support. For example, Participant 4 reported that asking for help was not difficult when s/he reached a level of illness due to opiate withdrawal that became intolerable, stating :

> not really no, when you are sick, no one likes being sick you know, so you just kind of do whatever to not be sick right.

This idea that asking for help became easier in this circumstance was reiterated later when s/he noted,

> I was just tired of being sick all the time is why I just made myself change."

Participant 6 discussed how a relapse related to a work problem served as a catalyst. This relapse seemed to be particularly significant and prompt significant reflection as it followed a period of abstinence and employment stability.

> I was away from it for about a year, maybe a little longer and then when I got back in to work and all that I felt, you know, that I got it under control and you know it is a false sense of security and it just did not work.

Participant 5 talked about finding himself in a shelter leading to that deeper reflection of his circumstance in his/her case, it appears, learning the process of asking for support:

> Well, 2-3 years ago I had major depression. I was alone all the time and I was working all the time, constantly, always up, had a hard time sleeping, smoking $300-400 per week in weed, just living to paint and work, no social activity whatsoever. I contemplated killing myself. I was out and I had to move . . . so I just moved to Georgetown for a month and then I went to a shelter and got some support through that ; that is why I am able to ask now.

General addiction counseling focuses on the consequences of substance use being an indicator of addiction and often a motivational shift. For the participants in this study the consequences seemed to have also required a deeper personal reflection. In this small sample, legal problems, the loss of a child to Children's Aid or through marital separation, troubles at work, significant health problems, and serious mental health issues leading to suicidal thoughts are all represented as crisis events that appeared to be the motivation for participants to seek social support as a means of working towards changing their situations. What was also interesting was that many of these participants also reported multiple previous attempts at recovery, along with multiple negative consequences of resumed substance use, however, these previous consequences did not appear sufficient to move

them to request support. It was impactful to hear the significance of these consequences but also to appreciate the magnitude of consequences needed in each case to prompt help seeking.

What became apparent from the dialogue was that an internal focus on readiness must accompany the external consequences to prompt meaningful seeking of support. That focus seemed to move beyond such factors as shame, guilt and regret and was deep enough to overcome the obstacles to help seeking.

2. Emotional Readiness

In the previous section I discussed specific consequences that participants indicated accelerated requests for help. The individual instances discussed revealed some alarming circumstances. Consistent with my experience as a counselor, a single major consequence or episode may, indeed, set the stage for requests for support, but it does not ensure it. When participants spoke of their current situation – entering the ASI program or otherwise requesting help – they seemed also to have reached a level of desperation or frustration and importantly, a level of honesty : a point at which there was a recognition and admission that the process of recovery cannot be accomplished alone. Once at this point, clients still spoke of the difficulty of progressing from the intention to seek help to the step of actually doing it. It appears that the strength of the intention first must to overcome the hesitancy caused by any number of individual factors. For the purpose of this paper it has been termed emotional readiness. This emotional readiness was described by participants in many different ways.

One participant noted how a particular crisis event led not to an immediate to desire to seek support, but to a period of decline, to increased substance use. In describing the heavy period of substance use before seeking support Participant 1 stated:

> I met a girl who after 3-4 months we got engaged; she worked at the Hamilton Airport and had been in the army for ten years, amazing woman; she died of cancer in my arms. After that I kind of gave up after a while you know, that is when I started using heroin heavily. At that time I didn't want any (support) because I was so hurt.

At least for this participant the process took some time to reflect on his need and his circumstances in an honest way and move to help without the encumbrances of pride and loss of self- respect. In this case he admitted he was not the one to direct treatment and recovery. When speaking about finally moving towards help, Participant 1 said:

> I do know that for my future, for the success that I want to create around me, I do need support because from what I have learned is I need to be taught by, most likely by somebody who has been through or has knowledge of what I am going through because, to me, this is all new.

Participant 2 described this turning point with an even greater emphasis on the importance of honesty, of admitting to oneself what needs to happen for change to occur:

> Where to start, well hiding it for 3 years does not help.

When asked to talk a bit more about the difference between attempting to 'go it alone' previously and the decision to now seek support, s/he replied,

> No, I tried, I have tried and I kept going back to my DOC (drug of choice) and I kept going back.

For this participant what seemed to underlie an emotional readiness was this desire :

> I just want me back.

S/he alludes to a level of honesty and internal focus again when asked to provide advice for program participants:

> They have to do it, I could not do it because my Mom wanted me to, I could not do it because my kids wanted me to, I have to do it for me.

Participant 3 seemed to echo this same focus when describing his/her first unsuccessful

attempt at residential treatment:

> the first one I did not go for myself, it was just to get everyone off my back.

Perhaps inconsistently, while this client indicated that he was internally ready, his comments reflect that seeking help remains a difficult process to initiate :

> At this stage I am doing it myself and I think that is growing through it. I'm am just ready now and I have no, well I am sure I would have support if I were to ask for it but I'm not asking for it.

Interestingly, this participant had just entered the ASI program, which represents a request for support in itself, but seems to maintain, perhaps stubbornly, that he is doing it on his own. While seemingly paradoxical, for this client, this sentiment/belief seemed to function as a way to preserve his pride while reaching out for support.

Participant 4, like all the participants, acknowledged that s/he had failed previously on her/his own, and entering the methadone program was an admission that recovery could not be done alone. Like Participant 3 he was reluctant to indicate he could not do it one his own but his actions indicated he had accepted that fact.

Participant 5 however was very open about needing help:

> Well, I knew I have needed help quitting. I have tried to quit on my own before and I have gone 4-5 years without smoking weed and soon as I get in contact with someone who actually smokes it again it sucks me right back in, so I have never actually been shown any skills to stay away from weed except for staying away from people who actually smoke it.

Further on in the interview, Participant 5 elaborated on this point, suggesting:

> I think that was my fault because I was unable to say no.

S/he was able to clearly link this admission to the need and desire for support, stating :

I have not had outside support, mentoring support, or emotional support or anything like that so I think this would really help.

This participant spoke clearly to the need for honesty:

> Be honest with yourself; if you can't see the problems that you have to overcome you won't be able to talk about them.

Participant 6 came at the notion of emotional readiness from a slightly different angle, understanding that in asking for help s/he was looking for people who would challenge her/him on her/his level of honesty, seeming to recognize that honesty can be difficult to sustain:

> They can't pull punches; they have to tell me if they think you are bullshitting them.

Again, a recognition that help in consistent honesty was needed by outside sources rather than being managed alone.

What emerged in these discussions seemed to be a humility – achieved through honest reflection – that leaves participants quite vulnerable, generally took them a while to get to, and often followed a number of failed attempts.

Participants identified what appeared to be a final, difficult process in their emotional readiness seemed critical to taking action. It appears that even in the light of overwhelming consequences of substance use, recognition of an honest admission of the need for support, that it is very difficult to take the initial steps. This is described by the participants in what follows.

While Participant 5 was at the point of openly admitting to the need for support, arriving at this point was not easy:

> I have been alone for a long time. Just the process of opening up and asking for help, that is a huge one for me. Knowing that I need the help, knowing that I have not got the tools to do it on my own, it was a wake up call that I needed to have.

And later,

> Definitely realized that asking is better than suffering through in silence.

Participant 1 summed up the challenge for her/him this way:

My biggest problem is holding things in.

Asked to elaborate on the reasons for this, this participant stated:

> I am scared to ask her for help, you know, so maybe it would be good if she (OW case facilitator) could see me and she hears me talk about my fiancé (who passed away) and say "look you need grievance (counseling)" and try to push me in to something…I think it has a lot to do with people not wanting to admit that they are weak…It is hard admitting that you are a loser, straight up.

This fear of asking for help was similarly described by Participant 2, however, seemed to be rooted less in self-esteem and concern for how one is perceived by others, and more in fear of a material consequence related, in this case, to child protection concerns:

> Not being afraid to ask for help, that is the number one thing, everybody is afraid to ask for it if you have a family.

Being honest and overcoming the fear of disclosing a need for support was tied to the risk that Child Protection Services would apprehend the child.

Participant 3 also spoke about how the honesty required to seek support can be risky. In talking about individuals in the initial stage of recovery, this participant noted:

> It is so easy to break people because they are already broken, but where is the carrot on that? And I think in reaching (out), cause they are so fragile coming in and they are fearing whether it is legal or anything like that, with a lot of, there are so many factors in it.

S/He appeared to link the fear to legal and emotional factors. Participant 5 articulated yet another source for the fear:

> …raised as a kid, I was put down all the time, and always beat, and any time I would ask (for help) it was always "no", so I learned to live without…so for 40 years I was doing it on my own and not bothering to ask.

This fear seems related to Participant 3's comment above indicating the risks of reaching out given previous negative, non-supportive experiences. Participant 5 again, urging patience in the

process with clients who have become accustomed to less than supportive responses :

There is so much fear to begin with and that is going to take a little bit of time

My observation would be that readiness and the process of asking for support appears to be an emotional struggle which, at least for several of our participants seems to progress somewhat sequentially. There seems a general order to the buildup of asking for help involving 1) Significant consequences of substance abuse, 2) An emotional reaction that seems to be a low point accompanied by a deeper level of honesty, 3) A recognition that the remedy cannot be achieved without help, 4) Overcoming the fear. The process was not always described as being linear, and for some participants requires repeating the process before step 4) is accomplished.

3. Motivators and Deterrents to readiness for seeking support

This theme was included as clients mentioned these items with some consistency and they tend to serve to strengthen or inhibit participant's motivation to move through the process discussed in the last chapter. My observations in this category do not appear to be complicated, they generally relate to physical health, relationships, and work. They appear to solidify the motivation to seek support or interfere with it.

Motivators

Participants in general spoke of very conventional motivations. In three cases employment was the focus.

Participant 1

> I want to get an education and work at getting my license back and I want to find a steady job and I am going to enjoy, you know, but in the meantime my main concern is staying clean, keeping healthy you know.

Participant 3 spoke of retraining to resume employment as did Participant 5.

Participant 2 was clear about her/his focus on family.

> The goal is having the little ones back in my care is huge and just the willpower from myself to be able to not think about it and know what I want and know what I am working towards" and later "I'm going to have my down days where I am going to want, where I want to go back to what I was doing and then I just get that hug from my little guys.

Participant 4 spoke of "not being sick" any more and Participant 6, who had indicated s/he had made several attempts at recovery also alluded to personal health :

> No, (I'm not looking to return to work right away) this time I am just going to make sure that all the cobwebs are gone and all my supports are in place.

Deterrents

One deterrent to seeking support stood out above the rest and is best described as "negative influences in the context of support" – this will be discussed later.

To begin the reporting of deterrents to seeking support, I focus on other deterrents, primarily emotional, that were seen by participants as getting in the way of their efforts to find support. They often appear to relate to the fear described in the "Emotional Readiness" section. These considerations seemed to have the effect of disabling the client, leaving him or her "stuck", often despite the negative consequences that continued substance use perpetuated.

Participant 1, for example, talked about the grief s/he experienced after her/his fiancé's death, noting how the event derailed his/her help seeking efforts:

> After that I kind of gave up for a while.

Similarly, Participant 3 discussed his/her depression as an ongoing factor in her/his substance use and ability to seek and use support. It appeared to have been compounded by what appears to be guilt and a desire to be independent: both of which are also perceived to be holding her/him back:

> I don't want to be a burden to anybody and I just don't want to have to pretend anything…I don't want "how are you doing?", just like I am not sick, I don't want any pity or anything.

Guilt appeared to be a deterrent for Participant 6 as well, and can be read in this statement. It appears this participant is describing his fear that in seeking help he may be denied forgiveness from his family, a feeling that has held him/her back from asking :

> I can get to a stranger something that I could not tell my family, which they might not forgive me for because it is something I did to them.

Participant 5, discussed an emotional deterrent seemingly attached to his/her perception of how others have responded to his/her attempts to secure social support. This participant shared her/his previous experience with attempts at seeking help :

I've had times where they have looked at me like I should not be around, you know, not very good responses. Not very (many) times that I have asked for help and people have actually opened up their arms to help me out.

The deterrents described here appear to have been emotionally rooted and were seen as obstacles by these four participants.

For Participant 4, a deterrent appeared to relate to lack of knowledge about substance use and treatment. This participant discussed having questioned whether or not to continue with

methadone treatment given the long term nature of the process and her/his concern that once on methadone, s/he would never be free of it:

Well, like I told my doctor, I did not want to be on it for life because most people once they get on it are on it for life.

As she/he became more knowledgeable the fear appeared to reduce.

Participant 2 talked about practical deterrents, such as a lack of funds for transportation and the process, meetings and paperwork, required to gain admission to a residential treatment program. Interestingly, this was one of very few references to financial resources. My experience in the field would indicate that the administrative process can interrupt client motivation substantially ; a typical wait time for a residential treatment facility is 2-3 months after all the paperwork has been completed.

The deterrents reported by the participants here seemed to be quite personal and there was little consistency that emerged. They also appear to undermine the good intentions of participants to begin the help seeking process. If overcome however, via the attainment of a level of humility and emotional readiness articulated earlier in this chapter, a more supportive cycle for continued progress would seem to be opened up for participants. The next section of this chapter begins to report what the participants felt might be useful supports and importantly what appears to be crucial, timely supporter responses that encourage disclosures for help when a client is ready ; approaches that, given all the vulnerabilities of OW clients, may provide insights to unravelling the components of a fragile process.

Supporter Considerations

The themes discussed here relate primarily to attributes/skills of supporters/non supporters

that participants viewed as related to the help seeking process initially and ultimately in the change process.

Participants spoke of the challenges in finding the right therapeutic mix.

1. Informal versus Formal Support

Assessing an individual's level and sources of formal and informal support is a widely used process in addiction counseling. They are thought to be related to a client's coping abilities in managing stress and they are thought to be related to a client's coping abilities in managing stress and in reducing use.

Informal Supports**.**

In my experience in addiction counselling, support from family and friends is understood to be informal support and is generally seen as a positive condition in early treatment and a protective one in treatment maintenance. Participants in this study reported little or inconsistent support from family members in almost all occasions. In 2 of 6 cases there was no mention made of family being involved in the recovery process in any fashion. In other cases, while indicating that support from family is helpful, the stories told by participants often indicated broken relationships – at least initially. For example, Participant 2 described her/his mother as a principle supporter presently but noted that historically-rooted trust issues remain:

> Considering she almost ripped my head off the night all the stuff went down, she almost ripped my head off ….. there is all this trust that I have to build back cause I, the lying, everything when I was doing it …… every time I walk out of the house "are you using, are you using?". This is every time I walk out of the house.

He/she seemed to appreciate the support but appeared impatient in the slower pace of change acceptance from the supporter. Participant 1 also reported that her/his parents were supportive but that the relationship was strained and guilt ridden.

> I guess I have been blessed to have loving parents that I have went to for help - unfortunately it has probably created stress between our relationship, especially me and my father, because they raised me to be better than what I am.

Participant 4 considered her/his father a chief support but similarly reported occasional friction in their relationship describing her/his father's reaction to her/his decision to enter the methadone treatment program as "he just said it is poison".

For Participant 5 the strain in the family relationship was perceived by the participant to be a result of how s/he held family members responsible for her/his situation:

> Well, I had troubles with my family, and I actually wrote them all letters and everything else explaining how I felt about them, and I worked on that . . . . . in so many ways I was blaming them all the time, and just to get that monkey off my back was a big thing.

In the end this participant reported that family support was not involved in his recovery. One of the most positive reactions to my questions about family as a source of informal support came from Participant 6 who singled out the support provide by her/his niece, noting:

> I have got good family support, I know that. My niece is there for me whenever I need it, to feed me, drive me here and there, make sure I get to groups if I want to go.

This quotation from Participant 6 was the sole indication of unconditional support from family, support that was free of judgment and the additional and related stressors of shame,

guilt, and lack of trust. It is curious that this one example involves a somewhat distant relative, a niece. In total, there was only one mention of an actively supportive father and one of an actively supportive mother in the six interviews, and in each case the support is attached to some stressful emotions. There was one mention of a sister, by Participant 6, who said :

> I have a couple of sisters that support me but one drinks so I don't associate with her as much as I would like to.

For this group of participants emotional and moral support from immediate family was minimal, and when it was present it appeared to be emotionally complicated. This seems to be rather paltry overall support from family members for six participants, four of whom consider their battle with substance use as long term. It appeared that for these participants, family support in the long term is often as stressful as it is valuable, and may require a trust building period before family members can be fully included in a support network.

Similarly, support from friends was not strongly indicated by participants in this study. There was a specific reference to a helpful friend made by Participant 4; a friend who introduced him to the methadone program, and by Participant 2 who indicated he/she has a friend also recovering who he/she draws considerable support from. Largely, friends were a topic of negative support, an area of discussion that participants were often adamant about. Discussion on this topic is included in "Managing Negative Influences" later in this section.

Formal Supports

Access to informal support from either family and friends emerged as a challenge for virtually all the participants interviewed. In particular, friends were generally seen as being not helpful, and without significant involvement in the participants' recovery processes. Conversely, available formal support was regarded, by virtually all participants, as a strength. Formal supports would typically include those outside of family and trusted friends. Typically this would include community supports, health professionals, community and self-help groups and work/school supports.

Among those formal supporters identified and perceived positively by the participants in this study was the Ontario Works case worker. In 4 of 6 cases the OW worker was singled out and viewed favorably, often being seen as the principal support. For example, Participant 4, when asked what formal supports were most critical to recovery stated, "OW worker and my doctor". Participant 2 similarly named her/his worker as "very supportive". When asked whether there were others helping him/her, Participant 6 said, "you two people at OW, I have no one else in my life that is helping me do anything". Participant 3 was most complementary, calling his worker a "friend" and "really terrific". It appeared these formal supports contributed both instrumental help and emotional support, the latter making the process less imposing.

Virtually all the addiction service providers in Hamilton were viewed positively by the participants. Those specifically mentioned were, *Womankind Withdrawal Management Services, Suntrac Addiction Services, Men's Withdrawal Management Services*, individual

family and methadone clinic doctors, the *YMCA, and Mission Services*. In two instances, shelters (one participant was living there) were singled out as important catalysts for change. My impression was that while the organization (e.g. OW) may have been seen as somewhat imposing, the individuals the participants had come across were able to mitigate the apprehension inherent in seeking help. Participants stressed relationship issues rather than instrumental reasons as to why these formal supports were helpful, pointing to encouragement, caring and consistency, as opposed to program resources. It was my impression that formal supporters, generally identified through the individuals employed there rather than the service provider broadly - were generally seen as reducing the marginalization participants perceived to exist systemically, and had previously experienced. The next theme provides some insight as to how this might be accomplished.

2. Supporter Characteristics

Clients became quite candid when discussing the "how" of both formal and informal support. Characteristics referred to here are those that participants indicated related to the manner in which support was provided and how that enhances or deters the social support process. One particularly poignant comment came from participant 3 when commenting on institutional services:

> I think it is actually not the way they [services] are, I think it is the perception of the way they will be delivered.

Presumably this related again to the supporter's ability to alter the institutional culture that clients seemed to be apprehensive about, to one that was experienced as more personal. Later s/he described the initial client experience:

> They (clients) are shy and they are embarrassed and humiliated and guilt ridden for every reason, but they are actually afraid to make the connection…If these guys are already afraid at the bottom then they are not going to reach up even close enough, they are just going to bullshit.

This participant appeared to suggest that a service user brings numerous vulnerabilities to the process and if the initial contact is not positive they will be unlikely to effectively seek help.

Again Participant #3, seeming to appreciate the challenge formal supporters can face, indicated :

> So it is really hard from an external for you guys trying to help because they already see you as 'the man' so to speak (and later) So, I don't know how you can, by nature you are impersonal and it is structured, so I am not quite sure how you can bring the personal, I don't know how you can get them to you, get them at ease.

This client apprehension seems to serve as a delicate platform for any supporter. The word judgmental was used by many participants and seemed to speak to an additional and potentially interfering supporter characteristic. Participant 2 referred to an experience he/she found condescending :

> No one should be judging you when you are trying to get the help you need…when I was in detox some of those women, the workers there forgot what it is like and they look down on you because they are so many years clean.

Judgmental responses appeared to mitigate the client's willingness to share and

potentially the propensity of a client to ask for help. Possibly, a non-judgmental approach establishes a culture which allows supporters to be more directive in their support, a connection made by Participant 5:

> Workers should maybe be a little more forceful when it comes to making people do things to better themselves because, yes, treatment is the most uncomfortable thing anybody will ever go through, but once you are done you feel better than you have ever felt before.

Participant 5 appeared to be alone on this point, however it is a sentiment I have heard in the field often for individuals in early recovery. The client's lack of confidence seems to allow him/her to accept more direction when responded to respectfully.

3. Support in Developing Skills in Recovery

Conversation on this theme emerged in the context of questions around how participants actively sought support in an effort to develop skills. Clearly, this is a curious mix of comments. Learning skills/tools as a motivation for seeking support was not universally a priority. While 3 participants did not indicate this as a priority, 3 participants spoke of how learning tools such as coping skills, emotion management and refusal skills was a motivation for seeking social support, a notion it appears related to a realization their own resources were insufficient. Generally, they spoke of a lack of support in this area and a need to be taught. The references to this apparent deficiency were numerous:

Participant 1

> I do need support because from what I have learned is I need to be taught

Participant 2

> It is going to be easier if I go through the treatment and get the tools so I know what to and how to handle the every day stress cause I forgot what I was doing

Participant 5 discussed a lack avoidance or refusal skills.

> I have never actually been shown any skills to stay away from weed except staying away from people that actually smoke it.

Participant 6 didn't directly speak about pursuing new skills only that he wanted to "make sure all the cobwebs are gone and all my supports are in place". Participant 3 made no mention of skill development. S/he indicated he/she had attended residential treatment on 3 occasions ; it appears he felt s/he had the skills (possibly wasn't open to potential continued learning) ; he/she just needed to execute them.

4. Peer Involvement/Support

This particular theme, while in evidence, proved an inconsistent one. As was the case with most of the emergent themes, I did not specifically ask about the usefulness of peer involvement or support; commentary related to this topic was solely captured within the broader questioning. It was of considerable interest to me for the following reasons: peer support programing has been suggested within our program's advisory group on a consistent basis ; it was strongly supported by the recent program evaluation which was based on client

feedback; and it is consistently seen as a program gap within the ASI relapse prevention group (a support group of individuals in the maintenance stage of recovery). For the purposes of clarification, clients talked primarily of formal circumstances in which peers are an integral part of treatment. There was however, mention of the benefits of more casual peer involvement, often socially, which participants also valued as a means of reducing time involved with less "safe" individuals or groups.

As noted, commentary on peers was mixed and seemed to relate to the value of commonality of life experience, to a need for social activity with "safe" people, and also to guard against the "bullshit" factor. Participants 2 and 4, the youngest participants with the shortest history of attempts at recovery, made no mention of it. Participant 3, the most seasoned in terms of recovery, talked about the value of lived experience in the treatment process and discussed having been involved in treatment when s/he was not motivated and experiencing those with lived experience "call [her/him] on it". This conversation began when the participant spoke to having participated in a number of programs prior to being sufficiently motivated and the lack of commitment that accompanied these exercises:

> .. just to get through the six weeks or whatever but you don't solve anything that way." "I went through with stars and stripes, you could put me in anything, well, "how do you want me"? What made the difference was when peer supporters challenged this non-committal and desire to simply get through the program: "That whole first time (treatment) and they called me on it lots of time, [Participant's name] you are happy all the time, it is bullshit".

This appears to relate to the level of honesty discussed in the emotional readiness theme.

Participant 6 seemed to support this idea, stating:

> Oh, I have gone out and gotten temporary sponsors and then got a sponsor. I go with the old hard nose, the guys who have been around for 20 years cause they don't throw many punches, they tell me how it is if I like it or not.

Similarly, Participants 1 and 5, again both veterans of treatment attempts, felt peer involvement/support in some form would be a valuable assist to skill development and as a source of hope.

Participant 1 discussed the value of peer support based on similar experience and an ability to empathize. A connection may be made to the non-judgmental trait emphasized in supporter connection may be made to the non-judgmental trait emphasized in supporter characteristics.

> What I have learned is that I need to be taught most likely by somebody who has been through or has some knowledge of what I'm going through because to me this is all new.

And later she/he discussed the ability of peers to illustrate what change is possible.

> You need to be around people and you need to see the results of being clean, such as seeing people who have been sober for 10 years, 5 years, and seeing what benefits they now have in their life from one day they were in the exact same situation I was in.

Participant 5, who has recently engaged in several social programs in ASI was the most ebullient when discussing his/her interactions with peers in art therapy, again emphasizing the non-judgmental platform peers are often positioned from.

> You get to meet new people in the same situation that you are in open to conversations: people are not going to judge you, that is a support I have never had before; I'm anxious to get in to it.

5. Sustainability

Sustainability was not specifically addressed in the interview questions but was a consideration that seemed to be in participant's thoughts and appears to have implications from a practice perspective. The brief comments below seem to suggest that support needs some continuity and duration as sobriety is precarious.

Participant 1:

> I can't predict when life changing situations, stressful events, people die; when that stuff happens unfortunately I use instead of dealing with it the proper way whenever stress comes up I am always going to think or is it going to be in the back of my mind to using again heroin to numb it right, but I have no other means of support to go to so I don't fall down that same road again it can change any second

It was also expressed as a long term struggle. Participant 5:

> It is for the rest of my life
>
> I think the biggest part is me following through, through this support and for me knowing that I am never going to be better, I will be sober or whatever for a year or two, three but I still need, I am the same person so it is not like you know after a couple of years you are good.

Managing Negative Influences

It became apparent early in the interviews that participants had little difficulty identifying "people, place and things", a staple focus of early coping in addiction counseling, that represented negative support. Consistently, when asked about types of social support that were useful and important, participants also talked about the importance of avoiding negative influences. The message appeared to be quite simple in early recovery ; eliminating

or avoiding negative influences was seen as a greater priority than the difficult work of obtaining positive ones. Many examples of this were evident in the data, most of which related to avoiding relapse.

Participant 1

> Hanging out with negative people who are going to just, and when I am in that element am more susceptible to doing bad things, you know what I mean.
>
> If you are weak and you hang around negative people you are going to give in.

Participant 4

> I went a month and a half, maybe 2 months, I don't even remember, without using and was probably back to normal, I don't know, I see somebody that used and off we went.

Participant 5

> I have tried to quit on my own before. I have gone 4-5 years without smoking weed and as soon as I get in contact with someone who actually smokes it again it sucks me right back in.

Participant 2, when discussing treatment gaps outlined the broader environment, often a concern for welfare recipients, as a negative influence.

> Basically I would say one of the most critical things is housing. A lot of these people, like it is low income, obviously so you are stuck living in low income neighborhoods which are full of drugs, full of prostitution, full of negative things that are around you.

Participant 6 discussed the difficult predicament of avoiding previous acquaintances at the risk of isolating himself.

> I don't have any friends that I can go talk to because they all drink but that is fine

> There are a couple of friends, best friends I can't talk to even.

Participant 2 appeared to reflect on the same circumstance :

> I have dropped anyone that I was talking to that I was around, I dropped them all.
>
> It is a very stressful point sometimes when your friends are calling you and you can't even answer the phone from them.

Participant 3, whose entire strategy appeared to be based on isolation, had the only contrarian notion,

I am gaining more strength out of seeing guys who I quite like just throwing it away. I know I should surround myself with positive help but in a twisted way this is more of a motivator

(In addiction counseling this is sometimes called the "comparison" approach to distress.)

In summary, the findings provided useful and generally consistent information on the factors leading to support seeking, most notably addressing the distress level the participants appear to have had to reach to overcome the obstacles to seeking help. Additionally, clients spoke openly about the characteristics of supporters seen as most conducive to disclosures of the need for help when one is emotionally ready. Notable from a practice perspective was the lack of informal support and subsequently, the heightened importance of formal support resources.

DISCUSSION

This study was intended to explore through an open discussion, social support considerations for a unique population, individuals receiving Ontario Works assistance who have identified substance concerns as a barrier to employment. This population's voice is viewed by the writer as under-represented within the addiction field and within the Hamilton ASI program specifically. The study's premise was deliberately positioned as broad so as not to presuppose client priorities and the questions of participants were designed to allow for a flexible collective response.

The literature review initially focused on general concepts of social support within the field but revealed gaps in the understanding of the population being studied here and rarely linked social support to those addressing change in substance use. The participant responses prompted additional considerations, most notably the tension involved in seeking help/support and the value of supporter characteristics. The collective voice of participants has shaped this discussion section, however I will attempt to relate the analysis to the literature in general with particular attention to consistency, gaps, and opportunities for future study. Ideally, and in keeping with my hope that this work can be reciprocal as it relates to service users, this discussion will reflect upon potential opportunities to convert the knowledge gained from the topics "experts" to program and practice enhancements.

This section will explore four areas of discussion.

1) The factors impacting the process of Participants Seeking Help

2) The support factors clients view as instrumental to a supported recovery

3) Implications for practice

4) Key Research Implications

The Factors Impacting the process of Participant's Seeking Help

While being cautious to appreciate that participants' journeys through substance use and treatment leading to recovery are unique and often unpredictable, it was previously outlined within the findings section that much of the process - beginning with seeking support to actively engaging in it – contains components that were somewhat consistent in the stories told by the participants in this study. For these individuals there appeared to be a common set of factors, or steps, that facilitated the movement into treatment towards recovery. Participants seemed prompted to meaningful introspection of their substance use and its consequences as a result of a single or series of events, an introspection that was generally coupled with an emotional "bottoming out". While there might be a period of denial initially, this introspection and emotional struggle led participants to reach a level of honesty that moved them to appreciate that the problem is likely not temporary and that it cannot be solved alone. Seemingly, they are then in a period of tension. They realize they need help and often have practical motivators to seek it, but both emotional factors (for example, fear, guilt, previous negative experience, fear of consequences) and practical factors (such as housing struggles, insufficient knowledge of resources) create hesitation or a reluctance to move forward. This "window" may be when the "bridge" to support is best

nurtured. It also may be the time it is most fragile, given the likelihood of significant use at this stage and the negative influences and structural components working against intervention. The literature seemed to accurately reflect this struggle particularly that which demonstrated potential of support being simultaneously helpful and harmful (Kim et al, 2006). Our participants considered very few family members to be within their social support group ; only one participant named a family member as consistently helpful. The client may be strongly aware of the consequences of continued use but find it particularly difficult to ask for help.

Cohen's work (1999) was particularly useful in describing the factors relating to the client's tension in moving from being motivated and well intentioned to actual help seeking behavior. There were numerous references to Brehm's (1966) concept of "loss of freedom" seemingly in client decisions to prolong asking. The Keith-Lucas model suggests that individuals must be prepared for "self disclosure" (Cohen, pg. 70) a consistent struggle for participants in this study. Cohen's work, for me, clearly delineated an additional element in what the literature and addition community commonly describes as readiness or motivation ; that being the factors involved in the process of moving to help seeking action.

Cohen's perspective, and more importantly the participant's comments in this study, point to a connection and possible nuance in connection with a prominent theory in addiction treatment, the Stages of Change theory (Prochaska, 1992). According to this model, clients move progressively through a series of stages in their progress towards

treatment and recovery. They are seen to progress through a "contemplative" stage, when they are considering making changes but remain undecided about starting the process of seeking change. They are understood to have entered a "preparation" stage when consequences, physical and emotional states, and practical circumstances (e.g. legal difficulties) move clients to a point where they have an intention to pursue change and may make some preparatory behavioral steps towards recovery. Clinicians often speak of clients "not being ready" when they are unable to move either to or beyond the preparation stage. The assumption can be that the motivation remains unclear rather than it being well solidified. Our participants appear to challenge this assumption. Potentially some of the characteristics of this population (e.g. mental health concerns, legal concerns) as outlined in particular by Lightman et al (2008) and Morgenstern et al (2002), or the lack of emotional management skills (Ciarrochi and Deane, 2001) or the fear well articulated by our participants, adds an additional layer to the process. While readiness for these clients was clearly important, emotional preparedness emerged as a prominent factor at this stage. Participant responses suggest that there may be a place for an additional stage to be added to the Stages of Change model. This might be best termed a "nurturing" period. ("ready but scared") which supports the "bottoming out" and works to alleviate the uncertainty of moving forward. Often clients can eloquently identify the reasons to make a change which will clearly outweigh the reason "not to" but nonetheless remain stuck. Clients routinely spoke of consequences of substance use that were alarmingly significant to an objective observer but not motivating enough to overcome the emotional fear or discomfort.

It should not be assumed however that the readiness "journey" is necessarily sequential or inevitably linear with a fixed outcome. It appears to contain components (e.g. emotional bottoming, a deeper level of honesty etc.) as described above but support seeking appears to occur when the emotional frailty is met with a supportive response.

Supportive Factors that clients view as Instrumental to a supported recovery

Participants spoke in terms of factors they experienced that were more complex than a legal problem, the loss of a home or job, or physical health crisis. What appears to be an understandable, simple process is complicated by low levels of informal support and any number of emotional obstacles. The participant experience seems to often include a period of drifting ; for participant 1 a devastating experience (death of a partner) moved him into a longer period of substance use and lack of concrete steps in seeking help. A model based on concrete consequences and motivation seems to minimize the individual human experience.

The fortunate news for service providers is that strong opportunities for intervention are often presented more than once. Importantly, again for the clinician, is that timing and approach may be as critical as providing the perfect practical support. Presumably, when the initial lack of trust and barriers are adequately mitigated, the client will return to receive specific supports.

The research regarding supportive characteristics was reasonably well validated by the participants in this study. Such factors as being non-judgmental and the "friendship qualities"

(Kim et al, 2006) participants spoke about seemed to offset the anticipation of marginalization this population may regularly encounter. Several clients were clear about the value of peer support particularly for empathy reasons and in support of initial and sustained honesty in treatment. Participant comments seemed to echo the literature supporting the value of service user involvement in treatment programming (Jones, 2010) and as part of a client's "recovery capital" (Best and Laudet, 2010). Participants, given their lack of informal supports generally, in my experience appear open to substantial support from professionals, particularly during the initial recovery period when distancing themselves from non supportive people potentially creates isolation.

Implications for Practice

While acknowledging that six interviews represent a small sample and that considerable caution must accompany any specific recommendations stemming from this study, I feel that the life experiences conveyed by the participants warrants a review of a number of traditional addiction treatment bias', as well as ASI program components.

To expand on this notion, I draw on my own experience in the field which leads me to believe that consideration of the nurturing period described previously might both prompt and create an opportunity for academics, researchers, and clinicians to re-examine the prevailing view that the client will return to treatment when s/he is ready. The assumption appears to be that client inaction generally signals that the client's motivation has not been

solidified. What may follow is the premise that the clinician then is unable, or without a mechanism by which to re-engage the client in treatment. A possible alternative approach would be to regard this period of tension for the client as an opportunity for the clinician to focus on clinical soft skills to a large degree; for example, deepening the relationship, demonstrating trust and unconditional support, and assisting to move the client forward in small steps. The focus of this type of engagement with the client would be to try to shorten the time frame between a client having arrived at the understanding that additional supports are needed and their actually taking the steps to seek and secure them. Regrettably, this can be a time consuming process and clients may in fact be resistant initially. Nonetheless, such engagement with clients might then be time and effort well spent regardless of the immediate client response. If the initial opportunity to engage with the client does not materialize, the clinician has demonstrated interest and non-judgmental regard, which may be invaluable when the client has cause to consider support again. In my experience the components of the ASI program would generally reflect this orientation however attempts to provide opportunities for client engagement (i.e. orientation groups, social "drop ins") have been largely unsuccessful. That does not however diminish the potential for greater focus on this critical time period for the client and for nurturing attempts to continue to be made. This research would suggest that the program should continue to consider suitable interventions to allow for flexible re-entry and should work to resist a structure that formally or informally considers client motivation or potential in terms of concrete steps to seek help early in the program.

In general, the research would indicate that clinician response, ideally, charisma, optimism, and enjoyment working with substance use disorder patients makes a difference in client retention and outcomes (Najavits et al, 2000). Moreover low degrees of cynicism, blame, boredom, hostility and control were favourable in clinicians (Najavits et al, 2000). This appears to echo the participant comments in this study. For this reason, programs in the addictions field, particularly those serving a population exhibiting multiple barriers may be well advised to employ their best "engagers' at intake. Initial screening processes may be well served to focus primarily on motivational interviewing skills rather than technical assessment. For the general population of O.W. recipients the initial request for help is through a call to the program secretary or through their O.W. case worker followed by a screening by a worker with addiction experience. Given the sensitive nature of the first meeting other engagement options should continue to be considered within the field. Again, the ASI program to date has made attempts through "open social" programs to the general O.W. and should continue to seek alternative comfortable entry processes. Future processes could involve an introductory/information session facilitated by case facilitators, trauma counselors, and addiction counselors. The setting could be relatively short unless the client situation warranted specific individual counselling and hopefully would be presented in a low risk, social manner. It could be developed to include a peer support element, possibly co-facilitated by long standing program participants. This may leverage one of the strengths of self help groups such as Alcoholics Anonymous, and a sense of colleagueship rather than client/clinician, (one participant (3) described it as program staff

being “the man”). The purpose here is to minimize initial client trepidation, maintain client self determination and hopefully establish a basic trust level. Again, an attempt at best managing a nurturing opportunity as the client contemplates a support request. Certainly, drop in intakes could also assist in encouraging a population that may require flexibility.

Secondly, service providers in general may not be recognizing the lack of informal client support clients arrive with. Our 6 participants discussed 3 family members and 2 friends that were actively involved in their recovery and emotional support was provided in 2 instances. Conversely, formal support was identified more often and seen as more effective. Client service in our field generally attempts to minimize the number of times a client must tell a story. The ASI program currently addresses effective connections to complimentary service providers by providing services on site. Trauma counselors, brain injury consultants, art therapists are presently all available at the ASI offices in addition to the addiction counselors. While care ought to be taken to not overwhelm clients initially, the “team” atmosphere seems to be supportive ; in practice clients rarely object to information sharing amoung related program staff. Case facilitators currently also accompany clients to appointments (when aware of the availability) with Children’s Aid workers, to mental health and doctor’s appointments, the methadone clinic and withdrawal management services. This approach appears to have been validated by this study’s participants and should be expanded where possible. Tracy (2010) identified “helping behaviors” specifically for women with substance use concerns ; a number of these activities were alluded to by our participants. The funding formulas for services within the field may not generally support

the perceived inefficiency of extensive helping behaviors in programs within the field but may be short sighted in terms of potential gains in engaging clients. Funding formulas may be well advised to ensure resources are directly aimed at initial (and likely extended) engagement and to challenge the efficiency perspective. It is also possible the social work values related to client autonomy and self- determination may benefit to moving somewhat in the direction of nurturing (one participant called it being more directive) when working with this population. My experience would indicate that thoughtfully developed trust in the client/ clinician relationship can accommodate this such that clients find it acceptable and helpful in accessing initial help.

Peer support, based on participant voices, likely warrants greater prominence in addiction treatment. Participants seemed to value time spent with others in recovery, both for support and as a check for authenticity. Their comments mirrored those of existing program participants. Peer support also creates an opening for sustained support after exit from the program. It may also assist in managing the program's population that are not engaged in regular activities and may still be in a contemplative stage. The ASI program holds monthly "Collective kitchen" events in which fresh ingredients are purchased at the Hamilton market, the group prepares a lunch in the market kitchen, eats the lunch, socializes, and takes home the "leftovers". It is limited to 10 participants but is rarely full ; 300 are engaged in the program. One wonders if a greater element of peer support could mitigate against the resistance/apprehension that seems to accompany events such as this while the client is still pondering seeking help. While respecting one of the program's guiding

principles, self determination through voluntary involvement, is important, possibly more attention should be paid to more opportunities for modest engagement through peers for what appears to be a large portion of those in the program and in the problem substance use population in general.

The interviews provided an opportunity to reflect on social work practice and policy. Although a very broad topic beyond the scope of this paper, structural circumstances cannot be excluded as a factor in the client's process toward accessing support.

The first area to consider is social work training. The participant voices seemed to be consistent in the importance of good listening skills, communicating a sense of caring and respecting client pace. Establishing trust appears to be an entry level skill for workers engaged with populations with multiple barriers and histories of marginalizing experiences with institutions. Participants in this small sample mentioned Children's Aid, the police and court system, and elements of the social welfare system. Social workers are presumably adept at the softer skills ; empathy, compassion, regard for self determination, all skills that are presumably innate and were then reinforced in school. Less emphasis is placed in understanding institutional culture, the cyclical nature of poverty and the experience of marginalization.

In the addiction field standard tools are employed to measure readiness for treatment. Such factors as social support in place, consequences of use, impact on daily living, quality of life and confidence to resist use are routinely assessed. This study would suggest standard

tools to gauge client trust levels, ability to assess/utilize supports needed and emotional challenges to engaging with treatment or support be considered rather than being done principally intuitively. Tools which gauge "willingness to seek help/support" are not actively utilized. Such tools can potentially address client concerns such as the need for reciprocity, loss of freedom in accepting help, internal versus external attribution for seeking help, and threat to self esteem (Cohen, 1999). In terms of worker effectiveness, the study may suggest that the ability to nurture trust, challenge participant denial or lack of motivation supportively, instill motivation and alleviate fear ought to be core competencies and subject to feedback sought of participants with respect to worker effectiveness. This may lead to insights regarding client dropout, preparatory work needed prior to engagement, and program entry processes.

Relatedly, clients spoke often of lack of skills or tools in their recovery, often after years of recovery efforts. Typically work in the addiction field centres on coping skills, therapy regarding underlying issues, and managing emotions. Through traditionally recognized relapse prevention exercises and solution focused, cognitive behavioral and dialectical behavioral therapies, the practice of treating addictions seems well armed to address these issues. Perhaps the clinician's tool box warrants review. Less well developed are those therapeutic processes designed to manage initial anxiety, improve self advocacy and provide practical support seeking skills.

Key Research Implications

This research only adds to the broad potential for future study with implications for policy. A number of research possibilities with implications for social work/addiction counseling come to mind that may provide insights in tackling the following questions.

Structurally

The findings from this research point me to ask, "In what ways can we try to address and offset negative influences in recovery efforts?" Improving housing conditions for clients so that they are more appropriate to their needs and more stable and long-term; enhancing the availability and provision of formal supports, as well as addressing the lack of informal ones; investigating how to provide greater income support to clients in recovery, improving access to employment and the creation of more supportive work environments are all researchable factors that are indicated by this study's findings. These are, of course, not new ideas, but the participant experience revealed here certainly reinforces their importance in impacting recovery.

Addiction Recovery Supports

Research focusing on opportunities to reduce negative influence and increasing positive support activities could be particularly useful. These were sentiments raised almost universally by our participants and the existing research appears to broadly support their importance. Studies exploring the value of increased social/recreational opportunities, easier access to inpatient treatment, and paid peer support programs could potentially

leverage the periods of inactivity for potentially "ready" clients who for whatever reasons are able to seek help easily.

Clinician practice

Research investigating the value of the addiction services community entering more aggressively at crisis points (eg., prisons, detox centres) could be potentially useful in creating early nurturing and timely formal support. Certainly processes to reliably measure willingness to seek help seem timely. The Cohen article (1999) had considerable application as it related to the participant comments in this discussion but I was unable to find significant subsequent attempts at determining validity of this or other like instruments with this population and in my experience, such a tool is not widely used in practice. A reliable tool could potentially inform clinical skills in mitigating client fear and emotional obstacles.

Of course, given my experience in completing this study, seeking client voice must continue to be a research priority with respect to marginalized populations. The insights confirmed or illuminated by the modest group of participants in this study will improve my clinical practice measurably.

Summary/The Client Platform

Certainly, the process of supporting those in the population studied here has gaps, gaps which are understandable and at least in the case of the OW-ASI program reasonably well identified, and understood. In this writer's opinion the existence of programs such as

this are a terrific platform with which to enhance support for those on social assistance battling a substance abuse concern. Moreover, there is demonstrated hope in the voice of this study's participants that ought to encourage clinicians and researchers. While there are clear challenges in assisting clients at both the structural and clinical level, the overriding impression in the interview process is that our clients can become equipped and supported in making changes and clearly demonstrate enormous resilience. This may run counter to the perception of some in the field working with this population. The doggedness of their recovery attempts is remarkable and the positive approach in a difficult circumstance provides a valuable platform for clinicians. A sample of some comments :

Participant 1

> I know I got a lot of goals that I want to do in life and stuff like that. There are a lot of things I still need to do and I just need the proper environment to be able to go about to do these goals."

Participant 2 (in discussing the ASI program)

> I don't know how long I can be there for but I want to be able to get everything so I can hold down a job

Participant 3

> I don't want to get comfortable. I want to be uncomfortable to motivate myself to get the hell out.

Participant 4 (after being asked who provided the most important support)

> Tough call, I would say all of them, everyone has been great.

Participant 5 in discussing his love of cooking,

> When I am on the line cooking it is like no other feeling that I have had before, especially on the job, every other job has been ok but the first day I started cooking I fell in love

Participant 6

> As I get stronger maybe I could go and help support somebody which is support for me.

Certainly clients engaged with a helping professional can be quick to blame, focus on their shortcomings and exhibit little or no hope. My experience however in these interviews revealed clients much more occupied with looking forward, being grateful for the support they have rather than the deficiencies they face and seeing themselves as persistent in their recovery efforts rather than emphasizing setbacks.. The challenge may involve finding a way for resilience, mutual support, and celebrating incremental steps to punctuate treatment plans. There may be ways to create support systems within treatment programs rather than emphasize developing external supports.

Certainly, for the formal support community, managing the initial impression that clients have of the supporter would appear to be a tall order, with the expectation or desire by some participants for gentleness, and for others, of being directive. The preferred response appears to put a premium on listening and reserving judgment. I am hopeful that the non-threatening nature of my interviews confirmed the participant's views that the manner of the supporter can have an impact on client disclosure and potentially set the stage for greater help seeking. I spoke with 6 participants I had met for the first time. I went to some length to assure participants were comfortable with privacy, confidentiality and the purpose of the study. Participants were thanked for their participation throughout and comments were accepted without judgment. In these 6 sessions I learned of guilt and

shame on several occasions, grief, fear, numerous mental health concerns (it appears self diagnosed), separation/ disassociation from family, social anxiety, and legal issues, among others. I heard that clients seeking help are often quite vulnerable and often in heavy use phases of their addiction. Nonetheless it appears that if clients find the wherewithal to attend, and receive the supporter in the right light, there is potential for in depth disclosure and hopefully help seeking even in the absence of a significant trust building period.

Dissemination

While recognizing the sample involved in this research does limit the broad applicability of the findings here, circulation of this thesis appears to be potentially useful and supports the goal of the research being reciprocal. Potential audiences could include the City of Hamilton Ontario Works and Community Services leadership, colleagues within the addiction community locally, and fellow ASI delivery sites. The inclusion of participant involvement in dissemination would be ideal not only for the impact it may have on readers but also as a clear process of ensuring the "voice" is communicated in a clear manner. The process may be an engaging and encouraging one for particpants who would like to be involved. The general sentiment of participants was the idea that their candid sharing could potentially aid future program participants; hopefully their inclusion provides an opportunity to contribute directly to this objective.

Appendix A

McMaster University

School of Social Work

Kenneth Taylor Hall, 319
1280 Main Street West
Hamilton ON Canada
L8S 4M4

Phone 905.525.9140
Ext. 23795
Fax 905.577.4667
Email socwork@mcmaster.ca
http://www.socialwork.mcmaster.ca

Appendix A

Date :

LETTER OF INFORMATION / CONSENT

An Exploration of Social Supports Recommended for Ontario Works Clients Identifying Substance Use as an Obstacle to Employment

Investigators :

Student Investigator :

Greg Shupe

School of Social Work

McMaster University

Hamilton, Ontario

(905) 546-4800 x 5491

Faculty Advisor

Dr. Ann Fudge - Schormans

School of Social Work

McMaster University

Hamilton, Ontario

(905) 525-9140 ext. 23790

Email : greg.shupe@hamilton.ca

fschorm@mcmaster.ca

Purpose of the Study

Evidence suggests that social supports can play a key role in client treatment of substance use concerns. While the Ontario Works Addiction Services Initiative is aware of this potential role there has been no specific process to date for participants to provide their experience to program components in this area. This research will explore potential

participant views of what may be beneficial to consider for the program.

Procedures involved in the Research

I am seeking 12 Ontario Works participants who have identified a substance use concern, to provide input on the type and value of supports the program might consider.

If you agree to be in this study, you will be asked to take part in an individual interview lasting 60 to 70 minutes during which you will be asked to talk about your experience of social support (often described as emotional, instrumental, moral, recreational and mentorship support). It will take place in a location that is safe and conducive to an open conversation. With your permission, the interview will be audio-recorded and these recordings will be transcribed. After the information is analyzed, a summary report will be written and you will be welcome to see the report and provide your feedback.

I would like to retain the transcripts to use for my Master's Thesis.

Potential Harms, Risks, or Discomforts

The risks involved in participating in this study are minimal. However, the interview may raise issues that you find difficult to thinks and talk about. You may also worry about how others will react to what you say. Please know that you do not need to answer questions that make you uncomfortable or that you do not want to answer. I will also work to ensure the interview setting is a safe and respectful place.

While every effort will be given to protect the identity and confidentiality of participants, some may still worry their identity and confidentiality will be compromised. Please see the section below on confidentiality.

Potential Benefits

While there may not be direct benefit for you in participating beyond having the opportunity to share your story, your participation may inform the OW-ASI program and lead to program enhancements.

Reimbursement

You will receive a $20 Tim Horton's gift card, a thank you card and light refreshments will be served during the interview.

Confidentiality

We will undertake to safeguard the confidentiality of the interviews. Your audio-recorded interview file will be transferred and stored in a password protected computer file or encrypted computer storage device which will, in turn, be locked in a file cabinet. Only I will

have access to the locked cabinet. I will not use your name on any documents (it will be replaced with a code name) or any information that would allow you to be identified on the data (such as transcripts or field notes on computer files). Anything that could identify you will not be published or told to anyone else without your permission. The only other person who will have access to the data will be my supervisor, Dr. Ann Fudge Schormans.

Prior to the completion of the final report participants will have an opportunity to view the contents to ensure that quotations used are not identifiable to specific individuals.

I respect your privacy. No information about you will be given to anyone without your permission, unless the law requires so, as for example there is immediate harm to you or someone else.

Audio files of the interviews will be erased once they are transcribed. Following completion of the research study the transcripts will be kept for 5 years and then be destroyed.

Participation and Withdrawal

Your participation in this study is voluntary. It is your choice to be part of the study or not. If you decide to be part of the study you can decide to stop at any time, even after signing the consent form or part way through the study. If you decide to withdraw, there will be no consequences to you. In cases of withdrawal the information you have shared will not be included in the study results.

You will be given a copy of this consent form for your record.

Important Disclosures

Participation in this study is not related to Ontario Works benefits in any way.

Participation in this study will not affect the wait time for the ASI (Addiction Services Initiative) in any way.

Participation in this study does not include addiction treatment.

The researcher is currently an addiction counselor within the ASI program. There is a small possibility that the researcher may at some point be in a position to provide addiction counseling to participants in this study. The researcher and program management will take whatever steps necessary to minimize this possibility and will provide options to participants for an alternate counselor should this circumstance occur.

Information about the study

If you would like to receive the summary personally, please let me know how you would like

me to send it to you (ie. mail, e-mail).

Questions about the study

If you have questions or need more information about the study itself, you may contact :

Greg Shupe (Investigator) : 905-546-4800 x 5491

Dr. Ann Fudge-Schormans (Supervisor) : (905) 525-9140 Ext. 23790 or e-mail fschorm@mcmaster.ca

This study has been reviewed by the McMaster University Research Ethics Board and received ethics clearance. If you have concerns or questions about your rights as a participant or about the way the study is conducted, please contact:

McMaster Research Ethics Secretariat

Telephone : (905) 525-9140 Ext. 23142

c/o Research Office for Administrative Development and Support

---

CONSENT

By signing this form :

1) I agree that you have explained the study, the possible harms and benefits of participation, and my right to withdraw from the study at any time even after I have signed the consent without reason being asked. You have answered all my questions.

2) I agree that the interview will be audio-recorded. __ Yes __ No

3) I agree that I have been told that my records will remain private. You will not give my information to anyone, unless the law requires you to.

4) I agree that I have read and understood pages 1 to 3 of this consent form. I agree or consent to take part in this study.

_____ _____ _____

Research Participants Name Research Participants Signature Date

_____

Phone No.

_____ _____

Name of Person Obtaining Consent Signature

_____ _____-

Date Phone No.

APPENDIX B

INDIVIDUAL INTERVIEW GUIDE
An Exploration of Social Supports in Substance Use Treatment

Gregory Shupe

I) INTRODUCTION AND INSTRUCTIONS:
Hello, my name is Greg Shupe. Thank you for agreeing to participate in this interview. Just to remind you, I'm looking at opinions about social support.

Refreshments are available

First, I would like to review again the consent form that is in front of you which you previously signed.

FOR FACILITATOR: REVIEW INFORMED CONSENT FORM AND ANSWER ANY QUESTIONS ABOUT IT. COLLECT SIGNED CONSENT FORM AND ENSURE THAT PARTICIPANTS HAVE A COPY OF THE LETTER OF INFORMATION TO TAKE WITH THEM

Confidentiality: Before we begin our discussion of social support I want to spend a few moments **talking about confidentiality.**

- The information which we will collect today will be attributable *(connected or associated)* anonymously ; your name will not be included in the research report
- We will not identify quotes or ideas from *any one person.*
- I may also step in if I feel the conversation is straying off topic.
- *A*fter the discussion, I will invite you to fill in an anonymous "post-workgroup information sheet" (*If appropriate*) to us help generally describe the kind of people who are part of this study.
    - You can expect this interview to last about 1 hour. Should you like a break please let me know.

Use of Tape Recorder *[If applicable]*

- As you will recall, this discussion will be recorded to increase accuracy and to reduce the chance of misinterpreting what anyone says.
- All tapes and transcripts will be kept under lock and key by the researcher.
- Names will be removed from transcripts. Participants will have coded numbers attached to their name which only I will know.
- Only I and my thesis advisor will have access to transcripts (with personal names removed) of this interview.

- I'll also ask that when using abbreviations or acronyms, you say the full name at least once to aid transcription.
- I may also use a "flip chart" to write down key points during the focus group and take notes.

[HAND OUT ANY MATERIALS (IF APPLICABLE) THAT THE PARTICIPANTS WILL NEED DURING THE FOCUS GROUP INCLUDING PENS OR SCRAP PAPER. GIVE THEM A FEW MINUTES TO READ OVER ANY WRITTEN MATERIAL NOTING THAT THEY CAN MAKE NOTES IN THE MARGINS BEFORE THE DISCUSSION BEGINS.]

II. INTERVIEW

-
- *Open up discussion for general responses of participants to each question.*
- **Interview questions**:

SOCIAL SUPPORT

Social support can come from anyone you trust and feel comfortable approaching ; for example :

- Your partner or family member
- A trusted friend
- A health professional

Kinds of Social Support

1) Emotional Support – someone with whom you can discuss feelings
2) Moral Support – someone who can give you encouragement
3) Instrumental Support – someone who can help you with practical tasks such as child care or transportation
4) Support from a mentor – someone who can give you guidance and instruction
5) Recreational support – Someone you would like to share your free time with

We are interested in the general topic of social support as it relates to Ontario Works recipients who are working on substance use concerns. Today's questions are designed to improve understanding of what kind of support is needed, whether it is seen as important and why, and how it might be improved upon. The discussion in these interviews can potentially inform programs such as the Ontario Works Addiction Services Initiative.

1. Let's spend a few minutes learning a little about each other. Can each of you please briefly tell me about yourself, your current situation and how you may be able to comment on the topic today. Please feel free to share only what you are comfortable sharing.

2. As you consider your goals regarding a change in alcohol or drug use comment on how you see the process in terms of support. For instance, is this a process you are working on by yourself or are there others involved.

3. As you reflect upon your personal situation what type of support do you view as most critical and why? It would be helpful if you could rank the above types of support in terms of their importance.

4. Are there supports that you view as important that are not listed in the above group? Why are they important?

5. It is quite rare for individuals to be fully supported in every way. In your experience what can be done when additional support is needed.

6. What are the challenges you anticipate, or are currently experiencing as you work to enhance your support.

7. In the general area of substance use treatment, do you see any "gaps" in support resources that if filled, would be of assistance to you?

8. If you could advise a program such as the OW ASI program what advice would you give in the area of social support to assist participants?

- Is there anything we forgot or something important that we should know about?

Wrap-up:

.

▪

▪ Thank the participants.

Appendix B
[An Exploration of Social Support in Substance Use Treatment
INTERVIEWEE BACKGROUND INFORMATION SHEET

INTRODUCTIONS: Please fill in this form that will provide us with some basic background information about you.

DO NOT Put your name on this sheet.

1. I'm a (Check one):

[ ] Male
[ ] Female

2. I'm (Check one):

[ ] between the ages of 21-30
[ ] between the ages of 31-40
[ ] between the ages of 41-50
[ ] between the ages of 51-60

3. I'm (Check one):

[ ] single
[ ] married
[ ] separated
[ ] divorced
[ ] a common-law spouse
[ ] prefer not to answer

4. My primary substance of concern is :

Please turn over this brief information sheet and leave it on the table when you leave. Thanks.

APPENDIX C

Oath of Confidentiality

(*Check the following that apply*)
I understand that as:
[ ] an interpreter
[X] transcriber
[ ] audio assistant
[ ] video assistant
[ ] research assistant
[ ] other (*Please specify*) _____

for a study being conducted by Greg Shupe of the Department of Social Work, McMaster University, under the supervision of Professor Ann Fudge-Schormans, confidential information will be made known to me.

I agree to keep all information collected during this study confidential and will not reveal by speaking, communicating or transmitting this information in written, electronic (disks, tapes, transcripts, email) or in any other way to anyone outside the research team.

Name: _____ Signature: _____
(Please Print)

Date: _____

Witness Name: _____ Witness Signature: _____

Appendix D

Greg Shupe, a McMaster student and social worker with the City of Hamilton and the ASI program, has contacted the Ontario Works Addiction Services Initiative asking us to contact our clients about a study he is doing on social support.

The study is designed to explore the factors of social support that are seen as important for those who view substance use as a barrier to employment. The information gathered can potentially inform treatment planning in this area. Participants will be involved in one on one interviews lasting between 60 and 70 minutes. More information about the study can be found on the attached letter of information and consent.

If you are interested in getting more information about taking part in Greg's study, PLEASE CONTACT HIM DIRECTLY at 905-546-4800 ext. 5491.

Your participation/non participation in the study will in no way impact services provided or the wait time for service. Participation is entirely voluntary and is designed to ensure your confidentiality and anonymity is protected. Although the study is being done for research purposes it can potentially be an excellent opportunity to provide a client voice in programs being considered in the field.

This study has been reviewed and cleared by the McMaster Research Ethics Board. If you have questions or concerns about your rights as a participant or about the way the study is being conducted you may contact:

McMaster Research Ethics Board Secretariat
Telephone: (905) 525-9140 ext. 23142
Gilmour Hall – Room 305 (ROADS)
E-mail: ethicsoffice@mcmaster.ca

Sincerely,
Lynn Foye
ASI Program manager

APPENDIX E

SCRIPT TO BE USED IN THE CIRCUMSTANCE OF A STUDY PARTICIPANT BECOMING INVOLVED IN AN INDIVIDUAL OR GROUP COUNSELLING SESSION WITH THE RESEARCHER AT A FUTURE DATE

It has come to our attention that you will soon be involved in counseling (individual or group) with Greg Shupe, a social worker in the Addiction Services Initiative (ASI) program. You may recall that Greg was involved in a research study on social support conducted in April 2013 in which you participated.

Please be assured that your participation in this study in no way will affect the counseling provided through the ASI program and Greg's involvement in your treatment plan. Having said that, we realize that your preference may be to be involved with a different counselor. Should this be the case please advise Greg directly or your case facilitator and arrangements will be made to provide treatment through an alternate counselor.

ASI Manager

Appendix F
Counseling Resources

Should you feel upset, triggered or in any way uncomfortable as a result of today's session you are encouraged to advise the facilitator such that supportive resources can be provided.

Should any of the above concerns present themselves after leaving the session the following resources should be considered.

If in need of crisis services please call COAST at 905-972-8338. COAST is available 24 hours/day.

For crisis services related to substance use, **women** please call WOMANKIND addiction services at 905-545-9100. This service is available 24 hours/day and can also be used to arrange withdrawal management and to access treatment programs.

Men please call the Mens Withdrawal Management Services at 905-527-9264. This service is available 24 hours/day and can be used to arrange withdrawal management and to access treatment programs.

For non crisis related services :

Catholic Family Services - 905-527-3823. Appointments can be arranged through your case facilitator or case manager. Walk in counseling is offered on Tuesdays between 12:30 PM and 6:30 PM. No appointment is required.

In addition, your case manager or case facilitator can provide information regarding mental health services and support, and specific counseling needs such as trauma, grief or abuse.

Appendix G

After completing the program work, namely orienting the client and scheduling a screening appointment, the worker will use the following script :

"There is a researcher here, who is also involved in the ASI program, who is conducting research regarding social supports for his thesis at McMaster University. He is looking for individuals who might like to participate in the study. It will involve an interview lasting about 60 minutes and he is compensating participants with a $20 gift certificate at Tim Horton's. It's entirely voluntary. If you are interested I can transfer you to his line ; you may get his voicemail but he will return your call. Would you like to me to transfer you so you can get the details directly from him?"

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