Exploring Experiences of Men Accessing Residential Addictions Services: Towards an Anti-oppressive Policy Development and Implementation Perspective

by

Mark Streibel
BSW, University of Victoria, 2013

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Supervisory Committee

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Abstract

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Many men seek to address their substance use issues in a variety of resources including hospitals, detoxification centres, treatment programs, supportive recovery housing and more. How policy is constructed and implemented has a direct impact on how effectively clients achieve their recovery goals. There is little literature on the topic of how policy is developed and implemented in residential addictions services. What research could be found did not include the voices of the recipients of these services. The goal of this research is to gain insight into the experiences of people accessing residential addictions services to inform policy development and implementation. Thorne's (2008) interpretive description was the methodology used to guide this study. Eleven qualitative interviews with men accessing residential addictions services were conducted. Several themes were identified and an interpretive description was made. Eight theories are proposed. Several recommendations were formulated. Three suggestions for future research considerations are discussed.

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Dedication

I would like to dedicate this work to my partner, my family, my friends, and the mentors who made it possible for me to engage in post-secondary studies while working full-time.

Chapter 1
Introduction

Policy development and implementation in residential addictions facilities is significantly under-researched. In addition, little attention has been given to including the recipients of the services offered at these sites in these processes. This research explores the experiences and ideas of men accessing services at a residential addictions facility in Surrey, B.C. called New Horizons Recovery. In this chapter I discuss the research topic, the objectives of the study and research questions, significance of the research, and my location to the topic. In subsequent chapters, I provide a review of the relevant literature, a description of the theory and methodology guiding the study, and present my findings and recommendations.

Problem Statement

Substance use is a prevalent phenomenon in Canadian society (Veldhuizen, Urbanoski, and Cairney, 2007).

According to the 2012 Canadian Community Health Survey, 4.4% of Canadians aged 15 and older met the criteria for a substance use disorder (Canadian Centre on Substance Use website, 2014). Data collected by the National Treatment Indicators project, shows that in 2011 approximately 151,000 Canadians accessed publicly funded treatment services (Pirie, T., Jesseman, R., Di Gioacchino, L., & National Treatment Indicators Working Group, 2014).

In my nine years of experience working in the field of residential addictions treatment / recovery I have been exposed to several different service delivery models. Some aspects of these models appeared supportive of clients' growth more than others. I worked in a residential treatment centre for over six years ending in December of 2013. By choosing to work there, I was often placed in a position to either promote policy or advocate against it on behalf of clients.

In the early days of my tenure I followed direction and executed policy even when it did not feel right to do so [which was often]. As the years progressed, I found myself advocating more and more for clients and embroiled in conflict with other staff and members of management as a result. I felt better inside, but grew tired of the constant rub. The following example marked the turning point for me which ultimately led me to the threshold of this thesis.

During my career at the previously mentioned men's residential addictions treatment facility I occupied the role of clinical support worker. Part of this role involved me facilitating discussion groups with clients to help them clarify what they wanted to work on while at our centre. For one such group I prepared a session discussing the topic of honesty in relationships. I asked questions like:

- How many of you have people in your life that you love and want to be close to?
- How many of you have ever been lied to by someone you love?
- How many of you have lied to someone you love?
- How did these experiences affect you?; and
- How did they affect your loved ones?

We then went into a discussion where the participants defined what honesty meant to them and how important it was or wasn't in their relationships. We finished the session by talking about the importance of practicing honesty in our lives and in their recovery processes. Shortly after the group ended I began cleaning up the room; collecting papers, erasing the white board, and arranging chairs. I looked up when one of the group members re-entered the room. He had been one of the quieter members of the group. He asked if I had a few minutes to talk. I replied "sure". We pulled up a few chairs. He sat down and began talking about how he felt when he first arrived at our centre. He hadn't slept for three or four days because of the drugs

coming out of his system. He then handed me a tiny opened package of marijuana. He said that after our group that day he felt a strong desire to make a fresh start and begin practicing complete honesty. He disclosed to me that he had smoked one joint a day and a half after he arrived at our centre so he could relax and get some sleep as he was still withdrawing from heroin dependence. I commended him for being honest with me. He told me that he was tired of living in a web of lies. He asked what was going to happen to him as a result of his honesty in this case. I explained that I was required to disclose it to the clinical team and the team would decide what to do. He was aware that the centre had a zero tolerance policy when it came to using drugs on the property. I assured him that I would advocate very strongly that he be able to stay given how he came forward with this issue and his willingness to change. It is important to note that prior to this conversation I had no plans to drug test him and even if I did he could have easily lied and said that he'd used daily prior to arriving [marijuana can stay in your system for weeks]. We would not have known about this incident but for his honesty. I spoke to the clinical team the following morning and presented the issue. The team voted to discharge him immediately, effectively rendering him homeless. I presented all the angles I could. I stated that I didn't support the decision. The reasons given by the team never seemed to go beyond "because it's policy". Afterwards, I spoke to my clinical manager. He said that he sympathized with me and appreciated that I'd built a great rapport with the client, but that he could not reverse the decision. He suggested that I go speak with the executive director. I followed this suggestion, but was met with the same result. At the end of it, I refused to discharge the client. I said that I believed we were making a mistake and I didn't support it. Two other staff members ended up discharging him and I was warned that failure to follow management direction could lead to disciplinary action. I went home that day feeling defeated, sad, angry, and frustrated. I don't

know what happened to the client afterwards. He never returned to our centre and I can certainly see why.

Although it can be argued that rules and consequences such as the one used in this case can be beneficial to clients subject to them in terms of providing external motivation to practice abstinence from problematic substance use, it can also be argued that, from a harm reduction perspective, these kinds of rules can be detrimental to a person's health and wellbeing as they often contribute to homelessness and further problematic substance use.

This is but one illustration of how power is used via policies and their implementation in a manner that may not serve the best interests of a client. There are several other examples I could draw on including clients being discharged prematurely due to possessing cell phones or other such prohibited devices, clients being discharged due to unsubstantiated reports of stealing from other clients, and clients being penalized or discharged for having difficulty attending various kinds of therapeutic groups. These policies and how they are applied may be beneficial to some clients in some situations, but they may be harmful to others in different situations. This research is aimed at exploring which policies are beneficial and which ones are not.

Objectives of the Study / Research Questions

The topic of inquiry in this study is how residential addictions services policies are used to either support or impede clients achieving their recovery goals. The questions I seek to answer in this thesis are: ***a) What value is there in engaging clients in policy development at the sites where they access services? b) How do clients engage with policy development and how is policy enacted in practice?*** and ***c) What residential addictions services policies and policy implementation support clients to accomplish their recovery goals and what policies and policy implementation impede them?*** The goal of this research is to gain insight into the value of

engaging clients in the policy development and implementation process. Special attention is given to policies and policy implementation that creates barriers to clients accessing desired services. Within the context of this research, oppressive policies are those which limit or deny clients' access to services necessary to address their substance use problems when their actions do not present a physical or psychological risk to others. In order to avoid generating oppressive policies or policy implementation practices I do believe the most suitable place to start is in gathering information from service users themselves. The findings of this research will be used to make recommendations for policy development / implementation at the facility where the research took place. New Horizons Recovery Services management and staff members invite the collaboration of both the clients and the researcher in this endeavour. Secondary consideration will be given to the development of processes that other residential addictions services can use to accomplish the same goal if they choose.

Research Site

This research took place at a residential addictions recovery facility called New Horizons Recovery. New Horizons Recovery was started in April of 2014 by a woman already involved in the recovery facility business in Surrey, BC. Her goal was to design a facility and program that offered substance use counselling services in a recovery house setting to adult men in the community. It was designed to be a hybrid of community living and treatment services with support to access medical, legal, and other resources. She enlisted my help to design the clinical program, hire counselling staff, and develop both administrative and clinical policies. I offered to do so in my spare time without financial compensation. The New Horizons Recovery facility is a thirty bed house located in central Surrey. Clients that access services there are over the age of nineteen, have current or recent problematic substance use, are not acutely suicidal, are not

convicted sex offenders, and consent to service. Many have experienced homelessness, poverty, mental health problems, criminal justice involvement, health problems, and other conditions that contribute to marginalization. Clients are required to attend a psycho-education group three days per week, a counsellor led discussion group four days per week, and peer or counsellor led house meetings as needed to discuss ongoing issues that arise. Once clients have attended six weeks of groups, they can transition into life planning and engage with personal goals such as seeking employment, life-skills training, and securing independent housing. Clients have access to a physician whom they can see each week. An acupuncturist offers her services to those who wish once per week. They also have access to outreach nurses who come and do free vaccinations on a regular basis.

Researcher's Location

My relationship to the topic is multi-layered. In my younger years I experienced problematic substance use. This ended when I attended a residential treatment centre. With support I was able to abstain from problematic substance use and have not used any mood altering substances since. I was able to build a family, find employment, go to school, and eventually obtain work in the substance use counselling field. I have offered a variety of services to people in a residential setting for the last nine years. In those nine years I encountered many different systems used to guide service delivery. Most of them were very paternalistic and controlling. Eventually I left this field of work, and moved into a different career. The farther I travelled away from it, the more I was able to gain insight into just how oppressive some of the systems governing addictions treatment are. Over the years I often found myself thinking about how I would do things differently than the agency mentioned in the example if I ever found myself in a governing role. Although I moved into a different career, opportunities to work in the

field of addictions kept presenting themselves to me and I acted on the ones that I thought I could make a positive difference in. I am currently occupying the position of consultant to New Horizons Recovery Services which offers housing and counselling / support services to adults experiencing problematic substance use and related life issues. This agency is just starting out and presents some interesting possibilities. Those of us involved have the opportunity to build a new agency and develop some new approaches. In my work with this organization, I am viewed by staff as somewhat of an expert and have been given quite a bit of power to inform policy and clinical services. Now that I am in a position to inform policy development / implementation I wish to do so in a manner that fosters collaboration between clients, staff, managers, and directors. It is my goal to design policies that are supportive, empowering, and inclusive. It is also my objective to include the voices of the clients.

Research Significance

The goal of this research is to gain insight into both oppressive and enhancing experiences of people accessing residential addictions services in order to inform policy development at residential centres, particularly New Horizons Recovery. A review of the literature on this topic showed that research is very sparse. An investigation of what little research could be found indicated that almost all policy in this field is developed by the professionals involved in the agencies, the owners of the institutions, or governing bodies. Most policy seems to be based on the opinions of paraprofessionals and professionals making judgements about what clients need. One particular project called “Nothing about us without us” (Jürgens, 2005) addresses the absence of client voice in its exploration of the services offered to illicit drug users and its inclusion of their perspectives in its report. What appears to be lacking in

my particular field of study is client participation in policy development in residential addictions services. It is my hope that this research can be used to change this.

The need for new ways to develop policy is also evident in the region where this research took place. In Surrey, B.C. there are more than seventy unregistered unlicensed recovery houses. These houses are not regulated by any governing bodies. They do not have to follow any healthcare guidelines or ethical codes. Headlines such as “Unregulated addiction recovery homes targeted by Surrey in wake of hockey mom's murder: Officials want to clamp down on the drug dealing and other crime often associated with them” (The Vancouver Sun, January 2014), and “OD deaths in private drug recovery homes: Probe” (CTV News, December 2012) are a common occurrence in local media speaking to the severity of the problem in this region. The facility where this research took place is located in Surrey, B.C. The lack of training, experience, and resources available to staff and owners of recovery facilities in Surrey may be contributing to the difficulties occurring in them. There are many other factors at play. Having collaborated with several different recovery houses over the years, I have found that owners are often embroiled in addiction themselves or fall back into it while operating their houses. The City of Surrey is taking steps to regulate these facilities and close down houses that present risk to clients and communities. Although it is not the primary goal of this research, it is possible that it could provide insights for other facilities to use in developing their own anti-oppressive policies as well as inform the requirements of governing bodies such as the Ministry of Social Development and Social Innovation, Community Care and Licensing, and the Assisted Living Registry.

Chapter 2

Literature Review

Kovach (2005) states that while historically the aim of mainstream research methodologies was to benefit society, “the exclusion of ways of knowing from the perspective of marginal groups thwarted the abundant possibilities of what knowledge could encompass” (p.22). She goes on to say that “within the realm of research and its relationship to the production of knowledge, this absence of voice is significant and disturbing” (p.21). Kovach (2005) suggests that “emancipatory research seeks to counter the epistemic privilege of the scientific paradigm” by centring the voices of the marginalized (p.21). This literature review seeks to counter the epistemic privilege of the scientific paradigm in the chosen field of inquiry by uncovering the ways in which the voices of men accessing residential addictions services are excluded from predominant research and policy developed from it. Thorne (2008) states that “the kind of literature review that will best support an interpretive description is one that grounds the study within existing knowledge, offers critical reflection on what exists and what does not, and offers commentary on the strengths and weaknesses within the overall body of knowledge” (p.61). This literature review pertains to the subject of policy development and implementation in residential substance use treatment. In particular three areas of literature are delineated, that address: the *prevalence of substance use* in Canada, *policy development* in substance use treatment, and the presence (or lack thereof) of *client engagement* in the development and implementation of policies at the agencies where they access substance use services. These categories are useful in my examination of the data in relation to the primary theme of anti-oppressive policy development and implementation in residential substance use services.

I have worked in the substance use treatment arena for over nine years and I do my best to stay abreast of the most current research in the field. I also conducted a thorough review of all

the literature I could summon in preparation for this research project. It is important to note that there was only one study I could find in my search of published texts, academic databases, internet search engines, and peer-reviewed journals that specifically focuses on in-depth qualitative interviews with men residing in residential substance use programs / facilities concerning their perspectives on the policies which govern the services they receive and participate in. This particular study gathered consumer feedback on their experiences accessing addictions beds in British Columbia from a nursing perspective. Due to this, there is very little evidence-based literature for review that compares to my study. This alone provides ample justification for my research.

Terminology - For the purpose of this study it is important to differentiate between recreational substance use and problematic substance use. *Recreational substance use* is defined as the use of psychoactive substances with reduced risk of negatively affecting one's health and life or other people's lives (Stokols, 1992). *Problematic substance use* is defined as either *abuse,* a "pattern of recurrent use where at least one of the following occurs: failure to fulfill major roles at work, school or home, use in physically hazardous situations, recurrent alcohol or drug related problems, and continued use despite social or interpersonal problems caused or intensified by alcohol or drugs" or *dependence* where "at least three of the following occur in the same 12 month period: increased tolerance, withdrawal, increased consumption, unsuccessful efforts to quit, a lot of time lost recovering or using, reduced activity, and continued use despite persistent physical or psychological problems caused or intensified by alcohol or drugs" (Statistics Canada, 2012). When discussing substance use within the scope of this thesis, I am referring to problematic substance use. *Residential addictions services* refer to facilities where individuals live while receiving services to address their problematic substance use. The term *recovery* is

used to describe the process or efforts engaged in by individuals experiencing problematic substance use to reduce or eliminate the harms caused by their use of psychoactive substances.

Prevalence of Substance Use

According to Statistics Canada in 2012, approximately 6 million Canadians met the criteria for a substance use disorder during their lifetime. Certain populations experience higher substance use rates than others including, but not limited to: Indigenous peoples (especially those in remote regions) (National Aboriginal Health Organization, 2014), queer communities (Gillespie & Blackwell, 2009), homeless individuals (Substance Abuse and Mental Health Services Administration, 2003), those experiencing mental illness (National Alliance on Mental Illness, 2014), and other marginalized groups. Marginalized groups are overrepresented in addictions services. This will be explored further in the study.

Policy Development

The therapeutic community model of residential addictions treatment is premised on utilizing the knowledge and experience of individuals whom have ceased problematic substance use to help others who are striving to do so. The therapeutic community approach was formally conceived in 1946 by Thomas Main in his paper "*The hospital as a therapeutic institution*" (Main, 1946). In 2000, De Leon published a report called "*The therapeutic community: Theory, model, and method"*. This report contained his ideas about what a modern therapeutic community is, what theory it is based on, and how to go about constructing one.

Flynn, Knight, Godley, and Knudsen (2012) presented the findings of twelve studies designed to gather information on the "interplay between nested agents operating within organizations and external influences, with an emphasis on implications for organizational functioning, innovation adoption, and client outcomes" (p.111). These studies looked at: staff

retention/turnover, program structure, operations, costs, training, innovation adoption, certification, organizational change, organizational factors, and client outcomes. They found that funding, accreditation, and financial resources / management affected service provision quality and the facilitation of new innovation. Organizational contextual factors influence staff turnover, attitudes towards training, organizational functioning and organizational change. Leadership seems to impact the adoption of innovation, while a broader attitude of openness among staff and management appears to effect staffing stability. Organizational health, such as staff stability / turnover, had implications for organizational outcomes and client outcomes.

Forman, Bovasso, and Woody (2001) conducted a study of staff beliefs about addiction treatment in the United States of America. Their survey of 317 staff members revealed that,

> More than 80% of respondents supported increased use of research-based innovations, 12-step/traditional approaches, and spirituality in addiction treatment, while only 39% and 34%, respectively, endorsed the increased use of naltrexone and methadone maintenance... 35% of respondents indicated that confrontation should be used more, and 46% agreed with discharging noncompliant patients... individuals with more formal training tended to be less supportive of confrontation and more supportive of the increased use of medications. (Forman et al., 2001, p.1)

McCarty, McConnell, and Schmidt (2010) collated the findings of several studies presented in four papers spanning multiple domains of policy research in the field of addictions treatment in the United States. All of the research was funded by an initiative called the Substance Abuse Policy Research Program (SAPRP). The four papers articulated priorities in policy research for tobacco cessation and control, drug abuse prevention, alcohol abuse

prevention, and addiction treatment. This research was designed to inform the "(a) organization and delivery of care, (b) quality of care, (c) evidence-based practices, (d) access to care, and (e) financing, costs, and value of care" (p.87) of tobacco, drug, and alcohol prevention and treatment services / organizations. They report "there is little research on the organization, financing, and management of addiction treatment services, particularly as it is changing over time" (p.88). In terms of quality of care, the focus needs to shift from a static approach measuring certification and counsellor qualifications towards process implementation and performance measures. They suggest that research into developing policies for widespread implementation of evidence-based practices is necessary. McCarty et al. (2010) present that policies need to be developed promoting the inclusion of those who need treatment but do not seek it, and specificity in terms of different populations (i.e. youth, adult women, or Aboriginal groups). They propose that there is a demand for cost-effectiveness analysis, as well as cost-benefit analysis for treatment services and recovery medications.

Luty and Rao (2008) conducted a survey of staff views on addiction treatment policy in England. They gathered data from one hundred and eighty participants representing a range of roles within the addiction treatment arena. Their primary focus was the exploration of views on a government policy shift allocating more resources to the treatment of illicit drug users (especially offenders) and less to the treatment of alcohol users. They found that 11% of respondents believed "government targets for treatment of illicit drug users has had a beneficial effect on the provision of alcohol treatment services"... but, by contrast, "53% endorsed the view that government targets for treatment of illicit drug users has had a disastrous effect on the provision of alcohol treatment services" (Luty and Rao, 2008, p.118). They suggest that while funding and services for alcohol treatment have increased for illicit substance users, funding and

services for alcohol users has not. In concert with this, alcohol and illicit drug use treatment services have been merged (Luty and Rao, 2008). They propose that this has had a negative effect on the treatment of alcohol dependence and abuse.

Client Engagement in Policy Development

The World Health Organization states that "governments should support the creation and/or strengthening of mental health service user and families organizations... such groups are in the best position to highlight problems, specify their needs, and help find solutions to improving mental health in countries and have a crucial role to play in the design and implementation of policies, plans, laws and services" (WHO, 2015, p.1).

Campbell and Davidson (2009) provide an examination of how mental health law, policy and organizational arrangements lead to coercive practices with service users. They critically analyze the formal and informal ways that coercion is used to obtain compliance with mental health service users. Campbell and Davidson (2009) found that "despite the promise of a contract between the state and its citizens, all too often the rights of those who were subject to the physical and psychological harshness of the institution were disregarded" (p.251). They also suggest "the views that service users have of their experiences of coercion may be just as important to this discussion as those of the received ideas of professionals" (p.252), but noted that they were absent in the predominant literature on the subject. Their final conclusion proposes that "if service users are listened to and treated with respect, even when they are being coerced, their perception of the mental health social work intervention may not be as damaging as it might be... this in turn could help in the service users' recovery process and strengthen their present and future sense of trust in professional decision making" (p.252).

Brun and Rapp (2001) conducted a review of consumer informed research in the development and delivery of social work case management services. They discovered that "one of the reasons for the dominance of person-blaming interventions [is because]... the people we seek to help have not been judged to be important informants or collaborators in the execution of research" (p.280). Brun (1997) in Brun and Rapp (2001) conducted a meta-analysis of 54 studies on the efficacy of social work interventions and found that little data was collected from the actual recipients of the interventions. Brun and Rapp (2001) went on to conduct a qualitative study with ten men receiving strengths-based case management for addictions aftercare treatment. The main themes reported by the participants were "I can make it" and "I didn't know nobody cared that much" (p.283).

Wilkinson, Mistral, and Golding (2008) conducted a study of both client and staff views of the most and least useful aspects of residential addictions rehabilitation in the UK. Semi-structured interviews were conducted with fourteen clients and twelve staff members and thematic analysis was used with the data. Several themes emerged as important to clients. These included:

- Residential treatment representing a safe place to get well, with removal from a risky, harmful environment or individuals.
- Group work, feeling closer to others, getting feedback, support, and understanding in a non-judgmental way which contributed to a sense of therapeutic community.
- The 12-Step program, particularly Steps 1 and 2 about uncontrollability and hope of recovery providing a theoretical basis for understanding and combating addiction, along with cognitive strategies for relapse prevention.

- Counsellors or key workers who were understanding, non-judgmental, and who provided educational advice and practical assistance were deemed most helpful.
- The quality of the support network upon discharge, and an understanding family, were seen by some as the most important factor in maintaining recovery.

Participants also spoke about valuing the quality of the relationship with their key worker, the attitudes of the key workers towards rehabilitation (particularly 12-Step), and the practical assistance they received in dealing with the process of admission (p.408).

Lopez-Goni, Fernandez-Montalvo, and Arteaga (2011) conducted a study of treatment participant drop-out rates in substance use programs. They gathered and analyzed data on socio-demographical information, substance consumption patterns, personality variables, and psychopathological factors to draw correlations that could potentially predict treatment drop-out rates. With drop-out rates reaching as high as 80% in treatment programs, the authors proposed that this information could be used by clinicians to increase client retention. The study included 122 participants (84 program completers and 38 drop outs). The authors used EurpoASI, SCL-90-R, and MCMI-II assessment tools to gather data on participants. Lopez-Goni et al. (2011) found that significant differences existed between program completers and drop-outs in their "employment situation, the substance that motivated treatment, the MCMI schizotypal personality dimension, and EuropASI variables related to employment, alcohol abuse, and family problems" (p.80).

Jürgens (2005) summarizes the findings of the joint project between the Vancouver Area Network of Drug Users (VANDU) and the Canadian HIV / AIDS Legal Network aimed at involving people who use drugs in the services and programs that affect their lives as well as advocacy and policy work on HIV / AIDS and HCV. The project identified several imperatives

indicated by VANDU members including the need for the Canadian government and other organizations to include the more marginalized groups living with HIV / AIDS in their work, the idea that drug users themselves are often the best sources of information when it comes to identifying public health imperatives affecting this population, and the ethical perspective that "all people should have the right to be involved in decisions affecting their lives" (Jürgens, 2005, p.4). The project identified several barriers detracting from greater involvement of drug users in service planning and delivery. Firstly, drug use is predominantly viewed as a legal problem and should be seen as a health issue instead. Secondly, ongoing efforts to criminalize illicit drug use and drug users undermine public health efforts. Lastly, stigmatizing people who use drugs undermines their human rights and acts as a barrier to involvement responding to the HIV / AIDS epidemic. The authors state that the following supports are necessary to support more meaningful involvement of drug users in HIV / AIDS services development and delivery:

- Explicit recognition of drug user organizations such as VANDU by Health Canada and the Public Health Agency of Canada
- Capacity building and funding initiatives for existing and new groups of drug users
- Support for "innovative and/or model projects and programs" of drug user groups; and
- Funding of a national group or network of drug users (p.6)

The project also gave birth to several policy and practice strategies for creating greater involvement of drug users in the discussion, creation, evolution, and delivery of HIV / AIDS services in Canada and potentially worldwide.

The Mental Health Commission of Canada (2012) undertook a project called '*Changing Directions, Changing Lives*' to develop the first national mental health strategy Canada has seen. The goal of this work is to 'bring mental health out of the shadows' and create recognition that

mental health is an indispensible part of overall human health. The commission determined that "a key driver behind its development has been the testimony of thousands of people living with mental health problems and illnesses" (MHCC, 2012, p.8). Service providers, researchers, and policy experts also added their voices to the endeavour to identify challenges within our current mental health paradigm and develop strategies to address them. *Changing Directions, Changing Lives* is the second part of a strategy born from a report published in 2006 called '*Out of the Shadows at Last*'. *Out of the Shadows at Last* (2006) calculated that "in any given year, one in five people in Canada experiences a mental health problem or illness, with a cost to the economy of well in excess of $50 billion". The authors also discerned that only one in three adults and only one in four children or youth that experience a mental health problem or illness have received services or treatment. *Changing Directions, Changing Lives* (2012) extrapolated six strategic directions necessary to address the current deficits in our mental health system. The first focuses on the need to "promote mental health across the lifespan in homes, schools, and work-places, and prevent mental illness and suicide wherever possible" (MHCC, 2012, p.11). The second aims to "foster recovery and well-being for people of all ages living with mental health problems and illnesses, and uphold their rights" (MHCC, 2012, p.11). The third calls for government, agencies, and communities to "provide access to the right combination of services, treatments and supports, when and where people need them" (MHCC, 2012, p.11). The fourth speaks about reducing "disparities in risk factors and access to mental health services, and strengthen(ing) the response to the needs of diverse communities and Northerners" (MHCC, 2012, p.11). The fifth addresses the need to "work with First Nations, Inuit, and Métis to address their mental health needs, acknowledging their distinct circumstances, rights and cultures"

(MHCC, 2012, p.11). The sixth talks about mobilizing leadership, improving knowledge, and fostering collaboration at all levels (MHCC, 2012).

Crombie (2011) conducted a study on the experiences of people accessing addictions facility beds. In her research she explored these experiences and generated five themes from the interviews she conducted. She found that "individuals are the best authority on their care and their needs, that there are many challenges in gaining access to supports for problematic substance use, that flexibility and creativity of the system while still letting people know what to expect are qualities highly valued by individuals accessing the system, and that present and previous experiences affect future experiences accessing care" (Crombie, 2011). She offered five suggestions on how these themes could be utilized in improving residential resources offered to people utilizing them. She suggested that both staff and agencies stay informed of research being done in the field of addictions and implement it into their practice; staff should seek insight into how their behaviours affect others (clients); with increased health risks for the addictions population, nurses can have a positive impact by creating positive connections with clients; agencies should build transparent and easy to access / use services; and society as a whole should advocate to a greater degree for quality services.

Discussion of Literature in Relation to the Topic of Inquiry

The literature on the topic of policy development and implementation at the service delivery level is diverse. Flynn, Knight, Godley, and Knudsen (2012) present several recommendations for agency structure and policy development from an administrator's perspective. They did not include any recommendation for client inclusion in this process. McCarty, McConnell, and Schmidt (2010) discuss the findings of a national research project studying the full range of services and service delivery in publicly funded addictions services in

the United States. They conclude that more research needs to be done to develop policies that can be used universally. They also argue for the inclusion of service user perspectives in this research, as well as the voices of those who may need the services but do not access them. I appreciate the recommendation for client and potential client inclusion in this, but I am wary of the universal approach to service delivery. Each population is different and each group and individual within that population requires consideration. Campbell and Davidson (2009) completed a study exploring the experiences and needs of mental health clients accessing government run services; in particular, how coercion is used to elicit compliance from clients mandated to follow treatment orders. They argue that "the views that service users have of their experiences of coercion may be just as important to this discussion as those of the received ideas of professionals" (p.252), but noted that they were absent in the predominant literature on the subject. Although this is a slightly different population, the mental health and substance use services systems are very similar and overlap significantly in terms of clientele, treatment methods, and organizational structure. Due to this, Campbell and Davidson's (2009) argument for client inclusion supports the need for it in residential addictions services policy development as well. Brun and Rapp (2001) conducted a similar study and found similar results. Their exploration of the causes and effects of person blaming interventions in mental health case management can be attributed, in part, to the lack of client consultation by service providers. Wilkinson, Mistral, and Golding (2008) did consult clients as well as staff in their research, but their focus was on treatment outcomes rather than policy development. If clients are deemed worthy and capable of offering input on the therapy they receive, it makes sense that they should be asked for feedback on the policies they are subject to as well. In his work with the Vancouver Area Network of Drug Users and the Canadian HIV / AIDS Legal Network, Jürgens (2005)

concluded that “all people should have the right to be involved in decisions affecting their lives” (p.4) and service users, regardless of their socioeconomic status, should have the opportunity to inform the services they use and need. The findings of this research provide a strong argument supporting both the ability and the value of substance using people in offering input on service and policy development. The Mental Health Commission of Canada (2012) successfully demonstrated the need and usefulness of service users informing service development and implementation. Their work in *Changing Directions, Changing Lives* (2012) was a precedent setting approach that relied significantly on the voices of thousands of people with mental illness and their experiences both within and against the mental health system of care. This work did not speak directly to the topic of client-informed policy development in residential facilities, but it did show the value of client input in working towards addressing serious systemic flaws. Crombie (2011) used a qualitative approach to explore the experiences of people accessing addictions facility beds in western Canada from a nursing perspective. From this research she concluded that clients are the best authority on their own care. This assertion validates the need for and appropriateness of client consultation in designing and implementing policies governing their care.

Although there is plenty of client informed research on treatment outcomes, a review of research on policy development in residential addictions services showed only one study that included the voices of the recipients of these services. In studies on policy in residential addictions services, staff members and management personnel are consulted. Although she did not focus on policy development, Crombie’s (2011) research demonstrated the value of client consultation in developing recommendations for the addictions services they access. One of the strengths of the existing body of knowledge in this area is the care and concern implied by

measuring how well therapeutic interventions benefit clients accessing services. One of the weaknesses in the existing body of knowledge on policy development is the lack of consultation with clients. A brief survey of recovery facility websites shows a strong presence of top down policies (*see Appendix A for an example). It is not clear if these were developed with or without client engagement. What appears to be lacking in residential addictions policy research is the voices and input of the users of these services.

Chapter 3

Methodology

Exploring the experiences of individuals who have lived or are living in residential recovery facilities can provide us with rich descriptions of data that can be used to change how individuals are supported in these institutions. Exploring what kinds of residential experiences contributed to their sense of well-being, inclusion, growth, and freedom can shed light into how to intentionally create these in their current circumstances. Exploring what kinds of residential experiences contributed to situations where they were excluded, silenced, and abused can help illuminate ways to avoid reproducing these phenomena.

The methodological approach used in this study is interpretive description informed by narrative inquiry. Interpretive description can fit inside of a natural inquiry paradigm. Bailey (1997) explains,

> The term 'natural inquiry' reflects the initial work done by qualitative researchers. It implies the acquisition of knowledge in a manner other than empirical research. Interpretive or hermeneutical research, terms used interchangeably with natural inquiry, simply refer to the basic nature of qualitative work, that of interpreting meanings within the context of the natural environment. (p. 19)

This research was conducted in the context of the participants' natural environment and will, ideally, support them to manage this environment in a manner that helps them meet their individual and collective recovery goals.

Interpretive Description

The pioneer of interpretive description, Thorne (2008), proposes that researchers who seek to describe and interpret a phenomenon for clinical use, while recognizing the larger context within which their topic of interest is located, often use interpretive description. This

methodology was designed for use in healthcare settings by researchers / practitioners seeking to utilize client perspectives to improve practice or policy. For these reasons, interpretive description is ideal for this research project. Interpretive description stresses the importance of the researcher practicing reflexivity and self-location in relation to the phenomenon of interest (Thorne, 2008). It requires that researchers make explicit their "theoretical ideas" and "personal relationship to the ideas" (Thorne, 2008, p.64). In interpretive description,

> Findings reflect an interpretive manoeuvre within which the researcher considers what the pieces of data might mean, individually and in relation to one another, what various processes, structures, or schemes might illuminate about those relationships, and what order and sequence of presentation might most effectively lead the eventual reader toward a kind of knowing that was not possible prior to your study. (Thorne, 2008, p. 163)

Current residential addictions services often rely on paternalistic policy development and implementation models that exclude the voices of the recipients of these services. What this study seeks to know is how clients view the systems that offer these services and what manifestations of power encourage or limit clients' growth within these systems. Because interpretive description focuses on both the practical applications of the data gathered [policy development in a specific residential facility in this case] and the larger context within which the topic is located [the field of residential recovery services] it is well suited for this thesis. Data collection took place via individual interviews. Thorne, Reimer-Kirkham, and MacDonald-Emes (1997) explain "interpretive description acknowledges the constructed and contextual nature of human experience that at the same time allows for shared realities" (p.173). Given the individual

and community aspects of client experience in residential addictions services, interpretive description is ideal for exploring these dualities.

Narrative Inquiry

When exploring how to best go about forming interpretive descriptions I encountered the problem Levinas (1969) referred to as exercising ‘totalities’. ‘Totalitizing the Other’ occurs when we seek to understand / interpret / explain another’s experience or being through our own ideas, beliefs, and knowledge about what can and cannot be known. Levinas (1969) explains that we cannot avoid totalitizing the Other, but that to practice ethically is to take ownership of the ways that we do this and attempt to view the infinity of the Other – that which is outside of the known. Because interpretive description relies on interpretation by the researcher, totalitizing the experiences of the participants involved was unavoidable. I sought to use some aspects of narrative inquiry to counter this. Connelly and Clandinin (2006) define narrative inquiry in the following text,

> Arguments for the development and use of narrative inquiry come out of a view of human experience in which humans, individually and socially, lead storied lives. People shape their daily lives by stories of who they and others are and as they interpret their past in terms of these stories. Story, in the current idiom, is a portal through which a person enters the world and by which their experience of the world is interpreted and made personally meaningful. Viewed this way, narrative is the phenomenon studied in inquiry. Narrative inquiry, the study of experience as story, then, is first and foremost a way of thinking about experience. (p. 477)

Language is the medium by which we code our experience and stories are the means by which we invite others into our world. In order to minimize obscuring the Other via my own theorizing I attempted to make space for their stories. Carter (1993) suggests “the analysis of story is of central importance... as a framework for reorienting our conventional analytical practices and for attacking many of the basic issues of interpretation, meaning, and power we face” (p.11). Given that I am new to formal research as well as being raised as a Caucasian male in a White, Eurocentric, male-dominated world, it is important for me to challenge how I interpret meaning and power. Narrative inquiry provides the means to accomplish this. My desire in this research was to centre the stories and the themes described therein as purely as possible. With permission from the participants, I included pieces of the actual narratives given in my proposal of theories. It is also important to note something from experience in working with people in the field of addictions. In the early days of my practice I often tried to implement the theory being taught to me via mainstream post-secondary education in my interactions with clients. Much of the time I found myself teaching clients the language of the theory, showing them how it applied to them, and then encouraging them to generalize it to their lives. This was usually met with very limited success. What I have found over the years is that almost everyone can tell their story and most wish to do so. In my early practice, theory often created separation between the client and me. Because of how it gives license to the speaker to explain their experiences and ideas in their own words, utilizing narrative inquiry helped me avoid eclipsing the experiences of the participants with my own views.

The final piece of methodology borrowed from narrative inquiry is one that promotes social justice through changed identities. Clandinin and Huber (in press) suggest that,

> Through engaging with participants, narrative inquirers see themselves and participants as each retelling their own stories, and as coming to changed identities and practices through this inquiry process. Change also occurs when phenomena under study are understood in new ways and, in this way, new theoretical understandings emerge. In this midst, much possibility exists for social change, that is, for the creation of shifted social, cultural, institutional and linguistic narratives. (p.17)

As this thesis is focused on promoting social justice, the possibilities contained in the exchange of stories between the inquirer and participants were attractive for what I sought to accomplish. Saleebey (1996) explains "one of the characteristics of being oppressed is having one's story buried under the forces of stereotype and ignorance" (p.301). The social justice promoted in this research was an uncovering of these stories and identification of the forces of stereotype and ignorance that oppressed them. It would have been naive to believe that I would not be impacted by the participants' stories or that they would not be affected by my listening and exploring. While the goal of the research was to explore the experiences of men who have accessed residential addictions services, changing identities through the exchange of stories may have occurred for the participants; it certainly did for me. Although I cannot comment on what the participants took away from our exchanges, I was deeply touched. Seeing how these men used the services at New Horizons to improve themselves and their lives gave me a profound appreciation for the strivings of the human spirit to face pain, loss, and hopelessness and reach for something better.

Naturalistic Inquiry

Naturalistic inquiry promotes post-structural considerations in this research. At the heart of the problem are structures, in the form of institutions, utilizing universalities to control and manage peoples' lives. Rigid policies, uninformed by those governed by them, are often enacted to satisfy staff, managers, and directors' needs for control, stability, and uniformity. The "key axioms of naturalistic inquiry", such as those delineated by Lincoln and Guba (1985) provide post-structural constructivist underpinnings for research design, including:

> 1) There are multiple constructed realities that can be studied only holistically. Thus, reality is complex, contextual, constructed, and ultimately subjective.
> 2) The inquirer and the "object" of inquiry interact to influence one another; indeed, the knower and known are inseparable.
> 3) No a priori theory could possibly encompass the multiple realities that are likely to be encountered; rather, theory must emerge or be grounded in the data. (p.5)

These tenants of naturalistic inquiry were implemented to satisfy my desire to invite multiple realities into the conversation. I offered a starting point for interviews that allowed each participant to add their experiences to the data pool. This starting point focused on their experiences of residential services in the past and present. Although thematic analysis occurred, naturalistic inquiry was utilized as a means to counterbalance any positivist tendencies I may have tried to exercise given the many years of influence traditional research has played in my life.

Methods

***Setting* -** This research took place in a 30 bed residential recovery facility for adult men in Surrey, B.C. operated by New Horizons Recovery Services. It is a three floor house with

surrounding yard designed to house up to 30 clients with offices for staff and a group room for programs. It is shared accommodation. It is staffed by the executive director, a counsellor, a volunteer driver, and two client monitors. It offers housing, counselling, access to a doctor and nurses, and support with attending appointments such as probation, court, medical specialists, and other community resources. Clients attend psycho-educational and process groups each day during the week. The centre staff support participation in self-help groups such as Alcoholics Anonymous, but they do not require it as a condition of residing at the facility.

Sample **-** The population of interest for this research was adult men currently receiving housing, medical, counselling, and peer-support services at the New Horizons Recovery facility. The age range was 21 to 41 years old. Morse (1995) invites researchers to sample from the most predictable variations within the theme being studied, although, Thorne et al. (1997) caution that "the positions or experiences that each participant or informant might represent cannot be known until data collection is well underway" (p.173). Rather than exercise my own judgment of who may present points which can be used to represent maximum variance, I invited all who were interested to sign up with the understanding that only ten participants would be selected. Both Marshall (1996) and Nastasi (2004) suggest that a sample size of ten for this type of research is ideal. Polit and Beck (2004) define the method of convenience sampling. Convenience sampling "entails using the most conveniently available people as study participants" (p. 292).The maximum number of potential research participant candidates available at any given time in this facility is thirty as that is the maximum capacity of the facility where the research took place. I selected eleven participants because eleven volunteered for the study. Because it is an all male facility, only males were sampled. Convenience sampling has its advantages and disadvantages. One the one hand it expedites data collection, is easy to use, reduces travel and time costs

associated with more extensive sampling methods, and allows researchers to gather data from a specific location readily (conveniencesampling.net, 2014). On the other hand it can produce biased results, may not provide findings that are transferrable to larger systems, and may miss data that is important to the topic of inquiry but is not represented in the sample drawn (conveniencesampling.net, 2014). The primary aim of the research was to uncover themes that may eventually be used to develop policy for this facility. Because of this and the lack of need to generalize the findings to a larger system, this method of sampling seemed appropriate. The executive director gave permission for this research to be conducted at this facility.

***Recruitment* -** Recruitment for this project began with the executive director presenting the recruitment information and recruitment letters to the potential candidates at the New Horizons Recovery facility. She also left these on each floor of the centre (*see appendices for copies). She offered the following scripted conversation, "A MSW student named Mark Streibel from the University of Victoria is interested in doing a research project with clients of the New Horizons Recovery facility. It is called 'Exploring Experiences of Men Accessing Residential Addictions Services: Towards an Anti-oppressive Policy Development and Implementation Perspective'. He has prepared the following information letter and flyer. If you are interested in possibly joining the study please read through the letter and flyer and contact him using the phone number or email provided. If you have any questions about it once you read through the information letter, please feel free to contact him for more information. I will post a copy of the information letter and flyer on each floor of this facility". Eleven potential candidates contacted me over the next two weeks. Two participants contacted me by text and the rest expressed their interest while I was onsite, either just before or immediately following a scheduled interview. I scheduled times to come in and conduct individual interviews. At the beginning of each

interview I explained the voluntary nature of the research and the principle of ongoing consent which they could revoke at any time without penalty of any kind. I self-located in relation to the research and my interest in it and I invited questions about this self-location prior to describing specific aspects of the research. Absolon and Willet (2005) explain that "research conducted from a neutral or objective location is Eurocentric and is, therefore, unethical... Eurocentric writing can be avoided, however, if the writer reveals his or her epistemological location at the outset through a brief introductory autobiography" (p.107). This was my intention. Following this, I introduced the topic of my research and the details required for each potential participant to make an informed decision about whether or not they wanted to be a part of it. I explained the potential significance of it. I informed each participant that their participation or lack of it would not in any way affect the services they received. I reviewed the ethics and consent conditions. We discussed the interview process and I answered any questions each participant had about it.

Data collection **-** The data collection method used included a semi-structured interview. With interpretive description the purpose is to understand "how individuals and groups make meaning and act in situations in which automatic responses are inadequate" (Oliver, 2012, p.411). This departure from quantitative research ontology supports the social justice aspect of this research given its constructionist nature and respect for subjectivity. Donalek (2005) proposes that interview "questions should be brief and unambiguous and, at the same time, sensitive to the feelings of participants" (p. 124). He instructs that questions should be easily understood by all participants and valid to the topic of inquiry. He also infers that questions should be sensitive to the positions of the interviewees in order to avoid causing feelings of exclusion or judgment. I formulated my questions based on these recommendations. The following questions were used to guide the interview process:

1. What kinds of residential addictions services have you accessed?
2. In your experiences accessing residential addictions services here at New Horizons Recovery and elsewhere, what kinds of things did you find helpful in supporting you to reach your recovery goals?
3. Have you experienced any difficulties in accessing residential addictions services? Please describe.
   - Tell me about a time when you wanted to get support and didn't.
4. Have you had an experience(s) in which you received the support you needed to accomplish your recovery goals from a residential addictions facility?
   - Please describe what was helpful to you in this experience(s)?
   - What other supports would have been helpful to you?
   - Can you imagine what a person might do to make you feel supported? Please describe.
   - What might an organization do to make you feel supported?
5. Have you ever been denied residential addictions services or been asked to leave a facility against your will? Please describe.
   - What would have worked better?
   - If you were the staff in this instance, what would you have done differently than the staff members at the time?
6. Every residential addictions facility has rules / policies that govern what is and what is not acceptable behavior in the facility.
   - In your experiences, what rules / policies helped you achieve your recovery goals?
   - What rules / policies prevented you from achieving your recovery goals?

- If you had a voice in making policies at New Horizons Recovery Services what would you say?
- How would you want to be included in policy making at this centre?

7. Who should be involved in developing policy and why?
8. What do you think clients have to offer on this subject that staff and management do not?
9. What limitations does having client input in policy making present?
10. What limitations does having client input in policy implementation present?
11. In a perfect world, what would residential support for substance use problems look like for you?

These questions represented the structured part of the interview and were designed to bring to light encounters with oppression as well as encounters with enhancement experienced by the participants while accessing residential addictions services in the past and present. After the first two interviews were completed I changed the interview questions in the following ways (*see Appendix C for the revised list of interview questions). Question 10 was changed to “In a perfect world, what would residential support for substance use problems look like for you?” I found that in the first two interviews, participants did not seem to respond to the original Question 10, stating that they already answered it in Question 9 despite an explanation of the difference offered by the researcher. Question 11 became “How should residential centres respond to drug use?” Both of the first two respondents focused on this at some point during their interviews and it seemed important given that drug use by clients often results in discharge from recovery centres. A twelfth question was added, “What else do you think is important for policy makers to consider or know about this topic?” In both the first and the second interviews, the participants had more to share beyond what was discussed in answering the interview

questions. Given this common occurance, I thought it important to offer a formal invitation for the rest of the participants to do so if they wished.

Polit and Beck (2008) affirm that in this type of interview “researchers let participants tell their stories, with little interruption” (p. 392). During the interviews I focused on providing space for the participants to share their stories, and transitioned from question to question only when they seemed finished with the last. I attempted to limit redirection or interruption on my part and attempted to seek clarity throughout as a means of connection and validation.

Ethics

When doing research it is important to recognize and address potential harms and benefits to participants. It is important to consider possible emotional harms, social implications, consent to participate, full disclosure, and confidentiality. This research included confidential personal interviews that took place in a secure private office space at the New Horizons Recovery facility as well as one that took place in the home of a recent client of New Horizons.

Emotional harms including but not limited to feelings of stress, anger, fatigue, sadness, and powerlessness resulting from the participants sharing potentially distressing experiences from their lives were identified as a possible consequence of participating in the study. This possibility was explored with them during the consent process prior to the interview. Participants were informed that they may pause, stop, or end the interview anytime they wished. I made provisions with the counselling staff at the centre to offer counselling support if the participants requested it. Having provided counselling services to populations of this type in the past, I offered my time during or following each interview should participants require immediate emotional assistance. None asked for it.

Service exclusion including agencies making services inaccessible to participants in the future was / is a risk if clients' negative experiences of these agencies were shared and become public knowledge. Participants could also face stigmatization by other parties in their lives if their identities were published. During the recruitment stage I utilized an information letter (*see Appendix E) that offered an explanation of the ethical measures in place including a review of the following sections from the research participation consent form (*see Appendix D). The following excerpts are taken from the information letter used to recruit participants for this study:

> ***Benefits and risks of participating***
>
> The potential benefits of your participation in this research include an opportunity to have your voice and life experiences contribute to a thesis that will become part of the knowledge base on the topic. This research contributes knowledge that is vital to building and managing better residential addictions services. The findings of this study may be used to develop and revise the services and policies at New Horizons Recovery. It may also help other agencies and facilities approach the people that use their services to improve them.
>
> Potential risks may include: feelings of discomfort from speaking about previously or currently distressing life experiences; and disruption of services should you disclose information that you have recently harmed yourself or others or are in danger of harming yourself or others.
>
> ***Voluntary participation / confidentiality and anonymity***
>
> Your participation in this research is completely voluntary. If you decide to participate, you may withdraw at any time without any consequences or any explanation. If you do withdraw from the study it will be your decision whether any or all of the data that you provided in the interview may be used in the research. With

your permission, this interview will be digitally recorded. If, during the course of the interview, you choose to withdraw, the digital recorder will be turned off. At this time, I will ask you if any or all parts of the interview may be retained as part of the research. If you do not want your interview included I will destroy the recording. Participation in part or in full or lack of participation in this research will in no way impact the services you are currently receiving or may receive in the future from New Horizons Recovery Services unless you disclose that you have recently harmed yourself or others or may do so in the future. I will take every step possible to protect your confidentiality and anonymous participation in this study. I will not disclose who is participating in this study or any personal information you share while doing so with anyone unless you disclose that you have recently harmed yourself or others or may do so in the future. Neither the executive director nor your counsellor will have access to this information unless you choose to share it with them unless you disclose that you have recently harmed yourself or others or may do so in the future. The interviews will be held at the New Horizons Recovery facility or at another location of your choosing after staff have gone home for the day. Participants must not be under the influence of substances while consenting to participate in this study and during the interview."

Participants were also informed of the relevant ethical guidelines that I, as a Registered Social Worker in British Columbia, am expected to adhere to. This included an explanation of the following excerpt from the CASW Code of Ethics (2005):

1.6 Protection of Vulnerable Members of Society

> *1.6.1 Social workers who have reason to believe a child is being harmed and is in need of protection are obligated, consistent with their provincial/territorial legislation, to report their concerns to the proper authorities.*
>
> *1.6.2 Social workers who have reason to believe that a client intends to harm another person are obligated to inform both the person who may be at risk (if possible) as well as the police.*
>
> *1.6.3 Social workers who have reason to believe that a client intends to harm him/herself are expected to exercise professional judgment regarding their need to take action consistent with their provincial/territorial legislation, standards of practice and workplace policies. (p.8-9)*

I explained to the participants that in any of the above cases that I may need to break confidentiality and inform the necessary professionals or services (i.e. police, MCFD, or New Horizons management) to ensure that the participants' safety and the safety of other involved parties was supported.

Analysis

Before meaningful analysis can occur a starting point is necessary and ethical analysis demands a deconstruction of the researcher's preconceptions about this starting point (Thorne, 2008). This study was designed to explore the value of client participation in policy development and implementation in residential addictions services. It was born from distress I experienced as a clinician involved in residential addictions services who, at times, was asked to execute agency policies in different situations, some of which I believe negatively affected the clients they were aimed at. From this, I was inspired to embark on the exploration of this topic with clients who access residential addictions services. A thorough investigation of literature on the topic discovered a gap in knowledge which further necessitated this research. Analysis begins occurring prior to entering the

data collection phase. What can and cannot be known within the study is determined by the method and means by which the data is sought. Thorne (2008) mentions that “from the outset of your study, you are not collecting data as much as you are constructing an understanding of what constitutes data and how you will articulate it as such” (p.123). I designed a set of interview questions to ask the participants about their thoughts and experiences in residential addictions services. My goal was to increase both the reader’s and my understanding of client experiences in order to inform policy development and implementation for these services. My primary preconceived notion in this is that most clients accessing these programs and facilities want to be included in this process. This is my analytic starting point.

***Data analysis framework* -** Thorne (2008) suggests that an effective initial encounter with data analysis “involves making accurate records and spending time to be immersed in those records, developing a sense of the whole beyond the immediate impression of what it is that they contain” (p.143). Following this advice, I shelved my desire to jump right into identifying themes and spent time listening and re-listening to the interview recordings. I then applied Morse’s (1994) four cognitive processes of qualitative analysis. Morse (1994) articulated four sequential cognitive processes that are useful precursors to the kinds of conceptualization that interpretive description requires (Thorne, 2008). These processes include comprehending, synthesizing, theorizing, and recontextualizing.

The first process, comprehending, consists of making sense of the data by listening to the interviews, transcribing interviews, reading and re-reading through them, and checking and correcting the data. It involves identifying and coding the data for important items such as description of concepts and discovery of meanings (Morse and Field, 2002).

The second process, synthesizing, requires a careful sifting through the data in order to get a feel for the people, setting, and context. It involves a description of the norms and context of the setting and it includes the gathering of key themes and stories while accounting for any variations in

the data and the identification of unusual events, attitudes, and behaviours (Morse and Field, 2002). This phase involves comparing and contrasting the data between participants to determine links and relationships that may or may not exist in relation to the subject matter of the topic of inquiry (Morse and Field, 2002).

The third process, theorizing, involves interrogation of the data for explanations and forming different theories to explain them until the best theory emerges (Morse and Field, 2002).

The final process, recontextualizing the data, requires the researcher to generate a conceptual framework which is suitable to transfer to other populations and settings in the related area of practice (Morse and Field, 2002).

Analysis began with the first process, comprehending. The framework I used to accomplish this consisted of me listing the interview questions for each respondent then transcribing their responses to each one (*see Appendix G for an example). I also included comments offered that fell outside of the scope of the questions. I completed the comprehending process by writing a brief summary of the interview of each participant (*see Appendix G for an example). I coded the participants and the data. Participants were labeled Respondent with an assigned letter attached to protect their confidentiality. The questions acted as a means to code the data for each respondent and the responses given to them were collated with other respondents' responses in the synthesizing process.

I continued into synthesizing the data. As per Morse's direction I explored the setting, context, and people involved in the study (Morse and Field, 2002). The following was discovered:

Research setting – In my work consulting with staff at this agency as well as in the research interviews the following was noted about the research setting. New Horizons is an all male, adult recovery centre. It is a newly built house on a small piece of property in the heart of Surrey, B.C. The facility acts as a recovery house with therapeutic programming including: psycho-education groups, discussion groups, and process groups all facilitated by a trained counsellor with a counselling

diploma, 12 step groups, and acupuncture. The men reside in the facility and it is very much their home. Many of the men are referred there by the courts and are required to reside at the facility and follow the rules as part of their probation, community sentence orders, or bail orders. Each client pays rent. This is usually covered by the Ministry of Social Development and Social Innovation. The clients take responsibility for all the cleaning of the facility and yard, all the cooking, doing their own laundry, and all the tasks of daily living. The facility assists them in accessing a house doctor, accessing medications, transportation to appointments such as probation and court, and transportation to Alcoholics Anonymous and Narcotics Anonymous meetings if they choose to go. New Horizons covers the cost of food, bills, and rent as well as supplies men with donated clothing as it arrives. Many of these men would be homeless if not for recovery facilities like New Horizons. There are a total of 30 beds on three floors at New Horizons. The men are placed on restrictions for the first 3 weeks. They cannot leave without staff, they cannot have cell phones, and they must attend all programs offered by the counsellor (unless they are sick) during this restriction period. They are each given chores and asked to keep their personal living space in a neat and tidy manner. The counsellor is on-site Monday to Friday from 9:00am until 5:00pm. Two clients are given the opportunity to be house monitors and take a leadership role in monitoring curfews, chores, group attendance, intake procedures, and medication management. These monitors are appointed by the facility counsellor or executive director, but have the freedom to decline if they do not wish to occupy the role.

Context - The study was presented as an opportunity for clients to share their experiences with accessing residential addictions services including New Horizons. They were informed that the research may help shape policy and how it is delivered at New Horizons in the future.

The context of their day to day lives at New Horizons is unique to each individual. How they experience life there varied with each individual I interviewed. Some reported experiencing it as the ideal place to meet their living and recovery needs while others reported dissatisfaction with many elements of it. Some saw it as a requirement of remaining out of jail while others viewed it as a place

where they could change the course of their life. Some saw the rules and policies as restrictive and unnecessary while others saw them as an effective framework which facilitated a better way of living. Many viewed their stay there as somewhere in-between the above descriptors and others as well.

Participants - The population of interest for this study was men currently residing at the New Horizons Recovery facility in Surrey, BC. As this research is aimed at informing policy development and implementation at this site, canvassing the residents of the facility seemed the most appropriate way to gather relevant data. Thorne (2008) states that "in some instances, a sample created entirely by convenience is quite appropriate, in that the group of people that are closest at hand may well be an excellent source of insight for… a phenomenon" (p.89). At the time of this study's recruitment of participants the total population available was 17 clients. The suggested sample size promoted was 10 participants (please see methods for reasoning). Of these 17, 11 participants volunteered for this research. For the sake of inclusion, the researcher decided to interview all 11 volunteers. In doing so, the recruitment and participation goals were exceeded. 10 participants were current clients of New Horizons and one was a recent resident who heard about the study prior to discharging from the program. Recruitment began with the facility manager / counsellor hosting an information group in which she read a recruitment script, presented a recruitment flyer and information letter, and posted a recruitment flyer and letter on each floor of the facility. The first participant contacted the researcher by text using the number posted in the information letter. The recently discharged client contacted the researcher via the same method. All other participants approached the researcher while he was onsite either prior to or just after he completed a participant interview. They heard about his interview schedule by word of mouth from the participants being interviewed. All participants, with the exception of the recently discharged client, chose to use the confidential interview space provided onsite at New Horizons for the interviews. The recently discharged client opted to have the interview at his apartment in Surrey, BC. The interviews ranged in duration from 14 minutes and 31 seconds to

65 minutes and 10 seconds in length. Most of the participants applied to attend New Horizons from jail. A few were self-referrals who heard about the centre from friends or acquaintances at the centre or otherwise involved in the recovery community in Surrey. One came from a treatment centre. The participants varied in ages from 21 to 42 years of age. 6 were Caucasian, 3 had Aboriginal ancestry with 2 of these 3 identifying as Aboriginal / Caucasian, one identified as Métis. One identified as Asian / Canadian. All of them were born in Canada. Their experience with substance use spanned from 1.5 to 34 years in duration. Two reported their current stay at New Horizons as being their first experience with residential addictions services. On the other end of the spectrum, one client reported that he had accessed residential addictions services (detoxification centres, treatment centres, and recovery houses) 28 times. Consistent with findings presented in the literature review, several marginalized populations appear to be overrepresented in this research. For example, in my study, over one third of the participants identified as Aboriginal and Métis compared to 3.75% in the general population (Statistics Canada, 2006). Similarly, approximately one third of participants disclosed living with mental illness, while it is assumed that in the general population only 15% live with mental illnesses (CAMH, 2012). According to staff, all of the men residing at the facility are experiencing poverty compared to 13% of adult males in the general population (Statistics Canada, 2013).

Table 1 - Participant demographics

Participants	Age	Self-Identified Ethnic Background	Country of Origin	Length of Time Involved in Substance Use	# of Times Accessing Residential Addictions Services
Respondent D	32	Asian / Canadian	Canada	15 years	6
Respondent E	21	Métis	Canada	9 years	8
Respondent F	38	Caucasian	Canada	23 years	5
Respondent G	33	Caucasian	Canada	20 years	4

Respondent H	24	Caucasian	Canada	9 years	1
Respondent I	29	Aboriginal	Canada	2 years	1
Respondent J	21	Caucasian	Canada	9 years	26
Respondent K	42	Aboriginal / Caucasian	Canada	34 years	5
Respondent L	26	Caucasian	Canada	14 years	7
Respondent M	21	Caucasian	Canada	1.5 years	2
Respondent N	41	Aboriginal / Caucasian	Canada	28 years	28

All of the interview transcripts were reviewed to identify common themes between recipients as well as outliers, with the furthermost outliers determining the boundaries of the themes. I summarized the themes and their frequency of report as well as the outlying responses and collated these under each interview question (*see Appendix H). This was the first stage of synthesis. In the second stage I revisited the thesis questions and synthesized the themes identified in the first stage of synthesis in response to these questions (*see Chapter 4 - Findings).

In the third analysis process, theorizing, I speculated on what the data meant and formulated theories based on these speculations. Each theory was arrived at based on the frequency of themes reported. Each theory is grounded in the data with direct examples from the interview transcriptions offered in support (*see Chapter 5 – Discussion of Findings).

The final analytic process, recontextualizing, took the form of recommendations for both policy and process changes at New Horizons. These recommendations were also generalized in structure so they could be used at other residential addictions resources as well (*see Chapter 6 – Recommendations and Conclusions).

Limitations of the Study

There were several limitations of this research including: sample size, predictive power, gender homogeneity, context, and scarcity of resources. Given the small sample size of eleven participants there was limited representation of ethnicity, socioeconomic status, cultural and spiritual beliefs, and age. The total potential population consisted of 17 men. This presented limits in terms of recruitment, although, in my experience, this sample is generally representative of the types of clients that access recovery houses in the B.C. lower mainland region. Validity of this is confirmed by the multiple encounters with different residential addictions services reported by many of the participants.

Second, due to the subjective nature of human experience, it is difficult to generalize the findings beyond the participants that took part in the study. I structured the interview questions to include the participants' global experiences with residential addictions services in an attempt to elicit data that reflected common themes encountered by clients in these settings. Recommendations for ongoing consultation with clients by service providers are suggested in Chapter 6 to continually evolve policies to suit each cohort.

Third, the study took place in an all male facility which limits the perspectives and resulting recommendations significantly to suit this gender.

Fourth, the findings and recommendations of this study must be viewed within the context in which they were gathered. Thorne (2008) states "the conclusions we draw on the basis of our interpretive description research, therefore, must always reflect respect for the context within which they were derived" (p.206). The recommendations may be a fit for the participants that contributed their insights to the research that produced them, but this is just a snapshot in time of an ever changing landscape.

Although part of a debate much larger than the scope of this study, it is important to note the inherent lack of resources offered to men both at this site and within the wider scope of addictions services in the lower mainland of B.C. Gathering information to inform policy development and implementation offers interesting potential, but it may not significantly increase the amount of resources offered to these men to address their recovery goals.

Chapter 4

Findings

***"Just try to see where I'm coming from and what I'm going through and try to help me with that"**, (Respondent L)*

The striving of interpretive description, primarily, is to "generate a species of knowledge that captures commonalities within human subjective experience at the same time as it allows us to think about individual variation" (Thorne, 2008, p.185). Thorne (2008) states that we develop this "general knowledge, not because it represents truth, but because it allows us to grasp and communicate about patterns within human behaviour more effectively so that we may make better informed choices" (p.185) about how to go about our work as professionals. The phenomena of interest in this study include exploring the value of client participation in residential addictions policy development and implementation, reviewing the policies currently being used at New Horizons Recovery Services from clients' perspectives, and developing theories and recommendations for policy development at this facility and others of the same service delivery model. Several themes were discovered in relation to the thesis questions.

What value is there in engaging clients in policy development at the sites where they access services?

The immediate stakeholders in residential addictions services are clients, staff, management / owners, families / loved ones of clients, and funders. Although only one of the four directly involved parties was consulted in this research, namely clients, valuable insight was gained. The following themes emerged:

- Clients have an understanding of what it is like to be living in the facility whereas staff and management do not.

- Clients have an experiential perspective of what it is like to receive services, what it is like to be asked / required to follow the rules, and what is going on inside the facility that staff do not know about (i.e. drug use and other policy violations, relationship dynamics, and life challenges of other clients).
- Clients have an understanding of and compassion for each other that staff and management do not because of the similar histories and common experiences that they share with other clients.

How do clients engage with policy development and how is policy enacted in practice?

When accessing services at New Horizons Recovery as well as most other residential addictions resources participants attended they are required to sign a contract upon admission. This contract lists the rules of the facility and signing an agreement to follow them is a condition of receiving services. Most places list the consequences that the facility reserves the right to administer should clients break the rules. This is usually the first contact clients have with policy. Clients coming from jail are often required to sign this contract prior to being released to the facility. Although the question was not explicitly asked, none of the study participants disclosed being included in the policy development / implementation process before this study. In my experience as a residential addictions clinician, client's accessing residential services are required to agree to adhere to facility / program policy, monitored throughout the length of their stay to see if they do, and made subject to consequences by staff or management if they do not. As this research is aimed at exploring the inclusion of clients in policy development and implementation, several of the interview questions were designed to elicit responses regarding what participants thought the best way to go about this would be. Several themes emerged from

the data collected from participants regarding engagement in the policy development / implementation process:

- All participants disclosed being the subject of policies, but none reported being included in how they are made or enacted.
- Clients want to be involved in the policy making process.
- Clients should have some input, but staff and management should make the final decisions about which policies are implemented or changed.
- Several participants mentioned being discharged from programs or otherwise disciplined for not adhering to policies and believed that if they would have "fought" to stay or not receive the discipline that they might have been able to change the outcome of the situation.

What residential addictions services policies and policy implementation support clients to accomplish their recovery goals and what policies and policy implementation impedes this?

Supportive policies –

According to the study participants, the most common supportive policies are:

- Mandatory group / individual counselling sessions.
- Policies that enable clients to access medical doctors and medications by providing staff to arrange appointments, a house doctor, and assistance in retrieving and administering medications.
- Policies which provide a set structure in the form of a daily routine including: wake up times, chores, meal times, program times, onsite meetings (AA / NA), curfews, and lights out times.
- Set rules including: no drug use on property, no violence, and no threatening behaviour.

- Restrictions including: remaining onsite for the first 21 days after intake (except when accompanied by staff for appointments or errands), a graduated pass system (starting with one day pass after 21 days onsite, then two day passes after 28 days onsite, then one overnight pass after 35 days onsite, and full weekend and evening passes after 42 days onsite), no cell phones for the first 3 weeks after intake, and no employment during the week until the full 6 week rotation of counselling groups and topics are completed.
- Policies that support clients to attend AA / NA meetings in the community if they choose by providing meeting lists and a volunteer staff driver to escort them.
- A policy that enables clients to stay after they relapse so long as it happens off of property and consequences are enacted putting the person back on restrictions, but calls for discharge after either the second or third incidence of drug use.
- A policy that directs staff to refer clients to other residential recovery resources if they are being discharged.

Impeding policies –

The following themes emerged as the most common unsupportive policies by study participants:

- Policies requiring clients to engage in mandatory religious practices that are not congruent with clients' own spiritual philosophies and practices.
- Being required to wait for access to residential addictions resources when a person makes the decision to reach out for help.
- Policies that discharge clients for using while accessing residential addictions services regardless of the circumstances or contributing factors (especially when no referral is made to another residential resource).

- Behaviour focused policies that do not take into account underlying factors like mental health challenges or situational stressors (i.e. zero tolerance for confrontational behaviour, zero tolerance for smoking, and zero tolerance for minor crimes like theft or breach of curfew).
- Policies that prevent or limit clients from accessing physical fitness resources while residing at recovery facilities.

Interpretive Description of Findings

Clients of residential addictions services in the lower mainland want to be seen as people equal in value to the rest of society. They do not want to be seen as incompetent or unworthy of inclusion in the decisions that affect their lives while in residential addictions services. Clients recognize that they have perspectives that other stakeholders do not and these have value in informing policy development and service delivery. They understand that they are afflicted with a problem that affects their judgment and behaviours and they want structure and comprehensive services to help them increase control of their thinking and change their behaviours. They rely on facilities to provide boundaries and assistance for them and prefer that the management and staff of these facilities do so in an understanding, supportive, egalitarian fashion.

Chapter 5

Discussion of Findings

Findings in Relation to the Literature

Thorne (2008) suggests,

> Determining which ideas constitute the appropriate level of importance for further discussion requires that you understand the nature of your research question, the knowledge community from which the question arose, the construction of your data, and also the interpretive processes through which you transformed them into findings. (p.194)

There are three main themes identified in answering the thesis questions that I will discuss in relation to the literature. First I will discuss the value of client involvement in policy development and implementation. Secondly, I will explore client engagement in these processes. Lastly, I will speak about what clients see as supportive in assisting them to reach their recovery goals.

The value of client involvement. As the primary reason for the existence of residential addictions services, clients' needs are of paramount importance in deciding how to best go about structuring these services. Clients are best positioned to explore and communicate their needs to service providers.

In 2006, the Mental Health Commission of Canada (MHCC) came "to recognize the reality that profound change is essential if persons living with mental illness are to receive the help they need and to which they are entitled" (p.2). The Commission recognized that understanding the experiences of those living with mental illness and addiction was vital to the success of this endeavour. This finding is similar to those found in my study. Clients reported

wanting to be involved in the policy making and implementation process and how they have useful and unique perspectives to share regarding the policies that they are required to adhere to.

Crombie (2011) conducted a study of adults accessing addictions beds in healthcare facilities in British Columbia. She found that clients are the experts on their own needs and are well positioned to inform their care. Although my study did not produce this finding specifically, it did find that clients believe they have valuable input when it comes to their own care and they wish to participate in how that care is delivered. The findings suggest that clients have a healthy awareness of the dangers of trusting their own thinking entirely and would like to access services where staff can help them mediate these dangers.

Jürgens (2005) in his work with the *'Nothing About Us Without Us'* project proposes that "fundamental changes are needed to existing legal and policy frameworks in order to effectively address injection drug use as a health issue... people who use illegal drugs must be meaningfully involved in all these initiatives" (p.3). Although the project focused on healthcare and harm reduction services such as safe injection sites, methadone maintenance programs, and needle exchanges, the participants are very similar to those in my study in terms of drug use, underlying psychological distress, and marginalization. Jürgens (2005) also reports that,

> People who use illegal drugs have demonstrated they can organize themselves and make valuable contributions to their community, including: expanding the reach and effectiveness of HIV prevention and harm reduction services by making contact with those at greatest risk; providing much needed care and support; and advocating for their rights and the recognition of their dignity. (p.4)

This speaks to the value of client participation in collaborating with service delivery partners. Similar to Jürgens (2005), my research also found that clients are both capable and

willing to participate in policy making and implementation and they have insight that no other stakeholder possesses.

Brun and Rapp (2001) conducted a study on the efficacy of strength-based case management with substance users and found that clients were able to guide their clinicians in how to best meet their needs when asked for feedback. In comparison to Brun and Rapp's (2001) research, participants in my study were also able to identify which services and policies were useful to them in helping them achieve their recovery goals. Most were able to articulate the reasons why as well.

Client engagement in policy development and implementation. Evidence of client engagement in policy development in residential addictions services is sparse in the literature. This alone justified the undertaking of this research project. It does present the challenge of comparison to the literature given the lack of potential works with which to engage its findings.

Wilkinson, Mistral, and Golding (2008) conducted a study of treatment outcomes for residential addictions services in the UK. They interviewed 26 clients and 13 staff. The manner in which they went about gathering and analyzing the data is similar to my study. They found that clients seemed to be quite forthcoming in their responses and clients that had been in treatment longer seemed to have more insight into what they needed to be successful in recovery. Although this research was focused on therapeutic outcomes, its methods are transferrable to the topic of policy research given the homogeneity of the populations of both studies. Based on this, it would seem that the most efficient way to engage clients in policy development is to ask them directly about what they need to be successful in their recovery efforts. Wilkinson, Mistral, and Golding (2008) also found "a number of clients commented that, although initially the rules made them feel like children, after a while they could see they had been complaining

unnecessarily, indicative of their addictive styles of thinking" (p.408). Similarly, my research discovered that participants did not necessarily trust their own judgment at times or the judgment of other clients. They expressed concern that if clients were given too much power in the policy making process that many might try to abuse this power to engage in addictive behaviours. Almost all of the participants disclosed that they believed staff and management should have the final say in which policies are implemented and how.

Campbell and Davidson (2009) tackled the controversial subject of coercive practices in mandated mental health treatment programs. They found that if state power is to be exercised by social workers on their clients to coerce them to follow treatment orders then asking for and responding to the perspectives of the clients helped in mediating the damage done by this use of force. Although it is not the focus of my study to examine the use of coercion in residential addictions services, Campbell and Davidson's (2009) work is a useful comparison given how it seeks to study how clients engage with policy implementation. Client engagement with services at New Horizons Recovery is voluntary, but it is important to note that many advocate for themselves to go there as a condition of being released from jail sooner than they would have without this condition. As with Campbell and Davidson (2009) my research found that clients preferred to be asked for their input into services that they accessed. I found that clients preferred to be asked both in a confidential one-to-one manner as well as in a group with other clients and staff present what their thoughts and ideas were regarding policy effectiveness and changes.

Supportive policies in residential addictions services. Having established both the need for and value of client participation in developing and implementing policies in the residential addictions services they access the next step became which policies in particular are effective in helping clients meet their recovery goals.

Wilkinson, Mistral, and Golding (2008) passed on several useful aspects of residential rehabilitation services reported by clients of these services. These included treatment representing a safe place to get away from substance use, the effectiveness of counselling and support to access 12 step groups, and the compassionate connection experienced with other clients in treatment. My study also found interview participants valued policies that promoted a safe clean and sober living environment removed from the drug using lifestyle. Also paralleling the findings of Wilkinson et al. (2008), participants in my research expressed their belief in the effectiveness of counselling services as well as 12 step programs. Several participants also talked about the value of feeling understood by other clients. Perhaps due to the focus on policy, participants in my research spoke more about the importance of structure and rules that helped define the boundaries between recovery and addiction.

Crombie (2011), in her study of adults accessing treatment beds, found clients disclosed needing ready and easy access to addictions services when they asked for help. They reported the relationship between clients and staff as being an important determinant of success in reaching their recovery goals. Crombie (2011) also spoke about “the need to treat addictions care as chronic disease management rather than as acute care management” (p.73). My research found that clients reported having easy access to residential addictions services when they asked for help as important in making positive changes in their lives. More than one respondent shared that the window to access recovery services is small when someone struggling with problematic substance use reaches out for help. 10 out of 11 participants mentioned that they valued having the support of a counsellor to work on their recovery goals. Participants also spoke about the need to continue to provide services even when clients relapse into substance use. This parallels

Crombie's (2011) finding that addiction treatment needs to be viewed from a chronic health concern management perspective rather than an acute condition or one-time treatment event.

Proposal of Theories

The purpose of my research was to garner an understanding of the value of client participation in policy development and implementation to inform policy making practices at New Horizons Recovery. Thorne (2008) shares that we (clinicians),

> Work within the world of studying instances and integrating what we learn about them with our reflective clinical reasoning process, searching for underlying meanings that might further illuminate what is happening and develop a deeper appreciation toward what would ultimately be the optimal clinical response. (p.50)

Morse (1994) proposes that the point of research is to produce findings that "support established knowledge and theory, and to claim clearly new contributions" (p.34). To accomplish both of these objectives it is necessary for a researcher to venture into new waters and produce theories based on the findings of the research. The following theories were produced from this venture.

"The six weeks of restrictions helped me get my foot in sobriety".

(Respondent N)

Theory 1 - *Clients both want and need structure and rules to successfully achieve their recovery goals*. In reports given by several participants regarding experiences they had accessing unstructured recovery houses – problematic drug use, negative health outcomes, victimization, and increased criminal justice system involvement were experienced as a result.

"We should have the right to voice our opinion and have it be valid".

(Respondent D)

Theory 2 - *Clients are both capable and willing to engage in the policy development process*. Most residential addictions services in the lower mainland have policies which were developed and implemented by staff and management without input from clients. Although many positive outcomes were reported by participants who accessed these services, negative outcomes were also reported.

"Sometimes staff and management don't have addictions... co-clients know really what we're all going through with each other, and I think from one addict to another we know what the person can deal with". *(Respondent G)*

Theory 3 - *Clients have a unique perspective of residential addictions services that other stakeholders do not*. Because of their first hand experience living in the facility, clients have an understanding of what it is like to be required to adhere to policies as well as which policies are ineffective. Clients also have an insider status that makes them privileged to knowledge of what is going on inside of the facility that staff and management may not know about.

"The rules are good, just stick to them, no favouritism... some people get away with things".

(Respondent M)

Theory 4 - *Policies and practices are not always aligned in residential addictions services*. There are often discrepancies between how policies are written and how they are implemented. Clients prefer fairness and find policies that they may not like easier to accept if they are delivered fairly and impartially.

"There would be people that want unrealistic and crazy things".

(Respondent E)

Theory 5 - *Client engagement in policy development has the potential to be both beneficial and dangerous*. Almost all participants stated that clients should have some input in policy development because they have a unique perspective as service users. Several participants reported that some clients may try to manipulate the collaboration process to enact policies that detract from residential addictions services ability to support clients to meet their recovery goals in favour of "the easier softer way" (Respondent N). Participants seemed to fear that if clients were given too much power in the process that they would create policies which allowed for behaviours associated with addiction and crime.

"There has to be more to do... I know it's hard because the money's not there, but... school training, job training, life-skills training and job opportunities".

(Respondent F)

Theory 6 - *There is a direct correlation between funding and adequacy of services*. A lack of funding and staff hinders many residential addictions resources from providing the level of support that clients want and need. More funding to provide 24 hour staffing, better food, clothing, more programs (like anger management counselling, acupuncture, yoga, and life-skills training), recreational facilities, and second stage housing is needed.

"There is certain people that come here and you know they are not going to last and you're wondering what they're going to do while they're here that's going to cause issues for other people".

(Respondent H)

Theory 7 - *Life in a residential addictions facility can be chaotic*. The constant turnover of clients being admitted and discharging, clients accessing services with severe and persisting

untreated mental disorders, drug use, theft, arguments and threats, and difficulty accessing community resources can cause distress for many clients.

“You’ve got a person who’s decided to come here and has made a slip, you’ve got to almost respect that and expect those kinds of occurrences... a certain level of compassion is needed when addressing those situations”. *(Respondent I)*

Theory 8 - *Drug use is a common occurrence in residential addictions facilities and is a part of the recovery process for most clients*. Most participants shared that abstinence from substance use was their goal, but almost all of these participants acknowledged that substance use occurs regularly and should be viewed as an expected part of the recovery process. Arbitrarily discharging clients for using can alienate them from the services they need to address their problematic substance use.

Chapter 6

Recommendations

My aim has been to observe, record, and interpret participants' subjective experiences with policies in a residential addictions service in the lower mainland of B.C. This research was designed to explore the value of including the voices of residential addictions services users in policy development and discern what policies help them achieve their recovery goals and what policies do not. The following recommendations are suggested to implement a client informed policy making model at New Horizons as well as other facilities offering similar services.

General Recommendations

Thorne (2008) suggests,

> The world of application draws inspiration and often useful insights from its dance with the theoretical world, but at the same time refrains from fully committing to the relationship because the everyday practical problems towards which it is directed demand that at least one foot be firmly placed on the solid grounding that there is a 'real world' to be dealt with. (p.201)

A review of literature on the subject revealed that the 'real world' of residential addictions services has excluded the voices of the clients of these services in policy development and implementation. The following recommendations are suggested to rectify this.

a) Because of their insider experience as service users, clients should be included in the policy making process.

b) Client feedback should be gathered by the primary clinicians responsible for implementing policies in order to check for integrity between theory and practice.

c) The final decision for policy creation and change should rest with qualified experienced staff and management.

d) Government and non-profit funders should audit residential addictions services to identify those with the potential to utilize more funding effectively and provide these services with more financial resources.

e) Increased funding and resources for co-occurring disorders treatment, better screening protocols, 24 hour staff onsite, more programs, increased counselling staff, more drivers and vehicles to take clients to appointments, second stage housing, and recreational resources are required to make residential addictions services more effective in serving the populations that access them.

f) Abstinence-focused services should be provided for clients seeking abstinence, but policies should be designed to recognize relapses of substance use as a part of the recovery process and provide supports accordingly. Staff and management should consider each problematic substance use occurrence on a case-by-case basis and continue to provide support with increased restrictions for the clients involved if they wish to continue to access services.

Recommendations for Policy

Recommendations for current policies at New Horizons. The data suggests most of the policies at New Horizons serve the clients that access them well in achieving their recovery goals. The following policies should remain in place unless further review by clients, staff, and management in the policy development collaboration process determines they are no longer useful.

- Violence will not be tolerated and may result in discharge from the facility should staff and management determine that reconciliation between all affected parties is not possible or further harm is probable.

- Threatening behaviour is not allowed and staff will attempt to support the involved parties to find alternative ways for them to interact more successfully.
- Clients are required to remain abstinent from all substances unless prescribed by a physician; substance use (including alcohol) on the property may result in discharge from the facility (to be determined by staff).
- Urine drug screen testing is required of clients when staff deem it appropriate.
- Policies which provide a set structure in the form of a daily routine including: wake up times, chores, meal times, program times, onsite meetings (AA / NA), curfews, and lights out times should be continued.
- All new clients should be put on restrictions for the first 3 weeks at New Horizons; passes are granted on a gradual basis (one day pass after 21 days, two day passes after 28 days, one overnight pass or two day passes after 35 days, and full weekend and evening passes after 6 weeks at New Horizons unless substance use occurs).

Recommendations for policy changes at New Horizons. This research suggests that in order to implement a client-informed policy development model the following changes should be made to existing policies at New Horizons Recovery Services.

- Clients should be allowed to have their cell phones after 3 weeks following intake to New Horizons.
- Substance use off of the property should result in clients being put on 3 weeks of restrictions; clients should most likely be discharged from the program if they use prohibited substances more than twice during their stay (this will be considered on a case-by-case basis by staff and management with consideration being given to the health and wellbeing of the client as well as the recovery needs of the other clients at the facility).

- All clients being discharged should be referred to another suitable recovery resource should they desire it.
- Clients should have access to the onsite gym once daytime programming is finished so long as it does not interfere with their chores or mandatory onsite evening meetings (suggested access time - 3:30pm until 9:00pm on weekdays, and open from 9:00am to 10:00pm on weekends).
- Clients should have a chance to speak about their experience and wishes when encountering situations that may result in them receiving consequences.
- Clients waiting to access services at New Horizons should be given a list of community resources such as AA / NA meeting lists and community services information that they can utilize to begin the recovery process if they wish. Due to funding constraints, email should be used whenever possible to accommodate this.

Recommendations for Process

The second level of initiative in the policy making and delivery process involves the implementation of a system by which ongoing client, staff, and management consultation and collaboration can occur. It is suggested that staff and management conduct a bi-annual review of all policies within the organization with clients. The preferred method of gathering feedback is to hold a staff led discussion group with the clients. One-to-one confidential interviews should also be held with clients. It is suggested that staff and management use these methods to gather feedback when any new client-focused policy is being considered. Clients should be provided with a forum to discuss ongoing issues within the house once every two weeks. It is proposed that staff ask clients if they would prefer staff facilitate the group or have it be peer led. Peer led groups should elect a spokesperson to bring feedback forward to staff to incorporate into service

delivery. An anonymous complaint system should be implemented and all new clients should be informed of its existence and function.

Recommendations for Further Research

Thorne (2008) states that,

> All research ends with a consideration of what the next logical steps might be if we are to advance knowledge in this field even farther, and explicitly what it is that the new study has contributed that may inform future inquiries. (p.206)

This research represents an initial step in engaging clients in shaping the residential addictions services they use beyond therapeutic outcome measures. Much more needs to be done. Although there is plenty of research on staff and management views of addictions services policy, Flynn, Knight, Godley, and Knudsen (2012); McCarty, McConnell, and Schmidt (2010); and Luty and Rao (2008), there remains a need for research with families, partners, and others personally invested in clients who access residential addictions services regarding what they see as beneficial for the clients they have a connection with. It may be useful to conduct research with all parties who have a stake in residential services outcomes.

Given my power to influence policy making and implementation at this site, I chose to focus on laying the foundation for a client-informed policy development model. According to herising (2005), “a central component of critical research practice within marginal communities is to interrogate and challenge the various fields of power, authority, and privilege” (p.133) that operate within and around them. This study sought to increase client power by giving them a voice in the policy making process. Only a cursory glance at the roles of power holders and dynamics of how authority is exercised was taken in this work. A deconstruction of the systems of power that operate and govern residential addictions services like New Horizons to determine

points of transgression could be fruitful in increasing the emancipatory capacity of the clients that use them.

Although this study was successful in gathering client feedback regarding policies and developing processes to include this feedback in practice at New Horizons, more research is required if we are to see how this changes their ability to achieve their recovery goals. Longitudinal observation is needed to identify the efficacy of the client informed policy development and implementation model.

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Appendices

Appendix A – EXAMPLE OF CURRENT RESIDENTIAL SERVICES POLICY MODEL

TwoTen Recovery Inc. - Policies

1. All housing fees are due on the 1st of the month. If a resident moves from the house under emergency circumstances prepaid service fees remaining shall be refunded on a pro-rated basis. Any failure by resident to pay fee's when due, or failure to comply with any other of the conditions of this agreement allows TWO TEN Recovery Inc. to immediately void this agreement. Any infraction of the house rules may result in the immediate termination of the tenant agreement and expulsion from the house, and forfeiture of any tenant fees.

2. Curfew: All residents who are working will be expected to return to the house by 12.00a.m. Sunday - Thursday and Friday & Saturday. One needs specific permission to leave any earlier than 5:00 am. or return after curfew. THERE ARE NO EXCEPTIONS SO LEAVE IN GOOD TIME TO MAKE IT BACK TO CHECK IN. Curfews are designed to help our residents change behaviors and learn new skills.

3. New Arrival Curfew: All new residents will return to the house by 10:30 p.m. every day. Attaining employment immediately will directly benefit each resident. (min. 30 days and max. 90 days)

4. Medication:
TWO TEN Recovery doesn't dispense medication.
NO NARCOTIC MEDICATIONS ARE ALLOWED WHILE LIVING IN HOUSE.
Policy prohibits taking mind altering medication. Residents sharing, misusing or receiving medication will be terminated without question. All medications need to be entered in medication log.

5. Drug and Alcohol Use: Occupancy is made available on the strict understanding that the house is to be, at all times, drug and alcohol free. Should a resident use any illicit drug, consume alcohol, or take drugs not prescribed by a physician, the resident will be discharged immediately from the house. In addition, guests or visitors of a resident who are under the influence of any type of mind altering substances are not permitted, at any times, in the house or on the grounds. Protecting and/or knowing a fellow resident is drinking or using may be cause for immediate dismissal.

6. House Liability: TWO TEN Recovery is not liable for any personal property during or after the resident's discharge from the house. Personal property left for 30 days from discharge date will be removed from the premises. TWO TEN Recovery Inc. assumes no responsibility for the personal property of the resident.

7. Payment Plans: Payment plans will be written for all residents that are $200.00 or more in arrears in program fees. They will be written by housing coordinator and client together. Once resident agrees to plan and signs the document, the document will be enforced. All pay stubs are to be shown to housing coordinator.

8. Without director's written permission no resident will:

- Install paneling, flooring, built in decorations, partitions or railings
- Drill or attach anything to the floors, walls or ceiling of the house
- Bring in any dish washing, heating, ventilating, or air conditioning units, or any water filled furniture
- All personal property not belonging to Recovery Inc. is subject to insurance at resident's expense
- Put in any shades, blinds, window guards, and in or outside of the premises
- Permit the accumulation of refuse in the residential unit.

9. No loud music.MP3 Walkman type radios allowed. Loud and excessive noise disturbs other residents and will not be tolerated. The TV's will only be played at reasonable volume levels and violation of these rules will be considered disruptive behavior. Have respect for your neighbor.

10. Visitation: No visitors except for male sponsors and male spiritual advisors. Women are only allowed at the property if they are a family member. NO UNSUPERVISED CHILDREN ON THE PROPERTY AT ANY TIMES. Visitors must sign in and out with the House Manager. (only in common areas)

Appendix B: PARTICIPANT DEMOGRAPHICS

Please fill out the following information. This information is for statistical use only and any identifying information will be changed to respect your anonymity.

Age: _____________

Ethnic background(s): ________________________________

Country of origin: ______________

Number of months or years involved in substance use: ______________

Number of times accessing residential addictions services, including – detoxification centres, treatment centres, and recovery houses: ______________

Appendix C: INTERVIEW GUIDE

1. What kinds of residential addictions services have you accessed?

2. In your experiences accessing residential addictions services here at New Horizons Recovery and elsewhere, what kinds of things did you find helpful in supporting you to reach your recovery goals?

3. Have you experienced any difficulties in accessing residential addictions services? Please describe.
   Tell me about a time when you wanted to get support and didn't.

4. Have you had an experience(s) in which you received the support you needed to accomplish your recovery goals from a residential addictions facility?
   Please describe what was helpful to you in this experience(s)?
   What other supports would have been helpful to you?
   Can you imagine what a person might do to make you feel supported? Please describe.
   What might an organization do to make you feel supported?

5. Have you ever been denied residential addictions services or been asked to leave a facility against your will? Please describe.
   What would have worked better?
   If you were the staff in this instance, what would you have done differently than the staff members at the time?

6. Every residential addictions facility has rules / policies that govern what is and what is not acceptable behavior in the facility.
   In your experiences, what rules / policies helped you achieve your recovery goals?
   What rules / policies prevented you from achieving your recovery goals?
   If you had a voice in making policies at New Horizons Recovery Services what would you say?
   How would you want to be included in policy making at this centre?

7. Who should be involved in developing policy and why?
8. What do you think clients have to offer on this subject that staff and management do not?
9. What limitations does having client input in policy implementation present?
10. In a perfect world, what would residential support for substance use problems look like for you?
11. How should residential centres respond to drug use by clients?
12. What else do you think is important for policy makers to consider or know about this topic?

Appendix D: CONSENT FORM

Research Study:
Exploring Experiences of Men Accessing Residential Addictions Services: Towards an Anti-oppressive Policy Development and Implementation Perspective

You are invited to participate in a research study entitled: Exploring experiences of men accessing residential addictions services: towards an anti-oppressive policy development and implementation perspective. Mark Streibel is the primary researcher in the study. I am a graduate student in the School of Social Work at the University of Victoria. I have also acted as a clinical consultant to New Horizons Recovery Services by helping them design the clinical program, policies, and daily schedule that you currently use. For the purposes of this research project my role is to be a researcher conducting a study as part of my MSW thesis requirements. The information you provide will be analyzed and recommendations will be given to the executive director of this facility to change the policies in place here. It will be done so in such a way that any information you share that could be used to identify you or identify you as a participant of this study will be kept confidential to you and I. Exceptions to confidentiality are listed in the voluntary participation and participant anonymity and confidentiality sections below. You may contact me if you have questions: by email at Streibel@uvic.ca; or by phone or text at: _______________. As a graduate student, I am required to conduct research as part of the requirements for the degree of Master of Social Work. It is being conducted under the supervision of Dr. Leslie Brown. You may contact my supervisor at lbrown@uvic.ca.

Research Goals

The goal of this research is to identify what conditions are present when adult men feel supported, empowered, included, valued and respected or, conversely, when adult men feel excluded, discriminated against, devalued, or traumatized when accessing residential addictions services. The reason this knowledge is sought is to include clients in the building and management of services and rules that will assist them in reaching their recovery goals. In order to do this I will ask participants who are clients at New Horizons Recovery about their experiences with addictions services including those offered at New Horizons Recovery.

Research Importance

Research of this type is important because clients are not usually consulted about how programs and rules are made in the facilities that they live in. It is vital that clients are consulted directly so that we may research the impact of programs and rules on individuals accessing substance use services, and potentially use this knowledge to design better residential services. In addition, this research will make a contribution to the knowledge taught in universities about addictions services and the people that use them.

Research Benefits

The potential benefits of your participation in this research include an opportunity to have your voice and life experience contribute to a thesis that will become part of the knowledge base. Your input makes an important contribution to society, as it ensures that clients of this residential treatment program are represented in research that may shape future policy. Following the interview you may contact me to review your transcripts to ensure that they are accurate and

reflect the information you wish to convey in your interview. If there is information you wish to clarify, or remove because of inaccuracy, we will make these changes at that time.

Possible Inconveniences and Risks to Participants

Participation in this study may cause some inconvenience to you because of the time required to participate in the interview (approximately 1 hour.). If you choose to participate, it is my hope that you find our time together meaningful and productive.

There are some potential risks to you by participating in this research.

There is a chance that you may experience emotional discomfort, as I will be asking questions that relate to your drug use and possibly unpleasant experiences you have had with residential addictions services. To deal with these risks the following steps will be taken in the event that you experience discomfort: If at any time you experience discomfort during the interview you may request that the interview stop and it will be stopped. We will not proceed until you wish to do so. If any question causes you discomfort, you are free not to answer. If I suspect that you are experiencing undue discomfort during the interview I will ask you if you would like to stop the interview. Please feel free to contact me for de-brief following the interview. If you would like referral to available helping services in your local area I will provide you with that information to the best of my ability.

It is possible that you could have your access to services or stay at New Horizons Recovery Services withdrawn or subject to conditions if you disclose that you have recently harmed yourself or others or are in danger of doing so in the future as I may be required to report this to the executive director of New Horizons Recovery Services, the police, or MCFD. If you disclose that other clients or staff at New Horizons Recovery Services are harming themselves or others, I may also have a duty to report this.

Voluntary Participation

Your participation in this research is completely voluntary. If you decide to participate, you may withdraw at any time without any consequences or any explanation. If you do withdraw from the study it will be your decision whether any or all of the data that you provided in the interview may be used in the research. With your permission, this interview will be digitally recorded. If, during the course of the interview, you choose to withdraw, the digital recorder will be turned off. At this time, I will ask you if any or all parts of the interview may be retained as part of the research. If you do not want your interview included I will destroy the recording. Participation in part or in full or lack of participation in this research will in no way impact the services you are currently receiving or may receive in the future from New Horizons Recovery Services unless you disclose that you have recently harmed yourself or others or may do so in the future. In this case the researcher has a duty to report this danger to other parties so that your safety and the safety of others can be protected. These other parties may include: the executive director of New Horizons Recovery Services, the police, or MCFD. Participants must not be under the influence of substances while consenting to participate in this study and during the interview.

Participant Anonymity and Confidentiality

In terms of protecting your anonymity, only I will be aware of your identity; this is necessary because you will be meeting with me, the researcher, for the interview.

Ensuring that all data references to your identity are removed will protect your confidentiality. A pseudonym will replace your name in the transcripts, and no reference will be made to place

names, service/organization names, or any other specifically identifying information that you might share in the interview. Email correspondence during the recruitment process will be kept confidential; emails will be deleted as soon as the correspondence is completed. If it is necessary to keep an email, I will copy the email into a word processor file that is password protected, and delete the email itself. All transcripts will be cleaned of identifying information and kept in a separate location from the consent forms, which will be kept in a locked filing cabinet in the researcher's home office.

There are some limits to confidentiality due to the size of the sample from which participants are drawn. I will conduct up to 10 interviews for the purposes of this qualitative research study. Though names and identifying information will be removed from the transcripts, it may be possible for others to identify participants through the experiences they tell or the position from which they speak. Participants will be drawn from the New Horizons Recovery Services facility. All efforts will be made to ensure the confidentiality of your information and your identity.

If you disclose that you have recently harmed yourself or others or may do so in the future, I am obligated to break confidentiality between us to ensure that you and / or others are kept safe. If you disclose instances of recent harm to yourself or others or planned future harm to yourself or others I will stop the interview and discuss my obligation to report this to others. These other parties may include: the executive director of New Horizons Recovery Services, the police, or MCFD.

How the Research Will Be Used

It is anticipated that the results of this study will be shared with others in the following ways: this study will be written up in the form of a master's level thesis and will be distributed to a supervisory committee, staff and other students. A copy will be kept in the University of Victoria library. The thesis will be accessible online through the *Theses Canada Portal*. Results may also be used for academic and conference publications. The thesis will be accessible to participants and members of the public. The findings of this research will be used by New Horizons Recovery Services to develop policies for this agency and the program.

Digital files from the interviews will be kept separate from consent forms, in locked cabinet in the researcher's home. Electronic copies of transcriptions (which will be cleaned of identifying information) will be kept in a separate file on the researcher's personal computer. They will be stored in a password-protected folder. Digital recorder files will be kept until the thesis is complete, submitted, and either accepted or denied. Consent forms will be kept until the thesis requirements are met. Digital files will be erased, and then disposed of once the above conditions are satisfied. Electronic files on the researcher's computer will be deleted. Consent forms and interview transcripts will be professionally shredded.

Individuals that may be contacted regarding this study include:

Mark Streibel, Principal Researcher Streibel@uvic.ca

Dr. Leslie Brown, Supervisor lbrown@uvic.ca

In addition to being able to contact the researcher and the supervisor at the above emails and phone numbers, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Associate Vice-President, Research at the University of Victoria (1-250-472-4545) or by email at ethics@uvic.ca.

Please circle Yes or No in response to the following statements:

1. I Agree to be interviewed by Mark Streibel Yes No

2. I Agree to be digitally recorded during this interview Yes No

3. I Agree that the data provided during the interview can be used in a master's thesis
Yes No

4. I am not under the influence of substances at this time and understand the nature of this research, what the research will be used for, the limits of confidentiality, and the potential benefits and risks associated with participating in this research
Yes No

Your signature below indicates that you understand the above conditions of participation in this study and that you have had the opportunity to have your questions answered by the researcher.

Name of Participant	Signature of Participant	Date
______________________	______________________	______________

Name of Researcher	Signature of Researcher	Date
______________________	______________________	______________

This section is only to be used in the event of early withdrawal from the interview

Please initial in the brackets beside the statement which meets you approval concerning how your information may be used.

I hereby give permission for the researcher to use the information given in the interview up to the time that I chose to withdraw [ ]

I revoke consent for the researcher to use any information given during the interview and during the recruitment process [ ]

Appendix E: INFORMATION LETTER

You are invited to participate in a research study entitled: Exploring experiences of men accessing residential addictions services: towards an anti-oppressive policy development perspective with adults accessing residential addictions services. My name is Mark Streibel and I am the principal researcher for this study. I am a graduate student in the School of Social Work at the University of Victoria. As a graduate student, I am conducting this research as part of the requirement for the degree of Master of Social Work. I have also acted as a clinical consultant to New Horizons Recovery Services by helping them design the clinical program, policies (rules), and daily schedule that you currently use. For the purposes of this research project my role is to be a researcher conducting a study as part of his MSW thesis requirements. The information you provide will be analyzed and recommendations will be given to the executive director of this facility to change the policies in place here. It will be done so in such a way that any information you share that could be used to identify you or identify you as a participant of this study will be kept confidential to myself except in the event that you disclose information of potential harm to yourself or others. Participants will have the opportunity to engage in a one hour audio-recorded interview where they will be asked about their experiences and thoughts about rules and policies in residential recovery services including New Horizons Recovery Services.

Research Objectives

The first goal of this research is to identify what conditions are present when adult men feel supported, empowered, included, valued and respected or, conversely, when they feel excluded, discriminated against, devalued, or traumatized when accessing residential addictions services. The second goal is to gather information about the best ways to go about including your voices in the development of services at New Horizons Recovery.

Information Gathering Method

In order to explore this subject I will conduct interviews. The direct participation of individuals through in-person interviews is essential so that first hand information can be gathered and included in the development of services including the rules that clients are expected to follow while staying at New Horizons Recovery. Potential participants for this study must be over the age of 19 years, male, self-identify as having experienced problematic substance use, currently reside at the New Horizons Recovery facility, and not be under the influence of substances at the time of consenting to participate in the research and undertaking the interview. If you agree to voluntarily participate in this research, your participation will involve a digitally recorded interview with the researcher, Mark Streibel. The interview will last approximately one hour and can take place at a time and location convenient for you. This interview will consist of a series of open-ended questions, which are designed to guide the conversation between us.

Research Significance

Research of this type is important because clients are not usually consulted about how rules are made in the facilities that they live in. It is vital that clients are consulted directly so that we may research the impact of policies on individuals accessing substance use services, and potentially use this knowledge to design better residential services. In addition, this research will make a contribution to the knowledge taught in universities about addictions services and the people that use them.

Benefits and Risks of Participating

The potential benefits of your participation in this research include an opportunity to have your voice and life experience contribute to a thesis that will become part of the knowledge base on the topic. This research contributes knowledge that is vital to building and managing better residential addictions services. The findings of this study may be used to develop and revise the services and policies at New Horizons Recovery. It may also help other agencies and facilities approach the people that use their services to improve them.

Potential risks may include: feelings of discomfort from speaking about previously or currently distressing life experiences; and disruption of services should you disclose information that you have recently harmed yourself or others or are in danger of harming yourself or others.

Voluntary Participation / Confidentiality and Anonymity

Your participation in this research is completely voluntary. If you decide to participate, you may withdraw at any time without any consequences or any explanation. If you do withdraw from the study it will be your decision whether any or all of the data that you provided in the interview may be used in the research. With your permission, this interview will be digitally recorded. If, during the course of the interview, you choose to withdraw, the digital recorder will be turned off. At this time, I will ask you if any or all parts of the interview may be retained as part of the research. If you do not want your interview included I will destroy the recording. Participation in part or in full or lack of participation in this research will in no way impact the services you are currently receiving or may receive in the future from New Horizons Recovery Services unless you disclose that you have recently harmed yourself or others or may do so in the future. I will take every step possible to protect your confidentiality and anonymous participation in this study. I will not disclose who is participating in this study or any personal information you share while doing so with anyone unless you disclose that you have recently harmed yourself or others or may do so in the future. Neither the executive director nor your counsellor will have access to this information unless you choose to share it with them unless you disclose that you have recently harmed yourself or others or may do so in the future. The interviews will be held at the New Horizons Recovery facility or at another location of your choosing after staff have gone home for the day. Participants must not be under the influence of substances while consenting to participate in this study and during the interview.

How to Sign Up

If you would like to participate in this study please contact me via email or phone at the address or number written below. I would be very grateful for your participation in this study. Please contact me for further information, or to set up an interview.

Email: streibel@uvic.ca

Phone or text: __________________________

Thank you for your interest in this research!

Appendix F: RECRUITMENT FLYER

Interview candidates needed for research study on experiences of individuals accessing residential addictions services

You are invited to participate in this research if:

- *you are over the age of 19*
- *you self-identify as having experienced a problem with substance use*
- *you are currently residing at the New Horizons Recovery facility*
- *you are not under the influence of substances when consenting to participate and during the interview*

Participants will have the opportunity to engage in a one hour audio-recorded interview where they will be asked about their experiences and thoughts about rules and policies in residential recovery services including New Horizons Recovery Services. For further details or to arrange an interview please contact the researcher: Mark Streibel, University of Victoria graduate student. Phone or text: ____________________________.
Email: streibel@uvic.ca

Appendix G – ANALYSIS PROCESS 1 'COMPREHENDING'

Transcription Excerpt 1

Interview Question 5 -

Researcher: *Have you ever been denied access to residential addictions services or been asked to leave against your will?*

Respondent D: *I've been asked to leave a detox facility because um I uh pissed hot during a urine screening and they had suspicion that I was using pot on premises at ________ detox and um not denied though, denied residential services no, but to come back into the same detox facility I would have had to wait another 30 days before coming back, which is pretty much the general time frame if you screw up at any residential or addictions services type place they usually want 30 days depending on what case happened.*

Researcher: *Would you have preferred to stay at that facility?*

Respondent D: *Um definitely yup, I really liked ________ just because I had a sense of comfortability there and um the second place they referred me to was ________ detox. Oh yeah and another thing too ________ treatment centre also when I got the boot from there from a dirty urine screen they wanted me to wait 30 days to come back and they referred me to ________. Those are the only denials I had and that's cause of my own actions though right so it's fair enough.*

Transcription Excerpt 2

Interview Question 5 continued –

Researcher: *If you were staff in that instance what would you have done differently than they did?*

Respondent D: *Um they pretty much gave me a lot of options right, they put me in the shelter ________, gave me ________ days to sober up and to come back and pee clean you know they weren't um they weren't just booting me to the curb they stood there they were very supportive of my relapse and were pushing me to go to detox again and get back on my feet and try again so really I don't see how the staff would take care of that situation differently, I think they did the*

proper thing in discharging me and referring me to a different facility and giving me the opportunity to come back in 30 days, yeah I wouldn't do it differently.

Respondent D interview summary

Respondent D spoke about his life in addiction (the highs and the lows), his stature in the criminal world, and his experience of losing it all and going to jail. He talked about how he got into recovery and many of his experiences in the recovery world. He talked about the different services he accessed. He shared his ideas about what is useful in treatment and recovery and what is not. He gave feedback on the services he is receiving at New Horizons Recovery. He also shared some of his goals and dreams for the future.

Appendix H – ANALYSIS PROCESS 2 ‘SYNTHESIZING’

Initial Themes and Collated Data

Example –

5. Have you ever been denied residential addictions services or been asked to leave a facility against your will? Please describe.

5 respondents (Respondent E, Respondent G, Respondent H, Respondent J, and Respondent L) reported that they have never been denied access to residential addictions services or been asked to leave a facility prematurely.

4 respondents reported being discharged from facilities: Respondent F due to violence towards someone at an outside meeting that was witnessed by other clients and reported to staff as well as another occasion for smoking at a centre that did not allow smoking, 2 (Respondent D and Respondent N) were discharged for drug use in programs with a zero tolerance for using, and (Respondent M) was asked to leave due to conflicts (outbursts of anger and threats towards other clients that “were pushing (his) buttons”.

2 respondents (Respondent I and Respondent K) reported having difficulty getting into facilities / programs: Respondent I was put on a waitlist and he did not “have the patience to follow up”; and Respondent K was referred to 5 different houses and treatment centres that did not have room or would not accept him without his funding being in place.

What would have worked better?

Respondent F reported that more understanding of the difficulties with being entrenched in crime as a result of drug use and the struggles that go along with it would have helped as well as being allowed to continue to access services when these struggles arise.

Respondent F also reported that clients should be given a chance when they break the rules (smoking in this case) rather than being denied services.

Respondent D reported that being allowed to stay at the facility after submitting a positive urine drug screen test would have worked better.

Respondent N suggested that being moved to another recovery facility instead of being “kicked out onto the street” would have been more ideal for him.

Respondent M proposed that staff having the skills and the agency having the policies necessary to mediate the conflicts he was having with other clients would have worked better as he would have preferred to stay.

Respondent I thought that having more communication with staff at the centre he was waitlisted for may have helped him stay engaged in the process and successfully get into treatment.

Respondent K stated that just being accepted into the programs he applied to rather than being denied would have worked better.

If you were the staff in this instance, what would you have done differently than the staff members at the time?

Respondent F stated that not “forcing religion down clients’ throats” (in reference to the centre that he was asked to leave due to smoking) would have been a more professional way for staff to handle the situation.

Respondent D was given a lot of options to choose from in terms of going to another recovery facility or shelter and states that he would not have handled the situation differently.

Respondent N stated that if he were staff in this instance he would have made sure all the drugs in the client’s possession were taken from him and then he would have sent the client to another recovery facility and put him on restrictions there.

Respondent M would have intervened in the conflicts and mediated the issues or set boundaries limiting the interactions between the arguing parties rather than discharge the client.

Respondent I would have engaged in regular contact via the phone with the client while he was on the waitlist.

Respondent K spoke about understanding some of the systemic factors limiting clients without funding from getting into places and did not have a response beyond this.