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Social Support and Early Engagement in Addiction Treatment

by

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Dedication

I dedicate my thesis to my parents, Marino and Conchita Hidalgo, for their sacrifices and unconditional support and love. I would not be the person I am today without them.

I also dedicate my thesis in memory of my grandmother, Luisa Mun, whose kind, gentle, and humble spirit will forever live on in my heart.

ABSTRACT

This mixed method thesis examined the relationship between social support and early engagement in residential addiction treatment. Study 1 involved a secondary data analysis of a prospective cohort of clients entering a residential addiction treatment program. The multivariate analyses tested associations between client perceived social support and early engagement and retention in treatment. The study revealed that high level of social support from family was positively correlated with treatment participation. Study 2 involved in-depth qualitative semi-structured interviews with clients (different from those participating in Study 1) attending the same addiction treatment program, using a grounded theory approach. The theory generated from this study described how the treatment centre functioned as a gatekeeper to control clients' access to social supports. Taken together, findings suggest the importance of treatment process components that use social supports to promote early engagement in addiction treatment. Implications for research and practice are provided.

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"It does not matter how slowly you go as long as you don't stop." ~ Confucius

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CHAPTER 1: INTRODUCTION

Overview

This chapter provides a review of the literature on addiction treatment and the factors influencing treatment effectiveness, including: (1) the significance of retention in addiction treatment, (2) factors affecting addiction treatment, (3) the role of early treatment engagement in the treatment process, (4) factors affecting treatment engagement, and (4) the role of social support in addiction treatment outcomes. The chapter concludes with the overall rationale, objective, and an overview of the study methods.

Retention in Addiction Treatment

Client retention in alcohol and substance addiction treatment programs is a major concern among practitioners and clinicians in the addiction field (Pulford, Sheridan, & Adams, 2010). Alcohol and substance using clients are a particularly difficult group to retain and engage in treatment (Meier, Donmall, Barrowclough, McElduff, & Heller, 2005). An early review of this literature indicated that over half of the individuals receiving addiction treatment drop out within a month, and approximately 80 percent drop out within three months of starting treatment (Stark, 1992). These results have been confirmed in more recent studies. For example, approximately one-third of clients receiving a diverse range of treatment modalities for illicit drug dependence and abuse dropped out before treatment completion (Dutra, Stathopoulou, Basden, Lyro, Powers, & Otto, 2008). Cocaine and opiate patients tend to have higher dropout rates than patients treated for cannabis and poly-substance use (Dutra et al., 2008). Treatment is less effective for those clients who dropout of treatment early and treatment providers can incur financial losses due to client attrition (Pulford et al., 2010; Simpson & Joe, 2004).

Retention is thus a “gold standard” for gauging treatment effectiveness and accountability of addiction treatment (McLellan, McKay, Forman, Cacciola, & Kemp, 2005; Walker, 2009). Retaining clients in addiction treatment is

important as length of stay in a program is one of the most consistent predictors of post-treatment outcomes across different treatment settings and modalities for both adults (Simpson, 2001 & 2004; Simpson, Joe, & Rowan-Szal, 1997; Walker, 2009) and adolescents (Williams & Chang, 2000). Evidence suggests that being retained in treatment programs for 90-days or longer is required for clients to achieve positive post-treatment outcomes, while retention for one year is recommended for opioid addicts in outpatient methadone treatment (Simpson, Joe, Broome, Hiller, Knight, & Rowan-Szal, 1997; Simpson, Joe, & Brown, 1997). Treatment retention is associated with significant improvements in treatment, post-treatment substance and alcohol use, reduction in criminal activity, employment, and improvements in psychosocial functioning (i.e., emotional well-being, cognitive functioning, and interpersonal relationships) among clients (Bell, Richard, & Felz, 1996; Condelli & Hubbard, 1994; Simpson, Joe, Fletcher, Hubbard, & Anglin, 1999; Simpson et al, 1997; Simpson, Joe, & Rowan-Szal, 1997; Simpson, Joe, Rowan-Szal, & Greener, 1997; Warren, Stein, & Grella, 2007; Zarkin, Dunlap, Bray, & Weschberg, 2002).

Predictors of Retention: Client Characteristics and Functioning

Research to date across various addiction treatment modalities has extensively investigated pre-treatment client characteristics and functioning in relation to client retention. Some results suggest that clients who were younger (Rempel & Destefano, 2001; Stark, 1992), female (Arfken, Klein, di Menza, & Schuster, 2001; King & Canada, 2004; Stark, 1991), lower education level (King & Canada, 2004; Manu, Burleson, & Kranzler, 1994), and non-Caucasian ethnicity (King & Canada, 2004; Saloner & Lê Cook, 2013) are associated with early attrition from treatment. These findings are not conclusive, however, since other studies indicate that gender (Mertens & Weisner, 2000; Stark, 1992) and ethnicity or race (Rempel & Destefano, 2001) are not associated with client retention. Generally, the evidence on demographic characteristics as predictors of retention is mixed.

Other research examining the relationship between client functioning (e.g., severity of substance and alcohol use, psychological functioning, treatment

motivation, readiness for behavioural change, and social resources at treatment entry) and retention is contradictory. Some research indicates that clients with high levels of problem severity (Evans, Li, & Hser, 2009; McKellar et al., 2006; Mertens & Weisner, 2000; Roberts & Nishimoto, 1996; Warren et al., 2007) are more likely to drop out of treatment, compared to clients with low levels of problems severity. Conversely, one study found that clients with less symptoms of alcohol dependence were more likely to drop out of treatment (McKellar et al., 2006). Other studies have found that longer histories of substance use were associated with longer stay in treatment (Dutra et al., 2008). In addition, greater cognitive and psychosocial dysfunction (McKellar et al., 2006; Simpson, Joe, Broome, Hiller, Knight, & Rowan-Szal, 1997), co-occurring diagnosis (Amodeo, Chassler, Oettinger, Labiosa, & Lundgen, 2008), and psychiatric symptoms (Broome, Flynn, & Simpson, 1999) were related to treatment drop. On the other hand, some studies have found that psychiatric symptoms (Hawkins, Baer, & Kivlahan, 2008; Roberts & Nishimoto, 1996) were not significantly associated with length of time in treatment. Research has begun to examine additional factors associated with client retention beyond sociodemographic characteristics and problem severity. Some authors have argued that motivation for behaviour change and readiness to enter treatment are the strongest client predictors of retention across a variety of addiction treatment settings (Simpson, 2004; Joe, Simpson, & Broome, 1998). Higher levels of motivation and readiness for treatment (Anglin & Hser, 1991; Brocato & Wagner, 2008; Joe, Simpson, & Broome, 1998 &1999; Ryan, Plant, & O'Malley, 1995; Simpson & Joe, 1993), and greater legal pressure (Anglin & Hser, 1991; Brochu, Cournoyer, Tremblay, Bergeron, Brunelle, & Landry, 2006; Ryan et al., 1995) were related to longer stay in treatment. These studies highlight the key role that early treatment engagement plays in understanding retention in addiction programs, as well as the importance of understanding the dynamic nature of therapeutic response (Moos, Finney, & Cronkite, 1990).

Early Treatment Engagement

Early treatment engagement is a major phase in the recovery process and appears to be crucial for retaining clients within the first month of treatment (Simpson, 2001 & 2004). Typically, if early engagement in treatment programs is not achieved, the likelihood of clients dropping out prior to completing their course of treatment increases. Early treatment engagement is typically measured through program participation, i.e., attendance at counselling sessions and other programming, along with the formation of therapeutic relationships or alliances with treatment providers (Simpson, 2004). With respect to the latter, developing a therapeutic relationship is an essential ingredient for effective treatment. Researchers have argued that this captures clients' *active* participation in the treatment process, which includes a subjective dimension of cognitive involvement and satisfaction with the process (Broome, Knight, Knight, Hiller, & Simpson, 1997; Joe, Simpson, & Broome, 1999; Simpson, 2001 & 2004). Moreover, it is an important factor in predicting treatment engagement and retention in substance abuse treatment (Meier, Barrowclough, & Donmall, 2005).

Early Treatment Engagement and Treatment Outcomes

Previous studies have demonstrated the association between client treatment engagement and treatment outcomes (Fiorentine, Nakashima, & Anglin, 1999). For example, one study found that the number of sessions that clients attended during the first three months of methadone maintenance treatment was positively correlated with improvements in substance using behaviour and psychosocial functioning (i.e., self-esteem and risk taking) during treatment (Simpson, Joe, Rowan-Szal, & Greener, 1995).

Studies have also found that client perceptions of a positive relationship with counsellor enhanced treatment experience. For instance, one qualitative study found that patient perceptions of the quality of their therapeutic alliance (e.g., mutual respect, understanding, and availability), was positively related to patient perceptions of the quality of treatment in an opioid maintenance treatment clinic (NordfJaern, Rundmo, & Hole, 2010). Similarly, another study found that positive expectation of therapy, greater session attendance, and positive

perception of therapeutic alliance was associated with improved client satisfaction (Dearing, Barrick, Dermen, & Walitzer, 2005). In contrast, other studies have found that therapist ratings of therapeutic alliance were a better predictor of treatment retention than client ratings (Cournyer, Brochu, Landry, & Bergeron, 2005). Findings from a residential addiction treatment program indicated that therapist-rated alliance significantly predicted dropout, but client ratings of the alliance was unrelated to dropout among clients attending a residential drug treatment program (Meier, Donmall, McElduff, Barrowclough, & Heller, 2006). In addition to confirming the role of therapeutic alliance in early treatment engagement, these findings suggest that rater perspective (i.e., client, counsellor, or observer ratings of therapeutic alliance) may differentially predict treatment retention.

Predictors of Early Treatment Engagement

Studies have also explored client- and program-centred predictors of treatment engagement with regards to session attendance and therapeutic alliance. Age, pre-treatment substance use, and treatment motivation are important client factors related to treatment engagement. In one study, for instance, the strongest predictors of treatment engagement (defined as completion of the first phase of four consecutive months of drug-free and sanctionless participation in drug treatment court) were legal coercion (i.e., legally mandated or family court case) and older age (Rempel & Destefano, 2001). Another study found drug-related problems were associated to quality of client-counselor therapeutic relationship among probationers attending a residential addiction treatment centre (Broome, Knight, Knight, Hiller, & Simpson, 1997). Finally, readiness for treatment and treatment motivation were positively correlated with therapeutic involvement, counsellor rapport, and treatment participation across various treatment modalities (Joe, Simpson, & Broome, 1998; Joe et al., 1999; Simpson, Rowan-Szal, Joe, Best, Day, & Campbell, 2009). A comprehensive review concluded that client demographics and functioning were less influential than pre-treatment client motivation as determinants of early therapeutic alliance (Meier et al., 2005).

In addition to client factors, there is a growing body of research examining program-centred predictors of early treatment engagement, such as staff characteristics, treatment philosophy, treatment modality, staff size, and service structure (Ball, Carroll, Canning-Ball, & Rounsaville, 2006; Brener, Von Hippel, Von Hippel, Resnick, & Treloar, 2010; Evans, Li, & Hser, (2009); Grosenick & Hatmaker, 2000; Meier & Best, 2007). Fiorentine and colleagues' (1999) findings indicate that perceived utility of treatment, the perceived utility of ancillary services, and the empathy or helpfulness of the counsellor were more likely to be associated with treatment engagement than client characteristics (i.e., demographic, pre-treatment drug and alcohol use, treatment history, criminal history, mental health, attitudes, and expectancies) among clients attending outpatient treatment programming. Another study of a prison-based drug treatment program found that program characteristics of a therapeutic community, including counsellor competence, counsellor rapport, peer support, and program structure predicted better treatment engagement (Welsh & McGrain, 2008). Further, a study found that increase in treatment satisfaction of outpatient addiction services was significantly associated with increased session attendance among male veteran clients (Hawkins et al., 2008). Findings from a study that examined diverse treatment settings in England indicated that treatment engagement was influenced by perceptions of program needs, professional skills, and organizational climate (Simpson et al., 2009).

Summary of Early Treatment Engagement

The research presented above demonstrates the importance of early treatment engagement as a critical part of the recovery process as well as a crucial determinant of client retention rates (Fiorentine et al., 1999; Simpson et al., 1995; Simpson, Joe, Broome, Hiller, Knight & Rowan-Szal, 1997). However, little attention has been paid to the role that social support plays in relation to early treatment engagement (Kelly, O'Grady, Schwartz, Peterson, Wilson, & Brown, 2010; Meier et al., 2005), and this factor will be explored in the following subsection.

The Role of Social Support in Addiction Treatment

There is a growing recognition that social supports play a significant role at various phases of the recovery process, including post-treatment treatment outcomes. The next section will provide an overview of the conceptualization and measurement of social support.

Conceptualization and Measurement of Social Support and Addiction Treatment

Social support is defined broadly as "resources provided by other persons" (Cohen & Syme, 1985, p. 4). Another definition of social support captures the types of social support and the benefits of the interaction: "the process of interaction in relationships which improves coping, esteem, belonging, and competence through actual and perceived exchanges of physical and psychosocial resources" (Gottlieb, 2000, p. 28).

There is substantial evidence that highlights the importance of social supports for various health outcomes (Berkman & Glass, 2000; Cohen & Syme, 1985). Although the evidence suggests positive association between health outcomes and social support, there remains confusion and contention with the definition, conceptualization, and operationalization of social supports among researchers in the field (Barrera, 1986; Hupcey, 1998b; Williams, Barclay, & Schmied, 2004). This is because social support refers to multiple dimensions of social relationships. The literature discusses four major aspects of social support: structural, quality, functional, and perceived relationships. There are also a number of instruments that assess these components of social support as described in the social support literature (see Barerra, 1986 for review of social support measures).

Structural Social Support

Social support depends on the availability of social network ties surrounding an individual, including the number, type, and strength of social relationships possessed by a person (Umberson & Montez, 2010; Cohen & Syme, 1985; House & Kahn, 1985). The *structural component* of social support refers to

an individual's *social network* or interconnectedness of social ties surrounding an individual, including the number, type, and strength each relationship in an individual's social network (Umberson & Montez, 2010; Cohen & Syme, 1985; House & Kahn, 1985). This aspect of social support is commonly operationalized in terms of presence or absence of social relationships or supports, the total number of social relationships or supports that a person has, or frequency of social contact (House & Kahn, 1985). One instrument commonly implemented in addiction treatment is the Client Evaluation of Self and Treatment (CEST)[1], which in part assesses structural aspects of social networks and supports of clients during treatment (Broome, Simpson, & Joe, 2002; Joe, Broome, Rowan-Szal, & Simpson, 2002).

Social Integration or Embeddedness

Another component of social support, related to structure, is *social integration* or *embeddedness*. *Social integration* refers to "the extent to which an individual participates in a broad range of social relationships" (Brissette, Cohen, & Seeman, 2000, p. 54). Another term used is *social embeddedness,* which refers to "the connections that individuals have to significant others in their social environments" (Barerra, 1986, p. 415). Social integration and social embeddedness may be used interchangeably as they refer to a similar and an important aspect of social support – involvement in social interactions of "both the behavioural component of active engagement in a wide range of activities and/or social relationship and the cognitive component of a sense of community and an identification with one's social roles" (Brisette et al., 2000, p. 56).

Measures of social integration or embeddedness include role-based assessments (e.g., the number of recognized social positions or social identities that a person has), social participation (extent and frequency of social activities), and perceived integration (individuals' own view of their communality; Brisette et al., 2000; Umberson & Montez, 2010). Instruments used to assess social integration include the Social Network Index (SNI; Berkman & Syme, 1979;

[1] The CEST is a self-report instrument developed by Texas Christian University (TCU), which includes assessment of pre-treatment motivation and psychosocial functioning (Joe et al., 2002).

Cohen, 1991), and Orientation of Social Support (OSS) instrument (Alemi, Stephens, Llorens, Schaefer, Nemes, & Arendt, 2003).

Functional Social Support

In contrast to these objective, structural features of social support, other researchers emphasize *functional* features of social support, which is the most commonly used perspective on social support in the literature (House & Kahn, 1985). *Functional* aspects of social support refers to activities that others provide in a social networks, such as providing emotional affection, as well as instrumental (tangible) supports, appraisals, and informational supports (Cohen & Syme, 1985). For example, *emotional* support includes "intimacy and attachment, reassurance, and being able to confide in and rely on each other – all of which contribute to the feeling that one is loved or cared about, or even one is a member of a group, not a stranger" (Schaefer et al., 1981, p. 385). *Tangible* support entails direct aid or services. *Informational* support "includes giving information and advice which could help a person maintain a social identity and a sense of social integration" (Schaefer et al., 1981, p. 386). It is important to make distinctions between these functions of social support as they have independent effects on health and outcomes (Schaefer et al., 1981). The Interpersonal Support Evaluation List (ISEL; Cohen, Mermelstein, Kamarock, & Hoberman, 1985) is an example of a functional social support instrument.

Perceived and Enacted Social Support

Finally, social support can also be conceptualized as *perceived* and *enacted* or *actual social supports*. Perceptions versus actual or enacted support influence health behaviours differently (see Gottlieb & Bergen, 2010). It is important to distinguish between perceived versus enacted support as research suggests that perceived social support does not always accurately reflect what type of support is available or what was actually provided (Hupcey, 1998a).

Perceived social support refers to the assessment of the supportive quality of social interactions, i.e., resources provided by other individuals as well as reception of social support (Barerra, 1986; Cohen & Syme, 1985; Gottlieb &

Bergen, 2010; Schaefer, Coyne, & Lazarus, 1981). There are a number of instruments that measure perceptions of social support, including two dimensions, perceived availability and adequacy (Barerra, 1986). A common instrument used to assess general social support among clients addiction treatment for substance and alcohol use is the Perceived Social Support (PSS) instrument developed by Procidano and Heller (1983) to evaluate an individual's appraisal of and subsequent coping with stress. A shorter version of the PSS instrument was adapted by Rice and Longabaugh (1996). The PSS makes a distinction between perceptions of support from family members and from friends. Although this instrument measures two specific types of social relationships, it fails to consider other close relationships that clients may perceive as important. Other social support instruments have been developed to include other social relationships. The Multidimensional Scale of Perceived Social Support (MSPPS, Zimet, Dahlem, Zimet, & Farley, 1988) assesses three aspects of perceived social support: family members, friends, and significant others.

In contrast to perceived social support, *enacted* or *actual support* is the "mobilization and expression" (Gottlieb & Bergen, 2010, p. 512) of support, or "actions others perform when they render assistance to a focal person" (Barrera, 1986, p. 417). Instruments of enacted social support complement other social support instruments by evaluating what individuals actually do in the provision of support (Barerra, 1986).

The Influence of Social Networks on Entry into Addiction Treatment

This subsection reviews research on social support and the role it plays in facilitating access to, and completion of, addiction treatment. When examining social support in the context of alcohol and drug abuse addiction treatment, it is important to bear in mind findings from the previous subsection indicating that that social support is multi-faceted and is conceptualized and assessed in various ways. Research on social support prior to initiating addiction treatment focuses on the impact of social networks (e.g., concerned family and friends) on an individual's decision to initiate addiction treatment or to engage in self-help. One approach that makes use of support from loved ones in a treatment environment is

the Johnson Intervention (JI; Fernandez, Begley, & Marlatt, 2006; Stanton, 1997). The JI is a carried out by a combination of family, friends, and co-workers, where the goal is to confront and pressure the loved one as an attempt to motivate him or her to enter addiction treatment (see Fernandez et al., 2006; Stanton, 1997). The process is staged and guided by the help of a hired professional, in which the person who has alcohol or substance issues is unaware that the intervention is going to take place. During the intervention, the intervention team presents the loved one of the reality of his or her problems with alcohol or substance in a caring and compassionate manner, typically through letters read by each individual from the intervention team. At the close of the intervention, acceptable treatment options are presented along with consequences of noncompliance. Despite the widespread use of JI, the effectiveness in changing an individual's alcohol and substance problems is controversial (Fernandez et al., 2006; Stanton, 1997). Success rates of JI range from 23 to 90% successful treatment engagement (see Fernandez et al., 2006). One limitation of JI is that the technique's confrontational approach may not always be appropriate for family and friends as well as the loved one who has alcohol and substance problems. This approach may be ineffective at getting the individual into treatment and may result in getting him or her to continue with alcohol or substance use.

An alternative approach to the JI that family and social networks can use to influence people who have alcohol or substance use problems in a less confrontational approach is *A Relational Intervention Sequence for Engagement* (ARISE; Garrett, Landau, Shea, Stanton, Baciewicz, & Brinkman-Sull, 1998; Landau et al., 2004). ARISE uses a three-staged, graduated continuum approach that involves and creates a supportive intervention environment for both the person who has alcohol and substance problems and his or her social network (i.e., concerned family and friends) in an attempt to minimize reactivity from the loved one (see Garrett et al., 1998 and Landau et al., 2004 for detailed description of the process). Landau and colleagues (2004) recruited 110 concerned people (e.g., family members and friends) to participate in a project that used ARISE. Ninety-one percent of loved ones with alcohol or substance abuse entered

treatment or engaged in self-help. Over half of treatment clients entered treatment at the first stage; an additional one-quarter entered at second stage; and less than two percent engaged at the third stage. Since a small proportion of people used the third stage, which is similar to the JI approach, the findings indicate that ARISE is effective in getting individuals into treatment in a less confrontational manner and that it involves and respects the person with issues in the intervention process.

The intervention approaches discussed above highlight the influence of social networks for getting an individual with alcohol and substance use issues into treatment programs and to change their substance use behaviour. Unfortunately, few studies have examined the effectiveness of social network interventions on treatment outcomes such as treatment completion and retention or alcohol and substance use (Loneck, Garrett, & Banks, 1996a & 1996b).

Social Support in Relation to Outcomes and Early Treatment Engagement

Studies have examined associations between pre-treatment social support and treatment and post-treatment outcomes. Evidence to date is inconsistent. For example, one study reported that clients attending a 21-day inpatient treatment program who reported lower perceived social support from family members at treatment entry were more likely to complete treatment, while those with higher perceived social support from family were more likely to drop out (Westreich, Heitner, Cooper, Galanter, & Guedj, 1999). The findings suggest that patients who had higher perceived social support scores from family were more likely to take shelter with their family and were less obligated to stay in inpatient treatment. In contrast, another study of outpatient addiction treatment found that lower levels of perceived social support at treatment entry were associated with significantly higher attrition rates than clients with higher levels of perceived social support (Dobkin, De Civita, Paraherakis, & Gill, 2002). These contradictory findings suggest that clients who perceive high levels of support, specifically from family may have better treatment outcomes in outpatient setting rather than inpatient program, as they already have positive supports.

Findings are also inconsistent with social support and treatment engagement. In a methadone maintenance program, poor family and peer relations at intake predicted poor psychosocial functioning, which in turn was related to higher levels of motivation, which was associated with higher engagement. Ultimately, higher engagement was related with less opioid use and less criminal activity at one year follow-up (Griffith, Knight, Joe, & Simpson, 1998). Contrarily, peer deviance and family dysfunction prior to treatment were not associated with therapeutic alliance, but peer deviance was associated with re-arrest at one-year post-treatment (Broome et al., 1997). These mixed results highlight the complexity that exists between social support and treatment engagement.

Prior research has investigated social support as a predictor of post-treatment outcomes. For instance, clients with negative social support that consisted of substance using individuals, such as a significant other or peers, had a negative impact on post-treatment abstinence (Buckman, Bates, & Cisler, 2007; Buckman, Bates, & Morgenstern, 2008; Goehl, Nunes, Quitkin, & Hilton, 1993; Broome, Simpson, George, & Joe, 2002) and with consequences of substance use (Goehl et al., 1993). Other studies have reported higher levels of social support and pre-treatment non-using social support from family and peers predicted decreased post-treatment substance use (Warren et al., 2007; Williams & Chang, 2000) and improved psychological symptoms (Warren et al., 2007). These findings suggest the importance of having positive, healthy social support prior and during treatment as well as in recovery.

Summary on the Role of Social Support in Addiction Treatment

Measures of social support are continuously being developed and revised, reflecting the lack of clarity of the concept (Hupcey, 1998b; Williams et al., 2004). The multidimensional nature of social supports has not fully been addressed within research on addiction treatment, resulting in over-use of simplified, global measurement tools (Hupcey, 1998a; Williams et al., 2004).

Global instruments measuring social support are useful, but these instruments cannot take into account how social supports may play different roles

in different contexts for those seeking treatment. Levels and types of social support may vary between outpatient and inpatient treatment programs, but research on social support in addiction treatment using some measures (e.g., the CEST social support scales developed by TCU) are mainly conducted in the context of outpatient programs, such as methadone maintenance, which may not be relevant for inpatient programs, where levels of access to social support may be different. Further, the CEST network measures include social support from friends and family within the treatment environment, but exclude other supports, such as significant others and community services.

Finally, research on social support is mainly on social networks as predictor of treatment and post-treatment outcomes. More research, however, is needed to examine how the various components and the nature of social support influence initial treatment engagement and the early phases of recovery, when dropout rates are the highest (Dobkin et al., 2002; Hawkins et al., 2008). This underscores the importance of examining social support and early treatment engagement in addiction treatment in different contexts.

The Current Study

Retention is a key factor influencing the effectiveness of addiction treatment. Research on factors that influence retention and early engagement in the therapeutic process of addiction treatment remains inconclusive. To date, most studies on social supports in the addiction treatment field have examined the association between social support and post-treatment outcomes. Little research has explored the influence of social support on client engagement early in the treatment process and treatment engagement outcomes. Further, the general social support measures typically used in research to date fail to take into consideration the context of treatment programs. The current study examined the dynamic nature of social support and its relationship with early treatment engagement among clients seeking residential addiction treatment.

Research Objectives

To address the gaps in the literature and the limitations described earlier, the overall goal of the research was to examine the role of social supports and early treatment engagement in addiction treatment for substance and alcohol, using a mixed method approach. The study addressed two specific research objectives. The first objective was to determine whether an association exists between a general or global measure of perceived social support and early engagement among clients entering addiction treatment. The hypothesis for this objective was that clients reporting high levels of social support from family members and friends would have better treatment engagement and stay in treatment longer, and was tested using quantitative methods.

In order to address limitations created by using a general measure of perceived social support, the second research objective was to provide an in-depth description of different kinds of social support experienced and received by clients entering addiction treatment in relation to early engagement. Results from this study were intended to provide a better understanding of the treatment engagement process to improve the effectiveness of treatment intervention strategies. No specific hypothesis was developed for this descriptive research objective, which was undertaken using qualitative methods.

Overview of Methods

These research objectives were addressed using a mixed method approach, in particular, a sequential mixed method design (Creswell, 2003; Teddlie & Tashakkori, 2006). This design employs quantitative and qualitative data collection and analysis, in that order, and is useful when research goals use qualitative methods to expand upon or elaborate on quantitative findings.

Study 1 involved a secondary data analysis of a prospective cohort of clients entering an addiction treatment program. Analyses of the quantitative data were used to address the first research objective and to inform data collection procedures for Study 2. Specifically, the findings informed the sampling strategy, which added a social support measure to select clients with the highest and lowest

social support scores for maximum variability. Further, the findings were also used to develop the interview guide.

Study 2, a qualitative study using semi-structured interviews, was designed to provide further insights into the findings from Study 1. The second study also provided in-depth descriptive information on how a purposefully sampled subset of clients selected from the same addiction treatment program experienced and received social support in relation to early treatment engagement. The research objectives related to the data collection procedures, analyses, and how the data was used for each study is presented in Figure 1 below.

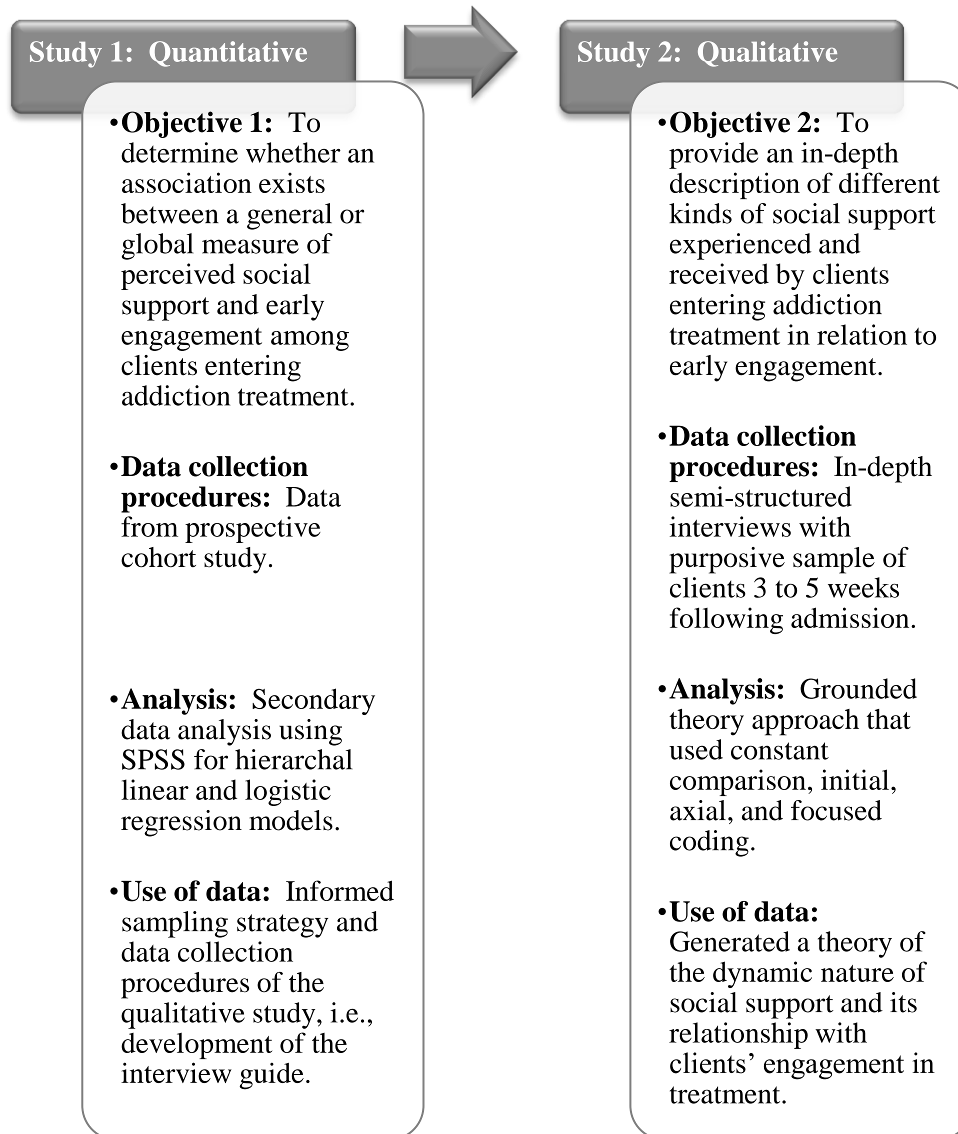
Study Setting: Residential Addiction Treatment Centre

The study took place in an intensive residential addiction treatment centre located outside of Edmonton, Alberta, Canada. The residential addiction treatment centre was a unique setting that used a holistic approach to address physical, emotional, mental, and spiritual needs of clients, combining elements of Aboriginal cultural and spiritual beliefs with a 12-step, abstinence approach to recovery. Aboriginal activities included traditional smudging and sweat lodges along with educational sessions and group therapy. The treatment centre offered a 42-day, 90-day, and two week follow-up programs for treatment of alcohol, drugs, and gambling. The program was available to both adult male and female adults (18 years and older) from all ethnic backgrounds, individuals with concurrent disorder, and high risk pregnancies. Individuals were required to: (1) be mentally and physically capable of participating in the program, (2) be clean from alcohol and mood altering substances for at least 72 hours prior to admission, and (3) handled legal, medical, and social matters prior to admission. Priority was given to pregnant women. The 90-day program was only available to young adults (18 to 24 years old) and Albertan residents.

The researcher was provided permission from the Supervisor Counsellor to access and conduct interviews with clients from the treatment centre for the qualitative study (see Appendix A for Letter of Support and Memorandum of Understanding). The Letter of Support and Memorandum of Understanding (see Appendix A) outlined the mutual agreement between the researcher and treatment

centre in terms of: (1) objectives of the study, (2) recruitment and data collection procedures, (3) ownership and storage of data to protect identity of clients and treatment centre, and (4) sharing and dissemination of information from this study.

Figure 1. Overview of the mixed method study.



CHAPTER 2: METHODS – QUANTITATIVE STUDY

Overview of Quantitative Study

Chapter 2 and 3 present the methods and results, respectively, for the quantitative study. The secondary data analysis of a prospective cohort study focused on quantitative associations between levels of social support from family and friends at treatment entry and treatment engagement and retention among clients attending the residential addiction treatment setting described in the previous chapter.

Background: Social Control and Coercion Study (SCC)

The data for the secondary analysis was from the Social Control and Coercion (SCC) Study, which was conducted by the Addiction and Mental Health Research Laboratory (AMHRL) at the University of Alberta. The SCC study examined how different types of social controls (e.g., court-ordered treatment; treatment that is required for work or social assistance programs; pressure from friends and family members to enter treatment) are used, how often they are used, what it is like to be in treatment or have a client that is in treatment because of social controls, and how being pressured to enter treatment affects someone's experience in treatment. Three studies were conducted, but for the purpose of this study, data from only one study was used: the cohort study. The cohort study examined how being pressured to enter treatment was related to engagement with addiction treatment. The researcher had no involvement in the study design and minimal involvement in data collection (see *Recruitment and Data Collection Procedures* below for more detail).

Recruitment and Data Collection Procedures

Recruitment and data collection occurred from August 2008 to June 2009. The researcher was involved in the first month of recruitment and data collection of the SCC study; another research assistant (RA) was involved for the remainder of the study.

Recruitment of participants occurred during the first day of clients' treatment program at an orientation session. New clients were admitted into the treatment program on a weekly basis. In the orientation session, the RA provided a brief presentation about the project to new clients. Clients were informed about the background and rationale of the study, the details of their involvement in the project, the ways in which privacy and confidentiality were addressed, and that participation in the study was voluntary. Clients were provided the opportunity to ask questions related to the study. Interested clients were provided with the project information letter and provided written consent.

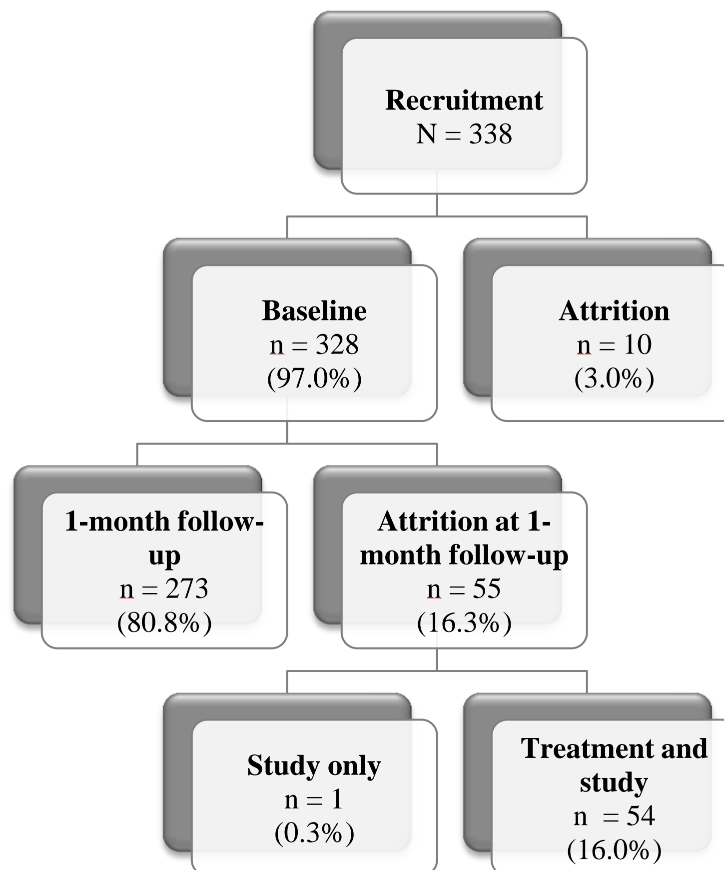
A total of 338 clients were recruited. To be eligible for the study, clients had to be 18 years and older and admitted in the 42- or 90-day intensive residential treatment program and be in their first week. Clients were not eligible for the study if they previously completed the baseline questionnaire (e.g., enrolled in the two-week follow-up program or dropped out and entered treatment again). A total of 328 clients (96.8% response rate) completed baseline surveys. At follow-up, 273 (80.8% response rate) completed follow-up surveys at one month. With respect to attrition, only 1 (0.3%) client declined to complete the follow-up questionnaire, 10 (3.0%) clients who signed consent forms but did not complete the baseline surveys dropped out shortly after they were admitted, and 54 (16.0%) clients who did not complete the follow-up surveys were unreachable or did not provide other contact information. The recruitment and data collection procedures are presented in Figure 2.

The baseline and follow-up surveys were completed within the treatment facility, during a time that did not interrupt clients' programming. The baseline survey was completed on the following Monday after recruitment with clients who signed their consent form. Participants completed surveys within the treatment facility, during a time that did not interrupt clients' programming. Completion of the baseline survey took 30 to 40 minutes. An optional information sheet was attached to the baseline survey asking clients for contact information (i.e., telephone, email, or personal contact) in the event that they were no longer attending residential treatment at the time of the follow-up survey.

The follow-up survey was administered one month after treatment entry and asked about their treatment experience. Duration to complete survey was 10 to 30 minutes. For clients who were no longer attending the residential addiction treatment centre, surveys were typically administered via telephone (n = 21) or email (n = 4).

Participants received a $20 gift card for compensation for completion of both questionnaires.

Figure 2. Recruitment and data collection procedures for the prospective cohort study from August 2008 to June 2009.



Measures

The baseline questionnaires collected sociodemographic variables, including: gender, age, education level, employment status, income source, and marital status. Clients were also asked about their reasons for entering treatment,

legal status, treatment-related information, history of drug and alcohol use, motivation, perceived social support, and problems that they have been having because of their drug and alcohol use.

The one-month follow-up collected data on self-reported involvement in treatment, including treatment engagement and participation, past 30-day substance use, and severity of problems related to substance use (SPS) within the past 30-days.

The current study determined the association between the level of social support at treatment entry and client characteristics, treatment engagement, and retention. Client characteristics included sociodemographic characteristics (i.e., gender, age, ethnicity, marital status, and education level) and clinical characteristics (i.e., severity of problems related to substance use at baseline, treatment motivation, and pressure to enter addiction treatment).

Main Predictors

Social support. Perceived Social Supports (PSS) is a 14-item global measure of perceived social support with two 7-item sections asking questions about support from friends (PSS-Fr) and family (PSS-Fa; Procidano & Hiller, 1983; Rice & Longabaugh, 1996). Internal consistency (Cronbach's alpha), was excellent for the PSS-Fr and PSS-Fa (α = .88 and .90, respectively). Responses for the social support measure were on a 3-point scale (yes, no, and uncertain). Each response indicative of perceived social support (i.e., yes) was scored as +1. Scores ranged from 0, i.e., indicating no perceived social support to 7, i.e., indicating maximum perceived social support.

Treatment motivation. The 9-item modified version of the Treatment Entry Questionnaire (TEQ-30; Wild, Cunningham, & Ryan, 2006; Urbanoski & Wild, 2011) was used to assess reasons why clients enter treatment. The TEQ-9 demonstrated high internal consistency in both residential and outpatient samples (Urbanoski & Wild, 2011). The TEQ-9 is measured on a 7-point Likert scale ranging from 1 (strongly disagree) to 7 (strongly agree), assessing the reasons for entering treatment. Treatment motivation score was calculated by adding subscales in the domains of *external motivation* (two items), *introjected*

motivation (three items), and *identified motivation* (four items). *External motivation* is related to a client's beliefs that treatment is sought because social events have coerced, demanded, or pressured the clients to seek help. *Introjected motivation* is related to internal conflicts (e.g., feelings of guilt and anxiety) associated with the treatment decision. Finally, *identified motivation* occurs when client personally identify with the goals of treatment, commit to these goals, and choose to seek help.

Treatment Outcomes

Treatment engagement. A modified version of a self-reported treatment engagement measure was from a battery of psychometrically-sound measures developed by Simpson and colleagues from the Texas Christian University (TCU). The original measure consists of three subscales: confidence in treatment, rapport with counsellors, and commitment to treatment (Joe, Simpson, & Broome, 1998). The coefficient alpha for each subscale demonstrated good reliability (α = .68, .83, and .73, respectively; Simpson, Joe, & Rowan-Szal, 1997).

Confidence in treatment reflected client's perception of whether the program was helpful in terms of stopping or reducing drug use and addressing problems related to drug use along with the likelihood of completing treatment. Modifications were made to this subscale to take into account for item interdependence and unequal scaling in the original subscale. Specifically, two questions: "Has this treatment helped you stop or cut down on your alcohol or drug use?" and "Would you say it has helped…?" were originally on a 2-point scale (yes or no; and a little or a lot, respectively). A third variable were combined to create one variable into a three-point scale (not at all, a little, or a lot), helping to create consistency of response options among items for this subscale. In addition, the responses for the item, "Maybe this place will be able to help me," were changed from a three-point to a 4-point scale. To account for the irregularity, this item was rescaled to have an interval of 0.75 between responses instead of 1 resulting in responses ranging from 0.75 and 3. The sum of the four

items in the confidence in treatment scale were calculated, which ranged from 4 to 12, with higher scores indicating a greater confidence in their treatment program. The Cronbach's alpha reliability for this sample was .60, indicating acceptable reliability.

Rapport with counsellors assessed the clients' perception of the strength of the therapeutic rapport using a five items on a 3-point scale (not at all, a little, or very much). Scores were calculated and produce a subscale score range from 5 to 15, with higher scores indicating greater rapport with counsellors. The reliability of the Cronbach's alpha for this sample was .79, indicating good reliability for rapport with counsellors.

Commitment to treatment measured the clients' perception of the decision for "action" for addressing their problems (Joe et al., 2002), consisting of five items using a 4-point scale (strongly disagree, somewhat disagree, somewhat agree, and strongly agree). Scores of these items produce scores between 5 and 20, with higher numbers indicating a greater commitment to the treatment program. Calculation of the reliability of the Cronbach's alpha for this sample was .57, indicating acceptable reliability for this subscale.

Means of the three subscales were calculated. The sum for all 15 items of the treatment engagement measure was calculated, with higher scores indicating higher engagement in treatment program.

Treatment participation. Treatment participation was a 12-item scale one part of the self-report instrument Client Evaluation of Self and Treatment (CEST) also developed by Simpson and colleagues from the TCU. Treatment participation measured the cognitive and behavioural aspects of clients' involvement and participation in treatment (Joe, Broome, Rowan-Szal, & Simpson, 2002; Garner, Knight, Flynn, Morey, & Simpson, 2007). The Likert scale responses ranged from 1 (strongly disagree) to 5 (strongly agree). Treatment participation was determined by calculating the mean and then the mean scores were multiplied by 10 producing a final score ranging from 10 to 50, with higher scores showing greater participation in addiction treatment. Internal

consistency (Cronbach's alpha) for this sample was .87, indicating good reliability for the treatment participation measure.

Treatment retention. Client retention was recorded from client reports and chart review. Retention was measured by the number of days in the program. Retention data was supplemented by the chart review recording whether clients attended session and whether they stayed in treatment. For the secondary analyses, retention was measured on whether they stayed in treatment and these variables were dichotomized to "Treatment completion" and "Non-completion."

Data Analyses

Data was analyzed using the statistical software Statistical Package for Social Sciences (SPSS) version 19. Several general statistical analyses were conducted on client characteristics. An independent t-test was conducted to compare perceived mean levels of social support from family members and friends among males and females. Pearson product-moment correlation coefficient was computed to assess the relationship between social support from family and friends and age. A one-way analysis of variance (ANOVA) was used to compare mean levels of social support from family and friends in relation to education, marital status, and ethnicity.

Pearson product-moment correlation coefficients were computed to assess relationships between severity of problems, treatment motivation, and pressure to enter addiction treatment and social supports from family and friends.

Hierarchical stepwise linear regression analyses were performed to test the hypothesis that social support from family members and friends at treatment entry was associated with subsequent treatment engagement. Hierarchical stepwise logistic analyses were also performed to test the association between social support from family members and friends and retention, with a dichotomous measure of treatment retention.

The first step of the hierarchical linear and logistic regression analyses adjusted for effects of client characteristics (i.e., gender, age, ethnicity, marital status, and education). The second step adjusted the three subscales for treatment motivation (i.e., external, introjected, and identified). The final step included

social support for family members and friends. This was a conservative analytic approach that examined the impact of perceived social supports on client engagement only after taking into account the impact of client demographics and treatment motivation.

CHAPTER 3: RESULTS – QUANTITATIVE STUDY

Description of the Sample

Demographic information for the sample is reported in Table 1. At baseline, 289 clients (88.1%) were enrolled in the 42-day program, while 38 (11.6%) were in the 90-day program. Approximately half of the clients who completed the baseline survey were males. The mean age was 32.49 years of age (*SD* = 10.38 years). Just over half of the clients were single, and 22.9% had post-secondary education.

At the one month, 273 clients completed the follow-up questionnaire. One client (0.3%) declined to complete the follow-up questionnaire and dropped out of the study, while 54 (16.0%) dropped out of treatment and the study (see *Recruitment and Data Collection Procedures* for detailed reason for attrition rates). A total of 242 (88.7%) were in the 42-day program and 30 (11.0%) were in the 90-day program. The demographic characteristics were similar at the one-month follow-up, which indicate that demographic characteristics were not related to attrition. Half of the clients were females; the mean age was 33.22 years (*SD* = 10.22 years); approximately half were Aboriginal, half single, and over one-quarter with post-secondary education.

Client Characteristics

Table 2 presents the means, standard deviations, and statistical tests from the bivariate analyses to examine associations between client characteristics and the different types of social support of the treatment centre clients. The results indicated that there were no significant associations between any of the client characteristics and social support from family. On the other hand, there was a significant effect for gender ($t(314) = -4.87$, $p < .001$), with female clients ($M = 4.37$, $SD = 2.32$) reporting higher levels of perceived general social support from friends than males ($M = 3.09$, $SD = 2.32$).

Marital status also had a significant effect on social support with friends ($F(3, 310) = 2.80$, $p < .05$). Tukey post-hoc tests indicated that the mean score for

social support from friends for single clients (*M* = 3.90, *SD* = 2.39) was significantly different than married or partnered clients (*M* = 2.99, *SD* = 2.40).

Table 1

Sociodemographic Characteristics of Clients at Baseline and at One-month Follow-up

	Baseline		**One-month follow-up**	
	N = 338			
	n	%	n	%
	n = 328		n = 273	
Program				
42-day program[1]	289	88.1%	242	88.3%
90-day program	38	11.6%	30	11.0%
Missing	1	0.3%	---	---
Gender				
Males	161	49.1%	131	48.0%
Females	157	47.9%	139	50.9%
Missing	10	3.0%	3	1.1%
Age	*M* = 32.49, *SD* = 10.38		*M* = 33.22, *SD* = 10.22	
18-24	83	25.3%	60	22.0%
25-34	97	29.6%	85	31.1%
35-44	71	21.6%	66	24.2%
45+	46	14.0%	39	14.3%
Missing	31	9.5%	23	8.4%
Ethnicity				
Aboriginal/First Nations/Métis	162	49.4%	140	51.3%
Caucasian	94	28.7%	79	28.9%
Other ethnicity	17	5.2%	15	5.5%
Missing	55	16.8%	39	14.3%
Marital status				
Married/partnered	69	21.0%	57	20.9%
Single	177	54.0%	146	53.5%
Widowed/separated/divorced	70	21.3%	67	24.5%
Missing	12	3.7%	3	1.1%
Education level				
Primary school	47	14.3%	40	14.7%
Secondary school	186	56.7%	151	55.3%
Post-secondary (college, university)	75	22.9%	71	26.0%
None	7	2.1%	5	1.8%
Missing	13	4.0%	6	2.2%

[1]One client was enrolled in the 42-day gambling program.

Table 2

Social Support (SS) from Family and Friends in Relation to Client Sociodemographics

	SS from family		SS from friends	
	Mean (*SD*)	Statistics (*F* or *t*)	Mean (SD)	Statistics (*F* or *t*)
Gender		$t(314) = 0.20$		$t(314) = -4.87^{**}$
Male	3.58 (2.44)		3.09 (2.35)	
Female	3.52 (2.44)		4.37 (2.32)	
Age		$F(3, 291) = 0.19$		$F(3, 291) = 0.48$
18-24	3.76 (2.35)		3.78 (2.36)	
25-34	3.50 (2.48)		3.93 (2.59)	
35-44	3.52 (2.57)		3.53 (2.33)	
45+	3.57 (2.44)		3.52 (2.48)	
Ethnicity		$F(2, 269) = 0.47$		$F(2, 269) = 0.25$
Aboriginal/First Nations/Métis	3.51 (2.37)		3.64 (2.39)	
Caucasian	3.77 (2.53)		3.81 (2.56)	
Other	3.29 (2.66)		3.41 (2.37)	
Marital status		$F(2, 311) = 0.18$		$F(2, 311) = 4.03^{*}$
Married/partnered	3.71 (2.34)		2.99 (2.40)	
Single	3.52 (2.47)		3.90 (2.39)	
Widowed/separated/ divorced	3.49 (2.49)		3.94 (2.39)	
Education		$F(3, 309) = 0.56$		$F(3, 309) = 0.88$
Primary school	3.66 (2.24)		2.29 (2.36)	
Secondary school	3.42 (2.43)		3.74 (2.50)	
Post-secondary	3.84 (2.61)		3.81 (2.35)	

$^{*}p < .05$, $^{**} p < .01$

Clinical Characteristics

Pearson correlation coefficients were calculated between the clinical characteristics and perceived social support from family and friends. The results from the analysis are displayed in Table 3. Overall, there was no significant relationship between all of the clinical characteristics and both forms of social support. The association between introjected motivation and social support with family was slightly significant ($r = .09$, $p < .10$).

Table 3

Social Support (SS) from Family and Friends in Relation to Clinical Characteristics

	SS from family Pearson correlation coefficient (*r*)	**SS from friends** Pearson correlation coefficient (*r*)
Pressure to enter treatment	.04	.03
Informal pressure (spouse/partner, friends, family)	.06	.07
Legal pressure (legal authority)	.07	.03
Formal pressure (employer, children's aid, Alberta works/AISH health worker)	-.09	.06
Other (community)	.05	.05
Treatment motivation	.03	-.05
External motivation	.02	-.08
Introjected motivation	.09[a]	.06
Identified motivation	-.03	-.05
Psychological and daily living functioning	-.04	-.02
Relation to self/others	-.04	-.02
Daily living/role function	-.02	-.03
Depression/anxiety	-.05	-.003
Impulsive/addictive behaviour	-.09	-.01
Psychosis	-.04	-.03
Substance problem severity	-.02	-.03

[a]$p < .10$

Predicting Treatment Engagement

Table 4 presents the results of the hierarchal linear regression analyses that predicted treatment engagement, controlling for gender, age, ethnicity, education level, and treatment motivation. The results showed that social support (family and friends) did not significantly predict three dimensions of treatment engagement, i.e., confidence in treatment, rapport with counsellor, and commitment to treatment. However, it is important to note that age ($\beta = .23$, $p < .01$) and education ($\beta = -.21$, $p < .05$) significantly predicted commitment to treatment. Treatment motivation, introjected ($\beta = .13$, $p < .10$) and identified ($\beta = .14$, $p < .07$) were slightly significant with client-rated commitment to treatment ($\Delta R^2 = .01$, $F = 2.28$, $p < .01$). This suggests that clients who were older and reported higher levels of motivation (i.e., introjected and identified), reported

higher levels of commitment to the treatment program. Conversely, clients with only secondary level education reported lower levels of commitment.

Table 4

Results for Hierarchal Linear Regression Analyses for Predicting Treatment Engagement

Predictor	**Confidence in treatment**			**Rapport with counsellor**			**Commitment to treatment**		
	ΔR^2	F	β	ΔR^2	F	β	ΔR^2	F	β
Step 1:	.04	0.86		.03	0.78		.08	1.80[a]	
Gender									
Age									.23**
Ethnicity									
Caucasian									
Other									
Education level									
Secondary school									-.21*
Post-secondary school									
None									
Marital status									
Married/partnered									
Single									
Widowed/separated /divorced									
Step 2:	.01	0.83		.03	1.09		.06	2.45**	
TEQ external									-.12
TEQ introjected									.12[b]
TEQ identified									.14[b]
Step 3:	.01	0.91		.01	1.08		.01	2.28**	
SS family									.03
SS friends									-.11

** p <.01, *p < .05, [a]p < .07, [b] $p \leq .09$

Predicting Treatment Participation

The results from the hierarchal linear analysis, displayed in Table 5, show that the overall the adjusted model significantly predicted client-rated participation in treatment ($\Delta R^2 = .03$; $F = 2.40$, $p \leq .08$). In particular, social support from family ($\beta = .16$, $p < .01$) along with age ($\beta = .24$, $p < .01$) and identified motivation ($\beta = .16$, $p < .05$) significantly predicted treatment participation, with age as the strongest predictor. This suggests that clients who were older, had stronger personal commitment and sense of personal choice about entering treatment (i.e., identified motivation), and higher perceived social support from family had better participation in the treatment program.

Table 5

Results for Hierarchal Linear Regression Analyses for Prediction of Treatment Participation

Predictor	**Treatment participation**		
	ΔR^2	F	β
Step 1:	.07	1.75[a]	
Gender			
Male			
Female			
Age			.24**
Ethnicity			
Caucasian			
Other			
Education level			
Secondary school			
Post-secondary school			
None			
Marital status			
Married/partnered			
Single			
Widowed/separated/divorced			
Step 2:	.05	2.20*	
TEQ external			-.05
TEQ introjected			.10
TEQ identified			.16*
Step 3:	.03	2.40**	
SS family			.16*
SS friends			-.07

** $p \leq .01$, *$p < .05$, [a] $p \leq .08$

Predicting Treatment Retention

Hierarchical stepwise logistic regression was performed to predict treatment retention. The results for the hierarchical stepwise logistic regression are presented in Table 6. Social support was non-significant and did not predict treatment retention in the adjusted model. However, age (*AOR* = 0.94; *CI* = 0.91-0.98, $p \leq .01$) significantly predicted retention, while secondary education level (*AOR* = 2.34, *CI* = 0.98 – 5.61, $p < .06$) moderately predicted treatment retention. The findings indicate that younger clients were less likely to stay in treatment than older clients and clients with secondary level education were two times more likely to remain in treatment than those with less than secondary level education.

Table 6

Results for Hierarchical Stepwise Logistic Regression Analyses for Predicting Treatment Retention

Predictor	**Treatment retention**		
	β	***SE***	***AOR* (95% *CI*)**
Step 1:			
Gender			
Male			
Female			
Age	-.06	.02	0.94 (0.91-0.98)**
Ethnicity			
Caucasian			
Other			
Education level			
Secondary school	.85	.45	2.34 (0.98-5.61)[a]
Post-secondary school			
None			
Marital status			
Married/partnered			
Single			
Widowed/separated/divorced			
Step 2:			
TEQ external			
TEQ introjected			
TEQ identified			
Step 3:			
SS family			
SS friends			

** $p \leq .01$, *$p \leq .05$, [a]$p < .06$

Interpretation of Results

Results from bivariate analyses revealed significant associations between two of the client characteristics and social support from friends. Specifically, female clients reported perceived higher levels of social support from friends than males. Similarly, single clients also perceived higher levels of social support from friends than those who were married. Client and clinical characteristics were not associated with social support from family.

Beyond these sociodemographic differences, results from the multiple regression analyses provided mixed support for the hypothesis that perceived social support would be positively associated with early client engagement and retention. Recall that this hypothesis was tested using a conservative approach that first adjusted for the impact of sociodemographic, clinical, and motivational factors prior to examining the impact of social support on measures of three measures of treatment engagement, self-reported treatment participation, and retention at follow up. Multiple regression analyses indicated that perceived social support was unrelated to client ratings of confidence in treatment, rapport with counselors, and commitment to treatment. Similarly, logistic regression analysis indicated that perceived social support was not related to client retention in the treatment program. On the other hand, perceived social support from family members was positively related to clients' ratings of participation in treatment program activities. In addition to these tests of the hypothesis, the regression analyses revealed other important predictors of treatment engagement, highlighting the role of client motivation to enter treatment, and in particular, the positive impact of identified motivation.

In general, findings from Study 1 suggest that social support from family and friends did not influence clients' level of treatment engagement and length of stay, while social support from family, along with age and identified motivation were factors that contributed to better treatment participation among clients entering treatment. Finally, the quantitative findings identified pre-treatment client characteristics that influenced these outcomes. Age was the strongest client factor that influenced commitment to treatment, treatment participation, and

retention. Pre-treatment client motivation was also an important factor, which positively influenced commitment to treatment to an extent and strongly influenced treatment participation. Lastly, secondary level education was negatively associated with commitment to treatment, but moderately associated with retention in treatment.

CHAPTER 4: METHODS – QUALITATIVE STUDY

Overview of Qualitative Methods

This chapter provides an overview of the qualitative methods used in Study 2. The chapter will cover: (1) the rationale and background on grounded theory, (2) the researcher's reflection on perspective entering the setting, (3) the description of the process of relationship building with research setting and participants, (4) data collection and analysis, (5) ethical considerations, and (6) rigour for this study.

Rationale for Grounded Theory

The previous chapter documented that perceived social support from family was positively associated with client participation in residential addiction treatment. Unfortunately, these quantitative results do not provide in-depth detail about the nature of this association, e.g., how clients experienced social support or how the treatment centre dealt with the issue of social support. In order to expand on the quantitative results, grounded theory was used to describe the social processes by which social supports was related to treatment engagement.

Background on Grounded Theory

Grounded theory (GT) is a method that provides a set of techniques for studying social phenomenon (Charmaz, 1990). The tradition of GT methodology originated from sociologists Barney Glaser and Anselm Strauss. They outlined systematic strategies for qualitative research practice to manage qualitative data and advocated in the development of substantive theories from research grounded in data rather than deducing testable hypotheses from existing theories (Charmaz, 2006; Corbin & Strauss, 1998; Glaser & Strauss, 1967). GT uses multiple stages of data collection and analysis concurrently to inductively derive a theory to understand the social worlds under examination in a qualitative research study (Creswell, 2003; Charmaz, 2006). Essential analytical techniques used in GT to generate a substantive theory consist of theoretical sampling, constant

comparative analysis, memo-writing, and saturation (Kearney, 1998). The theoretical foundations of GT are deeply rooted in sociology and include symbolic interactionism, which postulated that the "self" is defined by social roles, social expectations, and perspectives set on self by society and people within society (Annells, 1996).

Since the inception of GT, Glaser and Strauss had different conceptualizations of GT and developed different approaches. Glaser maintained the principles of classic GT that theory is inductively generated, while Strauss collaborated and co-authored with Juliet Corbin, moving GT toward verification a new coding paradigm that involved conditions, context, action/interactional strategies, and consequences (Dey, 1999). The current study used another approach to GT, the social constructionist approach (Charmaz, 2006), which views the researcher as an active participant in the research process:

> [A] social constructionist perspective assumes an active, not neutral, observer whose decision shape both the process and product throughout the research….The interaction between the researcher and the data result in 'discovering', i.e. creating categories….creating discoveries about the data and constructing the analysis. (Charmaz, 1990, p. 1165)

Strengths and Criticisms of Grounded Theory Approach

There are a few strengths with using a GT approach. First, since a theory is derived from the data, which will represent "reality" (Corbin & Strauss, 1998). Second, GT approach moves qualitative inquiry beyond descriptive studies into the level of explanatory theoretical frameworks, in which the approach provides abstract, conceptual understandings of the phenomenon under investigation (Charmaz, 2006). Third, GT provides flexibility in which researchers start with a general research question. If the research question is irrelevant, the researcher can refine and adapt question to reflect the field or use a different research setting (Charmaz, 1990). Fourth, GT outlines explicit set of analytic guidelines and procedures, in which they are implicit in other qualitative methods (Charmaz, 1990). Finally, GT approach provides a balance between science and creativity whereby the systematic approach to the data maintains a certain degree of rigour, yet allows for flexibility and creativity "to ask stimulating questions, make

comparisons, and extract an innovative, integrated, realistic scheme from masses of unorganized raw data" (Corbin & Strauss, 1998, p. 13).

Criticisms of GT relates to the interpretation of the language used, raising issue of the epistemological and ontological assumptions. GT approached has been criticized for using positivist language (Charmaz, 1990; Dey, 1999; Mayan, 2009). For instance, there is lack of clarity and understanding of the terms "theory," "discovery," and the notion of "ground" used in GT, which undermine the underpinnings of qualitative inquiry as inductive (Thomas & James, 2006). Glaser and others have also accused Strauss and Corbin's coding paradigm for imposing a pre-conceptual framework which constrains data analysis, rather than letting theory emerge through the data (Dey, 1999; Thomas & James, 2006). Furthermore, GT oversimplifies complex meanings and interrelationships in data (Thomas & James, 2006).

Despite these issues, GT was an appropriate approach for this study based on the strengths mentioned above as well as generating a theory of the role of social support in relation to client engagement.

Acknowledging the Researcher's Perspective

It is important to state the researcher's perspective prior to entering the study. According to Charmaz (1990 & 2006), researchers bring to the research setting their assumptions of reality, knowledge, and experiences, which influence interactions within the study setting; researchers are thus obligated to be reflexive about what they bring to the setting, what they observe, and how they observe the setting.

The researcher did not enter the research setting without prior experience and preconceptions. Rather, the researcher was aware and familiar with addiction treatment and the recovery process through her past work experience interacting with addicts in recovery in the context of drug treatment court (DTC) and with the staff in the research setting:

> Although I do not struggle with an addiction, I am familiar with recovery from my previous work experience working on the evaluation of the [drug treatment court]. I worked on the project

> for two years prior to starting my Master's program. Working on this evaluation project, I learned more about addiction and the recovery process…Bringing and having this prior knowledge I think will be helpful for me when interviewing clients at [the treatment centre][2]….I am an outsider to the recovery world, but at the same time I do have an understanding of recovery and addiction from a research perspective and in the context of drug treatment court.
>
> (Field notes, November 9, 2011)

By acknowledging the researcher's perspective and the biases that she brings is important as it influences and shapes how the data was collected and how the data was analyzed. This is also important because the researcher's perspective produces and analyzes data that reflect the research participant perspective and experience, in this study, client treatment experience in relation to social supports.

Rapport Building with the Treatment Centre

An important aspect of the current study was relationship building with the residential addiction treatment centre. Through the researcher's previous research experience, she established and maintained a relationship with the research setting. Specifically, the researcher maintained contact over a two year period preceding this study with the supervisor counsellor, which was a significant factor in gaining access to the treatment centre, as documented in the following field note:

> As well, I had the opportunity to work with [the treatment centre] as part of the [drug treatment court] evaluation. This was how I developed a relationship with [the supervisor counsellor]. Over the years, I maintained contact with him. In October 2010, I saw him at the Canadian Drug Treatment Court (CDTC) conference….Since that time, I kept him posted with where I was with my research project after I met with my supervisor and committee member about my study. In July, he invited me to the annual Pow Wow where we planned to discuss some of the logistics of doing my study…I feel that my prior relationship and involvement with [the treatment centre] facilitated my access to do my study at this treatment centre.

[2] The treatment centre was not named to protect the identity of the organization.

(Field notes, November 9, 2011)

The researcher also spent time at the treatment centre to further develop rapport with other treatment centre staff prior to collecting qualitative interview data. On the second round of participant recruitment, the supervisor counsellor invited the researcher to attend a client case meeting to inform the counsellors and staff about the research study. The researcher learned more about the spiritual aspect of the treatment program and some of the additional programming offered at the treatment centre and build rapport with treatment staff:

> The previous week, one of the counsellors and [the treatment centre] staff suggested that I come speak at the client case meetings…The meeting commenced with smudging and a prayer. This was my very first time smudging.…After smudging, all of the counsellors and I were in a circle holding hands and they recited a prayer and we all had a circle hug after. I assume that this ritual occurs at every meeting….The Elder also mentioned that on Wednesday nights, family members of clients come to the treatment centre.…I sat down near the front desk, observing what was going on.…Sitting near the entrance was a really good way to meet other staff members….I met the evening Program Attendant (PA)…
>
> [O]ne of the counsellors invited me to sit in the cafeteria and have coffee and breakfast with her. This was a great opportunity to get to know her as well as the programming offered at [residential addiction treatment]. She spoke more about the 90-day program for youth. In her opinion, she feels that it is a really good program because it gets younger clients to keep busy with different activities.
>
> (Field notes, November 17, 2011)

The researcher was also invited to have lunch with the treatment staff and clients most Thursdays during recruitment and data collection. The researcher became more familiar with the treatment setting and the treatment programming, developed rapport with the treatment staff, and increased presence and visibility among the clients in the cafeteria so that the clients become more comfortable with the researcher:

> After recruitment, I headed to the cafeteria… [The supervisor counsellor] invited me to grab a tray and eat lunch with him. As I was getting my lunch, the client that I was speaking to at the end of

> my recruitment invited me to sit with her, I said I would. But when I was walking to a table, [the supervisor counsellor] urged for me to sit with him and the other staff members.…I was also unsure if I was allowed to sit with clients or not. I noticed that the staff and clients do not sit together.…After I finished lunch, I approached the client who invited me to sit with her, apologizing and explaining that [the supervisor counsellor] had asked me to sit with him. She appeared to be not offended for me not sitting with her.
>
> (Field notes, December 8, 2011)

Overview of Study Procedures

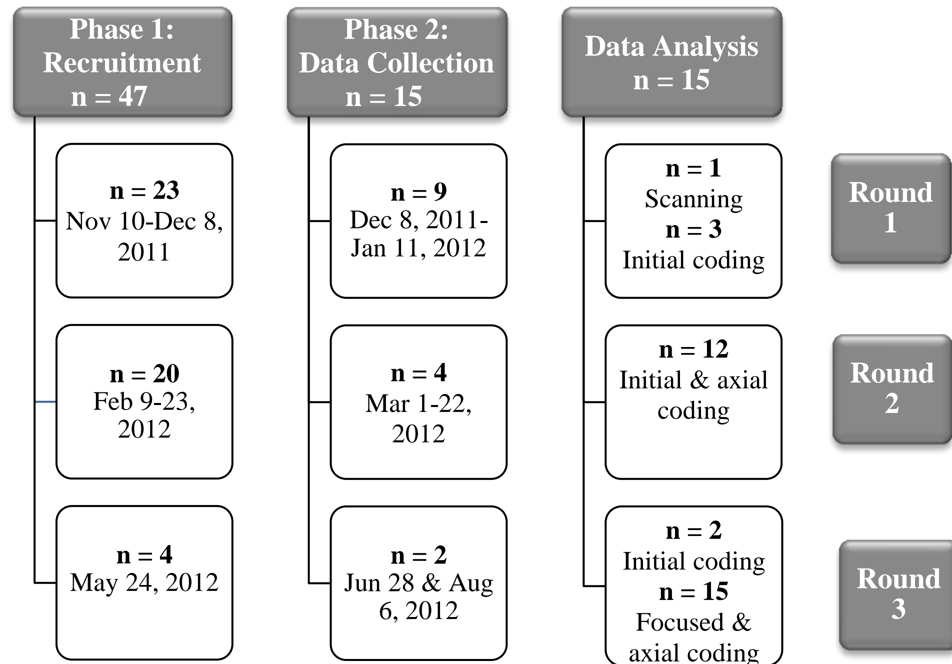
Study 2 was designed and implemented by the researcher. A two-phased study occurred over an eight-month period, between November 10, 2011 and August 6, 2012. The Study 2 implemented a similar recruitment procedure as used in Study 1, the prospective cohort study (see Chapter 2, *Recruitment and Data Collection Procedures*). The sample recruited for Study 2 was not from the original sample of clients recruited in Study 1 for the reason that the data collected for Study 1 did not involve the researcher and the implementation of Study 2 occurred two years after Study 1.

Clients were recruited for Phase 1 of the study during orientation, the first day of the clients' treatment program. Interested clients completed a consent form and then a short questionnaire that included a measure of perceived social support (see Appendix D). In Phase 2 of the study, Phase 1 clients were purposively recruited for a qualitative interview based on their quantitative social support scores. Clients with the highest and lowest scores were selected for the qualitative interview for maximum variation sampling. Figure 3 displays the three rounds of recruitment and data collection from November 10, 2011 to August 6, 2012.

Data collection and data analysis occurred concurrently. Recruitment and data collection continued until codes and categories derived from the interviews were elaborated and refined to develop an emerging theory about the role of social support and treatment engagement and until *data saturation* was reached,

defined as the point when no new ideas or categories emerged from the interviews (Charmaz, 2006).

Figure 3. Recruitment, data collection, and data analysis from November 9, 2011 to August 6, 2012.



Data Sources

Data sources for Study 2 included in-depth semi-structured interviews, field notes, interview notes, and memo-writing. All data for Study 2 was collected by the researcher.

Interviews were semi-structured, face-to-face, and digitally recorded. Interviews ranged between 35 and 90 minutes. Participants were asked to describe: (1) their significant relationships prior to entering and during treatment; and (2) their perspectives on treatment engagement and the role of support (e.g., family members and friends) of entering treatment (see Appendix G for the semi-structured interview guide).

Every time the researcher went into the research setting, including interactions with the clients and treatment centre staff (e.g., recruitment, data collection, and meetings), field notes were written to document observations during recruitment and the time spent at the treatment centre (e.g., meetings and lunch time) and impressions of recruitment. In addition to the field notes serving as observations at the treatment centre, these notes served as an analytic tool (Bailey, 1996) by providing context and ideas about themes emerging from the data. For example, one of the preliminary categories that emerged from the first round of recruitment and data collection was the rules, policies, and procedures related to clients accessing external social supports, a theme which was supported by a casual conversation with one of the treatment centre staff members, as documented in the following field note:

> I sat with [the supervisor counsellor] and other [treatment] staff members. I didn't [realize] until after, but there was a client who sat at the table too. I had today's Metro newspaper with me at the table and the client asked me if she could look at it. I gave it to her. [The treatment staff member] said that a few years back, clients were not allowed to watch the news or read the newspaper or anything associated with the outside world. I asked [the treatment centre staff member] why they weren't allowed to connect with the "outside world." She replied that [the treatment centre] wanted clients to "focus on themselves," which is consistent with what clients I have interviewed say that they need to "focus on me." They decided to let clients watch TV, news, and read newspapers because during hockey playoffs, clients would be wondering about the game. I get that clients need to be less distracted from the outside world, but at the same time I think it's important for clients to be connected to the outside world, especially if their friends and family are a positive part in their recovery or to be updated as to what's going on in the outside world.
>
> (Field notes, January 5, 2012)

The researcher also wrote interview notes for each individual client after interviews, reviewing their digitally recorded interviews. These notes documented: (1) observations and impressions of the interview; (2) main points that clients mentioned related to social support, treatment engagement, and connecting to external social supports; and (3) how the researcher handled sensitive issues that were discussed in the interviews. Similar to field notes, the

interview notes served as analytic tool to guide the data collection and analysis process as the researcher noted themes emerging from the interviews:

> When I was reviewing the interview and transcript for Adam[3], I was able to pay attention more to what was being said and how it relates to my research question: "How does social support affect treatment engagement?"
>
> I know that at the time that I did the interview, the impression I left that interview was that I wasn't really getting at the research question. But in listening and reading the transcript (not coding), one of the most important aspects that he alluded to was how the treatment centre's policies and procedures are an impediment to his treatment experience. I definitely could have collected richer, thicker description of how these policies and procedures have affected his treatment experience. This could have been accomplished through basic probing such as "How did that make you feel?" or "How did that affect your treatment experience?" or "How do you think other clients feel about or how does it affect their treatment?"
>
> It isn't just this interview, subsequent interviews I really didn't ask how social support affects their treatment engagement. If I could do this again, I would have transcribed interviews right away and given a few weeks to really sort out what I'm trying to get at it. It's just now with the transcribing that I am finding more specific opportunities for reframing and re-wording questions. I will most likely have to conduct more interviews, around 3 to 5 more interviews [to align] with what I had proposed in my thesis proposal.
>
> (Interview notes, Adam, January 27, 2012)

Finally, the researcher wrote study memos between interviews and data analysis. In traditional GT, memo-writing documents theoretical hunches, decisions, and modifications throughout the study. Memos elaborate on categories, specify their properties, define relationships between categories, and identify gaps. Memos also allow for the development of ideas, providing ways to compare data, to explore ideas about the codes, eventually leading to the development of conceptual categories (Charmaz, 1990 & 2006). Memo-writing was important for guiding data collection and analysis, documenting reflections

[3] All names mentioned from this point forward are pseudonyms to protect the identity of the clients interviewed.

on the data collection and analysis process in several ways. Firstly, memos documented the researcher's reflections on the data collection and analysis process, guiding the next steps and where to focus the questions for subsequent interviews:

> [My supervisor] reviewed three of the four transcripts I…sent. Overall, he felt that I needed to be more directive and encourage more elaboration on their responses to get richer data via probing. [My supervisor] did highlight that I am not getting rich data related to *how social support affects the quality of clients engaging in treatment*. I totally agree that I have not been effectively collecting evidence towards how social support affects treatment engagement. In subsequent interviews, I was able to get more at that, but still not elaborate and rich, thick data.
>
> [My supervisor] suggested for me to ask more probing questions such as: "How did that policy or procedure make you feel?" "How do you think other clients feel about that?" "Can you provide me an example?" I do think transcribing has also helped in trying to figure out where I can re-frame questions on the interview guide.
>
> (Memos, January 27, 2012)

Similarly, memo-writing was used to reflect on the data analysis process and how the researcher used GT analytical techniques:

> Currently I am going through the interview transcripts via NVivo scanning for data that is relevant to my research question suggested above [reference to Strauss & Corbin (1998)] and my supervisor (stating that I need to be "ruthless" with my coding and only highlight text that is relevant to my research question) by highlighting sections of the transcript and creating codes (referred to as "nodes" in NVivo), which at this point are broad categories (to be flushed out when conducting a closer read). My next steps after I have reviewed all the transcripts are to have a closer read of the relevant sections employing line-by-line coding as one of the suggested techniques of grounded theory to create more specific, discrete codes which this is referred to as *initial coding*.
>
> (Memos, March 8, 2012)

Finally, the memos were used to document some of the categories that the researcher noticed between the clients:

> One of the main [categories] that appear to emerge is how the structure, policies, and procedures are helpful or not helpful to connecting with people or important social supports for clients.

> Clients have different perspectives on the phone policy: Some clients think it's important for [the treatment centre] to monitor phone calls, while other clients completely disagree with completing a support sheet for making phone calls. That's just one of the examples of the contention with the policies.
>
> Another theme that appears to be emerging from the interviews are the types of social supports available to clients prior and while they are in treatment. Again, there is contention about how connected clients should be to the outside world. There is talk about being at [the treatment centre] for clients to there for "themselves" and to focus on their own recovery.
>
> (Memos, January 17, 2012)

Overall, the notes (i.e., field and interview) and memo-writing facilitated the researcher in developing the theory for the social processes of social support and treatment engagement at the treatment centre.

Phase 1: Recruitment

The researcher recruited clients during the treatment centre's weekly orientation sessions held for new clients. Three rounds of recruitment occurred: November 9 to December 8, 2011, February 9 to 23, 2012, and May 24, 2012. A total of 47 clients were recruited into this phase of the study. None of the participants in this Study had previously participated in Study 1. Initially, the researcher provided a 5 to 10 minute oral description (see Appendix B for recruitment script) of the full study and the possibility that interested clients may not qualify for Phase 2 of the study. Next, all clients at the orientation session received an envelope that included the study information letter, consent form, and questionnaire (see Appendix C and Appendix D). All clients were required to read the information letter. All clients, interested and not interested, were required to keep the information letter. Interested clients signed the consent form and immediately afterwards completed a standardized data collection form that gathered demographic information, previous treatment experience, and a standardized measure of social supports (see Appendix D). The social support measure that was used was the Multidimensional Scale of Perceived Social Support (MSPSS; Zimet et al., 1988), a 12-item scale that assessed three sources of social supports – family members, friends, and significant others. The

rationale for using this measure as opposed to the perceived social support scale used in Study 1 (PSS-Fa and PSS-Fr) measure, was that it included significant others as another form of social support. Although the MSPSS has not been used among alcohol and substance abusing populations, the MSPSS has high internal validity and test-retest reliability, construct validity, and discriminant validity, specifically among adolescent populations (Bruwer, Emsley, Kidd, Lochner, & Seedat, 2008; Chou, 2000; Zimet et al., 1988). The standardized data collection form was used for purposive sampling design. A purposive sampling approach was used to select clients who had the lowest and highest social support scores.

Contact information from interested clients was also collected, for the researcher to contact clients who were no longer at treatment centre at the time when interview was conducted (see Appendix E). The researcher collected all the envelopes from all clients that included the recruitment material (not including the information letter). Completion of the consent procedure and standardized forms ranged from 15 to 30 minutes.

After recruitment, the researcher entered the names of the interested clients into a password-protected document and assigned each client with an identification number. The researcher then entered data from the standardized data collection form into SPSS 19 and scored the social support measure for each client.

Phase 2: Qualitative Interviews

Phase 2 of the research involved in-depth qualitative interviews conducted with clients who participated in Phase 1. Similar to recruitment, there were also three rounds of interviews: December 8, 2011 to January 12, 2012, March 1 to 22, 2012, and June 28 and August 6, 2012[4].

The sampling strategy typically used in GT is *theoretical sampling* which is the process of seeking data that is relevant to developing the theory (Charmaz, 2006). This involves elaboration and refinement of codes and categories that constitute the theory. For this study, Round 1 used *initial sampling* in which

[4] There was a lag period in data collection in the third round due to issues with communication and coordination with the treatment centre.

clients were selected clients based on their social support score as a starting point to address the research question. For each week of Phase 1 recruitment, two clients were selected and targeted for recruitment into Phase 2 of the study with the lowest and highest social support scores. Clients who qualified for the interview phase of the study were re-contacted three to five weeks following their admission into the treatment centre. One client who was in the 90-day program was interviewed 10 weeks after admission. Similarly, the subsequent rounds of interviews continued to select clients based on the highest and lowest social but also adjustments were made to the interview guide to further explore categories to enhance the theory and reach saturation (see *Data Collection and Analysis* below for detailed procedure of sampling strategies).

Interviews were conducted with clients who were still in treatment at three to four weeks commencing treatment. The supervisor counsellor granted permission for the researcher to approach potential interviewees to be available to participate in the interviews after lunch at 1:00 PM every Thursday. The researcher set up appointments the day of the interviews. This interview protocol was also followed in the SCC study, in which the research assistant would attend the treatment centre with a list of potential interviewees.

During lunch, the researcher requested that the front desk staff member page or call the client(s) of interest to come to the front desk. When the client was at the front desk, the researcher asked the client if he or she was interested in proceeding with the participating in Phase 2 of the study. If the client agreed to take part in the interview, the researcher confirmed that the interview was not interfering with the client's programming. The researcher then directed the client to go to roll call at 1:00 PM and inform the counsellor at roll call that he or she will be in one of the group rooms to do an interview for 30 to 60 minutes. Further, the researcher informed the front desk staff the client and the room in which the interview was taking place, for safety reasons (see *Ethical Considerations* below). Arrangement of where the interviews were to be conducted was set up with the supervisor counsellor in one of the private group rooms or one of the private offices (counsellor or Executive Director).

Prior to starting the interview, the researcher reviewed the project information sheet with the client, outlining the purpose of the study, informing them participation in the study is voluntary, and how confidentiality and anonymity would be maintained (see Appendix F for reminder script for interviews). The researcher also had clients to sign the consent form for Phase 2 of the study.

Only those who completed both the first and second phase of the study received a $20 gift card as a token of appreciation for their time.

Data Collection and Analysis

Round 1: Interviews and Initial Coding

The initial round of interviews were for the researcher to have the opportunity to feel more comfortable with interviewing and enhance her interview skills, even though she had previous experience conducting qualitative interviews with similar research participants. The first round of recruitment occurred from November 10 to December 8, 2011 in which a total of 23 clients were recruited. A total of 10 clients were targeted for an interview, but only nine clients participated in an interview from December 1, 2011 to January 11, 2012. The reason for the odd number of clients in the first round was that in the fourth week of interviews, the researcher interviewed only one client rather than two. The first interview that day was about 90 minutes in length and the researcher did not have time to interview the second client of interest.

None of the clients that the researcher approached declined to take part in an interview. However, there were two clients that the researcher was interested in interviewing who were not physically at the treatment centre. One client had visitation privileges to connect with her children (first week of interviews), while the other client was on an outing as part of the 90-day program (third week of interviews). There were several targeted clients who were prematurely terminated, so the researcher selected the next available client who was at the treatment centre with the similar social support scores. For example, during the

last week of interviews the researcher selected a client from another week who had a similar high score as the targeted client but also selected him because he was in the 90-day program. Initially the researcher did not select clients based on whether they were in the 42- or 90-day program. But at that point, the majority of the clients interviewed were in the 42-day program. The researcher was curious to see whether clients experienced treatment differently in the 90-day program than those in the 42-day program (Field notes, January 12, 2012). Finally, the researcher intended on interviewing clients who were no longer in treatment. Due to time constraints, however, the researcher did not contact or follow-up with the terminated clients.

Between each interview, the researcher listened to the digitally recorded interviews prior to conducting subsequent interviews to adjust the interview guide by rephrasing, reordering, and/or deleting or adding questions to further explore ideas to reach data saturation.

Simultaneously with the first round of data collection, the researcher transcribed each interview verbatim and checked each transcript in relation to the original audio recordings for accuracy. Pseudonyms were inserted into transcripts and records to protect the identity of clients and organizations (see *Ethical Considerations* below). On average, one hour of interview took about seven hours to transcribe, plus an additional two hours to insert pseudonyms and clean transcripts or check for accuracy. The researcher transcribed eight of the nine[5] transcripts prior to conducting the second round of interviews (this overlapped with the second round of recruitment).

After the first round of recruitment and data collection, the researcher started analyzing the interview transcripts. Transcripts were entered into QSR International's qualitative data analysis software, NVivo 9, to manage and to code the qualitative data. A variety of GT analytical techniques were used in the analyses. Concurrent with transcribing, the first phase of data analysis was scanning the first interview (Maggie) to look for potentially relevant analytic

[5] Initially, the interview with Paul (Interview #7) was not transcribed because the researcher was uncertain whether the interview was relevant or addressed the research objective.

material (Glaser & Strauss, 1967; Strauss & Corbin, 1998). Relevant material included portions of interview text that contained material related to the research question. The following initial codes were created and guided by the researcher's notes (field and interview) and memos (December 29, 2011 & January 20, 2012), which included: (1) stories of how clients ended up in addiction treatment at the residential treatment centre; (2) the main people in clients' social networks who were supportive (prior and during treatment episode) and not supportive (prior to treatment); (3) examples of how people who were supportive and not supportive to clients; (4) how clients were involved in their own treatment program; (5) aspects of the treatment program (e.g., treatment activities); and (6) how the treatment centre allowed clients to connect to outside world through rules, policies, and procedures. After scanning the first interview, the researcher went back to the first interview, recoding relevant sections via *initial* or *open coding*, in which the relevant sections were further analyzed and closely examined through line-by-line coding to further make discrete and smaller elements that were more specific called *codes* (Charmaz, 2006; Strauss & Corbin, 1998). The codes that emerged from initial coding were then applied to the next two transcripts (Mindy and Adam).

Based on completing nine interviews, transcribing, and analyzing three of the eight transcripts, the researcher decided to conduct a second round of interviews as data saturation was not reached. Despite that clients provided accounts about the types of social support (prior and during treatment), how support was provided, and how clients were engaged and not engaged in their current treatment program, there was minimal data obtained on *how* those social supports identified affect the quality of clients' engagement in their treatment program at the treatment centre:

> I really need to get at: (1) how [the treatment centre] policies and procedures allow or don't allow clients to access social supports and clients' perspective on this, and (2) what does social support mean to clients in residential addiction treatment centre such as [the treatment centre] and how does their perception of social support affect their engagement in treatment.
> (Interview notes, Paul, January 6, 2012)

Furthermore, the researcher's supervisor closely read three transcripts, also advising the researcher to conduct another round of recruitment and data collection.

Round 2: Attaining Theoretical Saturation

The goal of the second round of data collection was to address the gaps in the data in the previous round. Prior to starting the next round, the researcher revised and adapted the interview guide to focus on how social supports influence treatment engagement, with advice and guidance from her supervisor. The second round of recruitment and data collection occurred from February 9 to March 22, 2012. A total of 20 clients were recruited from February 9 to 23, 2012. Interviews were conducted with four clients. The goal was for researcher to interview six clients, but interviews were conducted with four clients from March 1 to 22, 2012. None of the clients who were approached by the researcher declined to take part in the interview. During the second week of interviews, the researcher intended on interviewing two clients. However, there were no clients at the treatment centre as they were all on an outing. As a result, none of the clients from that week of recruitment were interviewed. There were two clients who were targeted for interviews in the last week, but they were not available:

> When I arrived [at the treatment centre], [staff member] at the front desk informed me that all the male clients were away on a trip with [the supervisor counsellor]. The only clients at the treatment centre were women and the new clients. I was a bit disappointed because the two people I intended on interviewing today were males.
>
> (Field notes, March 22, 2012)

The researcher selected two other clients on the list who had the next highest and lowest scores.

By the end of the second round of interviews, clients were providing rich, accounts on their perceptions of connecting with outside social supports, how that affected their engagement in their treatment program, and perspectives on "focusing" on oneself:

> I did realize that at this point that I have reached some point of saturation with the data. Many clients expressed that there should be connection with the outside supports, specifically family

> members, but not on a regular basis. There were some clients that did mention that connecting with family members was imperative for them to focus on their programming and early recovery at [the treatment centre].
>
> (Eva, Interview notes, March 22, 2012)

Further, no new information was obtained with respect to the broad codes from the first round of data collection mentioned above and the researcher decided to stop recruitment and interviews.

Concurrent with the second round of data collection, interviews were transcribed, and data analysis continued. Codes derived from the first round of initial coding were applied to the first six transcripts. At this point, the researcher was advised by her supervisor to strategically decide what material was not relevant, including: (1) stories of how the client ended up in current treatment centre, (2) history of substance and alcohol use, and (3) previous addiction treatment experience(s). Interview transcripts describing or referring to these broad categories were excluded from the analyses, if clients did not discuss them in the context of social support (prior or during current treatment episode) and how clients were engaged or not engaged in the current treatment episode (Memo, March 10, 2012).

Once the second round of recruitment was completed, 12 interviews were analyzed. The initial codes from the first round were applied to all the transcripts. During this phase of initial coding, codes were merged, modified, and clarified in addition to the creation of new codes. The next phase of initial coding was sorting by grouping codes that were conceptually similar in terms of events, happenings, objects, and actions to create categories (Strauss & Corbin, 1998). By grouping the initial codes to create categories, this allowed for *constant comparison* analyses of the data, which is a systematic approach by concurrently "using explicit coding and analytic procedures" (Glaser & Strauss, 1967, p. 102) to generate theory, fundamental to GT. Tables (see Appendix I) were created to systematically compare within the individual transcripts and between the transcripts as part of the process of constant comparative method and the next phase of initial coding. The initial codes were sorted and grouped to fit into

categories. The sorting of codes into categories also resulted in the creation of subcategories.

The next phase of data analysis involved *axial coding*, which is the process of relating categories to subcategories along the lines of their properties (i.e., descriptions or characteristics of a category) and dimensions (i.e., location of a property along a range or the depth of a category) with the purpose of reassembling the fragmented data during initial coding to give coherence to the emerging analysis (Charmaz, 2006; Strauss & Corbin, 1998). Axial coding further explored the *factors* affecting the process of treatment engagement (i.e., facilitators and barriers) such as treatment components (e.g., clients and counsellors and programming), the ways that clients connect with people outside of treatment via rules, policies, and procedures to connect with outside people and the supportive social support during treatment episode (Memos, April 6, 2012). Axial coding also played an important part in the initial development of the theory. It was also at this point that the researcher shared her initial thoughts and development of the theory with her supervisor. He provided guidance and suggestions on the analysis and the initial development of the theory with respect to the treatment centre's role connecting clients to supports to influencing client engagement.

Round 3: Ensuring Theoretical Saturation

Although the researcher felt that theoretical saturation was reached in the previous round, she decided to conduct a final round as she was encouraged by a colleague to do another round of recruitment and interviews (Field notes, May 24, 2012). The goals of the third round of recruitment and data collection were to: (1) ensure that data saturation was achieved, and (2) confirm the codes, subcategories, and categories from the 13 transcripts.

Recruitment occurred on one day, May 24, 2012, in which four clients were recruited. Two clients were selected for interviews on June 28 and August 6, 2012. For the first interview, the researcher selected a client who was in the 90-day program with the low score, rather than the other client who had the lowest score and in the 42-day program. At this point the researcher was still

interested in interviewing clients in the 90-day program as most of the clients interviewed at this point were in the 42-day program. Some clients mentioned that the younger clients in the 90-day program were not engaged or disruptive in the program. The second round analysis indicated that younger clients were not as engaged and were disruptive in sessions and the researcher wanted to follow-up with that with that. The researcher also was interested to explore whether their views varied from those clients in the 42-day program with respect to views on social support, treatment engagement, and connecting to external social supports.

The researcher experienced challenges with communication and coordination of scheduling the second interview, which was the reason for the time gap between these two interviews. On the last day of interviews, one of the counsellors refused to release one of the targeted clients from programming to meet with the researcher to do the interview, so she selected the next client on the list.

The two interviews were transcribed verbatim. There was repetition in the interviews that part of early recovery and attending residential addiction treatment was the need to "focus on yourself," which emerged as an important category and related to how clients talked about treatment engagement. Both clients also shared their perspectives on the treatment centre's rules, policies, and procedures, reiterating similar perspectives as previous clients interviewed. At this point, the researcher decided to no longer recruit and interview clients as no new information was emerging from the data. As well, the researcher was experiencing fatigue from being in the field and analyzing data.

After all 15 interviews were transcribed, all transcripts were further analyzed. The codes that emerged from the initial coding process from the previous rounds of data analysis were applied to the last two interviews conducted in the third round.

Once all the transcripts were transcribed, the next level of analysis involved going back and forth between *axial* and *focused* or *selective* coding in three phases. The first phase was *focused* or *selective coding*, which is the process of using the most significant initial codes to sort through the interview

transcripts, with the goal of determining the adequacy of the codes that reflect the data or in vivo codes (Charmaz, 2006; Straus & Corbin, 1998). During this phase, *clients' perspectives on social support* and *treatment engagement* were the main categories of focus, in which the researcher focused on the codes related to these two categories. Again, codes were merged, modified, and clarified.

The second phase of data analysis for this round was axial coding in which the focus was on exploring the role of social support in treatment engagement and how the treatment centre's role relates to their views on the extent to which clients were engaged in treatment (i.e., were 'working the program'). The next step further articulated how the treatment centre's environment affected treatment engagement.

The final phase was focused coding, which involved integrating and refining the theory (Strauss & Corbin, 1998). The *treatment centre's role as gatekeeper* was identified as the core category, which emerged from two of the broad categories from initial coding (i.e., how the treatment centre's rules, policies, and procedures affected treatment engagement, and how the treatment centre allowed clients to connect people outside of treatment). Although the researcher identified the gatekeeper role of the treatment centre earlier on in the coding process in axial coding, this was solidified with confidence in this phase. Diagrams and tables were used as visual tools along with memos for the researcher to flesh out and further articulate the connections between the core category and the other categories identified in initial coding, i.e., clients' perspective on social support and treatment engagement. Furthermore, the researcher examined the latter two categories in greater depth to support and strengthen the emerging theory.

The final step was rereading all the transcripts in their entirety to ensure that the elements of the core category were captured, accurately depicted, and the context was correct. Through this process, the researcher felt that codes, categories, and theory were accurate. The theory and components of the theory were verified by the researcher's supervisor through proofreading drafts of this thesis project, in which he provided feedback and suggestions for strengthening

the theory. Further, as stipulated by Charmaz (1990), the writing and re-writing of Study 2 fostered analytic clarity.

Ethical Considerations

Ethical approval for this study was obtained by the Health Research Ethics Board (HREB), panel B, at the University of Alberta. The researcher used the Alberta Research Ethics Community Consensus Initiative (ARECCI) ethics tools to assess the level of risk and to identify ethical considerations that were incorporated into the current study (http://www.ahfmr.ab.ca/arecci/areccitools.php). ARECCI tools are used primarily for quality improvement and evaluation project; this tool, however, was appropriate for the current study.

Ensuring Confidentiality, Anonymity, and the Safety of Clients

The researcher ensured confidentiality and anonymity of clients at various phases of the current study. Recruitment was conducted in a group setting rather than approaching clients individually. All clients present at recruitment were provided an envelope and a recruitment package that included the information letter, consent form, standardized form, and contact information sheet. The consent form (see Appendix C) included a section asking participants whether they were interested in taking part in the study. Regardless of whether clients agreed to participate in the study, all clients were asked to place all recruitment material in the envelope except the information letter and seal it.

Interviews were typically conducted on the premises of the treatment centre. Arrangement of where the interviews were to be conducted was set up by the supervisor counsellor. The designated interview room varied from week-to-week, typically conducted in one of the private group rooms (i.e., “Respect” and “Strength” room) or in the Executive Director’s office. To maintain anonymity and confidentiality of clients, the researcher: (1) did not share who was being interviewed with the supervisor counsellor, and (2) seek permission from the client to close the door in the private room.

Although the researcher did not interview clients who prematurely terminated the treatment program at the three to five week mark or outside of the treatment centre, a protocol was established beforehand to address issues around anonymity, confidentiality, and safety of clients and the researcher. The researcher intended to reach these clients via the contact information they provided at orientation, scheduling interviews either on the phone or at a place that was convenient and comfortable for the participant, preferably in a public space (e.g., coffee shop or restaurant). For phone interviews, the researcher intended to digitally record the conversation on speakerphone and in a private room at the Edmonton Clinic Health Academy (ECHA). If clients requested for a face-to-face interview, the interview would have taken place in a public space (e.g., coffee shop or restaurant) that was mutually agreeable. The researcher would have ensured that the interview takes place in a quiet and secluded area, away from other people. If the participant was willing to do the interview on campus, the researcher intended on booking a private meeting room located in ECHA.

Pseudonyms were inserted throughout the interview transcripts, field notes, and interview notes, to protect the clients' identity, the treatment centre, and organizations mentioned in the interviews. Further, numeric identification was assigned to link clients' baseline surveys, contact information, their pseudonyms, and interview transcripts. The numeric identification linking information was password protected, and stored on the secure server of the School of Public Health (SPH). Furthermore, contact information, consent forms, and other data collection material were stored separately and in a secure room in a locked cabinet at the SPH.

Because of the possibility that interview questions may make clients feel mildly upset or emotionally distressed, the researcher emphasized verbally and on the information letter that if clients needed additional support as a result of taking part in the project encouraging clients to connect with their counsellor or staff at the treatment centre, and had a list of other community supports such as the AHS

Hotline and Mental Health Help Line (see Appendix H) was available for clients, if needed.

Ensuring Capacity of Research Participants

Typically, clients admitted into the treatment centre were required to be free from alcohol and drugs 72 hours prior to starting treatment. The researcher was aware of the possibility that some clients may experience some withdrawal symptoms and/or appeared to be intoxicated, which could affect the clients' capacity to understand and to participate in the study. If that was the case and the client was selected to take part in Phase 2 of the study, the researcher had the opportunity to go over the information letter and consent procedures one-on-one, ensuring that the client understood what was involved in participating in the study and the risks and benefits associated with participating in the study.

Protecting the Researcher

To address the safety of the researcher, interviews were conducted on the premises of residential addiction treatment centre in which the supervisor counsellor and front desk staff were aware where the researcher was conducting the interviews. The researcher informed the front desk staff the client and the room in which the interview was taking place. Furthermore, the researcher was required to check-in the treatment centre's log in book in case of emergency situations (e.g., fire). The researcher never felt that her safety was at risk while spending time at the treatment centre.

Due to the nature of addiction and the questions, some clients disclosed very intimate and private details (e.g., emotionally traumatic events). At times, the researcher experienced some emotional distress as a result of clients sharing their life experiences. The researcher had the opportunity to debrief with her supervisor and other colleagues after interviews. As well, the researcher debriefed with a health professional during data analysis and the writing of findings.

Rigour

Rigour throughout the data collection and analysis was guided by the principles of credibility, transferability, dependability, and confirmability as articulated by Guba and Lincoln (1981 & 1985).

Credibility

Credibility is analogous to internal validity in quantitative research, referring to the "truth" or the data adequately reflects the participants and/or data (Guba & Lincoln, 1981 & 1985; Mayan, 2009). There were a number of strategies to ensure credibility. First, prolonged engagement in the setting "is the investment of sufficient time to achieve certain purposes: learning the 'culture,' testing for misinformation introduced by distortions either of the self or of the respondents, and building trust" (Guba & Lincoln, 1985, p. 301). For this study, the researcher attended the treatment centre on a weekly basis over a period of five months for recruitment and data collection. The researcher had also familiarity with the treatment centre from previous experience in recruitment of treatment centre clients for the drug treatment court from February to September 2008. In addition, the researcher has maintained relationship with the treatment centre staff, specifically the supervisor counsellor. Furthermore, during recruitment and data collection, the researcher was invited by treatment centre staff to eat lunch on Thursdays. This allowed the researcher to develop rapport with the staff and the clients at the treatment centre (see *Rapport Building with the Treatment Centre* in above section). To reduce the concern and tendencies to "go native" (Guba & Lincoln, 1985, p. 304), the researcher had breaks between each round of recruitment and data collection as well as attending the treatment centre only once a week between November 2011 and March 2012.

Another strategy employed to ensure credibility of the analyses is persistent observation, which "identify those characteristics and elements in the situation that are most relevant to the problem or issue being pursued and focusing on them in detail" (Guba & Lincoln, 1985, p. 304). The field notes captured the researcher's observations during lunch time including interactions and conversations with the treatment staff, in particular the rules, policies, and

procedures for clients to connect to external social support that provide additional context to what clients articulated in the interviews:

> ***Sunday Passes and Sunday Visits***
> Typically, residents are not allowed to get a Sunday pass in the first three weeks of their program. Residents [clients] can leave the treatment centre from 9 AM to 9 PM on the Sunday pass. After the three weeks, residents are granted a Sunday pass if they have no A's. If a resident gets three A's, then they will not be allowed to have a Sunday pass. [The supervisor counsellor] provided some examples of how a resident may not receive a pass for certain actions and behaviours including having a messy room, not learning or listening in class, and not complying with the rules.
> (Field notes, March 29, 2012)

Triangulation is another way to ensure the credibility of the findings and interpretations, which involved combining multiple data sources and research methods (Guba & Lincoln, 1985). The qualitative study is part of a mixed method approach in which the findings of the qualitative study to further explain the findings in the quantitative study. The researcher also corroborated the findings with the treatment centre's documents found on their website and conversations with the treatment centre staff, documented in field notes. For example, clients mentioned the rules, policies, and procedures for connecting with people outside of treatment in the interviews, which was confirmed by reviewing of the treatment centre's *Treatment House Rules* and conversations with the treatment centre staff documented in field notes. Finally, the current study used two data collection sources to explore the level of social support provided at treatment entry to clients first objectively through a standardized social support measure administered at baseline (see Appendix D) and clients' description of their social support prior to initiating the treatment episode via semi-structured interview (see Appendix G).

Transferability

Transferability is analogous to external validity, which assesses that the findings are applicable in different contexts or with other subjects. Transferability is established through collecting thick, rich descriptions of the context, setting, and characteristics of the participants (Guba & Lincoln, 1981; Mayan, 2009). The

researcher provided details of the treatment centre and interactions with clients and treatment staff documented in the researcher's notes (field and interview notes). In the interviews, the clients' provided rich details by providing examples and situations, for instance, about their important social supports and how that support was provided during their treatment episode; their perceptions on treatment engagement; and how the treatment centre allowed them to connect with the external world and how that affected clients' engagement in treatment.

Dependability

Dependability is the equivalent of reliability to determine whether the findings are consistently repeated "with the same (similar) subjects in the same (or a similar) context" (Guba & Lincoln, 1981, p. 104). Dependability was achieved through an audit trail, referring to the documentation of the researcher's decisions, choices, and insights (Mayan, 2009). Interview notes and memo-writing were integral to the audit trail process that recorded the researcher's decisions about recruitment, data collection, and analysis and the ideas and thoughts around the initial development of the theory (i.e., the role of the treatment centre and social support in a residential addiction treatment centre), discussed in the previous section.

Confirmability

Finally, *confirmability* is similar to objectivity "to establish the degree to which the findings of an inquiry are a function solely of the subjects and conditions of the inquiry and not the biases, motives, interests, perspectives, and so on of the inquirer" (Guba & Lincoln, 1981, p. 104). Similar in establishing confirmability, an audit trail is also used to establish confirmability. The audit trail included: (1) raw data, i.e., baseline surveys and digital recordings and transcriptions of interviews, (2) field and interview notes that integrated the researcher's reflexivity of capturing "self" in the research setting, data collection, and analyses (Guba & Lincoln, 1985), (3) memo-writing (including various PowerPoint presentations discussing the researcher's earlier conceptions of the theory of treatment engagement in a residential addiction treatment centre at

conferences), and (4) data analysis from NVivo and the use of tables to document the preliminary themes, categories, and codes.

CHAPTER 5: RESULTS – QUALITATIVE STUDY

Overview of Qualitative Results

This chapter elaborates on the findings that emerged from the data analyses techniques described in Chapter 4 and will: (1) provide the characteristics of research participants based on the questionnaire administered at treatment entry; (2) elaborate on the main categories that emerged from initial coding, and; (3) present the theory generated from axial and focused coding.

Description of Sample

A total of 47 clients were recruited, with 15 clients selected to be interviewed. Summary of the client characteristics is depicted in Table 7. The average age was 35.07 years of age (*SD* = 10.88 years), over half (53.3%) were males; one-third identified as Aboriginal/Métis/First Nations, about one-quarter (26.1%) Caucasian, and 13.0% other (black or visible minority). Approximately one-third (34.8%) had a grade 12/13 education level, while 17.4% had either a college diploma (technical) or university degree. The average MSPSS score was 56.7 (*SD* = 16.9) with scores ranging from 18 to 82, higher scores indicating high level of social support. Most (73.3%) of the clients had previously entered residential addiction treatment.

Table 7

Client Characteristics and Social Support Scores at Treatment Entry

Name[6]	Age	Sex	Ethnicity	Education level	Number of prior residential addiction treatment episode(s)	Social support scores (MSPSS)
Maggie	33	Female	Caucasian	Grade 9	8	57 (High)
Mindy	38	Female	Aboriginal	Grade 8	4	38 (Low)
Adam	36	Male	Aboriginal	Grade 12/13	1	71 (High)
Joshua	32	Male	Aboriginal	Grade 11	3	28 (Low)
Andy	49	Male	Caucasian	Grade 10	3	61 (High)
Erin	31	Female	Caucasian	Grade 12/13	0	66 (High)
Paul	Missing	Male	Caucasian	University degree	6	64 (Low)
Brian	22	Male	Caucasian	Grade 12/13	1	67 (High)
Jonah	31	Male	Caucasian	Grade 12/13	3	59 (Low)
Tyler	28	Male	Caucasian	Grade 11	1	82 (High)
Joanie	51	Female	Caucasian	College/technical degree	2	57 (Low)
Anna	42	Female	Caucasian	College/technical degree	3	18 (Low)
Eva	55	Female	Aboriginal	Grade 10	4	71 (High)
Simon	22	Male	Caucasian	Grade 12/13	0	58 (Low)
Ariel	21	Female	Aboriginal	Grade 9	0	53 (Low)

Main Categories that Emerged from Initial Coding

The first phase of data analysis, initial coding generated five broad categories: (1) social support (supportive and non-supportive), (2) treatment engagement or 'working the program,' (3) perspectives on connecting to outside people or supports while in residential addiction treatment, (4) how the treatment centre's rules, policies, and procedures affected treatment engagement, and (5) how the treatment environment affected treatment engagement and experience. Table 8 summarizes the subcategories and codes that fell into each of the main categories. The subsequent sections will describe the former two categories, followed by a discussion of the latter three categories as part of the theory of social support and treatment engagement.

[6] Pseudonyms have been used to protect the identity of the clients interviewed.

Table 8

Categories, Subcategories, and Codes that emerged from Initial Coding during the Second Round of Data Analysis

Category	Subcategories	Codes (Subcodes)
Social support (SS)	Supportive (people there for you)	• Meaning of SS • Types of SS prior (family members, community supports/resources, friends, other) • Examples of how SS was provided prior to treatment • SS during treatment (family members, community supports/resources, friends, other) • Examples of how SS was provided during treatment • How SS affected treatment engagement for clients
	Non-supportive (people not there for you)	• Types of people who were not supportive prior to treatment (family members, acquaintances, "using" friends) • Examples of how people were not supportive prior to treatment • Types of people who were not supportive during treatment (family members, friends, clients, and treatment staff) • Examples of how people were not supportive during treatment
Treatment engagement: 'Working the program'		• Examples of how client was engaged in their own treatment program • How clients was not engaged in their treatment program • Perceptions of how clients should show that they were engaged in their treatment program • Perceptions of how other clients were engaged in treatment program • Perceptions of how other clients were *not* engaged in treatment program • How other clients' level of engagement affected treatment program
How treatment centre allowed for clients to connect with people outside of treatment	Christmas procedures and policies	• Policy or procedure • Description of policy or procedure from clients' perspective • How policy or procedure affected connecting with outside people • How policy or procedure affected how client is involved in treatment program

Category	Subcategories	Codes (Subcodes)
	Treatment centre's policies and procedures	• Policy or procedure • Description and/or conditions from client's perspective • How policy or procedure affected connecting with outside people • How policy or procedure affected how client was involved in treatment program
Connecting with outside people or supports while in residential addiction treatment		• Ways to connect with people outside of treatment • Perspective on connecting with outside people or supports
Program components (e.g., clients, treatment staff, and environment/structure)		• How it facilitated treatment engagement and experience • How it was a barrier to treatment engagement and experience • How it related to social support

Client Perceptions on Social Support

Client perspective on social support was identified as a main category through initial coding. When clients were asked about what it means to have social support or "people there for you," clients shared their general perspectives on social support. Some of the clients described social support from the perspective of the availability of people such as family members and friends who care, had faith and believe in them, and provided them with a sense of self-worth:

> [Having "people there for you"] gives you a feeling of self-worth…if you do have a good support system and it helps you to knowing that you have loving family and friends out there that do care about you. And they want you to succeed in life….they help to realize that there is more to life than just being an addict.
> (Maggie, lines 80-4)

> [J]ust people…have faith in me and that believe in me…if I'm helping myself, they'll help me as well.
> (Erin, lines 41-6)

> [T]hat's the biggest thing…just to know that somebody cares enough to…It doesn't even matter what it is…I'm not asking them

> to move mountains…Even just to hear that, a voice. Like a familiar voice, it's really nice…
>
> (Joshua, lines 451-61)

On the other hand, *non-supportive* or people "not there for you" were described mainly as those who did not understand and were judgmental about their addiction; did not support and respect their sobriety; or were not available or helped them throughout their addiction and recovery. The following sections will provide an in-depth description of the types of people and how these people were supportive and non-supportive to clients prior and during this current treatment episode.

Supportive People Prior to Treatment

The majority of clients identified at least one family member, either from a parent, their children, and/or sibling, as people who provided support prior to clients initiating this treatment episode. The support from their family was provided in various ways. Some clients described their families providing support emotionally through verbal encouragement:

> [My daughter]…was always supportive….just through uhm verbal, you know, uh encouragement and stuff like that.
>
> (Mindy, lines 225-34)

Verbal encouragement was also displayed by one client's mother saying that he was her inspiration:

> My mom's been there too…she's even told me…I inspire her after I got out of treatment the first time 'cause I went through all that crap…I was like, "Wow! That's pretty crazy!" You know I went from being a drug addict to now I'm inspiring my mom because I came through such an adversity…
>
> (Tyler, lines 283-90)

Similarly, one client described how her son was an inspiration for her to make changes to her lifestyle:

> And then I have… my son…. he's 25 almost, and straight, so proud of him. He inspired me actually to make my changes….So he's been there done that. He doesn't wanna do [drugs] anymore and I says, "Are you happy?" He says, "Yup." I said, "Are you sure your happy without doing any partying?" This was when I was drinkin' and I was bombed one day and we were driving together.

> And he says, "No I'm happy" and I says, "Wow! I wanna be like you when I grow up." And so that really stuck in my head and shortly after I started to clean up my act and make changes.
>
> (Joanie, lines 118-34)

Family members were also described as those who were caring, showed concerned about the clients' well-being, which made clients feel valued and heard:

> [My daughter and I] never had a bad relationship…she's not judgmental. She actually takes what I say to her in value… She listens to me….she believes almost everything I say, and I don't lie to her, I'm very open and upfront with her.
>
> (Maggie, lines 95-107)

> [L]ike my relatives they actually were really supporting me, you know, they wanted me to get some help and they wanted the best for me, so.
>
> (Erin, lines 51-3)

> [J]ust by showing love. Like my mom and aunt, like, out of all the times I keep messing up, they keep supporting me and like they can see I'm taking it serious now…they'll basically do anything to support me while I'm...in recovery.
>
> (Jonah, lines 63-9)

One client described a situation of how her daughter provided emotional support for her decision to address her addiction issues, despite her daughter's initial disappointment:

> [T]he last time when I was in detox and I phoned [my daughter] and I told her, "Well I messed up again." She goes, "Messed up how?" I said, "Well I'm into the drugs again, but I'm looking into fixing it and going into detox." And she goes, "Mom! How can you do that?...I've had enough of it!" But then later on when I gave her a week to kinda calm down…then later on she said, "Mom, you know I'm not that heartless. You're the only one I really have to talk to, so do what you need to do and I'll still be here when you get out." So it's really meant a lot to me…
>
> (Maggie, lines 154-67)

Most clients stated that family members provided them tangible support such as financial assistance, driving them to appointments and 12-meetings, and spending time with them:

> [My parents] were very supportive…they drove me to psychiatrist meetings…take care of my pills, my medication…they just helped out, I would live there, I didn't have to pay rent…they did go to a few meetings as well just to get an idea of what I was going through….then they came with me to a meeting…[My aunts, uncles, and cousins] have me over and have me over for supper…have a talk with me, or uhm take me out shopping or, you know just uh out for lunch…they'd stop by and visit and to see how I was doing...[My parents] did help me with some of my bills…They were positive influence on me; so that helped me out in a lot of ways.
>
> (Erin, lines 24-70)

> [L]ike when I had my addiction and I was really bad…[my mom] knew the consequences that would happen to me…she basically kept me drinkin' 'cause she knew I'd die, like with massive seizure, shakes, like all of that….she actually helped me to live….she saw me at my worst and it was so hard gettin' into [the treatment centre]…
>
> (Andy, lines 190-200)

> [My parents showed support] in every way possible. Either it was, taking me to meetings, you know, being there to talk to them, anything under the sun, any problems I had I could bring them up with them…I think now that everything's out on the table it's a lot easier to talk about my drug problems and money problems and all that stuff, so….I live with my dad now so that definitely plays a big role….whether it's goin' for a coffee or even goin' out for a meal to my mom's, you know, watching movie, we do all sorts of things now that, before we never ever did….spending quality family time.
>
> (Brian, lines 86-149)

> And [my aunt] paid for me to go treatment before and she's like always been there no matter what I do….she would never give me money, which is good 'cause I was a drug addict, but she would always bring me groceries….Drive me place[s], uh, just call me, even though I wouldn't answer the phone half the time. Call me to see if I was alive….
>
> (Jonah, lines 279-95)

Friends were also an important source of support for some of the clients prior to initiating this treatment episode. These friends were typically clean and sober friends who were not addicted to drugs, with some who smoked pot occasionally or drank alcohol moderately. One client described how his friends

avoided alcohol when they spent time together and offered to help him out after he completed treatment:

> [M]y friends helped out in a sense by not inviting me to parties….to avoid the alcohol and that…'cause the lifestyle I'm kinda, kinda in is motorcycles and we all ride…beers are kinda associated [laughter] with motorcycles…we still get together and…going out for dinners…movie nights and stuff like that. Or getting together with my closer friends and playing pool. Uhm we just avoid the alcohol all together…like I said earlier, we are separated me and my wife…whether or not I'm going back to the home they've been supportive in regards to if I needed a place to go, I could come there…anything I need, uhm, money, uh, vehicles, anything I just pretty much need access to they're, they're right there helping me…
>
> (Adam, lines 171-88)

Another client explained how his friends cared for him during his drinking episodes:

> There's two women that live in the building and I'm really good friends with them. And they're drinkers…very limited amounts…they're really helpful…they're really happy I'm here, so they're a really good support….they were always upstairs at my place, taking care of me: "Andy you've had enough..."…they would, help me upstairs and [laughter] and get me into my uh apartment and stuff like that.
>
> (Andy, lines 278-310)

One client who was in recovery before entering this treatment program described how his friends, who were also in recovery, were supportive during his relapses in the following ways:

> [M]y ex-girlfriend is so a big support of me, actually she's helped me through a lot! [Laughter] I was ready to give up and almost run back to B.C. actually after the first relapse and it was her talking to me and it she wasn't even giving me advice, she was asking me, "What do you think is best for you Tyler?"…but, most people are trying to throw stuff down my throat…I didn't want to hear what I'm supposed to do…. when she tells me to do something or not do something but gives me advice, it's because she uses it in her life and it works for her, I've seen it two years almost clean…she practices what she preaches….I have a lot of respect for that, right because I can see it working.
>
> (Tyler, lines 82-123)

> [My friend who I met at my first treatment centre] Louis actually he helped me through a lot of stuff in the beginning….he gave me really good advice because he's seen it….he's been there for me through a lot of my relapses….I call him crying one day, just bawling 'cause I was so ashamed of what I was doing.…He's like, "We're here for you. I'll come pick you up no matter what the situation is, I'll come get you."…it's nice to actually have friends that care about you, instead of friends that just want you because you bring booze and drugs to the party...
>
> (Tyler, lines 643-62)

Further, some clients mentioned that support was provided by a variety of community organizations. One client mentioned that the community supports funded her to attend treatment: "I have social assistance….that covers my medication and my psychiatrist and they covered the fees to come to this [treatment program]" (Erin, lines 73-6). A few clients discussed how a family physician and counsellors helped them in the process of entering the current treatment program, respectively:

> [M]y…[is] a big support as well. Well he has, well he works with me closely on different aspects of uh just my mental and physical health and uh he gave me a temporary, or sick note for [employment insurance] benefits...He helped with doctor's note, he also helped with uh filling out the uh paper work for [the treatment centre]…
>
> (Adam, lines 53-75)

> [M]y other big, huge support was…my [government agency] counsellor….she bent over backwards to get me in here….I called the day before I was supposed to come in here and like my funding still didn't come in. And [the government agency] made it happen in an afternoon. Sometimes it takes like weeks, but they made it happen like that. So I was pretty lucky.
>
> (Joshua, lines 277-87)

> [My government agency counsellor]…she said, "Here's the sheet to [the treatment centre]. Do you wanna go for rehab? Or you can leave?...So basically what was then I came to realize now I'm here is that she gave me the opportunity of life and death and I chose life. So about a half a week later after that I was dropped down over here and into the 90-day program.
>
> (Simon, lines 30-8)

Other community resources also helped these clients in their addiction and recovery:

> I'm with an agent [community outreach program]…because I was a prostitute before, uhm and they helped me get off the street and they put me in safe housing and then helped me get my own place…I have a support worker her name is Belinda and she's very supportive....that's what's supported me…a lot of times when us girls are out there…[you] don't take care of yourself...[the community outreach program] help you get your doctors' appointments…you had a bad date…they take you to the hospital and sit there with you…helping you with clothes and help you get an apartment…
>
> (Mindy, lines 120-50)

> [M]y mental health worker actually is probably providing the most support 'cause she specializes in addiction….she's the one that basically gets me the appointments with certain people and gets my meds in line…
>
> (Jonah, lines 84-7)

Finally, one client mentioned how her significant other supported her over the years:

> [My boyfriend has provided] [j]ust all tons. Prayer, prayer and just uhm, financial and stuff like that. 'Cause I got raped, uhm, like whenever I first came on to the streets and stuff, so, he's basically… helped me whenever I was unable to help myself and take care of myself…he's always stood by my side…
>
> (Mindy, lines 255-59)

Clients also identified characteristics or qualities of supportive people prior to treatment. Supportive people were described as "calling them on stuff," non-judgmental, and understanding:

> I would rather have one person that understood me [clear throat], that supported me…that I could talk to and be open with, that was not trying to feel sorry for me or try to fix me, but just there to listen. If I had one person like that, it would be better than ten people….maybe seeing through me, calling me on my stuff….I've learned to manipulate, I've learned to…get my way in certain situations…call me on that, when I'm starting to do that. Sometimes I do it without even knowing it.
>
> (Joshua, lines 107-26)

> [M]y sister-in-law and my neighbour…with my sister-in-law's phone calls and we visit sometimes….if I call her, she's very

> prompt to return my calls and she just supports and she's the one who will challenge me and call me…in a very nice way, she's just straight up….And my neighbour as well….She's like crotchy…she calls me on my stuff, big time…she's like, "Stop doing that then!"…it's healthy stuff, right? She's good.
>
> (Joanie, lines 91-116)

Receiving Social Support prior to Treatment

For some clients, support they received was conditional. Some clients expressed that in order to receive support from others they had to admit they had a problem:

> And once you can admit it to somebody, even yourself, then that's where your self-help or your support systems come in…But I feel if you would go to your family and say, "I have a problem, I need help", they, they are able to support you a little bit better instead of finding out about it through some other way.
>
> (Maggie, lines 578-589)

Adding to the previous example, some clients described that their support systems came into place once they made the decision to cope with their addiction, as explained by these clients:

> [T]hings got worse and worse and [my parents] just pretty much said, "Look you need help. You need to help yourself some way." So uhm, they said they'll, "Support you, you can live here," like at their house [clear throat] "if you do help yourself."
>
> (Erin, lines 25-8)

> I[7]: …how has your dad showed support since you've been in treatment, for you?
> Paul: Ahh, since I started takin' my alcoholism seriously. He's been right behind me.
> I: You said that he's been taking your…alcoholism more seriously?...
> Paul: That I'm battling it. He's, he's known I've had to battle, I had to come to a point where I had to battle it. He's right all behind me, 100 percent till. One hundred percent backing as long as I'm trying.
>
> (Paul, lines 595-604)

On the other hand, one client described that she received unconditional support, even in her active addiction:

[7] I: refers to "interviewer" or the researcher interviewing the clients.

> [H]aving people "there for me" means, uhm ,that they support me…bettering myself, but even at times…when I'm not per se doing what's in my best interest, you know, like when I was in my addiction…they still try to help me you know like offer me rides to go to meetings or you know offer me rides to go to the doctors, you know just stuff like that.
>
> (Mindy, lines 98-104)

Summary of Supportive People Prior to Treatment

To recap, many clients identified their family members as being supportive prior to entering the current treatment episode along with friends who were non-substance abusing or in recovery and community resources. These supports were described as healthy and positive whereby they helped clients through emotional (e.g., providing verbal encouragement), tangible (e.g., providing financial assistance), and informational (e.g., providing advice and guidance). Furthermore, the important qualities of supportive people as described by some clients was that they were understanding and non-judgmental, making them feel valued as a person rather as an addict. Finally, a few clients described that the support they received was conditional in that they needed to admit they had a problem plus take action to do address their addiction issues.

Supportive People during Treatment

During the current treatment episode, clients identified their main social supports as those who were within the treatment centre such other clients, counsellors, and treatment staff such as the program attendants and the Elders. Most clients expressed that one of the most important aspects of receiving support within the treatment centre was that they were understanding and non-judgmental. Some clients' perceived that counsellors and treatment staff were supportive because they experienced addiction themselves and understood the struggles that clients experienced in addiction and recovery:

> The counsellors, the staff, they've all been through addictions as well, so when you go and talk to them about something they can relate with you on a lot. And that's what I like about [the treatment centre], they don't judge you, they don't you know tell you "Oh you should be doing this and this and this." They ask you what you feel you need. And then they help you work on that.

(Maggie, lines 311-7)

> [J]ust the way [the counsellors and staff] act and stuff, they care about your recovery. The ones showing interest and the ones that you may not know, or cross paths with, they don't hinder your recovery at all….They show support especially the ones that have been there, that have recovery.
>
> (Paul, lines 746-57)

> But some of the [program attendants] have like told me some pretty intense [stories in their addiction]…it just shows you there's hope, 'cause people have been way worse off than you and succeeded in this sobriety.
>
> (Jonah, lines 588-92)

In addition, the counsellors and staff members provided emotional support by listening, being empathetic, caring, and showing concern, as described by this client:

> I wasn't feeling well the other day, I actually had a cold…I was waiting in line for the kitchen, like to open up for lunch…but the lady that runs the kitchen, she was like, "Ew you don't look very good today Anna." And I said, "Well yeah I just want some soup." …She asked what kind I wanted and stuff and extra crackers…she wanted to make sure, "You know I hope you're feeling better" and it's just a real insignificant things that like that seem insignificant, that really do carry a lot of weight. 'Cause that day I wasn't out in programming. I was basically in bed most of the day, so at the point she was really the only person I had talk to…But she felt some need to be kind and you know be nice…
>
> (Anna, lines 174-93)

> So even like the staff that do the cooking for our meals, they have the same pleasant, sort of uhm outlook, they always ask…how you are, like they know you by name, they're very friendly and positive, so you see that even right down to the cooking and cleaning staff all the way up to, I've had like the director come and sit with us at lunch and just sort of talk while we were, just casually shared lunch with us and she talked too about...how the day was going and how things are and if you're enjoying it and stuff. So you kind of get a feeling like that all of the staff are sort of here as supports, even in the most minimal way, but they're still supports…You know you're safe and there's people who care, right?
>
> (Anna, lines 144-55)

They also supported clients by providing advice and guidance such as sharing tools for self-improvement and recovery:

> [My counsellor] listens to me…She tells me the truth, you know, she doesn't just tell me what I want to hear….in a very professional manner…
>
> (Mindy, lines 266-8)

> I got so lonely I had to go talk to the counsellor…he did this little trick on me, some breathing thing, and it's helped me get in touch and then I felt really good after that and then from there, I like that feeling of after...so it was really nice, and I just kept, kinda movin' on with that.
>
> (Joshua, lines 4 -69)

> [J]ust,[my counsellor has been helpful] like talking to me and stuff…she gave me a book to read a book it's called *The Black Swan*….And it's about…healing for…loss of a loved one, and I was reading it and it's really good….the book like helped me to…not live in the past, and don't think about the future but just to live today and stuff with now...in the moment. Not think about the future.
>
> (Ariel, lines 289-307)

The counsellors were also supportive by communicating openly, honestly, and "calling" clients on their stuff, as mentioned by these clients:

> [My counsellor has] been looking out for my well-being. Like uhm, just in a positive manner…they have feedback about things that I talk about…it might not always be what I want to hear but at least they're giving their honest opinion, which I appreciate….
>
> (Erin, lines 94-7)

> [T]he staff here I find are definitely, probably the biggest thing around here. Not so much in the fact that they're, always there, but if anything does come up, there's always someone to talk to and they always give you an honest answer. And I think that plays a big role in, you know, pointing out little things that, not only you can fix but other people can fix too….[providing] [s]upport and advice…
>
> (Brian, lines 347-56)

> [My counsellor] calls me on all my shit!...Everything!…I say I want to try not swearin'…Today I walked out of the, the kitchen, I knew I was gonna be late for group…I go into [my counsellor's] office, "…I'm not gonna be on time. Fuckin' buddy..."…He goes to me, "What did we say about swearin' Simon? What did you say

> about swearin?" "Carlos I don't have time for this." He's like, "What did you say though?"…I'm like, "Not, I shouldn't be swearin'. But this isn't the time for this." He's like starts talkin', "Well?"…he calls me on all my shit….Or if I'm sleepin' in the programming, "What the hell man?...is this what your aftercare is gonna look like?" You know like, straight up...he figures you're, we're all addicts and we're all manipulators, and we can all be really good liars, and he was an addict at one point too, so he'll call you straight out if you're bull shittin' him….he knows how to [rate it], he's been doin' this for a while…
>
> (Simon, lines 339-65)

Another client described how the "spiritual guy" and the Elder were positive role models for him, expressing that he admired their humble nature:

> [T]he Roger guy, he's the spiritual guy here….when he talks, people seem to listen. [The other clients] respect him a lot too…a lot of things he says and stuff like that I can really take to heart because that's the person I want to be…very humble man though, he's very soft spoken, I really like that….listening to him talk…he's taught me some things… the grandfather guy [Elder] here...the same thing though, when he talks [all the clients]…shut up, 'cause some of the other teachers in the classes, people are just cross talk left, right, and centre, but when those two men are in those meetings, everybody is just quiet…they obviously have a lot of respect for those two…very both humble men though….something I could look up to though.
>
> (Tyler, lines 599-632)

Like the counsellors, other clients were also an important source of support for some of the clients during treatment because they could "relate to each" (Adam, line 127; Eva, line 38):

> I: …have [the clients] been a source of support for you?
> Anna: Absolutely!... we learn to…help each other out when …we've had a difficult day or whatever, to…nurture each other and stuff, because again we know we're all in the same boat...a lot of us are displaced from our families or have been disowned from their families or you know, having their children taken away and all these kind of things, so. It's nice to have a peer that you know understands sort of what you're feeling and doesn't judge you, doesn't go, "Well it serves you right for having your kids [laughter] taken away."…I mean that would be the natural reaction, it's not good but, you know whereas in here people understand because they too have had a similar encounter or whatever…it's not all cut and dry…

> I: So they understand like you guys are going through the...you guys can relate because you're going through the same process of...being in treatment and as well as the addiction?
> Anna: That's right, exactly.
>
> (Anna, lines 312-54)

> Gene is number one support….he's my "brother in arms"…the first day I showed up here, he hated everything, I want nothin' to do with anyone…I walked in here, I hated everyone, I'm gonna sit on the side…I'm gonna do this program by myself, get out here, these guys are all a bunch of tweekers, I [don't] give two shits of what they all gotta say, and Gene had the same [laughter]...attitude the first day….we're talkin' and over the next two or three days we, we both just secluded ourselves by ourselves at first…found out, I'm pretty much the same person as he is, just 11 years younger….we grew up with the same type of mother, same things, stepdad, his dad wasn't around a whole lot…I never met my real dad….we're like, "'K, this guy knows what, where I'm comin' from, I know where he's comin' from." And then we just start openin' up and then after that, I started to feel more comfortable around the other people…
>
> (Simon, lines 207-30)

> Ariel: 'Cause everything is helpful in a way and like in groups, I like hearing other people's stories and stuff like...because…like after I lost my babies' dad I just feel like…my life sucks.…hearing other people's stories and…it's way worse, than mine is…when you think you have it bad 'cause there's always somebody out there that has it worse and stuff…but I like hearing their stories and stuff…
> I: …it's nice to hear other people's stories to know that you can relate, you guys can relate...
> Ariel: Relate too, yeah.
> I: ...other people.
> Ariel: Yeah that too.
> I: And to know that, it's probably do you think it's good for you to hear other people's stories too because you can hear how they dealt with it?
> Ariel: Yes, that's exactly what I was tryin' to say, somethin' like that too.
>
> (Ariel, lines 741-67)

One client explained a situation in which his roommate was helpful by providing an alternative perspective and approach to handling a situation:

> [T]hen I met my roommate…he's a great guy, real calm. I'd come in and flippin' my lid about somethin' and he's just sit down, "Oh

> how's it goin'?...What's wrong?" I never had anyone like you know, like my buddies it's, "Let's go get that fucker" kinda thing…like my buddies back home….Whereas with [my roommate] it's just like, "Let's work this out..."well I'm like "I'm gonna tear his head off!" He's, "No, no, chill out. Like, what did he do?" …by the end of the conversation, I've, I've scratched my head thinkin', "Why was I flippin' out so much over somethin' so small?"…he worked me into the park. Me and [another client] we vent off each other, like two hungry dogs. Where he was just this calm kinda guy that you know.
>
> (Simon, lines 231-52)

Some clients also provided emotional support to others in the following ways:

> [T]he clients there's a lot of support…for instance, when you, you might be going through some stuff one day…they give you a high five or smile at you or…give you your space or offer to give you a hug…Sometimes when people are going through stuff you gotta give them their space and just let them feel it out…
>
> (Mindy, lines 275-82)

> [The] clients have by being friendly, uhm, listening to what I have to say, and uhm having you know having an open mind about everything and having respect…
>
> (Erin, lines 119-21)

> But as time went on I started meeting people and they became supportive….all of a sudden had guys in my group, like when I started gettin' involved with guys in my [group]…they'd walk up to me, "Hey Andy wanna sit? Do you need something to talk about? You looked like you're pretty stressed out."… that's how they became supportive….eating dinner with me…goin' for walks around the building…if I'm havin' a bad day…I got comfortable with the fact that I could walk up to 'em and say, "So-and-so can you, do you have a minute? Can I talk to you?" And they do the same to me too sometimes. If I was havin' a great day, he might be havin' a bad day, so we work together.
>
> (Andy, lines 754-82)

A minority of clients connected with individuals outside of treatment who were also in recovery, who provided support to them. One client discussed how his girlfriend who was at a different treatment program encouraged and supported him during treatment:

> Oh [my girlfriend is a] huge [support]. She sends me letters. Right? She comes out [to visit at the treatment centre], she always has something planned for us…she sends me uh, books, self-help

> books, you know like that, she always encourages me. She's showing me what she's learning [in her treatment program], right? And she tries to bring that…She's really understanding, really tolerant.…doesn't see my action or my behaviours as me, but just as my behaviours, right? So she can see beyond that, which is really, really good. And it's really helpful. And that's just from her like going through [treatment too]…
>
> (Joshua, lines 471-9)

Similar to the support provided by family members and how they supported clients prior to treatment, these were also an important source of support during treatment for some of the clients. Emotional support was provided by encouraging clients to stay focus, communicating through listening to clients, and visiting clients at the treatment centre. Further, concrete support was provided by family members bringing food and essentials to the treatment centre, taking care of children while in treatment, and providing financial assistance. This additional help from people external to the treatment centre allowed these clients to focus on their treatment program rather than worrying about outside distractions, as the following examples suggest:

> [A]s for the wife, she shows up here on Thursdays, Thursday evenings for the opening meeting and so is my Goddaughter. So they're here….Just fill me in on what's going on in the home life…bring me cigarettes [laughter] and...My essentials, shaving, shaving razors and stuff like that…I like the fact that I still have contact with them I suppose.
>
> (Adam, lines 416-24)

> [T]hey picked me up on my pass the next Sunday…that support and positive support…I'll call them and they'll be happy to hear from me and they'll just be and yeah reminding me…"Hang in there!" …And then they go out of their way to provide me with food if I need in here…'cause I'm not getting that much money [from financial aid]…[my parents] don't mind helping me out as long as I'm helping myself, so.
>
> (Erin, lines 126-37)

> Plus my mom's really good support as far as helping me out through this….Just being there when I needed her, like as far as talking and uhm, if I'm through, going through rough times, and she's been here every weekend since I've been here, same as my brother. Like for visits and if I need stuff, they're always here for that….[my brother and my mom] actually went and cleaned my

> old apartment up while I was in here….Well my daughter…she was born…with a bit of a bad artery and a heart, so she's kinda behind [mentally]….she's supportive just because she's so loveable [laughter]….she loves me to death and she cares about me…[My daughter is a support by] [j]ust talking to me….she says to me, "….I'm really proud of you dad."…That's about what she does.
> (Andy, lines 205-75)

> My parents and…my grandma….She helps with my girls, my daughters 'cause they're keepin' my daughters right now….so that's why I'm thankful to them…without them I'd probably wouldn't be in here…they've been in here since day one…Generally like send me money and stuff for like smokes…pay off my phone bill…I talk to my mom. I talked to both of [my parents] and I tell them, 'cause like, my, I was talking to my dad …I was like, "…I'm scared to leave, like I'm scared to leave from here."…My dad told me like, I'll be fine 'cause I'll get a lot of help anyways from here around supports in the city here.
> (Ariel, lines 189-257)

Lastly, one client described how his employer supported his recovery:

> [My employer] given me the time off to come here and work on myself….With the temporary leave of absence….my employer has helped out in regards to my children. He takes them out on outings. Uhm, tobogganing, sledding, skating, and such out to dinner just so that there's still a role male model in their lives. Uhm, my employers also spoke with me just this past week and he said, "We're not going to put you back into work at full force, we're just going stand you in slowly." Until I'm more comfortable and instead of back in and then go back to full-time work.
> (Adam, lines 50-64)

Summary of Supportive People During Treatment

Similar to supports prior to treatment, clients described supportive people as those who were understanding and non-judgmental. Family members remained a main support, emotionally and materially. However, the biggest supports during treatment were the individuals within the treatment centre such as other clients and staff. They were particularly important because most of the clients could relate with them since they experienced addiction.

Non-Supportive People in Clients' Lives Prior and During Treatment

Clients also identified people who were non-supportive that included

friends and family members. Generally, non-supportive people were barriers to some of the clients' sobriety:

> Not respecting my…not trying to be clean….Using around me or drinking around me. Pushing things on me….If you push recovery on me…without letting me find it myself, it gets very unattractive, right? It's like to push on something to me, right? I don't really respond, I don't like being told what to do. Yeah. If you allow me to find it…it's easier for me.
>
> (Joshua, lines 371-9)

Opposed to supportive people who were described as understanding and non-judgmental, non-supportive people lacked understanding of the addiction process, as described by this client:

> [S]omeone that knows nothing about addiction and they think you can just quit like that. Maybe misinformed, ignorant people aren't supportive….
>
> (Jonah, lines 167-95)

Prior to initiating this treatment episode, "using friends" or "acquaintances" were considered to be non-supportive people:

> [A]ll the people I used to hang out on the streets, they're not there for me, so. "Street friends," those aren't really friends, "street associates"….when you're in the lifestyle…they're like "I'm here for you for life! I'm down with you." They're not down with you, 'cause they're not down with themselves…you cannot help someone if you can't help yourself…. it's just kind of hard to help somebody else if you can't help yourself…when you go to the hospital and when you go to jail, they're not there to help you…They're not supporting you to go to treatment and stuff like that and saying, "Well you need to get help really, you're really messed up."…they just want more money or more drugs or something…
>
> (Mindy, lines 311-34)

> [T]here's a few friends that are still caught up in addiction…so that wasn't support what so ever because I was using with them….not giving me uhm, positive energy, I could say…having a negative outlook on things….if I'm surrounded by negativity…it rubs off on a person…
>
> (Erin, lines 142-53)

> I definitely think, hm, almost all the people who weren't supportive, their only real interest were the drugs, especially 'cause I was selling for a while there, most of them were pretty much

> were only acquaintances…when they needed something…makes you realize, not only who your friends were but who the acquaintances were…when you're going through really tough times, you come to realize who your true friends are whether they're there to support you or they're there to just even, you know, listen to you, or spend time with you. And I found, especially with my friends, once all the really big things in my life came up, pretty much all of them weren't there, especially being caught by the law, a lot of them were, I don't know so much scared, but they didn't wanna so much get involved….especially when with drugs and stuff, it's hard to come across people who are truly honest and there for you I find. Most of them are pretty much only there for the drugs or alcohol…
>
> (Brian, lines 376 -96)

> [P]eople you use with….I always knew that people I used with, I was using them for something too, they weren't my friends I knew that…I was smart enough to know that, I was just using them like they were using me….Drug friends…'cause they talk out of their ass and when usually when they're high they'll say things that aren't true. And uh, obviously they don't support you, they're chasing the high.
>
> (Jonah, lines 167-95)

> No [old friends are] not supportive at all. They just used me….couple of people pointed it out before…I've never noticed it. I didn't want to notice it because my whole of addiction was feeling accepted. I wanted to get accepted…those people when I came there I spent $300 on booze, they were like, “Yah Tyler, you're the man”…It made me feel like I was welcomed and I was wanted. But as soon as the beer and the drugs are gone at the end of the night, “Okay we're going home. Bye.” Didn't see them till payday again. They weren't supportive at all. They didn't care about me. They just care about their next, their next thing…
>
> (Tyler, lines 672-82)

In the same way, one client provided a number of examples of how other people who were also in recovery were non-supportive by not respecting or supporting his sobriety that led him to relapse, implied in the following excerpts:

> My ex-girlfriend….I was with her for nine years. And I remember when I first came to detox, I'd be calling her up and she always gave me crap, telling me how lonely she is and trying to make me feel basically guilty. And I always told her, “I'm going to treatment right now and you're making me feel bad for bettering my life”…it's not that she's not supportive…she refuses to take any

> action towards her recovery….I relapsed a couple of times with her as well….I try to tell her where I'm at and stuff like that, I try to give her advice and she just shoots it right back in my face, trying to think I'm preaching…she just doesn't understand...she's a "dry addict"…when I talk to her, it just brings me right back to where I was.
>
> (Tyler, lines 729-52)

> There was my friend here. I met him…day two in detox. He became my best friend and I went into the same treatment centre in [previous residential addiction treatment centre] with him. It's not that he's not supportive…I quit smoking for three weeks, I was doing really well. I came back from… my first relapse…Next thing you know he wanted a "wingman" for him because he had to go meet a girl…So he goes, "Can you come with me?" so he can stay sober. So I'm like "Okay I can do that."…next thing you know we're sitting outside the bar and uh he starts going on…and talking about cocaine…he knew I had a pocket full of money….it did trigger me in a big sense because I know he can get it: I'm sitting with money, in front of a bar…as soon as I lit up that cigarette, I, I was okay, "Screw it, let's go pick up!"…I dropped him as a friend before I came in here….I told him, "You only come around when you need something or you want something from me. You don't come around 'cause, you don't care about me…You don't care about yourself really either too." So he kinda drag me down with him…
>
> (Tyler, lines 754-79)

> That's, that's a key thing [practicing what you preach]. Like I had one friend back in last summer…he'd give lots of good advice, he helped through some stuff, but once I started relapsing and stuff like that, he was very critical of me…it's not like I didn't need to hear it but it's, he's a hypocrite. He…tells me something like say, he'll give me relationship advice and he'd turn around and does the exact same thing he's telling me not to do.
>
> (Tyler, lines 110-6)

One client provided an example of being romantically involved with someone when they were both in early recovery, which affected her sobriety:

> I met a guy [in recovery program]…but we ended up hooking up. And I thought he was healthier… he was very unhealthy in a sense of… he was just starting recovery. And I thought he had more going for him...and more desire…I saw him as going to meetings and, but then, he had some tough stuff goin' on and he just wasn't goin' to meetings and I would still go, it just made everything really hard…he was doing dope and stuff… and I was like…just

> white knuckling it…I fell into some traps of slipping, doing drugs and alcohol, uh in that year of 2011….He didn't say it ever but he didn't support me, “walking the walk”…I'd say, “Come to a meeting!...” he came like once…
>
> (Joanie, lines 40-66)

One client described how his co-workers were not supportive:

> Co-workers is a definite one [who weren’t supportive]! 'Cause they used just as much as me. And they thought I was there friend but I could see right through them and uh, a lot of times they'd like call me their best friends and stuff…'cause they like to party with me, but, I've, I'd say to myself, “These guys are idiots!” Like, they're blowing hot air up my ass, but they don't realize…but I hated myself in addiction and I hated them….I would just use them for their money or whatever. Or for a drug friend, 'cause it's not always fun to use alone. But yeah, people at work, very unsupportive.
>
> (Jonah, lines 235-50)

Family members were also non-supportive through their lack of understanding of the addiction process:

> [Some family and some friends] said they supported me but they were always judgmental about it they were always wondering, you know, “Oh why can't you just stop?”… When my mom was alive she couldn't really understand, about my addiction. Well she was a gambler too but I always felt with her it was she looked at it as different then the gambling addiction, which to me is an addiction is an addiction, you know, it takes you through the same processes, you know, the same feelings of guilt and shame...and all those other ones and uh self-esteem issues as well. You know, and I think that's where the shame then it builds to lower self-esteem, holding on to that shame.
>
> (Maggie, lines 130-46)

A few clients also described how their family were not emotionally supportive while they were in treatment:

> My family it hurts, I, that bothers me a bit [them not supporting me]….I thought they'd be more supportive knowing that my brother and my mom and my daughter are really behind me on this one because they know I'm really shootin' for the stars…it kinda upsets me that, like, two of my sisters don't even know that I'm here…And that kinda hurts.….I actually called my brother on Christmas…he knew I was here but he didn't have time…he actually brushed me off…but in a way I can't really blame some people you know, they given me chances even when I was in [past

> residential addiction treatment centre] the family that I don't get much support from, they did support me….they came for visits…Even my ex-wife, like she she was supportive when I was [at past residential addiction centre]…it's almost like like they've given up. They just said, "Oh God Andy's goin' to [current treatment centre], big deal!" I'm sure that's what crossed their minds.
>
> (Andy, lines 557-88)

> [J]ust over the Christmas holidays…my sister was coming back, she works in [Alberta city]…. And so I was gonna come back [to the treatment centre] so, I didn't have to see her, because she really provokes me! That's being unsupportive…. She would say, "So now you think you're better than me, yeah? You've only quit drinking and you were the worst." And she'd say things like that, that's going out of your way...Just don't go out of your way to start bugging me….Unless I deserve it, which I don't.
>
> (Paul, lines 698-733)

> [M]y uncle and my auntie were supposed to come pick me up the last two weekends in a row. The first weekend I thought, I sat in by the front lobby and waited for four-and-a-half hours. They didn't answer their phone or nothin', I sat there and waited, no one showed. They were supposed to come Sunday, I got a phone call about 10 in the morning sayin', yeah they're gonna be busy, they can't really come and do it, so. Yeah I haven't had a whole lot of supports from the outside.
>
> (Simon, lines 385-91)

Summary of Supportive and Non-supportive People

To sum up, supportive people prior and during treatment were important to maintaining clients' sobriety. The nature of support offered by family members was emotionally (e.g., verbal encouragement) and tangible (e.g., driving client for errands, visiting at treatment centre) prior and during treatment. The support provided by other clients and staff members at the treatment centre was therapeutic in nature. Interestingly, community organizations were also significant supports for clients through helping clients enter treatment and providing financial aid.

Most of the clients stated that social support was imperative in recovery: "I definitely think that [having people provide support] plays a major role in

staying sober and not going back out to using" (Brian, lines 85-6). The following clients also expressed the importance of accepting help from supportive people, especially in recovery:

> I'm starting to realize that…trying to do everything at once and then plus I don't ask for help. So now I do need to use my community resources and like go to meetings and go to my counsellors' appointments and go to the places I'm supposed to go to. Yeah, and use my support system, because that's the most important thing. You can't do it alone, you really can't.…I try to be strong and say, "I can do it myself, I don't need anyone!" But I do, I do need meetings, I do need support.
>
> (Mindy, lines 642-9)

> [Y]ou need that support in regards to uh, so you don't fall and you don't feel overwhelmed.
>
> (Adam, lines 35-7)

> I guess it all depends on where you're at, right? 'Cause I can remember being, very standoffish, right? "I don't want any help at all, I can do this on my own." And that never got me anywhere [laughter], right? I could do it for a little while and I could maybe willpower it out, but, truly without help. I couldn't do this on my own, I know I couldn't.…I think you have to be open for [receiving help] for one.…you definitely have to be open for it. And, and you cannot refuse it, it's so easy to refuse.
>
> (Joshua, lines 147-63)

> [W]ith my supports, that's the biggest thing because I try to, I try to bottle up my feelings so much and try to deal with it myself and I explode. Happens every time; I noticed it ever since addiction started, happens every time I cannot do this on my own and my supports are my family…
>
> (Tyler, lines 352-6)

> [I]f I didn't have the support system that I have, I don't think I'd be here. I honestly don't. If my family wasn't here, I mean, I, I don't know how some people can do it without them. I honestly don't and that's why I'm very supportive for other people, if they don't have people around them because you need it. Well I need it, I can't do this alone.
>
> (Tyler, lines 1207-1212)

> [N]ow [support is really important] because now I don't have such a bad attitude and you know, "eff you" attitude, like this [makes middle finger gesture] to the outside world…"I can do it on my

> own, I don't need no help." So, so I'm learning to let people in […] and to ask for help. That's still pretty tough.
>
> (Joanie, lines 307-17)

On the other hand, non-supportive people such as old using friends or acquaintances were barriers to clients' sobriety. One client acknowledged that to maintain her sobriety after treatment, she needed to cut ties with her using friends: "I don't wanna move back to [the town I previously lived in] 'cause I have a lot of friends and everything, that still party and uh I'll just fall easy" (Ariel, lines 205-7). Conversely, family members were non-supportive through their lack of understanding of addiction and emotional support. Thus, clients' social networks, both supportive and non-supportive, had implications on the treatment centre's role in reinforcing healthy, clean, and sober types of interactions and social supports during this treatment episode, which will be discussed in greater detail as part of the theory.

Clients' Perceptions of Treatment Engagement

Clients' perceptions on treatment engagement emerged as one of the main categories from initial coding and one of the major components of the theory. Specifically, client perspectives on treatment engagement had implications on the treatment centre's role with respect to clients accessing their social supports, within and external to the treatment centre. This section will present clients' description of treatment engagement, then present the Cree medicine wheel as the framework to understand treatment engagement, and conclude with how clients were not engaged in the treatment program.

Describing Treatment Engagement

Treatment engagement was described by clients as a complex process. Some clients described treatment engagement as a dynamic process, which varied at different points during the treatment program among clients:

Sometimes it takes people a little while longer than others…[to] adjust…you never know what someone else has been through too, so.

(Mindy, lines 574-80)

Some people it takes longer….I can remember…I had to find out everything the hard way…you told me not to, you told me to do something, I wouldn't do it, but I'd find out why.…it took me a really long time…I'd learn one lesson, but there'd be like five more there that I'd have to learn…it's not an easy [process]…some people like, even just their first time [in treatment]… you come to a place like this, and you feel so good…you do a little work and then your changing, and you feel great and now all of a sudden you have a lot of stuff to offer!…And now you're fixed!... [you] go get into a relationship…it just doesn't work like that…I feel for people when they leave here, it's the worst day. I hate [graduation] day because…[people] have no idea what's comin'…'cause I never did [laughter]…it's a few more years…Of struggling!…even in recovery it's hard.…it's the stuff that you don't know and you can't see. Because, you know that really gets you.

(Joshua, lines 796-831)

I: …can you describe to me how you're involved in your treatment experience here at [the treatment centre]?
Jonah: I went in waves like a rollercoaster. Uhm, it's been good for the last week. Like, I pretty much done everything they ask me to do, and now it's just relaxing and walking around and talking to people….I'm going to a year-long program after this so. I'm kinda saying to myself this is just a steppingstone. So I'm kinda slacking now, 'cause…I'm not going right on to the streets; I'm going to a safe place, so I'm not scared at all […][8]
I: …And like when you initially first came into this program, how were, like you said you were going in, it was like waves.
Jonah: Oh, I was letting stuff bother me, letting people bother me when I first got here….And uh I was still have bad drug cravings. And, and it just it got better…

(Jonah, lines 450-69)

Well that all depends like people that are first starting out you can tell by just lookin' at 'em…they're not happy.…People in their last week they're excited because they're finishing the program, right? So, it's, ups and downs, right? I notice people in their first, second week, I know what they're goin' through…they're on a roller coaster right now, right? They hate this place and next day you love it, next day you hate it…it's the truth, that's what being in

[8] […] indicates interruption or cut off by the other speaker.

> addiction and comin' off addiction is all about. You know, some days you just wanna blow your head off and the other day you're happy as, a peach I guess.
>
> (Andy, lines 1070-81)

Clients also described treatment engagement as how they 'worked the program.' Addiction treatment "must help the individual stop using drugs, maintain a drug-free lifestyle, and achieve productive functioning in the family, at work, and in society" (National Institute of Drug Abuse, 2009, p. 1). The current residential addiction treatment centre used a holistic approach to address the mental, emotional, physical, and spiritual aspects of an individual to make positive changes in drug use and behaviour. The treatment centre's *Treatment House Rules*[9] stated that one of their main objectives was to help clients "focus" on their own treatment program or "self." Similarly, some clients stated that they selected this particular residential addiction treatment centre for that reason, to focus on their program and to be away from external influences:

> [R]ight now I really focus on myself…I don't trying to focus on what's going on out there right now. Uhm, even though my daughter just came back into my life I haven't seen her in fifteen years…it's hard for me…it's a really short period of time, 42 days…I just really focus on myself.
>
> (Mindy, lines 355-64)

> I need to focus on me. And, just leave everyone behind…. I don't really care what [my old friends] do, it's their loss not mine….like they say to be selfish but in a good way…like do the steps and stuff like I'm workin' on my step three.
>
> (Ariel, lines 555-72)

Another client stated that the reason he initiated treatment was to take a closer look at himself:

> I came back this time to take a good long look at myself 'cause I realize drugs and alcohol are not my problem, it is myself right, and I need to look at myself and why do I go to drugs and alcohol, right, so.
>
> (Tyler, lines 45-8)

[9] Clients were provided with a folder at orientation that included the *Treatment House Rules*. To maintain the anonymity of the treatment centre, this document will not be cited.

Focusing on self, therefore, was identified by both the treatment program and by clients as an essential part of treatment engagement. Further, treatment engagement was described by clients as how they were involved, focused, or ‘working the program:’

> [‘Working the program’] means to me like I'm actually doing something to help myself, like all throughout the years I thought I could quit on my own. It feels good to get things out…to take a step in the right direction actually…do something to help myself. Yeah I feel good about that.
>
> (Erin, lines 545-51)

> But, coming in here, it almost open up the new door and made you realize you have to do it for yourself and, not only self-centred yourself but whatever, you have to focus more on yourself, improve them, important qualities and positive qualities, so that it helps you in the future.
>
> (Brian, lines 426-30)

> [‘Working the program’] means, [pause] like, taking care of my body and my like health, like in a healthy way, being sober and clean. And, [pause] and being happy with myself…
>
> (Ariel, lines 634-6)

Clients described their involvement as actively “working” on self and their program, which included learning more about self:

> [Y]ou learn more about yourself and you learn in here about self-esteem, and how to love yourself, and how to respect the people around you, 'cause uhm, you know, a person wants respect given to them, then you have to respect others in return …
>
> (Erin, lines 247-50)

The last two examples suggest that some clients described ‘working the program’ in a manner that was holistic, which entailed healing and restoring balance to their overall health and well-being: mentally, physically, emotionally, and spiritually. Their description was also consistent with the treatment centre’s Aboriginal worldview and holistic approach. Thus, the Cree medicine wheel or circle as a framework will be used to understand clients’ perception of treatment engagement at this particular treatment centre.

Rationale for Integrating the Cree Medicine Wheel Framework for Understanding Treatment Engagement

The Cree medicine wheel was an appropriate framework to examine clients' perceptions on treatment engagement for several reasons. First, the treatment centre was oriented towards an Indigenous and holistic perspective, which was grounded and rooted in the Cree medicine wheel and as such constituted the crux of the program. Second, although clients did not explicitly make reference to the medicine wheel to describe treatment engagement, it resonated implicitly through references to a more holistic approach to addressing their addiction and other issues, emphasizing spirituality, more than the researcher expected and more that is included in a typical health framework. One client described the treatment centre as focusing on healing rather than focusing on the disease aspect of addiction:

> You're sort of looking more forward. I mean you're still living in the moment…you're seeing yourself in recovery, as opposed to seeing yourself "sick." But [in a past residential addiction treatment centre] you felt that you were being told you were sick and you have an addiction of that and addiction is an illness. But you're stuck in the sick part of it. Whereas here, everything is about recovery and getting better, healing. So it's a different mindset and I think it's much more positive when you look at it in those terms, but the fact is, both are correct…if you know that you're recovering, you're getting better, then it's a lot, you're a lot more optimistic….And it seems a lot more…doable and a lot better of a scenario then just viewing yourself as sick and you'll never get better and you're an addict and you're always gonna be one...
>
> (Anna, lines 111-25)

Third, during axial coding, 'working the program' generated these following subcategories or components of treatment engagement: (1) participating in treatment activities, (2) communicating openly and honest through sharing, (3) helping others, (4) connecting or reconnecting spiritually and/or culturally, and (5) learning and developing new skills and tools to sustain abstinence and recovery. As well, axial coding generated the category to describe the process of treatment engagement of "self-discovery and healing," which included: (1) self-forgiveness, (2) self-acceptance and self-worth, (3) enhanced

self-awareness, and (4) enhanced self-esteem and self-confidence. Treatment engagement conceptualized during axial coding is summarized in Figure 4. The medicine wheel was the framework to examine the components of treatment engagement at this treatment centre, which corresponded to one of the four parts – mental, physical, emotional, and spiritual – of the Cree medicine wheel, beginning in the east direction and moving clockwise, depicted in Figure 5. The use of the medicine wheel to conceptualize treatment engagement helped to explain how client engagement was assessed by the treatment centre to connect to social support, which was part of the theory.

Figure 4. Components of 'working the program' that emerged from axial coding.

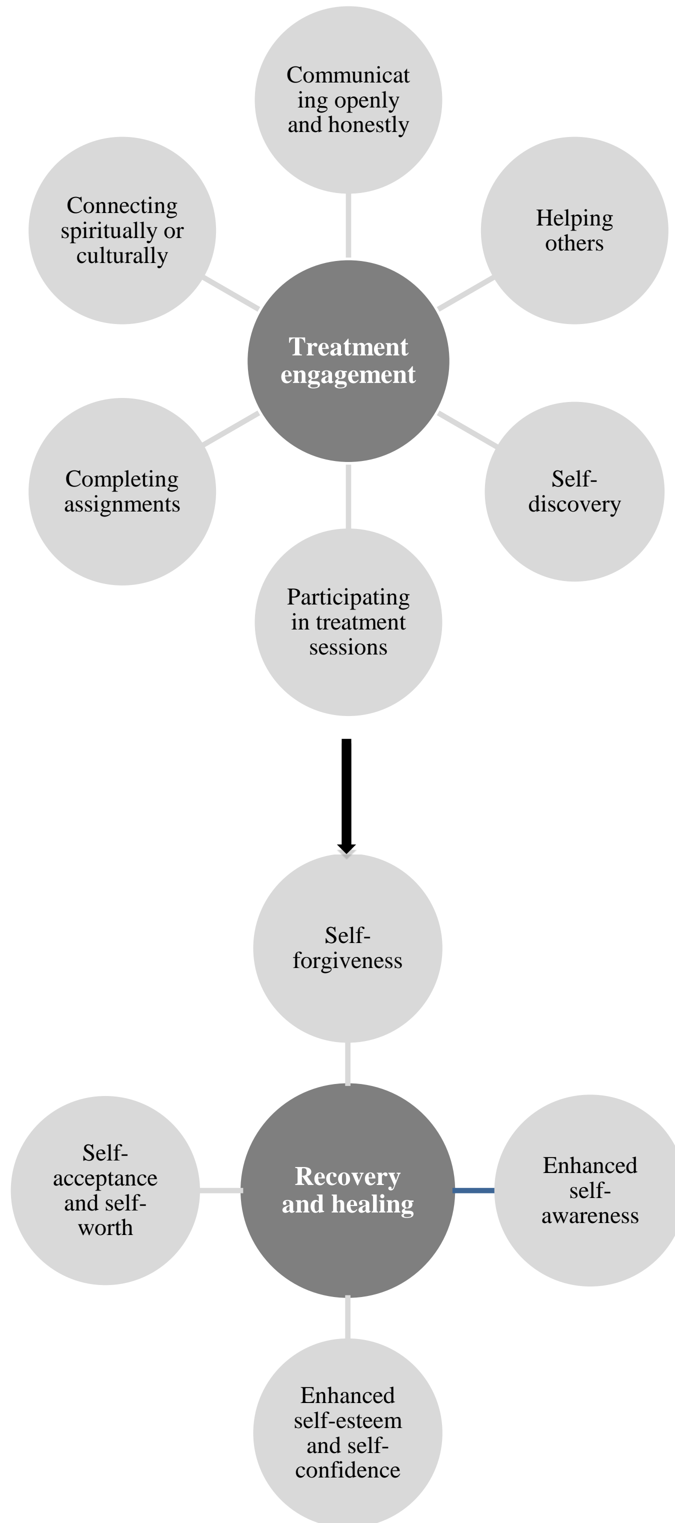
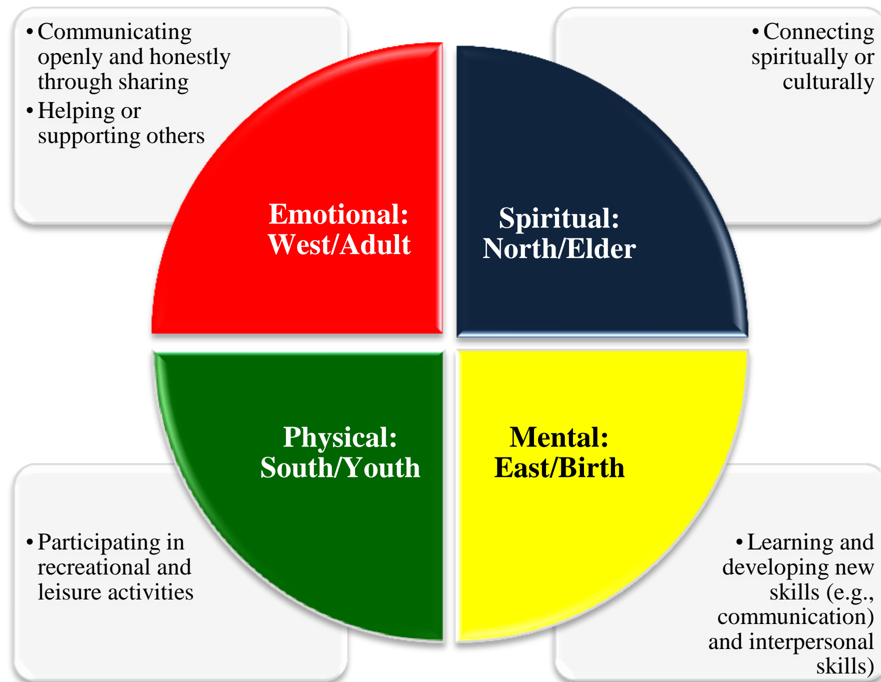


Figure 5. Components of treatment engagement integrated into the Cree medicine wheel.



The Mental Dimension: Learning New Skills and Tools for Recovery

Some clients were engaged in their treatment by learning more about themselves or "self-discovery" (Joanie, line 335) as part of addressing the mental dimension. Mainly clients described that learning about self included identifying the "root" cause, which was an important part of clients' treatment engagement, as articulated by these clients:

> Because [the residential addiction treatment centre] do a lot work on self-help and make you realize…where your addiction started, what are the past traumas in your life to make you keep using.
> (Maggie, lines 196-9)

> [L]ike reasons for why I used in the first place. Uhm, what drove me to using and dysfunctional…in your attitude…your personality like in the first place. You have to go to the root of the problem [clear throat] to find out exactly why you used something to cover something else up.…it's not necessarily the drugs that are the problem, 'cause, were you only using the drugs because we're

> covering something up or we're looking for something that, you know, we can't find in everyday life…we don't know how to go about it yet…you gotta find the root of the problem…That's what I've been learning…issues that we have to deal with within ourselves in order to actually conquer being sober or clean.
>
> (Erin, lines 308-23)

> So I came back this time [to treatment] to take a good long look at myself 'cause I realize drugs and alcohol are not my problem, it is myself right, and I need to look at myself and why do I go to drugs and alcohol, right, so.
>
> (Tyler, lines 44-7)

> It's awesome here….I will be working on myself. And getting down to the root of why, 'cause I'm an angry person, I fight lots, I am very confrontational, I'm very black and white…there are no shades of grey. I'm really working on that part of myself and where did my anger all stem from? Why did I start using?...Where did this all, it didn't just pop out of nowhere.
>
> (Simon, lines 59-67)

It was important to identify the root causes of their addiction and explore issues such that clients could start the healing process and move forward in other aspects of their own lives, such as being a positive model for other family members:

> [Talking about a conversation with her daughter] "Well [being in treatment is] just the way to help me work on myself because it's my choice that I made and it's led me to have guilt and shame about it and that's where [the treatment centre] come in because they will help me figure out what those issues are that I have within myself and to help make me better...as a person." So I'd be able to educate [my daughter] about [drug use]…to mainly boost my self-esteem making me feel better about myself...so I'm more mentally stable for her.
>
> (Maggie, lines 349-60)

> I'm sick and of tired of walking out of the bush, with all this money and pissing it away!…No nice clothes!...there's like literally nothing! Like the amount of money I pissed away in four years is phenomenal…I eventually want to have kids. I want to have a family, and you can't be an alcoholic or a drug user when you're a dad. You can I guess, but not a very good one.…I wanna be that positive role model for my sister, for other family members 'cause I got a lot of family members with addiction.…And my health too…it used to be all fun and games and laughs and jokes. Now whenever I drink and use, and I'm by myself, I turn suicidal and

> the next time I do drink or use, it could be my last.…I wanna live. I like life.
>
> (Simon, lines 660-97)

Once clients identified root causes and a better understanding of their addiction, clients were in the position to acquire new skills and tools for their recovery. During addiction, a few clients mentioned that they had a “hard time” (Brian, line 105) or had “communication breakdown” (Adam, line15) with family members. The treatment centre provided a safe environment in which clients had the opportunity to practice and improve on their communication and interpersonal skills. One client discussed that part of his involvement in his treatment program was speaking during group treatment sessions:

> I force myself to talk at meetings and do readings and stuff, just so I can get better at public speaking. 'Cause my self-confidence is getting better, better than it's been in years, thanks to this place. [Before this treatment centre] I couldn't look people in the eye when I was high or sober. It was hard for me. I was pretty evasive, uh. It was hard for me to be comfortable in my own skin in public.
>
> (Jonah, lines 476-83)

Another level of improving communication skills was that clients were learning how to better relate with other people. A few clients through working his program, they learned to communicate more effectively with other clients:

> [T]he last three weeks I've been really involved, 'cause I'm gettin' my sense back now, you know, I'm learning again, and I'm starting school all over…I'm learning how to uh, uh, sense to communicate better with people, to think properly, to show my emotions, to show my self-esteem, get that back…I'm more focused with people. I communicate a hell of a lot better. And I can think properly…I'm more focused on things. Somebody asked me a question, I can answer it. Ha!…Not like before. You wouldn't believe what [alcohol] does to you…you just lose everything. It's the truth.
>
> (Andy, lines 1089-1117)

> [L]earning to ask for help or practicing that [with other clients]….I've done a few things where I uh normally would have just sucked up in the past…[As Chief] I got to practice some things there 'cause I got take over responsibility...and I thought, “No I'm not gonna do that part.” And I'll delegate it to someone else, who's my co-worker as well. And uhm I'll say, “No. I'm sorry I can't do

> that would you go to so-and-so or maybe you could uhm provide me with a different alternative"…
>
> (Joanie, lines 371-83)

Since the treatment centre was a mixture of clients from various backgrounds who were at different stages in their addiction and recovery, one client used the environment as a learning opportunity to improve on coping with different personalities, in preparation for when he left treatment, articulated in this excerpt:

> [S]ome people here at first annoyed me. But then I just looked at it like this, just, they're younger than you, they're entertaining, just go with it. Like, that's what treatment is a big melting pot, you gotta learn to deal with people.…there's all these different ages and personalities and that's how it is out there, so. If you deal with it….this place has taught me lots about acceptance and…the things you can't change, don't worry about. I used to always worry about dumb shit and have anxiety over stuff I couldn't control.…It's gotten better….the way the staff have told me to hear it from someone else like, "Don't get all mad about stuff you can't control."
>
> (Jonah, lines 391-411)

For another participant, working on herself through openness and honesty improved communication with her parents:

> [O]pening up and learning more about myself is helping my parents because…I'm not keeping anything for myself…I'm able to be more of a positive person…learning about myself is giving to the people around me as well because they get more of me, rather than somebody who's trying to cover something up or who has issues that are not dealt with yet…it brings up the true me…way easier to communicate with my parents and be more honest with them.
>
> (Erin, lines 394-420)

Since a majority of the clients in the sample had prior residential addiction treatment experience, many participants shared their stories of relapse, situations, or circumstances that brought them to initiate this treatment episode. One client discussed a relapse prevention strategy he learned at the treatment centre:

> No I'm ready to leave….what I learned in here also was, [from] one of the counsellors, "Wind the clock forward. If you're getting the urge to drink, just go forward what's gonna happen?" My last relapse I knew what happened….it was not worth it…I have too much to look forward to.…And I'm strong now, if I take that first

> drink, I won't be.…So everything I planned for will be thrown away, so it's too much to lose.
>
> (Paul, lines 937-50)

Although very few clients discussed withdrawals and drug cravings experienced during treatment, one client discussed how she learned how to manage her drug cravings while she was in treatment through arts and crafts:

> [T]here's like arts and crafts. Like when I myself making dream catchers, it's calming to me. Like if I'm having a bit of a craving or a withdrawal, I'll sit and I'll work on a dream catcher and it'll calm me down.
>
> (Maggie, lines 234-6)

Another important aspect of addressing the mental dimension of treatment engagement was developing awareness and knowledge of community resources and services through developing an aftercare plan while in treatment. The aftercare program allowed clients to connect with resources to set up housing, employment and education, financial aid, and/or further treatment or counselling. The aftercare was an integral part of the treatment program in which the treatment centre helped to set up clients for their recovery by connecting them to appropriate community resources:

> [T]hey have a lot of aftercare stuff and everything like that...they let you use the computer here too on certain nights.…they have…a list of uh safe houses you could go to and you like you know sober living places and stuff like that, so.…They'll help you arrange for it to you.
>
> (Mindy, lines 803-11)

> [B]ecause we start working on our aftercare plans basically within the second week of being here….it's an on-going process that we do through the whole time while we're here is working on those aftercare plans.…So it's about half of the program…I know that there are like for example, there's a woman who didn't have proper accommodations to go to because she basically she's going back to an abusive boyfriend. I know they've helped her look at options for housing and things like that and helped her get her into…and same with like for myself, I need to go for further treatment when I leave here 'cause I have [concurrent disorder]…they have been helping me get the paperwork for that, so. Anybody that needs any additional supports specific types of supports or assistance in any kind of way, they do it on a case-by-case, help people find something suitable so they're going from here to somewhere safe

> enough that there's gonna be, you know, proper environment to continue their recovery. And that's even as counsellors too, I know they've set people up with uhm with therapists and things and stuff if they need them.
>
> (Anna, lines 391-421)

In fact, establishing aftercare plan was a crucial part of clients' treatment engagement and recovery, as explained by these clients:

> But, I mean, [my aftercare], that was really on my mind, like that's huge, that's a huge part of my recovery right now is like, what I'm gonna do.…I know I'm capable of using and I know what happens...So if I don't have anything in place, or if I don't have a plan…it's gonna lead me back there eventually, right?
>
> (Joshua, lines 573-83)

> But also too you know they teach us about aftercare…I can't really see myself, walking out of here and still to this day I can't see myself walking out of here sober. I have a hard time seeing a day-to-day life sober 'cause I've been doin' since I was 12, so. Like I can't, you know it's all I know.…But I am workin' on that and you know I'm gonna be takin' in everything and try to work on my aftercare.…Maybe I'll be able to straighten out.
>
> (Simon, lines 80-90)

In summary, addressing the mental dimension in this residential addiction treatment centre involved identifying root causes and a better understanding of their addiction and issues, developing skills and tools for communication, relapse prevention, managing cravings, and awareness and knowledge of community resources and services as part of their treatment engagement to prepare clients for their recovery after leaving the treatment centre.

The Physical Dimension: Participating in Recreational and Leisure Activities

The treatment program set strict rules in the *Treatment House Rules* requiring clients to report at roll call, participate in meditation and smudging activities, attend all sessions including recreational and leisure activities, and attend 12-step meetings. Failure to comply with scheduling and attendance rules had implications on receiving their Sunday pass privileges (discussed below in *Theory: The Role of the Treatment Centre as Gatekeepers for Clients Connecting with Social Support to Enhance Treatment Engagement*). Thus, it was not

surprising that clients mentioned attendance as an important aspect of 'working the program.'

To address the physical dimension of health, clients were required to participate in recreational activities. Activities that clients participated in included yoga (Maggie), team sports (Maggie, Paul, and Ariel), swimming (Anna and Eva), and dancing (e.g., Zumba, ballet, and jiggin'; Ariel). The rationale for requiring clients to attend recreational activities with the hope that clients were exposed to "fun and drug-free activities" in which they could adopt and integrate in their recovery, as expressed by one of the counsellors:

> Prior to entering treatment, [the supervisor] stated that [clients] have been isolated while in their active addiction, and he wants them to know what's available out there and engage in healthy activities. Furthermore, he hopes that the activities that residents learn while at [the treatment centre] and in their recovery they can do them and have the opportunity to share what they have learned with other people in their lives, i.e., family members and friends.
> (Field notes, March 29, 2012)

One client was hopeful that recreational and leisure activities could be integrated in her own recovery process:

> [W]e do outdoor activities. We do yoga, two days a week, for an hour, an hour and a half out of the day….as old as I am, I've never been uhm I've never exercised or went for a jog or anything…now that I'm clean and I don't, I'm not on the drugs anymore, then I do want to participate in a lot activities like that.
> (Maggie, lines 239-49)

Some clients started to take better care of themselves during this treatment episode and they noted improvements in their sleeping patterns (Erin), eating habits (Andy), and exercise regime (Jonah, lines 475-6). For one client, participating in recreational activities not only improved her physical health, but also her mental and emotional health and well-being as part of her sobriety:

> Erin: [Prior to coming to treatment] I wasn't really exercising very much and I was eating quite a bit of junk food…I wasn't taking the best care of myself, so. But since I've been here I've been eating three meals and good meals and I've been working out pretty much every day…I feel a lot better…And mentally too, you know, it really helps me, you know, mentally and emotionally, and physically to release that energy…be able to think better….

> I: Yeah, has this program helped you kind of identify that physical activity and eating healthy [...]
> Erin: Is a part of it. Yup, it's a lot of part of sobriety….it really will affect, affect you in the long run….I want to start living a healthier lifestyle…
>
> (Erin, lines 217-39)

In addition, physical activity was important part of one client's involvement in this treatment program and recovery: "I like to get involved in sports, working, going to the gym, like I said that's a huge part of my recovery, makes me feel good" (Tyler, lines 1030-1).

Along with improving overall health and well-being, one of the treatment staff members helped one client identified leisure activities he enjoyed prior to his addiction and the importance of integrating them in his recovery:

> I need to have leisure. To take time for myself. To be selfish in a sense and work on myself.…the one attendant that I was talking about he just you know, "You need some time for yourself. You need to take time out of your day to take time for yourself." I find myself [in treatment centre]…drawing more, playing chess more, uhm, playing guitar more…I just realize that these are things I used to enjoy doing….before my addiction and before all the responsibilities of my life, I haven't really taken that time…[I] decided I was gonna take up the martial arts again. I used to be heavily involved in the martial arts...And with that it will build a better self-discipline.
>
> (Adam, lines 349-64)

A few clients described the physical dimension as identifying and developing better self-care strategies in the way of sleeping, eating, and exercising to improve overall health and well-being during this treatment episode. Learning and developing healthier behaviours were part of treatment engagement for some of the clients. Exposure and participation in these activities could help clients integrate them into their recovery and sobriety.

Emotional Dimension: Enhancing the Inner Self

Some clients shared stories of the shame, guilt, and emotional pain experienced during their active addiction, which contribute to disharmony from an Indigenous perspective (Cross, 1997). Thus, initiating treatment was a crucial step to learn more about self and identify and address root causes of issues that

led to one’s addiction, described in the previous section. One client articulated the challenges of dealing with issues as an addict:

> I mean one of the things of being an addict is that you know at times you don't behave properly. You behave in ways that are…inappropriate and or not considered the norm of social acceptable behaviour. And it's frustrating because you behave that way and yet you know not to, and you also know that those around you, like your family or friends and stuff, don't like it. So you carry a lot of shame and a lot of humiliation because of it.…We know that the staff understand, then you know you can let your guard down...and be more who, who you are with the faults and that is part of the healing process of forgiveness and self-love. Where at some of the other places in your life when you're an addict trying to make your way, you don't get that kind of unconditional understanding. And so you walk…with your guard up and you can see a lot about yourself, which of course in the long run prohibits you from getting better, right?
>
> (Anna, lines 234-52)

The example suggests that the treatment centre was a safe place for some of the clients to start the healing process, specifically the emotional dimension of health, to enhance self-awareness, self-esteem, self-confidence, and to allow for self-forgiveness, important aspects of treatment engagement.

Key for clients to focus on their treatment program was communicating openly and honestly, the foundation in Aboriginal culture for creating healthy relationships (Jo-Ann Daniels, personal communication, February 1, 2013) and key aspect of 12-step programs (12-step.org; Carr, 2011). Part of communicating openly was the clients’ willingness to share their experiences throughout their addiction and past treatment experiences:

> I like to speak up when I can, you know, in lectures and stuff…I like to give my, “my two cents” or whatever. I like to share some of my experiences with some of the people in here, especially the younger people….I like to talk to a lot the younger guys, share what went wrong for me and my early recovery and why I relapsed. And in a sense listening to them and talking to them, it reminds me of where I came from, and it actually helps me out listening them too when we're actually talking about recovery.
>
> (Tyler, lines 1013-25)

Central to communicating openly and sharing during clients’ treatment experience was doing so honestly. The treatment centre reinforced the importance of honesty

as the foundation for recovery, outlined in their document *12-Steps to Get the Most from Treatment* that clients received as part of the orientation materials. Being honest was an essential step in moving forward because during addiction, individuals were not honest with others, as described by these clients:

> I think the biggest part was that though was being as honest as possible. I think that's the big difference now a days is, not always having to cover everything up with lies, you know? Honesty is, I think, the number one key to my success [in recovery], at least at this moment.
>
> (Brian, lines 139-42)

> [T]hat actually kinda got the ball rolling with the complete honesty thing because if I'm lying, it keeps me sick.…it's easier to be honest than it is to cover up lie after lie after lie…it so much more relieving…but it feels good that I can do it, it so much more relieving, you know, it's, oh it feels so much better! [Laughter] 'Cause I don't have to hide things…I've been doing that for so long…
>
> (Tyler, lines 336-43)

Thus, in recovery, before one could be honest with others, a few clients emphasized that one must first and foremost be honest with one's self:

> [T]he other day I shared my step one and I shared a lot of personal things in there, but I still opened up about it and I was honest. And that's the main thing that they teach you in here is to be honest with yourself. And once you're open and honest with it, then you're able to move on.
>
> (Maggie, lines 436-40)

> [T]he biggest thing I found in here is, that, to be honest. That's huge for me. I think I lied to myself for so long.…I don't have to be honest with anybody, except for myself…But if I'm honest with myself it makes it easier to be honest with others, right?
>
> (Joshua, lines 642-8)

Through the process of sharing openly and honestly, some clients were capable of "letting go" of past shame and guilt, for instance, to start that process of healing emotionally:

> [T]his time I'm dealing with grievances…that I've held onto and I've never told anybody or talked to anybody about it. So this time I'm letting go…I'm not feeling so shameful and guilty about it anymore…
>
> (Maggie, lines 460-65)

> [Y]ou gotta be willing to be open because that's the only way you're gonna conquer uhm in, success within this course or this [treatment] program?…if you're able to open up and actually let that out…you're just kinda doing it for yourself…I'm able to talk about anything in my life because this is a place where you can get it all out, you know, it's a safe place. And it gives you the chance to actually deal with certain things like emotions and situations…
>
> (Erin, lines 337-53)

Finally, letting go allowed one client to be more attuned and better cope with her own emotions:

> [L]etting go of anxiety before it gets huge. Uhm, keeping emotions down, uh turn down the volume and uh, reframing…to uh see a different reality that is more befitting and more rational…fits more for myself. Rather than the magnifying, maximizing…all or nothing, black and white, more of travelling the grey, middle ground.
>
> (Joanie, lines 335-42)

The treatment centre's programming encouraged some clients to communicate openly and honestly in numerous ways. For instance, group sessions were a safe environment for these clients to connect with others and share openly and honestly:

> But I really enjoy the groups…I really enjoy the all-women's groups…our counsellor and a few other women, but when the whole, the whole treatment centre all the women, when we all connect that's really nice too, yeah. We go on in and do our beading and stuff and so that's nice.…There's no men in there…a few women so it's a safe place to, uhm, talk about whatever…we go around in a circle like…listen to that person talk, how they're feeling and stuff like that and everybody takes their turn. And then uhm, feedback offered…
>
> (Mindy, lines 505-30)

> Well in our groups…we're supposed to share.…if they don't want it to be heard, they don't have, they don't say it. But I think that being able to come out group and actually say or talk about certain events in your life, it really actually allows you to overcome them…to get you where you want to be going…in the group nothing goes outside the group, you know, it stays in group, so.
>
> (Erin, lines 341-50)

Likewise, arts and crafts were another way for clients to heal. This was a useful way to help one client take a closer look within her:

> [The counsellors] know what I need to work on, I just do it, and it's teaching me stuff you know what I have to learn.…for instance today, uhm, one of our assignments is working on low self-esteem…I like suffer from low self-esteem at times…She wants me to make a collage…how you feel on the outside and then make some things about what's on the inside…just self-awareness stuff…Working on your…self and…learning how to forgive yourself and love how to love yourself. Yeah, we do a lot of journaling, which really helps me…
>
> (Mindy, lines 472-87)

Completing assignments was also a mechanism for learning and working on self. Journal writing in particular was an important tool for clients to engage in treatment. Clients were required to write in their journals on a daily basis and to be submitted to their counsellor every morning. Journal writing helped one client to remain focused: "I've been forcing myself to write in my journal every day. Just, I like to keep busy otherwise my mind wanders" (Jonah, lines 474-5). Moreover, journaling was an important tool for self-awareness to document their growth and response to certain situations in treatment. One client described the most important aspect of focusing on his program was spending time on his own. In fact, his alone time allowed him to concentrate on his homework, to have time for self-reflection, and to be away from the distractions within the treatment centre:

> Sitting in my room, spending time by myself.…it gives me more time to reflect on it and I can understand it better, reading by myself....music's huge for me too in recovery…I just like to turn on the radio and just and go out of town, I get lost in my work sometimes and I get really focused.…journaling, step work, any stuff like that, reading…spending time by myself is probably the best thing that I get from or allows me to focus more on my recovery.
>
> (Tyler, lines 1173-86)

Not only did assignments enhance client's self-awareness, they played a role in building clients' self-esteem:

> I: Okay and how are other ways that you've 'worked your program'…there's homework assignments...
> Andy: …through workin' for myself like you know, I had a lot of issues…like my self-esteem and stuff like that, I've been really workin' on that…I'm gettin' that back, so the program's helped me in that aspect.
> I: So it's helped you with developing your self-esteem?
> Andy: Yeah, gettin' over my emotions, gettin' over everything, like basically it's really helped me.
> I: I know that earlier in the interview you've mentioned, like you're more aware?
> Andy: Yeah, yeah, yeah. Big time.
>
> (Andy, lines 1040-50)

The final step of the 12-step program encourages individuals to help others: "Having had a spiritual awakening as a result of these steps, we tried to carry this message to other addicts, and practice these principles in all our affairs" (12step.org). Similarly, helping other clients was another aspect of clients' engagement in treatment. "Service" or helping others was an important aspect in Indigenous culture (Blackstock, 2011; Cross, 1997). Sharing personal experiences during their active addiction and past treatment experiences was beneficial, highlighted in these cases:

> So this time I'm letting go and I'm actually telling people about the losses in my life. And I think that's making other people open up because then they see how much better it makes me feel about myself being able to let go of that and tell somebody because then I'm not feeling so shameful and guilty about it anymore.…And [sharing my experiences is] helping people to see, see how it helps me, so they want it to help them as well so it's making them realize that "Hey, maybe if I open up and tell somebody about it, then it will make me feel as good as her!"
>
> (Maggie, lines 461-76)

> I: So you talked about, you've been sharing like your experiences and sharing recovery with the younger...clients. Do you think that's been helpful to you for focusing on your treatment […]
> Tyler: For me yes! Because, sometimes I forget about that kinda stuff.…when I share my own stuff, and listening to their feedback too…it definitely helps because it keeps on reminding me of those mistakes I made because sometimes I find myself falling back in the same patterns and now I catch myself…so it brings a more awareness to myself…it makes me feel good that I can try to help,

> you know, do what I can, at least with my experiences with other people. Like I said, I like to help people.
>
> (Lines 1116-31)

Another client helped newer clients by wanting to make them feel more welcomed as he struggled in first week in treatment where he was losing focus on his program:

> [Y]ou get new recruits comin' in every Wednesday, I became really comfortable knowing that I could walk up to 'em because I, I was in the same boat as they were…I'd walk up to them and greet them…"Welcome to [the treatment centre] this is a great program. And if you need anything just let me know and I'll do my best to help you."
>
> (Andy, lines 1031-7)

Overall, emotional healing at the treatment centre focused on building the inner self with respect to enhancing self-awareness and self-confidence.

Spiritual Dimension: Connecting or Restoring Spirituality

Some clients felt that addiction involved an abandonment of one's spirituality:

> I used to go to [Catholic] church a lot and of course in the last four to five years, my spirituality went down the tube, so. I stopped going to church. And uh, I was really uhm faithful to my church, right?...I grew up in a church actually, like, my life, being involved with it but my addiction totally wiped that out.
>
> (Andy, lines 97-102)

> I always believed in God, that stuff. But I chose not to when I was using 'cause I knew I was doing wrong.
>
> (Jonah, lines 561-3)

> As soon as I started doing drugs, I mean all spirituality goes straight to the terrain.
>
> (Tyler, lines 613-4)

Because of the loss of spirituality during addiction, some clients selected this residential addiction treatment centre specifically to connect or restore their spirituality that was abandoned in their addiction:

> [T]he reason I came to [the treatment centre] to get my spirituality back….So, that's why I'm here, to gain that back and that's what I'm doin'.
>
> (Andy, lines 119-27)

> [W]hy we [detox centre and I] decided on [the treatment centre] was because there is a high uh spiritual component to it and that was sort of when you do the 12-steps they talk about higher power, that was sort of the piece I was having a really hard time, uh figuring out, so I thought this would be the best place to come to as opposed to a different treatment centre.
>
> (Anna, lines 11-16)

Spirituality, thus, was another integral aspect of clients' engagement in treatment.

Step two of the 12-step program asserts for individuals to search for a higher power in their recovery. The treatment centre provided the opportunity for some of the clients to find and believe in their higher power:

> That's actually my higher power in AA. It's the number of people that have recovery, that have been where I've been, close to in similar situation, and have recovery. Like serious recovery, that's my higher power to me.
>
> (Paul, lines 756-9)

> [I]t's very spiritual here....now I'm starting to have that sense of what a higher power is and what it feels like to follow that and to have faith in that and as I get more comfortable with that I'm also finding that the other aspects of healing for my recovery right now, I'm now able to actually accomplish that because I have that piece of faith that everything's going to be alright. Whereas before I didn't. Before…I had to do all the work, I mean I still have to do work, but you have that fear of you fail yourself, then you fail at it and it's gonna…end in a relapse. Whereas here you know if you know that you are able to follow that higher power, there's something bigger than you that's holding you up.…it just makes you feel a lot more confident and a lot more comfortable exploring some of your own issues and things and stuff, so it's really helpful.…but at the end of the day, you still have something bigger than you looking out after you, so you're able to really look after those problems without being guarded and not wanting to…totally look at them.
>
> (Anna, lines 71-103)

> I'm still working on that, finding my higher power, like giving myself into a higher power.…Whereas here, there is no bad people, they explain.…you're higher power is the earth…their religion here is, is so open…it's the creator, the cosmos. It's not a God or all seeing being that you know, you're a bad [and] judges you…I'm definitely opened my mind to this and it's, it's helping me a lot.…'Cause to be uh, a good member of earth Creator's

> world…you can't be a drug addict or an alcoholic, you have to be serene. You have to be clean and serene, you have to help your fellow man…you can't be taking and being a waste of skin…'cause as far as I'm concerned, all alcoholics and addicts we're just a waste of skin…we're not moving forward, we're all stepping back…
>
> (Simon, lines 133-62)

The examples highlight that defining one's higher power varied from client-to-client. As well, believing in a higher power was important for having faith and providing guidance for healing in recovery: "[this treatment program] taught me to…got me in touch with spirituality and how I can have this outside force guiding me in recovery" (Jonah, lines 539-40).

The treatment program required clients to participate in cultural activities, including sacred practices such as a morning smudge ceremony and weekly pipe ceremonies (participation in weekly sweat lodge ceremonies was optional). Even if a client did not believe in the Aboriginal spirituality, one still took away something and developed an appreciation for the spirituality learned at the treatment centre:

> [T]he Aboriginal part, I've, I know that they do believe in God, I'm still working that out because we do say the "Our Father" a lot here…my spirituality is my religion [Catholicism], which is, everybody has their own spirituality...I follow the Catholic religion, right? But I still, I enjoy learning about [Aboriginal culture]….I'm gonna have good memories of it and I appreciate it and I know the values of it…
>
> (Andy, lines 123-35)

As seen in the previous example, clients defined spirituality in his or her terms. The client in the previous example described his spirituality in terms of the religion he practices, another client described spirituality in the following way:

> Adam: …And fortunately this place has made me realize that or uh, helped me bring my spirit back to me, like my faith, my belief, my higher power…
> I: …Can you describe the spirit?
> Adam: Uhm. I guess the ability to be human, to be compassionate of other humans. To be aware of their feelings, and beliefs in respects. When I pushed mine aside, I couldn't be bothered. I didn't care about your problems….To be compassionate of another,

> another human being.…To be human here.…That's one thing that we do in our addiction is we push our spirit aside. And we become selfish. But to be human again, is to be selfless, right?
>
> (Adam, lines 662-82)

Located within the treatment centre was a ceremonial room for sacred practices as well as access to the Elders (Moshum and Kokum[10]). Thus, the treatment centre was a supportive environment for these clients to explore and determine their own spiritual practices, such as praying and meditation, also emphasized in step 11 of the 12-step program:

> I have a little routine I do at night. Where I, I read the bible and I pray and I listen…I take part in ceremonies that they have here and that's huge for me….I always try and pray to God in the ceremony....I kinda figured out my own little…type of [laughter] prayer…it helps more than anything because it keeps me…more open-minded and calm…
>
> (Joshua, lines 604-42)

> [Eva] provided an example that she meditates when she cannot sleep and the night staff members have been helpful by setting up one of the group rooms where she can meditate. When she meditates, she listens to a CD or tape for 40 to 45 minutes, which has helped her to go to sleep. She also stated that when she meditates it helps to deal with her emotions and anxiety.
>
> (Eva[11], lines 44-9)

> [E]ver since I've been here I just like praying more, like every day, and smudging and…I like the feeling and stuff.
>
> (Ariel, lines 90-2)

In fact, praying played a role for one client to remain focused on his treatment program:

> I'm praying now that's something which is different for me….people have been telling me for the last year in recovery, "Start praying. Pray, pray, and…" I'm not really an organized religion but praying is definitely actually helping me, it makes me feel better. And it humbles me actually too a lot, it makes me stay focused too. I noticed especially in the last week.
>
> (Tyler, lines 611-21)

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[10] Cree words for grandfather and grandmother, respectively.

[11] The interview with Eva was not recorded; the researcher documented the interview via notes using voice in third person.

Not only was praying was helpful in remaining focused on treatment, it helped one client to better manage his own emotions during this treatment episode:

> Serenity prayer is [part of 'working the program']. I say that, I swear I say those lines about a hundred times a day....someone pisses me off and I have to sit there, "God grant me the serenity, God grant me the serenity" you know, keep goin' the whole prayer like, over and over and over in my head, like 'cause I'm not freaking, my counsellor Carlos says he seen me in the last month in leaps and bounds, like, today I was left to do dishes by myself for breakfast. The first day I walked in here, I would have flipped my shit, I would have found the guy and drag him into the kitchen and make him come and do the dishes. Whereas, I got mad, but I stayed cool, calm, did them by myself and I brought it up in group in a calm matter. Like so, still mad, I was still swearin', I was still, but where I was before to now...
>
> (Simon, lines 109-21)

More importantly participating in spiritual practices played a significant role in the healing process. Spirituality and the practices allowed clients to let go:

> [T]he spirituality part is having you believe in something, whether it's yourself, whether it's your creator, whether it's you know whatever you choose to believe in.…And to me it's just believing in yourself and believing that you do it for yourself. You don't necessarily have to believe in God and just to believe in, in the spirit world…It's just, letting go of resentments and stuff as well. As soon as you can let go and let God take over…It's helped me believe more in myself. Spiritually.
>
> (Maggie, lines 283-98)

> I didn't even know what [smudges] were. But the feeling in the smudge room is not describable, indescribable.…it's a place to go to meditate to let things out. Let things out in, like whether you're internally or actually speak. This place will leave that and the sweat, the place to go, and, leave your troubles there. And, it feels really good into one of those.
>
> (Paul, lines 1042-9)

> Like the sweats and the smudge ceremonies…I love the cultural piece.…it's so, healing, in way too, uh with that cultural piece and the spiritual piece of I came here to forgive self, to heal, to let go…further my spirituality. Which is a big part of my recovery. It's huge, it's number one for me now.
>
> (Joanie, lines 294-304)

> [Eva] felt that the program was a good program because of the healing part of it. She really likes the spiritual/cultural aspect of the program. She likes the sweats because you go in and you sweat everything out, which has been helpful for her anxiety issues: "releases anxiety that you build up inside that you don't let go."…She also likes smudging and has been smudging every day…. and she really likes it because she feels protected and safe, allowing her to share with the other clients and in group and let go of the pain and issues she has held on to.
>
> (Eva, lines 154-66)

Ultimately, the spiritual component of the treatment centre played a role in clients experiencing spirituality through interconnectedness with other clients and developing a sense of belonging:

> Cultural activities, uhm, for example, tying ribbons on spiritual uh, ceremony uh, out in the trees….with the sweat lodge and that there's a past clients there are certain ribbons for certain aspects of their ceremony or their healing…the Elders have us go out and tie ribbons on trees…for smudge healing or smudge ceremony, we're out in the tepees there one day and we were uh helping the Elders scrape off the [hide], just getting stuff prepared for the ceremonies, uh, helping with tepees, taking them down, uhm, getting us to work together as a tribe…with all the men outside stacking and chopping wood…just, being out there with the men in a group away from the women…trying to just be relating with each other…
>
> (Adam, lines 524-38)

> [T]ribal circles.…we go around, and talk, or, it's short 'cause there's a lot of people. And, it's just, uh, put concerns out and tribes, and the way they organize things is different. Whether I agree with it or not, it works.…that's the whole tribe. Then we segregate into little groups, the tribe.
>
> (Paul, lines 1099-1115)

> Simon: …I like group smudges.…Because it's, it's an aura, it's an energy from everyone else. Everyone else is peaceful, everyone else is prayin' for you, for themselves. They're the greater good in general….We're, we're all brothers and sisters here and that's what it is or, I don't know. Because, have you ever been to a smudge?
> I: I did my first one actually back in November.
> Simon: They're great. Like what did you think about it?
> I: It was just so neat to be around other people and just for like, there's definitely like a peaceful feel, I felt really connected with people, I don't know if that's how you feel.

> Simon: Yeah it's exactly what I'm saying…we're all brothers and sisters, we're all.
>
> (Simon, lines 185-99)

Part of the reason for creating the connectedness among the clients, the staff share the spirituality perspective, explained by this client:

> I: …you talk about that the counsellors and the staff they share that "paradigm," what paradigm were you talking about?
> Anna: Just the idea of being like of, really being spiritually connected to yourself and to the world around you, that we're all part of the same world…we're all connected…and feeling that feeling of belonging and…we're all pretty much safe, you know. There's a past for everyone and stuff like that, so. It's just the spiritual aspect, the higher power, the constant of a higher power….And that sense of belonging.
>
> (Anna, lines 196-205)

In short, spirituality was an essential component of treatment engagement. The Aboriginal spirituality in parallel with the 12-step program created an environment that was safe for some clients to find their higher power and integrate praying and/or meditation practices tailored to clients' spiritual needs for their recovery. The examples suggest that the spirituality component of the program, significantly influenced some clients healing process, specifically emotionally, and developed and strengthened a sense of interconnectedness among the clients and a sense of belonging in the greater world.

Judging Client Engagement: "You can Tell"

In the previous subsections, clients described how they focused on their program through the dimensions of the medicine wheel. Clients also judged their own involvement and perceptions of other's involvement in treatment, articulated by these clients:

> [H]owever much you participate and show up for smudges all that, definitely goes to show, not only about you but your work ethic and all that, so…
>
> (Brian, lines 369-71)

> There's a girl that really 'works her program.' She's quiet when she needs to be, loud when she needs to be. Speaks when she needs to be, she, she's constantly working on herself. Constantly working on her worksheets, she's constantly every day, doing

> something, and lifting people up. People are down and stuff, she goes and tells her story and, somehow it gets you out of a slump, like she's really good for that.
>
> (Simon, lines 734-9)

Clients' motivation was identified (implicitly and explicitly) by most clients as an important indicator that they were 'working the program.' Most clients were adamant that they were attending treatment for themselves, as articulated by this client:

> I think a person comes down to myself and what I want. I can't really do [treatment] for anyone else but myself at this moment. In a sense you have to be selfish, but, you know at least the next three months…are gonna help me for the rest of my life. So I might as well put all that I can to it now…
>
> (Brian, lines 411-15)

> [I]t all comes down to the person…You get out of it what you put in, I think, especially while you are in treatment, it's all about hard work and focusing on yourself.…one of [my counsellor's] mottos is that "You get out of it what you put in" and it goes to show at the end of the 90 days you know, what you have and haven't done, so. As much as the counsellors and staff are here to give us direction and all that, at the end of the day it comes down to what you put into it, you get out…
>
> (Brian, lines 542-51)

One client made a clear distinction about a family member being an "inspiration" (Simon, line 653) rather than the motivating factor to complete treatment:

> I: It sounds like [your younger sister has] been your motivation to get through this program.
> Simon: The first and foremost is doin' [the treatment program] for myself.
> I: Yeah, and is that what's keeping you focused, like doing it for yourself?
> Simon: Yup 'cause I need to…
>
> (Simon, lines 656-60)

Willing and wanting to focus on their program to help oneself was viewed by clients as a marker or indicator that they were engaged:

> [I]f they give it a try or if they are willing to, you know, try to work on themselves, uhm they realize that, "Hey yes, I do have a problem" and then at that point they take control of their own treatment or willing to work on themselves.
>
> (Adam, lines 566-9)

> You have to be willing to make it work, it's a lot of yourself in here….Like, for any new clients coming in here don't come in here… expecting to be fixed. You have to work this place.…You have to, do the work, like do all the paperwork it might seem repetitive or hard…Just do it, and, even though you may seem like you're not getting anything, it does come in. I found. Like in patience was my issue before I got in here; like I wanted things now. Done a certain way otherwise…I'll just drink, and I won't care. So I've had to learn a lot of patience in here…
>
> (Paul, lines 1170-81)

Finally, clients' attitude and behaviour indicated that they were 'working the program:'

> You can just tell by their attitude, how they are. I can really see it. With myself I don't know whether or not people see me as I'm not gonna make it or make it, I have a 50/50 thing in my head whether I am or not, I don't know. But some people you can right out say it. I don't associate with those people…I don't wanna associate with someone who's gonna relapse. Why would I want that?
>
> (Simon, lines 268-74)

To recap, some clients identified indicators of engagement that included work ethic, motivation level, willingness and wanting to 'work the program,' and having the appropriate attitude for recovery.

Clients' Perceptions on not 'Working the Program'

The above subsections described the client perspective on 'working the program.' In contrast, some clients also described treatment engagement in terms of their perception of how others were not 'working the program:'

> I: …I asked how people are not involved in their treatment and you said, you said, you can tell by their attitude….Not following rules [...]
> Mindy: ...they isolate…they don't want to… be part of the group. And you know not following the rules basically like rebelling.…you have to have rules and structure. Like a lot of us coming in here off the [streets]…from where ever and everywhere in life there has to be rules, you know, there's rules everywhere you go [laughter].
>
> (Mindy, lines 550-61)

> [Y]ou don't show up when you're supposed to. Right? You don't show up to anything. You'd rather be uhm, somewhere else. You'd rather be dissing the place or complaining about everything, but not trying to come up with anything that will help.…you're more about acting out when you get scared or you have to look at something…some people clown [around]…[like being] really disruptive, like, start, dramas. You might start a relationship.…I think it all comes down to 'cause you, don't wanna look at what it is, right, that's making you feel like that….[it could also be] having a really hard time with dishes….Nobody wants to do them…but some people figure they don't have to. Some people are really inconsiderate of others…if you were 'working the program,' those things start to change.
>
> (Joshua, lines 731-48)

> Brian: …those who just sleep the day away here and don't bother doing any of the work and journaling and all that kinda stuff, so.
> I: Those are the ones that are sleeping in not doing anything they're the ones that you feel are not motivated?
> Brian: Exactly, yup.
> I: Not working the program?
> Brian: Yup, they're pretty, unless you've been here for a day or two you can definitely notice which ones are not.
>
> (Brian, lines 557-64)

> Like some, just like not doing smudges and stuff and it's mandatory.
>
> (Ariel, lines 1039-40)

Some clients perceived as not engaged showed it through their attitude and behaviour:

> [People who are not involved in their treatment program] they really don't, uh, want be here you can tell in their attitudes, uhm, just the respect level, uhm, they're just kinda here floatin' through it and not really got much input or participation.
>
> (Adam, lines 574-6)

> [C]omin' in late, goin', walking out all the time. Not showing up. Uhm, attitude...Specifically, uh the walking out, going to the bathroom…I understand havin' to go to the bathroom, but I don't understand, we're given so much time here. Uh, that's showing lack, of wanting to be into it…just general attitude.
>
> (Paul, lines 1144-61)

> Some people they're just itchin' the last week, "Well I can't wait to get out of here!" And they completely stop the whole program and

it's like, “I don't want your number, and I don't want you to have mine, because I see you the first three hours, you're gonna be relapsing!”...Just the way people talk, the way they present themselves, they way they hold themselves, you can tell who's serious and who's not.

(Simon, lines 841-7)

Clients who were also “forced” (Adam, line 557) into treatment (e.g., mandated by drug and family court) were perceived by others as not engaged in treatment:

[A] lot of people, think, maybe, are here for court or their kids.…I think it's different because uhm, they didn't just choose to go to come here. Uhm, they're kinda put in a situation where coming here, would allow them that help to get them their kids back or to you know, go to court and have this certificate, that, to show that they're helping themselves, right? But at the same time…I don't know if they're here for themselves, right? Or just for that reason only.…if you're doing [treatment] for something other than yourself, uhm, in the long run, I don't think that you'll be able to face the, what life has to throw at you like, in the sense in being able to actually want to stop using.…I think that you have to have the initiative that you're here for yourself and you wanna do it for yourself not just 'cause you wanna look good in court…'Cause after court, life still goes on and there's still gonna be those temptations out there so it's like, well is it just for that one reason for the court and that person's sobriety or they're not practicing their sobriety…I'm pretty sure you come here for yourself, you're willing to work the program, so, uhm, you're gonna benefit from the program, if you do.

(Erin, lines 276-304)

Adam: …It's really up to the client whether or not they're willing to uhm work on their treatment or if they're, 'cause there are other clients here…they have been forced into here or...court-ordered to be here…the ones that are willing to be here and that want to be here, you can see great changes in them.
I: So you talked about people that were are like court-ordered or kinda forced to be here...would you say those are people that are not involved in their treatment?
Adam: Uhm, probably at first, but once they give it…[a] try to work on themselves…

(Adam, lines 554-67)

[T]hen there's people that have to be here.…they don't wanna change, for myself. It's gonna be hard. I wanna change for like

> 'cause like my girlfriend wants me to change, right? It's different then when you wanna change yourself because you can only do that for so long…you can only change for so long and then you start getting resentful, like, "Look at me, I'm changing! I'm doin' it for you!"…it turns into something else.
>
> (Joshua, lines 703-12)

> I: So you said that you mentioned, like the second group of people, that you mentioned, there's people that are really focused on their recovery and want to be here, and then you have people that have to be here. Who are those people?
> Joshua: I used to be one of those people. I used to be coming out of jail. And I was just here, right? I was here, I heard a few things that I picked up, I picked up a few things I had really it had really helped me uh, be around people again and not have to have that jail mentality, right? It helped there, but I tell you as soon as I left here, I went and scored [laughter]! Right? You know, it wasn't, it was just like a nicer place to be.…it's a better place than where we came from. Right?…It's treatment. I guess it depends on your treatment's a place of change. You gotta learn things in here, right? And if you don't care about anything, what are you gonna learn? Right? I remember that, I didn't learn too much. I've heard a lot [laughter].…But I hadn't learned anything, right?
>
> (Joshua, lines 677-701)

> Paul: [H]ere in [the treatment centre] there's two different types of people out, there's, like people who are court-imposed to be here and that.…see that's the difference between here and [past addiction treatment centre]. In [past addiction treatment centre] everyone was there, like in the same boat, on free will.…
> I: So how is this program, you said that there's more court-imposed people [...]
> Paul: It's not. I don't feel people are taking their, most, a lot of people aren't taking their, addictions seriously, as, as they should. A lot are, like a lot of people are, don't get me wrong.
>
> (Paul, lines 426-43)

> A lot of the people are in here because their parents sent 'em or because the law; half these people are here for the fuckin' drug court, to get some time shaved off…you wanna get sober, you're doin' it to get the hell out of jail! You know, better food…
>
> (Simon, lines 813-18)

However, one client clarified that not all clients forced to enter treatment were not engaged:

> I: Do you say the people from court, like that are told to come here, do you think that they are just, not as involved in their program, they're not 'working their program' do you think?
> Simon: …Danny is great! First I figured he's another one of them drug court guys. He is in here for drug court, but he's a little bit more, he is here for his daughter, and he is here for, you know? And you can tell that he is, 'cause he, I think he took a two-week extension, he's supposed to be [graduating the program] this Tuesday, but I think he took the two-week extension. 'Cause he wasn't done, he hasn't learned about himself….that shows…there's a guy that really wants to learn, that's a guy I wouldn't mind gettin' his number off of him, when it's all said and done. You can just tell by people.
>
> (Simon, lines 826-39)

Another client understood why others who were forced into treatment would not be engaged in treatment, as he was in that similar position before:

> I: …then you have people that have to be here. Who are those people?
> Joshua: I use to be one of those people. I use to be coming out of jail. And I was just here, right? I was here, I heard a few things that I picked up, I picked up a few things I had really it had really helped me uh, be around people again and not have to have that jail mentality, right? It helped there, but I tell you as soon as I left here, I went and scored [laughter]! Right? You know, it wasn't, it was just like a nicer place to be….It's treatment. I guess it depends on your treatment's a place of change. You gotta learn things in here, right? And if you don't care about anything, what are you gonna learn? Right? I remember that, I didn't learn too much. I've heard a lot [laughter]….But I hadn't learned anything, right?
>
> (Joshua, lines 679-701)

Other types of clients identified as not engaged included younger clients, clients starting a romantic relationship with another client, respectively, as mentioned by these clients:

> I: [H]ow would you say people are not involved in their program? What are certain things?
> Jonah: Maturity level.…Just, I don't know you can kinda see it the people like 18 to 22. Maybe they're serious but they don't seem serious. They just joke around, they're late for everything, they complain about dumb stuff. Uhm, but you see people's growth as time goes on, they get better.…getting A's all the time, shows that you're not trying very hard.
>
> (Jonah, lines 514-26)

> I: I know, like kind of going back to your friend…do you think… when she was here being involved with somebody, being in a relationship with somebody, do you think that was not 'working the program'? [Laughter]
> Ariel: Oh yeah!
> I: [Laughter]
> Ariel: Definitely 'cause it's like, she was tryin' to get jealous over like other girls and stuff over…
> I: She's causing drama?
> Ariel: Yeah [laughter]…And like even though like I was friends with her…I was like, that's messed up, like I even though [the couple] were my friends I still thought it was wrong…
> I: Mhm. Not helpful for them in their program, right?
> Ariel: [Laughter and in agreement with interviewer; client at this point was getting tired and needed to go for a smoke break]
> (Ariel, lines 1037-60)

It was also suggested by one client who noted that the younger clients who do not 'work the program' drop out of treatment:

> Usually though I've noticed though those people don't last very long in the program anyway and within a matter of a week or so they've been terminated or self-terminated. So it's just one of those unfortunate realities of you know, I'm 41 and they're 18, so, you know, we're not on the same plane, right?
> (Anna, lines 989-1015)

For the most part, only a few clients admitted that that they were not involved in the program:

> But as far as the clients the first week and a half, I didn't really know anybody. I was really kept to myself. And so then after about two weeks just told myself I gotta focus on myself and this program….'Cause I wasn't following anything when I first got here, I wasn't doin' anything, I was just, wasn't doin' homework, stuff like that. And then I started sayin' to myself, "Okay Andy, you're here for yourself. Who cares about everybody else."
> (Andy, lines 745-52)

> I: …And I know you described that you were not involved in your program the first little bit [beginning of the program] and that you were not doing your homework, you not showing up [...]
> Andy: I was showin' up but I just wasn't uhm, involved….like learning skills and stuff like that and I wasn't paying attention, I'd be lookin' at the ground, or looking at the wall, or ceiling, like, "Like get this hour over with!"

(Andy, lines 1080-6)

> I haven't done my lifeline….I've said some mean things to people, some of which I've apologized to. I still gossip about some people. Uhm, I joke around in the smudge room. Uhm, I just, I like stirring the pot, not in a bad way, but, I like just to, I don't know. I have a weird sense of humor I guess.
>
> (Jonah, lines 508-13)

> I: … are there other ways that you haven't worked the program?
> Simon: Uhmmm. I don't got a sponsor. And you know, not every day [laughter] you're gonna "work your program"….I'm still new to this. Like, like not every day you're gonna wanna be like, "You breathe sobriety." You know, "Smiles!" And you know, "Help your fellow man!" Basically sometimes I'm just like, "Fuck you! Fuck you! And I'm just goin' to bed!"…there's lots of times I haven't "worked my program," days where if I wasn't in here, I would totally relapse….I'm still new that's why I'm here and I'm in safe walls, right?...So, I think I'm allowed to every once and a while in here and not 'work my program'...
>
> (Simon, lines 701-21)

Realistically, the latter client went on to say that it's difficult to work the program every day:

> [T]here's a few [clients] that you know, they do 'work their program', but even still, yeah people goin' uh 20 years sober, 15 years sober, they still don't 'work their program' every day….It's, it's damn hard possible to. You can't always be on….You can't always be thinking of that….what would Bill do, the writer of the *Big Book*? What would Bill do?...What would it be like?
>
> (Simon, lines 739-51)

To be in treatment, some clients articulated that one must be in treatment for self. Those who were forced to enter treatment through the court system, younger, and getting involved in intimate relationships were considered clients who were not 'working the program.' However, a few clients recognized that in treatment and recovery that attitude, behaviour, and motivation levels vary whereby they could shift from being less engaged to more engaged. Further, only a few clients admitted that they were not focused on their program, suggesting that it could be difficult to determine whether a client was 'working the program.'

Summary of Clients' Perception of Treatment Engagement

Treatment engagement was a complex process. Treatment engagement was described by clients at this specific treatment centre as time for encouraging and developing *healing* and *harmony*. Healing entailed a holistic approach to address four dimensions of health, aligning with the treatment centre's spirituality by engaging clients in a variety of treatment activities. The treatment centre was a safe environment for some clients to explore self along these dimensions of health such as trying different recreational and leisure activities with the potential of establishing these activities in recovery; awareness and practice skills learned to maintain sobriety; enhancing self-awareness and self-esteem, and; connecting to spirituality. Treatment engagement was a personal journey for each client since clients were at different starting points initiating this treatment episode:

> A lot of [other clients] aren't as far along in their addiction as I am. So like with a lot of the younger ones when there was a couple that got contracted for being too close.
>
> (Maggie, lines 481-3)

> How bad do you want it? How bad do you want to be sober…like some people might come here for, some people might come here because they have family members, you know courts, you know, for instance, for myself. But, how bad, how bad was your addiction out there, you know what I mean?...do you want to live or do you want to die?...Everybody is at different levels.
>
> (Mindy, lines 591-600)

> [L]ike people that are first starting out you can tell by just lookin' at 'em that they're, they're, you know, they're not happy. You can know, like I told you, you can always tell. People in their last week they're excited because they're finishing the program, right? So, it's, ups and downs, right? I notice people in their first, second week, I know what they're goin' through. You know, they're on a roller coaster right now, right? They hate this place and next day you love it, next day you hate it, you know?
>
> (Andy, lines 1070-5)

> [B]eing in here because I'm not new to recovery…I've heard a lot, I know a lot more than most of the people out here; I don't know everything, that's cocky sometimes in my attitude, but, being around people that are fresh coming from, like I said, when I came out here [to Alberta from B.C. and went to treatment for the first

time], that's when I was in that hatred of me, the hatred of the world, when I came in here [the treatment centre] I wasn't like that, I was motivated, I knew what I had to do right and being around a lot of people raw from their addictions, it really gets to me sometimes because I'm so used to people with recovery.
(Tyler, lines 215-24)

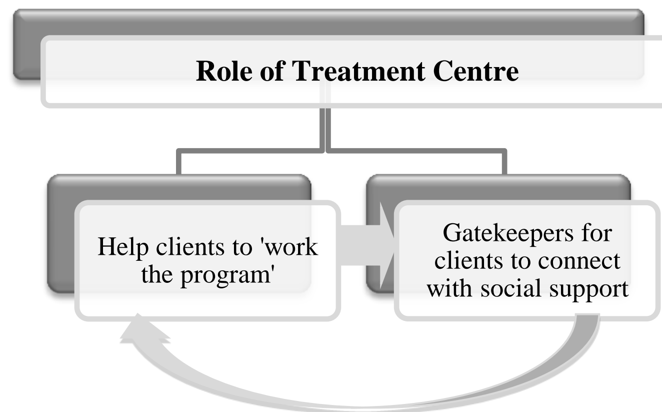
As well, this section examined clients' evaluation, which identified indicators of those who were focused and not focused on the treatment program. Clients' perception of treatment engagement was related to how treatment centre's connected clients' to social support as part of the theory, which will be discussed next.

Theory: The Role of the Treatment Centre as Gatekeepers for Clients Connecting with Social Support to Enhance Treatment Engagement

Overview of Theory

The previous section described clients' perception of social support and treatment engagement, which had implications on the treatment centre's role. Chapter 4 described discussed the role of axial coding to generate the theory. This section of this chapter will elaborate on how axial coding helped to determine the relationship between social support and how the treatment centre's role related to their views on the extent to which clients were engaged in treatment. Axial coding highlighted the role of the treatment centre in clients' treatment engagement, which was to: (1) help clients focus on their treatment program, i.e., 'working the program,' and (2) act as *gatekeepers* for clients to connect and engage in healthy, clean, and sober social support networks within and external to the treatment centre, which in turn helped clients to 'work the program.' The treatment centre's role is conceptualized in Figure 6.

Figure 6. The role of the treatment centre as gatekeepers to help clients 'work the program.'



To fully understand the treatment centre's role in treatment engagement, focused coding was used to closely explore the other two categories from initial coding, i.e., how the treatment centre's rules, policies, and procedures affected treatment engagement and how the treatment centre allowed clients to connect people outside of treatment. Focused coding confirmed and solidified the importance of the treatment centre's role in clients' treatment engagement, in which the core category was the *treatment centre's role as gatekeeper*. Thus, the emerging theory that generated from all phases of data analyses was *the role of the residential addiction treatment centre as gatekeepers controlling clients' access to social support to maximize clients' treatment engagement and facilitate clients to create healthy social supports during treatment and for recovery*.

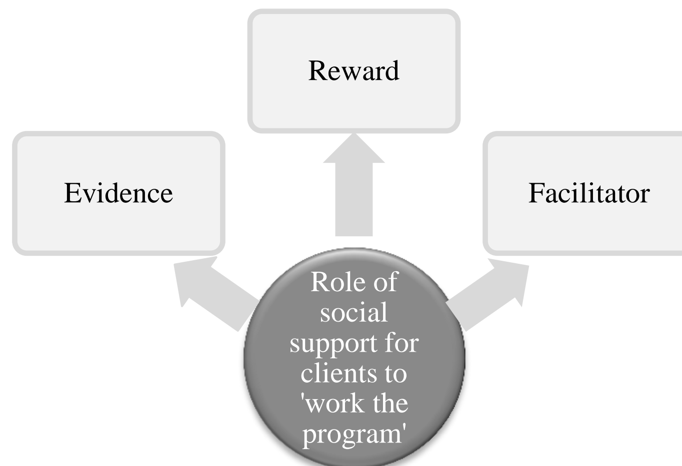
The following sections will discuss in detail the components of the theory, with respect to the treatment process components and environment, including: (1) the treatment centre's rules, policies, and procedures to access external social support, (2) the treatment centre's programming to help clients access community resources and supports for recovery, and (3) the availability of other clients, counsellors, and treatment staff as additional supports within the treatment centre.

Controlling Clients' Access to External Social Support: Rules, Policies, and Procedures

The treatment centre controlled clients' access to their social support networks outside of the treatment centre, i.e., family members and friends, through a variety of rules, policies, and procedures designed to ensure that clients were 'working the program.'

The treatment centre used clients' external social support as: (1) evidence and a reward that clients were engaged in their treatment program and (2) a mechanism to facilitate clients to engage in their treatment program, which is depicted in Figure 7.

Figure 7. How the treatment centre used clients' external social support to help clients 'work the program.'



'Working the Program' in Order to Qualify for Social Support

The treatment centre's role as gatekeeper required clients to 'work the program' to qualify for privileges like accessing external social supports. Connecting to external social support was regarded by program staff as a reward that could be obtained when there was concrete evidence that a client was 'working the program.' The treatment centre evaluated clients' treatment engagement based on their level of compliance with the rules and requirements that included attending all session and being on time, participation in treatment

sessions, and completing assignments. Recall that in the previous section (see *Clients' Perception of Treatment Engagement)* clients provided examples of their involvement in treatment, which reflected the treatment centre's criteria. The following subsections will provide specific examples in relation to clients' perspectives on their experiences qualifying for Sunday and Christmas passes and the telephone privileges. Clients' perspectives on the treatment centre's role as gatekeepers will also be discussed.

Sunday and Christmas Passes as Rewards for 'Working the Program'

Connecting to external social support was evidence that a client was 'working the program.' Clients earned the Sunday pass as a reward for 'working the program.' Clients were scheduled to participate in activities from Monday through Saturday from 9:00 AM to 10:00 PM. Sundays were clients' rest from the program. For the first three weeks, clients were required to stay on the premises of the treatment centre; visitors were permitted to visit them at the treatment centre. After the first three weeks, clients had the opportunity to leave the treatment centre from 9:00 AM to 9:00 PM on a Sunday pass. Clients needed to earn their Sunday passes, granted by the counsellor based on clients' demonstration of focusing on the program with respect to their attitude, attendance in sessions, participation, and completing assignments:

> And then after you've completed your third weekend you get a Sunday passes from nine till nine on Sundays. Unless you've done something like not participating in the programming, they can take your pass away from you if you're goofing around. So, but as a general rule, most people get their passes, if you're doing your program, you're going to get your pass.
>
> (Anna, lines 787-92)

Nevertheless, if a client was not 'working the program,' the treatment centre did not grant the client a Sunday pass:

> I: …how do you earn your...pass to get out?
> Mindy: …make sure that you are on time to your programs. You know, like every program they do roll call.…on time for group and roll call and stuff like that and you do your assignments and, yeah just your behaviour…If you get three A's then you don't get your pass.
> I: Three A's what does that mean?

Mindy: ...three absences.

(Mindy, lines 373-86)

Similarly, clients over Christmas time also had the opportunity to leave the treatment centre for overnight stays, ranging from a few days to a whole week. Again, clients earned the Christmas pass, which was at the discretion of the client's counsellor, as articulated by this client:

> [Getting the Christmas Pass from December 24, 2011 to January 2, 2012] all depends on your counsellor or if, it depends on how many A's you get, it depends on your behaviour, and your attitude towards, towards things and uhm. If you've been participating and what not, it's kinda in your counsellor's hands if she thinks or he thinks that you're safe to where you're going because we have to fill out a form too about where we're going, if we feel we're safe, or is there going to be anything around us, and uhm we have to fill out a form and if they're feeling that…we're not in a secure situation, uhm or place at the time, they might just let us go for a few days and then. Like some people are coming back on the 27th and it's really up to your counsellor to decide that if you're ready to go to a safe place, if you have only a certain amount of A's or no A's, if you have a good attitude towards things.…I think I get my pass, I'm pretty sure 'cause I've talked to my counsellor… she says she gets a good feeling about where I'm at in this program, in life…she knows I'm gonna be going to my parents, it's a safe place, so. I'm pretty sure I'll be getting a pass, that'll be nice.
>
> (Erin, lines 514-35)

Since most clients expressed that it was important to have limited access to outside influences, they endorsed the idea that the rules, policies, and procedures for the Sunday passes were fair and in place to help them benefit and focus on their treatment program:

> I: …And you said that [the counsellors are] looking after your well-being. So what do you mean by well-being?
> Erin: …what's best for me, like if I should be going out on the weekends on my day pass…if they don't find that I'm ready to do that…as much as I want to go, you know, the first week here [I had] a few A's [absences] so… counsellor didn't let me go, but I respected that and…I think maybe it's a good thing because I wasn't ready to go, so.
>
> (Erin, lines 100-8)

> I think it's good, that you only see [outside people] on Sundays.…Because, a lot of people, their parents leave or family

> or whoever leaves, and they're distraught….Destroyed kinda thing, if you're able to see them every night or you know for supper or [little] stuff, do you know how much that fucks your program real bad…you get to see them from Sunday till 6…you cry it out, you have the rest of the week to recover...if it was every night, you'd have some people already, I, guarantee that 60 percent of the people here would have already termed themselves, like, "I fuckin' can't do this!"…the Sunday [passes] are great for that…
>
> (Simon, lines 878-93)

One client felt that, depending on where you were at in your recovery and what you needed to maintain recovery, he understood that certain clients needed to connect to their family to stay focus:

> Some people need [to connect with outside people], like constant attention….there's a couple of people…in here that they have to see their mom. And mom isn't coddling them at end of the week…that is what they need to be able to, hug mom, know that there's someone that loves them...unconditionally and stuff….if that's what keeps them sober, power to 'em. It doesn't matter how you get there...do what you need.
>
> (Simon, lines 546-63)

The Sunday visits and passes appeared to be a positive aspect for few of the clients on several levels. First, Sundays provide the clients the opportunity to leave the treatment centre to have a break from feeling "trapped" (Eva, line 119), "secluded" (Tyler, line 891), or "in jail" (Joanie, line 268), especially with the nature of the program being inpatient rather than outpatient:

> I went out last Sunday. My son came and I went out and saw some friends, so that was a really good day. Uh, weird though transition, from being here for like, I found it too long to be here to be in for three and a half weeks….it felt like I put myself in jail, again [laughter], 'cause I've been in, you know, rehab before where there's a long, for safety, they have you stay a couple of weeks without goin' out, but this was like almost three-and-a-half weeks, so.
>
> (Joanie, lines 265-73)

Sunday visitations were also helpful for one client to refocus on his program:

> I have some tough days here sometimes I just feel like I'm locked down. And when [my ex-girlfriend] comes and visit me, it's like [a] breath of fresh air…I forget about being here…I more enjoy myself, it usually lasts a couple of days….it's just like any of my other friends…when they come by…it makes me just, a big smile

> on my face…it uh grounds me somewhat…because I find myself get distracted in here a lot.…I get caught up…the old using stories and stuff like that…it doesn't really help me talking about stuff like that, I want to talk more about recovery and when my friends come I can talk about my problems and stuff…it kinda just starts motivating me again to start moving forward in the direction…get me refocused…it makes me happy, more positive…
>
> (Tyler, lines 139-66)

> [W]hen you're not on a pass they allow visitors [at the treatment centre], that's nice.…it's a very slack day, it's kinda boring. I get very bored when we're not being kept busy, especially in here because…I'm stuck in a treatment centre [laughter], so. It definitely helps allowing them to come in from the outside and talk and stuff like that.…even seeing other people's families come to see them. It's, it's just seeing them light up, you know? They could be having a bad day and they see their kid running or something like that. Just me watching that, it's, it's really, it's inspiring…even though we're all addicts…some of these people…seeing that light go on in their face…it's really neat.…family's huge for me and seeing other people, with the same passion for their family, is very, very good for me, I like to see that, so.
>
> (Tyler, lines 941-57)

One client stated the importance of practicing those tools and skills learned in treatment:

> I think the biggest thing about this place is just getting, it's not so much that all of us don't have the tools to stay sober and that. I know we all learn a lot of new things too, but I think it's more so putting them into place. I think a lot of us know what's right and what's wrong, what's healthy and what's unhealthy, it's just a matter of actually living that lifestyle and not going back to our old ways. So I think that, yeah just taking the tools that we know we get here and putting them into play.
>
> (Brian, lines 570-6)

Thus, the Sunday pass served as an opportunity for clients to practice their skills and tools to maintain sobriety:

> Simon: I think [the that the treatment centre’s rules] it’s good, that you only see them on Sundays.…after four passes or four weeks of being here and your fifth week…you get to go on your pass.…you get to test your toes in the water…they monitor your shit too, piss test and all that other kind of stuff. And they give you a chance to

> hang out with your buddies.…Can you, is he able to stand on one leg? If not by this point, then you shouldn't be here.…
> I: Yeah. So you think that it's good though…you have safe place here, but…you [have] those allowances to like try it out[...]
> Simon: Yes, that's it, just test your toes in the water and stuff…
>
> (Simon, lines 878-909)

Interacting with external influences provided an opportunity for clients to practice and build on some of tools learned in treatment. As well, the Sunday pass provided an opportunity for one client to practice saying “no.” It also allowed her come to the realization that she had to let go of her old, drinking friends who were non-supportive of her sobriety:

> [M]y other friend's boyfriend…he wanted us to all go over…for a barbeque and, so my daughters can play with his daughter uhm I was like, “No,”…like of course there's gonna be beer there…and that would be...a big trigger!...[my friend] just kept on phoning and buggin'…“Just come over,”…I don't feel like goin' over there….and then [my other friend] she's like, “You, you don't want to go over there?...I guess you wouldn't want to be around alcohol and stuff.” And it's like real dumb…“Of course not!”…I said “No”…but I got to see [my friends] for a bit……so I just dropped them off [at the barbeque] and then went home, uhm, as soon as I got home…I just started crying...'cause, I realize I can't be friends with them no more. And it sucks….like, everyone who drinks like I can't even be friends with anybody…I don't wanna relapse too and, like all my old friends and like, [sigh]…But I really found out who my true friends are.
>
> (Ariel, lines 462-501)

One client discussed that he ideally would prefer to have no contact with external social support networks because he would lose focus on himself, but at the same time it would allow him to learn to cope with issues that could arise from those external interactions:

> [M]y mom because she definitely has a problem with prescription drugs….the stress level in the house gets to everybody and then they just, at the end of the month they get their cheques, it's like they're gone for a few days and then, the rest of the month it's like hurting and bad, and that it's like that whole cycle of addiction, right? So, when I go out on Sunday pass, I see that and it just kills me, and it's like, sometimes I wish I don't go. Sometimes I wish I didn't even have to see that and hear about it, everything that's goin' on, because it makes me wanna run [laughter] and fix it, right? And try and do what I can…

(Joshua, lines 217-26)

> [N]o contact with them [family and girlfriend]…I can, uh, easily get unfocused, on myself, and easily focus on them.…I'd have a really tough time, but then again, on the other hand uh, if I, if they weren't goin' through those tough times and I didn't find out, I would not have learned how to try and deal with that....So you can avoid it, right? Which would be no contact…Which would be the more comfortable thing for me to do. Or I could uh, actually have it the way it is and uh, try to learn how to deal with that on my own.…in a safe place…
>
> (Joshua, lines 841-64)

Furthermore, the privileges during Christmas break were also an opportunity for clients to test and gain confidence with maintaining sobriety, as described by this client:

> Like I said it's changed me, I'm just more glowing. I don't know I can, like I went to bars over the holidays, and at the track, and I didn't, I'm different.…I wasn't annoyed that people were really drinking. My brother was drinkin' right in front of me. He even asked me do I mind, I didn't even notice. So I'm different.…[This treatment centre] has changed me.…But when I did go, out [Christmas week pass] and, I did have one sober day with my sister.…And I wasn't planning on my next drink….I wasn't consumed by drinking, which I have been for a long time. I, even in my last treatment centres, I was always in there completely functioning and everybody thought I was great, and cared, and, "This guy should never drink again." But me, I was planning on drinkin'. I, that was my reward when I got out.…when I got out on that pass, I showed it. And I felt it, by not planning on, not plannin' nothin, even when I get out…I'm not planning for a drink…
>
> (Paul, lines 813-51)

From the former example, being around individuals who were drinking around him on his Sunday pass affirmed his desire to maintain his sobriety:

> But [my sister]…she totally respected my sobriety….I watched her get drunk, but she wouldn't drink in front of me. But I watched her get drunk and then, it actually reaffirmed me wanting to get sober.
>
> (Paul, lines 686-97)

This implies that one of the benefits of being in a residential addiction treatment rather than an outpatient program was that clients could temporarily leave the safe confines of the treatment centre and practice their skills and tools learned in

treatment. However, the Sunday passes could also be detrimental for some clients. One client described that this was his second time at this treatment centre as his first time he was terminated for using illicit drugs on his pass. Although he used on his pass the first time around, that experience was his motivation to stay clean this time around:

> I was here a month ago, I got terminated, but I'm back again….the first time around, I think, it's not so much I wasn't ready, 'cause I still really wanted it. But I think before I had reservations 'cause I kept telling myself I didn't get the last good high and first Sunday pass came around and I went out and used, so. I got terminated the first time around…as soon as I got terminated, I re-applied and they actually got me back in here in exactly 30 days…surprisingly after I had gone out and used and got terminated…one of the things that changed that was that I ended up in the hospital….I haven't touched anything since then, so. It's kinda a rude awakening, but I think, I kinda needed that kick in the ass to get me, even more motivated to stay away from everything, so.
>
> (Brian, lines 230-57)

Overall, the privileges of the Sunday and Christmas passes were given conditionally, on evidence that a client was 'working the program,' based on the counsellor's evaluation. Most clients perceived the rules, policies, and procedures for these privileges were fair. In addition, the visits and passes were important for clients to take a break from treatment programming, to regain focus on their treatment program, and to test their sobriety outside of the treatment centre.

Facilitating Clients' Treatment Engagement through the Phone Policy

The treatment centre facilitated clients to focus on their treatment program by minimizing connection to family members and friends in particular. The rules, policies, and procedures accessing clients' family members and friends had implication on clients' treatment engagement.

Clients had the opportunity to use the phone through the week. Clients could use the phone (ranging from two times a week or every day) for between five and ten minutes each call. To make phone calls, clients had to seek permission from their counsellor by completing a form referred to as a "support sheet:"

> [F]ive minutes, one phone call per day, provided you have a support sheet.…a support sheet [is] from your counsellor uh, requesting that you are able to make this phone call.…So basically they want to know who you're calling, when you're calling, and uh why you're calling…
>
> (Adam, lines 602-10)

The counsellor based his or her decision for a client to connect to external social support via phone on where the client was at in their treatment program and how that interaction could affect the client's focus on their program, which varied from client-to-client:

> I have to talk to a counsellor if you need more than two phone calls a week to keep in touch with your loved ones and then they'll let you. But then also too if they feel that it's affecting you, and you know there could be issues on the outside that are brought up that really affect you, then they'll say "No, no more phone calls for a few days until you deal with this one issue and then we'll move on to the next."
>
> (Maggie, lines 327-33)

> I: …And what does [the treatment centre] or what do they say about social support?
> Brian: …when it comes to family, it all depends on situations I guess, every person's different, personally I think. So, I guess it all depends on your ties to the person, how important in their life they are right now to you, especially how they monitor your phone calls and everything, it's, you actually have, to have a legitimate reason to reach out to them.
>
> (Brian, lines 431-8)

> I can see how it could be bad because I've seen some of the people get on the phone and after that they're crying and stuff like that 'cause they're still doing…I can understand…in the first treatment centre I went to, I'd get on the phone calls and it got to the point where I got so angry because I'm dealing with problems that aren't in treatment. So in that aspect I can understand why they limit it and they monitor it somewhat and keep it to a short thing because really you're here to focus on yourself, right, and not to focus on all that crap out there because…that's why you have residential treatment so you can focus on you.
>
> (Tyler, lines 846-56)

> I've known of a couple of people who, they'd requested…to call so-and-so from their life and this counsellor said, "No, I don't think it's a good idea. No you can't."…But that's their job. I mean we're

> sick, right, and we don't know necessarily always know what's best and the counsellors have been hearing us talk and everything for this much and probably may have at times better idea of what's a good situation and what's not a good situation, right?
>
> (Anna, lines 823-31)

Although clients expressed the importance of having social supports throughout recovery, most clients expressed that while in the residential addiction treatment centre, it was important to focus on their own treatment program, which even included having minimal or no contact with family members and the outside world. Further, there was consensus among most clients that they supported the decisions made by counsellors around accessing external supports via the phone. Participants understood that the treatment centre’s rules, policies, and procedures were necessary to ensure they were focused on their treatment and recovery:

> I definitely think, when it comes to family, it all depends on situations I guess, every person's different, personally I think. So, I guess it all depends on your ties to the person, how important in their life they are right now to you, especially how they monitor your phone calls and everything, it's, you actually have, to have a legitimate reason to reach out to them.…they have to be someone who's important to you, who can help you in your sobriety.…So it's a lot more, difficult, not so much difficult, but you have to have reasons for reaching out to other people, other than those that are actually important in your life…I definitely think that's one of the, probably the better things around here just because you don't know who anyone else you could be talking to, so. I think the support sheets here definitely play uh, an important part in that aspect.
>
> (Brian, lines 433-51)

> I definitely think it’s for the better [having limited phone calls]….I think the more you focus on yourself…the better you will be improving your life. And it's not so much that I don't feel the need to contact them…it's almost better to be focussing on yourself in here and not worrying about outside influences 'cause you're already changed how the day goes and that kind of stuff…And it's still important to talk and you know socialize with your family supports…it's not always good to feel the need to call them every single night…But at the same time it's not good to go three months without making a call or anything like that, so. I think it all depends on the person and finding the right type of balance, especially in their recovery, so.
>
> (Brian, lines 515-30)

'Cause [it's important for other clients to contact other people outside of treatment] they have kids, uh husbands, wives. But as long as they get support sheet done up and time it right, they can do that.…People only complain because it's their fault and they don't get everything set up. But [the treatment centre] is actually like, everything here is really simple to follow…the way they have it where you need a support sheet done up, like some, that's good because…[if] it was free reign of the phone to people who call drug dealers, they could call people that aren't beneficial to their recovery, so it's like that for a reason.

(Jonah, lines 349-70)

I: Do you think it's important for people to that are like in residential treatment even to connect with other people outside of treatment?
Joanie: Depends if they're healthy or not. You know, if they're healthy people, yes. But if they're not, I don't think so. It's terrible actually. There's all kinds of drama that goes on in here because people…unknowingly or knowingly connecting and engaging with these, uh people who are, you know, let's say not sober….Or toxic in a relationship…friends and stuff, it's not really necessary to, to contact toxic people unless you absolutely have to, maybe somebody's taking care of your kids or, you know, I think the less the better.

(Joanie, lines 209-22)

But that is something that [the treatment centre] allow and I believe those calls, like you need a support sheet. So you have to provide your counsellor with the name and number, who that person is before they would allow you to call that, it's obviously for your own safety…you're not given a pay phone and just phone whoever you want….Which make sense 'cause you might not be engaging in healthy conversation…they restrict it to make sure they know who you're calling and why you're calling….I do agree with [treatment centre restricting phone calls] because sometimes you're not thinking properly, you're wanting to call some ex-boyfriend or something you're, you know supposed to be breaking off the relationship because it's not healthy or phoning your dealer or calling your mom that you don't like…

(Anna, lines 799-818)

I think there's a reason they limit to five to ten minutes….Because five to ten minutes, I know a lot of arguments that would have went on with my mother, for hours! Whereas just like, "Mom I got, I'm only on for ten minutes." You know, like, just yellin' but I'm only on for ten minutes! Click!...I think that really gives you

> an opportunity to say, “Hi!” “Bye!” And not have these big dramatic arguments, with someone's lady, shoving something down your throat, so whatever else: “You know, you know what you did? You know what you did to our family…”
>
> (Simon, lines 913-26)

Adding to the latter example, a few clients described experiences of the consequence of connecting with individuals outside of the treatment centre could divert their attention from “working” on themselves:

> It can also, uh really messes somebody up. I know a couple of people that uh, have left, in the last couple of days, who used “outside things,” allowed outside things to get to them and had brought it in here and used this place and what was going in on in here as excuses with something goin' on out there. So I guess it depends on where you're at.…'Cause they, stresses, uh people needing them, uh things happening, they got too much of them [outside people/influences], and they unfortunately didn't uh, learn to deal with it…And just did what they normally do….'cause it is early treatment, right? So they kinda got caught up in that and brought in here and…they got into that negative headspace, instead of asking for help or being honest about it, they kinda bottled it up, until they couldn't take it anymore and they bolted, right? And then who does that affect? Doesn't affect anybody here. You know, “I'll show you guys, I'll leave.” You know, they're always doin' the same thing…It's them that has to be out there now. Feeling like they've failed maybe, or maybe feeling like their fixed, which is even worse…I guess it depends on the situation, right?
>
> (Joshua, lines 867-91)

> I did call the one girl, my ex from back in B.C. I called her the other day down in [Alberta city]. She has my PlayStation 3 ® I want back, but she ended up putting it in the pawnshop though but, ahhh two minutes on the phone with her, I got off the phone with her and I was steaming!... And yeah I was so mad…
>
> (Tyler, lines 819-59)

> I've called [my mom] one time just to tell her that it was going okay….But like I said, right now I try not to talk to her much more that that [laughter], 'cause it ends up being an argument….I don't want her to interfering in the actual stuff I need to be working on too, eh?...I don't want, I'm not here to deal with her, I'm here to deal with me...right now, so.
>
> (Anna, lines 591-606)

Conversely, a few clients expressed that he disagreed with the treatment centre's approach to limiting access to external supportive people:

> [I]n regards to uh, support sheets and certain procedures and certain policies I just don't agree with… as I find it disorganized.
> (Adam, lines 629-31)

> Andy: Oh what do they [counsellors at treatment centre] think [about people being "there for you"]?…Oh they want that, they feed off that…when I first started here I didn't associate with anybody, they helped me! To get my self-esteem back and they worked on that big time!…
> I: That's kinda really interesting too that…it sounds like they're very supportive like you know being in touch with other people….In the treatment centre [they say] that support is very important, but you're only allowed two phone calls?
> Andy: I know! See that's what I mean and that's why I said to them, it makes no sense to me.…these people in [treatment centre] say, "They're comin' off addictions, they're just like you, so we want you…" Not only have they helped with me but I'm also helpin' them. They think my family, the way that I've got it is my family, they push 'em aside: "You always got your family, you can see your family later", which I totally disagree with and I don't understand that…
> (Andy, lines 980-1006)

Furthermore, it was beneficial for some clients to access their external social supports to focus on their program:

> [P]hone calls definitely helps…when I'm in a bad mood it just takes me to talk to the right person and I just snap right out of it, when I get off the phone big smile on my face again…especially on one of the days that I wanted to go….but then I just got on the phone with somebody else, psh, that much better!…for me it is beneficial [to call or access people], very much so because…I have nothing but positive people in my life that help me out.…But for myself, it is definitely is a plus, it's very good for me because sometimes I need a, just reassure myself for what I have out there…
> (Tyler, lines 820-59)

It was also important for this client to connect to his outside supports to keep him engaged and stay in treatment:

> If [the treatment centre] closed me off [to connect with outside people]…I'd probably would have left. If I had no access to, that's the biggest reason why I came to this one, but, uh for

> myself…probably wouldn't be able to get through [laughter] here….if I had no access to anybody else out there…It reminds me of why I'm here, reassures me that life is good out there.
>
> (Tyler, lines 1000-6)

Moreover, limitations on the number of phone calls to family members negatively affected a few clients. In one instance, the limitations on phone calls were a major barrier for one client's focus on his program as his family was a crucial source of support:

> Andy: …It actually really bothered me sometimes…I think two phone calls a week, come on! When I was out livin' on myself I talked to my daughter four or five times a day!…And now I could talk to her once a week? Out of seven days? That's unheard of! And that really affected my daughter as well.
> I: Yeah. And how has that affected your treatment experience here?
> Andy: Horribly! There were a few times where I wanted to leave. It did, it really affected me big time. Oh yeah, there's a few times I just wanted to walk out the door and say, "Screw it!"…"What?! You tellin' me I only get to talk to my daughter once a week?!"…that didn't help my program though….see my daughter's my life and that…she's a huge support for me. And only gettin' to talk to her once a week? That's not fair….So yeah, that's, that didn't help my program though. That actually really stressed me out big time. A lot of stress in that.
> I: And it didn't help you with like you weren't as involved in your program?
> Andy: No, no, I was losing track…I was showin' up but I just wasn't uhm, involved….like learning skills and stuff like that and I wasn't paying attention, I'd be lookin' at the ground, or looking at the wall, or ceiling, like, "Like get this hour over with!"
>
> (Andy, lines 905-1088)

> I felt very, uhm, shut down. I felt very nervous, I, very secluded, but I thought it was a joke, of course, which is natural, and then, I started focusing on myself and, like it gets pretty crazy here sometimes. Like I, my age and then plus so many young people, so that was a big factor. Like I got really stressed out, I, I'm still gettin' over that. It's just overwhelming at first…I just became really secluded because I had no choice 'cause I couldn't talk to anybody, right? It's not like I could pick up the phone and call somebody all the time.
>
> (Andy, lines 681-91)

In response to the client's lack of focus in his program, the treatment centre allowed him more phone calls than normal:

> When I came in here, I got super support from [my younger brother], my mom, and my daughter and they very helpful the first week and a half that I was here. 'Cause [the treatment centre] really let me use the phones here a lot when I first started here. Because first off 'cause my daughter's special needs and that, so they were really helpful and but that kinda drained out. So I got a lot of support that way.
>
> (Andy, lines 736-41)

Once this client started focusing in his program and reaching out to support network within the treatment centre (i.e., other clients), the treatment centre limited his phone calls to the allowable phone calls per week. This example suggests that the treatment centre exercised flexibility with the rules, policies, and procedures to help clients focus on the program by connecting with his family members. Similarly, another client described a situation where she was permitted to make a phone call to a family member outside the regular scheduled time, demonstrating the treatment centre's flexibility to adapt to both the client's treatment and social support needs:

> [I]f we want to, like to talk to our families and stuff, my counsellor is pretty good…like I'm havin' a bad day and like I'll ask to use the phone, even during the day if I'm having a rough day and she'll let me use it…'cause I need to talk to my mom or someone or my dad.…I think it's good, it's good every time I talk to them. They know what to say too, to me and, even though like sometimes like would I'd hear it before again…
>
> (Ariel, lines 833-45)

The two latter cases also highlight the treatment centre's flexibility to adapt to the varying social support needs of client, by providing clients the needed additional access to their external social support networks to focus on their treatment program.

Inconsistencies in Connecting Clients to External Social Support

The treatment centre maintained structure for clients through rules, policies, and procedures. This was important because some clients expressed the need for structure as they were addicts:

> I mean I understand you know, like with the treatment centre…you have to have rules and structure. Like a lot of us coming in here off the…from where ever and everywhere in life there has to be rules, you know, there's rules everywhere you go [laughter].
>
> (Mindy, lines 557-61)

> I've learned to manipulate, I've learned to…get my way in certain situations…I've learned to try make things happen the way I want them to happen. You know, just through my addiction, right?
>
> (Joshua, lines 117-21)

Despite the need for structure, the treatment centre exercised flexibility to maximize clients' treatment engagement and address their support needs. However, the rules, policies, and procedures followed by the treatment centre were inconsistent and done so on an *ad hoc* basis. This was evident in the instance of family emergencies in which the treatment centre handled situations differently. In one situation, one client bypassed the formal procedure of completing a support sheet:

> [M]y dad's sick, right, and he's in the hospital again...they're givin' me extra calls…counsellors…they'll help me out. Like if I need to make an emergency phone call even to the hospital, they allow me that, which is not protocol. So I've been very fortunate to have some, just whatever I need, which I don't ask for a lot, but when I do need something, they've been there.
>
> (Joanie, lines 172-83)

In another case, the treatment staff followed protocol and did not inform the client immediately of the family emergency:

> [T]here's not much organization goin' on. I find that uhm, sometimes it seems that people are just kinda droppin' the ball….I'll give you an example, last week my wife had called, uhm, Thursday afternoon. Apparently she was having a migraine attack. But when she had seen the doctor, they told her that she could be possibly having a stroke, she was sent to the hospital, and she had left a message at the front desk for me to…give a call and check to see how things are going. And unfortunately I didn't get the message until 18 hours later, which really upset me…I guess maybe it could be just procedure or uhm, chain of messages and I felt kinda, betrayed in a sense that it didn't take priority, that this message needed to be given to me...immediately as I have young ones at home…It's an unforeseen event… that message didn't get to me for 18 hours. So in that sense the program rubbed me the wrong way.

(Adam, lines 284-316)

The inconsistencies in handling this particular situation had a negative impact on the treatment experience of clients and perception of the treatment centre, as in the latter case.

Another situation was for clients to have extra visits from outside people beyond the regular visiting hours. Some clients were mandated to enter treatment as part of child welfare. There was only one client, Ariel, who was partially in treatment to get her daughters back. She did not mention having additional visits with her children outside of the regular visitation time on Sundays. However, one client discussed that the treatment centre allowed for extra visits in this particular situation:

> I know some people here do get have little kids, they are able to see their children more often than what the normal visitation would be. I'm sure for them that's what they needed, that's why [the treatment centre] agreed to it...the policy normally is for anybody, just on Sundays, to have visitors on Sundays. And then after your third weekend, uhm on the final weekend, you can start having outside passes on Sundays. But I know that there's some people have, would be younger children are getting two visits a week…but they have little children…my son's age and younger. So, uhm, I know if I had asked to have that I probably could have had that too…they do accommodate above what's normal or if they feel the need I'm sure…case-by-case tailored to what the client…where they're at and what will benefit them and their family…It is a great policy 'cause they do have some flexibility, which is nice. 'Cause I'm sure in some situations they do need …that much visitation for whatever reason.
>
> (Anna, lines 713-44)

Similarly, this client also had a young son in which she had the option of seeing her son more often, but preferred to minimize the contact with her son so she could focus on herself and maintain some sense of stability for her son:

> I could have seen [my son] every weekend. And I actually have pulled that back but I…this is just for me personally…I don't think that it's good to necessarily with certain situations…For me I…would not have benefitted me to say, have seen him twice a week or every weekend because of my shift and my focus would come on worrying about how he's doing.…I've kept my visiting

> with him to a minimum, about every two weeks, every three weeks…But I know if I saw him too much, I'd be focusing on him too much and I have to here focus on myself and just be…I would obsess about him and it would all become about how he's doing and how quickly can I get home…And that's what it should not be right now.
>
> (Anna, lines 672-711)

Summary of Treatment Centre's Role as Gatekeeper to Connecting Clients to External Social Support

Generally the rules, policies, and procedures to connect to external social support were imposed for clients to 'work the program' by minimizing clients' access to the external world such as family members and friends. The treatment centre's approach and philosophy aligned with clients' desire to focus on their program. The above examples highlight that social support needs differed among clients: Most clients preferred minimal or no contact with their family, while a few needed frequent and regular access to those external supportive networks in order for them to 'work the program.'

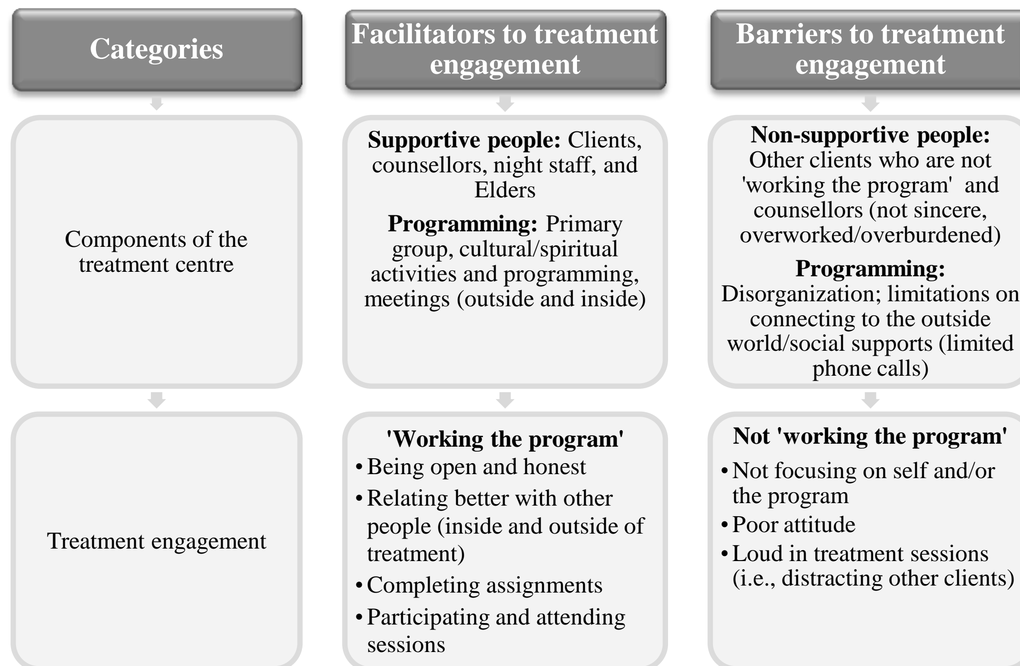
As well, the examples above suggest that the treatment centre adapted their rules to respond to clients' needs through counsellors' assessment of their level of engagement in the program, in which the treatment centre bypassed the typical protocol. Although the treatment centre exercised flexibility, there were situations, described above, in which their decisions were inconsistent. In one case where the treatment centre followed protocol resulted in this client having a negative perception. Thus, the treatment centre's flexibility had implications on client engagement and perceptions of treatment experience, which will be discussed at the end of this chapter.

How the Treatment Centre's Environment Affected Clients' Treatment Engagement

Part of the theory examined how the treatment centre as gatekeepers monitored clients' access to their external social supports, as discussed extensively above. The treatment centre as gatekeepers also facilitated clients' focus on the program and monitored connection with other clients and treatment

staff, i.e., internal social supports, through the treatment environment. The treatment centre's role in this manner was less obvious and not as explicit as controlling clients' access to external social supports. This component of the theory was related to the category from initial coding *components of the program*. Displayed in Figure 8, this category explored how parts of the treatment program were facilitators and barriers to clients' engagement, which included: (1) the treatment centre programming such as the aftercare program, group and cultural group sessions, and 12-step meetings, (2) other clients, counsellors, and treatment staff (e.g., program attendants) and, (3) the treatment environment or structure.

Figure 8. Facilitators and barriers to treatment engagement.



This section will explore how the treatment environment affected clients' treatment engagement and experience, which will cover: (1) how the treatment program as facilitated clients to access and create healthy social support networks during their time in treatment, and (2) how the structure of the treatment environment affected clients' treatment engagement and experience.

Reinforcing and Facilitating Healthy Relationships

The previous section described the treatment centre's role to minimize contact with family and friends to ensure that the clients were 'working the program' in order to connect with those support networks. Although the treatment centre minimized clients contact with their family members and friends, the treatment centre counsellors and staff encouraged clients to create healthy relationships that consisted of clean and sober network of people who were in recovering members from 12-step meetings, having a sponsor, and connecting to community resources, as articulated by these clients:

> They say go to meetings, get a sponsor, uhm, and I guess it depends on the individual's situation, but some people's family aren't always supportive, 'cause they might use with their family. But in my case they say talk to your family 'cause they say they're supportive. But mainly it's go to meetings and build social support there.
>
> (Jonah, lines 431-5)

> Well [having social support is] an absolute must. Or else it's a waste of time. If you don't have your outside supports, for when you, you know, finish here, so it's important to have an aftercare plan while you're here. A lot of people don't have residences, so, you know, there's a lot of things that they do. They're very good here as far as I can see in uh, having that uh, component there for, you know the next step.
>
> (Joanie, lines 457-63)

> Well [counsellors and treatment staff] definitely recognize that we need social supports…
>
> (Anna, lines 362-3)

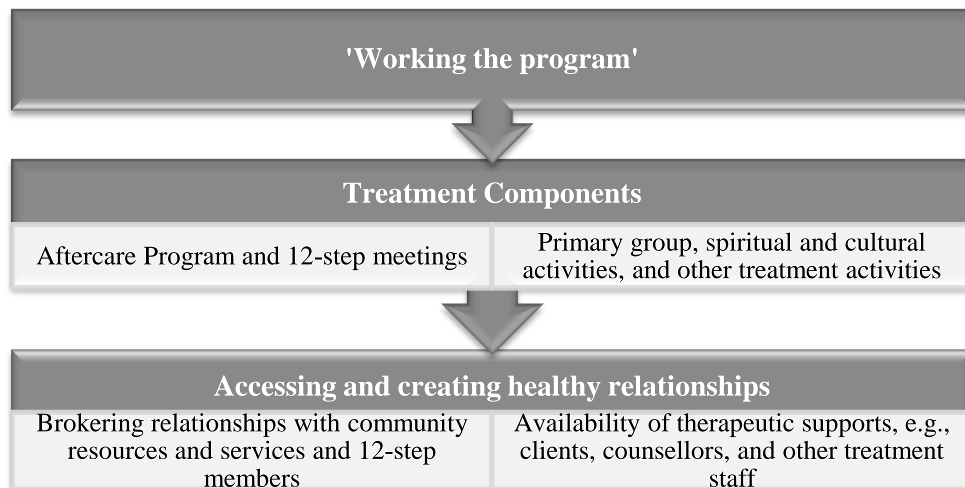
> I: What do the counsellors or the staff say about, uhm, you know about social support here? Like what are their ideas?
> Simon: …they totally shove that down your throat!...[Laughter] Social supports, "Always have your supports with you!..." They're totally gung ho about have as many supports as possible!...Have like nine members that you can call just in case someone doesn't pick up. 'Cause that, that call could very well save from relapsin' and, supports like, have good, healthy friends to go out and go bikin' with or go sober fun activities…that's their big thing, have lots of supports out here….I think I'll find supports in the rooms and then you know, people I'll get along with, like you will find people that, you will get along with in those rooms, they attending

meetings…actually get a sponsor….meet his sponsees…get to know people inside the groups.

(Simon, lines 778-810)

As gatekeepers, the treatment centre monitored, reinforced, and facilitated creating healthy supportive networks and relationships for their recovery as part of 'working the program.' This included: (1) brokering relationships to community supports and services through the aftercare program and 12-step meetings, and (2) availability of therapeutic supports with people within the treatment centre for additional supports during treatment and for recovery through primary group. Figure 9 presents how the treatment components related to accessing and creating healthy supports.

Figure 9. Creating healthy supportive networks during treatment and for recovery as part of 'working the program.'



The Treatment Centre Brokering Relationships to External Social Support Networks

The treatment centre brokering relationships clients with other external social supports beyond family members and friends was another example of their gatekeeper role whereby the counsellors were more lenient and flexible with the rules, policies, and procedures. As mentioned earlier, some clients described that working on their aftercare program was part of the mental aspect of 'working the

program' (see above in *Clients' Perceptions of Treatment Engagement*), by allowing them to connect to external social support such as community resources:

> Anna: …that's another thing we do a big section on building on aftercare. And that's a big focus point in having a clear aftercare plan….identifying and gathering as much supports from different areas as possible. So those supports could be both within… addiction sort of recovery…that would be your…NA supports...sponsors and members, non-using members from there, [government agency] counsellors and doctors or therapists, but that also includes looking for resources…like non-using friends, family members that you can trust…Some people have families, the whole family uses...if you don't have those supports in place…if you're close to relapsing, there's nothing there to help you….you're in deep water…a person that has more of these supports in place it does already using it before things get bad, is a far more likely not to relapse and to weather the storm kind of thing, so.
> I: So it sounds like uhm here at [the treatment centre]…they really encourage you, they provide the support for you to establish other people…like other supports and stuff.
> Anna: Yeah…
>
> (Anna, lines 362-421)

Technically connecting to community resources clients were required to complete a support sheet, since they were accessing a resource external to the treatment centre. However, a few clients mentioned that in this specific case, their counsellor would allow them to connect without following protocol:

> [My counsellor is] really good with business calls. If you need a business call to any place like that [for housing, funding, connecting employment agencies, etc,] he's all for it. It's just more of the personal ones….And I can understand why….if you're worried about what's goin' on out there, then, you're not worried about what's goin' on here.
>
> (Joshua, lines 551-99)

> I: …they like let you make those phone calls...with your counsellors [outside of the treatment centre]. Do you need a support sheet for that?
> Anna: You technically do need a support sheet, but they never say no when they ask for a support sheet to be made, uhm for counsellors or for anything like that, you know?
> I: It sounds like they're pretty flexible with that…
>
> (Anna, lines 880-8)

As well, the counsellors were encouraged and permitted the flexibility to help and support clients work on their aftercare plan:

> [The] supervisor encourages the counsellors to help develop an aftercare plan. He gives as much supports to clients to allow the residents to develop their support system after leaving treatment. He allows counsellors to use the treatment vehicle to go to outside community supports or organizations to have residents connect with positive supports.
>
> (Field notes, March 29, 2013)

Similarly, one client also emphasized the importance of connecting to community supports to help prepare for the transition from being in the program to leaving the treatment centre:

> Well [I think it's good to have connections to outside world and supports] because then I have a liaison and some continuity for when I get out. So if I have access to my…supports now, like groups and stuff, or...it's a good continuity and practice for paving the way to leaving.
>
> (Joanie, lines 281-9)

Clients were also required to attend inside and outside 12-step meetings, which was another mechanism for clients to connect and build healthy social support networks during treatment and recovery. A few of the clients discussed the importance of meetings in their treatment program. Meetings for one client who was newer to recovery were especially important for him to manage his drug cravings and to meet new people in recovery:

> I need those, they are the life force, like the blood that keeps, the clean blood that keeps me goin' kinda thing, like they are, if I don't get a meeting in every, at least two days...I can be just sitting there just cravin'…I'm sittin' there like, edging out, go to an NA meeting, ahh [sigh of relief]…even if I don't talk, I still, phhh, there are other people that are feeling the same way that I am, right now, great!...the outside ones are better though….'Cause the inside ones you see the same faces every day and you hear their story every day….The outside ones you see new faces...another fresh side.
>
> (Simon, lines 478-505)

One client mentioned that the 12-step meetings as another mechanism to connect with his friends in recovery who were not attending this current treatment episode:

> The CMA meeting that comes in here, I'm actually a home group member.…But the CMA is awesome! Like when, I've had a couple bad Saturdays when after that meeting I'm all smiles…but [the meetings] definitely help. The ones they bring us to on Mondays and Tuesdays, it's great because you get to get out of here. They bring you to an outside meeting. And it's good to hear different perspectives. Those are actually, I look forward to them.…just getting on the bus and just seeing the out, driving on the roads, it just makes me feel like you're so secluded up here, right, so. But yeah meetings or definitely, and you hear about recovery, like I said, it's not just...war stories.
>
> (Tyler, lines 862-95)

> I: So it sounds like having those connections with the outside world is really important to you...
> Tyler: For me, definitely because they're positive…But with me I'd rather know where we're going because I know a lot of people in meetings.…Because I think the first Monday I was in here I was, the same thing again, I wanted to leave, I'm looking at all the differences and all this and blaming it on [the treatment centre], but it's actually in my head. But then we ended up going to the CMA at the Monday, and that's my home group, so. I walk out, I know everyone in the building right, that was just awesome! Like I walked out of there, just going, "Okay I feel awesome! I feel really good!"…it's nice that I've built all these, these relationships with people through the rooms…
>
> (Tyler, lines 959-84)

Overall, connecting to external supportive networks such as community services and organizations and members from 12-step was important for some clients to focus on their program, as well as build healthy relationships for their recovery. Further, for some clients to connect to these external supports, clients did not necessarily need to go through formal procedures of completing a support sheet as they required when accessing family members and friends.

Availability of Therapeutic Supports within the Treatment Centre

The gatekeeper role for the treatment centre was less obvious with respect to clients connecting with individuals within the treatment centre (e.g., clients and treatment staff members). The most explicit way the treatment centre acted as gatekeepers was by monitoring interactions between clients to ensure they were appropriate, which was also stated in the *Treatment House Rules*: "We encourage

healthy **relationships** between clients, but any suspected sexual/intimate relationships will not be tolerated and will result in immediate termination." A few clients shared the similar perspective as the treatment centre's perspective on intimate relationships as it negatively affected clients' focus:

> [T]here was a couple that got contracted for being too close and I said, "Well you gotta understand where the staff is coming from because they're here to help you and once they see that you're losing focus on yourself because you're at a vulnerable stage in your life or here, then all they're doing is trying to help you because they're here to help you and once they see you're losing focus, then they're going to separate that…it's not that they're judging you or trying to take anything away from you. It's just they want you to work on you. You know, you're here for you, nobody else." Not to find a boyfriend because rehab relationships don't work. Like addicts cannot be together because they end up bringing one person down anyways, like no matter which way it is one person always brings the other person down.
>
> (Maggie, lines 479-95)

> I don't think it's good [to be in a relationship with another client during treatment] because you gotta focus on yourself and…I think when people go into relationships they don't focus on themselves…when these other two [clients] got terminated, not too long ago here…[one of the program attendants] here, we were talking she's like, uhm, "So they got terminated?" "Yeah."…she said like, "They should make, they should uh, uh make a couple, a couple's treatment centre and something"…I was like…"I don't think so. Because you like have to focus on yourself…it would be hard for them [the couple] to if they were in a relationship and stuff." She was like, "Yes you're right."
>
> (Ariel, lines 936-50)

It was implied that having social support was part of clients' 'working the program,' through clients focusing on the spiritual aspect, i.e., having a sense of interconnectedness with other clients and mental aspect, i.e., helping others by sharing experiences in addiction and past recovery. Implicitly, the treatment centre's role as gatekeeper was reinforcing and facilitating clients to build healthy relationships with each other through the primary groups and cultural or spiritual activities, which was articulated by this client:

> Anna: …I think, just because of the way this program works. We're sort of, we're not told to, but it just seems to automatically

> happen that we do use each other as supports as well because we do sharing circles and stuff. So we get to learn quite a bit about each other….
> I: And you said that…the way the program's set up, uhm you're supposed to use each other as supports. What did you mean by that?
> Anna: …I don't know if it's something that they, [the treatment centre] themselves, doesn't say, "Use each other as supports." But because we do the sharing circle and the prayer together and stuff, it is just actually does end up happening. The people in your group, your tribe, there's only about between five to…12 people per tribe, those are the people you're with for the whole time you're doing your treatment. So you get very close to those and so only now actually we you, we tend to build a rapport that's with each other that's, you know self-supporting...Like a tribe…
>
> (Anna, lines 312-53)

Further to that, some of the clients developed closer relationships with each other whereby they intended on maintaining contact after treatment as additional supports in recovery, as described by these two clients:

> Adam: …I've met lots great friends, friends in here uh, who actually live close by and we've uh, made arrangements and kinda agreement to get together once a week and go to meetings ourselves uh, go to Tim Horton's for coffee and play some chess, uh, I ride motorcycles in the summertime, uhm so that's in sense one of my leisure's…
> I: …It sounds like you have, you've created a very strong social support with the other clients here. And it sounds like you guys are going to continue that, continue keeping in touch...and going to meetings.
> Adam: Well few of us, have uh, got similarities…we're gonna get together and do some hunting, do some quading, do some hanging out, and being ourselves.
>
> (Adam, lines 374-401)

> Like I'm gonna get Ryan's number, I'm gonna had Gene's number, so if I can't make it to a meeting, I still phone them up and tell them, "Hey." Someone who knows what I'm goin' through, someone that knows what the hell is up. I'll know who to phone when I want, a really good advice, you know a solid sit down…and another person to just vent! And to get them to vent right back with me! So I got the two..and I said I'd be there for them, they're gonna be there for me.
>
> (Simon, lines 530-8)

Another less obvious way that the treatment centre acted as gatekeepers for clients to connect with supports within the treatment centre was the availability of treatment staff. A few of the clients mentioned that they did not have a strong level of rapport with their counsellor, while others did not feel connected with other clients for reasons such as their lack of engagement in the program. Other treatment staff members were important for clients as additional supports. In particular, some of the clients spoke highly of the program attendants as being supportive by helping clients focus on different aspects of 'working the program' and staying in treatment:

> [T]here's one night attendant that works here…he kinda came from the same lifestyle I did growing up…He helps me to identify things…that I maybe miss [in group sessions]….With me he has kinda one-one-one, checking in to see where I'm at…I'll tell him how I'm feeling…it's like well you know "Have you looked at it this way? Or have you looked at it that way? You know, from what you're telling me, this is what I see." Yeah, so, it's more constructive feedback.
>
> (Adam, lines 233-43)

> [T]he staff here they're excellent….especially the night time program attendants. I get along with all of them really well, they're really helpful ….they listen…give you tips on recovery, on working out, healthy living….most of them have walked in our shoes before or walked in my shoes. They've experienced addiction and uh I think they love their job. They love working with people helping them….they're like really empathetic, they don't judge…
>
> (Jonah, lines 87-102)

> I: And do the program attendants also…help you focus?
> Tyler: They do…I'm not as chippy as I was yesterday; yesterday I was just having a great day, absolutely fabulous. But…I just get in these weird moods….the staff do help though. I'm learning, because I feel comfortable enough now I can go talk to them…I can actually be like, "Okay I'm in a bad mood."…they'll ask me why I can start talking about my feelings and stuff because I'm getting comfortable, that was a hard thing for me to do, as I love to talk, but talking about how I feel was a different story, especially reaching out and without them coming to saying, "Hey are you okay?" It's me going up to them and saying, "I'm not okay." And I do feel comfortable with, with most of the staff to do that.
>
> (Tyler, lines 541-57)

> I: …the staff like, some of the staff they've really helpful because you've been, they've been able to share their experience...as well as, you listen [to their stories]. How else have they been helpful?
> Tyler: They're for me, towards me, they're all very friendly. Like I don't have any problem with the staff here… some of the other clients they do but this is because of their own attitudes I think, at least from my perspective….[the staff are] very helpful, I mean they're kind, they go out of the way to help people sometimes…a lot of the time they have smiles on their faces, at least when I'm talking to them, right and that makes me a lot more comfortable too. Uhm, when I need questions asked for the most part, I get answered…
> I: And how do you think that affects your treatment experience here?
> Tyler: Much better! [Laughter] If…I had a bad view of some of the staff, it's just gonna make me wanna go and take me out of doing my program. It's gonna make me think of why I don't want to be here instead of why I want to be here…having friendly staff…I wanted to leave a couple of times and…they didn't really calm me down, they just, they put into perspective for me, they made me realize, "Okay you're here for a reason." If I leave, I don't wanna be back here again in a couple of months going, "Oh crap! I'm doing it all over again" so. They've helped me just realize a couple of things…just with their perspective…change my perspective a little bit, it grounds me…if they weren't the way they were I wouldn't wanna be here, I wouldn't get anything out it…
> (Tyler, lines 454-82)

> [A] lot of [the program attendants] have been through what we've been through. And when you go sit down and talk to them, "Yeah, totally been there!...I know exactly what you're going through." And that's, they'll sit down and tell you how they dealt with it, or maybe they didn't deal with it, they shoved it in the back closet, whatever, like they, they're great…
> (Simon, lines 986-92)

In addition to the treatment centre controlling access to external supports in various forms, they also reinforced clients to access and create healthy relationships within the treatment centre with other clients through programming and the availability of treatment staff to help clients focus on the various dimensions of 'working the program.' The treatment centre also monitored relationships between clients, discouraging romantic relationships as that diverted attention away from focusing on their program.

Clients' Perceptions on Barriers to their Treatment Engagement and Experience

This section will focus on clients' perception on barriers to treatment engagement and experience. Three major barriers were identified by clients including: (1) other clients in primary group sessions, (2) perceptions of the counsellors' skills, qualification, and availability, and (3) the structure and organization of the treatment program.

Some clients expressed that other clients were supportive during this treatment episode. However, there were a minority of clients who expressed that the other clients such as the "younger people" (Anna, line 988) who were disruptive in group sessions affected their learning in sessions and ultimately their focus on their treatment program, as described in the following examples:

> I: …I know you've talked about the clients and…their war stories...How have they affected your treatment experience?
> Tyler: It's alright, like I'm [sigh] it doesn't really bother me that much, but when you hear it day in and day out, I need to hear about recovery that's why I miss meetings…it's when we're like in the lecture hall, we're supposed to be learning and when you hear people going, "Chchchch" and stuff like that, it's very distracting. I don't learn in that kinda environment…Like I tune out the entire lecture, I just go and I read my book because…I don't learn from [other clients]…here [in group sessions] we're talking about our using…It does get tiresome over time…I get drawn into it sometimes too and I don't even realize it. And then I kinda lose focus my sense of why I'm here sometimes too….when people are, have bad attitudes, I tend to take on other people's problems…and then they get to my attitude…I'm a product of my environment - when I'm around positive people, I'm a very positive person and when I'm around negative people, I'm a very negative person and when I start to get into a negative aspect…
> (Tyler, lines 483-508)

> Like for me it's really hard being here in a sense that I'm an introvert and I like my quiet and I like my time….And here it's overwhelming. And the kids, like, they're like my high school students but [laughter], "Turn up the volume!"….Some of the young [clients], yeah, I find it very frustrating…But it all caught up to me the other night 'cause they wouldn't shut up when we had a speaker and I was so frustrated and I was telling them to be quiet, I couldn't hear, it's just craziness!...I just ran to the [program

> attendant] in the hallway and told her I was so frustrated and I had talked to someone regarding my father…at the same time back-to-back and I said, "You know, I'm just so frustrated…I almost feel like leaving."
>
> (Joanie, lines 391-407)

> Sometimes some of the younger people that they bring in and I realize 'cause they have a 90-day program. I sometimes find some of the younger people could be really disruptive when we're doing, uh, like if we're having a learning, like a PowerPoint and a reading thing on a topic and that can get on your nerves after a while….And they're goofing around…Well [the treatment centre] should be maybe a little bit more strict I think with some of the younger people…it seems like they're not ever really reprimanded or at the time to behave….It is distracting…..there are times when we're sitting there, some of us older people are sitting there kind of going, "Okay now, this is like I didn't even hear what the instructor said" or whatever because they're talking in the back and stuff, but, I've learned to sit in the front now… and adjust [laughter].
>
> (Anna, lines 988-1011)

> [S]o you tolerate having [other clients] in the room...as much as you can…sometimes I just get up and leave...because a little tight knit group of people were pissing me off. I just, talked to my counsellor afterwards, tell him you know like, "I can't, I can't do it when they're you know doin' this or can't like...I'm seriously tryin' to work on my program here. Seriously I wanna be sober and stuff. And [cough] they're, they're making a big joke out of it fakin' it."…There is a time to be jokin' around….Even when we're in group if someone says the odd joke…that's fine…but when the same retarded person saying the same shit over and over again…it affects my program…You're being loud, you can't hear what the person's tryin' to say, I can't concentrate on what I'm tryin' to do, like it's just like when you're in school…there's that rambunctious kid that's disturbing the rest of the class so that they can't learn….That's some of those people….I don't have a lot respect for these people.
>
> (Simon, lines 277-329)

One client who was further along in his recovery commented that he was not learning from the other clients in the group sessions and found it tiring to hear the same "war" stories whereby he lost his focus in group at times:

> Like groups and stuff, they, they don't do it for me as much, because it's not like a meeting, it's talking about our past…I wanna know where we're goin'. That's what I wanna focus on…what I'm

> doing today to make tomorrow better…I need to look at my past obviously, to deal with some of it, but listening to other people…You know it's kinda old to me now, I get really, just bored kinda sometimes….I get more out of one-on-one or say a meeting or talking about recovery not about why we're addicted. I don't really care why I'm addicted, I know what it did to me.
>
> (Tyler, lines 1092-1115)

The quality of their treatment experience and level of engagement was affected by clients' perceptions of the counsellors' qualities and availability. For example, one client generally stated that counsellors who were "fake" could make one less inclined to be open, suggesting that he or she would be less engaged in their treatment:

> I've had other counsellors they, you can see right through them, they just seem fake….they just say like, "Good for you! Way to go! Live one day at a time!" Just stuff that is kinda transparent…With like one counsellor I had here was like that. I just, and everyone thought that…[now he has another counsellor he connects better with] let's just say if I had a counsellor that I really didn't like, I'd probably give up easier and wouldn't strive as hard as a counsellor I get along with and that pushes me and can relate to me….And what I said about like counsellors before, like they may mean well, but, you know, you just kinda can tell. I can any way. But I don't really want to open up to them, I guess some of them.
>
> (Jonah, lines 116-97)

Although many clients expressed that it was beneficial for counsellors to have experienced addiction, one client was concerned about the professional qualifications of some of these counsellors at the treatment centre:

> [N]ow not to go bashing, I just believe that a lot of counsellors should be credited or have a degree in what in their chosen field here and not just uhm, "Hey I'm a recovered addict and I wanna help." And there should be schooling for that or degrees, stuff like that. Uhm, I just find the program a little disorganized in a sense.
>
> (Adam, lines 633-7)

Two clients shared their frustrations with the availability of their counsellors with respect to scheduling one-to-one time to help them address aspects of 'working the program,' such as handling issues that arose during treatment and working on aftercare, respectively:

> [W]hen I first came in here…I thought like my counsellor wasn't listening to me. I thought that I was ah, not important, because I had concerns, I had issues…I felt like I wasn't heard….one thing about [the treatment centre] though, and I brought this up a few times is that, it's not very one-on-one oriented….Like I don't think I've had a one-on-one with my counsellor yet, and I've been here for a month, like just sit down like we are, he hasn't asked me like what's goin' on, right? We do a group thing, where like uh, I think, once a week we come in, "How you doin'? How was your weekend?"…I understand that they're short staffed. I understand that it comes and goes and there's a lot of people in here sometimes. I understand that the way they set it up is uh, a lot of paperwork….The writing out the support [sheet]…he's got all the journals he has to read….I actually started writing to him and then I stopped and I started writing to myself in my journal. And then I just write him notes if I need him too. But I don't think there's enough of him. I think him alone is just too much; I see him burning out [laughter].
>
> (Joshua, lines 383-428)

> Tyler: …I don't really get much from [my counsellor] myself. I don't really connect with him…he teaches me patience, which is something I need….I do get very frustrated with him sometimes…and I feel like, "This is my life. Why aren't you paying attention to me?"…I just forget that, you know he's dealing with a lot of other people too….
> I: Mhm. Do you think that's affecting your treatment?
> Tyler: It does on some days, I get in bad moods. I do, 'cause it's, I'm trying to do aftercare something like that, and he'll procrastinate and put it off, or he won't let me do certain things and, but then I start thinking about him like, "Well why am I really getting this mad? It's not the end of the world." You know, but it is frustrating at points….I haven't said anything to him I guess about it….I just, I'm learning to just accept it. [Laughter]
>
> (Tyler, lines 559-82)

The structure and organization of the treatment centre also affected clients' treatment engagement and experience. Some of the clients expressed their frustrations with the inconsistencies in the schedule and lack of structure in group sessions, described below:

> [W]hen I went to [a past treatment centre] we had gotten a schedule, we knew what to expect, day-to-day-to-day-to-day, throughout the whole course of our treatment; as to here, we haven't gotten a schedule, we don't really know what's going on from day-to-day-to-day or what we're covering, uhm, it just seems

a little disorganized. But then that could be just me and my addiction and everything to me needs to be meticulous or organized…

(Adam, lines 265-316)

[The treatment centre] need[s] [to be] a little more strict…Apparently it used to be. That's actually why I came here too…in some areas it's slack, some areas it's not. But I need structure.…they're trying to implement new changes to the schedule and stuff like that. Very frustrating…when you go and talk to a staff member and nobody has a clue where we're supposed to be or what we're doin'…it would be nice if there was more knowledge…the people teaching it have no clue what they're talking about. They're just reading it off the board….it would help, a lot of us though, when you ask questions, [you get], "I don't know." If I ask a question, I would like to be answered…you should know what you're talking about, even when your teaching people about stuff, so that's very frustrating.

(Tyler, lines 1136-53)

Joanie: Oh well of course if they had their schedule organized….I love that it's cool and laid back here, I like that more than I don't. I've been to other treatment centres where they're far more strict…love to see it step up a bit in the uhm, listening skills for clients, like "Listen, you know, it's serious, don't interrupt", it's constant chitter chatter constant, you know, whispering, laughing, you know, the rules are bended a little [...]
I: Uh huh. Do you think the chitter chatter, do you think that affects your treatment?
Joanie: Yeah, well it gets on my nerves like crazy, but it's good for me to practice my patience. However, I can't hear some things that are being said. And I brought this to the attention of my counsellor today….I know the staff do their best…[with] [t]heir philosophy….but it's tricky because they promote healing, so how can you have rigid…Perhaps with that and they don't wanna scare people away…but it does interfere with my learning….I get frustrated and, at the same time it's good practice though about frustrations when you get out, you know? Especially for people when they're brand new. It's kinda good, but then sometimes it can break. You know sometimes people leave and the gossip, you know? Girls gossip, they are on it all the time…but I think they're pretty, maybe overly tolerant here….it's not organized too. I wouldn't say on the whole… the workers try and they're scrambling, I feel bad for them. I don't know why there's such disorganization, because it makes it harder for everybody…It

> makes it harder for the workers. And it makes it harder for the clients and […]
> I: Yeah, do you think it makes it harder for clients to focus?
> Joanie: Oh big time! Yeah 'cause when they're short-staffed, you see a ripple effect, big time, I saw that, yup, every time they're short, yup, and they're scrambling and then…[the] energy's - wrong.
>
> (Joanie, lines 466-508)

> Simon: That could be [done to make treatment experience better]? Consistency…If I could show you our, our schedule, it's all fucked up. You never know when you're having a break. You never know what's all goin' on in the day, and it's not consistent enough, I find.
> I: How does that affect your treatment?
> Simon: I wanna know what I'm doin' everyday, like I think there should be some sort of level of consistency because we're all, we've all been for how many years, livin' an inconsistent life: Do what you want, when you want, as you wanna do it, with, I think there should be a little more structure!...we've all been used to, like I said doin' what we want and when we wanted.
>
> (Simon, lines 969-82)

As mentioned before, connecting to people especially the outside 12-step meetings was important for a few clients to focus on their treatment program. There were also instances, described below, in which the treatment centre was unable to bring the clients to outside meetings, which had implications on clients' engagement:

> Like we missed that this week. They're, they're not on the ball with their scheduling here….And so we missed our outside meetings that we have on Monday and Tuesday. Uhm, there's been other things that have been goin' on, you know, that we've been missing. All this week's been pretty messy, but typically speaking, uh there's outside meetings on Monday and Tuesday and that's, that's excellent.
>
> (Joanie, lines 239-46)

> Eva talked about going to outside meetings. She talked about for two weeks that she was at [the treatment centre], the staff would take the clients out to outside meetings. But the last two weeks they were unable to go and the treatment centre had their own meeting. When I asked Eva how she felt about not going to the outside meetings, she stated that she was "sad." When I asked her

> how other clients felt about not going to outside meetings, she also stated that they felt the same way that she did, i.e., sad.
>
> (Eva, lines 104-11)

Because the clients were addicts, the examples suggest that the clients needed structure and organization during this treatment episode, in which the inconsistencies and lack of structure at the treatment centre affected clients' focus on the program.

On the contrary, only one client perceived the lack of structure as intentional in which eventually helped her develop faith in a higher power:

> I: …so you said that it's like very laid back environment...
> Anna: It is...much more spiritual.
> I: How does that affect how you're focused or involved in your treatment program?
> Anna: Well, like I said at first…I found it difficult. I actually found it annoying and I didn't like that I didn't always know exactly what was going on…the schedule wasn't exactly steadfast that sometimes there are changes made on the fly. But I've come to realize that that was having faith in the system, having faith in a higher power, and being able to let go, and have faith that things will work out. So, I found that it, it really has been very helpful that way…
>
> (Anna, lines 58-70)

In general, most clients were satisfied with their overall experience during this treatment episode, which was expressed by these clients:

> My experience has been great. I've met a lot of friends, I've helped a lot of friends, in a sense of identifying things for them that they missed themselves. And uhm, on the same token they've helped me uh a good friend in here he's helped me identify a lot of things, a lot strengths about myself in that.
>
> (Adam, lines 639-44)

> I think this is a really good place…I find that the counsellors are very uhm, cooperative and they're very helpful and uhm I think the way that they go about this course is really good.
>
> (Erin, lines 538-44)

> [T]his place is great. I love it here. I would recommend it to anyone, it's an awesome place, lots of, lots of good people here, like for the [program attendants] I mean.
>
> (Simon, lines 984-6)

> I just like it the way it is….I think [being in treatment] the best thing that happened to me.
>
> (Ariel, lines 1065-71)

However, some clients shared frustrations with the disruptions in group sessions from other clients, perceptions of their interactions and impressions of counsellors, and lack of structure and consistency with respect to the programming and scheduling, which influenced clients' level of engagement and quality of treatment experience. More importantly, the situations and circumstances described by clients above also implied and reflected the treatment centre, at times were not as effective as gatekeepers to ensure clients were focused on the program and addressing issues that were barriers to engagement and building relationships.

Summary: Treatment Centre's Role as Gatekeeper to Social Support

Chapter 5 provided an in-depth description of the categories that emerged from initial coding, which are presented at the beginning of the chapter in Table 8. This chapter described clients' perception of social support, such as supportive and non-supportive people. In general, supportive people who were mainly family members, clean and non-substance abusing friends, community organizations, other clients, and treatment staff prior and during treatment supported and respected clients' sobriety in multiple ways. They also showed support by understanding and being non-judgmental. Conversely, non-supportive people were mainly using friends or acquaintances who did not support sobriety, while non-supportive family members were not emotionally available for clients in their addiction and when they were in treatment.

The chapter also focused on different elements of treatment engagement using the Cree medicine wheel. Treatment engagement or 'working the program' was described by clients as focusing and learning about self by addressing their issues holistically to heal. Contrarily, clients who had a poor attitude and behaviour (e.g., not attending or participating in sessions and not completing assignments), coerced into treatment, and younger were described as those who were not 'working the program.'

Finally, the chapter described the theory and the components of the theory that was generated from axial and focused coding. Components of the theory from the initial phase of axial coding are summarized in Table 9.

Both clients and treatment centre staff articulated the importance of social support in recovery. The treatment centre's role as gatekeepers reinforced and facilitated clients to: (1) focus on their treatment program, and (2) access and create healthy social support networks to facilitate their focus on the current treatment program and to prepare them for recovery. The treatment centre achieved this in a few ways through: (1) rules, policies, and procedures to minimize clients' access to external social support such as family members and friends, (2) brokering through the programming offered at the treatment centre (e.g., 12-step meetings, primary group sessions, and cultural or spiritual activities), and (3) availability of therapeutic supports within the treatment centre that included other clients, counsellors, and treatment staff. The treatment centre also reinforced a particular type of social support, which were healthy, clean, and sober relationships. At this treatment centre, clients were at different stages in their treatment program and recovery. Moreover, clients had different social support needs, articulated by this client:

> It doesn't matter what it is [to keep someone focused in their treatment program]. You need mommy, on your beacon call, just do it!...if you're fine goin' to meetings, if you're fine not going to meetings and you can quit it cold turkey and do your day-to-day life, that's great…Everybody needs…their own special thing that gets them through. But when it's all said and done, what's the end result and if…the end result is being sober, it doesn't matter.
>
> (Simon, lines 563-9)

The theory explained how the treatment centre as gatekeepers attempted to address and negotiate clients' treatment and social support needs, which is presented in Figure 9. The treatment centre demonstrated flexibility in their approach by tailoring clients' program to their needs, which was perceived by some clients as a positive aspect of the treatment program. At the same time, the *ad hoc* nature of connecting clients to supports, lack of organization and

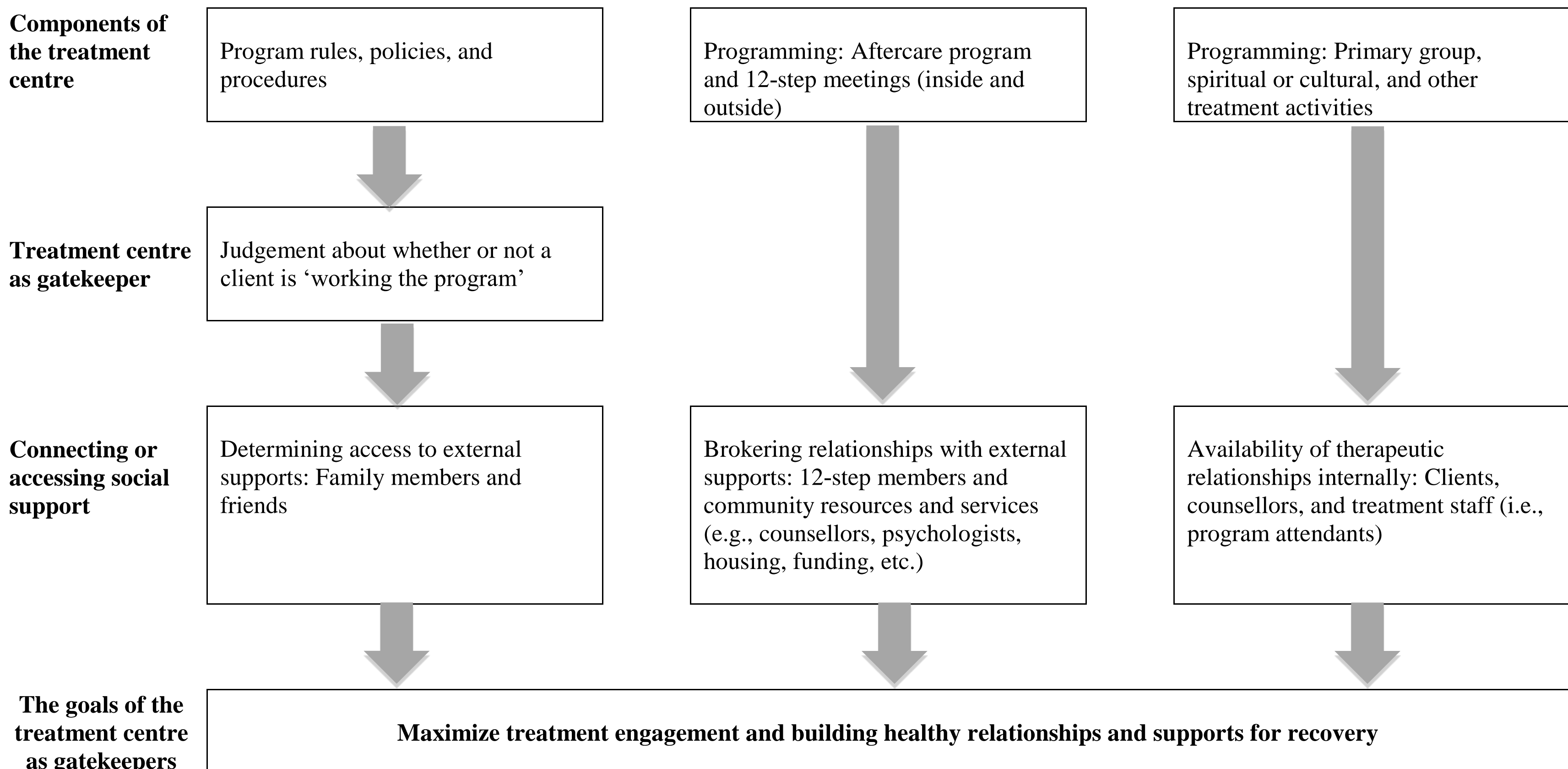
inconsistencies in the program negatively affected some of the clients' level of engagement and perceptions of the quality of their treatment experience.

Table 9

Evidence of Clients' 'Working the Program'

Action: What the program looks for as evidence that clients 'work the program' (i.e., focusing on self)	**Conditions: Factors that affect clients 'work the program'**
• Completing assignments and participating and attending treatment sessions or activities • Sharing, being open, and honest • Connecting or re-connecting spiritually and/or culturally • Learning skills and tools for sobriety (engaging in clean and sober activities, learning how to relate to other people, learning about self) • Helping other people or clients (being selfless) • Addressing root or causes of issues • Spending "me" or alone time	Client characteristics: • Admitting one has a problem and asking for help • Willing and wanting to help self • Being in treatment for self (motivation level) Internal factors - treatment environment: • Clients • Counsellors and treatment staff • Programming (cultural and spiritual activities, group sessions, and 12-steps) External factors • External social supports (e.g., family, friends)

Figure 10. The role of the treatment centre as gatekeeper by controlling access to social support to maximize clients' treatment engagement and creating healthy relationships.



CHAPTER 6: DISCUSSION

Overview

Treatment retention in substance addiction treatment is one of the most consistent predictors of therapeutic responses and post-treatment outcomes across different treatment settings. However, what predicts retention in treatment remains unclear; retention alone may not be an appropriate measure of addiction treatment effectiveness. Some evidence suggests that early treatment engagement has important implications on retention (Fiorentine et al., 1999; Simpson et al., 1995; Simpson et al., 1997). Unfortunately, little attention has been paid to the role that social support plays in relation to early treatment engagement (Kelly et al., 2010; Meier et al, 2005). Moreover, little is known about the role of social support in early treatment engagement of clients in addiction treatment. This thesis addressed these limitations, which examined the dynamic nature of social support and its relationship with early treatment engagement in a residential addiction treatment for substance and alcohol. This final chapter: (1) provides an overview of the findings from Study 1 and Study 2, (2) synthesizes major quantitative and qualitative findings, (3) discuss limitations and strengths of the mixed method research presented in this thesis, and (4) present some implications for future research and practice.

Study 1: Quantitative Findings

Study 1 prospectively examined the influence of perceived social support on early engagement and retention among clients entering addiction treatment. It was hypothesized that clients reporting high perceived social support from family members and friends would have better treatment engagement and stay in treatment longer.

Contrary to expectations, social support did not predict any of the three dimensions of treatment engagement. However, the model for commitment to treatment was significant for age and education level, while introjected and

identified motivation were marginally significant. The findings indicated that those clients who were older, entered treatment to avoid internal conflicts of guilt and anxiety (i.e., exhibited introjected motivation) as well as stronger personal commitment and sense of personal choice about entering treatment (i.e., identified motivation) were strongly committed to taking action to address their addiction and other issues in the treatment program. Conversely, clients with only secondary level of education had lower levels of commitment to the treatment program.

Clients' ratings of perceived social support from family members were positively associated with treatment participation, as expected. The findings also revealed that age and identified motivation predicted treatment participation, with age as the strongest predictor. This finding suggested that clients who were older and had stronger personal commitment and sense of personal choice about entering treatment (i.e., identified motivation), and higher perceived social support from family had better participation in their treatment, for example, attending and actively participated and involved in treatment sessions.

With respect to treatment retention, it was hypothesized that clients who reported higher levels of social support would stay in treatment longer. The findings did not support this hypothesis. Social support was not significantly associated with treatment tenure, but age was the strongest predictor, while education level was moderately significant. This finding suggests that social support networks at intake did not influence client tenure in treatment.

Study 2: Qualitative Findings

The objective of Study 2 was to provide an in-depth description of different kinds of social support experienced and received by clients entering addiction treatment and its relation to treatment engagement using a grounded theory approach. Results from Study 1 shaped the interview guide, which explored clients' perspectives on social support and engagement as well as determine factors that affect engagement.

Findings revealed that supportive networks provided emotional (e.g., verbal encouragement), material or tangible support (e.g., financially, driving

clients to appointments), and informational (e.g., providing guidance and advice). The diverse array of supports were provided by family members, non-addicted or clean and sober friends, community organizations (e.g., counsellors, funding agencies, mental health worker), and employers. During treatment, clients identified individuals within the treatment centre, such as other clients and treatment staff (e.g., counsellors, program attendants, Elders). The nature of these relationships was regarded by clients as therapeutic because they facilitated the sharing of similar experiences, and promoted a non-judgmental attitude towards clients. Non-supportive people, such as old substance-using friends or acquaintances or "dry addicts" did not support sobriety, while family members lacked understanding of addiction or did not offer emotional support. Participants generally affirmed that social support was needed throughout the recovery process.

Client perception of treatment engagement was another important type of finding for this study, where clients described treatment engagement as 'working the program.' Through 'working the program,' clients learned more about themselves in a holistic manner, i.e., mentally, physically, emotionally, and spiritually. Their perceptions of treatment engagement were important because this partly determined whether or not they qualified for access to their external social supports, judged by their counsellor.

Axial coding and focused coding identified the core category of the results as the treatment centre's role as playing a gatekeeper function with respect to social support. The emerging theory that was generated characterized the treatment centre as controlling client access to social support, with an aim to maximize client treatment engagement and to facilitate client access to build and maintain healthy social supports during treatment and for recovery. The treatment centre controlled access to clients' social supports through: (1) its rules, policies, and procedures to access external social support, (2) its programming to help clients' access community resources and supports for recovery, and (3) by facilitating the availability of therapeutic relationships supports within the treatment centre (i.e., other clients, counsellors, and treatment staff).

Overall, the qualitative findings suggest that social support was important during treatment, which included a range of supports, including external interpersonal relationships (i.e., family and friends), community organizations, 12-step members, and therapeutic relationships within the treatment centre. This also suggests that clients had varying support needs, in which the treatment centre exercised flexibility with rules, policies, and procedures to accommodate their support and treatment needs of clients by individualizing their program. However, this was done in an *ad hoc* manner, which had implications for clients' engagement and overall treatment experiences. The findings also suggest that the treatment centre's role as gatekeepers was a determinant of early engagement.

Integration of the Quantitative and Qualitative Findings

Types of Social Support at Treatment Entry: Limitations of the Global Measure of Social Support

Study 1 used a global measure of social support that assessed perceived supports from family members and friends. Using this measure, social support did not predict any of the three dimensions of treatment engagement. However, qualitative findings from Study 2 indicated that there were other forms of social support beyond family members and friends that may be influential for treatment engagement. Specifically, some clients identified community resources and services such as social service agencies and counsellors as crucial supports for accessing and initiating the current treatment episode. These influences were not captured by the perceived social support measure used in Study 1, which may account for the lack of evidence supporting the hypothesized positive association between social support and treatment engagement. Thus, the global social support measure only captured supports from family members and friends, which explained some of the non-significant results for treatment engagement and retention outcomes. In general, the social support literature points out that many studies base the premise that recipients will require the same type of support in a specific situation, failing to take into consideration that different sources of supports provide different needs of the recipient and at different times (Hupcey,

1998a). Similarly, the findings from the current study also indicated that most clients identified multiple sources of support within and external to the treatment centre who provided different support needs during treatment and recovery.

Social Support and Treatment Engagement

Study 2 findings confirmed the findings from Study 1 that social support from family and friends at treatment entry was not a factor of treatment engagement. In Study 2, clients emphasized that having social supports in early treatment and recovery was necessary. However, most clients expressed that connecting to supports outside of treatment, such as family members and friends was not necessary for them to 'work the program.' Rather, for them to 'work the program' was for self-improvement, in which clients identified as their treatment goal. For some of the clients to 'work the program,' it was necessary for them to be away from these distractions external to the treatment centre, including connecting with their supportive family members and friends. Hence, the treatment centre functioned as gatekeeper to help clients focus on their program by limiting their access to these external supports through rules, policies, and procedures. Thus, the limited access for clients to connect with family members and friends during the treatment episode may explain the non-significant association between social support and treatment engagement.

Despite the treatment centre restricting access to external supports, the treatment centre highly encouraged clients to have supports during treatment and recovery, reinforcing abstinence-oriented interpersonal relationships. These supports mainly consisted of other clients, treatment staff (e.g., counsellors and program attendants), and community services and resources (e.g., housing agencies, 12-step fellowship members), which was part of and promoted treatment engagement for some of the clients. The social support measure in Study 1 only assessed support from family members and friends, but other measures that assessed other types of supports were not included. This may explain the unrelated relationship between social support and treatment engagement.

Taken together, the findings suggest that social supports are needed during treatment, but the more influential supports that affect engagement in treatment were the therapeutic relationships, i.e., supports within the treatment centre, and community services and resources. Further, the current study findings underscore the importance of the treatment process components as factors influencing treatment engagement. Specifically, the treatment centre's role as gatekeeper controlling client access to their supports affected treatment engagement through the rules, policies, and procedures and treatment programming. This finding is unique as little research has explored the relationship between social support and treatment engagement (Meier et al., 2005). The current study contributes to the body of research in social support and addiction treatment, specifically the role of the treatment environment using clients' support networks to influence engagement. Prior studies investigated the role of social support at treatment entry on the number of sessions attended treatment and tenure in treatment (Griffith et al., 1998; Westreich, 1997), therapeutic alliance (Broome et al., 1997), and post-treatment outcomes (Broome et al., 2002; Dobkin et al., 2002; Griffith et al., 1998). Finally, the findings demonstrate the measurement issues with the global perceived social support instrument, which did not capture the multiple sources of support available during treatment and early recovery.

Client Characteristics on Treatment Engagement

The qualitative results confirmed that a few of the client characteristics predicted early engagement, in particular commitment to treatment. Some of the older clients identified the younger clients as those who were not engaged (i.e., not paying attention during sessions and disrupting other clients), which provided further confirmation of the quantitative finding that younger clients tended to be less engaged in their program. The data also highlighted the younger clients disruptions during sessions or lack of engagement, negatively impacted other clients' focus on their program and treatment experience. Conversely, previous studies found no associations between age and therapeutic alliance (De Weert-Van Oene, De Jong, Jorg, & Schrivjers,1999; Meier et al., 2005). The finding from the current mixed method study suggest that age as a pre-treatment client

characteristic effects another aspect of engagement, which is commitment to treatment.

Furthermore, the positive correlation between client motivation and commitment to treatment demonstrated in Study 1was supported in Study 2 through the client perspectives on ‘working the program.’ Specifically, some of the clients initiated this treatment episode to heal so that they could “let go” of the feelings of “shame and guilt” of their addiction, which reflected introjected motivation. As well, some of the clients explicitly stated that they entered treatment for themselves and they were wanting and willing to work on themselves, which reflected identified motivation. Positive associations with treatment motivation and treatment engagement were also reported in previous studies (Joe, Simpson, & Broome, 1998; Joe et al., 1999; Simpson et al., 2009). For instance, pre-treatment motivation was the strongest predictor of client rated personal progress defined (i.e., satisfaction with treatment, progress in making changes in life, help for drug use, and help for nondrug use problems) and therapeutic helpfulness (i.e., satisfaction with program characteristics and sessions, including friendliness of the program staff and helpfulness of individual and group sessions).

The mixed method study revealed that age and client motivation were indicators of early engagement, specifically commitment to treatment.

Rapport with Counsellors

The mixed method study also highlighted the complex nature of treatment engagement that could not be measured by the treatment engagement instrument, which may also explain the non-significant result between social support and client-counsellor rapport. The qualitative findings further explained how therapeutic rapport influenced client engagement, specifically the qualities of counsellors, which was not assessed in the counsellor rapport subscale. Some of the clients described their counsellor as nonjudgmental, understanding, and with lived experience of addiction, which promoted their engagement. The humanistic characteristics of counsellors allowed clients to feel more open and comfortable to express their feelings, discuss their issues, and accept their counsellor’s advice

and guidance. Prior research also found that treatment staff characteristics positively influenced treatment outcomes (Grosenick & Hatmaker, 2000). Staff members who were empathetic, warm-hearted, unconditionally caring, encouraging, understanding, and compassionate along with knowledge and personal experience with substance abuse were characteristics that helped female clients at a residential addiction treatment program achieve their treatment goals. A review of tailoring interventions to clients found some support that therapist who share the client's history of substance abuse may better provide help than therapist who do not share the same history, which in turn enhance therapeutic alliance (Beutler, Zetler & Yost, 1997).

The current study also revealed that particular counsellor characteristics were barriers to engagement for a few of the clients. Lack of sincerity and uncertainty of the qualifications or credentials of their counsellors were barriers to treatment engagement for a few clients, which decreased their levels of trust and openness to their counsellor. Similarly, some past investigations have reported that counsellor and staff treatment qualities negatively affecting treatment engagement and outcomes (Wylie, 2010). For instance, self-reported conflicts with staff, e.g., not liking, trusting or feeling valued by staff, were reasons for premature attrition in treatment (Ball et al., 2006). Alternatively, another study found that counsellors who were more confident in their skills and communal approach (i.e., engaging in professional community practices) improved client engagement (Broome, Flynn, Knight, & Simpson, 2007).

The availability of counsellors also influenced clients to 'work the program.' The availability of staff was influenced by the program structure. The programming at the treatment centre was mainly delivered through group sessions, with only a limited block of time daily for counsellors to see clients on a one-to-one basis. Further, there were circumstances that limited the availability of counsellors. During the current treatment episode, clients described situations such as staff shortage issues in which they perceived limited availability of counsellors, which negatively affected their treatment experience and level of treatment engagement. One study indicated that the availability of counsellors

was an important factor for clients to achieve their treatment goal (Grosenick & Hatmaker, 2000).

In summary, the current study suggests that there was a complex nature of counsellor rapport, which was also a factor influencing treatment engagement.

Social Support and Treatment Participation`

The Study 2 findings related to clients' perspective on treatment engagement confirmed Study 1 findings that social support from family members was a factor influencing treatment participation. Some clients mentioned that although they had limited contact, just knowing that they were receiving support, promoted their engagement. For example, some clients described that their family members provided emotional support through verbal encouragement. Further, external supports from family members provided tangible support by taking care of their bills and caring for their children. Findings were consistent with previous research that documented clients' social networks (i.e., family members and friends) providing emotional (e.g., encouragement, showing care and concern, communication) and tangible (e.g., bringing personal items, keeping in touch throughout treatment) support during treatment (Tracy, Munson, Peterson, & Floresch, 2010).

Clients participating in Study 2 provided rich and detailed accounts of how they were 'working the program' mentally, physically, emotionally, and spiritually, which aligned with aspects of the treatment participation measure used in Study 1. This in turn could explain the significant association between social support and participation. For instance, clients discussed the importance of "letting go" and talking about their emotions as part of treatment engagement, important for the healing process (reflecting "You are willing to talk about your feelings during counselling"). Some of the clients also described strategies that they have learned in sessions to deal with relapse or handle stressful situations (reflecting "You have learned to analyze and plan ways to solve your problems"). Moreover sharing openly and honestly with self and others during treatment sessions was described by some clients as part of treatment engagement (reflecting "You give honest feedback during counselling"). Clients, in addition,

described the leisure and recreational activities that they participated in during the treatment program, including arts and crafts and playing team sports. Finally, some of the clients described the Aboriginal spiritual and cultural activities which helped them find their higher power, important in 12-steps. The descriptions of treatment engagement mentioned are just a few examples that added and supported the quantitative participation measure.

The current study provided a better understanding of how treatment activities attempted to enhance treatment engagement and doing so in a holistic way.

Social Support and Treatment Retention

Since the qualitative study focused on treatment engagement rather than retention, there were limited qualitative results to substantiate the quantitative findings related to retention. The qualitative findings support the influence of age in relation to retention. The finding suggests younger clients' lack of engagement in the treatment program (i.e., being disruptive during sessions) could be an indicator of retention among this age group. This qualitative finding also provides an in-depth understanding of attrition among younger clients, which highlights the need to adapt and tailor treatment programming and approaches relevant and appropriate to this age group. The findings from the mixed method study were consistent with previous studies. For example, Rempel and Destefano (2001) found that younger clients were more likely to drop out of drug court treatment. Other studies have also found that older clients remained in treatment longer (Hiller et al. 1998).

Conclusions

Existing literature on social support in addiction treatment mainly focuses on post-treatment outcomes (Beattie & Longabaugh, 1999; Broome et al., 1997; Warren et al., 2007). Some studies have also examined pre-treatment social support and treatment outcomes (Knight & Simpson, 1996) and post-treatment social support and outcomes (Broome et al., 2002; Ellis, Bernichon, Yu, Roberts,

and Herrell, 2004). Few studies examine the relationship between social support and treatment engagement (Dobkin et al., 2002; Westreich et al., 1997). The findings of the study confirmed and contributed to the importance of social support during treatment and recovery to improve engagement and treatment outcomes. Specifically, the type and nature of relationships fluctuated throughout addiction, treatment, and recovery process.

More importantly, the results of the study revealed the significant role of treatment program characteristics on early engagement in addiction treatment. The body of research examining factors for improving the effectiveness of addiction treatment have traditionally focused on pre-treatment client characteristics and functioning. This study offered support for past research findings that indicated that age and client motivation were indicators of early engagement (Hiller et al., 1998; Mertens & Weisner, 2000; Strike et al., 2005; Simpson et al., 1995 & 2000).

However, there is a growing recognition of treatment process research to focus beyond pre-treatment client characteristics and turn to other factors such as program characteristics. Simpson and colleagues state that "what clients 'bring' into treatment is frequently less important than what they find when they get there" (1999, p. 205). Consistent with previous research (Joe, Simpson, & Hubbard, 1991; McKellar et al, 2006; Moos, 1990; Moos, King, Burnett, & Andrassay, 1997; Siqueland, et al., 2004) and the models of the treatment process (Simpson, 2004) and engagement (Moos et al., 1997), the findings from the current study, both quantitatively and qualitatively, suggest that treatment process components, such as rules, policies, and procedures, treatment programming, staff characteristics, and availability of therapeutic supports within the treatment centre, were important factors that enhanced clients' early engagement. Increasing clients' engagement was achieved through the treatment centre serving as gatekeeper by controlling access to clients supports within and external to the treatment centre. Consistent with past research (Timko, 1995), the evidence of this study indicated that client perception of lack of structure and inconsistencies in the program negatively influenced clients' focus on their program and

experience in treatment. Moos et al. (1997) found that high expectations for functioning, clearer policies, more structured programming, and involvement in facilities governance were associated with more participation.

Using a mixed method approach also highlighted limitations of a general measure for perceived social support and early engagement measures in addiction treatment, uncovering the complexities associated with defining, conceptualizing, and measuring both social support and treatment engagement.

Limitations and Strengths of the Thesis

The quantitative study, Study 1, was a secondary analysis of a prospective study, in which the researcher was not involved in the research design and implementation of the study. Thus, the researcher had no control over what measures were employed during data collection. For example, the social support measure was assessed only once (i.e., at treatment entry). As the qualitative study revealed, some clients identified that their main supports at treatment entry, (i.e., friends and family members) differed from their supports during treatment, (i.e. other clients, counsellors, and treatment staff). However, the global measure for perceived social support only assessed two forms of social support, i.e., from family and friends. The qualitative findings revealed that other supports such as community resources and services were important prior to initiating the treatment episode by providing funding for treatment or helping clients enter treatment, for instance. Future research may benefit from using several measures of social support that assess different types of supports and at various follow-up points (i.e., two weeks, one-month, and three-months). Furthermore, the measures used in Study 1 were self-reported and did not include counsellor-rated measures on social support, treatment engagement, and participation. In addition, only client characteristics were considered predictors for the multivariate regression models, and these analyses did not include program characteristics such as program staffing and size, policies, availability of services, and treatment orientation. Although the findings of the qualitative study captured the role of the treatment components and environment to facilitating clients' engagement through their

supportive networks, integrating objective measures of program characteristics would have substantiated the claim that program characteristics contributed to treatment engagement. However, a benefit of using secondary data for Study 1was that it was a practical, cost-effective and efficient way to test a general hypothesis about the relationship between social support and engagement in addiction treatment (Bibb, 2007).

Other strengths of Study 1 were that (1) the sample size was adequate, (2) the response rate was high at baseline and one-month follow-up, and (3) the research design used allowed for a prospective test of relationships between social support and treatment engagement.

A limitation of the qualitative study, Study 2, was that, because of resource and time constraints, the researcher did not complete member checking to verify findings with research participants. As well, verification of findings with research participants was not conducted as this population is difficult to reach at follow-up, based on the researcher's previous experience. However, the researcher used multiple techniques, such as an audit trail, collecting rich data, and writing memos to ensure rigour.

Third, the interviews captured the experiences and perspectives of clients initiating treatment. The interviews did not capture the perspectives of external social supports (e.g., family members and friends) and treatment staff members (e.g., counsellors, program attendants, Elders, and other staff). Thus, triangulation of this study's findings from these other sources was not possible. The perspectives of clients' family members and friends would have added and a complementary perspective of how their interaction with the client influenced treatment engagement. As well, interviewing treatment centre staff could have strengthened the theory, capturing their perspectives and insights on rules, policies, and procedures. The researcher informally met with the supervisor counsellor who shared his perspectives and provided additional information and context related to the treatment policies related to connecting clients to the outside world via field notes. This informal conversation indicates that formal interviews from different staff members may have offered additional insights and

strengthened the theory. Lastly, all clients interviewed were still in treatment and did not include perspectives of clients who prematurely left the program. Interviewing terminated clients may have added another dimension to the theory of how treatment centre's rules, policies, and procedures influenced their termination.

Finally, Study 2 did not include an objective measure of treatment engagement as part of data collection during the qualitative interviews. Including similar measures implemented in the prospective cohort study could have objectively measured clients' level of engagement and strengthened the theory.

One strength of using GT approach was that in addition for providing an in-depth description of social support and treatment engagement in addiction treatment, the findings generated a theory of the process of how social support was used by the treatment centre to influence clients' level of engagement and access and create health social support during treatment and recovery. It also illuminated the complex nature of social support and early engagement as well as the limitations of quantitative measurements, as stated above. Further, the GT approach for Study 2 demonstrated rigorous and systematic data collection and analyses procedures.

Mixed Method Approach

Along with the limitations from each study, there were also a few limitations with the mixed method approach used in this thesis. First, the sample for this study was only from one treatment centre, which was unique in comparison to other programs. The treatment program integrated Aboriginal cultural and spiritual aspects with 12-step programming. Thus, the findings may not be generalizable to other types of treatment modalities or programs, such as outpatient programs, and limited to residential addiction treatment settings.

Second, ideally for a sequential mixed method, sampling for the qualitative study should be from the quantitative sample (Morse & Niehaus, 2009). Due to timing and scope of the study, the sample for Study 2 was from another sample of clients at the same treatment centre than Study 1.

A strength of using a mixed method approach for this study was that each study complemented each other, resulting in a more comprehensive and accurate understanding of social support and client engagement in addiction treatment. The qualitative study illuminated the complex and multifaceted nature of social support and client engagement. It also illuminated the complex process of the treatment centre's role in using clients' social supports to influence treatment engagement.

Implications for Future Research and Practice

The results from this study were intended to provide an in-depth understanding of the role of social support in early engagement in addiction treatment to improve the effectiveness of treatment intervention strategies. This section provides considerations for further research in addiction treatment.

Future Research

Future research could expand on the findings by exploring the role of social support on treatment engagement in similar Aboriginal-oriented programs and other treatment settings, such as in an intensive outpatient program or in a non-Aboriginal residential treatment program. More studies need to look at the role of social support during treatment on retention and post-treatment outcomes.

Spirituality was an important aspect of most clients' treatment engagement and healing as part of their recovery process. More research is needed to examine the role of spirituality in treatment engagement and post-treatment outcomes in different treatment settings and programs. This study provided a unique perspective on the role of spirituality, beyond 12-steps. Although this study did not focus on spirituality, it emerged as an important way of viewing recovery as a part of the healing process, which moves beyond the disease model. Although the study did not focus too much on how clients' perceived addiction, it was implied that addiction was conceptualized as a disease, which continues to be the predominant concept in substance abuse treatment to date (Kearney, 1998).

With respect to research design, future research in addiction treatment could implement a mixed method approach to identify, conceptualize, and measure other dimensions of early engagement of different treatment modalities and programs. In light of the limitations of the general social support measure, more studies need to develop or adapt addiction-specific measures. A few instruments are available, for instance, the CEST consists of addiction-specific social support measures such as peer, i.e., supportive relationships with other clients in the program) and social support, i.e., having external support from family and friends (Garner, Knight, Flynn, Morey, & Simpson, 2007). Another tool is the Community Assessment Inventory (CAI) that assesses client perspective of community supports available within households, friends, families, and communities (Brown, O'Grady, Battjes, & Katz, 2004). Future research could also develop or adapt a more comprehensive social support measure that assesses multiple sources and types of support specific to addiction treatment by borrowing measures used in other disciplines. For example, the Child and Adolescent Social Support Scale-2000 (CASSS) provides a comprehensive measurement of five different sources of support (parent, teacher, classmate, friend, school) that encompassed four types of support (emotional, informational, appraisal, and instrumental) in the adolescent development field (Yu Rueger, Kerres Malecki, & Kilpatrick Demaray, 2010). Finally, general support measures need to be tested in different addiction treatment settings and other addicted populations beyond opiate outpatient and opiate-addicted populations.

As the study indicated, social support varied at different stages throughout addiction, early treatment engagement, and recovery. One of the strengths of the study was the implementation of two measures of early engagement. Future studies should continue to integrate different measures of treatment engagement like the instruments used in Study 1.

Practical Considerations

Based on the findings from the study, some practical considerations for the addiction treatment programs were suggested. Treatment centre staff members need to clearly communicate rules and policies among themselves and clients.

Moos et al. (1997) suggested strengthening treatment program policies by integrating tools like the Policies and Services Characteristics Inventory (PASCI; Timko, 1995) to obtain feedback about their program's characteristics and how they compare to other programs. Further, building the "professional community" within treatment centres could be an important force to improve staff interactions and workplace practices, in which counsellors collaborate with each other, observe and learn from one another, and engage in a reflective dialogue about therapeutic techniques and client change (see Broome et al., 2007). Engaging in regular dialogue among treatment staff could help create a treatment environment that improves engagement and treatment outcomes for clients.

McKellar and colleagues (2006) suggest that "clinicians need to find ways to implement supportive programs that involve patients in decisions about their own treatment and that are relatively structured but do not create a rigid or punitive setting that impels patients to leave treatment" (p. 457). Treatment programs could include objective instruments to assess client social support and level of engagement at various phases in the program, such as intake, two-weeks, and monthly follow-up, so that they can adapt and individualize client treatment programs to meet their needs, yet maintain structure in their treatment.

To improve engagement among the young adult clientele (18 to 25 years of age), addiction treatment programs should consider separating this age group from clients who are 25 years and older as well as developing and adapting the program which is appropriate for their age and addresses their needs holistically. Furthermore, an effective approach to enhance therapeutic engagement, specifically, commitment to treatment to make changes to their substance use, resolve ambivalence about change, and enhance client-counsellor rapport, is motivational interviewing (MI) and motivational enhancement therapy (MET) techniques (Moos, 2007). MI and MET help individuals use a collaborative approach between counsellor and patients to resolve ambivalence about change, reinforce personal statement about why they want to change, and strengthen commitment (Miller & Rollnick, 2002). As well, treatment programs could tailor

the program by matching client characteristics and therapy procedures such as matching client's coping style (Beutler et al., 1997).

Treatment programs need to integrate a multidisciplinary team of health professionals, such as physicians, psychologists, and social workers to address the various needs of clients, either providing these services onsite and/or referring clients for services in the community. Studies have shown that addressing needs early in treatment improved treatment outcomes (Joe et al., 1991). Receiving more psychiatric services reduced the likelihood of dropping out of treatment (Marrero et al., 2005). To facilitate improving clients' social relationships, treatment centres should consider integrating a family and couples counselling component to treatment as well. Involving family members or significant other in treatment may also present an opportunity to ensure clients to access abstinence-oriented social supports. For instance, an outpatient program for opioid-dependent patients implemented a unique intervention that involved patients identifying a non-using significant other to establish more accessible abstinence-oriented social networks to replace existing drug-using networks (Kidorf, King, Neufeld, Stoller, Peirce, & Brooner, 2005). The significant others' involvement included: attending weekly significant-other community monitoring and support group; meeting with patient at least once per week outside the program setting; monitoring and documenting patient's participation in social and recreational activities with non-using individuals, and; submitting urine samples to confirm abstinence from illicit substances.

Lastly, treatment centres need well-structured treatment schedule. Meier and Best (2007), suggest having adequate levels of treatment staff and funding, well-developed treatment schedule that includes an appropriate balance of duties, structured activities, and adequate time for individual counselling. Carroll (1997) also provided suggestions for improving structure and flexibility. Since clients who have a regular schedule (i.e., programming that occurs at the same time) are more likely to complete treatment, it is important for treatment centres to maintain consistency and the undesirability to altering the program schedule. As well, having a large pool of counsellors ready to deliver services is beneficial, which

may help to prevent interruptions in programming from counsellor vacation or absences, increase flexibility to accommodate the varying needs of clients.

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APPENDIX A: Letter of Support and Memorandum of Understanding from Residential Addiction Treatment Centre

September 20, 2011

RE: Letter of support for Ms. Maricon Hidalgo's thesis project

To whom this may concern:

As Counseling Supervisor at I [
confirm that I am aware and supportive of Ms. Maricon Hidalgo's thesis project, entitled, "Social support and early treatment engagement in addiction treatment". On behave of the Board's approval and from my immediate supervisor, I am prepared to provide support to Ms. Hidalgo by (1) granting permission to invite addiction treatment clients to participate in the thesis project being conducted by Ms. Hidalgo, and (2) granting permission for Ms. Hidalgo to conduct interviews with clients at the treatment facility.

I believe this thesis project will be helpful to counsellors and staff for having a better understanding of the factors that affect treatment and recovery for clients.

If you have any questions or concerns, I can be contacted by phone at,

Sincerely,

Accredited by the Canadian Council on Health Services Accreditation

Memorandum of Understanding between the University of Alberta and Treatment Centre

Social Support and Early Engagement in Addiction Treatment

Ms. Maricon Hidalgo, Master's candidate from the University of Alberta (UA) and Treatment Centre ( ) are entering into a partnership in support of Ms. Hidalgo's thesis project entitled the Social Support and Early Engagement in Addiction Treatment Project.

Client retention in alcohol and substance use treatment programs is a major concern of practitioners and researchers in the addiction treatment field. Although length of stay in drug abuse treatment is one of the most consistent predictors of therapeutic response and post-treatment outcomes across different treatment settings, only about half of people seeking addiction treatment drop out within a month of starting treatment programs.

Social supports may have important implications for both retention and treatment outcomes. Unfortunately, little is known about the role of social support in promoting early engagement of clients in addiction treatment. The purpose of this study is to explore the role of social supports and early treatment engagement in a residential addiction treatment setting. There are two parts of the study:

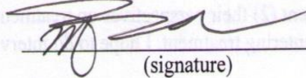
Study 1: Secondary analysis of the Social Control and Coercion (SCC) Project
The SCC was conducted at and examined how different types of social controls (e.g., court-ordered treatment; treatment that is required for work or social assistance programs; pressure from friends and family members to enter treatment) are used, how often they are used, what it is like to be in treatment or have a client that is in treatment because of social controls, and how being pressured to enter treatment affects someone's experience in treatment.

For the purpose of the current project, the secondary analysis will look at the relationship between levels of social support from family and friends at treatment entry and treatment engagement and retention at treatment entry at .

Study 2: Qualitative interviews with clients
I will be interviewing clients to better understand how social supports shapes the treatment process in a drug and alcohol residential treatment and to find out what social supports are important or not important to clients while in treatment. Clients will describe (1) significant relationships prior to entering treatment (2) their perspectives on treatment engagement and the role of support from family and friends of entering treatment. I hope to do interviews with 8-15 clients.

This Memorandum of Understanding pertains to Study 2. will provide support by (1) allowing the Ms. Hidalgo to recruit addiction treatment clients to participate in the research project, and (2) granting permission for Ms. Hidalgo to conduct interviews with clients at the treatment facility. This partnership is subject to the following mutually agreed upon guidelines:

- will have input into the procedures and content of data to be collected from clients.
- Clients of will be provided with background information about the study including, the purpose of the research, what will be required of each participant, and how data will be stored.
- All clients will be invited to take part in the study whether they are Aboriginal or not.
- clients will have the right to refuse to participate or withdraw from the study at any time and with no effect on their treatment.
- Confidentiality will be assured to all participants. Data and identifying information will not be disclosed to anyone beyond Ms. Maricon Hidalgo and Dr. Cam Wild (Supervisor).
- UA will retain rights to and ownership of data collected from clients via interviews and questionnaires administered by UA.
- UA will be responsible for safe storage of all data collected from clients via interviews and questionnaires administered by UA. All data will be stored in a locked cabinet and electronic data will be stored in password-protected files.
- will be allowed to review any publication using data collected from clients prior to its release. will have the option of allowing identification of as a source of data, or requiring confidentiality of their involvement in the project, at their discretion.
- UA will provide an in-service at to present study findings and to keep staff informed about the project.
- UA will provide with a copy of any reports or articles written for this study.
- This agreement is valid until April 2012, at which point the parties will meet to review the terms of reference and the status of the project.

Signed on behalf of	Signed on behalf of the University of Alberta:
	Maricon Hidalgo Master's Student, UA
	
	(signature)
Nov. 10/11. (date)	NOVEMBER 10, 2011 (date)

October 13, 2011 Memorandum of Understanding 2

APPENDIX B: Participant Recruitment Script

Participant Recruitment Script for [Residential Addiction Treatment Centre] Client's at Orientation

My name is Maricon Hidalgo. I am a Master's student at the University of Alberta. My supervisor is Dr. Cam Wild. He is currently working with [the treatment centre] on another project. As part of my studies, I will be conducting a study here at [the treatment centre].

The study is called "Social Supports and Early Engagement in Addiction Treatment". I am interested in finding out more about how people in clients' lives affect their treatment experience here at [the treatment centre].

There are two parts to this study. If you are interested in taking part in the study, the first part will involve you reading over information about the study and signing the consent form to give me permission use your information you provide me for this study. Next, I will have you complete a form that will be asking questions about your background, treatment experience, and questions about the people in your life such as family, friends, and significant others. This will take 5 to10 minutes for you to complete.

Just to be clear, not all interested clients who complete the first phase of the study will be selected to take part in the second part of the study. The second part of the study is an interview with me at the three to four week from now. The information you provide me today will be used to pick you to do an interview. So what that means is that if you are interested in being interviewed, only some people will be picked and others will not be picked. Unfortunately, I cannot interview everyone that is interested in the study due to limits of time and resources.

I will only contact people who are selected to do an interview with me. The interview will be here at [the treatment centre]. Interviews will take about 30 to 60 minutes. I will be asking you questions about the people in your life before you started your treatment program and now. I will also ask you what it means for you to have support from people and what it means for you to be involved in your treatment program.

I will set up an interview time that is convenient for you and that will not interrupt your treatment program here. If you are selected to take part in the interview and are no longer at [the treatment centre], I will still do the interview with you. I can either meet you at a convenient place, do the interview over the phone, or you can come to my office at the University campus.

Participating in this project is totally voluntary. If you take part in the study, you can change your mind at any time during and/or after completing the form and the interview. You do not have to answer all the questions on the form or during the

interview. You should know though, at *any time,* you could choose to stop the answering questions and/or skip any questions you don't want to answer. The interview will be audio recorded. If you are doing the interview, I can turn off the recorder if you want to. Your choice about taking part in the study will not affect any part of your treatment you receiving from [the treatment centre].

All your information - the form, and your digitally recorded and transcribed interview - will be kept completely confidential. Your answers and comments will not be shared with anybody, including people at [the treatment centre] (counsellors other clients), lawyer, family members, employers, etc. Your responses are kept private except when codes of ethics and the law require me to report anything. And any reports that talk about the interviews will not use your real name. Everything is kept secure in my office at the University of Alberta and the data is destroyed after 7 years.

Does anyone have any questions?

I will be giving everyone here a package that includes the information on the project, consent form, and a form that will be asking your basic information. Please read the information letter and then complete the consent form. If you are interested, please tick off "I agree to take part in this study, please sign the consent form and answer the questions on the form for your contact information.

If you are not interested in taking part in the study, select "I do not want to take part in this study". You do not have to sign the consent form or fill out the questions at this point.

Once you are done looking over the material in the package, please put all the forms into the envelope and seal it.

APPENDIX C: Information Letters and Consent Forms for Treatment Clients

[University of Alberta letterhead]

Information Letter and Consent Form for Clients at [Residential Addiction Treatment Centre]: Phase 1 – Recruitment

Title Project: Social Supports and Early Treatment Engagement

Investigators: Maricon Hidalgo; Dr. Cameron Wild

Dear [Residential Addiction Treatment Centre] Client:

I am a student at the University of Alberta who will be doing a study with clients at [the treatment centre]. My supervisor is Dr. Cameron Wild, is currently conducting research with [the treatment centre]. For my study, I am interested in finding out more about how people in your life affect your treatment experience here at [the treatment centre]. I will also ask you what it means for you to have support from people and what that means for you in your treatment program.

What is involved?

There will be two parts to this study. I will ask you in the first part of the study to fill out a form with questions that will:

- Record basic background information (e.g., age, gender, education level, employment status); and
- Ask you about the support that people in your life give you such as family, friends, and significant others.

The form will take about 10 minutes to fill out. Not all clients that complete the first part of the study will be asked to take part in the second part of this study. The information that you provide about your support from other people will be used to help me select people for the second part of the study.

The second part of the study will be an interview three to four weeks from when you started at [the treatment centre]. If you are selected to take part in the interview, I will then contact you. I will to set up an interview time that is convenient for you and that will not interrupt your treatment program. The interview will take about 30 to 60 minutes of your time.

Potential Risks

I do not expect any risks in taking part in this study. Your privacy will be respected, but I may ask questions that you may not wish to answer. The information you give will not be shared with anyone, except my supervisor. If you are upset as a result of any of the questions I ask you, I can provide the name and number of some supports that you can use.

Potential Benefit
There may be no direct benefit to you for taking part. But as a result of this study, changes may be made to the [treatment centre]. These changes can help you and others in the program.

Confidentiality
All personal records will be kept confidential. All names of people and organizations will be removed from the record of your interview. Any information kept will not identify you by name. Your name will not be in any reports based on this study. Your data will not be shared with anyone, including your counsellor, employer or place of work.

Paper data will be kept in a locked cabinet at all times. Electronic data will be password protected. Only Maricon Hidalgo and Dr. Cameron Wild will have access to your data. Data that is not part of the public record will be kept for seven years. After that it will be destroyed.

Voluntary Participation
Your participation in this study is strictly your choice. If you take part in the study, you can change your mind at any time during and/or after the completion of the form and the interview. You can skip any questions you wish on the form or during the interview. You can stop the interview at any time by telling the interviewer. Your choice about taking part in the study will not affect any part of your treatment you receiving from [the treatment centre].

Who has approved the study?
The Health Research Ethics Board (HREB) at the University of Alberta has looked at this study. They have given it ethical clearance. If you have any concerns about this study, you can call the University of Alberta Research Ethics Office at 780.492.2615. The information from this study may be looked at again in the future to help with other questions. If so, the ethics board will make sure the information is used ethically.

You may ask any questions about the study at any time. Please contact:

Maricon Hidalgo at hidalgo@ualberta.ca or 780.492.6753 or 1.866.4924550 (Toll free)
Dr. Cameron Wild at cam.wild@ualberta.ca or 780.492.6757

Sincerely,

Maricon Hidalgo
Master's Student, School of Public Health, Centre for Health Promotion Studies
University of Alberta

CONSENT FORM: PHASE 1

Title of Project: Social Supports and Early Treatment Engagement

Investigator: Maricon Hidalgo Phone Number: 780.492.6753
Supervisor: Dr. Cameron Wild Phone Number: 780.492.6757

	Yes	No
Do you understand that you have been asked to be in a research study?	☐	☐
Have you read and received a copy of the attached Information Sheet?	☐	☐
Do you understand the benefits and risks involved in taking part in this research study?	☐	☐
Do you have any questions about this study or was there anything in the information sheet you would like to be explained more clearly?	☐	☐
Do you understand you can ask more questions later on if you like?	☐	☐
Do you understand that you are free to withdraw from the study at any time even after completing the form? You can do this without having to give a reason and without affecting your treatment at [the treatment centre].	☐	☐
Do you understand how your information will be kept private?	☐	☐
Do you understand who will have access to your records, including your contact information?	☐	☐
Has the issue of confidentiality been explained to you?	☐	☐

☐ I agree to take part in this study

☐ I do not want to take part in this study

Signature

Participant Printed Name Date

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

Signature

Researcher Printed Name Date

A copy of the information sheet must be given to the research subject.

Information Letter and Consent Form for Clients at Residential Addiction Treatment Centre: Phase 2 - Interview

[University of Alberta letterhead]

Information Letter and Consent Form for Clients at [Residential Addiction Treatment Centre]: Phase 2 –
Interview Title Project: Social Supports and Early Treatment Engagement
Investigators: Maricon Hidalgo; Dr. Cameron Wild

Dear [Residential Addiction Treatment Centre] Client:

You have been selected to take part in the second phase of the study, the interview. Just to remind you again of my study, I am interested in finding out more about how people in your life affect your treatment experience here at [the treatment centre]. I will be asking you to tell me about the relationships or the people in your life prior to starting your treatment program and how that may affect your treatment experience right now. I will specifically asking you how the people in your life have been helpful and not so helpful for your treatment experience.

What is involved?
You have been asked to take part in an interview three to four weeks from when you started at [the treatment centre]. The interview will take about 30 to 60 minutes of your time. Your interview will be audio-recorded. The interview will not interrupt your treatment program.

Potential Risks
I do not expect any risks in taking part in this study. Your privacy will be respected, but I may ask questions that you may not wish to answer. The information you give will not be shared with anyone, except my supervisor. If you are upset as a result of any of the questions I ask you, I can provide the name and number of some supports that you can use.

Potential Benefit
There may be no direct benefit to you for taking part. But as a result of this study, changes may be made to the [the treatment centre] program. These changes can help you and others in the program.

Compensation
You will receive a $20 gift card for participating in the interview. If you participate in the interview and decide that you no longer want to continue with the interview, you will still receive the gift card.

Confidentiality
All personal records will be kept confidential. All names of people and organizations will be removed from the record of your interview. Any information

kept will not identify you by name. Your name will not be in any reports based on this study. Your data will not be shared with anyone, including your counsellor, employer or place of work.

Paper data will be kept in a locked cabinet at all times. Electronic data will be password protected. Only Maricon Hidalgo and Dr. Cameron Wild will have access to your data. Data that is not part of the public record will be kept for seven years. After that it will be destroyed.

Voluntary Participation
Your participation in this study is strictly your choice. If you take part in the study, you can change your mind at any time during and/or after the interview. You can skip any questions you wish during the interview. Because your interview will be audio-recorded, you can shut off the recording of your interview at any time by telling the interviewer. Your choice about taking part in the study will not affect any part of your treatment you receiving from [the treatment centre].

Who has approved the study?
The Health Research Ethics Board (HREB) at the University of Alberta has looked at this study. They have given it ethical clearance. If you have any concerns about this study, you can call the University of Alberta Research Ethics Office at 780.492.2615. The information from this study may be looked at again in the future to help with other questions. If so, the ethics board will make sure the information is used ethically.

You may ask any questions about the study at any time. Please contact:

Maricon Hidalgo at hidalgo@ualberta.ca or 780.492.6753 or 1.866.4924550 (Toll free)
Dr. Cameron Wild at cam.wild@ualberta.ca or 780.492.6757

Sincerely,

Maricon Hidalgo
Master's Student, School of Public Health, Centre for Health Promotion Studies
University of Alberta

CONSENT FORM: PHASE 2

Title of Project: Social Supports and Early Treatment Engagement
Investigator: Maricon Hidalgo Phone Number: 780.492.6753
Supervisor: Dr. Cameron Wild Phone Number: 780.492.6757

	Yes	No
Do you understand that you have been asked to be in a research study?	☐	☐
Have you read and received a copy of the attached Information Sheet?	☐	☐
Do you understand the benefits and risks involved in taking part in this research study?	☐	☐
Do you have any questions about this study or was there anything in the information sheet you would like to be explained more clearly?	☐	☐
Do you understand you can ask more questions later on if you like?	☐	☐
Do you understand that you are free to withdraw from the study at any time even after completing the form and the interview? You can do this without having to give a reason and without affecting your treatment at [the treatment centre].	☐	☐
Do you understand how your information will be kept private?	☐	☐
Do you understand who will have access to your records, including your contact information?	☐	☐
Has the issue of confidentiality been explained to you?	☐	☐

I agree to take part in this study: YES ☐ NO ☐

Signature

Participant Printed Name Date

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

Signature

Researcher Printed Name Date

A copy of the information sheet must be given to the research subject.

APPENDIX D: Standardized Data Collection Form

Standardized Data Collection Form: [Residential Addiction Treatment Centre] Clients
Social Supports and Early Treatment Engagement: Qualitative Study

First Name: ______________________________ Last Initial: ________________

Age: ___________________

Gender (✓):
❍ Male
❍ Female
❍ Transgender

Race (✓):
❍ Caucasian
❍ Aboriginal/ Métis/First Nations
❍ Black
❍ Other visible minority

Education
Check only one answer ✓
❍ Grades 1-6
❍ Grade 7
❍ Grade 8
❍ Grade 9
❍ Grade 10
❍ Grade 11
❍ Grade 12/13
❍ College/Technical Diploma
❍ University Degree

Employment
Are you currently employed: ❍ Yes ❍ No

Check only one answer ✓
❍ Employed full-time (includes self-employed)
❍ Employed part-time
❍ Unemployed (looking for work, taking time off work, etc.)
❍ Student/retraining
❍ Disabled/not working
❍ Not in labour force (e.g. homemaker)
❍ Retired

Treatment Experience
Current treatment program (Check only one answer ✓): ❍ 42-day ❍ 90-day

Date of entry into program (yyyy-mm-dd): ________________________

Have you attended addiction treatment previously: ❍ Yes ❍ No

When was your last treatment experience? (mm/yyyy) _____________________

How many times have you been in residential treatment? ___________________

Social Support

Instructions: Read each statement carefully. Indicate how you feel about each statement.

	1 Very Strongly Disagree	2 Strongly Disagree	3 Mildly Disagree	4 Neutral	5 Mildly Agree	6 Strongly Agree	7 Very Strongly Agree
1. There is a special person who is around when I am in need.	❍	❍	❍	❍	❍	❍	❍
2. There is a special person with whom I can share my joys and sorrows.	❍	❍	❍	❍	❍	❍	❍
3. My family really tries to help me.	❍	❍	❍	❍	❍	❍	❍
4. I get the emotional help and support I need from my family.	❍	❍	❍	❍	❍	❍	❍
5. I have a special person who is a real source of comfort to me.	❍	❍	❍	❍	❍	❍	❍
6. My friends really try to help me.	❍	❍	❍	❍	❍	❍	❍
7. I can count on my friends when things go wrong.	❍	❍	❍	❍	❍	❍	❍
8. I can talk about my problems with my family.	❍	❍	❍	❍	❍	❍	❍
9. I have friends with whom I can share my joys and sorrows.	❍	❍	❍	❍	❍	❍	❍
10. There is a special person in my life who cares about my feelings.	❍	❍	❍	❍	❍	❍	❍
11. My family is willing to help me make decisions.	❍	❍	❍	❍	❍	❍	❍
12. I can talk about my problems with my friends.	❍	❍	❍	❍	❍	❍	❍

APPENDIX E: Contact Information Sheet for Treatment Clients

Contact Information

I will be doing interviews with you 3 to 4 weeks after starting your treatment program. If you are no longer at [the treatment centre] during that time, I will need your contact information to reach you. Your information will be kept private. It will be destroyed when the study is over.

How to reach you	
Phone number:	
Other phone number:	
Email address (print clearly):	
Other email address:	
Do you have someone else I can call to help me reach you (e.g., family member, friend, social worker, etc.)? I will keep the reason for my call private.	
Person 1: Name and relationship to you:	
Phone number:	
Person 2: Name and relationship to you:	
Phone number:	
Person 3: Name and relationship to you:	
Phone number:	

OFFICE USE ONLY

Participant ID: ___________________________

Treatment Start date: _____________________
yyyy-mm-dd

APPENDIX F: Reminder Script for Interviews

Reminder Script for Interviews with [Residential Addiction Treatment Centre] Clients

You have been picked to take part in the interview. I would like to interview today to find out more about your treatment experience at [the treatment centre]. Specifically, I will be asking you about the people in your life before you started your treatment program and now. I will also ask you what it means for you to have support from people and what it means for you to be involved in your treatment program.

This interview will take 30-60 minutes. There are no right or wrong answers, I just want to know your opinion and thoughts. You may choose not to take part in this interview. If you agree to take part, you can change your mind later. You can stop the interview at any time without giving me a reason and it will not affect the treatment you receive at [the treatment centre]. You will still receive the gift card.

Your answers will be kept private. I will not identify you by name. Your name will not appear in any reports based on this study.

If you feel comfortable with me, are you ready to start the interview?

Will it be alright with you if I use exact quotes from you in reports about the program? I won't use your name.

APPENDIX G: Semi-Structured Interview Guide

Semi-Structured Interview Guide for [Residential Addiction Treatment Centre] Clients

Can you tell me your story of how you ended up in treatment at [the treatment centre]?

What social support means to client
Please describe what it means to have people "there for you".

Who are the main people who were "there for you" prior to treatment? Tell me about how they were "there for you".

- What makes people "there for you"?

Who are the main people who are "there for you" now in treatment?

Who are the main people who were *not* "there for you" prior to treatment? Tell me how they were *not* "there for you".

- What makes people not "there for you"?
- Can you provide an example(s) of this?
- Now that you are in treatment, are they still *not* "there for you"? [If changed] How are they "there for you" now? What has changed?

Treatment experience and treatment engagement
Describe how you are involved in your treatment experience at [the treatment centre]? Tell me about a situation or an example.

- Now describe how you are not involved in your treatment program. Tell me about a situation or an example.

Thinking about the people that are "there for you", how are they involved in your treatment at [the treatment centre]?

- How are they affecting your treatment experience?

Thinking about the people who were *not* "there for you" prior to treatment, can you describe how they affect your treatment experience at [the treatment centre]?

What are some things that you need to make your treatment experience better for you with respect to having people who are "there for you" that is not working for you right now?

How has [the treatment centre] allowed you to interact with people that are "there for you"? Describe how this has been helpful for you in your treatment? How has this not been helpful for you in your treatment experience?

What do you think makes people to be involved in their treatment? Can you provide an example(s)?

What do you think makes people not involved in their treatment? Can you provide an example(s)?

For clients no longer in treatment:

What was your reason(s) for leaving [the treatment centre] early/why did you not complete the treatment?

- What would have made your treatment experience better?

Now that you are not in treatment, can you tell me the people who are "there for you"?

- How are they "there for you"?
- How are they involved in your recovery?
- How are they involved in your life right now?
- Who are the people that you feel that are "not there for you" right now?

APPENDIX H: Addiction and Mental Health Resource Contact Information for Treatment Clients

Resources

Alberta Health Services Hotline:
1.866.332.2322

Alberta Mental Health Help line:
1.877.3032642

APPENDIX I: Tables from Qualitative Data Analysis

Supportive: Social Support (SS) prior to treatment episode

Name of Client	MSPSS Score	Client's perspectives on SS	Types of SS prior to treatment	Examples of how support was provided
Maggie (Interview #1)	57 (High)	**Defining SS** *Gives someone a feeling of self-worth (Lines 80-4) **Importance of SS** *If you have a good support, it helps to know that there is support from family and friends who care about you and want you to succeed in life (Lines 80-4) **Condition for receiving help** *Once one accepts that he or she has a problem or is an addict and being honest about that, that is when one's social systems comes in and provide more support (Lines 566-97)	**Family members** *Daughter	**Family members:** *Values client's opinions *Non-judgmental *(Lines 141-143) *She's understanding *Respectful relationship between mom and daughter (Lines 95-107)
Mindy (Interview #2)	38 (Low)	**Definition of SS** *People provide support in "bettering myself", despite the consequences of addiction *Offer rides to go to meetings, doctor's appointments (Lines 94-117)	**Family members** *Daughter *Sister **Community services or resources** *Community outreach program [Crossroads] & Outreach worker *E4C **Friends:** *Friends from Tennessee **Significant other:** *Boyfriend	**General** *Driving her to appointments and meetings *Emotional and verbal support (Lines 98-117) **Family members** *Daughter* *She is her best friend *Verbal encouragement *Emotional and prayers or spiritual support (Lines 229-39) *Sister* *Say prayers for her (Lines 240-2) *Emotional support *Verbal encouragement

				Friends *Say prayers for her (Lines 240-2) **Family members:** *Phone contact/calls **Community services or resources:** *Assisted in getting into treatment centre *Find and establish housing *Encouraged her to pursue education and employment *Keep sex trade workers safe (Lines 120-7; 157-85) **Significant other:** *Prayers (spiritual support) *Financial support and during certain situations and emergencies (Lines 255-9)
Adam (Interview #3)	71 (High)	**Importance of SS** *Social support is important and is needed so that you don't fall or feel overwhelmed (Lines 31-9)	**Family members:** *Children **Significant other:** *Wife (separated) **Friends:** *Friends **Community services or resources for family members:** *Education system (school counsellor) *Al-Anon **Other:** *Employer *Doctor	**Friends:** *Don't invite him to parties anymore to avoid the alcohol *Spend clean time such as movies, dinner, and playing pool *Supportive in letting have a place to stay, money – provide him with anything he needs (Lines 168-93) **Other:** *Employer* *Given him the time off to go to treatment and work on himself (Lines 47-51) *Doctor* *Helped address physical and mental health, get doctor's note for EI benefits *Helped him fill out the paperwork to get into treatment centre (Lines 70-6)

Erin (Interview #4)	66 (High)	**Definition of SS** *Wants to be around positive people that have faith and believe in her and people that believe in themselves *Be around people that look after your own best interest (Lines 270-3) **Condition for SS** *People who faith and believe in her and help her out if she's helping herself (Lines 44-6)	**Family members:** *Parents *Relatives (aunts, uncles, relatives)	**Family members:** *Wanting client to get some help *Wanting the best for her *Provided housing on the condition that she helps herself *Driving her to appointments, pick up medication *Attended meetings to understand what client was going through (Lines 24-40) *Spend time with client: having her over for dinner, taking her shopping, talk with her *Financial support (i.e., pay bills) *Positive supports (Lines 59-70)
Joshua (Interview #5)	28 (Low)	**Importance of SS** *Perspective of support from family:* Importance of family, in that they will always be there for you - "Blood's thicker than water" (Lines 191-4) *Having social support is important **Perspective on SS** *Prefer for one person to provide support by not feeling sorry for him or to fix him, but rather to listen to (Interpretation: quality vs. quantity) *Somebody who is understanding and will call him on his stuff as he manipulates as part of being an addict **Perspective on reaching out** *Has difficulty asking for help, especially in the past (Lines 104-56) **Condition for receiving help**	**Family members:** *Mom *Sister **Friends:** *Sister's boyfriend **Significant other:** *Girlfriend **Community services or resources:** *Government agency [AADAC] & [AADAC] counsellor	**Family members** *Family is always there (Lines 191-4) **Community services or resources:** *Ensured funding went through for client the day before entering treatment (Lines 280-7)

		*Need to be open to asking and receiving support and cannot refuse it (Lines 161-3)		
Andy (Interview #6)	61 (High)	**Importance of SS** *Feels that having support is important for recovery *Recovery is not only for self but doing it for family *Identified family as an important source of support, especially his daughter **Perspective on reaching out** *You need help in recovery (Lines 915-21)	**Family members:** *Mom *Younger brother *Daughter **Friends:** *2 ladies in apartment building complex *"Support friends" or band friends	**Family members:** *Tons of support *Mom* *"Medically" supported client through alcohol withdrawal until he got into treatment *Talking to client *Encouraged client to get help *Brother* *When drinking was getting bad, encouraged client to get help *Daughter* *Has a medical condition, but very supportive because she's "loveable" (Lines 184-242) **Friends:** *Drink limited amounts of alcohol *Take care of him when he was drinking saying that he had "enough" *Happy that he is in treatment *Proud of him (Lines 280-309)
Paul (Interview #7)	64 (Low)	**Condition for receiving help** *Dad started providing support once client started taking "initiative" of seeking help and "taking his alcoholism more seriously"	**Family members:** *Dad **Friends:** *Other clients from other treatment centres (prior to starting current treatment episode)	**Family members:** *Dad* *Happy when client got into [Recovery Acres] *Financial support *There when client needs anything (Lines 393-403; 597-604) **Friends:** *"We are all in the same boat" (Lines 419-20) *Talking to them about his problems, laughing, and general, sober, friendship

				*Being there when he was down (Lines 509-27) **Other:** *Staff at treatment centres* *Show that they care about clients' recovery *The staff have recovery and gone through same experience (Lines 738-59)
Brian (Interview #8)	67 (High)	**Importance of SS** *Support plays a huge role in staying sober and not going back to using (Lines 83-4) **Perspective of support from family:* Support from family is the biggest thing for him staying sober at this time (Lines 393-4)	**Family members:** *Mom *Dad *Siblings (2 sisters and brother) **Community services or resources:** *Meetings **Friends:** *Best friend	**Family members:** *Parents* *Stuck by his side during hard times *Makes going through things much easier knowing that family stand beside and support client (Lines 87-8) *Driving him to meetings (Lines 102, 202, 475-7) *Improvements in communication: Talking to parents about his problems and issues (Lines 102-24) *Being honest has helped relationship with family members *Living with dad *Spending quality with family by going for coffee with dad, eating with mom, or watching movies with family (Lines 134-50) *Financial support or "money" *Siblings* *Siblings support him, but has let them down in the past *Relationship slowly improving as siblings see him changing, and they are accepting him for who he is (Lines 152-60) **Community services or resources:** *Meetings played role in keeping Brian sober

				and making a change (Lines 475-86) **Friends:** *She's in recovery
Jonah (Interview #9)	59 (Low)	**Importance of social support** *Fortunate in Alberta that there are social programs available to help addicts in recovery (Lines 601-15)	**Family members:** *Mom *Aunt *2 brothers **Community services or resources:** *Mental health worker **Friends:** *Two best friends (one that smokes weed and the other one just drinks)	**Family members:** *Mom and Aunt* *Showing love *Support him even when he would "mess up" *Taking recovery more serious now, they will do anything to provide support *Financial support *Invite him for dinner (Lines 63-82) *Brothers* *One brother is a drug dealer and uses drugs and does not use around him *Other brother doesn't know much about drugs and doesn't know what to say or do (Lines 216-31) *Aunt* *Paid for previous treatment episode *Doesn't give him money, but buys him groceries *Checked on him by calling him while he was in his active addiction *Spend time with him (Lines 280-95) **Community services or resources:** *Specializes in addiction *Helps him get appointment with certain people and help with getting medication (Lines 83-7) *Using community services such as NA meetings, AADAC education/information sessions, and detox

				Friends: *The weed smoker has watched him go through a lot of crap. He won't be smoking dope around client *The drinker has saved his ass many times (Lines 200-14)
Tyler (Interview #10)	82 (High)	*People supportive once he became truly honest about his addiction *There are not a lot of bad influences here in Alberta. At times he does reminisce about old times with friends in B.C. (Lines 786-95)	**Family members:** *Dad *Stepmom and kids *Mom *Grandma **Friends:** *People in AA, NA, or any fellowship *5 really close friends in recovery *Ex-girlfriend (main support) *Jordan and his girlfriend, Gina *Friend in B.C. **Other:** *Sponsor	**Family members:** *Don't understand addiction, but very supportive, they give him encouragement *Being honest has been helpful (Lines 320-36) *Dad* *When client reached out for help, dad paid for ticket to come to Edmonton, had treatment and detox lined up, and prepared to pay for his treatment (Lines 246-82) *Mom* *Said that client was an "inspiration" to her *Shared story of his last relapse. He was honest with his mom and she was supportive (Lines 282-98) *Story of support* *Comfortable sharing with mom and dad now after relapse and becoming open and honest *Grandma* *First person he became honest with and she was right by his side **Friends:** *Friends that actually care for him (Lines 663-7) *They are all in recovery and care for him when he falls (Lines 782-6) *Friends at meetings*

				*All into recovery *Feels welcomed at meetings (Lines 83-90) *Ex-girlfriend* *Talked to him his first relapse and did not advise him, but was there to help him figure out what to do (Lines 93-7) *Practices what she preaches and respects that (Lines 107-23) *Jordan* *Calls him on his “crap” *Can call him any time (dependable) *Practices what he preaches *Gives him rides to meetings *Jordan’s girlfriend and him inspire him as a couple because they are in a sober relationship *Friends in NA* *Bryan has many years in recovery, talk to him about problems *Louis met at first treatment centre and has been supportive- been there through alone times, relapses (Lines 639-61) *Friend and his wife from B.C.* *One of the first people he was honest about everything with and provided support *Wife has struggled with and they both understand addiction **Other:** *Sponsor* *Maintains sobriety even though going through rough times *Brutally honest *Continued to sponsor him even during relapses.

				*Guide him through the steps (Lines 370-96)
Joanie (Interview #11)	57 (Low)	*Previous attitude towards having supports was negative *It is important to have support now while in recovery and is learning to let people in (Lines 308-13) *Having social support is an absolute must	**Family members:** *Sister-in-law *Son **Friends:** *Neighbor, a female friend *Friends from SMART Recovery and other meetings	**Family members:** *Sister-in-law* *Answering client's phone calls promptly *Challenges her and calls her on her stuff or is "straight up" *Sets a good example for her *Admires and adores her (Lines 96-109) *Son* *Doesn't rely on him too much, but adores him – he's her "ally" *Her inspiration to make changes in her life (Lines 119-147) **Friends:** *Calls client on her stuff big time (Lines 110-16) *Taking care of her place while client is in treatment (Lines 111-17)
Anna (Interview #12)	18 (Low)	N/A	**Family member:** *Mom **Community services or resources:** *AADAC counsellor **Significant other:** *Ex-husband	**Family member:** *Only family member that talks to her **Community services or resources:** *Noticed that counsellors have faced addiction issue or close to it due to family member and the counsellors or staff relate to clients (Lines 288-308) **Significant other:** *Good support

Eva (Interview #13)	71 (High)	N/A	**Family members:** *Son *Brother and his wife and children *Grandchildren **Community services or resources:** *Counsellor	**Family members:** *Helpful because positive, talk to her and they don't have addiction problems *Being around grandchildren makes her happy **Community services or resources:** *Talks to her and can tell counsellor "what's on her mind"
Simon (Interview #14)	58 (Low)	N/A	**Community services or resources:** *AADAC worker, Libby (assumption)	**Community services or resources:** *Facilitated his decision to get into treatment (Lines 25-32)
Ariel (Interview #15)	53 (Low)	N/A	**Family member(s):** Parents and Kokum	**Family members:** *Supported her since the beginning when she was pregnant (Lines 198-201)

Supportive: Social support (SS) during treatment episode

Name of Client	MSPSS Score	Client's Perspectives on SS	SS During Treatment	Examples of how support was provided	How SS affected treatment engagement for client	Treatment centre's or counsellors' perspectives on social support
Maggie (Interview #1)	57 (High)	**Defining SS** *Gives someone a feeling of self-worth (Lines 77-80) **Importance of SS** *If you have a good support, it helps to know that there is support from family and friends who care about you and want you to succeed in life (Lines 80-4) **Condition for receiving help from SS** *Once one accepts that he or she has a problem or is an addict and	**Internal SS: Treatment staff** *Staff *Counsellors	**Internal SS: Treatment Staff** *Client to talk about cravings and withdrawals (Lines 234-8) **Qualities of treatment staff** *The treatment staff has experienced addiction as well and when you talk to them about something, they can relate to you *They do not judge you and do not tell you what to do *They help you by asking what the client feels need and help the client work on that (Lines 310-7)	**Perspectives on how treatment staff as social support help clients' treatment engagement** *Treatment staff is there to help clients and if the staff sees that a client is losing focus on "yourself" and help clients, even if it means telling clients to end intimate relationships *They are helpful because they do not judge and they have done that too *They want the client to work on "you" (Lines 479-92)	N/A

		being honest about that, that is when one's social systems comes in and provide more support (Lines 566-97) *Once you admit you have a problem and being honest, family will provide support (Lines 627-33) *Gave advice to a friend stating that if he was honest about his drug use and admitting it, that is when one's support system comes in and his family would have supported him if he was upfront about it *His family would have provided a bit more support if				

		he told them instead of them finding out from another source and they have been judgmental (Lines 566-99) **Most important SS** *Family is the most important support for an addict *Family became more supportive for client when she admitted she had a problem and honest about it (Lines 625-33)				
Mindy (Interview #2)	38 (Low)	*People provide support in "bettering myself", despite the consequences of addiction by offering her to rides to meeting, doctor appointments	**External supports:** **Family members** *Daughter *Sister **Friends** *Friends from Tennessee **Significant other** *Boyfriend **Community**	**Family members** *Verbal and emotional encouragement *Prayers for client (spiritual) *Daughter* *Implied: She will attend client's marbling ceremony (Lines 301-5)		N/A

		(Lines 98-117) **Importance of SS** *Started to realize that she needs to use her support system and cannot do recovery on her own like she did in the past *Needs to use her community supports such as going to meetings, counsellor appointments, and other places she has to go to *Try to be strong and asserts she can do it on her own, but she needs to use her supports (Line 642-50)	**resources** *Community support worker **Internal supports:** **Treatment staff** *Counsellor *Staff **Clients**	**Friends** Prayers for client (spiritual) **Significant other** *Implied: He will attend marbling ceremony (Lines 301-5) **Community supports** *Community support worker will attend her marbling ceremony (Lines 289-301) **Treatment staff** *Counsellor and staff* *She listens to client and tells the truth instead of having her hear what the client wants to hear in a professional manner (Lines 264-9) **Clients** *When client is going through some stuff, the other clients show support by giving a high five or smile		

				or offer a hug *Other clients give space for a client to "feel it out" (Lines 272-82)		
Adam (Interview #3)	71 (High)	*Social support is important and is needed so that you don't fall or feel overwhelmed (Lines 31-9)	**External SS:** **Family members** *Children (adopted and biological) *Goddaughter **Significant other** *Ex-wife **Internal SS:** **Clients** *Home group **Treatment staff** *Night staff or program attendant	**External SS:** **Family members** *Children are young so they offer support through pictures and phone calls *On Sunday pass, his children waited to put up the Christmas trees and decorations *Since he is in treatment, the older children have been helping out in the house and taking on more responsibility (i.e., helping out with the younger children, making lunches, doing chores) (Lines 120-54) **Internal SS** **Clients** *Home group or	**Clients** ***Helping others***: *Met a lot of friends in treatment and helped them out to identify things that they have missed *A friend in treatment has ***helped him identify his own strengths*** such as pursuing a career in teaching or counselling (Lines 638-44) **Elders** ***Re-connecting with spirituality and culture***: *Helped client find his spirituality again and reconnect with his "Native" culture *Involvement in in cultural activities such as going	N/A

				group therapy provide constructive feedback *Can relate with other clients on life experience (Lines 196-228) **Treatment staff** *Program attendant* *PA came from the same lifestyle (Interpretation: client can relate to PA) *The PA helps him to identify aspects he has missed in group sessions *He also does one-on-one, checking on the client to see where he is at and how he is feeling; provides client with another perspective and more constructive feedback *Elders* *Helped client "find myself to be humble" and care for mankind	outside to tie ribbons, build teepees, smudge ceremony, and working together with other clients as a tribe, which helps for clients to relate to each other ***Being open*** *Feels comfortable around them to talk (Lines 517-54)	

				*Elders are willing to drop what they are doing and talk to clients **Other:** *Employer* *Gave him the time off to attend treatment *Being a male role model to his children while in treatment (Lines 50-64)		
Erin (Interview #4)	66 (High)	**Defining SS** *People who believe in her and have faith in her and help her out if she is helping herself (Lines 41-6) *Wants to be around positive people that have faith and believe in her and people that believe in themselves *Be around people that look after your own	**External SS:** **Family members** *Parents **Community supports** *Financial assistance **Internal SS:** **Clients** **Treatment staff** *Counsellors	**External SS:** **Family members** *Parents* *Helping out with paying her bills (Lines 79-86) *Coming to visit her when she was not granted her Sunday pass *Picking her up on her Sunday pass *They provide positive support *Her parents are happy when she calls and provide her with verbal encouragement	**Family, staff, and clients** *Affect positively ***Focus on treatment program and recovery (implied)*** *Gives client courage, hope, and strength to want to do treatment even more *Having support from family and clients gives client a boost of energy to make positive changes in her life, i.e., not using	*Get a sponsor and surround yourself with healthy people, i.e., non-using, supportive people (Lines 260-2)

		best interest (Lines 269-72) **Condition for receiving help from SS** *People who faith and believe in her and ***help her out if she's helping herself*** (Lines 41-6) *Her parents do not mind helping her out while she is in treatment as long as she is helping herself (Lines 136-7)		*Bring her food into the treatment centre as she does not have a lot of money and her parents do not mind helping her out as long as she is helping herself out (Lines 122-37) **Community supports** *Cover fees for treatment centre, medication, and psychiatrist (Lines 71-9) **Internal SS: Treatment staff** *The counsellors look out for the client's best interest in a positive manner *Provide feedback on the stuff that she shares in an honest manner *They look out for her well-being in that they try to make her feel	drugs, eating healthy, working out more, going to meetings *These healthy habits help the client emotionally, mentally, and physically to think better and they are part of her sobriety (Lines 191-231)	

				comfortable in treatment and doing what is best for her in her recovery *The counsellor did not allow her to go on her Sunday pass because they felt that she was not ready to go, but the client respected their decision (Lines 89-112) **Clients** *Provided support by being friendly, listening to what she has to say, being open-minded, and having respect (Lines 118-21)		
Joshua (Interview #5)	28 (Low)	**Defining SS** *It's huge to have support *Prefers to have one person who understands and supports; to talk to and be open with, and there to listen and not	**External SS:** **Significant other** *Girlfriend **Family members** *Mom *Sister **Internal SS:** **Treatment staff** *The Elders *Counsellor	**Treatment staff** *Feels comfortable talking help from the staff *Counsellor* *Client was feeling lonely being in treatment and could not talk to external supports, so he was forced to		*Implied: Having an aftercare plan and social supports in place after leaving treatment (Lines 548-93)

		fix him *Because he has learned to manipulate as part of his addiction, he needs someone who can call him on his stuff *Someone who has been there (assuming been through addiction) or is aware of addiction so they can call him on his stuff or manipulation (Lines 107-26) *Biggest thing about support is knowing that someone cares enough to do something and it can be the littlest thing like hearing a familiar voice *The person does not have to do something big like move		talk to his counsellor *His counsellor made him do a breathing exercise that made him "get in touch" and feel better (Lines 461-9) *Counsellor allowed clients to use computer room as part of aftercare plan *Counsellor allows for "business calls" (Lines 548-93)		

		mountains (Lines 449-61) **Perspective of SS from family** Importance of family, in that they will always be there for you - "Blood's thicker than water" (Lines 191-4) **Importance of SS** *Interpretation: Having social support is important because in the past, he remembers being standoffish and saying that he can do recovery on his own and doing it on his own through willpower, but it never got him anywhere *Has difficulty asking for help,				

		especially in the past (Lines 147-56) **Condition for receiving help** *Need to be open to asking and receiving support and one cannot refuse it (Lines 161-3)				
Andy (Interview #6)	61 (High)	**Importance of SS** *Interpretation: Client is new to recovery and uncertain about how to define a good support; but meetings appear to be an important form of support (Lines 408-21) *Feels that having support is important for recovery *Recovery is not only for self but doing it for family *You need help in recovery	**External SS:** **Family members** *Mom *Younger brother *Daughter **Internal SS:** **Clients** *Few clients **Treatment staff**	**Family members** *Visit every weekend *Mom and brother cleaned his apartment while he was in treatment *Daughter is special needs: just "loveable" (Lines 208-275) **Internal SS:** **Treatment staff** *They were helpful the first week and a half of treatment by allowing him to use the phone more to talk to his daughter, mom, and younger brother (Lines 736-		*They want clients to have social support and the treatment centre helps connect with people *However, it does not make sense to him if he cannot connect with his family (Lines 999-1016)

		(Lines 915-21)		44) *When he first started the program and did not associate with anybody and they helped him get his self-esteem back and helped work on that with him (Lines 980-92)		
Paul (Interview #7)	64 (High)	**Condition for receiving SS** *Once client started taking his alcoholism more seriously or “battling it”, his dad has been 100 percent supportive (Lines 595-604)	**Internal SS:** **Clients** **Counsellors** **External SS:** **Family members** *Dad	**Qualities of SS** *Interpretation: Someone who has serious recovery and has battled addiction he considers his “higher power” in AA like his dad as a form of support (Lines 756-73)	**Family members** *If it was not for his dad, he would not be helping himself and he would not be where he is at in his recovery if it was not for his dad (Lines 779-89)	
Brian (Interview #8)	67 (High)	*Support plays a huge role in staying sober and not going back to using (Lines 83-6)	**External SS:** **Family members** *Mom *Dad *Siblings (2 sisters and brother) **Internal SS:** **Treatment staff** *Counsellors	**Family members** *Stood by his side *Support from family is the biggest thing for him staying sober at this time (Lines 393-4) **Treatment staff** *Counsellors	*It’s up to the client in who they socialize with in treatment as it is a place full of addicts and what it comes down to is the choices that individual makes and the work ethic	

				provide support and advice and available to have an honest conversation (Lines 347-57)	(Lines 357-71)	
Jonah (Interview #9)	59 (Low)	**Types of SS available** *Supports you get in treatment *Social programs that get you into treatment *Supports from family and friends *Going to meetings *Having a counsellor to keep in touch with (Lines 51-62) *Fortunate in Alberta that there are social programs and government support available to help addicts in recovery (Lines 600-23)	**External SS:** **Family members** *Mom *Aunt **Internal SS:** **Treatment staff** *Program attendants *Counsellor *All the staff (daytime or nighttime) **Clients**	**Family members** **Treatment staff** *Counsellor* *Listening *Genuine and not being fake *Program attendants* *Most helpful because they have told intense stories that give hope as there are other people who have been worse off and succeeded in sobriety (Lines 588-92) *Interacted and learned from people in treatment (Lines 594-9) **Clients** *Interacted and learned from people in treatment (Lines 594-9)		*Go to meetings and find a sponsor *Depends on an individual's situation *Implied: Family dynamics and support varies from client-to-client *For client, the staff encourages him to talk to his family because they are supportive *Go to meetings and build positive social supports that are not negative (Lines 429-46)

Tyler (Interview #10)	82 (High)	**Importance of SS** *He needs to do recovery with his support system, he cannot do it alone; they have saved his live *Realizes that he needs to start utilizing his supports a bit more and learn how to reach out *He has his support system in place but he kept on relapsing because of his stubbornness, ego, and he had a "do it by yourself" attitude *He would not know what to do if he did not have his supports; he would not be in	**External SS: Friends** *Friends from recovery *Ex-girlfriend *Jordan and his girlfriend Gina **Internal SS: Treatment staff** *Program attendants *Counsellor (David) *Spiritual guy **Clients**	**Friends** *Three friends come and visit him at the treatment centre *Ex-girlfriend* *Comes and visits during open meetings on Thursdays and Sunday visits *Picking him up on upcoming Sunday pass **Internal SS: Treatment staff** *Spiritual guy* *Implied: Sees him as a positive role model *Respects him for being humble, soft spoken, and when he speaks in lecture the clients listen to him *Client enjoys hearing him talk *He has taught him some things (assuming spirituality) (Lines 598-621)	*Spiritual guy* *Taught him to find his spirituality and he started praying *Praying has helped him to be humble and stay focus (Lines 598-621)	

		recovery (Lines 1208-24) **Most important SS** *Implied: Family *Does not know how other people can do it without support from family *That is why he supports other people because supports have been important for him in recovery (Lines 1208-24) **Condition for receiving SS** *****People were supportive once he became truly honest about his addiction (Lines 336-43)				
Joanie (Interview #11)	57 (Low)	*Previous attitude towards having supports was negative *It is important to have support	**Internal SS: Treatment staff** *Counsellor, supervisor, treatment staff *The Elders	**Treatment staff** *Allow her to make extra (emergency) phone calls and if she needs something,		

		now while in recovery and is learning to let people in (Lines 308-13) *Having social support is an absolute must (Lines	(Moshum and Kokum) *Program attendant (PA) **Clients** *Roommate and other clients **External SS:** **Friends** *Neighbour	they will comply (Lines 170-5) **Clients** *They have gone through the same thing so they can relate (Lines 166-7) **Friends** *Neighbour checking on her place while she is in treatment		
Anna (Interview #12)	18 (Low)	N/A	**Internal SS:** **Treatment staff** *Counsellor *Kitchen and cleaning staff *Director of treatment centre **External SS:** **Significant other** *Ex-husband	**Treatment staff** *Spiritually motivated *Pleasant outlook, friendly and positive *Director sat with clients during lunch and asking how their programming is going *Staff feel like support, even in the most minimal way *Client feels safe and you know that people care for you at the treatment centre		

				(Line 138-213)		
Eva (Interview #13)	71 (High)	N/A	**Internal SS:** **Treatment staff** *Counsellors *Other treatment staff **Clients** **External SS:** **Family members** *Grandchildren *Son *Brother, sister-in-law and their kids	**Treatment staff** *Counsellors* *They listen to her problems and give her advice *Encourage her to do her work and step one *Make sure work is done *In group, share and let it all out and heal (Lines 25-35) *Provides verbal encouragement *Other staff members* *The staff has been really good and nice. She stated that they are there to support her for her healing. She provided an example that if she meditates when she cannot sleep and the staff has been helpful by setting up one of the group rooms where she can meditate	**Interpretation** *Counsellors facilitate client to work the program (Lines 25-35)	

				Clients The other clients talk about their problems in primary group. She finds it helpful to listen to their problems because she can relate to them and it feels good to know people have gone through the same thing **Family members** *Hearing her "boy's" voice is helpful when she calls *Sister-in-law and family very supportive when she calls them (Line 176)		
Simon (Interview #14)	58 (Low)	N/A	**Internal SS:** **Clients** *Friend *Roommate **Treatment staff** *Counsellor *Program attendants (PA)	**Clients** *Friend* *"Buddy in arms" *Both had the same attitude coming into treatment of not doing program on their own (i.e.,		*Very gung ho about having as many social supports as possible *It's good to have many supports just in case someone doesn't pick up, one of them could prevent someone from relapsing *Having healthy friends to do

<table>
<tr><td></td><td></td><td></td><td></td><td>hating everything and not wanting to no anybody)
*Initially in treatment both secluded from the other clients and chatted only with each other to find out that they had the same family background growing up
*They know where they are coming from
Roommate
*He is very calm
*Provided example of how he was pissed off and roommate would calm him down and rationalize with what the problem was
(Lines 203-55)
Treatment staff
Counsellor
*Calls him on his “shit”
*He understands and knows where addicts come from</td><td></td><td>clean and sober activities
(Lines 778-93)</td></tr>
</table>

				as he was an addict at one time *Client provided examples of how he was trying to cut down on swearing and he was swearing in the morning and his counsellor reminded him that he wanted to cut down on his swearing *He provided another example of how his counsellor calls him on his stuff if he is not focusing in group *Program attendants* *Great people *Have been through what the clients have been through *PAs' share their stories, how they dealt with stuff and did not deal with stuff (Lines 985-996)		

Ariel (Interview #15)		N/A	**External SS:** **Family members** *Parents *Kokum (grandma) *Brother **Friends** *Friend **Internal SS:** **Treatment staff** *Counsellor *Moshum and Kokum **Clients** *	**External SS:** **Family members** *Parents and Kokum are taking care of her daughters while she is in treatment *Send her money for smokes and whatever she needs *Pay her phone bills *Talk and encourage her *Family come and see her and pick her up on her Sunday passes *Friend* *Although this friend has not come to physically visit in the treatment centre, she sends messages to see how she is doing over the Internet (via Facebook) **Internal SS:** **Treatment staff** *Counsellor*		

				*Talking to her and she knows what to say *Gave her a book called "The Black Swan" on healing for loss of a loved one *She had a bad day and felt like leaving and her counsellor talked her out of it *Moshum and Kokum* *They provide good teachings and client is learning from them every day *Clients* *They became close since day one in treatment *The friend marbled out before her and she came to pick her up on her Sunday pass		

Non-Supportive: People who are not supportive, not *"there for you"*

Name of Client	MSPSS Score	Client's Perspectives on people not providing support (General comments)	Types of people not supportive prior to treatment	Examples of how people are not support supportive prior to treatment	Types of people not supportive during treatment	Examples of how support was not provided
Maggie (Interview #1)	57 (High)	N/A	**Family members:** *Some family *Mom *Parents **Friends:** *Some friends	*Some friends and some family would said they were supportive but they were judgmental and wondered why she could not stop using (Lines 129-131) **Family members:** *Mom* *Did not understand her daughter's addiction and did not feel that her gambling addiction was the same as her daughter's addiction (Lines 136-41) *Mom would talk badly about her and did not		

				understand what she was going through and the addiction *Didn’t think her gambling addiction was the same as drug addiction (Lines 183-92) *Parents* *They judged her for not caring for her own daughter and did not understand the “sickness” as a result of addiction (Lines 178-82)		
Mindy (Interview #2)	38 (Low)	*Choosy about who she gets close to *If somebody had nobody while in treatment, it could feel lonely and sad	**Family members:** *2 brothers *Mother **Friends:** *”Street friends”, “Street associates”	**Friends:** *Part of the lifestyle where street friends say that they are there for you, but they are not there because they cannot help themselves *These friends are not there in certain situations and they are not supporting someone to go to treatment		

				*They want more money or more drugs (Lines 319-34)		
Adam (Interview #3)	71 (High)				**Treatment staff:** *Counsellors	**Treatment staff:** *Interpretation: Affected how he engages in his treatment program (refer to "Treatment centre programming affecting treatment engagement" table)
Erin (Interview #4)	66 (High)	*Being around people that use could tempt her to use and be around negativity and take on that negativity (Lines 267-70)	**Friends:** *Few friends still caught up in addiction	**Friends:** *Continued to use drugs with friends and did not encourage her to stop doing drugs or to do better for herself (Lines 132-7) *Using drugs with her and not giving positive energy *Their negativity rubs off on her (Lines 152-9)		
Joshua (Interview #5)	28 (Low)	*If not getting supported (from extended family), then he is backing off (Lines 534-43) *Did not want to identify friends or	**Family:** *Extended family **Friends** **Other:** *Self	*People not respecting him to be clean *Using and drinking around him *Pushing recovery on him because it is unattractive	**Family:** *Mom	**Family:** *Because family is caught up in addiction, difficult to go on Sunday pass because he wants to fix things (Lines 218-28)

		acquaintances as people who are not supportive because he would not let them get too close to him to get hurt or use him *Need to find recovery on his own *Need to be open to having people push recovery on you but it's hard at first because difficulty trusting other people (Lines 352-85)		(Lines 372-80) **Family:** *Extended family* *Family were drinking when he was trying to get clean, but they continued to drink around him and he didn't feel strong enough to be around the drinking (Lines 334-51) *Sister* *He was cleaning up but sister was using; he couldn't be there for her to avoid co-dependency (Lines 197-210) **Other:** *Put up own barriers that affects him to move forward or back (Lines 529-34)		
Andy (Interview #6)	61 (High)	*It hurts and bothers client *People are not supportive, then not friends (Lines	**Family:** *Older brother *2 older sister *Not very close with the above family members		**Family:** *Past treatment experience these family members have come to visit him at the last	**Family:** *Thought these family members would be more supportive, because mom and brother are really supporting him this time as he is "shooting

		*Understands why these family members are not supporting him currently because *People giving up on him	because drifted apart **Friends:** *Some friends		treatment centre, including his ex-wife *Some friends and family having doubts that he would finish this current treatment episode	for the stars" (Lines 562-6) *Called brother over Christmas and he brushed the client off (Lines 571-8)
Paul (Interview #7)	64 (Low)	N/A	N/A	N/A	**Family members:** *Sister	**Family members:** *She provokes him and going out of her way to make negative comments that were bothersome to client *At the same time, she was supportive by respecting his sobriety and not drinking in front of him while he was on his Christmas pass *Not talking about what he is doing in his sobriety (Lines 697-732)
Brian (Interview #8)	67 (High)	*Support from family is the biggest thing for staying sober at this time (Lines 393-4)	**Friends:** *"Acquaintances"	**Friends:** *Needed you when they needed something *When things started getting worse in his life, like getting involved with the law, none of these people were there *These people are		

				only there for the drugs and alcohol *Hard to come across people who are truly honest and there for you (Lines 374-94) *Mixed support from friends; the ones that were supportive, they did not have the best intentions (Lines 183-99)		
Jonah (Interview #9)	59 (Low)	*Someone who knows nothing about addiction and thinks that an addict can quit on his or her own *They are misinformed or ignorant people (Lines 166-72)	**Friends:** *Using or drug friends **Other:** *Co-workers	**Friends:** *He used them and they were using him *They really weren't his friends – associated with them *They don't support you, they're chasing the high (Lines 183-96) **Co-worker:** *They used as much as he did *He used them for drugs (Lines 241-51)		

Tyler (Interview #10)	82 (High)	*People throwing stuff down his throat (Line 97-9)	**Friends:** *Friend from last summer *Old friends *Ex-girlfriend of 9 years *Friend at previous treatment centre	**Friends:** *Friend from last summer (implied)* *Does not practice what he preaches about recovery – he is hypocritical (Lines 111-7) *Relapsed with a friend (Lines 79-82) *Old friends* *These friends "used" him *Didn't care about him *Liked him because he provided booze and drugs (Lines 665-81) *Ex-girlfriend* *Made him feel guilty when he was seeking treatment *She doesn't understand that he's in recovery and there was an instant where he relapsed with her *Friend at previous treatment centre* *He acts like he's		

				there for him, but he wants something *Provides example of how friend was there to get him to use *Drags him down and is not a friend (Lines 726-82) *There are not a lot of bad influences here in Alberta. At times he does reminisce about old times with friends in B.C. (Lines 786-95)		
Joanie (Interview #11)	57 (Low)		**Friends:** *Ex-boyfriend that she met in SMART Recovery	**Friends:** *He was going to meetings, but he was using and she ended up slipping a couple of times *He didn't "walk the walk" *He was not a healthy person (Lines 40-82)		
Anna (Interview #12)	18 (Low)	*Not really supportive* *Speaks to her brother, but she does not share	**Family:** *Family members *Mom	**Family:** *Family members do not want to speak to her anymore (Lines	**Family:** *Family members (did not specify)	**Family:** *They do not speak to her anymore (Lines 515-6)

		her problems with him *Come to the realization that she has to find her own supports through professional staff and new friends (Lines 522-26)		515-6) *Mom* *Only support that speaks to her, but they have a very toxic relationship *Hard to find and believe in self-love and self-forgiveness if mom is too critical (Lines 517-30)		
Eva (Interview #13)	71 (High)	N/A	**N/A**	**N/A**	**N/A**	**N/A**
Simon (Interview #14)	58 (Low)	*Realization that he has to go through recovery on his own	**Family:** *Most of family members *Mom	**Family:** *Most of family members are addicts (681-92) *Toxic relationship with his mom as they feed off each other (Lines 944-8)	**Family:** *Mom and stepdad *Aunt and uncle	**Family:** *Mom is negative when he calls her and they have arguments on the phone *Aunt and uncle were supposed to visit him on two Sundays but they did not come to visit or pick him up both times (Lines 391-4)
Ariel (Interview #15)	53 (Low)	N/A	**N/A**	**N/A**	**Friends:** *Old friends	**Friends:** *Continue to drink and invite her to party when on Sunday pass

Treatment Engagement: 'Working the program'

Name	Examples of how client is actually engaged in his or her own treatment program	Examples of how client is not engaged in his or her own treatment program	Perceptions on treatment engagement	Perceptions of how other clients are engaged in treatment program	Perceptions of how other clients are *not* engaged in treatment program	How other clients' level of engagement affects treatment program	Memos
Maggie (Interview #1)	**Learning about self** *Work on self: Self-help to realize where addiction started, past traumas to make an addict keep using drugs (Lines 195-8) *Dealing with mother's death *Abandonment issues with her father **Sharing, being open and honest** *Being open and honest with self *Shared Step 1 and personal stuff with group (Lines 436-2) *Sharing experiences in addiction and past treatment experiences with other clients *Has held on to past		**Motivation for treatment: Self and family** *Wants treatment to work for herself and her family because she cannot blame her addiction anymore (Lines 53-67) **Admitting that one has a problem** *Implied: Client needs to come to terms or ***admit that they have a problem or an addiction*** (Lines 573-8)		*Implied: Provided an example of younger clients who were romantically involved and not focusing on their treatment program (Lines 482-502) *Clients are not ready and goes hand-in-hand with being in denial, when one does not think that he or she has a problem (Lines 505-14)		*Developing trust among clients *Clients being supportive to other people

	traumas, so is letting go in this treatment episode *By opening up, that helps other clients open up (Lines 431-476)						
Mindy (Interview #2)	*"Full force" *Very honest *Completing assigned work *Working on self and learning skills to develop self *Doing what the counsellor feels that she needs to work on *Enhances client's self-awareness (loving and forgiving self) *Journaling (Lines 462-501) *Trying to focus on self and not what's going on outside (Lines 357-64)	*Client's perception: Definitely involved in own program (Lines 537-9)	*How badly do they want help? (Lines 580-1)		*Tell by their attitude *Not following rules *Doing things their way (Lines 539-561)	*It does and it doesn't – become more negative and focus on others (Lines 566-9)	*Working on self through the treatment program *Developing personal skills (HP principle)
Adam (Interview #3)	*More self-awareness, for example with co-dependency issues and how he relates with other people in his family **Learning new skills and tools**		*It's up to the client whether he or she is ***willing*** to put the work into his or her treatment program *You need to be ***willing and want to be in treatment*** to		*Some clients are forced to come to treatment (Lines 552-63) *If forced or court-ordered to come to treatment they are not willing to be		

	**Learning and realization* of the need to take time for himself by being selfish to work on himself and rediscover leisure activities that he enjoyed before his addiction and responsibilities in life took over (Lines 322-64) *Open with other clients, which may help other clients communicate *Relates to peers and has a lot of life experience which may help other clients bring out their own feelings *Open to life experiences, what he is feeling, and why he used (Lines 496-510)		make some major changes *Clients need to want and to be willing to be in treatment and work their program *It's up to the client whether he or she is ***willing*** to put the work into his or her treatment program (Lines 552-62) *You need to be willing and want to be in treatment to make some major changes *Clients realize that they have a problem and they take control of their own treatment and are willing to do the work on themselves (Lines 567-9)		there or work their program (implied) (Lines 561-9) *Can tell if someone is not engaged in his or her program by attitude, respect level, "floating through" the program, and not putting in as much input or participation (Lines 570-6) *Some clients are forced to come to treatment (Lines 552-63)		
Erin (Interview #4)	*Getting stuff out *Dedicated to program: showing up to class; participating in activities (e.g., recreation, arts and crafts); being respectful ; and being honest with self and		**Motivation for treatment: Being in treatment for self** *Need to be in treatment for ***self*** (Lines 286-313) ****Wanting*** to go treatment to help self or ***willing*** to work the		*Clients at treatment centre for court or their kids *They did not choose to attend treatment and are only doing the program to get certificate to prove		*By engaging in the program by learning more about issues and self, clients learn various skills that are intended to improve their life after treatment

	others (Lines 174-91) *Learning to eat healthy and exercise regularly (Lines 211-15) *Learning more about yourself , self-esteem, how to love yourself, and how to respect others (Lines *Implied: Learning more about the reasons or the root of her issue of why she used in the first place that led her to have a “dysfunctional” attitude or personality (Lines 308-23) *Eating healthy, having a good sleep, being physically active, and improving on communication with other people *Learning how to listen to other people’s feelings and feeling more comfortable (Lines 359-66) *More open-minded *Learning more about self is giving other		program (Lines 539-43) **Characteristics of being engaged** ****Willing*** to be open – talking about past issues and feelings (Lines 329-347) *Clients need to make the ***initiative*** to be in treatment for yourself and want to do it for yourself (Lines 291-3) *If a client works the program, he or she will benefit and get something out of the program (Lines 298-304) *You have to be ***willing*** to be open because that is the only way to succeed in the treatment program *Need to be open to talk about things that were kept hidden *Being able to come out and talk about feelings, past issues, and family issues to allow the client to overcome these issues		to the courts they are helping themselves but does not know if they are really doing treatment for themselves; they just want to look good in court *If in treatment for something else and not for yourself, then it becomes harder to deal with the life in sobriety as life continues on after court (Lines 279-304) *Implied: Treating counsellors like they owe the clients or to fix or be on the client is not helpful for treatment program; a client can say what the counsellor wants to hear, but that does not do well for the client (Lines 176-86)		including life skills, improving communication skills with other people

	people (her parents) the “true me”, making it easier to communicate and be honest with her parents (Lines 441-20) *Feels good to get things out and move forward in the right direction (Lines 548-51) *Opening up and learning about herself, she is helping her parents out. By letting things out, this is making her a positive person. By helping self, she is helping her parents (Lines 390-405)		and move forward (Lines *You have to be willing to help yourself or work the program and let out the secrets that make you sick. A lot of people are not ready for treatment and it depends on if clients are ready (Lines 538-42) *“Working the program” means helping self (Lines 545-8)				
Joshua (Interview #5)	*In the evenings, prays at night, reads the bible, and listens *Take part in ceremonies (i.e., sweats) *Connecting with the Elders when he has problems (Lines 605-19) *Tries to do assignments *Step work (working			**Perspectives on focusing on self** *Changing for yourself is different than changing for someone else because that defeats the purpose of going to treatment or	*People coming from jail – he can relate to these clients because he was that client once in the past (Lines 680-702) *People that have to be in treatment (Lines 704-6) *Poor attendance; complaining about the place; poor attitude; not helping		

	on step one) *Attend sessions that he is asked to do *Listens *Tries to help out *Tries to pray to God in ceremony			working on yourself (Lines 706-18) *Clients who are in treatment that want to make a change *Clients get something out of treatment even if it's just watching other clients change (Lines 719-21) *If a client starts 'working the program', attitude starts to change; thinking starts to change and become ***selfless*** and less self-centred and then recognize that the treatment centre is there	out with dishes; etc. *Some people isolate, clown around, be disruptive during sessions, or start a relationship *People get scared and don't want to look at things; they are inconsiderate *These change if clients 'work the program' (Lines 729-54)		

				for the client. *The client becomes part of the treatment centre and start to helping out *Reaching out to ask for help and wanting to make a change *Selfless means for someone who wants help, more willing to help, and is getting something (Lines 748-801)			
Andy (Interview #6)	*Supporting the new clients that come in *Working on self to develop self-esteem; more self-awareness *Show gratitude and being proud (Lines 1029-1073) *Giving advice to other clients on how to stay focused in the	*After first week in treatment, he wanted to leave *Feeling isolated *Mixture of feelings: nervous, shutting	*Varies at different phases in treatment (Lines 1070-81)	**Motivation for treatment** ****Focusing on self*** but treatment is also to ***help his family*** who are important social supports	*Can tell by attitude (Lines 1074-84)		*Developing personal skills (HP principle)

	program based on his experience (Lines 1129-1136) *Learning skills (Lines 1095-1124) *Working on issues such as self-esteem; develop self-esteem *More self-awareness *Gratitude and to be proud *Learning to communicate better *Think better *Taking better care of self (eating) (Lines 1089-1117)	down, stressed, and overwhelmed *Thought treatment centre was a joke (Lines 683-726) *Show up to learning sessions but not involved or “paying attention” (Lines 1089-1095) *Was not following anything; not doing homework; kept to self (Lines 750-60) *Implied: Client was “bothered” and overwhelmed with what was going on in treatment (i.e., other		**_*He is in treatment not only for himself, but for family as well_** (Lines 909-40) *Can tell by attitude (Lines 1074-1084)			

		clients) and was not focusing on treatment program *The first week in treatment he wanted to leave. He came to the realization as he progressed through the program that he needed to focus on himself (Lines 678-89) *After two weeks into treatment he decided to focus on himself because he was not focusing on his program *He needed to focus on himself and not worry					

		about other people (assuming other clients) or internal factors (Lines 746-52)					
Paul (Interview #7)	***Implied:** Smudging has helped to let things out (Lines 1042-9)	N/A	*Previous treatment centre, other clients entered treatment on their freewill ***Implied:** that forced to go to treatment they were not serious about treatment) (Lines 426-43) *You have to be ***willing*** to work on yourself *Must do the work (Lines 1170-81)		*Clients who are court-imposed do not take their addiction seriously (Lines 426-43) *Come in late *Do not attend sessions *Lack of wanting to focus on program *Attitude (Lines 1144-61)		
Brian (Interview #8)	*Putting in what you put in *Hard work		*Interact with clients on a daily basis and can be helpful (implied) to talk about recovery, but it can be "chaotic" at times with being around addicts, it comes down to the choices the individual makes with respect to the who you associate				

			with, what topics are discussed in group, and what activities you participate in that reflects who you are but more importantly your work ethic (Lines 357-71) *His support from family play a role in keeping him sober, but at the end of the day it ***comes back to the individual and what the individual wants*** *Have to do recovery ***for yourself*** and not for anybody else ****Need to be selfish*** while in treatment for the next three months so that it helps him out for the rest of his life, ***putting all he can do now*** and ***not worry about what is going on outside of treatment*** ****"It's all about me"*** *Being in treatment he realizes that he has to do it for himself, although self-centred,				

			you need to focus on yourself to improve important and positive qualities that helps you in the future (Lines 406-30) *Need to do treatment for self and nobody else; need to be selfish *The more you focus on yourself, the better your life will be in improving your own life *It's important to mainly focus on yourself while at the treatment centre, but at the same time it is important to talk to outside people, but need to find a balance; there is no need to talk to family every night (Lines 515-53) *Being in treatment is about hard work and focusing on yourself *You get guidance from the counsellors and the staff, but at the end of the day it's				

			about what you put into the program (Lines 540-53)				
Jonah (Interview #9)	*Forces himself to write in journal *Keep mind busy *Working out everyday *Force himself to talk at meetings *Do readings *Developed public speaking and self-confidence (Lines 476-83) *Learning how to cope with different personalities (Lines 391-411)	*Slacking a bit *Letting drama in treatment bother him (Lines 450-69) *He hasn't completed his lifeline *Jokes around *Mean to other clients (Lines 508-13)			*Younger clients and maturity level *Joke around *Late for and missing sessions *Complain (Lines 514-26)	*Initially let the drama from other clients bother him (Lines 391-411)	
Tyler (Interview #10)	*Speak up lectures *Share experiences with other clients (i.e., younger clients) to share where he went wrong in early recovery and why he relapsed *Remembering where he came from (i.e., addiction) *Helping out in the treatment centre (e.g., dishes	*Implied: Internal distractions in treatment makes him lose focus *He is at the treatment centre for treatment and it is only 42 days so he has to put the work into it	*Chose to be at the residential addiction treatment centre to focus on self as it is hard to focus on recovery in the outside world *Spending time in treatment by himself helps to focus on his own recovery rather than getting caught up in stuff inside treatment as well.			*Doesn't learn from other clients when they share their "war stories" *Chattering during sessions from other clients is distracting and he loses focus on his program (Lines 483-	

	*"Me time" in room and read recovery literature *Working *Going to gym and playing sports (Lines 1012-1091)	and if he's not focusing or putting the work in, what's the point? (Lines 521-31)	(Lines 1035-1091; 1115-31)			508)	
Joanie (Interview #11)	*Further spirituality (Line 302-4) *Journaling *Focusing/working on self *Connecting to self, being self-sufficient, genuine, honest, and comfortable with self (Lines 335-42) *Learning about what relationships are healthy and not healthy *Learning and practicing to ask for help (Lines 371-83)	N/A				*Younger clients make it hard for her to concentrate and is frustrating *She wanted to drop out of treatment because she was so frustrated with other clients (Lines 391-407)	
Anna (Interview #12)	*Having faith and higher power (Lines 71-103) *Working on aftercare program (Lines 391-421)	N/A	*Implied that working on aftercare program is important part of treatment engagement *Individualizing program to meet needs (Lines 362-421)		*Younger clients, but they drop out of treatment (Lines 989-1015)	*Finds younger clients to be disruptive during sessions (Lines 988-1011)	

			*Looking forward rather than seeing self as “sick” *It is about healing, being optimistic, and recovering at this treatment centre (Lines 111-25)				
Eva (Interview #13)	*Meditation and learning to cope with her emotions and anxiety (Lines 44-9) *Participating in spiritual/cultural activities which helps her to share with others and let go of pain and other emotions (154-66)	N/A					
Simon (Interview #14)	*Learning about the root causes (Lines 67-75) *Finding a higher power and connecting spiritually (Lines 133-62; 185-99) *Working on aftercare program (Lines 80-90) *Saying the Serenity Prayer (Lines 109-21)	*Doesn’t have a sponsor *Sometimes has a bad attitude towards other clients (Lines 701-21)	**Motivation for treatment** *Doing the program for himself because he is tired of walking away from work with all the money he has earned and wasting it away and nothing to show for *He wants to be a positive role model for his younger sister and the rest of his family who are also	*Described how one girl was “working the program” – completes homework, helps and supports others, and constantly busy (Lines 734-9)	*You can just tell by attitude *They are the ones who are most likely to relapse (Lines 268-74) *They are wanting to leave the last week of treatment *Attitude and behaviour indicates whether they will relapse or not (Lines 841-7) *Clients forced into	*Finds it distracting and making it difficult for him to focus on ‘working his program’ at times (Lines 277-329) *Doesn’t want to associate with those individuals who are not focused on	

			addicts (Lines 622-690) *Not everyday people are going to 'work the program' and feels there should be allowances for that (Lines 739-51)		treatment by parents or drug court (Lines 813-18)	program and are going to relapse (Lines 268-74)	
Ariel (Interview #15)	*Praying and smudging more (Lines 90-2) *Work on steps and focus on self (Lines 555-72)		*Taking care of physical health, being clean and sober *Having a sense of contentment (Lines 634-6)		*Not attending smudges and sessions (Lines 1039-40) *Provided an example of other clients starting drama (Lines 1037-60)		

Connecting with external people or social support while in residential addiction treatment

Name	Perspectives on connecting with external social support	Explanation or rationale for connecting or not connecting with external social support and how it affects treatment engagement	Memos
Maggie (Interview #1)	Minimal contact (implied)	**Negatively affects treatment** *She wants her daughter to be more educated about addiction and drugs but does not want her daughter to be involved in her treatment program. Her daughter may say something that could hurt and affect her treatment and the work on herself (Lines **Away from outside influences** *Needs to be in this residential treatment centre to "work the program" to stop using and be "away from the outside influences" 334-43)	**Interpretation** *To focus on self, there is a need to be in residential addiction treatment to be away from external influences *Having her daughter involved in her treatment program would affect her treatment
Mindy (Interview #2)		**Away from outside influences** *Really ***focusing on herself*** and ***try not to focus on what is going on outside*** even with her daughter being back in Canada especially that this is only a 42-day program and short *She is only allowed two phone calls per week (Lines 350-64)	**Interpretation** *Implied: Limitations on phone calls and contact (i.e., Sunday visits and passes) to connect to external social supports important for focusing on self
Adam (Interview #3)	Contact	**Family responsibility** *In client's case, he needs to keep in touch with family as he has younger children	
Erin (Interview #4)	Contact (implied)	**Contact** *Her parents see that she is working on herself and by seeing evidence that she is helping herself, her parents will help her out (Lines 367-81)	**Interpretation** *Focusing on own program, will benefit people or supports outside of treatment *Focusing on self, the client starts to make behavioural changes *Perspective that being in treatment for yourself benefits that person *Focusing on self helps with engaging in treatment or "working the program"

			See below “Ways Clients connect to outside people or supports”
Joshua (Interview #5)	Mixed: No contact and contact	**Focus on treatment** *Understands that reasons for restrictions on personal phone calls so that clients ***remain focused on their treatment program, rather than outside world*** (Lines 596-9) *Expressed that his family and girlfriend could be more supportive while he is in treatment if he did not have any contact with them because the ***client easily “unfocuses” on himself and focus more on them*** *Easy to focus on issues outside of treatment; witnessed some clients who let outside stuff “mess” them and ended up leaving treatment (Lines 841-94) **Learning to cope** *Treatment centre may be ***beneficial for dealing with outside stuff (i.e., issues) in a safe environment*** like the treatment centre (Lines 839-95)	**Interpretation** *Focusing on “self” ties into treatment engagement *Policies and rules around phone calls helps clients to focus on their treatment program rather than what is going on outside; the polices and rules are in place to help clients engage in treatment
Andy (Interview #6)	Contact	**Need for social support** *For client’s situation, his family is the most important social support for his recovery *Need support in recovery (Lines 909-40)	**Interpretation** *Limited contact with his external social supports negatively affected his treatment engagement (Lines 909-40) *Initially not focusing on the program, resulting in the client to be not engaged in his treatment program *Phone policies to connecting to his important supports outside of treatment when he was feeling overwhelmed and secluded while in treatment affected (i.e., hindered) his treatment engagement. As a result, he was not to focusing on himself. *However, the treatment centre allowed him more phone calls initially because he was not engaged and that helped him *The levels of focusing on “self” fluctuate

			throughout the program;
Paul (interview #7)	N/A	**N/A**	
Brian (Interview #8)	Mixed: Some contact, but mostly need to focus on self	**Focus on program** *He needs to ***focus on his own program*** the next three months and not the outside influences, ***to help him for the rest of his life*** *Do all the work now and not worry about the outside influences (Lines 406-29) *It's important to ***mainly focus on self***, but it is still important to talk to outside people, but need to find a balance. *However, there is no need to speak to your family supports every night (Lines 515-53)	**Interpretation** *Focusing on self is important to make changes in behaviour *Contacting outside people negatively affects treatment program, i.e., not focusing on self *Residential treatment focuses on the individual level *Important to focus on treatment program now so that you develop skills to deal with outside and have a better future
Jonah (Interview #9)	Mixed	**Maintain contact with external SS** *Contacts mom once a week and speaks more to his mental health nurse. Personally he does not need to keep in contact with people outside *Since he has no material things and nobody (i.e., significant other or children), and does not feel the need to contact his brother while in treatment, being in treatment is about "me" (Lines 337-42) **Perspective on connecting to external SS** *Understands that it is ***important for other clients to contact outside people, especially if they have children or a spouse/partner*** (Lines 329-50) **Focus on self** *Does not need to contact outside people as he does not have his own children and his best friend is overseas and it's about ***focusing on himself*** *He has nothing to worry about, but himself (Lines 329-52)	

Tyler (Interview #10)	Contact	**Focus and refocus on treatment** *Important for him to contact his external supports because the clients in treatment right now are new to recovery. He is not new to recovery, so when he talks to his friends in recovery, he gets recovery base rather than using and war stories ****Talking to his external supports or recovery friends grounds him*** *It helps to be in contact with his friends who have solid recovery while in treatment because it ***reminds him of where he once was and where he can go*** (Lines 208-42) **Using supports within treatment** *He has not kept in touch with his sponsor since being in treatment and should use his counsellor right now while in treatment *He ***gets more from connecting with his friends and family right now while in treatment***, it helps him feel like he's not in treatment, even when he is talking on the phone (Lines 399-407) *He gets distracted by the other clients during lectures where he does not pay attention; he also gets caught up in the war stories and the bad attitudes of other clients; however, when he ***connects with his friends he focuses on his recovery and the direction he needs to go in his recovery*** (Lines 483-519) *When he is having a bad day in the treatment centre, if he has the opportunity to *Because of the distractions from other clients in treatment that affects the treatment environment, ***when his friends come to the treatment centre, it helps him re-focus*** *It's beneficial for him to have access to his positive outside supports but understands why the treatment centre monitors so that clients can focus on their own recovery *But for him it reassures him the people he has out there (Lines 841-58) *Sundays when visitors are allowed to come to the treatment centre is ***helpful and seeing other clients interact with their families*** is helpful	*Other clients appear to negatively affect his focus on his treatment program (Factors affecting treatment engagement – other clients)

		to see as it is inspirational to him and makes him feel happy since his family is a positive support for him (Lines 208-42; 841-58) *Going to outside meetings and connecting with people in recovery in the rooms is helpful as it makes him feel at home and comfortable where he can be open and share with other people. Going to outside meetings have been helpful for keeping him in treatment during times that he wanted to leave *Important for him to connect with his outside supports or he would have left treatment (Lines 930-1005) **To leave the treatment centre** *Going to outside meeting to leave the treatment centre so that it does not feel like he is secluded in treatment **Contacting external SS negatively affects treatment engagement** *He contacted another ex-girlfriend and they had an argument leaving him angry and he wanted to leave treatment (Lines 832-40) *Understands why the treatment centre limits access to outside world because in treatment you need to focus on self (Lines 851-8)	
Joanie (Interview #11)	*Minimal contact *Mixed	**Focus on self** *Not really connecting with people from the outside because using time in treatment centre as "me time" *It's too hard to connect with people and she is used to doing things on her own (Lines 197-208) *It is not as important to connect with outside people when in residential addiction treatment because it is important to focus on yourself (i.e., connecting with self; feeling honest, genuine, comfortable, and free in self; and learning to ask for help; lines 365-72) **Perspective on connecting to external SS** *Only contact outside people if they are healthy (Lines 209-22) *Good to connect with supports while in residential treatment for continuity and transition when leaving treatment (Lines 280-8)	

Anna (Interview #12)	Mixed: Depends on situation	**Focus on self** *Personally for her to connect with her son, she has made the decision to pull back because if she contacted her son regularly, ***her focus would move away from her to him, resulting in hindering recovery*** *Connecting with outside supports or family depends on the family dynamics and it varies from client-to-client (Lines 669-716) *If she had more visits with her son, that would affect her treatment program to focus on her as she would be shifting her attention on her son rather than focusing on herself *It's nice to have visits from outside supports sometimes as it is good to see that people outside are doing well *Feels that it is important for some clients to connect with the outside world to help them build strength to get through the week in the treatment centre (Lines 837-68)	*Evidence that the treatment centre is flexible and tailors program for client
Eva (Interview #13)	Mixed	**Remain contact with family** *Important to contact family members once in a while, but at ***the treatment centre to focus on yourself***. **Perspectives on connecting to external SS** *Sees other clients calling external people and they get upset and feels that it interferes with their own treatment **To leave the treatment centre** *Although she does not have any of her family members come visit her on her Sunday passes, she thinks that is ***good and nice because you are "trapped" in treatment***. Leaving the treatment centre on Sunday passes is good for getting out of the treatment centre.	
Simon (Interview #14)	Mixed	**Perspectives on connecting to external SS** *Sees that for other clients that is important for them to connect with their family to keep them sober **Additional support** *Personally for him his two friends he met in treatment and meetings is all he needs for support *It would be important for him to connect with his two friends he met	

		in treatment when they leave, but it would devastate him if they relapsed, but would be more affected if they didn’t answer his calls (Lines 539-86)	
Ariel (Interview #15)	Contact	**To leave the treatment centre** *Sometimes it feels like being in “jail” *It’s good to leave the treatment centre or “we’ll all go crazy” (Lines 773-82) **Spending time with family members** *She likes to spend time with her family as she barely sees them since she’s in treatment (Lines 773-97)	