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QUALITATIVE EXPLORATION OF RELATIONSHIPS BETWEEN PEERS IN RESIDENTIAL ADDICTION TREATMENT

ABSTRACT

Relationships between peers are often considered central to the therapeutic process, yet there is relatively little empirical research either on the nature of peer-to-peer relationships within residential treatment or on how those relationships generate positive behaviour change or facilitate recovery. In this paper, we explore relationships between peers in residential addiction treatment, drawing upon the concept of social capital to frame our analyses. Our study was undertaken during 2015 and 2016 in two English residential treatment services using the same therapeutic community-informed model of treatment. We conducted 22 in-depth interviews with 13 current and 9 former service residents. All interviews were audio recorded, transcribed verbatim, coded in MAXQDA, and analysed using Iterative Categorisation. Residents reported difficult relationship histories and limited social networks on entry into treatment. Once in treatment, few residents described bonding with their peers on the basis of shared experiences and lifestyles. Instead, interpersonal differences polarised residents in ways that undermined their social capital further. Some senior peers who had been in residential treatment longer acted as positive role models, but many modelled negative behaviours that undermined others' commitment to treatment. Relationships between peers could generate feelings of comfort and connectedness, and friendships developed when residents found things in common with each other. However, residents more often reported isolation, loneliness, wariness, bullying, manipulation, intimidation, social distancing, tensions, and conflict. Overall, relationships between peers within residential treatment seemed to generate some positive but more negative social capital; undermining the notion of the community as a method of positive behavior change. With the caveat that our data have limitations and further research

is needed, we suggest that residential treatment providers should more routinely open the ‘black box’ of ‘community as method’ to consider the complex and dynamic nature of the relationships and social capital inside.

KEYWORDS

Qualitative research; recovery; residential treatment; social capital; substance use.

What is known about the topic

- Relationships between peers are considered central to successful treatment in residential addiction services.
- Social capital, comprising bonding and bridging capital, is an aspect of recovery capital that helps to initiate and sustain recovery from addiction.
- There is little empirical research on the nature of peer relationships within residential treatment settings, including how they generate positive behaviour change or social capital.

What this paper adds

- Residential treatment clients struggled to form relationships with peers who were different from themselves.
- The residential therapeutic community setting seemed to generate more negative than positive social capital.
- Residential treatment providers can increase their residents’ recovery resources by pro-actively fostering pro-social peer relationships within the treatment setting.

QUALITATIVE EXPLORATION OF RELATIONSHIPS BETWEEN PEERS IN RESIDENTIAL ADDICTION TREATMENT

INTRODUCTION

In this paper, we explore relationships between peers in residential addiction treatment, drawing upon the concept of social capital to frame our analyses. Within residential addiction treatment, relationships between peers are often considered central to the therapeutic process; facilitating the day-to-day operation of services and underpinning residents' recoveries (De Leon 2000, Melnick & De Leon 1999). Indeed, many residential treatment services adopt an explicitly relational approach to treatment, with the treatment community itself described as the 'method' or mechanism for behaviour change (De Leon 2000). For example, residents in therapeutic communities (TCs) are encouraged to use the 'community' to learn about themselves, change themselves, and effect change in others (De Leon 2000). Likewise, twelve-step treatment programmes offer residents support from a peer in recovery (known as a 'sponsor'), an arrangement explicitly designed to help both parties attain and maintain sobriety (Alcoholics Anonymous 2001). Via such strategies, people in residential treatment are expected to help each other, role model positive behaviours, attitudes and expectations, and monitor each other's conduct (De Leon 2000, National Treatment Agency 2006, Scott 2010).

Research suggests that peers receiving support from others during residential treatment (either from within the programme or from external sources) have better treatment retention and completion outcomes than those who do not receive such support (Knight, Logan & Simpson 2001, Lewandowski & Hill 2009, Soye et al. 2006). Additionally, those who stay in residential treatment for longer, and those who complete residential treatment, report larger social networks, increased support

from family and friends, better friendships with peers, and fewer associations with substance users than those at the start of treatment (Knight et al. 2001, Panebianco et al. 2016, Richardson 2002). Such findings are consistent with the more general theory that the nature and extent of substance users' positive social relationships (commonly referred to as their 'social capital') comprise a crucial aspect of the wider resources (or 'recovery capital') required to initiate and sustain recovery from substance dependence (Cloud & Granfield 2008, Granfield & Cloud 1999, Granfield & Cloud 2001, White & Cloud 2008). Since the concept of recovery currently underpins drug and alcohol policy internationally (Duke et al 2013, Neale et al 2014, Lancaster et al 2015, Neale et al 2016), the nature and quality of relationships between peers in residential treatment seems worthy of detailed study.

Social capital is a complex construct that generally refers to the resources individuals accumulate through engagement in reciprocal relationships and social networks (Bourdieu 1986, Coleman 1988, 1990, Portes 1998, Wacquant 1998). Positive social capital may be generated when members of a social network share the same values, trust each other, and support one another to achieve more than they could accomplish if they were acting alone (Wacquant 1998). Conversely, negative social capital can result when network members exclude individuals or resist group norms (Portes 1998, Wacquant 1998). Two common forms of social capital are: *bonding* social capital (relationships between people within a network who share similar situations, experiences, and values) and *bridging* social capital (relationships across diverse networks between socially heterogeneous groups) (Putnam 2000). Bonding social capital tends to mobilise solidarity within groups by offering members safety, protection, and an exclusive identity (Putnam 2000). Bridging social capital is more outward-looking, encourages the exchange of information and ideas across different social divides, and fosters social inclusion (Putnam 2000, Schuller Baron & Field 2000).

To-date, there has been relatively little research either on the nature of peer-to-peer relationships within adult residential treatment or on how those relationships are generative of either social capital or positive behaviour changes; thus we lack important insights into how the community acts as ‘method’ (Green, Mitchell & Bruun 2013, De Leon 2000). Instead, studies have tended to focus on relationships between residents and staff; generally reporting that residents with better coping strategies, social support, and a secure attachment style are more likely to develop good alliances with their counsellors (Cournoyer et al. 2007, Meier, Barrowclough & Donmall 2005, Meier et al. 2006). Several small qualitative studies have, however, found that residential treatment clients appreciate being amongst peers with similar issues and experiences, enjoy a sense of ‘belonging’, like having a ‘buddy’ or ‘big brother/ sister’ to help them, and value the emotional support provided by their treatment peers (Bluthenthal et al. 2006, Currie 2003, Duroy, Schmidt & Perry 2003, Reihman et al. 2003, Wilkinson, Mistral & Golding 2008). Furthermore, such mutual support seems to incentivise residents to remain in treatment (Duroy, Schmidt & Perry 2003; Nathan, Foster & Ferry 2011).

More negatively, there is evidence that relationships between peers within residential treatment can be complex, particularly in TCs where residents are expected to challenge and sanction one another’s attitudes and behaviour as part of the treatment programme (Bluthenthal et al. 2006, Currie 2003, De Leon 2000, Nathan, Foster & Ferry 2011, Richardson 2002). Residents may also find it difficult to cope if their peers leave treatment prematurely or resume substance use during treatment (Wilkinson, Mistral & Golding 2008). Additionally, residents can form negative cliques or exclusive relationships based on involvement in proscribed behaviours, romantic or sexual relations, or shared superior attitudes (De Leon 2000, Nathan, Foster & Ferry 2011, Reihman et al. 2003). Such relationships can threaten the operation of residential treatment by creating divisions between residents, sustaining drug-related attitudes, condoning poor treatment participation, encouraging residents to leave

treatment prematurely, distracting residents from recovery, and making it difficult for new residents to integrate (Bluthenthal et al. 2006, Currie 2003, De Leon 2000, Nathan, Foster & Ferry 2011, Reihman et al. 2003).

METHODS

Study setting

Our study was undertaken in two mixed sex residential addiction treatment services located in different regions of England. Both services were run by the same non-governmental organisation, using the same therapeutic community-informed model of treatment. They each treated up to 30 people aged 18 years and over at any single point in time. In line with accepted TC practice, the services operated according to a set of strict rules and regulations and followed a hierarchical structure. A privilege system was used to recognise and reinforce pro-social resident attitudes and behaviour, whilst anti-social attitudes and rule breaking were sanctioned.

On a day-to-day basis, the community of residents ran the services, overseen by a senior resident who acted as the house manager and liaised between residents and service staff. The therapeutic treatment programme lasted six months and comprised structured daily group therapy sessions, supplemented by weekly sessions of individual therapy with key-working staff. The services also held weekly peer-led encounter groups that were designed to make individual residents aware of their negative behaviours, thoughts, and feelings; so encouraging them to modify their behaviour.

At the time of our data collection (late 2015 - early 2016), there were approximately 25 residents living in each service. Residents shared (same sex) bedrooms, ate meals together, and

were expected to engage fully in the community as well as support each other in their treatment and recovery. Everyone had to commit to remaining drug and alcohol free whilst in treatment and all were discouraged from having sexual or romantic relationships with each other. During the first month of treatment, new residents attended their own treatment groups and were allocated a senior peer to ‘buddy’ and support them. As residents progressed through treatment, they were expected to use the community as a tool (sic ‘method’) for developing ‘pro-social’ attitudes and relationships and for changing their behaviours. ‘Senior residents’ (who had been in the services for longer) were encouraged to increase their responsibilities and independence whilst continuing to support newer residents and role model positive behaviours.

Data collection

A University Research Ethics Committee granted ethical approval for the study. Soon after this was received, a member of the research team (XX) visited both services to talk to current residents about the study. In order to capture the views and experiences of those not currently in treatment, service staff contacted former residents (both those who had successfully completed the treatment programme and those who had left the service prematurely), told them about the study, and asked them to contact the researcher if they were interested in participating. The researcher next approached a subgroup of those expressing interest. These individuals were selected to encompass diverse demographic characteristics and different treatment durations and outcomes. Everyone approached agreed to be interviewed and provided written informed consent.

An experienced qualitative researcher (XX) conducted all interviews in private rooms at the residential services or in community services. Using a semi-structured topic guide, XX asked participants about their backgrounds, substance use, and experiences of residential treatment,

including relationships with their peers. All interviews were audio-recorded and transcribed verbatim. At the request of the organisation, current residents were not reimbursed for their participation, but former residents were given a £10 gift card as a token of thanks.

Data coding and analysis

Data coding and analyses were undertaken in stages via Iterative Categorisation (Neale 2016). To begin, XX read the interview transcriptions and created a coding system comprising main codes and sub-codes based on the topic guide and issues that emerged more inductively during the interviews. The coding system and interview transcriptions were then entered into a specialist qualitative software programme MaxQDA (version 11) and all the interview data were assigned to one or more codes. During this stage, data relating to residents' relationships with each other were assigned to codes labelled: 'residents', 'buddy', 'peer support', 'community', and 'relationship changes'.

Next, all the coded peer relationship data were exported into Microsoft Word documents and reviewed line by line to identify themes. Any similarities or differences between subgroups of participants (for example, men/women; current/former residents; those receiving treatment for illicit drugs/alcohol) were also explored. The themes emerging from these analyses were then grouped into broader categories. The categories are presented below following a brief overview of the study participants. Verbatim interview quotations, with gender appropriate pseudonyms to protect participant anonymity, are used to illustrate key findings.

Participants

In total, 13 men and 8 women aged between 23 and 57 years were interviewed. In addition, one woman was interviewed twice (during her first week in treatment and then several weeks later, after leaving treatment prematurely). Therefore, 22 interviews were conducted: with 13 current and 9 former residents. Three of the former residents had completed their treatment successfully and 6 had left prematurely. The 21 participants reported using substances problematically for between 4 and 37 years. Participants' accounts of their pre-treatment relationships with family and friends provided some relevant contextual information. Consistent with previous literature (De Leon 2000, Dermatis et al. 2001, National Treatment Agency 2006, Richardson 2002), many reported having difficult relationships with others and limited social support both as children and as adults. The experiences they described included being physically and sexually abused, bullied, neglected, bereaved, lonely, isolated, and easily manipulated or led by others.

FINDINGS

Relationships during early treatment

A small number of participants said that relatives had supported their decision to go into residential treatment and had remained in contact with them. However, most spoke of having poor family relationships, few friends, low self-esteem, limited ability to trust other people, and difficulties forming genuine and meaningful attachments to others at treatment entry. Participants in treatment only for alcohol use also often explained that years of drinking alone had left them unaccustomed to being around people or making friends:

I've isolated myself for the last five years... I never went out and I never saw anybody... So coming into a community, I'm not great around people... because I've forgotten how to communicate... I've always been a bit of a... quiet person. (Claire, current resident, in treatment for alcohol use only)

Participants commonly commented that their peers in residential treatment were from 'all walks of life'. This included people with very 'different' backgrounds and treatment motivations from their own; people whom they said that they would not ordinarily meet. Overall, participants reported being reluctant to associate, and form relationships, with residential peers who were 'not like me' or whom they could not trust. In particular, participants in treatment only for alcohol use remarked that they had never met, or associated with, injecting drug users or former prisoners before and they found this very uncomfortable:

[The] people that I was with [when in residential treatment] were a mixture of people, mixture of alcoholics, drug addicts, both. I've never been involved with drug addicts before... I just felt slightly above the people I was with... Not my sort of people. (Max, former resident, attended treatment for alcohol use only)

Sharing spaces and experiences

A small number of participants felt that living together in treatment (sharing meals, cigarette breaks, and bedrooms etc.) afforded them a positive opportunity to 'hang out' with, 'chat' to, and start to get to know others. However, most (especially new residents) disliked the shared living arrangements. In particular, they complained about having little time to themselves and being surrounded by peers who were always 'arguing', 'bickering', and 'squabbling'; akin, as some participants noted, to being in a 'school playground'. Rather than spending time in the

company of others, new residents often wanted more privacy and personal space, away from peers and their constant disputes:

Everybody's arguing and fighting and squabbling... there's no peace at all... I didn't come here to like sit and listen to like a group of twenty-four adults, yeah, bickering over this that and the other every bloody day. (Sue, current resident, in treatment for alcohol use only)

Participants also expressed mixed views about the therapeutic practice of 'sharing' experiences with others in treatment. Some emphasised the importance of 'opening up' to peers, particularly in the smaller-sized separate treatment groups for new residents. For these individuals, sharing was perceived as a way of conveying understanding and support, whilst also helping new residents to get to know one another. In contrast, others reported that they were wary or unwilling to share experiences in a group setting with 'strangers'. In this regard, some residents said that they found it difficult to trust others (for example, women who had previously been abused by men). Others emphasised that they were only in treatment 'for themselves', not to 'make friends' or to 'help others', and so needed to be 'selfish' to 'succeed':

I'm just here for my programme. I'm not here to make enemies, I'm not here to make friends. (Tariq, current resident, in treatment for illicit drug and alcohol use)

I have realised that I have to be selfish for my recovery... I'm here for me, nobody else. (Dan, current resident, in treatment for alcohol use only)

Role models and 'buddies'

When participants reflected on their relationships with peers who had been in the residential services for longer than themselves, many explained how these individuals acted as positive role models to them. For example, senior peers provided explanations about the treatment process, seemed to understand problems experienced in treatment, could demonstrate how to act responsibly, and inspired belief that recovery was achievable. New residents especially respected senior peers who listened to them, provided advice and support, and fulfilled their role as a ‘buddy’ by looking out, and caring, for them:

I remember when I first got here, the house manager... he had been here for a while, he knew the rules, so I just sort of looked up to him and listened to what he said. (James, former resident, attended treatment for alcohol use only)

More negatively, participants also reported that senior peers were often hypocritical and had double standards, since they expected newer residents to adhere to the service rules even though they, themselves, did not. Thus, some participants accused senior residents of ‘flirting’, having romantic and/ or sexual relationships with other residents, neglecting their community duties, ‘picking on’ newer residents, or generally assuming a ‘superior’ manner and behaving as if they were ‘better than’ newer residents:

People that have been here longer, some of them are a bit, let power go to their heads... And they forget that they’re actually still one of us. [They] really do think they’re up and above because they’ve done a few weeks more... but... they’re no different to me... I ain’t going to be ordered around by an ex-alky or druggie. (Sue, current resident, in treatment for alcohol use only)

Such negative behaviours prompted some new residents and those who felt ‘less motivated’ in treatment to consider using, or even to actually use, substances again. Indeed, some newer residents reported that senior peers who modelled negative behaviours had made them question their own commitment to treatment and to others within the service:

[My buddy] give me some drugs... They're supposed to be role models! He were a senior peer... Then I ended up going to the pub because I was seeing people doing it normally, so obviously I thought I could do that. (Mike, current resident, in treatment for illicit drug use)

Making friends

Frequently, however, participants stated that they derived a sense of comfort from being around others within residential treatment. For example, some new residents explained that they had started to develop friendships with others who were also at the beginning of their treatment and therefore in the same situation. Generally, they reported that they had made friends with other residents with whom they felt some affinity because of shared backgrounds, circumstances, and attitudes; indeed, these were the people whom they felt that they could trust and to whom they could ‘open up’:

You just form a relationship... Obviously, you take to some people a bit more than others, but you're all associates and all in the same boat. And you become comfortable with each other, even if someone's got behaviours what annoys you, or whatever, because you get to know each other. (Tommy, current resident, in treatment for illicit drug and alcohol use)

Several former residents who had successfully completed treatment commented on the lasting nature of some of the relationships they had formed during treatment, explaining how friendships had endured after they had left the service. Additionally, a minority of current residents described a feeling of connectedness to senior peers, who had offered them support and inspiration:

I got support off some good peers in here, very strong peers, who's been through what I've been through. They've come out the other side and they're brand new now... it can be done. (Andy, current resident, in treatment for illicit drug use)

Keeping a distance

Despite the opportunities for friendship afforded within residential treatment, many participants reported feeling isolated, lonely and uncomfortable about trusting their peers. Some described being bullied and manipulated by their roommates or feeling intimidated by senior residents. Accordingly, residents often stated that they deliberately distanced themselves from peers whom they did not perceive to be *'like themselves'*. For example, residents in treatment only for alcohol use avoided residents who had histories of injecting drug use or crime, explaining that they had different backgrounds, moral standards and principles. Older residents limited their contact with younger residents, whom they considered to be *'immature'* or less *'serious'* about recovery. Meanwhile, those who said that they wanted to do well in treatment and were focused on recovery reported that they avoided peers whom they felt were not motivated, such as those who were mandated to treatment by the courts (known as *'prison swerves'*):

I don't like prison talk. I don't like street banter... It's not for me, so I keep myself

away.... I really have made very little bonds with anybody, bar the odd one or two people, and they tend to be people with a similar, sounds awful really, but educational background and work ethic, and I feel I can talk to them on a level. (Liz, current resident, in treatment for alcohol use only)

Conflict and tension

Lastly, many participants reported overt conflict and tension between peers in treatment. Arguments and the volatility between residents were identified by our participants as key factors that prevented peers from making friends with each other and even prompted some residents to leave the services without completing treatment. When this occurred, those who remained sometimes said that they had ‘*missed*’ the residents who had left, particularly if they had started to bond with them. More commonly, however, participants reported ambivalence or relief and an appreciation of the calmer environment that resulted when ‘*disruptive*’ residents departed:

Three have been given a notice to quit, seven days. One has already left, been guided out and sent to another rehab. So, for me, that’s good in terms of, they [the residential service provider] take it seriously because it is [serious]. These places should be... for people who want to change and want to sustain recovery. (Dan, current resident, in treatment for alcohol use only)

DISCUSSION

Relationships between peers are widely recognised as being part of the residential treatment process and a core component of recovery from substance dependence (De Leon 2000). Despite this, there are few empirical studies exploring the topic. Responding to this gap in the literature, our aim was to provide further insights into relationships between peers in residential addiction treatment in the hope that our analyses might increase understanding of how the community acts as a ‘method’ of positive behaviour change and facilitates recovery. Drawing upon the concept of social capital, we analysed data generated from 22 interviews conducted with 21 people who were currently, or who had recently been, in two residential addiction treatment services. Both services used the same therapeutic community-informed treatment model.

At treatment entry, participants mostly reported histories of difficult relationships, limited social support, low levels of trust in others, and problems forming pro-social attachments to others (c.f. De Leon 2000, Dermatis et al. 2001, National Treatment Agency 2006, Richardson 2002). These findings suggested that participants had limited positive bonding or bridging social capital when they arrived in residential treatment (Cloud & Granfield 2008, Putnam 2000, White & Cloud 2008). Once in treatment, few participants described bonding with their peers on the basis of shared experiences and lifestyles. Instead, residents tended to comment on the differences between themselves and their peers. Although these differences provided some opportunities for positive bridging capital (as when residents enjoyed spending time with, and getting to know, new people or when senior residents buddied new residents), it was more often the case that interpersonal differences polarised community members in ways that undermined their social capital further. For example, alcohol users avoided illicit drug users, older residents avoided younger residents, treatment motivated residents avoided unmotivated residents, and newer residents disliked senior peers who contravened expected behaviour codes.

That residents proactively sought out peers with backgrounds and experiences similar to themselves is perhaps not surprising. Homophily is the widely accepted tendency of people to be attracted to, and to make friends with, others who share similar characteristics (McPherson, Smith-Lovin & Cook 2001). Yet, many study participants also articulated a strong desire for privacy from others and some made it clear that they were in treatment only for themselves and did not want to form any relationships with their peers. Such absolute negative feelings and attitudes towards contact with others indicated that residents' limited bonding and bridging capital at treatment entry was often compounded by a lack of willingness or motivation to build reciprocal relationships with others or to develop supportive social networks as they progressed through their treatment.

Our findings additionally revealed how residents' relationships with each other affected behaviour both positively and negatively; thereby enhancing our understanding of the 'method' by which relationships within the community worked. Thus, relationships could operate positively when peers acted as constructive role models, provided care and support to each other, and shared experiences with like others. In contrast, relationships appeared to function negatively via inappropriate role modelling, residents having to spend time with people very different from themselves, lack of privacy, arguments, and abuse of seniority. Similar findings have been reported in research conducted with adolescents in therapeutic communities (Nathan, Foster & Ferry 2011).

Lastly, our analyses provided tentative insights into how relationships between peers in residential treatment seemed to impinge on residents' social capital and individual recovery journeys. Whilst this included some evidence of increased bonding social capital (feelings of comfort, connectedness, and new friendships forged), overall residents more often reported negative social outcomes (feelings of isolation, loneliness, wariness, bullying, manipulation,

intimidation, social distancing, tensions, and conflict). Furthermore, recoveries appeared to be undermined when peers left treatment prematurely, argued, resisted or contravened group norms and expectations, used illicit substances together, or became romantically involved with each another (see also Bluthenthal et al. 2006, Nathan, Foster & Ferry 2011, Portes 1998, Reihman et al. 2003). Relationships within the therapeutic community setting thus appeared to be generating some positive but more negative bonding social capital, and having no notable effect on bridging social capital. Negative relationships meanwhile impeded recovery.

These findings may feel uncomfortable to those who maintain that the community is a mechanism of positive behavior change (De Leon 2000). However, we acknowledge that our study has limitations and there is therefore a need for caution when interpreting the analyses. Critically, our data were derived from a small qualitative study conducted in just two residential services over a brief period of time. As such, our findings are exploratory, lack empirical generalisability, and do not provide insights into how relationships will likely vary over time as cohorts of residents change. Further, only three participants had completed the treatment programme at the point of interview. Consequently, our findings may not have fully captured positive social capital outcomes or the mechanisms by which these are attained when treatment is successfully completed.

By focusing our analyses on the relationships between peers in treatment together, we also did not consider residents' relationships with staff or other aspects of residential treatment programmes (such as one-to-one counselling or formal education, training or skills building) that might promote the development of positive social capital. Equally, we did not include sources of social and emotional support that residents may receive from professionals and others external to the residential treatment setting, both during treatment and after treatment

exit (see Neale & Brown 2015 and Neale & Stevenson 2015 for accounts of the diverse forms of professional and personal support people who have complex substance-related problems receive). Lastly, we recognise that residential services are underpinned by a range of theoretical models (National Treatment Agency 2006) and the specific model underpinning any given residential service may be more powerful in shaping the method of its treatment community than the more generalised nature of peer-to-peer relationships that we have described.

CONCLUSIONS

With the above caveats and an acknowledgement that further research in other services is needed to test and refine our findings, we end with some tentative suggestions for practice. At a very general level, we suggest that residential treatment providers should routinely open the ‘black box’ of ‘community as method’ to consider the complex and dynamic nature of the relationships inside. In so doing, it seems important that service providers make explicit connections with the concept of social capital; recognising that this can be both positive and negative as well as bonding and bridging in form. Indeed, service providers may benefit from reviewing residents’ social capital at treatment entry, during treatment and on treatment exit, and including it in individual treatment plans. In this way, providers might increase their residents’ recovery resources by fostering pro-social relationships not only within the treatment community, but also by linking their residents to external services and sources of formal and informal social support, as already advocated in the United Kingdom Drug Strategy (HM Government, 2010).

More specifically, providers may find it helpful to limit the diversity of residents within treatment or to group residents with similar backgrounds and histories together (Wilkinson, Mistral &

Golding, 2008). In an effort to increase the potential of ‘community as method’, all new treatment residents might also be encouraged to be accepting of diversity, not judge others because they are different, and be open to the possibility that much can be learnt from interacting with people who are dissimilar to themselves. Residents who have been in treatment for longer may need to be reminded that they are role models for new residents and therefore have a responsibility to abide by service rules and foster a supportive and caring environment. In addition, negotiated compromises may be required when asking those who are reluctant to share physical spaces or experiences or denying them privacy. Lastly, interpersonal conflict within residential treatment is likely to be unavoidable, but rapid and sensitive mediation by peers and staff may help to prevent bickering and minor arguments from escalating into more serious disputes that impact negatively on the wider treatment community and undermine treatment and recovery goals (c.f. Fischer et al 2008).

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