

ENGAGEMENT, REHABILITATION, AND QUALITY OF LIFE AT THE DR. PETER CENTRE

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We would like to thank all the Dr. Peter Centre participants, staff, and volunteers who participated in this study. We would also like to thank the Canadian Working Group on HIV/AIDS and Rehabilitation for their financial support.

EXECUTIVE SUMMARY

The purpose of this research project was to explore issues of engagement in rehabilitation and quality of life among a highly vulnerable group of persons living with HIV/AIDS.

The study took place at the Dr. Peter Centre (DPC) in Vancouver, and involved individuals attending the Centre's day program. The day program is the first of its kind in Canada and serves persons living with HIV/AIDS who have multiple challenges and are at high risk for declining health. The Centre serves a diverse community of participants that includes injection drug users, men who have sex with men, gay men, women, transgendered male to female, and First Nations participants.

Using a "mixed methodology" that combined structured interviews ($n = 76$), focus groups ($n = 26$), and various ethnographic methods (e.g., participant observation, intensive field note writing), the researchers explored the following questions:

1. What client factors and/or barriers affect engagement in rehabilitation services?
2. How does therapeutic alliance affect engagement in rehabilitation services?
3. What contextual factors affect engagement in rehabilitation services?
4. How does involvement in rehabilitation services improve quality of life?
5. How can rehabilitation services be improved at the Dr. Peter Centre?

The results indicate that participants do engage in rehabilitation, and that engagement is positively associated with quality of life. Therapeutic alliance, particularly a sense of bond, was also found to be positively associated with engagement. However, the data reveal that different groups of participants "live" rehabilitation, engagement, and quality of life in very different ways. DPC participants represent a cross-section of society and possess varying degrees of social "capital". By virtue of this capital, DPC members exhibit unique dispositions, and collectively these variations, and the social tensions they produce, shape the practice of rehabilitation and constrain the resulting benefits. For example, while engagement was associated with quality of life for the entire cohort ($r = 0.26$, $p < 0.05$), differential effects were observed for various subgroups, with gay men ($r = 0.35$, $p < 0.05$) appearing to benefit most, and injection drug users ($r = 0.18$, $p = .15$) appearing to benefit the least.

The contextual factors most strongly associated with engagement were “opportunities for input and participation” ($r = 0.36, p < 0.01$), “opportunities to socialize” ($r = 0.31, p < 0,01$), and “programming choices” ($r = 0.25, p < 0.05$). The results of the qualitative analysis also suggest that the mere structure provided by the day program, as opposed to any specific program, contribute greatly to quality of life, and in particular help participants reduce their use of illicit drugs. Other contextual factors that contribute to quality of life of DPC participants are the various forms of social support. While formal staff support was mentioned often, informal, unstructured types of staff support and peer support were mentioned as frequently.

Despite considerable innovations in providing an integrated approach to service delivery, the Dr. Peter Centre, like other community organizations, has experienced considerable difficulties in attempting to simultaneously serve HIV populations with diverse needs. Furthermore, while considerable efforts have been made to integrate harm reduction principles, tensions between harm reduction and recovery discourses remain. These issues must be reconciled in order to maximize engagement in rehabilitation and the associated benefits, and further education and training are needed to ensure that harm reduction practices are fully integrated within HIV/AIDS care settings such as the DPC. Given these challenges, it appears that certain HIV/AIDS subpopulations such as injection drug users and men who have sex with men may benefit more from exclusive programs and services that are designed to meet their unique needs.

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INTRODUCTION

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The study took place at the Dr. Peter Centre (DPC) in Vancouver, and involved individuals attending the Centre's day program. The day program is the first of its kind in Canada and serves persons living with HIV/AIDS who have multiple challenges and are at high risk for declining health.

In 1993, the Dr. Peter AIDS Foundation¹ established an advisory group consisting of representatives of the HIV community, local AIDS service organizations, and other health care professionals serving people with HIV/AIDS. Together the group developed a vision of the Dr. Peter Centre that complemented and but did not duplicate other local services. The "day centre" concept has been employed throughout North America to address the complex needs of people with HIV/AIDS. Modelled after other day centres such as Bailey-Boushay House in Seattle and The Village Nursing Home in New York, the Dr. Peter Centre offers a spectrum of services aimed at assisting HIV-positive adults to achieve and maintain an optimal level of health while living in the community.² More specifically, the goals of the DPC are:

- to provide appropriate day centre facilities in order to support HIV-positive people to live independently in the community;
- to improve the health status and quality of life of participants;³
- to promote the efficient use of health care resources and to decrease inappropriate hospital admissions and stays; and
- to provide respite for participants' caregivers.

¹ The Foundation and the Centre are named after Dr. Peter Jepson-Young, a young Vancouver physician who gave a face to HIV/AIDS in the early years of the epidemic through a series of weekly televised diaries. Before he died, Dr. Peter established the Dr. Peter AIDS Foundation, with the mission of providing comfort care for people with HIV/AIDS (see Gawthrop, 1994).

² Our literature review places the Dr. Peter Centre at the forefront of "integrated approach" efforts to create "therapeutic environments". These facilities have historically progressed from "isolating units" to the "specialized unit" approach (Morrison, 1991; see also Bennett & Ferile, 1994, and Wyatt, 1996).

³ Individuals who attend the DPC are referred to as participants in order to minimize the medicalization of the population.

The DPC currently has 121 registered participants, and there are 102 names on the waiting list. The participants who attend the Centre are all HIV-positive, at risk for declining health, and, generally, living with multiple challenges. The DPC is open Monday to Friday from 9:30am to 3:30pm, during which time participants have access to food and other services. Two hot meals are served each day. In addition, the DPC's multidisciplinary clinical team offers an array of therapeutic services. The clinical team is composed of nurses, counsellors, recreation therapists, a music therapist, and a dietician. The DPC staff view rehabilitation as a broad concept and strive to ensure that most, if not all, of the services offered at the DPC address issues of rehabilitation. The DPC is based on a client-centred, participant-based model. In her qualitative evaluation of the DPC, Shroff (1998) described the Centre's environment and participant model as follows:

The DPC professional staff and volunteers work together with the aim of creating a respectful, warm, and safe environment for participants. The DPC has embraced an empowerment philosophy that is focused on improving participants' ability to manage their own care and to increase their involvement in decision-making. Participants are engaged in weekly community meetings with staff members to discuss issues relating to the operation of the Centre such as the selection of activities. They are also given the opportunity to voice their opinions by becoming members of specific committees (19).

The current research project included three distinct phases: a quantitative evaluation of the issues related to engagement in rehabilitation services and quality of life (phase one); a participatory action research component aimed at developing and improving rehabilitation services offered at the DPC (phase two); and a final phase in which information gained from the two earlier phases will be compiled and shared with other AIDS care providers and service organizations (phase three).⁴ These three phases were guided by a series of general objectives and a few central research questions.

General Objectives of the Project

1. To identify the barriers among the multiply challenged HIV population that inhibit therapeutic engagement in rehabilitation;

⁴ A brief note about the researchers: Thomas Kerr is a counsellor with experience in quantitative research, and ethics. When the study began, Kerr was working full-time at the DPC. In 2000, Kerr obtained a Ph.D. fellowship and reduced his work to part-time to devote more time to his degree completion. Ibáñez-Carrasco Ph.D. joined the study later, bringing experience in curriculum design, ethnography, community-based popular education, and AIDS community work. He is also a man who has lived with HIV since 1985, and this was one of the reasons he was invited to participate.

2. To identify the impact of therapeutic alliance on therapeutic engagement (in rehabilitation) among the multiply challenged HIV population;
3. To identify the impact of various contextual factors on therapeutic engagement in rehabilitation;
4. To identify the impact of involvement in rehabilitation on quality of life of the multiply challenged HIV population;
5. To engage the multiply challenged HIV population in research activity designed to improve the quality of rehabilitation service offered at the DPC;
6. To share and disseminate information on issues of therapeutic engagement in rehabilitation to the HIV community and AIDS service organizations; and
7. To share and disseminate information on approaches to improving rehabilitation services offered to the multiply challenged HIV population.

Research Questions

1. What client factors and/or barriers affect engagement in rehabilitation services?
2. How does therapeutic alliance affect engagement in rehabilitation services?
3. What contextual factors affect engagement in rehabilitation services?
4. How does involvement in rehabilitation services improve quality of life?
5. How can rehabilitation services be improved at the Dr. Peter Centre?
6. How can rehabilitation services being offered to HIV-positive persons be improved?

Chronology

January 2000	Advisory group meeting
January 2000	Development of instruments
February 2000	Second research partner begins
February to March 2000	Survey administration
July to August 2000	Focus groups
September 2000 to June 2001	Analysis of data and drafting of final report

The Centre

The DPC is temporarily housed in an old red brick building on Comox Street in Vancouver. The building is a wing of St. Paul's Hospital, where the Sisters of Providence used to live. The day centre was set up on the second floor of the building; the ten-bed Dr. Peter Residence, which provides 24-hour supportive care for those who no longer find it possible to live independently, is located on the third floor, above the day centre. Although the entire place was given a facelift of carpets, lighting, colours, and a few decorative touches, it remains very close quarters. A large number of people in a small space makes for an intense and dynamic environment, and this was a consideration when carrying out the various forms of data collection. The DPC has plans and funding to move out of this overcrowded facility and into a three-storey structure to be built nearby in historic Mole Hill.

It was decided early on that the study population would include the entire DPC community: participants, staff, and volunteers. The DPC serves a population of 121 registered participants who are admitted following a comprehensive intake interview and assessment. The DPC team consists of nurses, counsellors, recreation therapists, a music therapist, a dietician, a physical site coordinator, kitchen and maintenance staff, a volunteer coordinator, administrative staff, and a complement of volunteers. On an average day, five team members provide health and therapeutic services, four oversee the physical site and kitchen, and two provide administrative support. A volunteer coordinator is present four days a week to oversee the many volunteers who visit daily. Volunteers assist with a range of services, including complementary therapies and food service. The DPC's executive director oversees internal operations and external relations. Various students completing practicums and internships at the Centre also complement the core team.

The participant population has a high degree of vulnerability to illness due to their various physical and social circumstances, including:

- Advanced stages of HIV disease;
- Psychological issues such as clinical depression and others;

- Disadvantageous psychosocial factors such as poor living conditions, chronic unemployment, homophobia, societal stigmatization through association with correctional services and mental health systems or because of intravenous or other drug use, etc.;
- Multiple diagnoses that may include clinical depression, hepatitis C, alcoholism and, most significantly, drug use. Here, drug use is seen as a medical issue and refers to a range of practices of ingestion, injection and inhalation of illicit or non-medically-prescribed drugs such as speed, crack, crystal, ecstasy, etc.

A richer description of the participant population will be provided later on.

Programs and Services

The DPC is open Monday to Friday from 9:30am to 3:30pm. During this time, participants have access to food and an array of therapeutic services offered by the DPC's multidisciplinary clinical team. Some of the programs that specifically address primary and secondary prevention goals of rehabilitation are:

- Recreation therapy: includes an art studio, fitness programs, community outings, and other individualized programs based on participant needs;
- Complementary therapies: includes acupuncture, reiki, therapeutic touch, cranial-sacral therapy, and massage;
- Music therapy: includes music-assisted relaxation and imagery work, music instruction, active music making, and therapeutic song writing;
- Nutritional counselling: includes information about nutritional issues relating to HIV/AIDS, counselling on nutritionally related side effects caused by medications, a shopping shuttle program, and a community kitchen program;
- Nursing services: includes education in and support of self-care habits, meeting immediate health needs (e.g., pain management), and a smoking cessation program;

- Counselling services: includes counselling and psychotherapy for a variety of individual needs, substance abuse counselling, and limited vocational counselling support.⁵

METHODS

Phase One

The Research Advisory Committee

Before data collection for phase one began, a research advisory committee of five staff members and two participants was formed. Because the participants had difficulty attending most of the committee meetings, one of the principal researchers met with the participant members individually to discuss the research plans. For phase one, the committee worked to identify which participant demographic characteristics were to be collected. As well, the committee developed a “contextual factors questionnaire” that asked participants to rate various reasons for coming to the DPC. The participant members of the committee played a critical role in deciding which contextual features should be included in the questionnaire.

The Participants

The DPC offers an opportunity to work with many individuals who otherwise would be hard to reach, given their transient and highly vulnerable lifestyle. Many participants who have been unable to secure housing through Wings Housing Society (a local AIDS housing project with a long waiting list) or other federal or provincial housing initiative, move between rental apartments and single rooms in hotels. Many of them live or have lived in Vancouver’s infamous Downtown Eastside. The researchers decided to work with everyone who was available and present during the data collection period.

Several survey instruments were administered to 76 day program participants. During the focus groups phase, additional participants who do not often attend DPC were also

⁵ There are differences between the stated program guidelines and the programs as offered and available. The complementary therapies, in particular, depend on the availability of volunteers.

contacted.⁶ Table 1 shows a breakdown of the participant population according to selected demographic characteristics. These data were obtained from intake files and reflect participants' self-reports. In instances where data were missing, the researchers consulted staff or the participant in question. As Table 1 indicates, the majority of the population is Caucasian (75%), straight/bisexual (62%), and male (83%). It should be noted that 20% of sample participants are of First Nations descent. As well, 77% of the participants reported being substance users (of anything from marijuana to heroin and cocaine). This number does not reflect the more subtle division between “active” and “inactive” drug use, or how often individuals move between one category and the other. According to their informal verbal reports, these periods can range from many years to a few weeks or days. A substantial number of participants (35%) reported having a history of incarceration. Many participants (51%) also live with a mental illness, and many others (34%) have histories of violence. Twenty percent of the participants reported having a health related condition other than HIV disease.

Table 1: Participant characteristics

Characteristic	(n = 76)	
Male	63	83%
Female	10	14%
Transgender (MTF)	3	4%
Caucasian	59	76%
First Nations	15	20%
Gay/MSM	29	38%
Straight/bisexual	47	62%
Injection drug use	57	75%
History of violence	26	34%
History of incarceration	27	35%
Mental illness	39	51%
Physical disability	15	20%

⁶ Contacting participants by phone can be difficult, and DPC staff members put a lot of time and effort into this. We were particularly interested in reaching women and transsexuals, who represent a smaller percentage of the registered population. Efforts were made to contact them and to have them attend the focus groups. The researchers deemed it significant to attempt to hear some of the reasons these individuals did not often attend.

Procedure

Seventy-six day program participants each completed three survey instruments in a private interview with a principal researcher. Participants were notified about the study through postings and community meetings. The DPC staff helped many of these individuals feel comfortable enough to meet with a researcher to answer a few questions. However, word of mouth proved to be the most effective recruitment method and also promoted a sense of “owning” the process; that is to say, the participants had some say and something at stake in the completion of this study. Participants were offered a \$10 incentive in the form of a supermarket coupon (the staff felt it was not appropriate to hand out cash), but this incentive was by no means the single determining factor in an individual’s decision to participate. Once participants agreed to come to the interview room, the researcher explained the purpose of the study, the roles and the responsibilities of participants and researchers, and written informed consent was obtained.⁷

The survey instruments were created to be self-administered but it was decided to modify their application for various reasons: (a) the highly variable attention range of the participants because of varying emotional states and side-effects of a range of medications; (b) varying degrees of literacy; (c) highly varying degrees of interest. The time that the researcher spent with each individual varied from 15 to 45 minutes.

Measures

Functional Assessment of HIV Infection Quality of Life Instrument

The Functional Assessment of HIV Infection Quality of Life Instrument (FAHI QOL), version 4, is a 44-item survey instrument that assesses HIV-related quality of life across five subscales. Both subscale and total quality of life scores can be obtained. The subscales include: physical well-being (10 items), functional and global well-being (13 items), emotional well-being/living with HIV (10 items), social well-being (8 items), and cognitive functioning (3 items). These subscales were derived from factor analysis and additional testing using the Rasch measurement model (Peterman, Cella, Mo, & McCain,

1997). Participants are asked to think about the last seven days when responding to self-referential statements (e.g., “I have a lack of energy”) on a five-point Likert scale (1 = not at all, 2 = a little bit, 3 = somewhat, 4 = quite a bit, 5 = very much). A recent psychometric assessment demonstrated that the instrument has good internal consistency reliability for total QOL and the various subscales (Peterman et al., 1997). As well, construct validity, known groups validity, and sensitivity to change have been demonstrated by the FAHI and additional indicators of functional status, psychological symptoms, stress, and illness severity (Peterman et al., 1997).

Agnew Relationship Measure

The Agnew Relationship Measure (ARM) client scale is a 28-item survey instrument designed to assess therapeutic alliance across five subscales. Therapeutic alliance is a construct that has been used to denote the characteristics of a working therapeutic relationship that are associated with therapeutic outcome. The measure yields both total therapeutic alliance score and subscale scores. The subscales include: bond, partnership, confidence, openness, and client initiative. For the purpose of this study, the client scale was modified slightly. All references to “my therapist” were changed to “the staff” in order to gain a sense of the therapeutic alliance with the DPC staff rather than one therapist. Participants noted their level of agreement with various statements concerning their relationship with the DPC staff (e.g., “The staff are warm and friendly toward me”; “I feel I can openly express my thoughts and feelings to the staff”) on a seven-point Likert scale (1 = strongly disagree, 2 = moderately disagree, 3 = slightly disagree, 4 = neutral, 5 = slightly agree, 6 = moderately agree, 7 = strongly agree). A recent psychometric assessment of the ARM used simultaneous component analysis to demonstrate the conceptual soundness of the various subscales (Agnew-Davis, Stiles, Hardy, Barkham, & Shapiro, 1998). This assessment also indicated that the ARM has good internal consistency reliability, and earlier testing revealed sound construct validity and test-retest reliability (Agnew, 1996).

⁷ As per current research standards and for auditing purposes, the principal investigators will keep these consent forms and other research transcripts, field notes, and materials in a secure location for up to three years.

Contextual Factors Questionnaire

A brief “contextual factors questionnaire” was created for this study by the research advisory committee. Participants reported their level of agreement with ten statements about reasons for coming to the DPC (e.g., “I come to the DPC for the food”) on a seven-point Likert scale. The reasons included: to socialize, location, choices (e.g., programming), safety, confidentiality, education, food, staff, opportunities for input and participation, and hours of operation.

Staff Recording Form

During phase one, the DPC staff was asked to record the amount of time they spent with each participant during a one-month period. The forms listed the names of the participants with spaces to indicate the amount of time spent with staff or in programs each day. Staff recorded times in 5-, 15-, 30-, 45-, and 60-minute intervals. The forms were checked against the staff schedule, and the compliance rate for form completion was over 95% (i.e., over 95% of staff completed forms on any given day). This high compliance rate may reflect staff members’ previous experience filling out this type of form.

Phase Two

Focus Group Participants and Procedures

A purposive sampling was carried out to conduct the second and qualitative phase of the study. A total of 26 people participated in five separate focus groups: 7 male participants self-identified as gay, 5 male participants self-identified as heterosexual, 5 female participants self-identified as heterosexual, 4 transsexual participants self-identified as women, and 5 staff members.

The researchers tailored the focus group format to the various target groups and to obtain relevant data that would both inform and build upon the analysis of the quantitative phase. One of the views most commonly expressed during the impromptu interviews that occurred at the time of administering the survey was that gay male participants and straight male participants did not want to be in the same focus group. The research team

honoured this general request by creating separate focus group for each representative social group at DPC. The gay men's focus group and the staff focus group were relatively easy to set up and they were well attended. The straight male, female, and transsexual focus groups took a long time to prepare and they would not have happened but for the time and energy provided by the DPC staff.⁸

For both male focus groups, the focus group was organized around an enlarged set of photocopies of the DPC floor plan. All the copies were posted on the walls of the room where the focus group would take place. The floor plan was chosen to serve as a low literacy icebreaker that would get the participants physically active and interested in the subject. The primary reason, though, for choosing this variant of "mental maps" (already drawn but requiring interpretation and completion on the part of the participant) was to establish a visual connection between the DPC and the events, motivations, and actions of people within the place. It was also designed to corroborate and/or correct the quantitative information collected in the first phase. It has been argued that "[g]raphic and cartographic (mapped) representation and analysis of data make it possible to go beyond statistical representation. It is possible to define a number of data sets that are statistically the same (same number of observation, same arithmetic mean, and so on) but graphically different" (Schensul et al., 1999: 52).

The focus group participants came to the assigned room, read the consent forms (or had the forms read to them), signed the forms, listened to and asked questions about the general guidelines of the focus group, and were asked to individually complete the floor plan in three steps: first, by marking their daily itinerary inside the DPC facility with a green felt marker, starting from the reception area; second, by marking in green the places that were generally positive for them and provided comfort and care; and third, by marking with a red felt marker the spaces that ranged from uncomfortable to threatening (this particular range had been obtained from the opinions expressed in the interviews).

After a brief recess, the second part of the focus group was devoted to asking a few pre-selected questions about participants' salient marking of their daily trajectories on the

⁸ In particular, we acknowledge the support and work of Staci McDonald, a recreation therapist at the Dr.

DPC floor plans. The questions were asked in relation to the data obtained in the first phase and with respect to emerging themes. In addition, some of the participants' misconceptions and questions about the results of the first phase of the research were clarified. The male focus groups were conducted by one of the researchers; a male DPC counsellor was present during the straight male group to provide resolution in case of conflict.

The female and transsexual groups were organized around the slogan "before and after" that has been popularized by television tabloid shows. It was chosen because it was readily intelligible to a 'female-identified' target group and not clinical. Two female staff members from DPC were engaged to facilitate and record these sessions. Before the focus groups took place, several meetings were held between investigators and the DPC staff members to review basic tools of facilitating and recording data in focus groups. After the focus group, the DPC research assistants presented a field note account of their experience and participated in a follow-up conversation.⁹

The staff focus group took place after work one afternoon and was conducted as a "walkabout" of the premises. Group members became "tour guides" to the researcher in this ethnographic technique. The purpose was to enact an "embodied" and "sensorial" form of reflection and "re-membering" of incidents, peoples, and their motivations as they are intimately tied to natural settings.

Non-traditional Data Sources

Given the particular characteristics of the DPC setting, it should not come as a surprise that what was originally set up as a standard administration of survey instruments became an entirely different process. The researchers had to be responsive to the nature and dynamics of the DPC and allow organic changes to happen to the data collection instruments and process. As a result, the survey administration and the time that both researchers spent at the DPC became sources of important ethnographic data. Surveys

Peter Centre.

⁹ The research team decided that any perceived bias in employing female DPC staff people to conduct the female and transsexual focus groups would be offset by the participatory quality of the interaction and the preexisting relationship of trust that existed between staff and focus group participants.

became impromptu interviews, and the time spent recruiting respondents became participant observation that yielded a wealth of field notes. It has been argued that ethnographic methods are well suited for examining behaviour and motivations (see Stephen Koester's article in Van Vugt, 1994; Trussler & Marchand, 1997).

The investigators maintained an "open door" policy to capture spontaneous feedback on the structure, process, and contents of the study. This "research attitude" was modelled after the flexible approach of DPC staff, who provide comfort and care whenever and wherever it is needed. The door of our small office was usually open for participants and staff to come in and chat. At the risk of turning every moment of the day into a data collection event, we tried to capture many views that were expressed in passing.

Individual Interviews

Interviews with DPC volunteers, participants, administrators, health care workers, and operations staff took place "on the fly" and in natural settings. The researchers made it clear each time that whatever was discussed would be recorded in field notes without identifying characteristics or names.

Participant Observation

Both researchers were present at the site for most of the working days of 2000. Kerr worked a good part of the year as a counsellor, which gave him an intimate perspective on the DPC community. Ibáñez-Carrasco spent about six months administering the survey, approaching participants in groups and individually, and talking informally with health care, operations, and administrative staff.

Community Meeting Minutes

The community meetings have as their primary goal to allow the participants democratic participation in running some aspects of the daily operations of the DPC. They are also described by the staff as a significant instance of socialization for people whose opinions and interests are not often seen outside a medical or criminal context. The minutes are often recorded by a participant or staff person, then typed or handwritten by a volunteer participant and placed in three-ring binders in the living room of the DPC where

everyone has access to them. Some copies of the minutes are distributed around the Centre for participants to peruse. The researchers scanned the community meeting minutes from 1997 to June 2000 to look for emerging trends and critical incidents described in them. The results of the scan and a brief analysis of the minutes were reproduced and placed in the public binders (see Appendix).

Field Notes

Numerous field notes were taken throughout the course of the research. Although such notes are strictly confidential, edited versions of some of these notes (without names or identifying characteristics) were circulated through key DPC informants to obtain feedback.

The overall process was flexible and sensitive to emerging concerns, grassroots understandings of the research, and theoretical understandings. Participants and staff showed some ownership of a social scientific process that tends to be alienating and non-participatory; participants initially showed a high degree of expectation of what this research could “do” for them.

THEORETICAL FRAMEWORK

To understand what we are looking for in the wealth of information obtained in this study, it is important to examine the concepts of therapeutic alliance and engagement in relation to current notions of rehabilitation.

Therapeutic alliance has long been identified in the psychotherapy literature as a key process determinate of treatment outcome (Horvath & Luborsky, 1991; Stiles et al., 1998). It seems to be a powerful predictor of treatment outcome regardless of the type of technique that is employed (Horvath & Greenberg, 1989). Alliance has been described and measured in many ways; however, most authors agree that alliance is most powerful as a predictor of outcome when the client perceives an alliance with a helping professional that is characterized by a sense of warmth, bond, openness, support, and confidence (Agnew-Davis et al., 1998). Similar findings on the impact of helping relationships have been reported in the nursing literature. For example, Fosbinder (1994) found a strong connection between the nature of the nurse-patient relationship and the patient's perception of the quality of their care (cited in Robinson, 1998).

Engagement has been described in various ways. However, most authors agree that engagement involves participation in therapeutic activity, and includes some form of positive outcome that results from treatment (Joe, Simpson, & Kirk, 1998). Engagement and therapeutic alliances take many different forms, though, and do not necessarily have to yield one single positive outcome or product. Indeed, engagement can have both positive and negative implications.

In the context of HIV disease, rehabilitation:

... addresses the impairments, disabilities and handicaps that result from HIV-related conditions and the side effects of anti-retroviral medication (Nixon & Cott, in press). The goal of rehabilitation is to slow the deterioration in an individual's condition by improving, restoring or maintaining activities and participation in daily life. Ultimately, rehabilitation aids an individual to optimise independence and quality of life, while minimising health and income support costs.

Therefore, the goals of rehabilitation are centred on the person living with HIV disease. Many different people and organisations can be involved in the rehabilitation process. First and foremost, the individual is often involved personally in self-care activities that minimise impairments, disabilities and handicaps. The individual's circle of friends and

family may also play a role in this process (CWGHR Position Paper 2000: 9-10; see also Horowitz, 2000: 98-119).

The statement above that “rehabilitation aids an individual to optimize independence and quality of life while minimizing health and income support costs” hints at the fact that, while individual autonomy and improved quality of life are not incompatible with the cost efficiency of rehabilitation programs, these two objectives are often played against each other.

Our literature review and data analysis suggest significant links between the care of the disabled and the elderly and the care of people living with HIV disease and multiple diagnoses.¹⁰ Horowitz (2000) in her essay on aging and disability states, “The ultimate goal of any rehabilitation intervention is to maximize functional independence, foster psychosocial adaptation to the disability, and enhance general quality of life” (110). Later, the author adds, “Any discussion of aging and disability must also address quality-of-life issues for the disabled elderly. Key among such issues is an awareness of the complex reciprocal relationship between psychiatric and physical morbidity in later life, especially in terms of the most common psychiatric condition in the elderly – depression” (115). This appreciation is applicable to the participants of the DPC community. The added challenge is that the mental health issues are many and varied, and the age range is wide; therefore, the approaches need to be, if not multifold (which might not always be possible), then flexible.

Clearly, quality of life is a concept that encapsulates cultural, socioeconomic, political, medical, and geographic perspectives. There is a departure from the medical model of “quality of care” that assumes that physical, social, and mental functional capacity of a person can be equated to well-being. A sociocultural viewpoint looks at the many components of the individual’s environment and his/her ability to be a functional part of that environment without discounting the individual (Esu-Williams, 1997: 142-3).

UNAIDS, the Joint United Nations Program on HIV/AIDS, has defined quality of life as “an individual’s perception of his or her position in life – in the context of local culture

¹⁰ Our current preoccupation with HIV infection rates among young men who have sex with men and other social subgroups often make us forget a growing population of people aging with HIV.

and value systems, and in relation to the individual's own goals, expectations and concerns" (Piot, 1997: 8). Piot proposes that the issues of respect, psychological support, palliative care, prophylaxis and treatment, and family support, among others (he makes no specific mention of rehabilitation) should be considered (8-10). He presents variants of this social scientific conceptualization of quality of life – for example, R. J. D. George's mathematical equation of the "gap between [individual] aspiration and achievement" (47). There is a pitfall in conceptualizing "rehabilitation" as a series of contiguous individual processes, thus forgetting the aggregation or overlapping of such processes into a larger macro-social scenario. In fact, many definitions of quality of life cover a continuum between individual aspirations/achievements and collective needs (including governmental fiscal restraint).

Progressive conceptualizations of rehabilitation and quality of life should include the notion of lifelong continuum as "learning" (e.g., the kinds of experiential and formal learning associated with home care, management of illness symptoms, coping, grief, and bereavement). This learning should depart, however, from the pervasive idea that, in general, one recovers individually and that the process has a foreseeable end (often, for younger individuals, to reenter the work force, for older individuals, to live independently, for sick individuals, to die). It is crucial to expand our understanding of the concepts of "rehabilitation" and "engagement" beyond those so narrowly defined by our "culture of recovery" that heavily relies on notions of incremental progress (with various "slip-ups") towards a "cure" or "abstinence" from addictions, in the constant re-telling of one's individualistic saga (Rapping, 1996).

Further, notions of rehabilitation and quality of life need to be tied to concepts of continuum of care and harm reduction. These connections have already been firmly established in the field. The researchers, however, did not take it as a given that such connections were tested and reliable in the case of DPC. The connections between the practices of rehabilitation and lifelong learning, empowerment, harm reduction, and continuum of care were examined to ascertain their internal logic.

Rehabilitation: The Internal Logic of the Practice

When it comes to social groups that are highly dispossessed and vulnerable to social ebbs and flows, it is often easy to argue that whatever is done for them – no matter how little or disorganized – is always positive. This commonplace belief stems from a place of constant emergency (e.g., constant deficit, lack of resources, etc.) and a specific notion of charity which is widespread in western societies. Charity is often confused with compassion, and even with rehabilitation. Indeed, practices such as rehabilitation and care are seldom found to be positive, productive, or desirable.

Rehabilitation is defined by CWGHR in terms of three significant items: impairments, disabilities, and handicaps. Of these three items, impairments and disabilities are often empirically observable and measurable. However, it is the third element, handicaps (“disadvantages for a given individual resulting from an impairment or a disability impacting on environmental barriers”), that calls our attention here. We propose to analyze the concept of “handicap” within a sociocultural framework. There are various useful social scientific instruments that can be employed; in this case, we have opted for a modified version of a constructivist sociological theory that describes how social actors behave in ways that appear highly personal and voluntary (e.g., erratic behaviour between drug abstinence and bingeing) that are rooted in collective and not autonomous practices.

To examine the internal logic of the practices of program delivery, support, and provision of comfort and care offered at the Dr. Peter Centre – and in particular the practice of rehabilitation as established in the objectives of this study – let us turn to a sociological definition of ‘practice’ put forth by sociologist Pierre Bourdieu: [*(habitus)* (capital)] + field = practice (1984: 101). We argue that this social scientific equation allows for a rich explanation that takes into consideration the various “local culture and value systems, and in relation to the individual’s own goals, expectations and concerns” (Piot, 1997: 8) that are called for in the UNAIDS definition of quality of life and in the CWGHR definition of rehabilitation. In this case, the *habitus* is a system of habits (also called dispositions, and one could argue of significations) among the participants and the staff at DPC that is “capable of generating similar practices” with “common properties sometimes legally guaranteed” or “embodied properties” such as vulnerability to HIV or drug and alcohol

use (Bourdieu, 1984: 101). DPC participants' dispositions to engage in "therapeutic alliance" with staff and with each other are all part of a *habitus*. For example, it is a general understanding at DPC that individuals come to the Centre to engage with others and participate in their own care, and this gradually generates a "habit".¹¹

The *capital* is given by a series of cultural and socioeconomic traits such as gender, ethnic background, years of schooling, socioeconomic background and social standing, etc. It also refers to participation in social networks (not all of them deemed legitimate or desirable, such as street crime networks and drug use networks). Capital also encompasses (dis)possession of social opportunities and (dis)advantages. Participants and staff at DPC are highly sensitized to recognize the various characteristics of individual capital.

A *field* refers not only to a physical space where these social actors gather and interact, but also to the structure of programs and services that more or less governs their behaviours during the DPC's hours of operation.

To revisit the equation ($[(\textit{habitus}) (\textit{capital})] + \textit{field} = \textit{practice}$), one could say that practices of rehabilitation require not only a structured program and adequate resources (field), but also a good fit between the rehabilitation program, the social traits brought into the equation by the participants and staff (capital), and the dispositions (*habitus*) of all of those involved in the practices of rehabilitation. The optimal effect of such good fit brought to practice is what one calls "quality of life". In the following section, we review the most salient points emerging from the various data sources that illuminate the factors that enhance or hinder the engagement and alliances (*habitus*) of DPC staff and participants in the practice of rehabilitation. Some of the details about their lives will further elucidate the capital that these various individuals bring to the equation of rehabilitation.

¹¹ Also see the explanations of Bellah et al. about "getting involved" in *Habits of the Heart*, pp. 167-195.

Units of Analysis

The terms of the sociological equation presented above – [(*habitus*) (capital)] + field = practice – have been adopted as the units of analysis.¹² The researchers carefully assessed the many practices of rehabilitation that they observed or that were reported by the informants during the study to draw out the most apparent and the least apparent systems of dispositions (*habitus*). This task is the most delicate one. Drawing out the sociocultural capital and the various elements that characterize the field (the institution, its staff, programs, and services) was, in comparison, a more straightforward task.

The sociocultural capital was extracted from the various “official” information systems that exist in the DPC – what the staff has previously recorded about the everyday lives of participants, their medical and mental health status, etc. The survey instruments collected other elements of the capital, such as cognitive, physical, functional, and global well-being. This information tells us about the background of the participants, how they live, what they eat, what kind of social network they have or do not have outside DPC, etc. – in short, what one could very generally term their “lifestyle”.¹³

To provide a description of the field of practices of rehabilitation and quality of life, the researchers drew information from “official” descriptions of what the DPC offers to its participants (as presented in fundraising materials, for example), from the minutes of its community meetings, and from the information presented by the study’s informants.

The focus of this analysis and its explanatory power reside in the fourth and most elusive element of the equation, the *habitus* or system of dispositions. To pull out the elements that form this *habitus*, the researchers looked beneath the surface of what the informants said. For example, when the informants consistently reported purely positive experiences

¹² Pierre Bourdieu has consistently shown the reliability and validity of this equation that summarizes an entire theoretical paradigm. Bourdieu has applied and tested this equation in the fields of popular culture and education, among others. Our application of the terms is also strongly influenced by Michel Foucault’s philosophical views on health, illness, sexuality, and medicine. The theories of anthropologists, medical anthropologists, and sociologists such as Thomas Zsasz; Douglas, 1992; Martin, 1994; Good, 1994; Hatty & Hatty, 1999 have been considered in writing this section.

¹³ The term “lifestyle” refers to external, observable, and measurable elements and in no way provides evidence of social dynamics (the “culture” of the individual) or individual motivations and dispositions (e.g., vulnerability).

at DPC, the researchers examined this discourse within current trends in western societies, such as the addiction/recovery model (Rapping, 1996). The analytical strategy here was not to second-guess the informants or discount their perceptions and interpretations, but rather to enrich their descriptions by revealing other layers of meaning. Thus, the main analytical effort has not gone into listing the obvious things that work or do not work for the participants, but to evaluating whether these things provide, in the long term, the basis for a disposition to rehabilitation. The first assumption here is that all individuals (to varying degrees, depending on social and political constraints) are able (though not necessarily prepared) to contribute to their rehabilitation. The second significant assumption is that individuals engage in therapeutic alliance and other behaviours toward rehabilitation in ways that are individualistic but not necessarily autonomous. Despite the widespread assumption (as reported by many participants) that one is fully autonomous (and makes good or bad decisions alone, as the addiction/recovery model would have it), one's power is intricately intertwined with the social standing of others, capital (background), and a collective system of dispositions (*habitus*). In this sense, it was our delicate mission to analyze the collected data to determine how DPC, its social actors, and the everyday activities of the Centre create various practices of rehabilitation and contribute to the quality of life of all those involved. The researchers see this aim as highly significant when attempting to describe and analyze the model of harm reduction, prevention, and continuum of care that lie at the core of this social project.

RESULTS

The Group Dimensions

A discussion of the findings of this research must include an analysis of the social structures inherent within the DPC participant population. All data sources, quantitative and qualitative, illuminated various experiences and constructions that separate the DPC cohort into distinct groups. This separation is played out in the organic socialization at DPC and in its formal rehabilitation practices. DPC participants draw lines along two axes: (a) heterosexual and homosexual participants, which tends to erase the existence of women and lesbians, and leaves transsexuals hanging in a sort of social limbo, and (b) drug users and non-drug users, which obscures many other possible overlaps and distinctions such as active/inactive drug users, gay drug users, and participants who abuse alcohol. While these divisions are particularly evident throughout the focus group transcripts and therefore could be seen as emanating from “researcher-created” focus group composition, it should be noted that many participants vehemently requested this exclusive composition and regarded it as essential; they would not share their distinct experience in “mixed company”. Furthermore, the quantitative findings provide empirical support for the participants’ contention that these distinctions exist. It is clear that participants come to the DPC with varying degrees of capital, and consequently participants experience and benefit from the DPC in distinctive and unequal ways. Differences in the capital certain groups bring are evident in Table 2, which compares quality of life (QOL) scores among two norm samples, the entire DPC cohort, gay male and IDU participants. As the table shows, the average QOL score for DPC IDUs (92.8) is lower than the average score of the FAHI QOL HIV-positive norm sample (102.1) that is characterized as symptomatic with CD4 <200. Meanwhile, the average QOL score for gay male participants at DPC (108.6) is slightly higher than the average score for the norm sample that is characterized as asymptomatic with CD4 >200. The cross-sectional nature of the data and the ever-changing health of people living with HIV/AIDS should however be noted. Indeed, many of the individuals with higher quality of life could have been quite ill at the time of their admission to the Centre. If this is in fact the case, it may

well be that these individuals have in fact benefited more from their participation at the DPC.

TABLE 2: FAHI Quality of Life scores by groups

SAMPLE	SCALES					
	Physical	Functional	Emotional	Social	Cognitive	Total
FAHI QOL norm sample 1 (CD4 <200, symptomatic)	21.8	30.4	20.3	21.5	8.1	102.1
FAHI QOL norm sample 2 (CD4 >200, asymptomatic)	27.7	35.0	17.3	20.2	8.1	108.1
Study sample (n = 76)	22.0	29.1	23.2	15.7	6.7	96.7
Injection drug users (n = 57)	21.4	28.0	22.2	14.7	6.3	92.8
Non-drug users (n = 19)	23.7	32.2	26.2	18.6	8.0	108.6

It is noteworthy that mental health issues are seldom recognized as a “difference” among participants. It is likely that the issues of mental health and depression associated with HIV disease and drug/alcohol use are often “softened” by the prevailing discourse of addiction/recovery. The following is an excerpt from the straight men’s focus group where participants make clear distinctions between sex and gender. Often such distinctions are value-laden, but in essence, they recognize the existence of an “other”, that is to say, someone who is fundamentally different from who they are.¹⁴

Interviewer: Okay, any other thoughts about participant women in the Centre? Do they benefit as much as you guys?

Greg: Are we talking about *women* or are we talking about guys who *think* they’re women?

Interviewer: We can talk about both. Your question is good because we can be also talking about a transgendered male to female. Do you have a different opinion about this group?

Lorne: I know what you’re saying. Correct me if I’m wrong. The women’s discussion group that is being held on Monday. Is that group

¹⁴ This is a “recognition” that goes beyond racial and ethnocultural differences. For example, the presence of aboriginal individuals at DPC was very rarely brought up in any of the formal or informal discussions during the data collection period of this research.

for women in *gender* only or is it for *women who are hoping to be women*?

Interviewer: We have two separate focus groups. One for females and one for transgender male to female.

Lorne: So, your question to me was on *women* and my opinion is that for the services that are available here for a woman are great. When I'm saying *women*, I'm saying a man that thinks he's a woman and whatever, through their actions, through the way that they want to present themselves or whatever. For the services that are available, that's good. For a woman that is a woman, I think it is a totally different, the services are still there, but I do believe that due to the lack of actual participants, women participants, they're very limited in there, due to the lack of the participants that are actually women, they're interacting back and forth between them with other women, I think it falls really short.

Tyson: There's only like four women coming to the Centre. [He refers to transgendered male to female.]

Interviewer: [looks at the survey findings in a page] There's a 12% of females, 84% of males. I have other numbers here: 12%, transgender, 4%. Now the other thing is, heterosexual population is 77%. So, how comfortable do you think women are?

Lorne: I think that women that are *real women* are not comfortable due to the lack of other women.

Greg: See, I agree with Lorne that women don't have enough women to relate with.¹⁵

Given their overwhelmingly disadvantageous starting point in terms of sociocultural capital, straight men stand to be a highly successful group in acquiring social "tools for conviviality". This social progress might often go unrecognized by them and by members of other social groups.

The following blunt judgment expressed by one of the straight male informants in the focus group might seem disheartening at first read. However, this participant and others who echo his sentiments acknowledge that there is "room to move", as it is expressed towards the end of this excerpt.

Lorne: The same way. I have no preferences as long as the person... I realize that the staff don't have all the answers just like *we* don't have all the answers. If a person treats a person as a person and starts

¹⁵ Ibáñez-Carrasco facilitated this focus group. He realized after the session that it could have been difficult if one of the straight males who dates a transgendered woman had been one of the informants. How would a straight male have reacted to the insinuation that the person they are emotionally and physically involved with is not *really* a woman? This type of (mis)recognition and the resulting silence underly many of the relationships at DPC and probably make for some degree of anxiety and discrimination.

understanding themselves and watches themselves instead of giving a bunch of cliché and a bunch of talk, they start knowing what they're talking about and feeling what they're talking about before they start giving advice to something, then it works. Now, everybody's got their own sexuality, their own preference. I don't understand it other than that people have needs and so they're taking care of their physical needs of whatever, but as far as agreeing with it, I don't agree with it personally. I think it's *demoralizing* society and I think that...

Interviewer: When you're saying you don't agree with it, you're referring to what exactly?

Lorne: I think that-

Mel: The gay.

Lorne: The gay population

Interviewer: You don't agree with homosexuality?

Lorne: I don't agree with where it's going to in society. I think it's Sodom and Gomorrah again, for Christ's sakes, you know.

Interviewer: How does it sit with you that this, that the participants at the DPC are bisexuals, homosexuals and heterosexuals?

Lorne: I don't care who they are as long as they're a person. Straight up. Great. If they start to crap with me, they're going to find out that they're not the person to start to crap with, right.

Interviewer: "Crap with you" is what, exactly?

Lorne: "Crap" is trying to come on to me or something like that or when I'm sitting down to eat I'm not interested in hearing about how some guy was hustling some other guy or whatever over the weekend or I'm not interested in hearing people talking about their genitals, you know. As far as I'm concerned, this disease wasn't formulated by the heterosexual society, right. To my understanding it was the disease came from the gay population and I must commend the gay population on what they're doing along with the various pharmaceutical companies and along with the doctors to do to alleviate the problem but, shit! They had damn well better do it. They caused the bullshit, right? I don't have any animosity. I'm not building any animosity into that because it's just a self-will run riot, that's what caused it, right.

Interviewer: It was what?

Lorne: Self-will run riot. Meaning they just thought about what they wanted to do at the moment and went for it without any care. The same way with myself. I could have made better choices, used cleaner needles or whatever. Like, I'm not sure how the disease came with me, but that makes no difference.

[...]

Lorne: [...] I try to analyze things but I'm looking into myself more and I'm understanding my own psyche more to the point that if something's bothering me, I go to find out what that reason is, why it's bothering me and nine times out of ten, what is bothering me, it's ego-based and when I say it's ego-based, I'm making a decision on the ego is wanting to make the decision, you know. An example would be, say this guy's a *flaming raspberry* but he's a good guy, right? So, if I've

got a lot of straight people that are friends, I'm making an ego-based decision, no, I'm not gonna be seen in public with this guy. Christ, my friends might think this and that, so I just said, "Hey, stop that. This is wrong." I'm making my decision on what I know about that person and how that person truly is, right. And, if you stand up, straight up, then that's the most important thing in my books, so I'm not letting my ego or somebody else's ego influence my decision.

Lorne giveth and Lorne taketh away. Cut and dried as this issue may seem, it is after all a reigning part of the discourse among straight men; they tend to acquire a series of social dispositions that allow them, maybe for the first time in their lives, to coexist under the same roof with individuals they would have otherwise dismissed as "morally askew".

Gay men at DPC occasionally show a similar attitude to that of straight men but to a lesser degree, an attitude that could be characterized as "tolerance". Gay men are highly attuned to various social needs, disadvantages, and injustice with respect to those regarded as "other"; however, they are not necessarily quick to bestow generosity upon their fellow DPC members.¹⁶ The following focus group transcript illustrates this point. In this selection, when the facilitator rectifies the erroneous belief that the majority of DPC participants are gay men (38%), the discussion once again turns to the attributes and behaviours of straight men at DPC:

[**Randy** recalls how one participant threatened all gay men during a community meeting.]

Lyle: If I was in charge of this place, that person would be out of here in a minute. I would not allow that kind of behaviour in this place, I would be looking after the safety of the *whole* group.

Interviewer: Some people would argue that people have different and multiple diagnoses. There are people with clinical depression and be a drug addict and be gay. Given such complex profiles, maybe they have to sometimes overlook certain kinds of behaviours. What do you think about this?

Wayne: They [the DPC staff] are too lenient. I am gay, I've never done drugs, you know, whatever, what are you going to classify me as? I'm still gay. A bisexual is still a bisexual no matter what. How about "three strikes and you're out"? I've seen people come in here complaining "Oh, I feel miserable, I need help" because they got high the night before, they come the morning after and they want all these things given to them, and they *are* given to them. Then, they are clean for a week and they start all over again.

¹⁶ One might go so far as to suggest that there is an entrenchment of DPC gay men in the social *victimhood* role that seems widespread in contemporary North American society. Evidently, such an assertion warrants further examination.

Interviewer: Are you suggesting that they [IDUs] should be punished for what they do outside DPC? Wouldn't it like being punished for going to bed with same sex individuals, would it?

Wayne: If they do not want help, why do we try to... they should be in detox, they are in a different group, and they should not be in a centre like this. They should get that part of them cleaned up before they get here, they can't clean up all five parts [that are going wrong] at once. If they have drug issues or mental health issues, they should deal with them first [somewhere else].

Interviewer: But, some people would say that the problem is that there are fewer agencies doing this kind of work.

Wayne: Who started these agencies? Gay men. Was it someone from the suburbs who said he or she would do something about it? No. Why are these resources being taken over then? They should go to rehab then come here and start over again. They go back and forth wasting all these resources. They keep coming to DPC and costing a lot of money.

Lyle: These people do not really want help, they are not ready to quit.

Interviewer: You used the phrase "resources have been taken over". Does anybody else want to comment on this?

Carl: "[Resources] are being taken over" was the phrase used. My understanding is that this is an HIV centre, I am here and a lot of people think it is a drug rehab centre, they [IDUs] come here because they think it is a rehab centre.

In spite of these and other criticisms, a number of gay men frequently access DPC services. The above extract illustrates gay men's "recognition" of the "other" but a resistance to acknowledge a few key issues: (a) gay men represent a significant majority of the North American population affected by HIV/AIDS, but they are not the only ones. There is a sense of historical entitlement over the spaces, services, and benchmarks in AIDS activism (lesbians and straight women and men are conveniently overlooked in this diachronic landscape); (b) there is clear scientific and anecdotal evidence that gay men (and to some significant degree HIV-positive MSM) engage in drug use, albeit of a different kind; and (c) there are disquieting parallels between the social disadvantage of IDUs and gay men in relation to HIV.

Thus, DPC informants report the acquisition of productive social dispositions (engagement) in various degrees; however, such acquisition is often the effect of having gathered a "motley crew" in one physical space and not the result of a concerted effort at implementing a series of techniques for the development of diversity. The DPC only indirectly creates the equalizing (democratizing) conditions for all those involved to

begin to understand the differences between the “other” and themselves. When qualitative reports are examined side by side with field notes and data obtained via participant observation of everyday interactions, it becomes evident that all social groups at DPC are somewhat successful in adopting social dispositions (tools for conviviality) to work with others as part of their “mutual recognition”. Informants in both the transsexuals’ and the straight women’s focus groups addressed many of the questions posed to them through a theme of caring for a man or other loved ones. This finding corresponds to the highly traditional and structured socialization of working class women in our society.

It is possible to conclude that one of the positive outcomes of this mutual recognition, barring the promotion of what Owens describes as the “begetting of indifference” (Owens, 1992), is that of a “good disposition” to work together, to participate. This was poignantly underlined at the end of the straight men’s focus group. When asked to state one of the most important things they have learned since coming to DPC, one of the participants answered:

Mel: For me, it was getting to know that the counsellors or whatever and they showed me how to control myself. [It’s] like, I was pretty much [angry] when I came here. I had something against gays and it took a while to get it [calmed down] but now it’s not there. I feel better by it and it’s given me time to think about things. And just that time being able to think about it, is like putting a new house over my head and it gives me more understanding of the people and I hope they can get better understanding of me and I care about them where I wouldn’t have cared about them before.

Correspondingly, this view was captured in one footnote from the impromptu interviews during the administering of the survey.

One mature gay male participant shared a piece of well-seasoned wisdom with me. He told me that when he initially came to DPC he thought drug users should all be rounded up and shot, but that over time he had come to a radically different understanding, and that today he is prepared to accept that drug use/addiction is a health problem (Field note: March 30th, 2000).

Despite the group divisions and the tensions that result from them, the lack of significant differences in the amount of time different groups spend at DPC is noteworthy. The

results from the quantitative analysis indicate clearly that different groups access the DPC equally. That said, results from the quantitative analysis also indicate that groups enjoy somewhat varying levels of therapeutic alliance with staff, and that this could be associated with differential types of engagement. A closer look at the various subscales scores that comprise the total Agnew Relationship Measure score indicate that therapeutic alliance at the DPC is accounted for by a sense of bond. Scores on other Agnew subscales (e.g., partnership, confidence, openness, and client initiative) contributed relatively little to the observed therapeutic alliance scores.

While engagement at the DPC was found to be associated with the quality of life for the entire DPC cohort, differential effects were again observed across groups. The results presented in Table 3 indicate that gay men appear to enjoy a greater association between engagement and quality of life. Unfortunately, because of the small group sizes, other meaningful group comparisons (e.g., women or transgendered participants vs. gay men) were not possible. It is interesting to note that quality of life was not significantly associated with the number of days one spent at the DPC. Quality of life was only positively associated with engagement as measured by the staff recording forms that noted the amount of time each participant spent involved with staff, or in a program or other group activity.

Table 3: Correlations between engagement, quality of life, and therapeutic alliance* for all participants, MSM, and IDUs

	Engagement with Staff	
	Pearson r	p-value
All participants (n = 76)		
FAHI Quality of Life	.27	0.02
Therapeutic alliance	.28	0.01
MSM (n=29)		
FAHI Quality of life	.35	0.04
Therapeutic alliance	.40	0.03
Injection drug users (n = 57)		
FAHI Quality of life	.18	0.15
Therapeutic alliance	.30	0.02

*Therapeutic alliance was measured using the Agnew Relationship Measure (client scale).

Improving Quality of Life

The data collected throughout this study illuminate the various positive outcomes that result from participation at the DPC. Despite tensions that arise from aforementioned social dynamics, it is clear that most DPC participants derive considerable benefit from attending the DPC. By virtue of differences in capital, participants exhibit unique dispositions. The variations in the quality of the elements produce differences in the practice of rehabilitation and the benefits participants enjoy in terms of improved quality of life. The most consistently mentioned benefits were reduced drug use, relaxation and reduced stress, increased social participation, and changing personal practices and improved living conditions.

Reduced Drug Use

Many participants reported that coming to the DPC helped them reduce their drug use. Surprisingly, this outcome was not attributed directly to established, structured programs and services, or professional support (e.g., drug and alcohol counselling), but rather the opportunities to reduce harm afforded by an alternative space – in this case, the adult day program. Participants reporting reductions in their drug use stated that the DPC gave them something to do with their day – something other than simply scoring or doing drugs. This outcome was reported primarily by women, transgendered participants, and straight male drug users. The significance of having legitimate opportunities to reduce harm to themselves is manifest in the following excerpt from a focus group in which female participants were encouraged to frame their talk in terms of ‘before and after’ coming to the DPC.

Interviewer: We would like to know more about what is it about the Centre that’s influencing your life. You might choose to describe a typical day here but also what it is that happens here is influencing your life. Again, don’t feel that you have to give a glowing report.

Betty: Because my life is stable. I come here and I feel safe. And the food is healthy. And the staff are very, very nice. I’m not afraid to talk to them. And there’s a lot of support. Like if you’re feeling badly you can go talk to any of the staff; they’re always there for you. If you have medical concerns then you can talk to them about that. And if you just need a shoulder... they’re always there.

Interviewer: Think about how your life was before coming to the Centre. Can you describe how the Centre has an influence on your life?

Jenny: I think it's helped me because if I wasn't coming here I would, say, be getting up at 3 o'clock in the afternoon or something. Now I automatically get up at 7 and get here. [The Centre] gets you into a routine... You say to yourself sometimes, if you're not doing drugs, what do you do? I mean, I've been doing drugs for so long I don't know what else to do. I can't hang around those people or even see those people that used to do drugs because they just trigger you. Maybe they're still doing it and you think, "Gee, I wish I could." Even just seeing someone... you kind of think about... "once you're a junky, you're always a junky." And it's true. You can quit for ten years and if the opportunity was sitting in front of your face you might take it. It's not a very good opportunity but... you know. So the Centre really helps me to put structure into my day. Maybe when I get an apartment it will even be a lot better. That's the biggest thing on my list is... it's horrible living in a hotel if you've got two people. You've got to run down the hall to the bathroom, to have a shower. There's no locks on the doors. Or you go to the bathroom and there's somebody using drugs in there... or you go in there and you see somebody squirting blood on the wall. Like, that's just what you want to see. You wonder if it's in the bath... I won't even taking a bath. I'll take a shower but not a bath.

This reduction in drug use needs to be regarded as greater than mere "unlearning" of "bad habits"; it is indeed what Lave and Wenger, building upon Pierre Bourdieu's theory of practice, have termed "legitimate peripheral participation" – a form of social and "situated learning" that is not "merely a condition for membership, but is itself an evolving form of membership" (1991: 53).

In one of the most revealing testimonies presented as evidence of this budding sense of identity provided by "legitimate peripheral participation", a straight male drug user in the course of a focus group synthesized his entire personal trajectory in a few sentences.

Gabriel: Some people call it recovery. Some call it rehabilitation. I grew up in foster homes from the age of six. I never asked to be a drug addict, a convict, and all those other labels that are derogatory and looked down upon in society. I call it "recovering the innocence" which I have a lot of in myself. I've been forgiven for the mistakes I have made and I correct mistakes on the spot if I make 'em. I have now become the gentleman that I respect. I am a gentleman. I respect people who do not act like one, but are one. I have come to my full potential but I will continue to change as long as I live I will continue to change my opinion at any time. I can change. If it's to enhance it, to learn further, understand it which I rediscovering the innocence because at one time I think we all knew it but we didn't consciously practice it or know it. So, it's helped me become the gentleman that I respect and I got a lot of people out there in society that respect me big time. Big time... But it's been good and the Dr. Peter Centre has been a stepping stone to help me in those directions and I thank you for that.

The One-Stop-Shop Option and Reduced Stress

Several participants also reported that the DPC helped them relax and reduce stress. Those who cited this outcome, particularly straight men, women, and transgendered participants, stated that the DPC provided much needed breaks from other environments (e.g., home, the Downtown Eastside) that were highly stressful. Again the effect appears to be in part generated by context rather than a set of specific programs or services.

Jenny: You don't know what it's like living in a tiny room and you have a pile like this. You've got a big bed in there, you've got a dresser and a fridge here and you've got this much for two people. And Greg would come over, and we'd get in an argument in the first five minutes he's in there because... that's how small my place is. You know on the weekend I just stay in my room, if I went out I'd use.

The reference to the weekend is interesting given that the Centre is open all day everyday except Saturday and Sunday. Given the earlier positive comments made about the structure provided by the DPC, it is clear that its unavailability on weekends has social impacts. Removing the safe and predictable context of the DPC rendered this participant captive to her single room occupancy hotel. Leaving her room without the support of the DPC made the risk for relapse too high.

Several straight male drug users and some women also noted that the DPC helped keep them calm. This calming effect was in part attributed to the complementary therapy programs and the patience and support of the staff.

Mel: Okay, I don't hang out in the quiet room. I like the living room a bit. I go in there. I talk to people and then we have our meetings, whatever, which I get a lot out of. So, that's a good room. And then, the complementary therapies are just number one. It helps you when you are angry against anything, against you, or anyone else... But altogether, this Centre has done me a world of good.

The calming effect of the DPC was also mentioned during the women's focus group:

Betty: When I first came here you know I was bouncing off the walls. The staff was very patient with me. I was a druggie. It's hard for me to get close to people. But I've calmed down a lot. It's helped my anger...

Many DPC participants reported that the “one-stop shopping” option makes life considerably easier for them. DPC provides food, nursing, recreation, showers, and

laundry; participants take care of many needs in one setting. The so-called “one-stop shopping” option was often noted by participants. The following comment was made in one of the focus groups:

Greg: Usually I come in, go straight through to grab a coffee and then usually I’ll backtrack either to the smoke room or to get medication, and then once or twice a week I’ll go down to the complementary therapies, but basically that’s what my route is... and then I’ll go from the smoke room to the living room to the music room all day long. I’ll just keep rotating.

When asked to elaborate or give examples of material aspects that contribute to their improved quality of life, participants mentioned frequently the assistance received from DPC staff in securing better housing. For participants who previously lived in single room occupancy hotels, new and better housing greatly contributed to improved quality of life. Many participants also cited positive changes in physical health, such as weight gain, and others reported that since coming to the DPC they have started taking better care of themselves. Several comments from participants suggested that the result or “end effect” of this type of change was improved emotional and social health. This type of change in personal practices and living conditions is described well during the transgendered participant focus group:

Claire: Since I’ve come to the Centre? Holy shit! My life has done a complete 360. I have gone from being on the street, doing drugs, weighing 98 pounds to 140 pounds, to going to school, having an apartment! Having friends again, learning to feel, learning to care, learning to accept my emotions, understand my emotions and my feelings. Learning to live again inside... And now I’m straightening out. And I’m learning that I am somebody.

Although participants acknowledged that having several services in one place was beneficial, some felt that more could be included:

Interviewer: Are you saying that you would prefer to get everything here or are you happy with...

Gabriel: No, because as a person progresses with this disease it’s hard to travel and keep schedules. In my personal life, everybody that I have employment with, they’re some kind of professional and they expect me to be there on their schedule when they tell me the time. They forget that I have a personal schedule. Just because I’m sick, I have to be here, there and there. Now, if I could just have more here, that

would save some energy that I wouldn't get sick at night or get sicker faster or be wearing out sooner throughout the day.

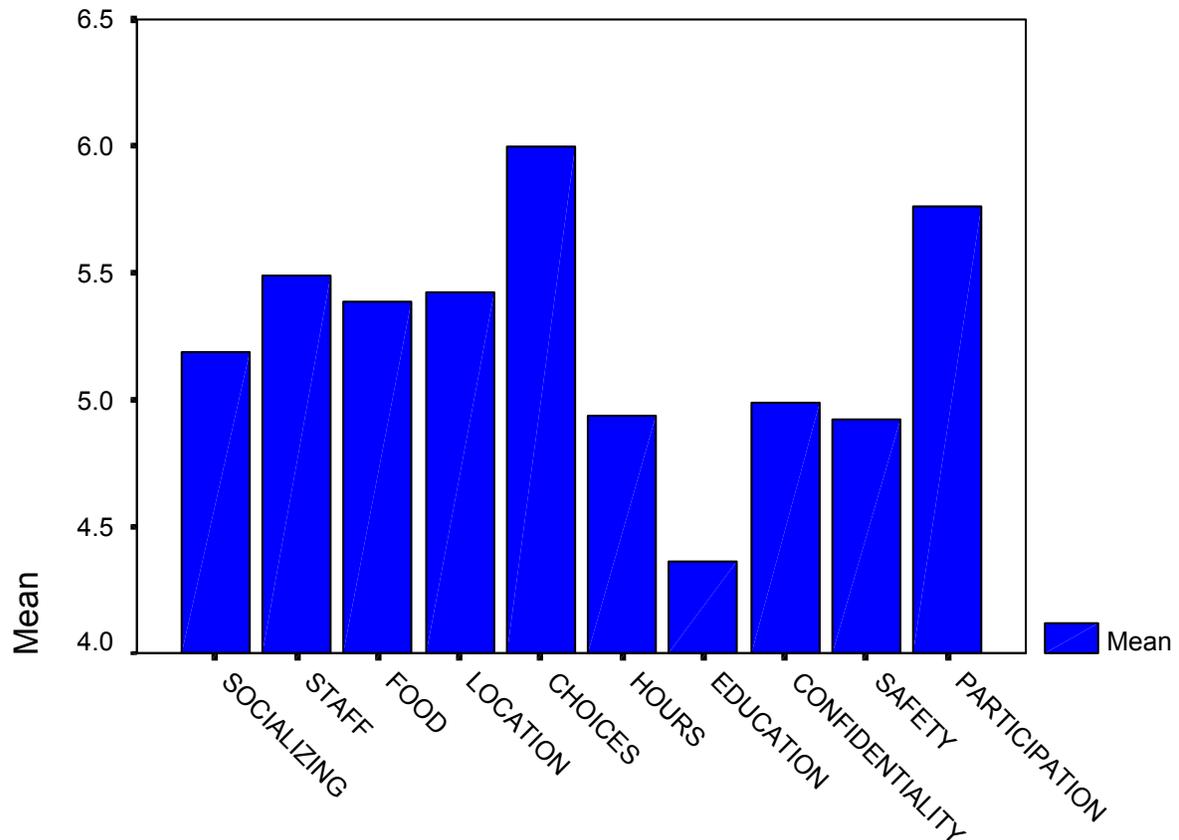
Among the specific aspects of the services and programs that do not work for DPC participants, informants mentioned the limited physical space (which is likely to be solved by the construction and outfitting of a new site), the fluctuation in the regularity and quality of complementary health services (because of the flux of volunteers), and what is perceived as a lack of transition and follow-up resulting from the turn-over of staff (particularly counsellors). When probed on the relationship between a high number of female staff members and the therapeutic alliance and overall engagement of a largely male population at DPC, the focus group informants reported minor concerns.¹⁷

Notwithstanding a predictable number of complaints and exceptions that are commonplace limitations to organizations that deliver non-profit health care services, most DPC participants reported an increase in their sense of membership by making statements such as “I live by myself, I get depressed and bored and I come [to the DPC] to interact with other people”.

Contextual Factors

Throughout the study participants were asked to discuss in a structured way various contextual features of the DPC that affect their quality of life. During the structured interviews participants were asked to complete a contextual factors questionnaire designed by DPC staff and participants. These various contextual factors were identified as features that likely contribute to engagement. In completing the questionnaire, participants were asked to rate reasons for coming to the DPC. The findings are presented below in Figure 1.

¹⁷ However, when considering the prevalence of the addiction/recovery model in DPC discourses and programs, one should not overlook the documented fact that this is a model that emerged from the 1970s feminist movements in North America. As discussed later, one of the possible implications is that the DPC community might work on a narrow premise of social agency and political mobilization around HIV/AIDS and the use of drugs and alcohol. This premise might in part contradict the philosophy that underlines the harm reduction model.

Figure 1: Participant ratings of selected contextual factors

The raw ratings indicate that participants rated “choices” (regarding programming and participation in services) most highly, followed by “opportunities for participation” and “staff” as reasons for coming to the Dr. Peter Centre. Other findings of interest include the low rating of “education”. The relevance of this finding will be discussed in a following section. Also of interest was the relatively average rating of “food”.

Throughout the study, the DPC staff mentioned that they felt that participants often came for primarily for the food, which made the DPC something of an “expensive soup kitchen”. Clearly these findings suggest otherwise.

Table 4 summarizes the correlations between level of engagement with staff and ratings of the various contextual features. The findings indicate that it is the opportunities for

participation, the opportunities to socialize and programming choices that are most strongly associated with therapeutic engagement.

Table 4: Correlation between engagement and selected contextual variables (n = 76)

Contextual Features	Engagement with Staff	
	Pearson r	p-value
Opportunities for participation	.31	0.006
Opportunities to socialize	.31	0.007
Programming choices	.24	0.038

p < .05, * p < .01

Programs

Throughout the study, the participants made reference to various programs at the DPC that contribute to their quality of life. While reference was made to most programs, a few were mentioned more frequently than others and consistently across groups. The programs do not appear to promote clear and predictable clinical effects, but rather are used in different ways to address unique needs. Somewhat surprisingly, the complementary therapies program, run by volunteers rather than professionals, was among the programs mentioned most frequently by participants. The complementary therapies program consists of a variety of therapies including acupuncture, reiki, and healing touch.

Jenny: And the therapies have helped me immensely. I've had some back problems and then I go to [the acupuncturist] and they've gone away finally and they don't come back. Even the other day, he helped me with my esophagus and that's helped me. And I wish I could get in to see reflexology more often. I've missed the last few appointments.

While many participants made reference to relief of physical problems through complementary therapies, others seem to suggest that it was also a positive view on health that they found refreshing:

Carl: There are views of the mountains in the outdoors and there is fresh air. The waiting room for the complementary therapies is positive for me because people go in there with a positive outlook on their own health and I like to share in that attitude.

Another program area that was mentioned frequently was the art room. Again, this program was mentioned by all groups. That said, different people appreciated the art room for different reasons, which might explain its broad appeal. The room is typically overseen by one or two therapists, and participants work either on individual or group projects. For many people the art room seems to provide a place to unwind:

Interviewer: The art, what in the art room works for you?

Mel: Because it's a place for me to go and unwind.

Interviewer: What makes it a good place?

Mel: Because it is nice and quiet. Everyone who's in there is at peace and they're all trying to do something nice with art. And I think that is really good because it gets me into the same perspective, right? And so Ibáñez-Carrasco it keeps me from boiling up or anything like that and uh... it's good.

Others acknowledged that they enjoyed being able to accomplish something in the art room while simultaneously relieving stress:

Sarah: ... the arts and crafts room. I feel like I can accomplish something, I've made something. And also with the art room I can relieve stress and relieve my withdrawal symptoms.

While many participants did not explain what it was they liked about the nursing program, this service also received frequent positive mention by all groups. It appears that the convenience of easy access to nurses is an aspect that is appreciated. Participants are able to see DPC nurses quickly on an as needed basis for a range of issues and problems. Indeed, one member of the gay men's focus group did acknowledge that having access to nurses reduced his need to see his doctor or use the hospital emergency room:

Jason: The nursing staff, if I have concerns about my health, instead of having to make an appointment to see my doctor or worrying about trying to get to the emergency room, I know I can come and see someone here and talk about my concerns.

Again, in this area, there was a fair share of specific complaints about deficit in the delivery of complementary services such as massage therapy (which are staffed by volunteers). Nonetheless, many participants expressed appreciation for whatever was available.

Social Support

Throughout the data collection it became evident that the open and unstructured environment of the DPC seemed to promote a variety of social support effects. These effects occur despite the ongoing tensions between the subpopulations of DPC participants. With such a large number of people in a non-clinical and home-like environment, it is easy to understand how these social support effects would be especially potent in this type of care setting. Like the structure provided by the DPC day program, the mere presence of the various social actors makes for positive impacts. These impacts do often occur independently of various structured programs and services and appear to enhance engagement. As the transcript example from the staff focus group indicates, the therapeutic potency of the social climate of the DPC is subtle and elusive.

Four of Six: As someone who is always observing the way things develop at DPC, it is interesting to see what the research had brought up so far. I was struck by the fact that we are always so focused on the food service for the participants, thinking that this is what the community at large wants to hear. It is interesting to see that the research so far has indicated that food is not the most important thing to people and that maybe we should start thinking about advertising ourselves as a more holistic agency in the community, not only as health care providers. I was struck by the fact that the amount of time someone spends here is not related to his or her engagement. Someone might come one a month and when she comes they utilize everything and get a lot out of that, and that there are people who come every day and don't do anything. The intriguing question to me is why people keep coming every day if they are not doing anything. I don't know why. I guess they are getting something out of it but it is something we're not seeing in any therapeutic context. What is that? Something we can't define with the terms we are using. There is always a conversation among us about what can be done with those people that don't engage in the ways we measure engagement.

While the social support effects that were mentioned seemed to occur independently of structured programs, much of the social support that was described was attributed to staff caring and involvement:

Interviewer: Yeah, so that's the part I would like to narrow in on a little bit more. Think about what you've just described in your last responses. Think about what it is at the Centre that are the growings and learnings for you. And maybe you can think about what type of services you received here helped. What makes the difference?

Claire: That is easy for me, the staff. They have never... I have never heard or felt any negativity from any of the staff toward me or anybody

in here. It's been nothing but positive, positive, positive, from the time I walk in the door to the time I walk out. I do something in the art room and to me it's like gaudy as hell, but everybody around me is telling me how great it is. And this Centre has boosted my self-esteem. It's let me find me again through positive people, from staff. And I see it in other members, too, when they come in here, self-conscious, dull, no self-esteem, nothing, and they're right up there, too. In fact, I take it outside the Centre. I'm in school now; I've got confidence to do that again.

While many people mentioned the social support they received from the staff, it was most often instances of informal staff support that seemed to make the biggest impact on people:

Gabriel: Well, I start my day by coming to into the receptionist area. I say good morning if I get greeted with politeness. That is a big portion of my day right there and if I'm in a shitty mood or not, I use manners...

Interviewer: So you pick up your vibe from the...

Gabriel: Right there, the front person is the number one front line.

Another member of the straight male drug user group agrees with Gabriel:

Tyson: Well, when I come in, I say hi to the people at the receptions and like Gabriel said, that makes a big portion of my day, you know, like it shows when you have somebody who has a nice smile and says "Oh, hi, Tyson." It's nice to have that.

While staff support was mentioned frequently, forms of peer support were mentioned just as often. The unstructured environment provides participants with the opportunity to develop supportive relationships with one another. As indicated in the following transcript example, these relationships often begin at the DPC but later extend beyond the immediate environment.

Gabriel: It was an anger management group that Mel and myself attended and it was one weekend that somebody got under my skin so bad that I was vibrating like this man. I had to get out of that apartment. I had to go to my apartment. I had to get out of that building. I would have snuffed him.

Mel: He was ready to snuff someone.

Gabriel: I had no problem. I went over to Mel's and me and him had a little anger management session. That's something we have learned here. On the weekend when we got all riled up I went out and aired it out.

In the dialogue that follows the reader can see how women's experiences at the DPC allow them to forge a "disposition of trust" with people they had never done that with before, noticeably with other women. This segment also indicates that, if given the right context and social tools, DPC women effectively act as resource persons, mediators, etc. for themselves. They do not always need the direct "intervention" of a counsellor.

Betty: Jenny knows that I had such an *attitude*. Remember? I wasn't nice to anybody but Jenny knew and she put me in my place. She said, "You know what? You're something else. If you don't shape up, you're not..."

Interviewer: What you're describing – both Kelly and Betty – is how you handled this issue yourselves. And you know I wonder whether you were able to access counselling.

Kelly: The last person was [participant's name]. So anyway, there was this one time when she said, "I can't get over how real you look." She thought I was a male. And I just, for every mistake I'd made, I'd prostitute my body for every man. And that being said about me like that by somebody who obviously... I just went, I've had it...

Betty: I've been asked that.

Kelly: And I freaked. And I totally held that against her and I totally was treating her really rotten. And then I realized that that's a compliment. [Group laughs] Because I could be (a) good looking as a woman, and (b) good looking as a guy, too. So there's a compliment. I take it on the lighter side. It's not a heavy duty...

Sarah: Well, for me... when I first came, I was somebody... like on the street I always... *I never wanted to make friends with women because I didn't trust them*. So I didn't make friends with women. I never really talked. And because I was around males all the time, I spent a lot of time with men and I wasn't close to women. Then I got to know some women.

Interviewer: So you're saying that in your experience prior to coming to the Centre you didn't get close to women?

Sarah: Yeah. I wouldn't get close to them. So gradually I started getting close to them.

Betty: I had a real lesson to learn when Gloria died. I had a real attitude around people that use. I was very judgmental. Nobody, pretty much, was ever judgmental towards me and I was very judgmental. I now I realize that I was there. With drugs... nobody wants to be a mess. That's why when she died... I'll never do that to anybody else. [Cries quietly.]

DPC provides a venue to women to begin exploring the possibility to forge relationships with other women living with multiple challenges. It is noteworthy that this workshop sparked great motivation among women who participate in it to continue meeting and

discussing issues that affect women. The focus group facilitator told them that she would support future meetings. The following excerpt shows that it is not easy to be a woman at DPC and this is not only an issue of numbers. It is difficult to be a woman living with HIV disease, period, as some members of male social groups do not make it easy for them.

Jenny: Ever since I've come here I've always gotten along with transsexuals and gay guys. They've always not been afraid of me or have not been courteous or telling me they don't like me. I've never had that problem. So when I came in here... at [another agency] there were a lot of women going in there. They felt intimidated. I never did but...

Betty: A lot of the men are rude to them in there.

Sarah: Yeah, and they're snobs.

Jenny: And they're all gay. Yeah, there aren't too many of them who aren't gay down there, including the people who work there.

Betty: Talk about homophobia.

Jenny: Yeah. But here I found... and when I first joined there wasn't very many women, there was a few. Good thing you came because I thought that there were only three or four women when I came in. Yeah, it was all men. But nobody in here has ever been really nasty to me. I haven't had a conflict with anybody. In all my life I've never even trusted women...

Betty: You're very mellow. You're very easy-going.

Jenny: *I've never trusted women.* I mean, I like them but I've never trusted them because every time I turn around my makeup is gone or my coat's gone or...

Susan: Or *my man* is gone. [Group laughs and claps]

Additional Findings

The Family Model vs. the Participatory Model

The DPC staff and participants agree that the larger DPC community operates like a family. For many participants, this sense of family is embraced, especially as it fills a void left by lost relations and alienation. While this point was made loud and clear during the qualitative data collection, the quantitative findings also reflected the isolation from family that many participants feel. The FAHI QOL instrument administered during the structured interviews contained a few questions on the social quality of life subscale that concerned family relations. On closer examination, it was low scores on these items that

accounted for the participants' comparatively low social quality of life scores (see Table 1). These points are captured in the following transcript example taken from the transgendered participants' focus group:

Interviewer: Do you ever think about coming here any more, in your future?

Claire: No, I don't. Without the Centre... I'd feel empty. It's like a family here, this is my family. I don't have a family, this is my family. My family had thrown me out. I hated them but I loved them.

While this sense of family promotes a feeling of belonging and bond that is positive, others, primarily gay men and straight male drug users, complain that the DPC staff maintain the role of "parent", which in turn limits the much enjoyed opportunities for input and participation. The following is a transcript from the straight male group. While Lorne points out the ultimate power held by staff, and the corresponding limits on input by participants, it is interesting to note his acknowledgement of the "code of conduct" that was "put together by everyone".

Lorne: I think that the staff, they have some growing up to do. In their process of growing up, I would hope that they would place as much faith in the participants, in their growth as they do in enforcing their code of conduct that was put together by everyone for the institute. For the well-being of the people. I think that the staff should realize that if there's a difference of opinion, if a participant has an opinion, that opinion is just as valuable as the staff's opinion.

Later during the focus group, Lorne provides one suggested solution:

Lorne: They should negotiate more, like the staff should be able to sit back and communicate, negotiate, whatever, bend over backwards as well as we should bend over backwards to make something work. If this is gonna work, we've all got to work at it together and so, just because something is in black and white doesn't make it right.

Other participants noted that the family-like atmosphere at DPC (with staff as parents) creates a culture devoid of an clearly understood sense of community morals, mutual responsibility, and ownership. This point is made by a member of the gay men's focus group.

Interviewer: There is a mission statement that DPC is to provide comfort care for people living with HIV/AIDS.

Carl: But what are the moral boundaries? What are the hustling boundaries here? What are the safety boundaries? Those things are unclear to the participants as well as the staff. There should be a rights and responsibilities contract. What is your responsibility? When you come in, do you sign a piece of paper saying, “I won’t talk about what goes on in here”? You didn’t sign anything! There is reciprocity at DPC. We are not working together at DPC. I know that this does not happen in every case, but this lack of reciprocity is institutionalized and makes it very difficult for some of us.

Interviewer: Some would respond to that by saying that DPC is not a self-help organization such as [another agency], it is not people-driven, it is service-driven, it is a place that provides services.

Carl: Well, then the DPC decides what services are good for people living with HIV and then we line up and we get them and go home. That creates a totally different culture in here. It becomes a series of line-ups and everyone for himself and we shove as many oatmeal packages (and other freebies) as we can jam in our pockets.

Interviewer: Are you saying that this system creates a different kind of... moral community?

Carl: It creates no moral community.

When the issue of family and power came up in the staff focus group, some of the group members noted that the control that staff maintain is essential to the integrity of the structure of DPC:

Three of Six: [Interviewer], you mentioned the word hierarchy. I think that is absolutely true. I think that there is a hierarchy and that we do have the power ultimately. I think it’s not in anyone’s interest to think that we don’t. One analogy we often use here is that we’re kind of like a family and like it or not, we’re kind of in the parent role. But a good parent does say, “I’m in charge, but within these parameters, this structure. You can make choices in terms of what you want to do, when you want to do it.” I think a lot of the participants’ backgrounds have been quite chaotic. They haven’t had that kind of structure. And even though a lot of people complain bitterly, you’ll find people also find the Centre very safe, that there are rules, that there are guidelines, that they know that certain things happen at certain times and in a certain way. Even though participants might kick against them just like children resisting the parents’ rules. But it wouldn’t be healthy to say, “Sure, here are the keys, take the car out” to the six-year-old. You have to set some kind of limits. And I think participants have an understanding of that, although we don’t see much of that. For example, if we had a system where anyone could come and ask for a meal at any time of day this would continually reinforce that sense of chaos, lack of control, lack of care for what participants do. So, it’s not just a heavy power trip of the staff, we don’t get a rush out of controlling the participants. However, it is very healthy for people to have controls and also help to socialize where these controls exist everywhere. At the same time, it doesn’t mean that those controls can’t be challenged and that’s what we encourage participants to do. They have a free choice to say, “I don’t like this” and participants certainly make good use of their choice. The

community meeting is a forum to challenge all this stuff and generally participants reach agreements that they understand why we do things a certain way, if we explain them in a respectful manner.

Challenges

The Trouble with Mixed Company

The general idea of what works and what does not work in an adult day centre such as the DPC comes across loud and clear in the sense of “displacement” expressed by gay men in the focus groups and in their everyday complaints about the place and the other participants. These complaints take the shape of consistent comparisons and judgments about drug users, their actions and their (supposed) motivations. Conversely, the drug users complain derogatorily about homosexuals and they openly despise transsexuals, but they report that the DPC is positive for them. The displacement of gay men is a historical trend in North America. The DPC does not provide a place especially geared for gay men, transsexuals, straight women, or straight men; it provides a general space that reflects the current social stratification in AIDS-related social services.¹⁸

Interviewer: Some people would argue that people have different and multiple diagnoses. There are people with clinical depression and be a drug addict and be gay. Given such complex profiles, maybe they have to sometimes overlook certain kinds of behaviours. What do you think about this?

Wayne: They [the DPC staff] are too lenient. I am gay, I’ve never done drugs, you know, whatever, what are you going to classify me as? I’m still gay. A bisexual is still a bisexual no matter what. How about “three strikes and you’re out”? I’ve seen people come in here complaining “Oh, I feel miserable, I need help” because they got high the night before, they come the morning after and they want all these things given to them, and they *are* given to them. Then, they are clean for a week and they start all over again.

Interviewer: Are you suggesting that they [IDUs] should be punished for what they do outside DPC? Wouldn’t it like being punished for going to bed with same sex individuals, would it?

Wayne: If they do not want help, why do we try to... they should be in detox, they are in a different group, and they should not be in a centre like this. They should get that part of them cleaned up before they get here, they can’t clean up all five parts [that are going wrong] at once. If

¹⁸ This silence about lesbian women is startling. No women identify as lesbian and no opinion was presented on the subject. This reflects the commonplace belief that AIDS has not played a significant role in the lives of lesbians and that lesbians have not played a significant role in AIDS work and experience.

they have drug issues or mental health issues, they should deal with them first [somewhere else].

Interviewer: But, some people would say that the problem is that there are fewer agencies doing this kind of work.

Wayne: Who started these agencies? Gay men. Was it someone from the suburbs who said he or she would do something about it? No. Why are these resources being taken over then? They should go to rehab then come here and start over again. They go back and forth wasting all these resources. They keep coming to DPC and costing a lot of money.

Lyle: These people do not really want help, they are not ready to quit.

Later in this discussion, the gay focus group participants bring this issue up again:

Carl: [Another local organization] has a policy of not allowing drug users to use their services.¹⁹

Randy: I think it is a good policy. I used to go to there when it started and the reason they implemented that policy was that it was getting just like this Centre is getting, so they had to put a stop to that. It is a good policy, I think it should be implemented here.

Interviewer: If we had a policy of no drug use here, this place might empty right out. Our survey indicates that 77.6% of the DPC population have had or presently have a history of drug use. Would this close this place down?

Randy: No, it wouldn't. Those who stopped coming here would come back then. I know many men who have stopped coming here because of the drugs. Some people don't come very often; they sometimes come, see what is going on and walk straight back out. A lot of people only come once in a while because they don't like what is going on here.

Interviewer: What kinds of people would come back?

Randy: The ones who want to get services for HIV, not for addictions.

Carl: There are lots of people in the community who don't come here. They feel that the DPC has separated itself from the other AIDS organizations in the community. DPC does not belong to the Pacific AIDS Network, it doesn't associate with other HIV groups, it doesn't cooperate apparently with other HIV groups, it has isolated itself from the [AIDS] community in practice and in appearance. DPC has a reputation in the community of being a drug [rehab] centre.

Wayne: DPC was in the gay pride parade this year.

¹⁹ Roughly, this policy is of no drugs, no aggressive behaviour, and no stealing on the premises, similar to that of DPC but, by all gay participants' accounts, enforced in subtly more authoritarian ways. The mandate of this organization is to serve people living with chronic debilitating diseases such as AIDS and cancer. Historically, this organization was formed by mostly HIV-positive gay men from another local organization of people living with AIDS whose membership rapidly increased with the presence of many heterosexual drug users in the mid-1990s. The offshoot organization this participant is referring to is likely to serve mostly gay men who live in a geographical area recognized as a gay neighborhood.

In clear reflection from macrosocial views, HIV is seen as primarily an issue of sexual orientation that was historically attended by gay men,²⁰ and rehabilitation is reduced to abstinence, detoxification, and recovery. This way of thinking is evident when AIDS care and services are discussed. Gay male participants, for example, offered rudimentary solutions such as banning drug users from the organizations, which would cut off the delivery of service to many gay men, or finding out whether an individual was homophobic during the intake interview, which would possibly make many gay men poor applicants.²¹ Nonetheless, these gay men reported visiting this organization and other health care and AIDS service delivery organizations on a regular basis. One possible explanation is that they do not have many alternatives; however, in small or large measure when compared with other social groups, they still find some of the services and care they need in places like the DPC.

In contrast to the complaints made by gay men, straight men, women, and transsexuals provide a glowing report of the services and care they find at the DPC. They do not express a historical understanding of HIV/AIDS – though they may be formulating one, just as gay men have configured a historical understanding over two decades – and they do not complain of displacement. In fact, straight men, women, and transgendered participants overall report a converse experience to the socio-dynamic experience of displacement. For many, the DPC has provided a *structure* in their otherwise chaotic lives, which, in their view, is invaluable.

In sum, the mixing of company produces tensions and expressions of animosity among self-identified groups. Because group membership is in part determined on the basis of who uses drugs or not, the discourse of abstinence is offered as a means of preserving one's space. As a consequence, a true acceptance of drug users and harm reduction cannot be realized. This mixing of company may also be at the heart of ongoing

²⁰ There are familiar hints to the effect that mostly gay men took care of the AIDS epidemic and that these gay men were *not* from suburban areas. There is also a slight confusion between service-driven and member-driven (self-help) organizations. DPC clearly belongs to the former type.

²¹ There is a generalized tone of “victimhood” to the statements made by gay men. Later in this report, it is argued that it stems from an addiction/recovery model that impairs one's ability to think critically about “difference”. The dominance of the abstinence/recovery model and the associated expectations were evident not only in the gay men's focus group, but also in the comments made by other participants.

challenges at the DPC: namely, the lack of a clear purpose and the near absence of targeted education and programming.

Unclear Purpose and Education

Throughout this study, it became apparent that participants, especially gay men, and some DPC staff felt that the DPC lacked a clear sense of purpose and needed more targeted education initiatives and health services. Again, these concerns may in part be a by-product of the ‘trouble with mixed company’ described in the preceding section. The confusion concerning what exactly is being done at the DPC is evident in a staff member’s comments about participants and the results of phase one of this study:

One of Six: I didn’t know what this place meant for them. I don’t know if I had any assumptions. I often question my work at DPC and whether I am making a difference or not and whether it really matters or not. The results presented seem to validate the possibility that I am making a difference.

The following transcript example taken from the gay men’s focus group illustrates the sense of a lack of clear purpose and a desire for more targeted programming:

Interviewer: You used the phrase “resources have been taken over”. Does anybody else want to comment on this?

Martin: [DPC] is for everybody, everybody is welcomed. [...]

Carl: “[Resources] are being taken over” was the phrase used. My understanding is that this is an HIV centre, I am here and a lot of people think it is a drug rehab centre, they [IDUs] come here because they think it is a rehab centre.

Interviewer: It is not a drug rehab centre, what is DPC for then?

Carl: Many things indicate that there is not much attention being paid to persons with HIV. There is no workshops on HIV issues. They have condoms available but no lube here! Where else would you offer condoms and no lube! How much attention is being paid to HIV? Nutrition? They don’t serve food to address [HIV] nutrition needs, they serve food for some other reason. I am not sure what the reason is. It seems that most of the staff [deals] with drug issues and not HIV.

Randy: I have been saying this for years, that nothing happens in relation to HIV here. When I first came here for my [intake] interview, *nothing* about drugs was ever said to me and I was shocked by it when I got here. [Someone else agrees and says that when he has asked a question he has been told to go and find the answer in a book at the library. They laugh.]

The issue of education was also considered in the quantitative analysis when participants were asked to rate various reasons for coming to the DPC. The results indicate that of all the contextual variables listed, education received the lowest rating. During the straight male focus group, participants were asked to identify specific educational outcomes but were unable to do so.

Safety and Solidarity

One example of what works differently for different social groups at the DPC – and yet it *works* for most participants – is the capacity to provide “a safe space” at the Centre. “Safety” and “confidentiality” are often measured together by participants. Non-gay participants ranked safety and confidentiality high in their surveys. They qualified this information in ways that indicate that the underlying theme was the safety provided by a space in which some of them could be drug addicts or alcoholics without the chaos of the drug scene; they determine the boundaries in terms of a “solidarity” system. In the following passage of the straight male focus group, we delve further into this issue.

Interviewer: What do you say to people who say there are drug deals going on in there, in the smoking room?

Mel: I have not seen it.

Interviewer: Lorne? No opinion?

Lorne: Oh, I've got an opinion on it.

Interviewer: Do you want to tell me?

Lorne: [laughs] Uh, well, I'll put it this way and I'll use myself [as an example]. Somebody asked me if I knew where they could get hold of some smoke. And I said – because the smoke's shitty out there, right – I said, “Sure, but I'm not gonna talk about this here. Wanna talk about this, let's talk about it outside.” That's the way it goes, right.

Interviewer: So it's not that people are selling and buying in here.

Lorne: That's where they've got it wrong here. People are not in the midst of buying and selling their drugs like it's going out of style. They're not. People might think it's going on, but there you go, it's just a rumour. If a person, you know, if a person does, wants to [buy drugs] or whatever. In my opinion, it's stupid and it's sloppy and they're being nothing but a [unintelligible] Ya got business? You do your business outside, away from here.

Interviewer: What would you do if you were aware that this is actually going on or if you were a witness to it?

Lorne: If I'm aware of someone sitting back “taking care of business” inside? I would make it a point to get in their face and tell them to quit

drawing heat on the institution. Take your business outside. If I can do it – I’ll use myself. If I have to do it or whatever, if somebody wants to know where they can pick up something or whatever, I’ll do it outside. If I can do it, I’ll do it out there, so why can’t they? It’s very simple and it’s respecting the institution and it’s respecting ...

Gabriel: [It’s respecting] the management and it’s respecting us.

Interviewer: Fair enough. I’ll get back to you Gabriel in a second. Greg, do you have anything to contribute on this topic?

Greg: The way I would look at it is I couldn’t see anybody dealing out of here as, in a sense, dealing, you know what I mean. Like, if he’s out there and he’s dealing out there to make a profit, that I couldn’t see, but personally, *I’ve seen a few people helping each other*, like, you know what I mean? It’s not a dealing situation. [Commotion.] Like, I’ve seen people handing other people drugs but it’s not a buying situation. They’re not selling drugs. They’re just ...

Mel: Trying to help a person out.

Greg: But I couldn’t see a person dealing out of here.

Tyson: I couldn’t either. It would bother me and I’d end up going to one of the staff.

Greg: There’s a lot of addicts who come in here because it’s safe. [It is a place] to get away from that.

Mel: I’m one.

Tyson: I’m one.

Greg: And I’m one. [Pause.]

This “helping someone out” theme of solidarity emerged in the transgendered focus group as well. The DPC provides a cultural space where individuals can take care of each other – and this entails their addictions – in ways that are dignified and self-regulated. Gay men, who often make efforts to differentiate themselves from people who use drugs, are aware of this kind of solidarity but they judge it in quite different terms.

Interviewer: You flagged the smoking room.

Carl: I wrote “toxic” there for a couple of reasons. The air is toxic – I smoked for 20 years – and the [environment] is psychologically toxic, the addicts are always trying to bum smokes from you and everybody else. I think it is toxic for the DPC; it is ironic that there is a place to support this addiction here.

Interviewer: Is the fact that some participants have addictions to harder drugs an issue for you?

Carl: I think that this [practice and how often it happens], bumming cigarettes to support one’s individual habit, granted it is a small one, but it is psychologically damaging. I could not make enough money to support my smoking habit, I had to quit. [I understand] these are individual decisions, but “these” people have enough [financial]

resources to put some aside every month for cigarettes every month if it really matters that much to them. They're sucking off from other people. I think it is negative to support one's own habit and then other people's habit.

This participant makes reference to the very significant practice of this organization to support – not encourage – certain habits.²² This idea of support, which we will refer to by using the more clinical term “maintenance” is, in our view, linked to the notions of harm reduction and quality of life. One of the DPC staff members encapsulated the apparent paradox between allowing participants enough free space to do what they need to do and their risk to fall back into “their old ways”.²³

One of Six:[...] It's funny that some participants say that this is the [smoking] room that tarnishes the reputation of the Centre – and this goes right back to statistics gathered in the first phase of this study that reveal that participants get the most out of this place when they're engaging with the staff – of course, they don't like this room because there's no staff engagement here. And for some reason, they need to have staff around. [...] They're not going to trade drugs up there [somewhere else in the Centre] because they wouldn't want to do it in front of us! Not only because they'd get kicked out but also because they just wouldn't do it! They don't need to do it here but for some reason they do. They go back to their old ways in here. Why do they do that? I don't know. Maybe that's what they're thinking when they say [this room] tarnishes the reputation [of the Centre]. The flip side of that is that I've had great conversations with people in here. [...] When a new participant comes in, if they're a smoker, I'll often have my first contact with them in the smoke room. This is where I introduce myself. [...] It's my way of letting them know that [stiff upper lipped professional] that they see in the hospital, that they can talk to me about whatever is wrong with them and so I really value this room for my own specific work in that I'm able to break down some preconceived barriers that I think they have about me [as a professional].

The smoking room was, in the words of many of the informants, a place that encapsulates intensely how some things at DPC work differently for different people. It was described as a negative but necessary room. The themes of smoking as an addiction (habit) and drug using were intertwined in the informant's comments. The one common disposition toward addiction is that one should accept that it exists and acceptance of its existence always came before qualifying it as negative or positive.

²² What seems “ironic” in this participant's intervention is that it represents views held by many gay men at the DPC and mirrors the “straight” views about drug use held in society.

²³ This might be assuming that many of the participants' “old ways” are negative.

DISCUSSION

Mixed Company

At the outset of this analysis, it was established that all the elements of the equation [(*habitus*) (capital)] + field = practice] are present at DPC, but in differing degrees. Two of the elements that make the practices (“outcomes” in the currently fashionable “logic model”) are the capital: evidently, DPC members represent a cross-section of society and bring extremely different kinds of socialization to the equation. By virtue of this capital, all DPC members exhibit different dispositions. These variations in the quality of the elements produce a variation in the type of practice of rehabilitation and ultimately in quality of life. As the quantitative findings indicate, engagement in rehabilitation is positively associated with quality of life, although the benefits are not enjoyed equally.

As reflected in the quantitative survey and the obtained qualitative evidence, straight male drug users stand to derive the greatest benefit from their engagement and therapeutic alliances at DPC. They do not necessarily talk more with staff or other participants, but they begin their engagement at DPC from a position of great social disadvantage and chaos; however, they do not often exhibit dispositions to trust or cooperate with others. The DPC marks a departure from social isolation and the street-based drug scene to fledging forms of community membership. This undoubtedly contributes to their quality of life. A similar result, somewhat hindered however by the conventional gendered hierarchy, can be observed from the engagement of straight women and transsexuals with staff and each other at the DPC. In general, gay men benefit in limited ways from what is offered at the DPC. They describe their experience as one of neglect, displacement, and disempowerment – in short, as victimization. Despite this perception, the fact remains that they use the Centre and engage with the staff in efficient ways. To be blunt, gay men obtain maximum yield from their limited involvement at the DPC and this does not seem like a great benefit because they often neglect to recognize their social advantage (capital).²⁴

²⁴ It is likely that the staff in their efforts to offer equity of services fails to recognize and incorporate this notion of differing socio-cultural capital among DPC participants. Again, this I partly due to time, resource

The collected evidence indicates that the field of the DPC reproduces the hierarchies of the outside social world. The guidelines of conduct and other policies serve to regulate the everyday behaviour of the participants and staff, but this does not alter the profound inequalities that already exist amongst the participants. Our mission was to clearly differentiate between the way in which the participants have been socialized to make such distinctions and the actual distinctions that exist. For example, transsexuals insist that as women one of their paramount roles is to care for others which is often a stereotype of the social and gender role of women. It appears as natural. However, straight males and females who greatly outnumber transsexuals make clear gender distinctions that place transsexuals in a sort of gender limbo. The sexual roles that transsexuals may play outside DPC are not even discussed, nor are the sexual roles of straight men and women, which again are taken for granted, taken as natural.

Thus, different individuals at the DPC are categorized within specific and highly stereotypical roles. In general, DPC staff and programming do not deal with these distinctions or the significant educational process of mutual recognition. One should not imply that this should be part of their mission and philosophy of providing “comfort care” to people living with HIV disease. However, one should be aware that individuals who start their participation at DPC from different vantage points are bound to get different results. That is to say that individuals who start their participation with sociocultural capital of great disadvantage (e.g., transsexuals and women, in that order) or sociocultural capital of advantage (e.g., straight males and gay males) will always have different experiences of rehabilitation. Although this inequality may seem commonsensical, it is often glossed over in the discourse that staff and participants have about participants’ “progress” in DPC programs and services.

One way of making the field more even for everyone, given their differing and influential sociocultural capital (which is often discussed as stories of addiction/recovery), would be to create specific programs for specific groups. This type of system has worked well in other countries such as Germany, where the national AIDS organization has created

limitations, and the challenges of serving such a diverse group. Also, one might not be able to offer equity of services to a population that is not even in social standing and power.

separate programs for gay men and injection drug users. These programs are in turn specifically targeted to meet the unique treatment and prevention needs of the group they serve. Many of the programs that serve injection drug users incorporate a range of harm reduction interventions (e.g., safe injection facilities, needle exchanges, and methadone clinics) that address issues of drug use and HIV. One can speculate that everyone would not always welcome such a bold political strategy. However, it is clear that a series of positive therapeutic alliances that create positive dispositions among participants (*habitus*) cannot amount to social change. Therapeutic alliances and their aggregate into a form of rehabilitation for people living with HIV disease might only work for those who are in the best position to make those alliances work for them.

The case of gay men at DPC is paradoxical and gay men recognize this paradox. They have been socialized to be the greatest victims of AIDS, or at least some of the individuals seen as legitimate victims. This is the historical result of two decades of AIDS activism. However, as certain biomedical issues around living with HIV are gradually resolved, gay men appear as less in need of direct social services. There is still neglect around issues of prevention and sexuality for HIV-positive men in general and HIV-positive gay men in particular. There is absolute neglect around the care of aging people living with HIV. AIDS, in our collective mind, remains an untimely epidemic of the young and healthy. In spite of this awkward social and historical position of gay men, they still come to places like the DPC with relatively great advantage (particularly if this advantage is measured in comparison with other social groups such as straight men who use drugs).

Despite these glaring differences in how the DPC structure and systems work for various individuals and social groups, DPC strongly and consistently offers a social space for individuals to find a “mutual recognition”.²⁵ This notion is based on a basic recognition of each other’s differences and the individual’s subsequent ability to claim ownership in various social groups at the same time and to see the world from multiple positions (Berlak, 1994: 49). This notion is based on the premise that “the process of categorizing

is inherently oppressive” (50) and it is not merely additive (e.g., one is a drug addict and gay and a sex trade worker, but all of these features function in an intricate relationship). The “mutual recognition” theory has at its centre that “[f]or recognition to be mutual, it must occur between persons who *see one another as both like and unlike themselves*. This is so because your recognition of me is only of value to me if I see you as other, as separate self, i.e., a self that is different from myself. But in order for your recognition of me to be of value, I must also be aware that you are like me – that we have a shared reality, that you are contacting my mind” (Benjamin, 1988: 37 paraphrased in Berlak, 1994:53). One central component of Jessica Benjamin’s feminist psychoanalytic understanding is that individuals are not autonomous or unconscious of their position vis-à-vis the “other” or unconscious of the “other’s” dispositions and practices. In brief, although it is not under one’s control, one intensely needs the “other’s” constant recognition of one’s difference to be in control of oneself.

Possibly, one of the underdeveloped areas of the DPC is the implementation of forms of non-formal (popular) education (e.g., social marketing) that lead to a more structured form of mutual recognition. This would involve integrating this understanding in the philosophy of “comfort care” of the DPC. Staff and administration need to find structured and explicit ways to make the participants aware of who the target population of DPC is, that they are included, and that by virtue of that inclusion they cannot exclude others.²⁶

There are many examples of how the DPC does or does not create an auspicious climate in which individuals with various dispositions may deal with HIV and addiction and, most importantly, may deal with these issues in a social context. Unfair as it seems to rank dispositions from most to least successful without generating broad value judgments, it is obvious that some members of particular social groups make great overtures to individuals whom they perceive as different. Indeed, some of them are quite

²⁵ We emphasize the agency of the participants here. The DPC is seen as a venue for social actors to rehearse new ways of relating to each other. It is not always the case that DPC programs and services prompt these new social dynamics.

²⁶ Evidently, this has nothing to do with the number of vacancies at the DPC. One option would be to implement a form of affirmative action (admit a certain number of members of various social groups according to established criteria) that runs parallel to the notion of triage that often determines who can become a participant when there is a vacancy.

successful at establishing permanent “working relationships” or “relationships of coexistence”. In measuring the extent of participants’ progress in adopting and sustaining favourable dispositions to coexist (and in assessing the impact this may have on their rehabilitation and quality of life), one must keep in mind their starting point (largely characterized by the sociocultural capital they bring into the DPC).

To conclude this section, it is significant to reiterate that the value of what goes on at the DPC in terms of rehabilitation and quality of life is not only linked to the staff, programs, and services, but also to the creation and sustenance of an auspicious social climate that allows people to work through incredibly complex processes. The issue of mutual recognition that involves recognizing one’s social situation and the need to have the other’s recognition is one of these processes. Unfortunately, it is often muddled by a lack of (de)constructive dialogue that helps the participants separate their moral(istic) judgments from issues of equity and equality of opportunity in the presence of HIV and multiple challenges. This unfortunately often renders the process of engagement and rehabilitation somewhat constrained and inadequately targeted, and efforts to integrate “acceptance-based” models of practice, like harm reduction, are fettered.

"No Glorified Drug/Sex Talk": The Addiction/Recovery Discourse

Our society has become a recited society, in three senses: it is defined by *stories* ..., by *citations* of stories, and by the interminable *recitation* of stories (Michel de Certeau, 1984: 186).

As in any hegemonic discourse or ritual, the absence of apparent ideology is itself the most powerful kind of ideology, since it can never be acknowledged or questioned. The political implications of this kind of thinking, this kind of process, are apparent and depressing (Elayne Rapping, 1996: 100).

Anyone who sees the everyday work at the DPC will be duly impressed, as everybody there works to maintain a frail social equilibrium that frequently swings between chaos and serenity. It is likely that people at the DPC see all kinds of progress in their health and in their overall quality of life. However, the stabilizing influence of the DPC might, in some instances, “arrest development” by maintaining participants through a series of therapeutic and clinical services, social activities, and even through policies that seek to protect them (from outsiders, from media, and from each other). In addition, the DPC, with its rich social environment and sense of “family”, is an attractive place to “set up

camp”. The DPC operates on a discourse of addiction and recovery that does not encourage individuals to do collective work or to see this place as a position from which to create collective forms of action that would be engaging and empowering.

Elayne Rapping, in her book *The Culture of Recovery* (1996), maps out the history of what she calls the “recovery movement” and the “feminization of addiction” in North America and their powerful effects on how we see each other and ourselves at present. Rapping records her participatory observation research process in a variety of self-help group settings. The results are mixed, but they are not encouraging.²⁷ This is what she concludes from her historical research:

One’s true identity, one’s true belief system, is rooted in a sense of space which is now psychological and spiritual; which requires that one *say* one is a member, is an addict, is in recovery, for it to be so. And here, despite the benefits individuals may gain through the “re-socialization” offered in recovery, is where we run up against the movement’s limitations. Thinking and feeling replace action as the mark of reality and truth here, as they do not in classic AA. This is the root of the social problem of recovery-as-social-religion. It *is* a religion after all, and one without a social crusade, beyond the marginal one of keeping people up and functioning, one more day at a time (126).

However, Rapping's conclusion must be read cautiously within the present context of the DPC and this quality of life study. This “effective” discourse of addiction/recovery that often translates into a culture of recovery – and to that one should add “victimhood” – does not cancel the achievements of the DPC. However, the existence of this tacit discourse – what we will call a hidden curriculum – raises questions beyond these achievements.

The qualitative data collected in interviews, observation, and focus groups show how participants and other members of the DPC consistently utilize the “feeling” jargon of the addiction/recovery movement and, in general, of the self-help movements in North America. In the following passage from the transsexual focus group, certain roles that in

²⁷ A scene from the controversial 1999 film *Fight Club* in which the male and female protagonists confront each other after running into each other in several self-help groups for various “disorders” comes to mind. A sarcastic squabble ensues between man and woman while dealing out the weekdays in which they will attend the various groups, so as not to step on each other’s toes. One underlying idea is that we have become accustomed to (and cynical about) these self-help groups. We do not expect them to do anything practical for us; we do not expect to do anything for them, or with our fellow support group goers. Thus, they almost become a contact sport.

a feminist sociological context would be catalogued as “sexist” or “patriarchal” are manifest in the addiction/recovery language.

Interviewer: So it sounds like there’s lots of similarities between your experiences: difficulties with your family; turning to the street; being in a relationship with a heterosexual man; caring for a man; staying with them.

Julie: Out of stupidity.

Gail: Yeah, but I don’t know how she feels, but I know that I need to be needed. That’s me, I’ve always been here to care for people. I live to care, right? And people say, “Gail, you need to care for yourself.” Please, don’t you see that I do care about me; I need to care for other people.

Interviewer: You need to care for others. Let’s look now to life in the present.

Claire: We’re back!

Julie: I’m bored.

Claire: [Aside.] She always gets like this.

Julie: It’s just this transsexual thing. I don’t call myself a transsexual, I’m a *woman*.

Claire: But it’s hard to know where we’re coming from because we *are* transsexuals.

Julie: Yeah, *legally* we are.

Gail: Actually, in the eyes of the law we are *men*. And that is a hard thing to... Even my birth certificate is changed to me now.

Claire: Legally?

Gail: Legally, yeah.

Julie: I don’t think we should put an emphasis on what we are. Why don’t we just talk about our life, as people? Not transsexual or...

Claire: Not this is a survey on women, transgender, gay men, straight men, etc.

Interviewer: What I think is meant, though, is issues around how groups are treated [differently]...

Gail: It used to bother me but I got past that. Now I am happy with... I can go through life and not feel that people are looking at me and can tell that I’m a transsexual woman.

Claire: That’s the thing. Nobody looks at transsexuals as just women. Just one time ...

Gail: I started out at the age of 15, and to the city I came back to and coming back has shown me that I had made it. Because all the people that I had talked to who would be able to pick out a transsexual in the crowd, did not. And that’s when you know *you’ve made it*. It’s a long road to making it...

As it is evident in this and other passages of this focus group, there is an insistence here in talking about labels, being a real transgender, a real woman (a similar dynamic took place in the straight women's focus group). A simplistic explanation is that the DPC provides a non-threatening, non-defining space for a range of sexual orientations and sexual and social roles. In fact, one of the participants literally states, "I have no problems with my sexuality here." Of course, not *seeing* sexuality as an issue does not mean that sexuality is *not* an issue at the DPC. As presented earlier in our analysis of social practices, sexuality is an issue and people at the DPC respond to well-entrenched gender stereotypes. The transsexual women see themselves through a thwarted process of "mutual recognition": they can only be real women as long as others agree to see them (even legally) as women, and they recognize that men often do not see them as such (as clearly stated by the straight males in their focus group). In the women's focus group, a similar role identification took place, as seen in this next passage.

Interviewer: What I hear from your stories is that there's something about being in the environment around so many people that it brings up issues around just getting along with each other and understanding each other.

Kelly: How do we get along together? We do all right. On our better days. [Group laughs.]

Betty: I've learned a lot about myself here about interacting with people. Because I've always had a big shield around myself. But it's like, you know, you can't keep blaming the past. You can't blame your childhood or this and that. You've got to start taking responsibility. Because you'll be much happier. I'm really trying to change. I'm surprised that [boyfriend] has put up with me for this long. He loves me. I've never met anyone like him. He's the same way at home as he is here. He's considerate, he's calm... I've never met anybody like him. And how I got so blessed... I thank God for him. And it really scares me to think about if we get sick. Not me so much but I'm scared if [boyfriend] goes before me.

Sarah: It's really scary when your partner gets sick. What I went through was hard.

Susan: I went through something like Sarah. Hugh was bedridden for about 5 months. I had to find ways of helping him. I had to take care of him. He was really sick... and I thought he was going to die.

Interviewer: So this is a real fear for many of you: the caring of your partner if they get sick.

Susan: I'm not worried about mine, I'm worried about him.

Sarah: I'm worried about being alone.

Susan: I'm not worried about being alone. Hugh already has someone lined up to take care of me. [Group laughs.]

Betty: I believe in the spiritual afterlife. But that doesn't provide much comfort. You know [participant's name]... when I lived with [participant's name]... and he died... we hadn't been together that long, we were pretty much good friends. We were just starting our relationship. And as bad as that was, as much as that devastated me, that's only minute compared with if Joe goes. I'm going to be a basket case. I try not to dwell on it every day. I just hope I go first.

Kelly: What is it... I'm thinking here... why is it that everybody here... I don't sense a wholeness to anyone here. That anyone here is a whole person.

Betty: What do you mean?

Kelly: You know how you do your Medicine Wheel?

Betty: Yeah.

Kelly: Okay, so that's being whole in oneself. Not counting your partner. Your partner is another whole being in himself, right. I don't sense I have...

Betty: You care about yourself as much as you care about your partner?

Kelly: Yeah, like I don't care as much about me as I would about Steve, like vice versa. And for the life of me... it just bugs my butt when the flame is high that I can't... I won't allow myself to feel that... to fill that myself. I have to have somebody else or something else to fill that void. Validating, yeah. Isn't that sick? That's what I'm trying to get through. But I can't...

Betty: But that's because for so many years we've been sitting there – especially in our addiction – we were down on ourselves. And it's hard to break that habit. And you will. As soon as you stay clean for a while, you start... and don't forget to give yourself your *affirmations* every day. Look in the mirror and say, "I love myself." I need to do that.

Kelly: To say, "I love you."

Betty: You are a good person. You have value.

Interviewer: As long as the Centre has been running, we have yet to have all sat down as women and hash out what is our experience. I was wondering how this time [in this focus group] has made you feel...

In spite of the facilitator's lead to talk about collective gain as women in the DPC, the conversation turned to *the care of straight men*. The discourse is individualistic and couched in commonplace self-help and addiction/recovery ideas of a "higher power", "self-esteem" and others. This discourse allows women to claim a voice to express their individual needs, but this voice is often seen in isolation and in direct subordination to the needs of others. It is noteworthy that in the excerpt presented above, the facilitator, in

closing the brief exchange, acknowledges that this activity of getting women together to talk about women's issues had not taken place at the DPC.

As expected, this type of exchange did not take place in conversations or in the focus groups with straight and gay males. However, the prominence of the addiction/recovery discourse and its debilitating political effects is marked, as can be observed in the excerpt from the straight male focus group reproduced below.

Interviewer: [...] Tell me what's the most important thing you've learnt. And I'm not talking about *education*, like learning math or something like that. By learning, I'm talking about something that could be a formal lesson or a life lesson, great or small, positive or negative, that is about people, about what they do, that is about this institution or what happens in this institution. So pick something and I'm going to ask you something about it in a second.

[We pause for a minute]

Lorne: The most important thing that I've learned [...] I learned it in the course in miracles. I took the course in miracles at Friends for Life. And the most important thing that I learned is that I have to sit back, I've already got an analytical mind or whatever and I try to analyze things but I'm looking into myself more and I'm understanding my own psyche more to the point that if something's bothering me, I go to find out what that reason is, why it's bothering me and nine times out of ten, what is bothering me, it's ego-based and when I say it's ego-based, I'm making a decision on the ego is wanting to make the decision, you know. An example would be, say this guy's a *flaming raspberry* but he's a good guy, right? So, if I've got a lot of straight people that are friends, I'm making an ego-based decision, no, I'm not gonna be seen in public with this guy. Christ, my friends might think this and that, so I just said, "Hey, stop that. This is wrong." I'm making my decision on what I know about that person and how that person truly is, right. And if you stand up, straight up, then that's the most important thing in my books, so I'm not letting my ego or somebody else's ego influence my decision.

Mel: For me, it was getting to know that the counsellors or whatever and they showed me how to control myself. Like, I was pretty much [angry] when I came here. I had something against gays and it took a while to get it [calmed down], but now it's not there. I feel better by it and it's given me time to think about things. And just that time being able to think about it, is like putting a new house over my head and it gives me more understanding of the people and I hope they can get better understanding of me and I care about them where I wouldn't have cared about them before.

Gabriel: Some people call it recovery. Some call it rehabilitation. I grew up in foster homes from the age of six. I never asked to be a drug addict, a convict, and all those other labels that are derogatory and looked down upon in society. I call it "recovering the innocence", which I have a lot of in myself. I've been forgiven for the mistakes I have made and I correct mistakes on the spot if I make 'em. I have now

become the gentleman that I respect. I am a gentleman. I respect people that who do not *act* like one, but *are* one. I have come to my full potential but I will continue to change as long as I live and I will continue to change my opinion at any time. I can change. If it's to enhance it, to learn further, understand it which I call rediscovering the innocence because at one time I think we all knew it but we didn't consciously practice it or know it. So, it's helped me become the gentleman that I respect and I got a lot of people out there in society that respect me big time. Big time. Um, they scare me. I think, "Who are you talking about?" But it's been good and the Dr. Peter Centre has been a stepping stone to help me in those directions and I thank you for that.

This passage suggests that there should be no doubt that all these learnings at the DPC are invaluable. These learnings are particularly illustrative of what straight males achieve by coming to the DPC. Notwithstanding, as scientists we need to see what they have learned and how they report it within a larger social perspective, a perspective that includes a long-term projection of the effects of this discourse. In this sense, the learnings reported by the participants are often accorded to specific self-help instances (engagement in therapeutic alliances within and outside the DPC); they are reported mostly as individual accomplishment and they are disconnected from a social reality about people living with HIV disease, in particular working class straight males living with HIV and often with issues of addiction. Again, addiction, recovery, and rehabilitation are seen as independent and not within a context of regulated poverty and regulated addiction (e.g., systematic failure to deal with addiction issues locally and throughout Canada).

When asked to comment on the results of the survey, the DPC staff invariably used a collective discourse that reveals a view of what DPC "does" for people as an *aggregation* of individual achievements, a series of successful therapeutic engagements that seldom merge into a collective social agenda.

Two of Six: I didn't attend the presentation but I heard about the results right after. The gist of what seems to make the [principal researcher] happy with the results was that people have choices when they are here. The main impression I had about why people come to DPC is not the main reason why people come. I thought they came mainly for the food [service] and then they engage in some of the services. That people come here for the food and then "we work on people" after that, that food was the greatest need being met. There seems to be some surprise around the fact that it is not the food [that primarily draws people to DPC].

Interviewer: What do you mean by "choices"?

Two of Six: That we offer an environment where people have a sense of self, that they have some control over their lives, that they can [counteract] the sense of learned helplessness in their [social] environment, that participants have an opportunity to increase their sense of self-awareness, that in our ways we [help them] move towards that.

Five of Six: I was at the presentation and I agree with what [the first two participants] had said about it. The priorities that people place on [various services] and I guess the conclusion that came out of the measurements that were done on service provision and engagements and correlations with quality of life brought up a lot of material for me to give me some direction.

Three of Six: The finding that [participants are] making a connection with staff members stood for me. The knowledge that we as individuals can form healthy relationships with participants that they value and keep them coming back, that was very validating for me. Are we here because [the participants find] something about us or is it just what we can do for people? Is that why they come? Having that clarified is helpful. It showed that the work that I do is having an impact, talking with people, spending some time together, forming relationships, people value that and that brings them back and hopefully it is something they use to improve their lives.

Six of Six: My thought was that while [participants] do come for the food, I have seen over my time working here how much interaction a participant has with various staff. This made me realize how much support each staff person gives to the participants. I thought that they came for the food and then they got support but it was interesting to see that probably food services are [of secondary importance] for them. That validated what I thought was happening here. I see everyone else doing something for the participants [in various areas].

However, the researchers were repeatedly reminded by the staff and participants²⁸ that it would be unfair to expect the DPC to do something *for* its participants within a service-delivery structure. The DPC, we were told many times, is unlike the BC Persons with AIDS Society or the Vancouver Area Network of Drug Users (VANDU) that are member-driven. Although this was a valid warning, we set out to assess the overall engagement of the participants and what they do *with* what they find at the DPC. In general, it can be said that the DPC works well within a framework of service-delivery, coordinated care, and harm reduction. However, there exists a tension among the practices of participation, harm reduction, and the addiction/recovery discourse. There is a contrast between these discourses which is likely to have significant implications in the

²⁸ A few straight and gay male DPC participants had a political view on these issues. Some of them stated that a board of directors or some other mechanism in which the PWA participants had a more direct input should guide the overall operation at the DPC.

long-term running of the DPC. On the one hand, DPC participants are expected to take responsibility for their actions within the Centre, to have a limited input into its policies and everyday running, and to acquire certain social skills (especially members of the most disenfranchised groups). On the other hand, the inherent reliance of a discourse of addiction/recovery is likely to translate into fairly restrictive notions of health and illness that do not contribute to ongoing organizing around issues of drug use, poverty, rehabilitation, and HIV disease. Furthermore, harm reduction and the associated disposition of acceptance of drug use are constrained, while abstinence is subtly and unintentionally reinforced through small gestures such as a compliment on how good one looks after a stint in a recovery house.

On Participation

In the twentieth century... the social basis of [a] process of moral identification, in which a conception of the community's interest comes to shape one's conception of self-interest, is fragile (Bellah et al., 1985: 175).

The capital that DPC participants bring into this environment of “controlled chaos” not only encompasses differing literacy and educational levels, social class, and highly gendered attitudes and behaviours, it also encompasses a “moral view” of individualism and participation and a view of what the “social good” is. The notion of participation and social support is essential to the measurement of quality of life at the DPC because it often replaces the more “technical” practices of counselling that strive towards “rehabilitation”, that is to say the implementation of a series of concerted efforts and techniques towards clearly defined goals.

One's immediate – and fairly prejudiced – view might be that many of these rugged individuals have spent such long periods of their lives in fairly disenfranchised positions that they might not have even a basic analysis of what the public good of “getting involved” is. It has been pointed out that one common element in the stereotype of “junkies” is that they are highly “needy” people, always cunning and willing to take, not often willing or able to reciprocate, at least not without ulterior motives. This, however, does not mean that an individual does not act upon some specific ideas of what participation is. At the DPC, individuals, both participants and staff, arrive with differing

moral views of what participation is. The qualitative phase of this research allows us to describe more or less identifiable participation trends and identify how compatible they may or may not be.

It has been argued that the North American notion of relationship between self and society is peculiar in that it presupposes that “individuals are expected to get involved – to choose for themselves to join social groups. They are not automatically involved in social relationships that impose obligations not of their own choosing, and social institutions that are not the product of voluntary choice of the individuals who constitute them are perceived as illegitimate” (Bellah et al., 1985: 167). In the quantitative survey conducted in the first phase of this quality of life study, “freedom of choice and participation” ranked highly amongst all individuals involved in the activities at the DPC; this does not necessarily explain the underlying rationale for such participation. It has been pointed out that the notion that a place like the DPC could be an extension of what used to be perceived as the conventional and traditional family – i.e., a “self-reliant congregation created and maintained by the voluntary cooperation of self-reliant individuals living in self-reliant families” (169) – has long been eroded by steady processes of urbanization and professionalization. At first sight, this is the widespread rhetoric of many service agencies and self-help groups today; on second examination, it simply blurs important distinctions on how individuals view their participation and the participation of others.

It is common to hear from the DPC staff that the involvement of participants in various activities (that have the community meeting as their centerpiece) eventually transforms self-interested motives (e.g., to find therapeutic and domestic nurturing) into personal and public commitments. The moral notion at play here is that “[e]nlightened self-interest established ‘habits’ that ‘unconsciously’ turned the will toward [specific] virtues” that are not “the product of interest calculations” (174). In other words, a place like the DPC should be able to produce instinctual “habits of the heart” towards common good (i.e., as expressed in the constant reminder that “sex and drug glorified talk” is not accepted behaviour). When the population of one single ad hoc community is deeply scarred and disenfranchised individuals, their “public commitment” does not amount to

unencumbered and disinterested participation. Individuals remain in a moral state of limbo – for long periods of time, if not forever – in which they struggle to satisfy their nagging self-interest, namely surviving AIDS, addiction and a series of other medical and psychosocial issues such as depression, as they simultaneously get involved in activities that have the community good as the ultimate goal.

The DPC staff is constituted mostly by young and middle-aged mid-level professionals whose views of participation align closely with what Bellah et al. (1985) described as “urban cosmopolitanism” and the “civic-minded professional” who “is one who tolerates and, indeed, positively enjoys diversity and uses reason rather than passion to resolve conflict with others” (185). Most staff members at the DPC are likely to see professional success as taking place as a result of their general contribution to the lives of others. As professional individuals, they see moral concerns as matters of personal preference, a virtuous relativity that makes it difficult for them to give any substantive definition of the public good. Their assumption is that “competing claims [from participants, staff, and administration] can be resolved peacefully by the creation of neutral technical solutions that are beyond debate” (188). This implies a level of analysis and skill not equally shared by individuals at the DPC, and perpetuates a hierarchy of those who are technically more prepared and have control over what seems to be the significant discourse (e.g., recovery/addiction, counselling, etc.) over those who participate peripherally as a result of the perceived lesser value (and virtue) of their social capital.

There are some hidden assumption in this “technocratic” view of participation at the DPC. First, in the long run, the interests of the parties are fundamentally compatible “so that one group does not permanently have to sacrifice its welfare for the good of another or for the good of society as a whole” (189). Second, this “technical solution” approach assumes technical expertise, “the ability to carry out comprehensive research” (189). For example, DPC policies are generated at the weekly community meetings, and they are often put forth and revised by DPC participants and staff members who have a degree of control over the dominant discursive forms. Often, the “professional activist” (191), marginally represented by a small overlap of the “old guard” PWAs, strongly reacts against this form of “technocratic” participation. During this research, we heard several

times that DPC participants should have a representative or two sitting on what is perceived as a distant board of directors. We also heard that certain policies at the DPC are profoundly undemocratic and that the DPC had strayed from doing HIV work (clearly defined in PWA terms of reference that have been amassed over twenty years of political activism around HIV/AIDS).

The language of the professional activist and her/his intentions and actions have been defined as fundamentally paradoxical in that they “cannot account for the moral commitments underlying their behaviour” (191). In practice, the participation of PWAs at the DPC is seen as representing “special interests” in an organization that strives to serve all its “clients” equally. Like the DPC staff, the few PWA activists (who are often self-identified as gay men) are motivated by a community concern, but “they see the community largely in terms of a variety of self-interested individuals and groups” and do not necessarily contribute toward defining a common public good” (191).²⁹

It is very important to keep in mind that the various forms of participation and social support described earlier (which often replaces ‘counselling’ and therapeutic ‘harm-reduction’ approaches at the DPC) do not cancel the genuine interest in providing comfort care for the DPC community. The differing notions of “moral capital”³⁰ that are rehearsed at the DPC compound the gendered and socioeconomic capital brought into the Centre by its various social protagonists. What seems to be absent in most of the moral positioning on participation is a sense of “continuity”; that is to say, a sense “that the public good is based on the responsibility of one generation to the next, and that an awareness of such a responsibility is a sine qua non for any understanding of the public good” (193). In this sense, there is a prevailing atmosphere of “aging towards death” at the DPC – a way of staying perennially in the present (in fact, issues about bereavement are discussed in ad hoc support groups; discussions about death, dying, and assisted suicide are almost unheard of at the Centre). Finally, there is an almost negligible vision

²⁹ Historically, in North America the alliances between gay PWAs and other social groups such as ethnocultural groups, women, IDUs, and others (many of whom have a number of members living with HIV) have been precarious at best.

³⁰ This complex concept of “moral capital” should be distinguished from the usual notions of morality and seen rather as a distinctive ethical stance on individualism and participation vis-à-vis AIDS, addiction, illness, etc.

for a new generation of people infected with HIV, young and old, and a new generation of “new addicts”. At the DPC, there is a fledgling sense of “community of memory” that remembers the past and the individuals who paved the way (e.g., shrines, acts of individual remembrance, peripheral participation in the Candlelight Vigil), but this is not often held as a view to the future. In this sense, continuity is “survival”; it is not “progress”. During this research, we asked repeatedly about a sense of “moving on”, a sense of future, but we found that this sense was not present; for example, there are no “discharge interviews” and no overall plans for rehabilitation that involve “back to work” activities. Furthermore, while the DPC staff is one of its strongest assets, some of their practices tend to be paternalistic and follow conventional health care practices that can erode AIDS activism and simultaneously resist critical medical/epidemiological approaches and collective/social efforts (e.g., silence = death).

What are the limitations of the model of practice offered by the DPC? The focus rests largely on concepts of addiction and disability that medicalize individuals. One risk is to disempower DPC participants by offering a refuge in which they are trapped in a loop of recovery. In this perspective, “recovery” focuses on individuals and their flaws. In practical terms, recovery does not foster collective ways of acting upon current social, medical, and legal conditions (e.g., decriminalization of drugs, advocacy against the differential treatment for injection drug users, etc.), nor does it promote an evolution of individuals and groups that extends beyond the DPC.

Conclusions

The Centre provides a *field* that is an alternative to what is often described as a vicious cycle in the lives of participants. In this alternative field, participants have a chance to relax, diffuse stress, and in general enact new ways of being in the social world. They also gain opportunities to modify their *dispositions* and to "participate" in legitimate ways. As a result, participants enjoy an increased quality of life through their participation at the Centre.

That said, participants also contradict positive reports about "choice" and "participation" with complaints about their lack of involvement in the governance and internal decision making at DPC. However, a clear distinction must be made. While participants reported limited participation in the governance (Board of Directors) and operations of the DPC, they consistently reported increasing degrees of "legitimate peripheral participation". This was most evident among individuals from marginalized social groups.

Dr. Peter Centre continues to make significant, positive contributions to the lives of its participants, although it does this in a generic and somewhat haphazard way. Yet even in the face of an inconsistent harm reduction approach, the Dr. Peter Centre is consistent in providing the opportunity for legitimate peripheral participation. However, the inconsistent application of harm reduction, which cannot cancel a pervasive discourse and practice of the addiction/recovery approach, makes for very uneven 'effects'. Thus, individuals who possess limited social capital, such as heterosexual drug users living with HIV, acquire tremendous personal and social proficiency. Conversely, individuals who traditionally possess larger amounts of social capital (e.g. gay men, who reported higher education levels and less discrimination in the community) benefit as much as their counterparts from the DPC structure and programs but consistently report little personal gain (they already have the tools for conviviality).

The highly gendered approach to services at DPC reflects the societal structures outside the Centre and can hinder the harm reduction approach. Transsexuals and women tend to behave in highly traditional ways with respect to sexuality, emotional relationships, and

even drugs. Traditional gendered ways do not lend themselves well to optimal engagement in harm reduction.

The issue of displacement is associated with a degree of discontent among self-identified gay men at the DPC and is a reflection of a current political debate outside the Centre. Clearly, it is not in the Centre's best interest to adopt a political position with respect to this issue. However, it may be that the time has come for AIDS service organizations to recognize that the blending of populations is a cause of great friction, which in turn constrains the benefits of participation. As seen in this research, the one-stop-shop option is a very positive one for all individuals; unfortunately, the one-size-fits-all option does apply well when issues of sexual orientation are prominent.

Placing "safety and solidarity" under the subheading of "challenges" is somewhat misleading. Indeed, it was largely reported that the DPC is a safe place. The safety and solidarity that DPC offers participants who use illicit drugs is not necessarily a challenge to the minority of participants who do not. It is a challenge to the staff and administration to adopt an explicit stance with respect to harm reduction and what it might sometimes entail: supporting drug users in maintaining a quality of life and an addiction at the same time.

The mixing of company and the associated discontents are not currently among the list of factors contributing significantly to rehabilitation and quality of life; however, the Dr. Peter Centre has presented a first step in this direction. The Centre has operated as a virtual laboratory of human behaviour. As such, it has succeeded in its efforts to maintain an atmosphere of controlled chaos when there could have been an imminent disaster. Greater clarity in the educational purposes of the Centre would allow what is now an almost magical quality of legitimate participation to become a unified curriculum, in which a diverse group of people are working together to improve their quality of life.

APPENDIX

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