Cultivating New Lives
An Ethnographic Pilot Study of Eco-therapy Provision for People with Alcohol-related Problems in Northern Ireland

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Abstract: Humankind’s relationship to, or place within, the non-human environment is a vast topic both existential and scientific, and is a rising concern in burgeoning subfields of anthropology. This paper offers a report on the findings of a pragmatic, practice-focused and policy-orientated ethnographic pilot study (Seifert et al. 2011). Following the observation of a gap in research in the dual areas of eco-therapy and non-medical alcohol interventions and rehabilitation in Northern Ireland, the pilot, conducted on behalf of Alcohol Research U.K., set out to locate and scope existing provisions of eco-therapy opportunities in Northern Ireland with particular recourse to interventions whose service users include people with a problematic alcohol-use background. Following the recommendations set out by various summary reports by anthropologists engaged in ‘alcohology’ (Gilbert 1991; Heath and Glasser 2004; Hunt and Barker 2001; Marshall et al. 2001; Weibel-Orlando 1989), public health more widely (for example, Hahn and Inhorn 2009), and eco-therapy in particular (Burls 2007; Milligan et al. 2004; Parr 2007), a multidisciplinary methodological approach was piloted as particularly relevant to a substantial further study reporting on the effectiveness of eco-therapy as a public-health intervention. An introduction to concepts surrounding eco-therapy precedes an illustration of two key eco-therapy project scenarios benefiting those with alcohol problems in Northern Ireland. The results of this brief analysis suggest both research-paradigmatic and practical directions that could advance the understanding and the effectiveness of this intervention in the future.

Keywords: alcohol intervention, alcohol rehabilitation, community-based therapy, community gardening, eco-therapy, green care, Northern Ireland, social and therapeutic horticulture (STH), substance abuse

The Problem: Alcohol Misuse in Northern Ireland

A comprehensive review of drinking patterns across the U.K. (Smith and Foxcroft 2009) revealed that the problematic use of alcohol in Northern Ireland has more than doubled since the 1980s. When alcohol consumption becomes a public health problem, there are almost always socio-political elements at play. Anthropologists tend to differ from other social scientists in that their approach to alcohol understands it in the context of ‘drinking cultures’ rather than merely as an epidemiological symptom (Douglas 1987: 4). In the Northern Irish context, drinking has always been a central backdrop to normal social gatherings for a majority of the population. However, the dramatic rise in rates of alcohol consumption in Northern Ireland suggests that the negative aspects of drinking culture are increasingly problematic. In Northern Ireland, since the 1980s, the proportion of men exceeding the U.K. government’s recommended weekly allowance has increased from 10 per cent to 28 per cent, while this
proportion in women has risen from 3 per cent to 11 per cent (Smith and Foxcroft 2009: 85). This is an anomalous pattern compared to the rest of the U.K. (ibid.). It is suggested that Northern Ireland’s burgeoning alcohol problems over the last three decades may have roots in the cultural shift in the North since ‘the Troubles’ began to settle and a new era of liberalism and modernisation began, fuelled by the economic surge of the ‘Celtic tiger’ in the Republic of Ireland. On average, Catholics appear to drink more than Protestants (ibid.: 87), a fact which, considered alongside alcoholism’s known co-morbidity with deprivation, suggests that this group still suffers from the tail end of a history of economic and cultural discrimination. Alcohol not only negatively impacts on physical health, but is also linked to a plethora of more subtle negative effects, particularly mental health problems (Regier et al. 1990) and reduced quality of life and opportunities (Foster et al. 1999). Furthermore, it is estimated that alcohol abuse costs the Northern Irish economy in the region of £679.8m per year, between health costs, social work, policing, court proceedings, prison costs, fires and wider economic impacts (DHSSPSNI 2009).

The demilitarisation of the warring ethnic groups and the lifting of the security cordons in urban areas have allowed nightlife to blossom in relative safety. However, as the above-mentioned statistics show, ingrained cross-community tensions, historical trauma and continued social inequalities across ethnoreligious communities, combined with increased spending power and access to drinking venues, have for many people contributed to a lifestyle in which alcohol abuse is a serious problem. The growth of this negative trend in Northern Ireland over the last three decades demands both immediate attention and creative solutions.

The Intervention: Eco-therapy

Within the social sciences, there is a growing rejection of the universality of the nature–culture binary. Current anthropological theorising continues to critique the essentialism of oppositional dualities by deconstructing principal binaries such as male–female, primitive–modern, human–animal and, fundamentally, culture–nature. Eco-therapy, while often professing more pragmatic aims, can be seen as a direct response to the much-criticised absenting of humans’ concerns from the organic world of which they are part. Eighteenth- to nineteenth-century theories of madness exemplify the development of anxieties regarding the relationship between nature, culture and mental health during the rapid industrialisation of the West (Foucault 1967: 197). It is unsurprising, then, that nature-based therapeutic activities were originally developed in mental institutions in the nineteenth century. The discourses around nature experiences shifted from a Romantic conception of the emotional purchase of ‘nature’ to a more pragmatic emphasis on the utility of healthful labour (Parr 2007). The practice of horticulture for therapeutic benefit became justified by and incorporated into the discourse of occupational therapy that emerged in Europe and North America during the early twentieth century (Davis 1998). Both discourses – the more romantic emotional response to the non-human environment and the merits of practical work – continue into the present. The second half of the twentieth century has seen a steady increase in eco-therapy projects across Great Britain (Sempik et al. 2003). Thrive, the governing body for social and therapeutic horticulture providers, has a database of around 1,500 projects across England, Scotland and Wales, though it does not include Northern Irish projects.¹

There is much evidence that eco-therapy is a cost-effective and highly successful intervention. Scientific studies of the value of eco-therapy interventions have been carried out amongst people with a wide spectrum of needs, ranging from learning disabilities (for example Bruce et al. 2008) to cancer survivors (Cimprich 1993). A systematic review carried out by Annerstedt and Währborg in 2011 reported that over 90 per cent of studies reviewed demonstrated mental and physical health benefits. An earlier systematic review by Sempik et al. (2003) investigated over 300 studies of therapeutic horticulture, specifically for people with mental ill health, also reported uniformly positive outcomes for psychological state, quality of life, skill development and enhanced life chances.

Eco-therapy falls squarely into the definition of a ‘Good Life’ intervention, going beyond treating symptoms to grant a space for all-round personal development. Developing out of positive psychology, the Good Life Model (Marlatt and Donovan 1985) is based on the presumption that people desire basic ‘goods’ – psychological states that are fundamental to well being such as connectedness with others, productivity, mastery experiences and mental clarity. While not an entirely new concept, ‘Good Life’ based interventions assist people in identifying and pursuing their self-identified ‘goods’, thereby improving their quality of life and subsequently reducing recidivism. While simply being in green environments is identified as a fundamental ‘good’ in and of itself by eco-
therapy providers, the exact mechanisms by which interactions with the non-human world bring about positive change in the mental states of humans remain under investigation. In 1984, Wilson put forward a strident case for what he termed biophilia, defined as an instinctive positive emotional response to non-human forms of life. This hypothesis has since been expanded and explored, finding purchase particularly in the burgeoning sub-discipline of environmental psychology. At present, the foremost theories for the utility of nature experience and ‘green’ exercise draw on evolutionary biology, following Kellert and Wilson (1993) in arguing that the sedentary, indoor lifestyles prevalent in the West today are an exceptionally recent development on the evolutionary time scale and that humans instinctively feel healthier in the natural environment to which we are subconsciously attuned for adaptive survival reasons.

The Study

While eco-therapy has extensive reported benefits, it is not yet taken seriously by public health bodies. As a consequence of this, it is vastly under-supported. Sempik (2007), working closely with a focus group of mental health professionals, concluded that the wider field of public health was unwilling to grant eco-therapy parity of esteem without what they considered qualifying evidence, namely quantitative data, ideally from a randomised control trial. This study sought to reflect on appropriate avenues for a substantial study of the effectiveness of eco-therapy for people with alcohol-related disorders which would be robust enough to be useful to policy-makers without being reductive. Following a review of a growing body of literature in public health and medical anthropology, a mixed methods approach was adopted. The study started with the premise that intervention is a fundamentally social process, in which ethnographic data collection and an anthropological interpretation are vital contributions to the call for nuanced cultural and social assessment in overcoming public health problems (Hahn and Inhorn 2009).

This investigation explores the possibility of a large-scale, policy-engaged study. It was both a scoping and a pilot study, identifying and analysing the organisational types of projects, user groups and modes of service provision, and exploring the usefulness of a mixed methods study in which ethnography is at the forefront. In the course of this investigation, a snapshot of Northern Irish eco-therapy provision has been gathered which I hope can make a small but specific contribution to the understanding of this burgeoning therapeutic intervention.

Methods

The study upon which this reflection is based is published elsewhere as a multidisciplinary report entitled ‘Investigating Community Gardening as a Form of Rehabilitation for People with Alcohol Misuse Problems in Northern Ireland: Findings from a Pilot Study’ (Seifert et al. 2011). A pilot of cross-disciplinary collaboration, the coding and statistical elements presented in the report to the commissioning body benefited from the expertise of a psychologist, a sociologist and a statistician from Queen’s University, Belfast. While the reflections and data brought together here are the author’s own, a debt to these individuals must be acknowledged.

The research was conducted from September to November 2011 across Northern Ireland, and included services on the border with the Republic of Ireland whose service provision ignored the border. In total, forty-seven eco-therapy projects were identified. Of these, contact was successfully made by phone or email with thirty-nine of the projects (85%), who were subsequently administered a detailed scoping survey. Having identified projects targeting those with alcohol problems, field visits were made to eleven of these, where a day was spent participating in activities and talking with users and staff. Sixteen project leaders and six participants were formally interviewed, while dozens of users were informally spoken to, but not interviewed due to the enhanced ethical considerations surrounding people who are currently in NHS treatment for mental health issues. Scoping data for projects that did not reply to the questionnaire was gathered through online searches and cross-referencing with other organisations.

Results

The thirty-nine projects surveyed can be grouped into five broad categories based on mode of organisation, type of users and scope. The five categories detailed are care or vocational day centres (13), community gardens (12), residential ‘total’ institutions (6), care farms (5), and equine assisted therapy providers (3). A further nine projects facilitated eco-therapy activities at sites beyond their own, at the behest of community groups or other bodies. These categories are internally heterogeneous due to the diversity inherent
in dynamic non-governmental projects that are mostly community based and, to varying degrees, seasonal (see Seifert et al. 2011 for comprehensive details of service provision). Despite the organisational heterogeneity, these categorisations remain useful as each of the five types of project share related core characteristics. Due to the alcohol-focused remit of this study, we will here concentrate on community gardens and rehabilitation institutions, the two types of project that most actively worked with people with alcohol-related problems.

The following presents a summary of two very different contexts, the formal use of nature-based ‘work’ in five addiction rehabilitation centres, and the burgeoning area of community gardening, or more accurately Sempik et al.’s ‘Social and Therapeutic Horticulture’ (2003). These are contrasting intervention contexts: rehabilitation centres offer treatment for severe alcohol problems, while community gardening occupies the opposite end of the spectrum, and acts primarily as a preventative measure. Notwithstanding that the former is highly institutionalised and the latter community driven and voluntary, both ultimately offer similar benefits. The following is a brief description of project characteristics, issues, themes of concern and musings on the functioning of these interventions by staff and users. Rather than providing an analysis here, these illustrations are merely of an introductory nature, intended to demonstrate the need to investigate specific contexts of the provisions in order to understand how they function as therapies.

Two Models for Alcohol Intervention

Community Gardens

The thirteen community gardens that responded to the survey are presumably only the very tip of the iceberg, and represent examples of the most common type of project, accounting for 33 per cent of eco-therapy provision in Northern Ireland. Community gardens are literally grass-roots operations, utilising mostly public green-space in an egalitarian, democratic manner. These projects rely on a range of informal networks to connect with clients. This is largely done through word of mouth or via a larger organisation of which the gardening project is a facet. Community projects were often known to local social workers and similar community actors. User numbers ranged from a handful of eight or nine to several hundred over the course of the year, which was the case with community gardens running courses and workshops.

Openness and a non-diagnostic approach typified most community gardens although the leaders often tried to recruit people in the community whom they knew to be suffering from poor mental health, long-term unemployment or social isolation. Interviews with clients and providers suggest there to be in community groups a sense that the groups are a place where personal problems can be addressed and support provided, but which lack the stigma of overt ‘mental health interventions’.

Because of the reluctance to separate users into diagnostic categories, inclusiveness and mixed groups were common in the community gardening scenarios. Providers reiterated the benefits of heterogeneous groups and expounded on the rationale of supportive inclusivity which was shared by other providers interviewed:

We try, our aim is not to specify too much, let’s say we’re a centre for people with depression or anxiety, purely because you lose, everybody’s different anyway, but it’s good to mix a whole load of people together, to have everyone’s different experience also, part of the ethos of what we do is enabling each other, and supporting each other. (leader, small rural STH project)

Beyond an emotional calming effect, exercise and a sense of achievement, benefits to be derived from the projects for those for whom alcohol abuse was a problem were often social, with the group activities functioning as remedial social alternatives, helping users break away from the negative influence of substance abusive peer groups. A female middle-aged community garden peer-mentor, who started gardening while in a homeless hostel, reflected:

I think it calms them down, it makes them think a bit more, and sometimes the whole situation of being there, it helps, it does help, it helps their mental health, because they’re getting out, and they’re getting away from the situation of maybe being sitting indoors, and not doing anything, and sitting looking out the window, and just going further and further down ... you see that sometimes, they seem to drink less, because they’re out, they’re outside, they’re away from that group of friends that drag them down the bar ... it gets them out of the situation.

Her observation is consonant with those provided by the other community project interviewees, and sums up the intertwining of the psychological and social in relation to alcohol abuse. We see here how in the Northern Irish case, community gardening and similar activities work as preventatives, getting people ‘out of the situations’, whether it’s drinking to self-medicate or social circles based on alcohol misuse.
‘It just gives you something to fill your time with’ several participants have told me as their reason for going. The people who commonly participate in these projects are from deprived areas and difficult backgrounds, and unemployment is a fairly ubiquitous problem. As many people with mental health problems are unemployed, they have less routine around which to structure their day and there is an increased risk of turning to substances to alleviate alleviate (Layard et al. 2006). Enjoyable work-based leisure activities are therefore gainful on several levels, at once helping treat short-term mental ill health and the skill development and connections within the community that may lead to further training, education or employment. It is notable in this specific context that the majority of these projects were based in working-class ‘interface’ areas of Belfast. Community gardening groups, especially in Northern Ireland, can provide an added level of social benefit, often bringing together communities and creating opportunities for people on both sides of the sectarian divide to meet and socialise on common ground.

The majority of these projects were urban, though the actual land location was often outside of the city, and the requirement for transport was a primary problem. As with most grass-roots projects, the adversaries that these groups faced were largely funding based. Groups which were part of sheltered housing organisations or large community groups could to some extent piggyback on larger groups’ funding, while groups run on private land by individuals or small groups unattached to larger community organisations struggled to generate enough financial support to maintain even a single staff member. Despite the adversaries they faced, however, community gardening groups, and lone facilitators who work in communities to help establish groups, are the most rapidly expanding eco-therapy service sector.

Rehabilitation Centres

By far the most direct form of interaction between people with explicitly stated alcohol problems and nature-based therapeutic activities is seen in the cases of the five addiction rehabilitation centres that included nature-based therapeutic work. All five residential systems were run by Christian charities and were integrated into the health and social trust establishment to varying degrees. Service users all come from an addiction background and undergo a programme of therapeutic activities at these residential centres with the aim of overcoming their addiction. Three of the centres required that the participants subscribe to a faith-based model of reform. The two which were most integrated in the larger system did not have an overtly religious element. Three of these centres have a set treatment length ranging from six weeks to six months. The fourth is a hostel that does not provide a formal treatment of set duration. The fifth project is a supported housing facility for people who had successfully completed the rehabilitation programme at a linked centre and were re-entering normal civic life.

Two of these centres only catered to men, both justifying this on the grounds that women and men mixing could distract from the therapeutic nature of the centres. In all cases there was no direct cost to the client. For residents of the hostel and the supported living centre, eco-therapy took the form of small urban vegetable gardens. Both of the overtly Christian residential rehabilitation centres were rurally situated, and required clients to undertake daily ‘therapeutic duties’ – structured practical work seen to have a character restoring effect. In one case, this included grounds maintenance and the working of several acres of vegetable gardens for up to four hours a day. The second facility ran a small shop, a landscaped garden of reflection, and a vegetable box scheme. The third large residential facility provided weekly trips to local National Trust properties, where National Trust staff facilitated sessions of landscaping, arboreal and gardening work. Once finished with their ten-week treatment, those who wish to can continue to return to the National Trust site every week to tend an on-site allotment kept there by the rehabilitation centre.

In these uniquely comprehensive institutions, the users’ fundamental lifestyle and attitudes are the object of reform. The eco-therapy activities were not part of the intensive, inward-looking talking therapy regimes that are the core of these programmes. The unique benefits of eco-therapy in this scenario derive from the hands-on, practical engagement with the non-human environment.

You’ve got sore arms and stuff, and you actually feel like you’ve done something you know, and it’s good to tell people too, you know, people are like, where were you today, and you say I was up to mah neck in mud, or I was cutting down trees or … (Ex-service user)

The option, or in some cases ‘therapeutic obligation’, to engage in eco-therapy activities was repeatedly cited as an opportunity to get away from the intensity of rehab, and provided a more ‘natural’ social, emotional and physical space, as this 31-year-old male programme user relates:

Yeah … it’s just to get them, well, bring them back like, from whatever level they were [in their therapeutic treatment] to bring them back to the roots like.
The frequent reiterations of this appeal suggest that horticulture, being outside of the institutional setting of highly structured routine, appeals to service users as a de-institutionalising activity. We see the added value of eco-therapy beginning to emerge: unlike other work-related tasks in which rehab patients may be required to engage, working outdoors with growing things connected people to the more primal, non-human natural cycle of the year – a phenomenon bigger than and far removed from rehabilitation frameworks and requirements. As this rehabilitation centre garden manager relates: ‘I think nature teaches you, teaches people, the simplicity of life. Everything has its time and its place’.

The possibility for users at some centres to continue to engage in social and therapeutic horticulture (STH) upon completing the treatment was positively remarked upon by staff and users, who related that it continued to provide something to look forward to, and gave structure in the week to those who were stepping back into the outside community and who often face unemployment and a stark lifestyle change. STH can help to fill this temporary void, as an ex-rehabilitation centre user (male, 38), who now returns weekly to help with the allotment, explains:

‘Having something to do in my day, in early recovery, is quite beneficial, I suppose, in early recovery, when I left here, was to keep myself busy, and to have a structure for my day, every day, so by coming here on a Wednesday it gave me structure to my weeks.’

Many participants in residential rehabilitation had experienced social exclusion as a result of their addictions. Often, the land-based activities were referred to as an interim, bridging environment that enabled them to get back into society.

Discussion

While these therapeutic interventions offer much material for a theoretical discussion – not least the tenets of post-humanism, the agency of ‘nature’ as a healer, and cross-community variation in relationships to notions of the organic world – this discussion is limited to the practical implications of initial findings to future research, with an aim to engage with health policy. While anthropology in its fundamental aims is concerned with the nature of humanity and the complexities of the webs of cultures in which human life takes place, too often the insights of anthropologists remain in purely academic discourses. While modern public health developments have had an inarguably positive effect on daily human life (in the arena of mental health particularly), the complex relations between human agency, physiology, social structure and health and social care systems are frequently unaccounted for in reductive scientific models. Conversely, as anthropologists involved in public policy work are already aware, the employment of quantitative tools and collaboration with colleagues in other disciplines is vital in order to produce work that will stand up to the scrutiny of superordinate institutions of knowledge production and decision making. Sensitive but robust analysis of provisions is required to legitimate these ground-up eco-therapy initiatives in the eyes of those institutions that are in a position to support their efforts financially and by linking them with the public health and social care system.

Many with substance abuse problems or a risk of developing them are undiagnosed, and intervention takes the form of community-based social organisations which function by providing socialisation and personal development opportunities, mitigating to some extent the social and psychological causes, rather than the symptoms, of alcohol misuse. Identifying participants who have alcohol misuse problems in any context beyond rehabilitation centres poses a methodological challenge. One of the community garden leaders interviewed muses:

‘People will often come to us, when they’ve kind of got to a space where they’re dealing with the alcohol problem, and it’s really hard, it’s hard to know whichever came first in their life, I mean, the whole thing’s so linked together.’

Subsequently, a more inclusive avenue of research would expand to an investigation of eco-therapy for people with mental health problems, including substance misuse.

Developing personal and cultural alternatives to problematic drinking can contribute to reducing recidivism, as anthropologists of problematic alcohol cultures have been pointing out for decades (Weibel-Orlando 1989). Social support and alternatives to a heavy drinking milieu are fundamental to countering alcohol abuse, in both treatment and preventative efforts. This study frames eco-therapy as a ‘Good Life Model’ intervention. Co-operatively developed goal-attainment scaling measures, which are commonly used in GLM interventions to quantify progress towards the user’s self-defined ‘good life’ (as recommended in Sempik’s (2007) exploration of eco-therapy relevant methodology), may be very useful for quantitatively tracking outcomes in this type of intervention. However, in-depth anthropological unpacking
of the cultures of care, institutional contexts, biographical narratives and social attitudes towards alcohol in Northern Ireland is needed to shed light on why and how various projects succeed or do not.

For a project research agenda that aims specifically to investigate the effect of eco-therapy on people with alcohol misuse problems, the highly controlled rehabilitation centre scenario seems to be ideal. These centres represent what Irving Goffman termed ‘Total Institutions’ (Goffman 1961). These residential rehabilitation centres, though attended voluntarily, adhere to the four criteria of a total institution: all aspects of life are conducted in single place, under a single authority; each member’s daily life is shared with a ‘batch’ of others, who are expected to perform similar activities and are treated similarly; the day’s activities are pre-planned and tightly scheduled; the various enforced activites are part of a rational plan, designed to fulfil the stated aims of the institution (Goffman 1961: 17). The set duration of rehabilitation treatments, regularised ‘doses’ of eco-therapy, standardisation of surrounding life environment by the institutions and the expressed willingness of these well-organised centres to participate in such research (Seifert et al. 2011: 18) would provide an ideal opportunity for both quantitative and qualitative investigation, with the possibility for a randomised control trial in which one group is allocated another activity and compared with those participating in eco-therapy.

However, based on the results of this exploration, the more exigent avenue of study is a mixed methods investigation of community gardening as a broad grassroots social and mental health intervention, utilising standardised outcome measures and user statistics where applicable, but informed and nuanced by a culturally sensitive analysis.

Moving Forward: Social Prescription for a Good, Green Life

In the course of conducting this research, a practical route forward has emerged from both the previous research into ‘green care’ and the data gathered in Northern Ireland. As a consequence of the relatively recent peace and increased funding for community development, eco-therapy projects in Northern Ireland were slow to start, but have begun to bloom, with over half the projects surveyed being younger than three years. The majority of projects reported that they had excess capacity, but cited a lack of integration with the wider health and social care system and concurrent dearth of funding as the primary barriers to extending their services to more participants. Extensive policy research carried out in the U.K. by the eco-therapy NGOs MIND UK (2007), Thrive (Sempik 2007), and in Europe by the EU COST groups (Sempik et al. 2010) all conclude that in order to realise the benefits of eco-therapy provision at a public health level, a green prescription policy must be designed and implemented. This has already proven successful in an ongoing nationwide trial in Scotland (Jepson et al. 2010). Health and social-work professionals signpost or write a green prescription for people with mental, social of physical problems who could benefit from nature-based activities. This serves to connect users and providers through the formal health and social care system. The summary report of eco-therapy in Scotland demonstrates that partnering and infrastructure support – which were enabled by the recognition of health and social care trusts in the region – were key to the high levels of success enjoyed by local green care providers and participants.

A pilot of a dynamic green prescription programme would help both people in need of positive interventions and the providers, which often struggle to fill places and meet costs. The initial implementation and development of green prescription in Northern Ireland will require ground-level qualitative feedback mechanisms in order to tailor the service to best support and accommodate the diversity of users and projects. This is especially the case when considering interventions that need to take account of the deeply cultural problem of alcohol misuse. A project such as the pilot proposed is an example of an arena in which an anthropology truly engaged with both the literal field (or garden), regional policy development and colleagues in the wider social sciences is ideally positioned to make a positive contribution to public health.

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Notes

1. One of the outcomes of the original scoping study was the identification and description of all eco-therapy projects in Northern Ireland for the benefit of the public.

2. Included in this category, by virtue of its classification as an institution and for purposes of statistical analysis, is a secure psychiatric ward that had a garden. Although the patients’ problems may have included historical alcohol abuse problems, their primary diagnosis was chronic mental ill health. As such, this institution was not comparable to the rehabilitation centres included in this analysis.

References


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