MONTREAL UNIVERSITY

The journey from homelessness to housing
Exploring Harm Reduction in a Housing First Setting

By

MARYSABEL MORENO

École de travail social

THESIS SUBMITTED IN PARTIAL FULLFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER'S IN SOCIAL WORK

PRESENTED TO: Sue-Ann MacDonald
Thesis supervisor

July, 2020

MONTREAL UNIVERSITY
École de travail social

This thesis is titled :

The journey from homelessness to housing
Exploring Harm Reduction in a Housing First Setting

Presented By

MARYSABEL MORENO

Evaluated by a jury composed of the following people

Elisabeth Greissler
Chairman-rapporteur /President-rapporteur

Sue-Ann MacDonald
Research Director /Directrice de Recherche

Carolyne Grimard
Member of the Jury /Membre du Jury

Summary

Homelessness is a complex problem that carries disastrous consequences for individuals and societies. To help address the problem, governments have adopted the Housing First (HF) model and the Harm Reduction (HR) approach. HF provides low-barrier access to housing and supportive services to people experiencing chronic homelessness who often have co-occurring mental health and substance use problems. HR acknowledges that some people are unable or unwilling to stop using substances. Therefore, it focuses on reducing the harmful effects of drug and alcohol use. The purpose of this study was to examine how the HR approach is deployed within a HF project, what are the factors that facilitate or hinder its use, how it helps HF residents and workers mitigate risk and understand substance use and what is its contribution to participants' reinsertion process. The humanistic and person-centered approach guided this research by highlighting the individual's capacity for self-awareness and growth within a HF project. Similarly, a conceptual framework was used to argue that in HF, the application of HR principles facilitates participant's ontological security. This is achieved by offering long-term support and accompaniment, and promoting their social inclusion, as well as exploring their relationship to substance use.

The data analysis demonstrates that practices such as outreach and low-threshold requirements to housing facilitate its acquisition for people experiencing chronic homelessness and therefore reduces the adverse effects of homelessness. These practices also have the ability to reduce the negative effects of drug and alcohol consumption as for some people finding ontological security means that they no longer need to cope with the dangers of living in the streets. Nevertheless, it is imperative to highlight that HF offers stable housing that is contingent to social housing benefits, therefore, permanency is not always guaranteed.

In a similar manner, long-term support seems to be a tool that helps people fight isolation, maintain housing and mitigate problems related to substance use. However, practices such as mandatory follow-ups and fiduciary programs within HF although beneficial for some can be considered pejorative for others. I concluded that the use of HR in HF requires intervention that takes into account the person's level of autonomy as well as their right to self-determination with the possibility of opting out of services if they do not feel the need.

In addition, the collected data shows that the meaning behind substance use requires full considerations of users' perspectives. It was evident that residents are mindful of their use and try to avoid problematic substance use. For example, they strive to maintain a stable dosage that allows them to remain functional in their daily activities. In this sense, residents have inherited HR tools based on their knowledge and experiences even though they manifest not being able to define HR principles. From the worker's perspective, HR is practiced by helping residents maintain their apartments, creating awareness about substance use, and providing support throughout the duration of the program. Nevertheless, the practice of HR faces several challenges, including the lack of education about the approach and the lack of inclusion of drug users in programs that serve them.

Key words: Harm Reduction, Housing First, homelessness, substance use, psychosocial intervention, social reinsertion

Résumé

L'itinérance est un problème complexe qui a des conséquences désastreuses pour les individus et la société. Pour répondre à ce problème, le gouvernement de Canada a adopté le modèle Logement d'abord et l'approche de réduction de méfaits. Logement d'abord offre un accès facile au logement avec des services de soutien aux personnes en situation d'itinérance chronique qui ont souvent des problèmes concomitants de santé mentale et de toxicomanie. D'autres part, la réduction de méfaits reconnait que certaines personnes ne peuvent pas ou ne veulent pas arrêter de consommer des substances psychoactives. Par conséquent, cette approche se centre sur la réduction des effets nocifs de la consommation de drogues et d'alcool.

Le but de cette étude était d'examiner comment l'approche réduction de méfaits et son déploiement dans le cadre du programme Logement d'abord à Montréal. Nous avons examiné les facteurs qui facilitent ou empêchent son utilisation, comment l'approche aide les résidents et les travailleurs à atténuer les risques et à comprendre la consommation de substances et quelle est sa contribution au processus de réinsertion sociale des participants du programme Logement d'abord. L'approche humaniste et l'approche centrée sur l'individu a guidé nos recherches en mettant en évidence la

capacité de conscience et de croissance de l'individu dans un environnement approprié. De même, un cadre conceptuel a été utilisé pour faire valoir que l'application de l'approche de réduction des méfaits nécessite que les participants expérimentent la sécurité ontologique, le soutien et l'accompagnement à long terme, l'inclusion sociale ainsi qu'une compréhension approfondie de de la place des substances dans leurs vies.

L'analyse des données a démontré que des pratiques telles que l'intervention de proximité et l'accueil à bas seuil pour avoir un logement facilitent son acquisition pour les personnes en situation d'itinérance chronique et réduisent donc les effets néfastes de l'itinérance. Avoir un logement réduit également la consommation et ses effets négatives, car les gens qui trouvent une sécurité ontologique n'ont plus besoin de faire face aux dangers de la vie dans la rue. Néanmoins, il est impératif de souligner que le programme Logement d'abord offre un logement stable qui est dépendant des ressources appartenant au logement social, par conséquent, y résider de manière permanente n'est pas toujours garantie.

De même, le soutien à long terme semble être un outil qui aide les gens à surmonter l'isolement, à maintenir un logement et à atténuer les problèmes de toxicomanie. Cependant, des pratiques telles que le suivi obligatoire et les programmes de fiducie au sein de Logement d'abord, bien que bénéfiques pour certains, peuvent être considérées comme dérangeantes pour d'autres. Cette étude conclue que l'utilisation de l'approche de réduction de méfaits dans le cadre du programme Logement d'abord nécessite une intervention qui prend en compte le niveau d'autonomie de la personne ainsi que son droit à l'autodétermination avec la possibilité de se retirer des services dont elle ne ressent pas le besoin. De plus, les données montrent que la consommation de substances devrait prendre en compte le point de vue des utilisateurs. Les résidents étaient conscients du niveau de leur consommation et essayaient d'éviter la consommation problématique de substances. Ils s'efforcent par ailleurs de maintenir un dosage stable qui leur permet de rester fonctionnel dans leurs activités quotidiennes. En ce sens, les résidents ont déjà des outils de base sur la réduction des méfaits en raison de leurs connaissances et leurs expériences même s'ils se montrent incapables de définir ces termes. Du point de vue des intervenants, la réduction des méfaits s'actualise en aidant les résidents à entretenir leurs appartements, en les sensibilisant aux effets négatives de la toxicomanie et en leur fournissant un soutien pendant la durée du programme. Néanmoins, la

réduction de méfaits dans ce contexte est confrontée à plusieurs défis, notamment le manque d'éducation sur l'approche et la manque d'inclusion des personnes toxicomanes dans les programmes qui les desservent.

Mots-clés : Réduction des méfaits, logement d'abord, itinérance, toxicomanie, intervention

Table of Contents

List of Tables and Figures

List of Acronyms

Alcoholics Anonymous (AA)

American Psychiatric Association (APA)

Assertive Community Treatment (ACT)

Diplôme d'études professionnelles (DEP)

Harm reduction (HR)

Harm Reduction International (HRI)

Homelessness Partnering Strategy (HPS)

Housing First (HF)

Motivational interviewing (MI)

Needle and Syringe Programmes (NSPs)

Needle Exchange Programs (NEP)

Opioid Substitution Therapy (OST)

PHF (Pathways to Housing First)

Réseau d'Aide aux Personnes Seules et Itinerantes de Montreal (RAPSIM)

Substance use disorders (SUDs)

Treatment First (TF)

Acknowledgements

First, I would like to thank God for giving me the capacity, knowledge, and wisdom to finish this project successfully. It is in Christ, where I found my strength for when I was weak, He made me strong, and when I was lost, he illuminated my path. I thank God for showing me that this project was not about obtaining a title but about engaging in a formative and transforming process that taught me humility, endurance, and perseverance.

I want to express my gratitude to Sue-Ann MacDonald, my professor, and my research supervisor, for all the support provided during the last two years. Every time I need it her guidance, I received it generously. Her approach pushed me to reflect further on the research questions, and it challenged my critical thinking skills. She also helps me to understand better, how my work with people experiencing homelessness influenced my research and my perception of harm reduction. I am incredibly thankful for all the help and advice I received from her.

I sincerely thank the PLM project workers and residents for trusting me with their experiences. It certainly expanded my knowledge about harm reduction, enlarged my perception of life after homelessness, and allow me to see the beautiful capacity people have to recover from adversity. I also would like to thank the Welcome Hall Mission and my supervisors and directors for supporting, for keeping me in their prayers and for always encouraging me to work with excellence. This project would not have been possible without the residents at Welcome Hall Mission, who inspired and challenged me every day to seek and research ways to improve the services offered to them.

Finally, I would like to thank my family and friends and all the people who supported this project. To my family, I am so grateful for all of their support and patience in this long process. I want to thank myself for not giving up, for pursuing my dreams tirelessly and for prioritizing my husband and kids in this process. Daniel, Max, and Aviva, you are my life, and your love is my most precious possession.

Introduction

Homelessness is a serious and multi-faceted issue facing Canadian society. People experiencing homelessness often endure individual and interpersonal challenges such as physical and mental health problems, addictions, and the breakdown of family relationships. These challenges are generally influenced or caused by structural and systemic barriers that include poverty and lack of affordable housing, discrimination and exclusion, as well as scarcity of social supports and services (Buckland, et al., 2001). Among the homeless population, people who are chronically homeless have the most difficulty getting back on their feet and are often labeled "hard-to-reach". Substance use has been incrementally observed among this population and is recognized as a key contributing factor to poor mental health as well as mortality risk (Grinman et al., 2010; Galea & Vlahov, 2002). Harms related to substance abuse among this group also include "higher risk of infection for severe diseases, including HIV, Hepatitis, and TB" (OHTN Rapid Response Service, 2009, p. 1). Although this group represents a small percentage of the overall homeless population, they are seen as the most problematic requiring a substantial amount of emergency and institutional services (Gaetz, 2012).

Traditional responses to attend to the chronically homeless in North America are to this day based on the "Treatment-First" (TF) approach. In Canada, this approach is typically used in the "Staircase" model of housing, in which individuals "progress from shelters to temporary housing […] to permanent supportive housing" (Fowler et al., 2019, p. 5). Programs employing this model require homeless individuals to abstain from substance use and encourage "compliance with psychiatric treatment [or addictions treatment, which is] considered essential for a successful transition to permanent housing" (Tsemberis et al., 2004, p. 651). However, an increasing amount of research shows that programs using the TF approach represent more of a barrier than an actual solution as these have proven to be ineffective for individuals living on the streets for extended periods (Collins et al., 2012; Denning, 2000). By focusing on individual challenges, traditional responses neglect to take full account of structural and systemic barriers that prolong and maintain people in homelessness. Some of these barriers are restrictive requirements to enter specific programs, lack of affordable housing and rental subsidies, as well as reduced funding to diversify the responses to homelessness (Miskey, 2016).

With the creation of the Homelessness Partnering Strategy (HPS) in 2006, the Canadian government moved away from the traditional models to homelessness management and towards policies and services that aim to eradicate the problem. In 2013, the HPS received funding of 119 million dollars to implement the housing first (HF) model across Canada (Gaetz, Scott & Gulliver, 2013). HF provides longer-term and low-cost housing as well as psychosocial support (Gaetz et al., 2016; Tsemberis et al., 2004; Tsemberis, 2010). This model runs under the principles of giving immediate access to housing, consumer choice, client-driven support, community integration, recovery orientation, and harm reduction (Tsemberis, 2010). The increment in funding for HF supposes that once housed and connected to a team of caseworkers, the cost and public care expenses for the chronically homeless will be reduced (Namian, 2019). However, housing provision is only a part of an equation in which substance use is a constant, acting both as causal and as a result of homelessness. Therefore, harm reduction (HR) plays a crucial role in HF programs. It facilitates housing attainment due to its pragmatic and low barrier approach towards people using or abusing substances. The main goal of HR is to mitigate the negative consequences of substance use as well as the risks related to harmful behavior, rather than preventing drug use in itself (Collins et al., 2015, Denning & Little 2012, Marlatt et al., 2012).

Recent studies testing the effectiveness of HF for chronically homeless individuals concluded that the HF approach is more effective at reducing homelessness and maintaining housing than the psychosocial interventions traditionally offered (Beaudoin, 2016; Goering et al., 2014). Other studies have demonstrated high housing retention rates, a decrease in alcohol consumption, and a reduction in the cost of health and social services for those in HF (Collins et al., 2012; Larimer et al., 2009; Tsemberis et al., 2004). In a similar way, studies of HR have provided considerable evidence for its effectiveness in reducing blood-borne diseases, preventing overdoses and reducing high-risk behaviour (Gibson et al., 2001; Kerr et al., 2006). However, there is little research about the effectiveness of HR within the context of HF for people who experience chronic homelessness and who continue to actively consume drugs and/or alcohol. Nevertheless, service providers argue that “reaching Canada’s homeless population through housing and harm reduction programming is critical to protecting and improving their health-related quality of life [...] and to lowering mortality rates among this high-risk group” (OHTN Rapid Response Service, 2009, p. 2).

Although both HF and HR provide a governance framework to address the basic needs of the chronically homeless at the individual, community and policy levels, "there are outstanding questions for housing first services that center on what happens after a chronically homeless person has been successfully rehoused" (Quilgars & Pleace, 2016, p. 12). In addition, research about the use and understanding of HR practices within HF programs is minimal. Much of the literature on this subject is centered on HR's role in accessing and maintaining housing by reducing barriers to services based on substance use. Still, there is little consideration to the real understanding of HR within the HF framework from the perspective of workers and participants, as well as its role in in social reinsertion for the participants.

This thesis examines the use of the HR approach within an HF program currently run by local community organizations in Montreal, Quebec. The research sought to understand how HF intervention workers and participants understand, mobilize, and deployed HR within a HF project. In order to answer this question, consideration is given to how the concept of HR is understood and used to prevent the negative consequences of substance use for HF participants; how workers and participants perceive substance use; and what factors facilitate or inhibit the practice of HR as well as its contribution to HF goals of community integration. The purpose of this study is to advance in the knowledge of the HR model as used by and with people who use drugs or alcohol in a HF program, in order to deduce possible approaches to sustain effective HR practices with previously homeless people.

This research project is inspired by my work experience at the Welcome Hall Mission, an organization working towards the social reintegration of homeless men, many of whom suffer from mental health problems and addictions. Working with this population has motivated me to inquire about the perception and experiences HF participants and intervention workers have with HR. To respond to the inquiries proposed in this research, Chapter 1 provides a reviewed the most relevant literature on the subject of homelessness and HF and HR. In this thesis, I provide significant data on the approaches of HF and HR and their role in addressing homelessness. In Chapter 2, I employ constructivism, humanist and social work theory to better understand the object of study. Through the conceptual framework, I put forward the concepts that I believe are important to better elucidate

the inquiry. The main concepts that underpin this study include ontological security, accompaniment, relationship to substances, and social inclusion. Each one of these provides additional concepts that are important to my research, such as housing and stability, therapeutic alliance, self-determination and empowerment, risk behavior, and reinsertion and community integration. These concepts appear in the literature about HR as crucial areas through which HR is mobilized.

The methodology in Chapter 3, qualitative research best fits the inquiry because of its emphasis to uncover the deeper meaning of human behavior and experience - in this case, people having experience chronic homelessness and people using psychoactive substances in a HF project - from their own perspective as well as the perspective of intervention workers. Chapter 4 reports on the findings from individual interviews and the focus group. Chapter 5 provides a discussion with a thematic analysis and interpretation of the key findings with elucidates and helps situate the findings within the literature on HR And HF and the theoretical concepts mobilized within the study. Finally, the conclusion contributes to the knowledge of fundamental issues encountered in the practice of HR in a HF setting, outlines the limitations of the study and gives recommendations for further research.

CHAPTER 1

Homelessness, Housing First, and Harm Reduction

1.1 Problem Statement

Thousands of people in Canada live on the streets and depend on social and community programs to meet their basic daily needs. Many of these individuals lack permanent and stable housing, as well as the ability or means to acquire it. The Canadian Homelessness Research Network recognizes that homelessness is a consequence of systemic, societal, and individual barriers such as "a lack of affordable and appropriate housing, [...] the individual's financial, mental, cognitive, behavioral or physical challenges and/or racism and discrimination" (Gaetz, Donaldson, & Richter, 2013, p. 12). Homelessness is, for the majority of people, a temporary situation mostly related to lack of financial resources, addictions to drugs or alcohol, and evictions by property owners (Latimer et al., 2015). However, a combination of personal circumstances, concurrent health problems, and public system barriers keeps some people on the streets for a long time.

In Montreal, the 2018 Point-in-Time count estimated that on a single night 3,149 people were homeless, from this group, 1,480 individuals had been homeless for a year or more, representing approximately 47% of the visible homeless population (Latimer & Bordeleau, 2019). According to Gaetz, Gulliver, and Richter (2014), individuals living on the streets and/or using shelters for a year or more would be considered chronically homeless. This subgroup of homeless people is the subject of this study for three reasons. 1) Individuals experiencing this type of homelessness are the most visible in public spaces and are often stigmatized through labels such as 'problematic', 'difficult', or 'hard-to-reach'. These labels put them at a "higher risk of receiving few or no services because policies and treatment methods conspire to deny access or to remove care from people who are not cooperative" (Denning & Little, 2012, p. 10). 2) Paradoxically, services addressing the chronically homeless involve a significant amount of public resources (Davidson, 2006). Gaetz (2012) confirms that federal spending on the provision of health, social, and judicial services costs the Canadian economy nearly 7.5 billion dollars per year. 3) People who endure homelessness for long periods are tremendously vulnerable to experiencing mental health problems as well as an increase in substance use (Burnes & DiLeo, 2016). These three reasons

lead this research to examine two strategies, HF and HR that are currently being used to approach two specific problems faced by this population, namely, homelessness and substance abuse.

Homelessness is a complex issue for individuals experiencing chronic homelessness. They often find it challenging to access, afford and maintain a stable place to live. According to the literature, this is in part due to individual challenges with mental health and substance use; structural and systemic barriers such as growing income inequality, lack of affordable housing supply, and difficulty in accessing social housing or rental subsidies (Gaetz, 2010). Furthermore, traditional programs serving this population often place housing at the end of the spectrum of needs. In the Staircase Model, behavior change, and abstinence are essential to moving up on the housing ladder (shelter, reinsertion or rehabilitation programs, supervised housing, and independent living) (Dyb, 2016; Tainio & Fredriksson, 2009). Dismally, for people experiencing chronic homelessness who suffer from concurrent problems such as addictions and mental health problems, these models often fail to provide effective solutions. According to Tsemberis et al. (2004), this is because requiring participation in treatment before being able to access permanent housing is "incompatible with consumer's priorities and restricts the access of consumers who are unable or unwilling to comply with program terms" (p. 652). Therefore, policymakers have called for the "development of low-barrier housing programs that might more effectively engage [homeless] individuals, house them and attend to their needs" (Collins, 2012, p. 1).

One of the main concerns in addressing homelessness is the high prevalence of substance abuse among the chronically homeless population. Some consider substance abuse as both a consequence and a leading factor contributing to the prolongation of homelessness (Burnes, & DiLeo, 2016). The incidence of consumption yields higher risks of potential harms associated with the use of psychoactive substances. Literature shows that problematic substance use increases vulnerability to accidental death, overdose, and contracting blood-borne diseases due to risky sexual behaviors or needle exchange (Burnes, & DiLeo, 2016; Pauly et al., 2013; Landry & Lecavalier, 2003). Other consequences related to drug use and mental health problems include "inability to work or stay in school, ruptured relations with family, friends and community members as well as problems with the law" (Landry & Lecavalier, 2003, p. 2). For individuals experiencing chronic homelessness, these challenges ultimately affect their autonomy, quality of life, ability to feel included in society

and relation to others (Quilgars & Pleace, 2016; Souleymanov & Allman, 2016). At the same time, these challenges can reduce their opportunities to secure and maintain housing, reintegrate into society, and recover from mental illness, addictions, and homelessness. Hence, a systemic response to chronic homelessness requires a combination of housing strategies as well as a framework to address and minimize the impact of substance abuse (Pauly et al., 2013; Collins et al., 2015).

HF stands in contrast to programs that require sobriety as a prerequisite to obtain stable housing, instead it provides stable housing to homeless individuals under the premise that housing is a human right and a basic need essential to survival. The HF framework involves choice and control for service users; separation of housing and treatment; active engagement without coercion; flexible support that is available for as long as is required; and person-centered planning, recovery orientation, and harm reduction (Padget et al., 2010). The main goal of HR is to minimize the risk and negative consequences associated with problematic substance use through the provision of support, education, safe consumption materials (Marlatt et al., 2012). As per Harm Reduction International (HRI), the HR approach exists to address and reduce social inequalities, discrimination and stigma by ensuring that people who use drugs obtain easy access to health and social services by including them in the design of the programs and policies that serve them, and by providing information about the risks and harms of substance use as well as safer ways to consume psychoactive substances (2019). HR is a major principle of the HF model as it offers a non-judgmental, humanistic and pragmatic approach to working with people who use and misuse substances (Marlatt, 1996). Tiderington, Stanhope and Henwood (2013) assert that the success of HR in HF lies in the process of the program, and specifically, in the relationship between consumers and case managers. However, more research is needed in order to understand the complex implementation process of HR within a population that is diverse in background, culture, substance choices and consumption practices.

Both HF and HR have made important contributions to public health policies and services worldwide. On one hand, recent studies have tested the effectiveness of project-based HF in improving outcomes for chronically homeless individuals who use drugs and alcohol. The results demonstrate increased housing stability, reduced utilization and costs of publicly funded services as well as reductions in alcohol use and alcohol-related problems (Collins et al., 2012; Larimer et

al., 2009; Pearson et al., 2007). HR on the other hand, has greatly contribute to reducing the spread of HIV, Hepatitis B, and other blood-borne diseases among substance users by implementing Needle Exchange Programs (NEP). It has also reduced deaths through Opioid Substitution Therapy (OST), Naloxone as overdose response and drug consumption rooms (Stone, Shirley-Beavan, 2018; MacNeil & Pauly, 2011; Gibson, Flynn, & Perales, 2001). Despite, the evidence of these two approaches in improving housing access and stability as well as in reducing the adverse effects of substance abuse, research on how these two models function and complement each other is still underdeveloped.

It is well known that HR is based on the recognition that many people are unable or unwilling to stop the use of drugs and alcohol. Within the HF framework, this perspective serves to acknowledge that abstinence is often unrealistic or undesirable for the chronically homeless population. Therefore, HR principles have allowed people experiencing lengthy periods of homelessness to obtain rapid housing without treatment contingencies. At the same time, it has given them access to psychosocial support with a focus on risk management and education about substance use. In a study looking at critical ingredients that facilitate consumer change in HF, Watson, Wagner, and Rivers (2013) found HR to be an essential ingredient for running a successful HF project. In the study, staff described HR as a tool to keep consumers housed, while residents saw it as " reducing the stress and fear related to the possibility of losing their housing due to substance use and "taking the judgment out" of their housing situation" (p. 174). HR low-threshold admission policies not only facilitate housing attainment for participants but also improve their mental and emotional state. Nevertheless, the mechanisms by which HR helps people stay housed and what is its role in the transition, adaptation, and reinsertion process are unclear.

Indeed, HR represents a paradigm change in addressing and treating substance use and abuse, as well as in becoming an integral part of strategies such as HF to eradicate homelessness (Denning & Little 2012; Pauly et al., 2013). However, there is little evidence about how HR is used and understood by both consumers and workers, once individuals with addiction problems are successfully housed through HF. This gap in the literature regarding HR misses crucial evidence about a population in which substance use and high-risk behavior are highly prevalent. More importantly, lack of scientific data about how HR is applied and understood (by workers and

participants) in HF might contradict HR principles of inclusion and participation for people who use substances by excluding them from contributing to research.

This study explores how HF residents and workers experience and employ HR principles, strategies, and practices. In pursuing this goal, I seek to find out how HR is deployed, what factors facilitate or hinder its use, what is its role in the participants' community integration process, and what are some of the social and health outcomes related to HR from participants' and workers' perspectives. Given the overwhelming amount of HF studies focusing on housing outcomes, and the lack of research about the role of HR within this framework, the purpose of this thesis is to advance in the knowledge of the HR approach as used in HF projects with drug and alcohol users that have experienced long-term homelessness. Implicitly, this study served as an outlet for participants and workers to express their perceptions on the subject and voice some of their concerns regarding HF and HR. According to Boucher et al. (2017) "People with lived experiences are often left out of the conceptualization of harm reduction interventions, despite calls to include their voice in recommendations for harm reduction service delivery and implementation" (p. 2). Therefore, this thesis examines HR from the perspective of residents and workers to produce an analysis that reflects both the similarities and tensions that arise from these two different points of view. Thus, a comparative analysis allows to better understand the experiences of substance use and high-risk behaviours in consumers and the role of workers in optimizing their professional relationship as a resource to reduce the negative effects of consumption. Finally, this process will reveal how HR can facilitate or hinder the process of social reintegration.

1.2 Research Gap

To date, there is little empirical evidence about how HF actors (program participants and intervention workers) experience, practice and comprehend the HR approach. HR's role in supporting housing stability, community integration and recovery for individuals who experience chronic homelessness prior to being housed is also unclear. In fact, researchers point out a "lack of clarity around the mechanisms by which [HF] is designed to deliver 'social integration" (Quilgars and Pleace, 2016). Even though Dorvil and Boucher (2013) make a strong case about how providing affordable and safe housing is a decisive factor in supporting community

integration and exiting homelessness, the document does not address how core elements of HR support this process.

Most studies on this area target people with severe mental illnesses or concurrent disorders and only a few focus on people with substance use problems (Dyb, 2016; Collins, Malone & Larimer, 2012; Collins et al., 2015). The literature shows that even though there is an increased awareness of the concept of HR, it is not widely understood and is rejected by many service providers working with a homeless population (Tiderington et al., 2013; Pauly et al., 2013; Marlatt et al., 2012). This confirms the need for "greater education on HR methods and how it can work in different settings" (Kraus, Serge & Goldberg, 2006, as cited in OHTN Rapid Response Service, 2009). Otherwise, Pauly et al. (2013) argue that "few studies of [HF] have focused on the impact of housing on the harms of substance use" (p. 285).

A small number of studies indicate that factors such as client-worker relationships facilitate the application of HR in HF, however, ethical and emotional tensions between workers and residents arise with respect to self-determination and tolerance about negative behavior, as well as social pressures to encourage behavior change (Mancini & Wyrick-Waugh, 2013; Tiderington, Stanhope & Henwood, 2013; Collins, Clifasefi, Andrasik, et al.,2012). On the contrary, factors such as poor understanding of HR principles and lack of fidelity to the model can affect the integration of HR within the HF approach (Pauly et al., 2013). In addition, researchers report that the intersection of housing provision and HR approaches can be challenging in practice due to clashing values. For instance, "HR values and principles can be in conflict with the established values of traditional services, thereby making it a 'threat to the status quo'" (Gaetz, Scott & Gulliver, 2013, p. 1). Others suggest that HR studies measuring and quantifying drug use and frequency fail to inform about how people who consume substances "organize their lives around drug use, [and how it can] negatively affect other aspects of their lives" (Ruefli & Rogers, 2004, p. 12). As HF programs continue to be replicated in diverse settings across Canada, concrete knowledge about how HR principles and practices are integrated into these programs becomes increasingly relevant.

Other HR research gaps require that I further investigate "interventions such as managed alcohol programs and other initiatives that integrate housing and [HR] to better understand the

effectiveness of interventions for different subgroups of the population" and "to pay explicit attention to the integration of [HR] principles and practices into systemic responses to end homelessness" (Pauly et al., 2013, p. 284). With regards to the use of public resources, research seeks to further analyze the costs and benefits of linking "housing and supportive interventions [such as HR] to outcomes in mental health, general health and welfare, labor market attachment, education and quality of life […]" (Pomeroy, 2005, p. 4). The research gaps also suggest the importance of examining the intervention strategies modeled after HF and HR that help keep people housed and prevent them from going back to the streets despite their substance use choices.

1.3 Purpose of the Study

The purpose of this qualitative study is to explore how harm reduction is understood and practiced within a Housing First project from the actors' (intervention workers and residents) perspectives.

1.4 Research Questions

The present research seeks to explore: **How do residents and workers in a Housing First project, understand, negotiate and actualize the Harm Reduction approach?**

In order to attain the above-mentioned objective, the following questions were explored:

1) How is the concept of HR understood and perceived by workers and participants in a HF project?
2) What factors facilitate or hinder the practice of HR with HF residents from the workers perspective?
3) How do HR practices reduce, limit or prevent negative consequences of substance use from the perspective of workers and participants?
4) How do participants and workers understand substance use and mitigate risk-taking behavior?
5) How do HR principles, strategies and practices contribute to HF goals of community integration?

To provide a community-informed account of the way HR is practiced within a HF project in Montreal, I develop and mobilize knowledge that will contribute to a better understanding of HR approach in a HF context and that will help to place the research questions within a body of literature. Moreover, the following literature review will highlight the importance of valuing and disseminating knowledge from people experiencing and practicing HF practices in a HF context as a worthy endeavor, as so little has been explored from their points of view, and it is hoped will better inform HR practices.

Literature Review

This section presents the literature relevant to the object of study. It begins with an overview of homelessness and the chronically homeless population. Then, it provides background on the primary intervention models addressing homelessness, namely the Staircase and HF models. These two models are theoretically different and approach homelessness in a different manner. The first model focuses on problematic substance use and mental illness among the homeless population, which I explore in-depth in a separate section, and the second focuses on housing provision. Due to the high prevalence of substance misuse among the population studied, the literature review examines the interventions addressing substance consumption and harmful use, which include the moral, medical and behavioural models. This review will then turn its focus on two evidence-based practices that are shifting the paradigm for responding to chronic homelessness, namely HF and HR. Research on HR from the perspective of stakeholders, as well as the role it plays in ending homelessness and specifically within Housing First (HF) programs will establish the relevance of this study. This chapter will end with a discussion centered on the challenges of implementing HR practices within the HF context, specifically when used to support previously chronically homeless individuals during the process of attaining housing stability and reinserting into society.

2.1 Historical Background and Context

During the 19th century, vagrancy increased in Montreal, exposing a problem that had long been cared for by religious communities providing charitable assistance. According to Aranguiz and Fecteau (2000), the 1930s crisis and World War II changed the supply of services from the

charitable arena to municipal jurisdiction. The first shelters were partly a solution and partially a form of social control at a time when vagrancy was severely punished, and vagrants were seen as a "source of social chaos" or undesirable people occupying public spaces (Aranguiz & Facteau, 2000).

The first shelters included police stations and the Montreal prison, where people without housing or employment were taken to spend the night and be fed. As poverty increased, so did the number of vagrants, forcing the city to set up the Public Assistance Office and create the first city night refuge. The Meurling Refuge known for its strict methodology failed to reduce the problem of homelessness in the city, which caused the shelter to change its mission to become a center of rehabilitation for the destitute, disabled, and alcoholics (Aranguiz & Facteau, 2000). In 1992, the Government of Quebec introduced the Health and Well-being Policy, which recognized the existence of preventable social problems, including homelessness. In response, shelter administrators and other actors involved in the work with homeless people started to recognize the need to help people exit the streets (Aranguiz & Facteau, 2000)

Between the 20th and 21st centuries, the number of shelters and the number of available places fluctuated. However, the request for help was concretely observable, and the presence of shelters justified its existence. However, the direct relief services provided by shelters simply served as emergency responses not addressing the housing issues related to homelessness. As a consequence, publically funded shelters have slowly shifted their approach to include a variety of supportive services for men, women, youth, and other populations experiencing homelessness (Bergheul, 2015). In recent years, the Canadian government has recognized the central role that adequate housing plays in mitigating homelessness. This acknowledgment resulted in integrating the Housing First model in Canada as a systemic response to end homelessness (Gaetz, 2012).

2.2 Defining Homelessness

The Canadian Observatory on Homelessness defines homelessness as:

> The situation of an individual, family, or community without stable, permanent, appropriate housing, or the immediate prospect, means, and ability to acquire it. It is the result of systemic or societal barriers, a lack of affordable and appropriate housing, the individual/household's financial, mental, cognitive, behavioral or physical challenges, and/or racism and discrimination. (Gaetz, et al., 2012).[1]

Quebec's National Policy to Fight Homelessness defines the problem as:

> […] a process of social disaffiliation and a situation of social rupture evidenced by a person's difficulty in having a stable, safe, adequate and healthy home due to the low availability of housing or that person's inability to remain in one, and at the same time by the difficulty of maintaining functioning, stable and safe relationships in the community. Homelessness is attributable to a combination of social and individual factors that influence the life course of men and women (Gaudreau, 2016, p. 4).

In both definitions, homelessness is considered the result of structural and individual challenges. However, the first definition conceives the problem as a circumstance (a condition connected to an event or action), portraying the issue from an individual's perspective, while the second one, sees it as a process of exclusion (a series of changes leading to a result) which reflects a structural view. This is one of the main discrepancies found in the literature when it comes to attempting to define the phenomenon of homelessness. For the purpose of this thesis the Quebec's National Policy definition is preferred as it depicts homelessness as a process of social exclusion. According to Gaetz, Donaldson, Richter, & Gulliver (2013) "homelessness and housing exclusion [can be explained as] the outcome of our broken social contract; the failure of society to ensure that adequate systems, funding and supports are in place so that all people, even in crisis situations, have access to housing and the supports they need" (p. 14). This is especially true for the chronically homeless population, who experience social disaffiliation and social exclusion and for whom programs such as housing first were created.

[1] The definition of homelessness used in this document was revised and tested in 2017 by the Canadian Homeless Research Network, however, the corrections were made on the 2012 document, therefore the original document was cited.

2.3 Demographics

Attempting to provide a clear portrait of homelessness can be a strenuous task because this population is extremely diverse with regards to age, gender, ethnicity, and socio-economic background (Gaetz, et al., 2013). According to The Homeless Hub 2016, this population is composed of single adult men, women, youth, indigenous people and families. In Québec, this portrait also includes elderly people and new immigrants (Ministère de la Santé et des Services Sociaux, 2014). Each group faces unique challenges, circumstances and risks that contribute to their homelessness that will be explain further in this chapter. For the sake of this thesis, I will be focusing on single adult men, who represent the highest percentage of individuals in this situation and who made up the majority of people experiencing chronic homelessness. Single adult men experiencing homelessness are usually between the ages of 25 and 55 and account for approximately 62 percent of the overall homeless population, according to the latest homeless count (2018) in Montreal. This group is highly represented among the elderly and veterans (Latimer & Bordeleau, 2019). Curiously, the elderly -above 65 years old- only represent a small percentage of homeless people "which may be explained by the expanded benefits accessible to seniors, but also by the much higher mortality rate of chronically homeless persons" (Hwang, et al. 2009, as cited in Gaetz et al., 2013, p. 25). Common characteristics of this group include high rates of unemployment, mental illness, and addictions.

The total count of visibly homeless individuals on the night of April 24, 2018, in Montreal was 3,149. Out of these, 74 % are men, and the most common reason for homelessness was eviction due to substance use (Latimer & Bordeleau, 2019). Concerning homeless chronicity, approximately 47 percent of respondents fit the criteria for chronic homelessness. According to the 2015 report, "people in this group are particularly significant for planning services because they live more precariously and have fewer chances of escaping homelessness without help (Latimer et al., 2015, p. 40).

2.4 Note on Counting People Experiencing Homelessness

As stated before, providing an accurate portrait of homeless demographics is extremely difficult, however, the point-in-time methodology offers a snapshot of the state of homelessness based on a

single night count. This count targets people who are visibly homeless, meaning those who are either living on the streets, in transitional housing or using shelters, or in hospitals and detention facilities (Latimer & Bordeleau, 2019). I decided to use the data provided by the count, not because it is the most accurate, but mainly due to its recognition by the public health sector and its influence on Canadian policy. However, the use of this information is done with careful consideration of its limitations and acknowledgement of its constraints.

Although the Montreal homeless count is useful for providing a point in time survey of the homeless population, it is essential to remember that homelessness is a complex situation from which people come and go; therefore, a one-night count cannot encompass all of the realities and situations lived of homelessness in Montreal. According to the Réseau d'Aide aux Personnes Seules et Itinerantes de Montreal (RAPSIM), the point-in-time methodology does not establish an accurate portrait of the problem, nor does it capture the actual number of people experiencing the issue. Instead, it underestimates the rate of the hidden homeless population, especially women, children and young people (Gaudreau, 2016, p. 4). In a similar way, those who do not wish to participate are excluded. Tobin and Murphy (2016) also state that numerical based descriptions can fluctuate "depending on who is doing the counting and the definitions and methods that they use" (p. 31). Also, they invite readers not to lose sight of the political motives involved in the counts. Governments tend to "employ the most conservative definitions and least extensive counting procedures, thus consistently producing the lowest estimates" (p. 31), which are then used for budgetary purposes that can affect the designated population. An example of this could be that the 2018 count defined the chronic homeless as people who had been on the streets longer than six months; therefore, this population had a higher representation than in the 2015 count in which the chronic homeless were defined as being on the streets for a year or longer. More significant numbers in this population could represent grounds to justify the need for programs such as HF.

2.5 Causes of Homelessness

According to Burt (2016) "at its core, homelessness results from inequality between a household's income and the cost of its housing [and] causes of homelessness are the factors that influence either the cost of housing or a household's ability to pay for it" (p. 49). An example of these disparities

is that “the average Canadian homeowner earns over twice as much as the average renter ($91,122 per annum as opposed to $43,794 per annum)” (Stock, 2016, p. 5), yet according to Clayton (2010), they receive the highest percentage of housing tax benefits (as cited in Stock, 2016). In Montreal, some of the factors include lack of affordable housing, progressive decline of rooms only residences, fragmentation of the social and community tissue and the constant influx of people transitioning between hospitals, prison or social services and the community (Ministère de la Santé et des Services Sociaux, 2014). Indeed, contemporary homelessness is shaped by the lack of accessibility to regular housing markets, the public housing crisis, the competitive employment industry, and the treatment of deinstitutionalized people (Gaetz et al., 2013, p. 13). Nevertheless, it is also the result of an “interplay between structural factors, systems failures, and individual circumstances” (Gaetz et al., 2013, p. 13).

Structural factors are described as a “complex set of interwoven demographics, social, economic, and policy trends” that deeply affect peoples’ opportunities and environment, putting pressures that they cannot cope with, resulting in homelessness (Koegel, 2004, p. 4). Among these pressures are “income inequality and poor distribution of wealth, a dearth of affordable housing, gentrification, discrimination and xenophobia” (Gaetz et al., 2013, p. 13). These factors diminish the ability of people to support themselves, either through social assistance or through conventional minimum wage jobs.

System failures “occur when other systems of care and support fail, requiring vulnerable people to turn to the homelessness sector, when other mainstream services could have prevented this need” (Gaetz et al., 2013, p. 13). A few examples to illustrate this point include “inadequate discharge planning for people leaving hospitals, corrections and mental health and addictions facilities and a lack of support for immigrants and refugees” (Gaetz et al., 2013, p. 13). Furthermore, a study to examine housing outcomes after residential addiction treatment, indicate that homeless people entering treatment are likely to return to the streets or not have a place to live following treatment. Subsequently, lack of basic needs, such as shelter, can trigger substance use relapse (Dyb, 2016).

Individual factors leading to homelessness encompass a broad spectrum of difficult situations, personal vulnerabilities and relational challenges. Traumatic events that cause people to lose their homes or jobs often lead to temporary homelessness. Other factors may include family violence,

relationship breakdown, lack of social network or lack of support from family and friends (Gaetz et al., 2013, p. 13). Furthermore, problems with physical or mental health or addictions can impede acquiring or maintaining housing and employment. Much of the literature on homelessness indicates a high prevalence of severe mental illness, as well as alcohol or drug-use disorders in the population (Koegel, 2004, p. 6). A study of Toronto's homeless population found that the overall lifetime prevalence of mental illness was 67%, while the overall lifetime prevalence of substance use or dependence was 68 % (Goering et al., 2002). Individual factors play an essential role in the social perception of homelessness, as there is a tendency to blame the individual without considering the broader context.

2.6 Typology of Homelessness

The duration and frequency of homelessness changes from one person to the other and depends on multiple factors. Most of the literature on this topic classifies the homeless experience into three categories based on different patterns and lengths of homelessness: transitional, episodic or cyclical and chronic (Kuhn & Culhane, 1998; Burnes & DiLeo, 2016). According to Quebec's health and social services, transitional or situational homelessness refers to a short period, usually three months or less of being roofless. This group represents the highest percentage of the homeless population. Episodic homelessness indicates that people are in and out of homelessness. This group is often characterized by concurrent problems with mental health, addictions and unemployment. (Ministère de la Santé et des Services Sociaux, 2014). The last category, chronic homelessness, represents a more entrenched form of homelessness and is the subject of this study, it will be explored more in depth in the following paragraphs.

2.6.1 Chronic Homelessness

The chronicity of homelessness is often determined by the length of time spent without stable housing. This measure tends to change from time to time, depending on the use and purpose of the definition. What does not change is the reality that people in this typology have to endure. People who experience chronic homelessness are vulnerable to co-occurring mental health and substance use disorders. They may also experience isolation and lack of financial, political, and cultural participation, as well as a rupture from social relations (RAPSIM, 2003). In addition to being

unable to exercise their citizenship, they are also exposed to multiple forms of discrimination embedded in systemic barriers such as the criminalization of homelessness, lack of health and social supports, and lack of affordable housing. These challenges can affect their health, behavior, quality of life, as well as their ability to find stable housing or recover from homelessness and addiction.

Chronic homelessness is a growing concern for society because addressing the unique and severe needs of this population requires not only a shift in social values and perceptions but also a change in the way financial resources are allocated. As discussed earlier, despite the high percentage of people experiencing it, chronic homelessness only represents about ten percent of the overall homeless population. However, this group involves high levels of interventions and significant social costs (Gaetz, 2012, p. 6). Davidson (2006) affirms that "prioritizing services for chronically homeless individuals recognizes that this population, particularly individuals with dual or multiple diagnoses, consumes a disproportionate [amount] of public resources" (p. 127). In an extensive analysis of the cost of homelessness in Canada, Gaetz (2012) confirms that this cost is as elevated as 7.5 billion dollars per year in Canada. Breaking it down, the annual basic cost per person using institutional responses such as prison, emergency rooms, and psychiatric hospitals is between $66,000 and $120, 000 per year. As a result, the problem of chronic homelessness has become of extreme importance in shaping both public health policy and local interventions.

Advocates of low-income housing as a response to homelessness argue that investing in emergency services as a means to reduce homelessness is no longer a viable solution. This argument is not only grounded in the fact that it is more expensive to provide emergency services to the chronically homeless than affordable housing but also on the fact that leaving people unhoused comes at a high human cost (Gaetz, 2012). Interestingly, Foucault's concept of biopolitics mobilized by Namian (2019), mentioned that shifts in politics around homelessness might not be so much to correct or prevent life disparities but to predict and manage "the risk these disparities entail, in terms of economic burden on the state"(P. 3). From this perspective, the reason why the chronically homeless obtain the most resources when compared to other categories of people without a roof might be because they represent the highest risk and cost in terms of health, income, and housing (Namian, 2019).

2.7 Intervention Models Addressing Homelessness

2.7.1 Staircase Model

The Staircase Model includes temporary emergency shelters, reinsertion programs, supportive housing, and subsidized housing (About-affordable-housing-in-Canada, 2018).

Emergency shelters provide temporary accommodation, food, showers, and support for homeless people all year round. One of their strengths is that it helps to connect homeless individuals with other resources available to them (Kuhn & Culhane, 1998). However, some argue that shelters do not adequately address the problem of homelessness. Segaert (2012) report that "between 2005 and 2009, there was little change in the number of individuals who use shelters on an annual basis [which shows] no evidence that our efforts to address homelessness in Canada have resulted in an overall reduction of the problem" (p. 12).

Reinsertion programs are designed for people who are exiting shelters, treatment programs, or the judiciary system and who need transitional housing before living independently (Maison l'Exode). Residents have to attend mandatory workshops and weekly individual meetings with an intervention worker (Maison l'Exode). Additionally, "in exchange for services, clients have to abide by the rules, curfews, limited liberties, visitation and limited privacy" (Padget et al., 2010, p. 249). Some authors argue that social reinsertion for the homeless is "too often judgmental to the people it serves, punitive in its practice, and largely ineffective in helping people with drug problems" (Denning & Little, 2012, p. 10). Individuals who do not abide by these rules and conditions immediately jeopardize their chances of obtaining housing through these programs.

Supportive housing combines rental assistance with housing and provides psychosocial support. Subsidized housing with social services "provides a more humane alternative to living on the streets and in shelters, and providers [in the US] report retention rates in such housing to be upwards of 70 percent in the first year after placement" (Culhane et al., 2002,

p. 107). However, these programs generally target people with severe mental illness and might exclude people with joint problems of mental health and addictions.

Social housing is provided by provincial governments in Canada, "to those who would otherwise be unable to afford to live in suitable and adequate housing in the private market" (CMHC, 2011, p. 127). That is those who spend over 30% of their income on shelter (About Affordable Housing in Canada, 2018). Individuals receiving social welfare as their income would end up paying over 70% of their income in the private market. For people who are homeless, subsidized housing is sometimes the only option. Therefore, many non-profit organizations working with the homeless population offer services connecting subsidized social housing to meet the basic need of shelter, as well as a variety of social and psychological needs.

The Staircase Model has been widely used to provide a housing continuum to those who are roofless. As described above, this model has several strengths and weaknesses. Nevertheless, the most significant criticisms center on its negative perception of homeless people as if they need to be 'fixed,' and its focus on abstinence as well as its contingencies to provide housing. Staircase programs assume that individuals living on the streets are unable, not ready, or not motivated to obtain and maintain housing (Tsemberis, 2010); however, numerous studies prove this assumption wrong. It has been shown that individuals living with severe mental illness and substance use problems do not need to attend treatment to be able to live autonomously (Padget et al., 2010; Goering et al., 2011; Watson et al., 2016; Tsemberis et al., 2004). Another assumption is that consumers best learn the skills needed to live independently if they first go through a reinsertion program or transitional housing, nevertheless, "research in psychiatric rehabilitation indicates […] that the most effective place to teach a person the skills required for a particular environment is within that actual setting" (Tsemberis et al., 2004, p. 652). These assumptions reinforce the negative perceptions of homeless people and can create substantial treatment and housing barriers for people experiencing chronic homelessness.

2.7.2 The Housing First Model

Sam Tsemberis founded HF otherwise known as Pathways to Housing, in the early 1990s in the United States to address the needs of the chronically homeless population of New York. The HFM is based on the belief that housing is a human right and functions on the premise that having secure housing is the first step necessary not only to avoid homelessness but to treat factors that cause homelessness, irrespective of whether or not these factors are personal or structural (Tsemberis, 2010). In the words of researcher and activist Cushing Dolbeare (1996), "The one thing all homeless people have in common is a lack of housing. Whatever other problems they face, adequate, stable, affordable housing is a prerequisite to solving them" (p. 34). The HFM is revolutionary for its humanistic and pragmatic approach towards housing. In contrast to the Staircase Model, HF provides housing that is not contingent upon readiness or treatment 'compliance,' irrespective of the individual's financial situation, personal or relational problems, mental or physical health problems, and addiction problems (Collins et al., 2012). A table of comparison at the end of this section presents the contrast between the two models.

HF is a complex intervention model that comprises three major components: (1) program philosophy and practice values emphasizing consumer choice; (2) community based, mobile support services; and (3) scatter-site housing (Padgett et al., 2015, p. 4). In its application, HF touches all levels of intervention -macro, meso, and micro- including systems models of services delivery, program models, and interventions with individuals. At a macro level, HF has dramatically influenced the systems-level response to homelessness becoming an essential part of the 'ten-year plans to end homelessness' (Burnes & DiLeo 2016), both in Canada and the United States, and to redirect public funding towards HF. At a meso level, HF has guided multiple programs created for specific populations such as youth or people with severe mental illnesses, as well as the chronically homeless, through its philosophy and principles.

HF is considered a program "when it's operationalized as a service delivery model or set of activities provided by an agency or government body" (Gaetz, Scott & Guilliver, 2013, p. 7). Lastly, at a micro level, each program can opt to use different types of intervention approaches based on the needs of the population they serve. The HFM suggests three stages of intervention. Assertive Community Treatment (ACT), to support consumers with acute needs such as people with severe mental illness, substance use problems or both; Intensive Case Management (ICM) designed for

people with lower acuity, but who need intensive support for a short period of time; And Rapid Rehousing which targets people with lesser need for support (Gaetz, Scott & Guilliver, 2013).

The core principles of HF include offering fast access to housing, client-driven support, community integration, recovery orientation, and harm reduction (Tsemberis, 2010). Immediate access to housing refers to the process of obtaining "safe, secure and permanent housing" (Gaetz, Scott & Guilliver, 2013, p. 5), in a timely manner. Client-driven support means that individuals have choices in terms of housing and supports (Tsemberis, 2010). For instance, people can choose their housing location as well as the services they desire. Recovery orientation ensures that "clients have access to a range of supports that enables them to nurture and maintain social, recreational, educational, occupational and vocational activities" (Gaetz, Scott & Guilliver, 2013, p. 6). In addition, community integration in HF provides opportunities for social engagement through employment or vocational and recreational activities. Harm reduction is used to help people with problematic substance use, reduce potential harms and risk associated with consumption. Because different contexts implement the HFM, these principles are used and actualized differently from one program to the other. This can be problematic because inconsistencies and lack of fidelity to the program can affect the goals that it is set to accomplish.

According to Tsemberis (2010), this evidence-based and cost-effective model "has been successful in influencing policy, improving quality of life of its users and increasing community integration among the homeless population in over one hundred countries" (p. 13). To date, the evidence demonstrates high rates of housing stability, as well as decreased hospitalizations and service costs on HF programs (Larimer et al., 2009; Padgett, Henwood, Abrams, & Davis, 2008; Tsemberis et al., 2004; Pauly et al., 2013). Further empirical evidence supporting this approach is encountered in one of the most extensive randomized trial studies on HF conducted to date. The At Home/Chez Soi (AH/CS) longitudinal study provides important data on the efficacy of HF for individuals with serious mental illness who experience chronic homelessness. One of the most important findings is that people who consume drugs or alcohol are still able to maintain housing (Goering et al., 2011). Empirical evidence that demonstrates the autonomy of people with concurrent mental illness and substance use disorders is imperative in reducing stigmatizing beliefs about the capabilities of this population to maintain housing. Nevertheless, despite the low cost and the

psychosocial support provided by HF, a small percentage (16%) of participants are still unable to remain housed under the program (Goering et al., 2011). In turn, this reflects that addressing the unique needs of the chronically homeless population, specifically those with co-occurring problems, requires further investing in various forms of resources and accommodations.

2.7.3 Limitations and critiques of Housing First

Even though the HF has been recognized as an evidence-based model, it has several limitations when it comes to its implementation and its outcomes. Johnson et al. (2012) argue that there is a trend in the literature to disregard some of the complexities identified in the implementation of the HFM. Consequently, in this section, I will explore the challenges HF faces in a climate of unaffordable private-market and shortage of social housing as well as lack of availability of tertiary support services for HF participants (Stock, 2016). I then explore concerns with regards to the terms 'permanent housing', the diversification of HF programs, and the debate about what constitutes 'successful' service outcomes for the chronically homeless (Pleace, 2011). Lastly, I will discuss a salient criticism of the HFM, stating that it prioritizes individuals who represent higher economic risks rather than those with significant housing needs (Namian, 2019).

A significant problem HF faces in the Canadian context is that the housing demand is higher than the housing supply, and that affordable housing stock (whether subsidized or market-based) is in short supply. According to Stock (2016), "there is a severe shortage of social housing and affordable private-market housing in many Canadian communities" (p. 11), which in turn affects the implementation of HF, as it requires that an abundant supply of affordable housing be available. This is problematic for several reasons. First, participants' choices on location and type of accommodation are reduced. Second, available housing might not meet the constraints of the participants' budget. It is essential to highlight that HF participants receive welfare or social assistance for the most part. Therefore, when the cost of housing exceeds 50% of their income, they would be considered in severe housing need (About Affordable Housing in Canada, 2018). Thus, resulting in "a reliance on shared accommodation, which [is] less desirable to participants and generally [leads] to worse outcomes, when compared to individuals housed in private apartments" (Stock, 2016). Another aspect where the implementation of HF is a challenge is its

dependence on tertiary support services to help people reintegrate into society. Some of these services involving third parties include food banks, addiction counseling or treatment, and employment agencies, amongst many others. Stock (2016) argues that when these services are not available, "it becomes increasingly difficult to ensure that participants remain healthy and housed" (p. 11).

The majority of the literature on the subject describes HF as a model that offers immediate access to permanent housing. Although, this might be the goal in theory, the implementation of both 'immediate access' and 'permanent housing' can be significantly jeopardized when, as mentioned before, there is a shortage of affordable private-market housing and when ongoing sustainability depends on provincial funding, which sometimes is only for a short-term (Polvere et al., 2014). These factors can also disturb housing stability for program participants. Furthermore, discrepancies between the theory and the implementation are also evident in the diversification of the program. The concern lies in the fidelity to the program implementation system. According to Dyb (2016), "the implementation of HF has taken different forms and it is questionable whether all the projects flagged as HF are faithful to the original idea" (p. 77). The fact that the model is not implemented in the same way throughout all the HF projects (Gaetz, Scott & Gulliver, 2013), has made the endorsement of it as an evidence-based model debatable.

One of the most substantial debates about HF service outcomes is whether or not it is a useful model for people with problematic substance abuse and addictions. Some have called for moderation when it comes to speaking of HF as the solution to chronic homelessness, particularly given a lack of evidence related to the effectiveness of the model people with problematic substance use (Kertesz et al., 2009). However, some studies have shown that housing outcomes vary depending on the type of substance being used. For instance, cocaine use is associated with lower housing stability (North et al., 2010 as cited in Rhoades et al., 2018), while alcohol and adverse outcomes related to its use decrease with time and intervention exposure (Collings et al., 2012). Other issues questioned by Pleace (2011) are related to employability and isolation. As per the author, "there is not as yet any real evidence that PHF (Pathways to Housing First) is effective at counteracting worklessness or social isolation" (p. 120). Although, Dorvil and Boucher (2013) will argue that providing affordable, safe housing with the right housing conditions is a decisive

factor in supporting community integration as well as supporting the exit from homelessness (p. 127). With that said, more consumer-driven research on outcomes is needed to understand further, how they define effective outcomes.

Another significant challenge in HF might be reflected in the way participants are chosen. Namian (2019) studies the procedures and tools or "instruments" used by front line workers to deliver HF services locally. She found conflicting effects "such as prioritizing individuals who represent higher economic risks, while discounting others with significant housing needs" (p. 4). Moreover, according to Namian the tools used to deliver the HF services are not neutral or centred on the needs of the population it serves, instead, it accommodates "the wider issue of an aging baby boomer population, reinforcing intersectional inequalities at a micro-level" (p. 4).

Namian (2019) argues that far from prioritizing those with higher needs, by targeting a specific age group (those born between 1958 and 1963) within the chronically homeless, HF responds to a broader socio-political need, which is preventing a potential economic burden caused by the aging population. According to Culhane et al. (2013), without proper housing supports, this generation could represent a great burden for homeless programs and require a significant amount of public resources (as cited in Namian, 2019). In addition, favoring older men "based on biopolitical calculations reinforces concretely intersectional inequalities within the homeless population" (p. 13). It favors aging men to dismiss other populations that might exhibit more significant housing needs, such as women, youth, and indigenous people (Namian, 2019). Osborne (2018) concords by stating that even though many benefit from HF, this model also creates barriers for those who don't meet the eligibility criteria, creating a climate where people experiencing homelessness are no longer vulnerable enough to receive housing.

2.7.4 Comparison of Housing First and Treatment First Models

Elements of Comparison	Housing First	Treatment First
Theoretical Framework	Access to affordable, adequate housing is the first priority and not contingent on treatment or abstinence	Mental health/addictions treatment is the first priority and treatment adherence/abstinence is

		essential to prove housing readiness
Program Model Description	The HF model provides chronically homeless people with a long-term place to live. Service users pay 30% of their income towards monthly rent and are required to meet regularly with a case manager or worker. Services such as addictions and mental health treatment are offered but not mandatory.	The TF model provides short-term accommodation (through transitional housing or shelters) while service users progress through a number of stages to reach housing readiness. Service users must prove their ability to live autonomously through abstinence, treatment adherence and the acquisition of other life skills.
Service Delivery	HF models often work in conjunction with Assertive Community Teams (to be described below).	TF models often employ case management or in some cases intensive case management
Target Population	Chronically homeless people, especially those suffering from mental health issues, substance use disorders or both.	Chronically, cyclically and transitionally homeless people.
Outcomes	Shorter periods of homelessness, (Greenwood et al., 2005; Stanhope & Dunn, 2011) a decrease in psychiatric symptoms, criminal activity (DeSilva, Manworren, & Targonski, 2011) reduction in alcohol intake (Collins et al., 2012) and lower residential costs (Padgett et al., 2006)	Participants more likely to adhere to treatment plans (Fisk et al., 2007; S. Kertesz et al., 2009)

Table 1: Table of comparison between HF and Treatment First Models [2]

A paradigmatic conflict could be found in the HF and linear models of homeless [embedded in the Treatment First (TF) model] intervention in that they apparently (1) target different primary problems (housing versus health/addiction), (2) apply different methods and measures (e.g., policy interventions versus clinical interventions), and (3) emerge from substantially different scholarly backgrounds (housing policy versus behavioral psychology). In addition, the two paradigms are easily mapped onto contrasting social

[2] Reprinted from Homelesshub.ca: Addressing Homelessness in Canada: Implications for Intervention Strategies and Program Design -A literature Review (Mott, Moore & Rothwell, 2012, p. 24-25)

messages (e.g., “housing is a human right” and “treatment works”), both of which can have a useful political effect (Kertesz et al., 2009).

Even though the HF model has been recognized as an evidence-based model, TF model is still a significant influence for many community service providers addressing chronic homelessness. This reflects social perceptions embedded in the ‘deserving and undeserving’ constructs, which shows that consuming substances is wrong, and lack of housing is the consequence. With that said, housing depravation is not the only problem people enduring chronic homelessness have to face, as mentioned previously, the high rates of mental illness and substance misuse represent significant health hazards for them. This highlights the importance of attaching housing to psychosocial services, specifically addressing recovery from mental illness as well as harmful substance use. In the following paragraphs, I will further explore how these problems affect the homeless population and frequently act as a barrier to receiving services.

2.8 Treatment VS Care : A Shifting Paradigm

Traditionally interventions related to homelessness have been linked to addressing addiction and mental health problems from a treatment standpoint inherited from charitable and medical approaches. They have normalized the moralistic and medical views of these problems. Nevertheless, in recent years, a paradigm shift underlines the emergence of services focused on care and support for people experiencing homelessness, diverging from treatment-centered interventions to advanced care focus approaches. This shift in thinking has led to an increase in intervention practices that prioritizes the use of accompaniment, motivation, and strength-based approaches upholding the individual's power to make positive changes in his life.

An example of this paradigm shift is the transition from a TF approach towards a HF approach. Treatment focus programs often require sobriety to move through the residential Staircase Model. This can be problematic for people experiencing homelessness because it places high barriers to housing access (Padget et al., 2010). Multiple research studies have demonstrated that this model is ineffective in engaging people in this particular population (Young et al., 2000; Dyb, 2016). One reason might be that requiring detoxification or sobriety or a commitment to treatment might be

"incompatible with consumer's priorities and restrict the access of consumers who are unable or unwilling to comply with program terms" (Tsemberis et al., 2004, p. 652). This model's lack of success in addressing the multiple needs of the chronic homeless population, housing being one of them, prompted the creation of the HF model.

Kertesz et al. (2009) warn readers about the need to understand the paradigmatic conflict between the HF and TF models to make a fair assessment of services providing intervention to a homeless population. The core differences between HF and TF approaches include prioritizing housing versus addiction, using different methods and measures such as policy versus clinical interventions, and having different scholarly backgrounds, for instance, housing policy versus behavioral psychology. Finally, the authors highlight that HF and TF models have different social messages; one says housing is a human right, while the other states that treatment is essential to maintain housing (Kertesz et al., 2009).

Another example of the paradigm shift going from treating to caring, is the use of Harm Reduction (HR) practices in services addressing the homeless population's needs to help improve their ability to seek and maintain housing. The overlap between chronic homelessness and substance use has called for special attention to high-risk behavior as imperative in addressing the needs of this population. Thus, harm reduction approaches that "deemphasize pathologizing alcohol [and substance] use and support the realization of client-driven goals that can reduce harm can improve quality of life [of this service's users]" (Collins, Malone, Larimer, 2012, p.932).

The care relationship appears at the crossroads of a series of debates; cultural, social and political dimensions related to social roles and ties. Care has generally been associated with the provision of support for people unable to care for themselves (Lesemann & Martin, 1992). Therefore, caring in the sphere of social services needs to be defined from an empowering perspective based on solidarities anchored in egalitarian relationships, wherein individuals are thought to be able to take care of themselves. For instance, the accompaniment practice has been imperative in creating a more egalitarian relationship between professionals and clients within services addressing homelessness. Accompaniment is used to encourage and motivate the person to take control over

his life, choices, and decisions while being supported in search of solutions to his problems according to his pace and perceptions (Gagnon, Moulin, and Eysermann, 2011).

Social work ethics have also had an essential input in changing this paradigm to support caring practices while challenging the treatment culture. The social work approach has been successful in enhancing self-esteem in substance users, strengthening their skills, and enabling them to control their environment; as a result, people experiencing addictions have increased their interpersonal skills (Raheb et al., 2016). With an increasing number of people experiencing homelessness for multiple reasons, providers have learned to distinguish the characteristics and course of homelessness to accept that not everybody wants treatment, but everybody can benefit from a caring approach.

2.9 Problematic Substance use and Mental Illness Among the Homeless Population

Substance use has been widely observed among the homeless population and is recognized as a key contributing factor to poor mental health, as well as mortality risks (Grinman et al., 2010; Galea & Vlahov, 2002). Grinman et al. (2010) conducted a study in Toronto homeless shelters, which reported that 40 percent of their study sample had substance abuse problems. Study participants were mainly single men, with low-grade education, who became homeless at a young age and had experienced homelessness for over four years. Cannabis and cocaine were the most used drugs among this population. According to the study, problematic substance use within the last 30 days was associated with significantly poorer mental health status but not with more inferior physical health status (Grinman et al., 2010). Furthermore, Fortier et al. (1998) point out that individuals living in homelessness who struggle with mental illnesses such as Depression, Schizophrenia, and Bipolar disorder also suffer stigma, a lack of personal development, isolation and marginalization (p. 46). Moreover, studies show that the longer a person is on the streets, the higher their risk of being exposed to trauma, which can lead to a decline in their mental health and wellbeing (Kertesz et al., 2005; Hwang, 2000).

Among the homeless population, substance use and addictions can be frequent and can result in an array of serious risks. Some of the harms this population is exposed to include: having

unprotected sexual encounters while consuming or in exchange for drugs, usage of broken or shared pipes and needles, contraction of HIV and bloodborne illnesses, as well as attempting alcohol withdrawal without supervision or medical assistance which can be life-threatening (Galea & Vlahov, 2002; Marlatt et al., 2012). Pauly et al. (2013) argues that harms such as “stigma, overdoses, and death are exacerbated by homelessness and unstable housing” (p. 284), and not only due to substance misuse.

For homeless people, substance use often serves as a coping mechanism to deal with the precarity they endure daily. According to Denning and Little (2012), “being homeless requires the development of certain responses to the world not needed by people who are housed” [… for example] “Drugs serve to either numb the mind so that sleep is possible or keep one awake throughout the long and dangerous nights” (p. 122). Substance use can also be a "way to relieve many problems, often related to untreated mental disorders" (Ménard & Simard 2013, p. 1, own translation). From a HR perspective, Denning and Little (2012) argue that “the primary motivation [for substance use] is usually self-care, not self-destruction”, while Tatarsky (2002) asserts that substance use is a problem-solving tool, for instance when the person is feeling anxious and needs to calm down (as cited in Marlatt et al., 2012). These understandings differ from mainstream moral and medical perceptions of substance use. Instead, they describe problematic substance use as a complex dynamic between biopsychosocial vulnerabilities and consequences that explain the frequency and intensity of consumption (Marlatt et al., 2012).

Galea and Vlahov (2002) analyze the correlation between poor health outcomes with socioeconomic factors, homelessness, and incarceration among drug users. Their findings demonstrate that problematic drug use is triggered by social factors such as poverty, discrimination, and segregation. This correlation creates a problematic cycle of substance use within the homeless population. By engaging in high-risk behaviors, the individual's health is affected, and consequently, a domino effect occurs when their ability to find resources, access welfare services, comply with medication and prioritize basic needs is jeopardized by poor health and substance use (Galea & Vlahov, 2002). This cycle is hugely problematic because it perpetuates homelessness by increasing health risks, limiting access to treatment, and impeding housing attainment.

The complexity of the issues experienced by homeless individuals living with mental health and substance abuse problems complicates the identification of effective, relevant, and tailored needs interventions. The prevalence of these issues is often seen as the root of the problem, and therefore, programs serving the homeless population uphold approaches such as Treatment-First as a road to provide housing. Paradoxically, people who refuse TF services "as a condition of housing only confirm[s] provider's perceptions that these individuals are "resistant" to treatment, not willing to be helped and certainly not ready for housing" (Tsemberis et al., 2004, p. 652). According to Stock (2016), the overrepresentation of individuals experiencing mental health and addiction problems among the homeless population indicates that these are significant obstacles for people to find housing. Consequently, "addressing concerns related to substance use has been identified as integral to a systems level response to ending homelessness" (Pauly et al., 2013; Galea & Vlahov, 2002).

2.10 Interventions Addressing Substance Consumption and Harmful Use

2.10.1 The moral model and Alcoholic Anonymous

Humans have consumed alcohol and other substances since the beginning of time. During the temperance and prohibition periods of the nineteenth and twentieth centuries, addiction was viewed as a sin, implying a lack of willpower (Brooks & McHenry, 2015), portraying the individual as blameworthy. Later, the goal of the temperance movement became abstinence. They "suggested that for that not reformed death will be the penalty" (Brooks & McHenry, 2015, p. 121). The punitive and moralistic aspect of the prohibitionist movement led to incarceration, public mistreatment, and humiliation, as well as an increase of users in mental health facilities. It also led to achieving the complete opposite of the desired effect, since a rise in alcohol users was seen and new forms of criminal practices arose from contraband (Lassiter & Spivey, 2018). Since then, the Moral Model and the criminalization of substance use go hand and hand. As per this model, the moral strength to stop addiction comes from reliance on religion or a superior human force. Therefore, this model greatly influenced addiction treatment with the creation of Alcoholics Anonymous (AA) and other 12-step abstinence-based models.

The twelve-step faith-based abstinence model was born in the United States under the direction of Bill Wilson and Bob Smith in the early 1930s. At its core, AA presents addiction as a "spiritual disease or soul sickness [that] emanates from an existential emptiness and disconnection" [from a higher power] (Brooks & McHenry, 2015, p. 123). Addiction, according to this approach, is not only a physical but also a spiritual condition for which treatment and recovery require a commitment to religious principles (Brooks & McHenry, 2015). Some critics of the A.A model argue that the model has "difficulty to relate to the losses discussed from people with dual diagnosis, and people with mental health problems (Denning & Little, 2012, p. 12).

2.10.2 The medical model and the pathology of addiction

According to the American Psychiatric Association (APA), "addiction is a complex condition, a brain disease that is manifested by compulsive substance use despite harmful consequence" (Parekh, 2017). Substance use disorders (SUDs) "occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home" (SAMHSA, 2015). SUDs are characterized by an "inability to abstain consistently, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response" (ASAM, 2011). In the medical field, many agree that due to the chronic nature of addiction, cycles of relapse and remission (sobriety) are expected; however, they warn that substance use disorders left untreated can lead to permanent mental and physical disabilities, as well as death. Treatment includes a vast array of options such as inpatient hospital and psychiatric care, medication, withdrawal management, outpatient or community care, residential or rehabilitation, individual or group counseling, and recovery support services (SAMHSA, 2018).

The medical model implies that substance abuse is not a choice, a habit, or the result of a flawed character, but an actual mental illness that can be treated. However, recent studies and emerging treatment approaches have challenged this model. Research demonstrates that unlike other diseases "most of those who meet the [APA's] criteria for addiction quit using illegal drugs by about age 30, […] quit without professional help, and that the correlates of quitting include legal

concerns, economic pressures, and the desire for respect, particularly from family members" (Heyman, 2013, p. 1). Marc Lewis, a developmental neuroscientist, asserts that treating addictions as an alienated pathology misses an integral part of interpreting neuroscientific data related to the understanding of brain functions such as learned behavior, motivation, and coping mechanisms (Snoek & Matthews, 2017). In Lewis' view, addiction is "a habit that grows and self-perpetuates relatively quickly, when we repeatedly pursue the same highly attractive goal" (Snoek & Matthews, 2017, p. 2). In other words, addiction will develop quickly, depending on what motivates the person to use.

Heyman (2013) and Heather (2017) rely on psychiatric knowledge, trajectories of substance use, and treatment studies to make a strong argument against the labeling of addiction as a disease, as it implies compulsion and lack of control. Instead, they argue that addiction is voluntary and a matter of choice. Marlatt (1996), a proponent of HR, also comments on the medical model, stating that addiction is a social learning process where individuals learn the behavior though observation. Harm reduction supporters argue that the language used by the disease model is dominated by the concepts of loss and denial, which is problematic to the power a person has over the addiction (Marlatt et al., 2012). Advocates of harm reduction also state that the focus on abstinence as the primary approach to recovery in the medical model, reflects "a dichotomous paradigm, a way of thinking, that is black or white, good or bad […] these constructs are synonymous with religious notions of good and evil and sinner or saved" (Denning & Little, 2012, p. 12)

Evidently, the moral and medical approaches to addictions are polarized. While the moral model considers substance consumption as a flaw of character, sinful, and weak, the disease model sees it as an illness where people have no control over their addiction. This is problematic because it depicts people with substance use problems as "inevitably progressing towards jails, institutions, and death" (Denning & Little, 2012, p. 11). Dismally, these negative predictors are overrepresented among the homeless population across Canada. Studies show an increase in the judicialization of homelessness (Bellot & Sylvestre, 2017), high mortality rates (Gaetz, 2012; Hwang, 2000), and a high prevalence of mental illnesses, depression, and anxiety (Hwang, 2000; Grinman et al., 2010).

The persistence of negative dynamics affecting the homeless population have not only revealed flaws in the mainstream models addressing the issue but also have called for changes in policy and public health systems to understand and tackle these issues more effectively. As a result, recent shifts in perception about the overlap between chronic homelessness and substance use are putting special attention on high-risk behaviour. Thus, HR approaches that "deemphasize pathologizing alcohol [and substance] use and support the realization of client-driven goals that can reduce harm and improve quality of life" (Collins et al., 2012, p. 932), have increased in use and popularity. Nevertheless, HR still at the beginning stages of its implementation; therefore, it is often used in conjunction with models such as the stages of change and motivational interviewing. In the next paragraphs, I will further explore these behavioral models as used within the context of services for homeless people and emphasize HR as a critical element for this study.

2.10.3 Common Behavioural Intervention Models

Stages of change

Prochaska and DiClemente developed the Trans-theoretical model of Stages of Change and in the 1980's to examine the constructs of how people change and how addictive behaviours function (Brooks & McHenry, 2015). They found that it is "necessary to ask *when* changes occur, to explain the relative contributions of client and intervention variables and to understand the underlying structure of behavior change" (Prochaska et al., 1992, p. 1102-1103). This model attests that individuals attempting to change addictive behaviours go through different stages that determine motivation to change and treatment readiness. These stages are pre-contemplation, contemplation, preparation, action, and maintenance (Prochaska et al., 1992). *Pre-contemplation* refers to a lack of intention to change and resistance in recognizing that there is a problem. C*ontemplation* is characterized by a rise in awareness and understanding of the problem and its consequences as well as considering a change. P*reparation* is the result of contemplation, and it generally means that the person is ready to take action. A*ction* is the stage in which individuals commit to making modifications to their habits, behaviour, and environment to overcome their problems. And *maintenance* indicates the achievement of change, but it requires work to consolidate accomplishments and avoid relapse (Prochaska et al., 1992). Although this model has significantly

been used in Staircase and Treatment First Models, it has also informed harm reduction practice. According to Tiderington, Stanhope and Henwood (2013) this model recognizes the need to calibrate treatment depending on the stage of change in which individuals are, hence, when someone is not ready to stop using drugs or alcohol, it might be more useful to help the person find strategies for safe use while reducing harm.

Motivational interviewing

Motivational interviewing (MI) has its roots in humanism and it is recognized as a client-centered approach. It uses a non-directive method to increase intrinsic motivation to change through the exploration of ambivalence (Hohman, 2012). Building on the work of Carl Rogers, MI uses the principles of collaboration, evocation, and autonomy support (Miller & Rollnick, 2002, as cited in Hohman, 2012). The aspect of collaboration entails positioning workers as partners in helping individuals understand their behaviours, motivation, and desire for change. Evocation refers to assisting individuals in exploring their ideas and thoughts to draw solutions about their problems as well as strategies for change. In this sense, MI proposes that people are continually wrestling with ambivalence; therefore, the goal of using MI in intervention is to help people find the motivation to position themselves in favor of healthier choices. The concept of autonomy support underlines the recognition that consumers are the ultimate decision-makers. In contrast, using warnings and consequences might make people more prone to disengage from their process. According to Hohman (2012) "honoring clients' autonomy helps avoid resistance and encourage engagement in problem-solving in a positive manner" (p. 5). MI is often used in conjunction with HR to discuss ambivalence towards substance consumption and behaviour change, not necessary to stop substance consumption, but instead, HR is used to reduce high-risk behaviour resulting from substance misuse.

2.11 Harm reduction

Despite the easy comprehension of the words "harm reduction" – "harm" generally understood as damage, and "reduction" as a minimization - defining the term as a pragmatic public health strategy towards drug use can be challenging. As with many globally used approaches, harm reduction (HR)

reflects a collage of definitions embracing the diversity of its applications, including policies, programs, and practices tailored to address different needs in different communities. Irrespective of these challenges, HR proponents demand the implication of users in defining this term. Ultimately, the users determine the effectiveness of the model. Thus, it is one of the purposes of this thesis to uncover the concept of HR as understood and defined by its users -whether they are substance users, or caseworkers directly employing this approach- in HF context.

In a sentence, HR can be described as a humanistic approach to intervention catering to individuals engaging in harmful behaviors. Marlatt et al. (2012) define it as "a set of compassionate and pragmatic approaches for reducing the harm associated with high-risk behaviors and improving quality of life" (Marlatt et al., 2012, p. 5). For its part, Harm Reduction International defines the term from a public health and human rights stance. In their view, HR is a set of "policies, programs, and practices that aim to minimize negative health, social and legal impacts associated with drug use, drug policies and drug laws" (Harm Reduction International, 2019). A distinctive feature of this approach lies in its focus on preventing harm instead of preventing the use of drugs. This approach accepts that licit and illicit drugs will be produced and consumed, that people are unwilling or unable to stop using them, and that substance abuse brings on negative consequences for individuals, communities, and society as a whole (Brisson, 1997).

2.11.1 Historical Highlights

Drug use has been historically treated as a social and public health problem impacting individuals, family relationships, institutions, public welfare, and public safety as well as the environment. The moral perspective that using drugs is wrong has deeply influenced drug-control policy in the United States and Canada, resulting in the criminalization of the consumption and distribution of narcotics (Marlatt, 1996). However, the "war on drugs" has not only been inefficient and costly, but it has actually "created a long wave of consequences affecting mainly drug users and in turn opening doors to dangers associated with the criminalization of the drugs" (Marlatt et al., 2012, p. 11). HR emerged as a response to one of the greatest public health crises in the world, the spread of HIV. It is estimated that about "10 percent of all HIV infections [worldwide] are related to injecting drug use" (Institute of Medicine. 2007, p. 35). Unfortunately, due to the illegal nature of

the activity as well as the stigmatization surrounding it, estimating the number of injection drug users (IDU) is difficult. Similarly, measuring the prevalence of HIV among this group would require systematic enumeration, which would be difficult to carry out, due to lack of access to places use for substance consumption and to the population itself (Institute of Medicine, 2007). Seeing the ripple effect and adjacent damage that comes with drug use, the need for alternative, low-barrier approaches to substance use becomes evident.

Great Britain made the first attempt to include the HR approach in policy in the 1920s when the government collaborated with Dr. John Rolleston to examine the current Dangerous Drug Act to develop more pertinent strategies to substance use control (Marlatt et al., 2012, p. 11). The Rolleston report introduced the disease model of substance dependence and paired it with HR approaches. Moreover, Rolleston deemed it imperative to determine "how controlled substances may legally be distributed" (Marlatt et al., 2012, p. 11). In the 1980s, due to the rise of opiate and cocaine consumption, the Netherlands established HR as their primary model to deal with drug consumption issues (Marlatt, et al., 2012, p. 13). As a result, activist groups such as the *Jonkiebond* also popped up, advocating for human rights and the health and safety of drug users. An important contribution of the *Jonkiebond* is the development of the needle exchange program (NEP) (Brisson, 1997). This program is currently implemented in 82 countries. Needle and Syringe Programmes (NSPs) "are one of nine interventions in the WHO, UNODC (2009) and UNAIDS (2014) comprehensive package for the prevention, treatment, and care of HIV among people who inject drugs" (UNAIDS, 2014, p. 52). These programs have achieved a minimization of blood-borne diseases such as HIV and Hepatitis C that are contracted through infected needles used by intravenous drug users (UNAIDS, 2014). The work done by advocacy groups such as the *Jonkiebond* has inspired social justice movements around the globe, informed policymakers, and dramatically improved health outcomes for those who otherwise would be marginalized, consuming drugs in the shadow of illegality.

In Canada, the introduction of HR practices started in the late 1980s with the opening of NSPs in Toronto and Vancouver (Riley, 1994). Subsequently, similar programs were implemented in other provinces and territories, notably Cactus Montreal, which works with drug users, sex workers, and transsexual people to promote health, well-being and social inclusion (Cactus Montreal, 2018).

Other HR programs have been introduced in several cities in Canada, such as opioid substitution therapies employing methadone or buprenorphine and naloxone, as well as programs to distribute crack kits (Marlatt et al., 2012). In Quebec, HR began to be employed at the end of the 1980s, when field intervention workers had already started to question the treatment philosophies in the domain of rehabilitation from substance abuse that was financed entirely by the state (Landry & Lecavalier, 2003). During a time when HIV rates were quickly rising in Quebec, when medical teams in Montreal had begun using substitution therapy for heroin users, and community agencies were working with people facing addiction problems often combined with mental health problems, the public health department opted for the implementation of HR (Landry & Lecavalier, 2003). In contrast, programs opting for a rigid framework that requires abstinence have been deemed discriminatory, exclusive and inefficient (Landry & Lecavalier, 2003), while HR has received great support not only from workers in the addictions field but also from Quebec's society in general (OHTN, 2012).

2.11.2 Principles and Goals

As per Harm Reduction International (HRI), this approach is based on principles of respect for the rights of people who use drugs, commitment to evidence, social justice and collaboration with networks of people who use drugs, and avoidance of stigma (HRI, 2019). The objective is to promote social justice, human rights, and positive change at all levels of intervention attending users whether these are policies, programs, or practices. HR is grounded in the acknowledgment that some people are unable or unwilling to renounce illicit drug use; therefore, it targets urgent priorities, such as avoiding deaths, reducing the harms of drug laws and policies, and offering alternative paths to seek to prevent or end drug use (HRI, 2019). These goals have moved away from previous discourses in which HR was mainly focused on an individual's actions, to include broader and more rounded objectives targeting systemic responses to drug use. This approach continues to move forward addressing the harms of substance use while taking into consideration popular critiques such as moral concerns, value-neutrality, and its role in informing drug-law, which will later be addressed in this chapter.

2.11.3 Evidence of Harm Reduction

HR has been broadly recognized as an evidence-based approach that is "practical, feasible, […] safe and cost-effective" (HRI, 2018). It has been found effective at reducing high-risk behaviors associated with the transmission of blood-borne disease through needle exchange programs, distribution of crack kits, overdose prevention, treatment referrals, and crime minimization (Watson et al., 2017; OHTN, 2012; Pauly et al., 2013; Marlatt et al., 2012). Thus, HR is positioning itself as a key player in drug control policy, as well as public health interventions to address the risk associated with the use of licit and illicit substances. In spite of this, the adoption of a "liberal" approach to substance use does not come without resistance or challenges. This is because HR is in conflict with multiple political and social beliefs and policies regarding diseases, drugs, welfare, and the criminal justice system (Barry et al., 2018).

2.11.4 The role of Harm Reduction in Addressing Chronic Homelessness

The high prevalence of substance use among the chronically homeless population, as well as the barriers they face to accessing housing services, has made HR a pragmatic response to address the needs of this population (Tiderington et al., 2013). By not focusing on substance use itself as a harmful practice, but instead concentrating on the adverse effects of destructive behavior associated with this practice, HR has opened doors, otherwise closed, for people who are unable, or unwilling, to stop using drugs and alcohol. Multiple research studies support the need for low-barrier approaches such as HR to address problematic substance use within the chronically homeless population. In effect, the need is evident when statistically there is a low demand for rehabilitation services among this population. Moreover, treatment engagement is often court-mandated or rewarded with access to housing and not based on personal motivation; thus, completion is not always achieved (Collins et al., 2015). Low treatment engagement might be attributed to the fact that abstinence is not necessarily desirable for homeless people. Collins et al. (2015) evaluated HR goal setting among chronically homeless individuals with alcohol dependence and found that goals involving drinking reduction and avoidance of negative consequences had a higher prevalence than goals of achieving abstinence. In addition, besides drinking-related goals, quality of life, and health-related goals were also highly endorsed. Therefore, Collins et al. (2015) conclude that HF participants with a history of chronic homelessness are able to generate and pursue goals that go beyond substance use while

highlighting the importance of patient-centered interventions to engage so-called 'hard-to-reach' populations better.

Pauly and colleagues (2013) state that HR can be optimized through the practice of social inclusion, which requires the participation of people who use drugs and alcohol in the development of policies and programs to address their needs. They argue that effective HR strategies require the input of substance users because it breaks the stigma, improves services, and increases individual control over health determinants. In addition, the application of HR calls for adequate and affordable housing. The assumption is that housing provides a safe environment to recover from trauma and homelessness as well as to reduce harms related to substance. Likewise, HR services should be offer on-demand and should be "available, accessible and acceptable for those who need them" (Pauly et al., 2013, p. 287). Finally, the authors recommend that best practices of HR approach require organizations to have clear policies and protocols that incorporate HR into their mission and values. Equally, HR training is necessary to ensure the appropriate planning and delivery of services (Pauly et al., 2013).

In the following section, I present the literature pertaining to the use of the HR approach within HF programs, the gaps in research as well as the potential challenges of its implementation. The presentation of this data represents the core of this study, as it helped guide this research to address the gaps associated with the use and understanding of HR within HF, as well as its impact in the social reinsertion and recovery of previously chronically homeless individuals from the actors' (residents and intervention workers) perspective.

2.12 Harm Reduction and Housing First: An Integrated Framework to End Homelessness?

2.12.1 The application of HR in HF programs

When looking at HR practices within HF programs, Henwood, Padgett, and Tiderington (2014) suggest that this approach effectively uncouples housing from treatment requirements. In other words, housing is considered a right and treatment an option; nevertheless, housing can be a component of therapy, as it is more challenging to keep substance use goals when people do not have stable housing. HR practice, advocates then, for low threshold access to different services

and supports without substance treatment contingencies, provides ongoing support to HF participants to help them develop healthier behaviors, and delivers educational guidance about harmful substance use and its consequences while maintaining a focus on recovery (Mancini and Wyrick-Waugh, 2013). Collins et al. (2011) report that a HR approach not only facilitates housing attainment and maintenance, but it was deemed an essential part of the housing stability process by both users and caseworkers. This is because people can consume substances at home without jeopardizing their housing status. Besides, "alcohol use was also cited as a means of staving off acute withdrawal, medicating psychiatric symptoms, and facilitating community-building" (Collins et al., 2011, p. 115). These findings are congruent with HR principles rooted in the belief that addictions are a "complex combination of biopsychosocial forces" in which people develop a relationship with their substance of choice, and motivation for substance use is primarily for self-care and not self-destruction (Denning & Little, 2012, p. 127).

In another study, Tiderington et al. (2013) highlights the importance of therapeutic relationships in the implementation of HR in HF. Their findings suggest that a strong alliance is a key factor in HR practice leading to open drug use discussions, while poor alliances can lead to limited drug discussions, which, in turn, can potentially lead to low self-determination as well as negative health outcomes. Mancini and Wyrick-Waugh (2013) explore the experiences of mental health practitioners and consumers with co-occurring disorders in a housing program using HR. Their findings suggest that the most critical elements of HR practice include "providing unconditional support and practical guidance while also embracing self-determination and choice" (Mancini and Wyrick-Waugh, 2013). Notwithstanding, practitioners disclose struggling with negotiating the boundaries of HR due to the impact of frustration and ambiguity inherent in HR practice, specifically when people engage in destructive behaviors (Mancini and Wyrick-Waugh, 2013). Whereas, Luborsky et al., (2002) stress that "social interaction between the provider and consumer [more so] than the intervention itself" (as cited in Tiderington et al., 2013) is a crucial factor for successfully applying HR practices in a HF context. Tiderington et al. (2013) conclude that the success of HR in HF lies in "the everyday decision making, the practical skills of the workers and addressing health needs even when clients are actively using" (p. 76).

2.12.2 Gaps in the Literature

The rise of HF programs brings important issues to the forefront regarding the use of HR practices in addressing substance use among previously chronically homeless people; however, this application has received little attention from researchers. In fact, very few studies have documented the usefulness of the HR approach as employed within the HF model for individuals with a history of chronic homelessness and alcohol problems (Tsemberis et al., 2004; Collins et al., 2011). In the course of this research, no studies were found that discuss the use of HR within HF for those using hard drugs such as opiates, methamphetamines, and cocaine, among others. Only one study addresses HR practice within HF projects from the caseworker's perspective (Tiderington et al., 2013). A few studies provide insight in regards to recovery and social integration outcomes in correlation with HR practices within HF programs (Padgett, Henwood & Abrams, 2008 and Rhoades et al., 2018). However, some of this data includes people with serious mental illness or concurrent disorders, which may not be representative of all HF residents. Lastly, a study carried out by Tsemberis et al. (2004) measured housing status, alcohol and drug use, consumer choice, and use of treatment services. The findings suggest high levels of housing retention and stability among previously homeless individuals with concurrent disorders, high levels of control and autonomy, low use of treatment services, and no increment in substance use. However, these findings do not clearly state what results come from the use of HF philosophy and what results are directly linked with the use of HR practices.

2.12.3 Challenges of Implementing Harm Reduction in Housing First Projects

Difficulties resulting from the conflicting values between HR and abstinence-based services reflect disparities between the conceptualization and the practice of HR. This is especially true for services addressing homelessness. Pauly et al. (2013) state that HR principles are not often integrated into systemic responses to homelessness. Watson et al. (2017) discuss three crucial barriers to the implementation of HR within HF programs: 1) lack of understanding of the term "harm reduction" by managers and caseworkers; 2) lack of fidelity to the guidelines of HR interventions; 3) commitment to abstinence-only approaches among HF providers. What these findings show is that, despite the increase of awareness of the concept of HR, it is still not widely understood (OHTN, 2009), and therefore not widely implemented by many homelessness service

providers. In the area of homelessness, Kraus, Serge, and Goldberg (2006) stress the need for "greater education on HR and methods on how it can work in different settings" (p. 55). Mancini and Wyrick-Waugh (2013) attest that practitioners, "require ongoing information and training that not only clarifies the principles and practices of HR but also helps them position its practice within a broader recovery-oriented practice framework" (p. 21).

While research shows that, in general, both practitioners and service users appreciate the practicality and flexibility of HR, as well as its role in education and ongoing support, several obstacles can prevent the optimal practice of HR in housing programs offering psychosocial support. According to Mancini and Wyrick-Waugh (2013), managing frustration is one of the main issues. In the present study, practitioners voice that frustration often arises from residents' engagement in negative behavior such as repeated substance use despite adverse health effects, trading money, sex, and other goods for drugs, as well as lying and manipulation. This frustration leads to a disconnection? between practitioners and consumers. Consequently, practitioners take measures such as controlling access to money or withdrawing support, measures that for consumers are in "direct opposition to what they need for their recovery" (p. 18). Tiderington et al. (2013) agree that, in circumstances where harmful behavior gets out of control, "the HR approach breaks down and case managers find themselves overriding consumer self-determination" (p. 76).

Another obstacle to the optimal practice of HR is working with ambiguity. Some practitioners argue that HR practice does not have clear protocols, is too general, or is ineffective as a stand-alone practice (Mancini & Wyrick-Waugh, 2013). In addition, "the ambiguity of the approach and the need for tolerance for drug-related behaviors caused serious moral and ethical dilemmas for many practitioners" (Mancini & Wyrick-Waugh, 2013, p. 20), which can lead to inconsistencies in the practice of HR. What these obstacles reflect is that careful consideration needs to be given to the human factor. In other words, practicing HR requires an examination of personal values and beliefs as well as a deep awareness of how these can influence how HR interventions are conducted. In this sense, Hendwood et al. (2014) prompt service users to be careful about "don't ask don't tell values," "which make[s] pathways to recovery less clear for those living in supportive housing who abuse illicit substances" (p. 8).

Although studies looking at the correlations between recovery and social integration outcomes concerning HR practice within HF were not found, the literature on the combined topics highlights essential considerations. One of them is the use of abstinence as a viable goal for substance use residents in HF. Experts stress the importance of understanding that the use of HR does not oppose abstinence; instead, it supports it as long as it comes from the consumer, and it helps improve the individual's quality of life (Marlatt et al., 2012). Nevertheless, others suggest that for people with a history of chronic homelessness, addressing substance use might be the least of their worries, when compared to taking care of "criminal justice entanglements, poverty, unemployment, housing problems, [stigma], trauma histories and other complications" (Padgett, Henwood, Abrams, & Drake, 2008, p. 333). Therefore, the application of HR requires awareness about the person's priorities and their relation to substances.

Lastly, the potential for isolation within HF should be anticipated as it can increase substance use and jeopardize recovery or HR goals. As discussed by Dorvil and Boucher (2013), the feelings of loneliness and isolation among HF participants are connected to the lack of supportive networks, the discomfort of sleeping indoors, and the discomfort associated with new and unfamiliar neighborhoods. Padgett (2007) demonstrate that during the transition period, participants would appear to be affected by the uncertainties related to the future, and more particularly to the obstacles to be overcome to live an independent and socially acceptable life, while at the same time having to confront forms of stigma and discrimination. These factors can result in lack of participation or integration into society. Therefore, providers have identified isolation as an essential target of intervention, especially when taking into account that social interactions and networks can lead to positive or harmful outcomes within the homeless population (Padgett, Henwood, Abrams, & Drake, 2008).

2.12.4 Limitations and Critiques of Harm Reduction

One of the main criticisms of HR is related to a moral concern that its strategies, programs and policies can lead to a rise in drug use and high-risk behaviour. The argument is that "it sends the message that drug use is acceptable and that the approach enables people to continue to use drugs

and alcohol by shielding them from the natural consequences of their behavior" (Mancini & Wyrick-Waugh, 2013, p. 15). This argument concords with a study carried out by Barry et al. (2019) in which the underlying arguments for or against safe consumption sites were explored. Barry and his colleagues found that the majority of the respondents believe that HR measures "encourage people to continue using drugs (53%), they make it easier for people to use drugs, (52%), they would lead to more illegal activity in the neighborhoods where they are located (51%) and medical professionals would be encouraging harmful health behaviors like opioid use (50%)" (2019, p. 20). However, it has been argued that problematic substance use is rapidly rising and is followed by its negative effects, hence the need for an array of strategies and approaches that change the direction of this phenomenon. HR proponents believe they have the solution to part of the problem that is to mitigate the negative consequences of misuse without necessarily addressing the actual consumption. The question would be, does addressing harmful use and high-risk behaviour in the short-term translate to better long-term health, social and economic outcomes for people with substance addiction?

Similarly, Miller (2001) offers a progressive critique concerning the application of HR from a Foucauldian perspective. The author states that a "focus on the reduction of harm to the wider community does not necessarily translate into a decrease of harm to the drug user" (Keane, 2003, p. 231). He argues that certain HR programs (such as safe consumption sites or needle exchange programs) have been created for the "protection of the 'general public' and [to reduce] health care costs, rather than concern for the well-being of drug users" (Keane, 2003, p. 227). Which in turn, diverts from "the things that produce the most harm for drug users: drug laws, dominant discourses of drug use and the stigmatization of users" (as cited in Keane, 2003, p. 227). Nevertheless, as shown previously, multiple studies have shown evidence of how the use of clean needles does protect the general public and reduce health care costs, as well as its massive impact in reducing HIV and Hepatitis C transmission among users. Miller (2001) seems to be comparing two different things, public health, and social discourse. Although these two do influence each other, questioning the concern for the well-being of drug users and not only of the society overall seems pertinent when discussing who HR is intended to serve.

2.13 The Rise of Harm Reduction in Social Work Practice

Inherently the practice of HR has brought together multiple disciplines including social work. Nevertheless, there is little knowledge regarding the use of HR concepts and how these translate into the practice of social work in Canada. In spite of services addressing substance use complexities being staffed and often following the social work ethics and principles, there is no theoretical evidence of the use of HR in combination with the professional practice of social work. Even though the use of HR practices would for instance be useful in services in which substance use can cause severe detriment such as in child protection where addictions often play a role in child neglect and child placement.

A common ground between HR and social work is empowerment and advocacy. Harm reduction is known to use the person-centered approach that advocates for substance users' rights and empowers them to reduce the risk associated with substance use. Social work has challenged historical constructs including stigma and labeling of substance users. Furthermore, several schools of thought in social work have questioned the hierarchical power often experienced in the client-worker relationship which are visible in the role workers have in implementing policies of surveillance and control (Namian, 2019).

Although, social work is likely seen as an anti-oppressive practice with the capacity to reach political spheres to make positive social changes, it is undeniable that social workers are often bound by the structures and organizations they serve. HR can diminish this power imbalance by creating spaces where the stigma of substance use is placed aside and the person is seen as an equal contributor to his own process. Applied in a context of HF, the practice of HR and social work can help to further take policy interpretation away from surveillance and control "allowing people to take part in the planning services though representative consultations and join with others in organising services in the way they want through self-help" (Payne, 2005, p. 302). In this way social work can continue to empower workers and residents through mutual support and shared learning, giving value to the knowledge acquired by the experiences of services users.

Conclusion

In this chapter, I have provided an overview of homelessness as a backdrop to the study. A thorough description of this complex problem reveals that homelessness is not just bad luck, or merely the result of individual choices, but the direct outcome of poverty and social exclusion. The social demographics of the homeless population reveal that it is not homogeneous; homelessness touches women, youth, and indigenous people, and yet adult men constitute the largest percentage of this population as well as the most visible. Adult men also have the highest prevalence among those experiencing chronic homelessness. This subgroup is the focus of attention because even though they represent only a small percentage of the overall homeless population, this population is highly stigmatized, marginalized, and often labelled 'hard-to-reach.' One factor contributing to this stigmatization is the high prevalence of mental health and addictions among this group. These two issues have tended to produce siloed responses, dividing services and approaches to addressing homelessness.

On the one hand, the TF approach embedded in Staircase programs focuses on addiction treatment as a way to combat homelessness. Unfortunately, multiple studies have shown that this approach is not practical for those who are unable or unwilling to stop drug or alcohol consumption. Instead, it represents a high barrier to attaining housing for the very ones it intends to serve. On the other hand, HF focuses on providing housing and supportive services, without treatment contingencies to people experiencing chronic homelessness. The assumption is that before addressing any other individual needs, the primary requirement for a safe, permanent, and stable environment needs to be addressed. However, concerns about how safe, how permanent and how stable these measures are prevalent among its critics.

HR is a crucial principle of HF. The HR approach is now widely known for its impact on reducing harms related to substance abuse, such as the propagation of HIV and other blood-borne diseases. Its pragmatic and humanistic approach has dramatically influenced policy, programs, and practices addressing the adverse effects that come with the use of licit and illicit drugs. However, there is little evidence of how this approach is implemented in HF programs and its impact on residents' dependent on substances. Current concerns about HR are related to enabling substance consumption and its impact on both social and health outcomes for people with problematic

substance use. Furthermore, its focus on addressing primarily urgent priorities has become relevant when attempting to clarify the role HR plays in programs such as HF. Therefore, this study focuses on exploring how HR is understood, mobilized, and practiced in an HF project setting. With this goal in mind, literature related to the integration of HF and HR as part of the responses to homelessness is included here. This information is complemented by several studies addressing the challenges of implementing HR in HF programs. In the next chapter, I will present the theoretical background of this research as well as a conceptual framework that will further help to analyze how the literature that was introduced in this section intersects with the data provided in chapters four.

CHAPTER 2

Theoretical Framework

The theoretical and conceptual framework of this study derives from a constructivist approach linking social work theory as well as sociological concepts, and empirical research to explore and guide the understanding of the problem as well as the analysis of the collected data. Exploring how HR is applied and understood within HF requires careful consideration of how this approach is considered and deployed across multiple layers encompassing participants, workers, and the HF program itself. This analysis must take into account the interactions between the segments mentioned above, not only among themselves but also concerning a broader social context in which substance use and harm occur as well as the way in which substance use is perceived especially amongst marginalized populations.

This study uses several theories and concepts to guide this research in order to make the findings meaningful, acceptable and grounded in theoretical constructs. **Humanism** and the **Person-Centered** theories are used within a **Constructivist** theoretical framework to better understand and explore the shared perceptions of residents and workers concerning men previously living in chronic homelessness with substance use problems who transition into HF. Within the practice of social work, this theoretical framework allows to recognize every person's self-worth and understand that personal and societal problems occur when people are devalued and excluded. Central to this study is the concept of unconditional positive regard, which demonstrates that change is possible in a context where the helping relationship is genuine and empathic. Based on the literature, this study argues that in HF projects, the occurrence of HR requires consideration of the following concepts: **ontological security**, **accompaniment, relationship to substances** and **social inclusion.** That is, HR can take place when individuals: feel safe and have a stable environment, receive the necessary support to control the risks and dangers of substance use, understand their relationship to substances, and can fully exercise their citizenship instead of being excluded. Therefore, to understand, negotiate, and actualize the HR practice, one must understand each one of the concepts proposed in the conceptual framework and how they connect and are interpreted within the broader theories presented in the theoretical framework.

2.1 Constructivist Background

This social work research endeavor exists within the larger frame of constructivist theory. Constructivism "looks at how different human practices and culture help to create and define social reality" (Carey, 2012, p. 34). Berger and Luckman (1971) developed the idea of social construction highlighting "the importance of relationships and the impact of contingent factors such as knowledge, learning, tradition and culture" (as cited in Carey, 2012, p. 34). This theory "recognises that people have choices and influence their present yet also realise that such choices are rarely free and open but are instead also likely to be restricted by group norms, traditions, institutional rules etc." (Carey, 2012, p. 34). As seen in the problem statement, research questions and literature review, this study focuses on individuals within the context of chronic homelessness and the reality of social exclusion while tracing two approaches that have challenged traditional methods, namely HF and HR. Thus, Constructivism is pivotal in the understanding of the context of human interaction as well as the social work's perspective of the client-worker relationship within the context of HF.

Social constructivism implies that while individuals can improve their health and their place in society, these opportunities can be impacted by negative experiences such as distress and illness, which exacerbate individual problems. HR, as the research topic of this study, clearly fits constructivism theory in that it recognizes individuals choices with regards to substance use, but challenges traditional approaches to substance use, by providing pragmatic solutions to this problem without patronizing or stigmatizing substance users. Instead, it promotes knowledge and education as a tool to reduce the harms associated with substance use. Similarly, HF is represented in constructivism as it provides alternative paths to respond to the basic needs of the chronically homeless population without prioritizing behavioral challenges. Harris (2006) argues that research using social constructivism must be used to improve the equality of relations and social conditions. Therefore, this thesis uses constructivism to provide participants an expressive voice to promote social change through the use of HR within the context of HF. Based on the constructivist approach used here, the content analysis from all collected data helped identify emergent themes in the subsequent chapters.

2.2 Humanistic Theory

Humanistic theory was developed in the 1960's to challenge two main behavioral approaches to psychology: psychodynamic and behavioral learning (Neukrug, 1994). While both of these theories focus on explaining problematic behaviors and how to change them, the humanistic theory highlights the strengths and positive aspects of the individual, as well as their capacity to make free choices leading to positive change (Payne, 2014). The two major contributions of these theories are the Person-centered approach of Carl Rogers and the hierarchy of needs by Abraham Maslow (Neukrug, 1994). These two components of the humanistic theory have been applied in multiple disciplines and have had great influence on different approaches and fields, including social work and HR.

To contextualize this research through the lens of humanism, it is essential to explain how some of the principles of this theory apply directly to the population of the study, the setting, and intervention practices used within HFP. For instance, it is well known that traditional responses to chronic homelessness focus on treating the negative behaviours related to substance abuse before allowing access to housing services. This is contradictory to humanism because it does not prioritize the person's primary need for shelter. In the hierarchy of needs —from bottom to top: physiological needs, safety, belonging and love, esteem, and self-actualization— Maslow stresses that "a lower-order need would have to be satisfied before the next need on the hierarchy could be approached" (Neukrug, 1994, p. 63). In the case of people experiencing homelessness, shelter is one of the individual's physiological needs as well as one of their safety needs. Because of this, Tsemberis et al. (2004), assert that there is "no empirical support for the practice of requiring individuals to participate in psychiatric treatment or attain sobriety before being housed" (p. 654). Thus, "Housing First [as the setting of this study] represents an important break from traditional models that focus on 'fixing' clients to make them 'housing ready', by emphasizing the "individuals as consumers entitled to make choices" (Kertesz et al., 2009, p. 497).

Humanistic theory also helps to understand practice models such as HR. In fact, the HR approach is deeply rooted in humanistic theory because of its willingness to reach substance users in their community, to make accessible the care and services they need, and to promote respect for their

rights and their ability to make their own substance use choices (Brisson, 1997). Concerning choices, the humanistic theory believes that we are all able to make choices and that we are constantly making choices to create our existence (Neukrug 1994; Forte, 2014). However, it is important to highlight that HR is, at its core, more pragmatic than theory driven. Marlatt et al. (2012) state that theoretical explanations of high-risk behaviors are difficult to generalize and, therefore, can obstruct the development of effective HR interventions. Thus, "harm reduction adherents tend to deemphasize general theory and ideology to seek out acceptable, feasible and effective solutions that are applicable to specific situations" (Marlatt et al., 2012, p. 21).

2.3 Person-Centered Theory

Derived from humanistic theory, is the Person-centered approach developed by Carl Rogers. This approach is best known for its principles of the conditions that facilitate a therapeutic relationship, as well as the conceptualization of the process of self-actualization and self-fulfillment. The central idea in the Rogerian approach is that counseling should be non-directive because "if the practitioner is empathetic, accepts the client with unconditional positive regard, and is genuine in his or her respect for the client, positive change will occur" (Greene, 2008, p. 113). Another key aspect of Rogers' conceptualization of the person-centered approach is the notion of freedom. Freedom, at its core, expresses the idea that a person has the ability to make choices and to determine their life course. Becoming, on the other hand, expresses that the individual has the capacity to engage in a lifelong process of growth and self-actualization (Greene, 2008). In this study, the person-centered approach is used to analyze and understand the practitioner's role and relationship to the consumer, as well as the implications of this relationship in the application of HR practices. In addition, understanding the concepts of accompaniment, self-determination and empowerment will guide the acquisition of knowledge with regards to HR intervention within HF.

Conceptual Framework

The conceptual framework mobilized in this chapter uses the four key concepts through which HR can be operationalized in HF. The concept of **ontological security** is used to explore the elements

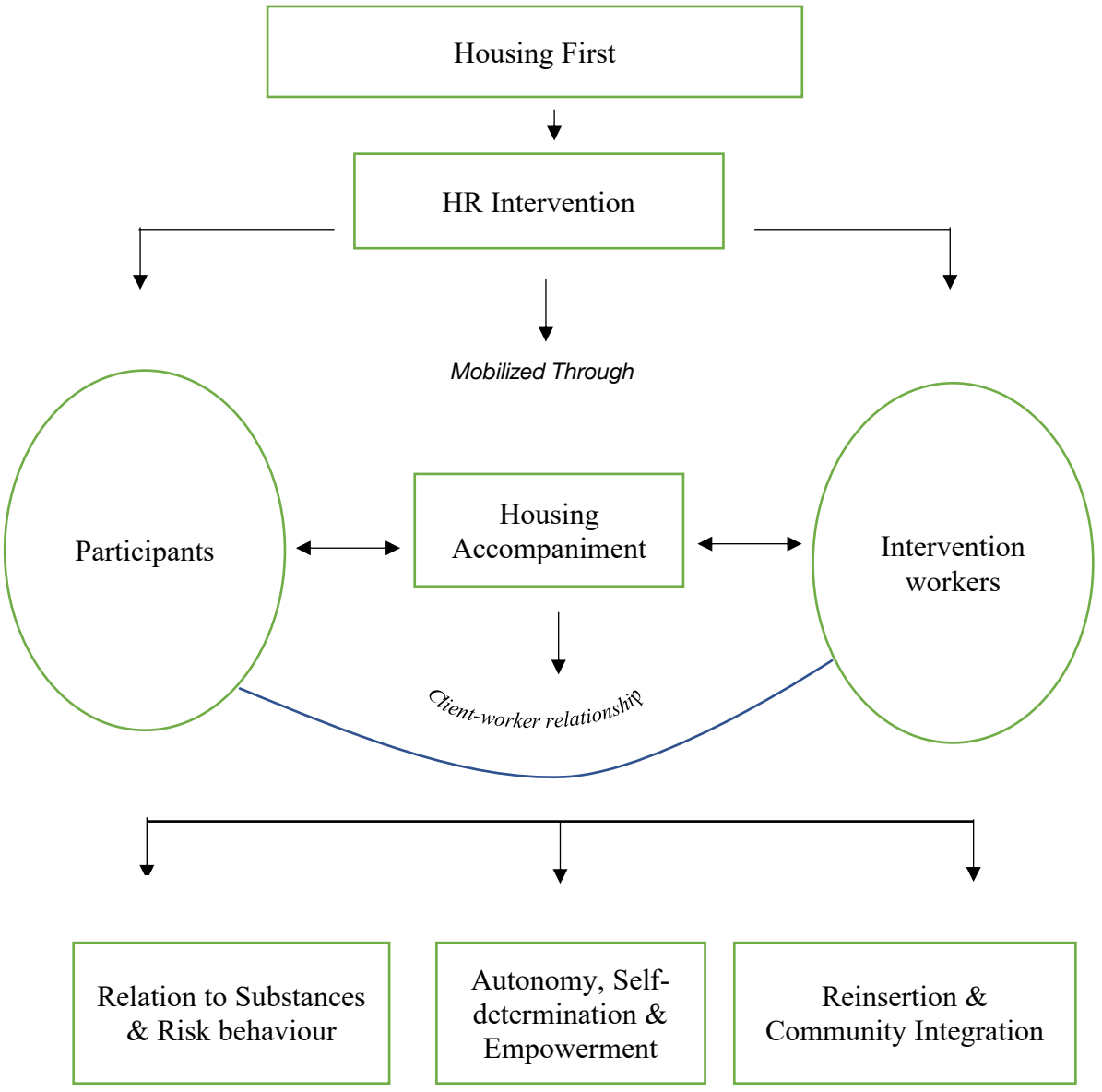
of housing and stability and their role in mitigating the negative effects of substance use. **Accompaniment** is conceptualized from the Roger's Person-Centered perspective which offers insight into how professionals "interact with their clients so that their clients' worth and dignity are validated, offering the potential for personal growth and development" (Langer & Lietz, 2015, p. 120). Appropriate supports and accompaniment have empirically demonstrate to be vital to the practice of HR within HF (Mancini & Wyrick-Waugh, 2013; Tiderington et al., 2013; Collins, Clifasefi, Andrasik, et al., 2012). Rogers, provides fundamental knowledge about the notions' therapeutic alliance, autonomy, self-determination and empowerment (Greene, 2008). Studies have shown that favorable client-worker relationships can lead to open discussion about substance use, resulting in turn in high self-determination and high health impacts, whereas poor client-worker relationships lead to limited discussion of substance use which leads to low self-determination and low health impacts (Tiderington, Stanhope & Henwood, 2013). The concepts of **relationship to substances** and **risk behavior** are conceptualized from a HR perspective**.** That is because understanding the residents' relationship to substances and the place these have on the individual's lives is known to be an important factor in practicing HR intervention and hence in reducing harms associated with substance use (Marlatt et al., 2012, Denning & Little, 2012).

Finally, the themes of community integration and social reinsertion are explored within the concept of **social inclusion**, which is a key element of the HR approach. Social inclusion is presented in this thesis as both a practice and an outcome of the HR approach. Social inclusion is made visible when HF participants have meaningful participation in their programs and interventions addressing their needs. In a similar manner, participants that previously experienced homelessness, a situation intrinsically linked to social exclusion, now reclaim their citizenship through the process of social reinsertion. HR is therefore linked to community integration from a social inclusion standpoint. This is because the social perceptions and understanding of substance use within the larger society can sometimes carry discrimination and stigma, which can ultimately affect the reinsertion process of people who have experienced long-term homelessness.

Figure 1 provides a description of the relations among the concepts previously mentioned. The HR approach mobilized though the elements of housing and accompaniment. The consumer-worker relationship as pivotal to understand the person's relationship to substance, to promote autonomy

self-determination and empowerment and to help the individual through the process of social reinsertion and community integration.

Figure 1: Conceptual Diagram



2.4 Ontological Security

The term ontological security is often referenced in the literature related to HF. Giddens defined the term as "the confidence that most human beings have in the continuity of their self-identity and in the constancy of their social and material environments" (Giddens, 1991, as cited in Hiscock et al,. 2001, p. 50). Ontological security is therefore one of the concepts that concords with humanistic theory in that people need more than adequate shelter to live fulfilled lives. In other words, people need something secure to go to when in trouble or fatigued, be it a physical place, a person or a routine (Hiscock et al., 2001). When a physical place provides a sense of security and wellbeing, it is called home, and it has been linked to positive mental and physical health outcomes specifically within the context of services to homeless people (Tsemberis et al., 2004; Woodhall-Melnik et al., 2017). Home is often conceptualized in literature as a place to be and a place to live. Sounders (1990) identified home as a source of ontological security, a place "where people feel in control of their environment, free from surveillance, free to be themselves and at ease" (as cited in Hiscock et al., 2001, p. 50). Several studies identified key conditions for the realization of ontological security that are congruent with elements of ontological security described by HF residents in other studies. Evidently, having a physical place to live is one of them, but not the only one.

Dupuis and Thorns (1998) identified the home as a privileged place for the realization of ontological security. They propose an operationalization of the concept based on four key conditions to achieve ontological security: the constancy and permanence of the home, the routines of everyday life that foster a sense of familiarity and comfort, the feeling of control over the environment specifically regarding privacy and intimacy, and housing as a guarantor of security by providing a basis for the construction of identity. The authors suggest that the proposed dimensions of ontological security can vary according to the age of the people, their sex, their status, as well as their social and historical context (Dupuis & Thorns, 1998).

In a similar way, Padgett (2007) indicates that obtaining permanent housing promotes the realization of ontological security. In this study, Padgett focused on homeless people with mental health problems participating in HF. The results identified four dimensions of ontological security

that are similar to those proposed by Dupuis and Thorns: control and self-determination, having a routine in daily life, having a sense of intimacy and last the repair of broken identities (Padgett, 2007). The authors shifts the typical focus of identity construction emerging from ontological security to focus on the repairing of broken identities. This shift acknowledges that for people having experienced homelessness, identity, rather than being constructed, needs to be repaired or reconstructed as it has been damaged by passed experiences.

Hiscock et al. (2001) propose that "greater ontological security [has to] do with having wealth, living in a nice area, living in a larger and better-quality dwelling and being settled in relationships and work" (p. 62). However, this statement needs to be seen within the context of homeownership. To contextualize the term from a HF and social integration angle, Quilgars and Pleace (2016) state several studies in which HF participants report experiencing more privacy, autonomy and freedom (Yanos et al., 2004), as well as housing being perceived as a place of safety, self-worth, a symbol of citizenship, and a place for social encounters (Coltman et al.,2015). These two contrasting views denote that for HF participants, ontological security is not necessarily material related or based on the quality of the space as it is for homeowners, but more so about how they connect to their living area and how it makes them feel. Finally, it will be interesting to explore whether the participants in this study perceive their lodging only as a form of shelter or as a home, otherwise described as a private and intimate environment where their strengths can flourish and where they find a sense of security and stability. More importantly, if participants do find ontological security in HF, how does it reflect on their substance consumption and in the way in which they approach risk?

2.4.1 Housing and Stability

Long-term and stable housing is the first condition for ontological security to occur. For individuals in HF, housing provision has been linked to a better quality of life (Goering et al., 2011; Quilgars & Pleace, 2016), positive recovery trajectories (Patterson et al., 2013) as well as improving social and health outcomes (Sylvestre et al., 2018). Housing provision is also said to be an integral part of minimizing the harms related to homelessness and substance use (Pauly et al., 2013; Gaetz et al., 2013). These harms might include but are not limited to premature death and various infectious diseases (Grinman et al., 2010), as well as social harms, including stigma and

marginalization. As per Duff (2010), housing can be studied as a place to obtain support, improve health and wellbeing, and mitigate specific risks and vulnerabilities. Consequently, this paper looks at the concepts of *housing and stability* not only as conditions for ontological security but also as a condition for the operationalization of HR.

Housing is often defined as a physical space where people find shelter, security, and protection (Boucher, 2008). These benefits result in social and health determinants that contribute to increasing or reducing disparities affecting the person's wellbeing (Sylvestre et al., 2018). For example, while providing housing to homeless individuals might reduce some health problems, "disparities in access to quality and affordable housing can further expand disparities associated with health status, feelings of inclusion/exclusion, and income" (Sylvestre et al., 2018, p. 446).

In a similar way, the benefits of housing can contribute to individual's trajectory of recovery, subsequently reducing the negative effects of substance use. In a study identifying trajectories of recovery among homeless adults with mental illness, participants in HF described more positive trajectories of recovery than those with no house or support provided (Patterson, Rezansoff, Currie, Somers, 2013). The study revealed that having good quality and stable housing was shown to reduced substance use and improve social support for people in HF. Conversely, unstable housing and lack of support was associated with hopelessness, eviction, and substance use problems (Patterson, Rezansoff, Currie, Somers, 2013). Notice that one of the conditions for a positive recovery trajectory is housing stability. Several studies also attest that increased housing stability leads to reduced utilization and costs of publicly funded services as well as reductions in alcohol use and alcohol-related problems (Collins et al., 2012; Larimer et al., 2009; Pearson et al., 2007). Housing stability is therefore not only a key part of achieving ontological security, but also an essential element to practice HR within HF.

In effect, the conditions for the realization of ontological security described by Dupuis and Thorns (1998) concord with how participants in a study exploring the meaning of housing stability define this last term. The interviewed men report stable housing to be a private and safe place permitting independence and control (Woodhall-Melnik et al., 2017). From a HR perspective, these factors could translate into substance use stability in that "consumers make choices about their drug use

that do not necessarily threaten their housing status" (Tiderington, Stanhope & Henwood, 2013, p. 72). However, there is some evidence that housing stability can be threatened by the negative effects that come from substance abuse for HF participants. For example, negative behaviour related to substance abuse can result in evictions from HF, which ultimately puts housing stability at risk. In addition, spending on illegal substances can cause difficulties in paying the rent on time, buying food and taking care of other responsibilities (Watson, Wagner, & Rivers, 2013). Therefore, strategies such as eviction prevention, is one of the ways used in "preventing consumer housing loss due to lease violations, [which] has significant overlap with HR in that it helps assure consumers will remain safely and securely housed" (Watson, Wagner, & Rivers, 2013, p. 174). Ensuring housing stability for participants is also essential to reduce social harms for substance users that might include, "marginalization, inadequate and unaffordable housing, violence, and lack of access to services to meet their personal needs" (Sylvestre et al., 2018, p. 445). Although, there is some evidence that without proper addiction support, some people will not attain positive outcomes despite housing status (Kertesz et al., 2009).

2.5 Accompaniment

Accompaniment is a term largely use in Quebec's French literature to describe the type of support offered to individuals in the mental health, addictions and homelessness sectors. This term contrasts with the traditional approach of 'taking care of the client' or in French, "*la prise en charge*", in which the person in need of services is seen as a guidance seeker while the professional is seen as a guidance provider. This use of the helping relationship creates a power dynamic between the consumer and the practitioner, often reflected in the goal setting and decision-making process that is heavily influenced by the values of the practitioner or the institution. In contrast, accompaniment rejects the perceived 'superiority' of the professional practice and embraces a more egalitarian perspective, in which the person is allowed to exercise control over their life, choices and decisions, while receiving support to find solutions to their problems in their own way (Gagnon et al., 2011). For example, Collins et al. (2015) found that "when goal setting is patient- versus provider-driven, individuals are able to generate a wide variety of clinically appropriate goals ranging from drinking-related goals to quality of life to health goals" (p. 189). These findings are in accord with humanism theory principles that asserts individuals as beings capable of self-

actualisations when the conditions allow positive change and growth (Langer & Lietz, 2015). One of these conditions is receiving support through a validating and positive relationship with their caseworker.

In effect, accompaniment is congruent with the therapeutic practice underlined in the person-centered approach, in which the "practitioner enters into an egalitarian relationship with the client to facilitate a freeing and unfolding of potential" (Greene, 2008, p. 123). Furthermore, "letting a client know that the relationship is safe, showing respect, and offering choices are necessary therapeutic conditions for personality growth to occur" (Greene, 2008, p. 123). Therefore, the accompaniment approach is not limited to helping the person to overcome challenges, but instead it empowers individuals to project themselves into the future. This approach seeks to help the person develop their potential to attain full autonomy, social integration, and well-being (Gagnon et al., 2011). Seeing it from this perspective, accompaniment could be described as being present, walking side by side with a person until a process is complete. In this study, the person-centered approach is used to analyze and understand the practitioner's role and relationship to the consumer, as well as the implications of this relationship in the application of HR practices. In addition, understanding the concepts of accompaniment, self-determination and empowerment will guide the acquisition of knowledge concerning HR intervention within HF.

2.5.1 Therapeutic Alliance

Carl Rogers developed the person-centered approach, best known for its principles of the conditions that facilitate a therapeutic relationship, as well as the conceptualization of the process of self-actualization and self-fulfillment. The central idea in the Rogerian approach is that counseling should be non-directive because "if the practitioner is empathetic, accepts the client with unconditional positive regard, and is genuine in his or her respect for the client, positive change will occur" (Greene, 2008, p. 113).

In terms of the therapeutic relationship, one of Rogers' major contributions came from the assumption that the individual possesses resources within to understand, direct, and change themselves (Greene, 2008) Hence, these "inherent client resources could be tapped if the helping

person provided a facilitating climate [encompassing empathy, unconditional regard, and congruence]" (Greene, 2008, p. 116). This could explain the findings of Tiderington, Stanhope and Henwood (2013) whose analysis of the use of HR in practice demonstrate that "the implementation of harm reduction within intense service models such as ACT (Assertive Community Treatment) is shaped by the relationship between consumers and providers" (p. 75). In addition, this study posits that strong alliances lead to open communication about substance use, which in turn can "improve outcomes for clients and also potentially lead to reduced substance use or even sobriety" (p. 75). When applying HR principles within the HFM, the therapeutic alliance is of central importance. Mancini and Wyrick-Waugh (2011) attest that "practitioners of harm reduction focus explicitly on the development of compassionate, collaborative partnerships with consumers in order to support them in making healthier, safer choices" (p. 15).

2.5.2 Autonomy and Self-determination

Autonomy refers to the power a person has to direct the course of his or her own life based on personal choices. According to Oshana (2005) in her essay titled *Autonomy and Free Agency*, to be autonomous a person must be able to act on his own behalf and have the capacity to do so. As per the author "an autonomous individual must not in fact be affected by other persons, by social institutions, or by natural circumstances in ways that render him incapable of self-control and of living a self-directed life" (as cited in Taylor, 2005, p. 184). The capacity of self-control and self-determination are therefore intrinsically associated to freedom of will and action. These concepts are central to the Rogerian person-centered approach. As per Rogers (1959) freedom is "something which exists within the person and quite aside from any of the outside choices or alternatives which we so often think of constituting freedom" (as cited in Greene, 2008, p. 116). Freedom is defined as, "the power or right to act, speak, or think as one wants without hindrance or restraint" (Freedom, n.d.). Self-determination, on the other hand, refers to the right of the people to make their own choices. This concept is deeply embedded in humanistic values that uphold the person's capacity to grow and change. Respect for the person's choices entails seeing the individual as a whole person in direct interaction with the environment and respecting their perception and interpretation of their own experiences (Payne, 2014).

These concepts are reflected both in HF principles, as well as in HR intervention practices. Both of these are rights-based, person-centred approaches that emphasize client self-determination in terms of housing and substance consumption. To illustrate this point, Pleace (2013) states that choice is a core value of Housing First, “it is also the reason given for success, because the humanity of chronically homeless people is recognised, their rights are respected and they can exercise choices over which services they use and […] where they live (p. 330-331). In addition, HR recognises that people will continue to engage in substance use and high-risk behaviours even when they are harmful. Consequently, it approaches the problem from a pragmatic and compassionate stance that is inclusive and respectful of people's choices (Marlatt et al., 2012). Tiderington et al. (2013) attest that “self-determination and a non-judgemental stance are integral parts of the HR approach, which with the act of ‘waiting’ can strengthen the therapeutic relationship and foster more direct communication” (p. 74).

2.5.3 Empowerment

Rogers’ person-centered approach is focused on personal empowerment due to its belief in the inherent potential of the human being. The term “empowerment” does not have a clear and concise definition in the literature, however, it can be defined as an approach "based on the belief that the people, both individually and collectively, have or may acquire the capabilities to perform the transformations necessary to ensure their access to [different] resources" (Ninacs, 1995, p. 70). Alternative definitions expand on the aspects of political power, economic power and dominance. However, recent developments in thinking suggest, “that dominance over people is often achieved through people’s lack of knowledge and understanding of their situation, [it is] suggested that people might overcome social barriers in their lives by a better understanding of the limitations on their opportunities to take action” (Payne, 2014, p. 298). Bossé (1998) reminds readers that empowerment is not a strictly individual attribute [but instead] the exercise of a power cannot be considered independently of the resources available in the environment.

Thus, HR can be interpreted as an empowering practice in which the provision of information, education and environmental management tools seek to establish (or reinstate) a responsible culture of safe consumption. By acquiring knowledge and skills related to the uses of different

substances, individuals can discover principles for better management of consumption, such as dosage control, quality of the products, attention paid to the frequency and motives of use, and choice of safe modes of consumption (Brisson, 1997).

HR proponents state that upholding abstinence as a goal can be disempowering for those who struggle to break the substance use pattern (Marlatt et al., 2012). HR, instead, accepts that "people are and will use drugs in ways that pose threats to themselves and their communities" (Tatarsky & Marlatt, 2010, p. 117). Thus, it seeks to "educate, support and empower individuals and communities to explore and understand various options for reducing harm" (Marlatt et al., 2012, p. 20) while recognizing that small changes can contribute to the person's quality of life. Consequently, HR focuses on several empowering practices, such as client-tailored counselling, person-centered goals and respect for individual choice.

Some studies have shown that practicing HR intervention, with the appropriate training, is less stressful and more effective for counselors, case managers and clients who have experienced chronic homelessness (Collins et al., 2015, Henwood, Stanhope & Padgett, 2011). In addition, HR practices can be effective in engaging people in treatment by providing them the practical support and services they desire, and educating and supporting them in using drugs and alcohol in a safe manner, while at the same time motivating them to think about change (Mancini and Wyrick-Waugh, 2013, p. 21).

2.6 Relationship to Substances

Helping professions using HR principles propose a view of the complexities of substance use from a biopsychosocial angle (Marlatt et al., 2012; Denning & Little, 2012). That is, the use of different substances is affected by *biological factors* such as genetics, mental and physical health; *psychological factors* such as the person's emotional, cognitive and behavioral functioning; and *social factors*, such as cultural, political and socio-economic factors. This approach differs from the medical and moral model, by arguing that substance use has different origins, meaning and purposes for different people. Tatarsky (2002) has "emphasize[d] that substances solve many problems, at least temporarily, and in this regard may be seen as multipurpose tools [that can also carry multiple meanings for the individual]" (as cited in Marlatt et al., 2012).

Denning and Little (2012) stress the importance of understanding substance use from a relational perspective. That is, understanding the dynamics between the substance and the user. They "find it more reflective of the diverse types of drug use to say that people have a relationship with drugs rather than an addiction. There is a relationship between users and their drug of choice, in which the drug takes on many elements of a primary attachment figure" (p. 39). To elucidate this statement, the authors voice that "users may idolize the drug, only to feel hateful toward it when suffering during a hangover or withdrawal. Promises never to do the drug again are reminiscent of a person swearing never again to go out with a lover who treats her badly" (p. 39). Tatarsky (2002) adds that problematic substance use needs to be addressed from the perspective of vulnerabilities and consequences embedded in the relationship between the user and the substance (as cited in Marlatt et al., 2012). For instance, a person living on the streets is vulnerable to increasing their use of substances as a coping method to face the raw realities of homelessness; therefore, addressing the issue of housing prior to addressing the issue of consumption is an option incrementally being considered. In this sense, the provision of housing should reduce the negative consequences associated with this phenomenon. Denning and Little (2012) agree, stating that "being homeless requires the development of certain responses to the world not needed by people who are housed" (p. 121), in which case "drugs serve to either numb the mind so that sleep is possible or keep one awake throughout the long and dangerous nights" (p. 122). This view is consistent with Khantizian (1985) who argues that people use drugs or alcohol for purposes such as self-medication, for example, they use "opiates for aggression, stimulates for depression and alcohol and sedatives for anxiety" (as cited in Marlatt et al., 2012).

2.6.1 Risk-Behavior

Marlatt et al. (1988), define addictive behavior as a "repetitive habit pattern that increases the risk of disease and personal and social problems" (as cited in Griffiths, 2005, p. 192). These patterns are often "characterized by immediate gratification (short term reward), often coupled with delayed deleterious effects (long term costs). Attempts to change an addictive behavior (via treatment or self-initiation) are typically marked with high relapse rates" (as cited in Griffiths, 2005, p. 192). In addition, these patterns can result in self-destructive or harmful behavior such as driving under the influence of drugs or alcohol, having unprotected sexual relations and

exchanging pipes or used injection material. Biological harms can include illnesses such as HIV, cirrhosis, hepatitis and lung disease among many others. Psychological harms may include paranoia, depression, anxiety, aggression, hallucinations, and other problems. Social harms may include family ruptures, unemployment and financial problems (Marlatt et al., 2012).

Within the HR framework, high-risk behavior is seen as a social construct, as a product of "a given time and culture and their associated values, norms and believes" (Denning, 2000 as cited in Marlatt et al., 2012). In other words, behavior can be seen as positive or negative depending on who is involved and the context in which it occurs. Recent research with chronically homeless people with Alcohol Use Disorder finds that high-risk behaviors can be adaptive or maladaptive. Collins, Grazioli, Torres et al. (2012) find that drinking can be used to reduce stress, avoid life-threatening withdrawals and reduce psychiatric symptoms. Therefore, an important part of HR practice entails exploring with people the pros and cons of their behaviors, the consequences, and the necessary actions to reduce the negative effects associated with that behavior. From a person-centered perspective, working with people who have a history of chronic homelessness and who consume different substances would, "involve helping the client to view a problem differently, to accept one's own feelings, to modify cognitive experiences, to recognize life's contradictions, and to modify the nature of relationships" (Greene, 2008, p. 123).

2.7 Social Inclusion and the Process of Social Reinsertion

The mechanisms and the effects of social exclusion and inclusion have been broadly studied in sociology and other related social sciences. In the literature, social inclusion and social exclusion often each represent one side of the same coin. In this study, the notion that chronic homelessness is represented an experience of multiple forms of exclusion that are reinforcing, and thus making inclusion that much more difficult. It is known that, "living in homelessness means experiencing exclusion in different ways: exclusion from work, housing, social circles, family, health services etc." (RAPSIM, 2003). Social exclusion is a process imbedded in the larger social apparatus connected to poverty, marginalization, vulnerability, isolation, and lack of financial, political and cultural implication as well as separation from social relations, in particularly family ties (Debordeaux, 1994). These structural inequalities and processes that are experienced at the

individual level allow for better understanding of how homelessness is represented and experienced in society. In contrast, social inclusion is described here more as a process of participation imbedded in the notion of citizenship and a process of social integration. In the next paragraphs, both the concepts of social exclusion and inclusion will be explored to better contextualize how social reinsertion occurs within HF projects, and thus, how HR serves as a vehicle to facilitate the inclusion of people often stigmatized for consuming substances.

The term exclusion gained popularity in the late 1980s in France where it was used to describe the radical changes happening in the economic, industrial and societal spheres (Castel, 1994; Paugam 1998). These changes "included long-term or repeated unemployment, family instability, social isolation and the decline of neighborhood and social networks" (Exclusion: UNESCO, 2017). Based on this description, homelessness became in itself the ultimate form of exclusion (Roy, 1995; Castel, 1997). For Castel (1997), social exclusion is a process of 'disaffiliation' marked by a double stall: regarding the absence of employment and the rupture of social bonds. Castel argues that unemployment and the rupture of social connections places the individual at a disadvantage in which they no longer have access to primary solidarity (work, family, neighborhood) causing them to lose their place as productive citizens and preventing them from meaningful participation in social activities (Debordeaux, 1994; Allman, 2013). In contrast, per Castel, social integration is reached when people have work guaranties, which in turn mobilizes a solid support system (Debordeaux, 1994). As per Castel, employment is the greatest determinant of social integration as it includes relational aspects that connect the individual within the greater society (Castel, 1994). Castel's assumption concords with Bretherton and Pleace (2015) who state that increasing education and economic participation of individuals experiencing homelessness can lead to social integration (as cited in Quilgars & Pleace, 2016). Nevertheless, employment leading to economic participation is only one aspect of social inclusion required for social reinsertion.

Exploring the terms social inclusion and social reinsertion is an important step in order to understand the interplay between these complex processes that the chronically homeless experience. On the one hand, Goffman (1987) defines some of the symbolic components of social inclusion encompassing the social recognition of the individual, the place he or she occupies within the system, as well as his or her perceived utility. On the other hand, the World Bank states that

social inclusion occurs when individuals and groups take [active] part in society (Huxley, 2015, as cited in Quilgars & Pleace, 2016). Paradoxically, Goffman portrays social inclusion, as a responsibility of the larger social structure, while the Word Bank asserts that for social inclusion to occur it is the individual that needs to take action in being part of society. According to Debordeaux (1994), social reinsertion is the act of belonging to a society; in other words, the identification of the person with the values of society as well as its implication and engagement within it (Debordeaux, 1994). Studies addressing social and community integration for HF participants describe the establishment of social networks and reestablishing links with family as positive evidence of social reinsertion (Padgett et al., 2008). In the following paragraphs, I will discuss the role of social and community integration as a goal of HF.

2.7.1 Social and Community Integration

Contrary to Castel's argument, some contend that housing is the primary source of integration for people experiencing homelessness (Rhoades et al., 2018; Milby et al., 2005). However, Quilgars and Pleace (2016) assert that although for the homeless population housing is a prerequisite for social inclusion it is not a guarantee of it. This is because there exist multiple barriers detrimental to the social inclusion of formerly homeless people. These are embedded in "the cultural, political and mass media images of homelessness that emphasise individual pathology—a supposed refusal to accept or abide by the conventions of mainstream society—and a combination of mental ill health and drug/alcohol problems as the 'causes' of homelessness" (Hansen et al., 2012; O'Sullivan, 2008, as cited in Quilgars & Pleace, 2016, p. 8). In a similar way, drug use results in "further social exclusion, as the stigma, discrimination and prejudice associated with drug use can further exclude individuals from mainstream society (e.g. being shunned by health services, negatively portrayed in the media and blamed by the criminal justice system" (Neale, 2008, as cited in Souleymanov & Allman, 2016, p. 1437). These negative and stigmatizing perceptions can affect people's ability to find housing and employment as well as to connect with others that are living different situations.

HF promotes community integration by providing scatter-site housing and working toward the social inclusion of people with psychiatric disorders and problematic substance use. According to

Hogan and Carling, “a scatter-site normative model, known as supported housing, has been considered the housing approach most conductive to consumer empowerment and community integration” (Hogan & Carling, 1992; as cited in Tsemberis & Henwood, 2016). Program staff support and encourage positive relationship with landowners, neighbors, family and other social networks to promote community living (Tsemberis & Henwood, 2016). However, as mentioned previously, stigma related to substance use or previous experiences with homelessness can act as barriers for community integration. Gowan, Whetstone, and Andic (2012) state that “stigmatization of the illicit drug user as “powerless” to a drug is considered an obstacle to employing HR strategies in one’s life” (as cited in Boucher et al., 2017, p. 2). To counteract these barriers for the practice of HR, the authors highlight the importance of community building within peer-centered groups promoting health education. Participants of the study found beneficial to help others who use drugs by sharing their personal experiences relating to drug use, promoting services and receiving overdose prevention training (Gowan, et al., 2012). In conclusion, the authors argue that a focus on destigmatization and incremental control creates the preconditions for assertions of social citizenship (Gowan et al., 2012).

2.8 Applied Theory to Social Work Practice Within a Context of HF and HR

Social work values and views often consider individuals within a context or in particular environments. This thesis proposes to mobilize the practice of social work within the context of HF and HR from the following tree spheres of action: addressing power dynamics through empowering therapeutic alliances, recognizing the role of social structures in the production of risk and harm associated to homelessness, and helping repair social ruptures for individuals enduring processes of disaffiliation.

Payne (2005) describes social work as a constructed practice shaped by those who practice it , those who seek social work services and those who affect the social context in which social work is practiced (p. 18). The practice of social work itself is embedded within the constructs of social roles that portray a persona as a professional and a person as a client existing within a power context. Due to socially constructed power dynamics rooted in the power given to academic education, these roles are not equivalent. Instead, the practice of social work with vulnerable

populations sets the client in a position of someone who needs help and the worker in the position of someone who gives help. However, the nature of social work practices evolve in response to social changes by utilising humanism and accompaniment approaches to recognize and break the power roles by engaging in more egalitarian relationships that prone self-determination and harvest empowerment.

From a social work perspective, theories centered on the person and his inherent capacity to overcome difficulties allow to see the person as an agent of growth and change capable of reducing harm. However, social workers must not overlook the role of the structures and institutions in the production and perpetuation of harm related to substance use. Social workers ought to offer critical thought to the tendency of health and behavioral approaches to presume that HR is primarily the individual's responsibility (Pauly et al, 2013). Instead, it is important to acknowledge that harm is produced at a systemic and structural level. For instance lack of adequate housing contribute to the harms of drug use while exacerbating the health inequalities produce by unsafe environments (Pauly et al, 2013). In opposition, the creation of safer environments can facilitate the implementation of harm reduction and thus produce the conditions in which healthier outcomes are possible (Rhodes, 2009).

An important dimension in social work is to help people repair relationships of exclusion that have affected them for long time. Social exclusion is characterized by a rupture of social bonds or connections in specific impoverished individuals enduring a process of disaffiliation (Roy, 2008). Therefore, the practice of social work demands offering a favorable context to build meaningful relationships with people and to assist individuals in establishing adequate relationships with their environment. For the population of this study, stable housing, accompaniment and the management of substance use can help repair these relationships. Moreover, the practice of social work within the context of homelessness calls for professionals to take an active role in laying the foundations that help re-establish significant links between society and people experiencing exclusion. In addition, counteracting social exclusion entails the involvement of service users in the development of policies and programs that aim to address their needs. As per Pauly et al. (2013), "involving people with lived experience can help break the stigma attached to homelessness,

mental illness and substance use, improve the efficiency of services and [promote health and self-esteem by]increasing individual control over health determinants" (p.286).

Conclusion

The different theoretical perspectives used in this thesis to analyze the experiences of men in HF programs are borrowed from the Humanist and Constructivist perspectives encompassing social work theories reflecting multidisciplinary approaches. The proposed framework permits to better understand the experiences of residents and workers in terms of safety, support, their relationship to consumption and risk taking, as well as their processes of social inclusion. The conceptual framework proposed in this chapter is, in essence, a collection of concepts contained in the structure of HF and by which HR can be studied and understood within this particular context. The argument is that reducing the adverse effects of substance use among previously homeless individuals in HF requires a stable and safe environment that provides ontological security as well as long-term support and accompaniment that superimposes people's power to make choices regarding their autonomy. It also entails a deep understanding of the person's perception of substances and their relationship to them. Finally, the optimal practice of HR demands a commitment to social inclusion that helps people reintegrate society in ways that are meaningful to them.

This chapter concludes with a section that highlights the contribution of concepts and notions embedded in the proposed theoretical and conceptual framework to the social work practice. From a constructivist perspective, social problems depend on how individuals and groups define different situations as problematic. Therefore, social work practitioners ought to acknowledge their power within the therapeutic relationships as well as the role of social structures in the problems related to harm and risks related to substance use. In addition, the practice of social work demands awareness and intentions to repair the social ruptures that have caused people experiencing homelessness to be socially excluded. The next chapter will provide a detailed review of the methodology used in this thesis to obtain data related to the object of study, from the perspective of workers and residents. In addition, a portrayal of the study's setting, recruitment process, data collection and analysis will be presented. In the last part, I discuss some of the ethical considerations that are pertinent to this study.

CHAPTER 3

Methodological Framework

3.1 General Research Strategy

This thesis seeks to explore the use and understanding of the HR approach from the perspective of residents and intervention workers within a HFP in Montreal. In order to accomplish this purpose, this study is guided by the following research questions: 1) How is the concept of HR understood and perceived by workers and participants of HF? 2) What factors facilitate or hinder the practice of HR with HF residents from the workers perspective? 3) How do HR practices reduce, limit or prevent negative consequences of substance use from the perspective of workers and participants? 4) How do participants and workers understand substance use and mitigate risk-taking behavior? 5) How do HR principles, strategies and practices contribute to HF goals of community integration?

This study employs a qualitative research methodology to answer these questions. Qualitative research is "used to understand people's beliefs, experiences, attitudes, behavior, and interactions" (Pathak et al., 2013), within specific environments and social contexts. For this particular study, a qualitative methodology was the most appropriate to explore both users' and consumers' perceptions of, and experiences with, a HR approach. In qualitative research, interviewees are empowered by taking an active role in the study and contributing directly to the construction of knowledge in the particular field of study. Finally, this method is flexible enough to foster "[less formal relationships] between the researcher and the participant" (Pathak et al., 2013). Informal interviews allow people to express their social world in their own terms (Rubin & Rubin, 1995; Van Den Hoonaard, 2012).

3.2 Setting and Program Description

Participants were recruited from a program employing a Housing First Model (HFM) that is currently run in partnership with the four major non-profit local community organizations addressing homelessness in Montreal: Mission Bon Accueil, La Maison du Père, Old Brewery Mission, and Accueil Bonneau. This HF project is designed to provide housing to 250 male

participants with a history of chronic homelessness, mental illness and substance use. This program provides scattered independent apartments to eligible consumers according to their needs and interests. The HF model prioritizes scatter-site housing over congregate models of housing, which means that units are rented from the private market (Gaetz, Scott & Guilliver, 2013). Housing provided within the program should be adequate, affordable and suitable for the person. Housing supports include helping the person identify appropriate housing, building and maintaining a relationship with their landlords, applying and managing rent subsidies and providing assistance as well as supplies to settle into the apartment (Gaetz, Scott & Guilliver, 2013).

Once the person is fully installed in their apartment, clinical support is given through a mobile team of case workers who offer weekly or biweekly follow-ups for psychosocial support. Other supports offered by the program include offering money management tools, referrals to community services and employment assistance activities. In addition, this HF project works in partnership with the provincial government to provide subsidized housing in which participants only pay twenty five percent of their income towards rent. This arrangement is given and managed by the project through the duration of program. According to the Canadian social development website, "The goal is to ensure clients are ready and able to access regular supports within a reasonable timeframe, allowing for a successful exit from the Housing First program" (Social Development Canada, 2018). To ensure this goal, participants apply for a regular social housing subsidy from the moment they are accepted into HF which puts them in the waiting list for regular social housing.

This program follows the HF principles of: 1) immediate access to housing for people experiencing chronic or episodic homelessness; 2) consumer-centeredness and self-determination 3) focus on recovery and harm reduction, 4) individualized support services with the aim of strengthening skills and promoting autonomy; 5) social and community integration (Tsemberis, 2010). The primary goal of this particular project is to ensure low barriers to housing attainment, encourage housing stability and provide access to rehousing when necessary. The team's mandate is to assist, evaluate, plan, support and, above all, maintain, housing for people experiencing chronic or episodic homelessness (Project Logement Montreal, 2017)

This program was chosen for this research as it employs the philosophy and practices of harm reduction. First of all, housing is not contingent upon participation in treatment for substance use, therefore, consumers are able to use substances in their apartments without jeopardizing their housing. Second, there is constant support from the intervention workers whose main goal is not to reduce substance use but to ensure safety and housing stability. And third, consumers' self-determination is respected by allowing residents to manage the pace and direction of their psychosocial follow-up, as they prioritize their goals. These aspects are consistent with the seven core ideas that characterize the harm reduction model according to Tatarsky (2002): 1) *Meeting the client as an individual* - help case workers to understand consumers' needs and strengths, 2) S*tarting where the patient is* - entails acceptance and respect for the client's goals, timing and choices, 3) *Assuming that the clients has strengths that can be supported* – case workers aim to mobilize these strengths to facilitate change and progress, 4) *Accepting small incremental changes as a step in the right direction* – this is an empowering practice that allows the consumer to discover their own path to recovery, 5) *Not holding abstinence as a necessary precondition for therapy [or housing]*- housing is provided without treatment requirements, 6) *Developing a collaborative, empowering relationship with the client* – case workers offer constant support to participants, 7) *Destigmatizing substance users* – positive regard can help deconstruct internalized stigma and its manifestations (as cited in Marlatt et al., 2012).

3.3 Recruitment, Selection Criteria and Sample Demographics

3.3.1 Research Project Presentation and Approval

The desire to pursue this research was first discussed in an informal meeting with a supervisor from the Welcome Hall Mission. During this meeting, the supervisor put me in contact with the director of the HF project in Montreal, where the research takes place. After exchanging a few emails, the director of the project agreed to meet with me. Following a long discussion about my work at the Mission, my purpose with the research, and the details of how the study would be conducted, the director granted me permission to conduct the investigation within the HF project. A detailed explanation of staff and consumer recruitment will be found in the following paragraphs disclosing the sample demographics of each group.

3.3.2 Participants Recruitment

Five individuals participated voluntarily in this study. The number of participants was chosen in accordance to the original design of the reach which aimed at acquiring data on the experiences of five residents and five workers involved in a HF program in Montreal. The goal was to obtain a manageable amount of data from both workers and residents. For the recruitment, I requested that all intervention workers ask participants if they would be interested in participating in this study. It was clear that workers were not to choose among their clients who could or not participate, instead, they would simply asked their clients if they wanted to participate in a research concerning HR. Intervention workers were given a detailed template on the subject of the study so that they could present it to their clients or residents on their caseload when asking for their participation. In this case, intervention workers acted as sponsors, meaning that their close relationship to their clients facilitated the introduction of the study to possible participants (Van Den Hoonaard, 2012). Given the nature of criteria used for eligibility to participate in HF, all participants had experienced chronic homelessness, meaning they had been in homelessness for at least a year. This study also required participants to be currently using substances on a regular basis. However, not all of the HF residents are substance users; therefore, I asked intervention workers to specifically target those clients with recurrent substance use habits. Thus, a purposive sample was used to select individuals that meet that specific criteria (Bui, 2014).

3.3.3 Practitioner Recruitment

A total of five intervention workers were interviewed during a one-day focus group that lasted two hours. Initially, I planned to do one-on-one interviews with five interventions workers, but upon discussion with the team and their management, most people had concerns related to their time and schedule. Hence, it was decided that a focus group format was a better and more convenient way to conduct the research with the staff. In a "convenience sample the researcher selects the individuals who are available and accessible at the time" (Bui, 2014, p. 143), and, in this case, also willing to participate in the research. The case workers manage a heavy load of cases and they have to adjust their schedules to accommodate meetings with each of the organizations they work for, as well as team meetings, therefore, one-time group participation was the most viable way of

collecting the data. An email with information about this study was sent to all workers asking them to kindly participate in this research. Five out of twelve workers decided to participate voluntarily. Once I received confirmation from the workers who wanted to join, the study was presented and explained in more detail to the staff during a short meeting. Then the team coordinator arranged a date for the focus group that was convenient for all participants. The day of the focus group, I began by restating the purpose of the research, and then the consent forms were read aloud and signed by the staff. Subsequently, I conducted a two-hour meeting in which questions were asked and all participants at the table were able to answer respond to the questions and add to each other's responses.

3.3.4 Inclusion Criteria

- Male HF project participants, living on the island of Montreal, between the ages of 18 and 65, receiving follow-up at least once a month by an intervention worker affiliated with the program. All participants in this program are Male.
- HF participants who self-identify as a drug or alcohol users or as dependent on any other psychoactive substances, who might or might not be seeking addiction treatment.
- Participants who suffer from mild mental health problems, such as undiagnosed anxiety or depression, were acceptable candidates for the study.
- Intervention workers hired by the housing project in Montreal whose clients included people identifying as substance users. These workers were drawn from the main organizations managing the program. Their time working with the project was not taken into consideration to participate in the focus group.

3.3.5 Exclusion Criteria

- Participants with serious mental health problems or severe mental illness typically involving psychosis such as schizophrenia, bipolar disorder and/or manic depression were excluded from participation in order to protect their health and to avoid contributing to potential psychotic episodes, as well as to ensure the clarity of participants' responses to questions.

- Intervention workers working for the Montreal HF project who were hired by the Welcome Hall Mission were excluded to avoid a conflict of interest due to the fact that the researcher is also an employee of the Welcome Hall Mission.

3.3.6 Sample Demographics – Participants Profiles

I conducted individual semi-structured interviews with five men aged 45 to 65 with an average age of 55. All of the residents were male as this is the population the program serves. Four out of five participants were Francophone and one participant was Anglophone. Two of the five residents were single, and three were divorced. One had completed elementary, three high school, and one technical college. All of the participants had experienced homelessness for at least three years. At the time of the interview, all of the participants had participated in a housing stabilization project through a HF program in Montreal and were receiving support from the program's mobile intervention team. All of the participants consumed some form of substance, including alcohol, crack, and cannabis. In addition, one participant took pain killers on a daily basis and one used Methadone, a medication to treat opioid addiction. All of the participants were unemployed at the time of the interview and received welfare or a disability pension and at least three participants had a criminal record. The results show that all participants consumed some kind of legal or illegal substance prior to being homeless, and in all cases, the onset of consumption was before eighteen years of age.

The data collected from the five participants shows that the circumstances that led to homelessness came from a combination and intersection of causes, causing a ripple effect. The key causes were substance use, the rupture of family relationships, the death of a loved one (parent) specifically death (n:1) or divorce (n:3), and economic hardship (n.5). The following section provides a brief summary of each participant[3] to help contextualize their experiences with substance use and the factors that contributed to their period of homelessness.

[3] Pseudonyms are used throughout the presentation of results as well as in the analysis to protect both the residents' and the workers' identity.

Guy :

Guy is a fifty-nine-year-old man who is divorced. He is currently receiving welfare and disability pensions. He revealed that he has a criminal record. Guy began consuming alcohol at age fourteen and has have an ongoing consumption throughout his life. Guy was homeless for four years before joining HF. He explained that his wife left their home due to his drinking problem, which caused him to be in and out of homelessness for thirteen years, however, in the last four years, he became chronically homeless. While staying at an emergency overnight shelter for men experiencing homelessness, he entered a reinsertion program offered there. However, he quit the program before completion because he felt it was prohibitive: the rules were too severe, he was not allowed to bring in visitors, his medication and money were managed by the program, he needed to ask permission to go out, and he felt as if he was in a prison. Subsequently, while renting a room, Guy was a victim of a criminal act that left him with lasting physical damage. Following hospital treatment, Guy was admitted to a short-stay convalescence program at a shelter, where he was presented with the option of joining the HF program.

Dan:

Dan was a single forty-nine-years-old man who completed studies in building maintenance and was receiving unemployment insurance at the time of the interview. Dan declared having a criminal record. Dan had a stable job and was married with no children, his divorce triggered an emotional decline that led to the loss of his job, an increase in his drug use and hence a depletion of his savings. Once his savings were gone, Dan was no longer able to support himself, which resulted in homelessness. Dan was homeless for six years. He joined the HF program while he was staying at a shelter and had been in the program for a year and a half at the time of the interview.

Manuel :

Manuel was fifty-seven-year-old divorced man who was receiving welfare at the time of the interview. He declared not having a criminal record. Manuel's preferred substance is alcohol. He told me that prior to being homeless, he was married, had a son, and was employed. He used to work nights and began drinking alcohol to be able to sleep after his night shift. Drinking alcohol

impacted Manuel's life negatively, resulting in divorce at his wife's request. Soon afterwards, he lost his job and ended up living with his mother. Unfortunately, his situation deteriorated when his mother became ill and was sent to a long-term care facility. Without the income of his mother or employment, Manuel was not able to afford the rent for the apartment and ended up homeless. He lived in the streets for over three years. Manuel joined the HF program in 2015.

Leo :

Leo was a sixty-one-year-old single man who self-identified as gay. He was receiving welfare and pensions at the time of his interview. Leo had no criminal record. As per Leo, he smokes pot and take prescribed pain killers. Leo decided to retire early from his employment because he felt that he had saved enough money to live comfortably for the rest of his days, however, when his mother died, his life changed. Unable to cope with the passing of his mother, he began to use hard drugs, such as crack and cocaine. The uncontrolled use of these drugs resulted in the loss of his savings and left him homeless. Leo learned about HF while staying in one of the city shelters for homeless men. He had been at the HF program for two years at the time of the interview.

Carl:[4]

Carl is a fifty-nine-year-old man who was single at the time of the interview. Carl was unemployed but received welfare. He had no criminal record. Carl preferred substance was crack-cocaine with onset at twelve years old. Carl was homeless for four years. After losing his employment, he was evicted from his apartment, which led to homelessness and subsequently to an increase in substance use. Carl claims that addictions have always be part of his life. He joined the HF program eight months prior to accepting to be interviewed for this research.

3.3.7 Sample Demographics – Workers Profiles

Five intervention workers were interviewed using the focus group method. One of the workers identified as man and four others identified as women. All of the workers were Caucasian. Three

[4] Carl is a bilingual man who grew up in Montreal and lived in Vancouver many years, therefore, some of the extracts from his interviews have mixed English and French.

of them had undergraduate degrees and two of them attendant graduate school in programs related to the helping field. All of these workers were employees of the four main organizations in Montreal providing services to homeless people. Three of them had been with the program for over a year and two for less than three months when the focus group occurred. The pseudonyms used to identify the workers are : Lana, Tim, Sara, Lila and ED. Each worker supports an average of fifteen to eighteen clients whom they follow weekly, biweekly or monthly depending on the client's needs. For instance, most clients will have a weekly follow up during the transition period, which occurs when a client first moves into their apartment. A biweekly follow-up generally comes immediately after the transition period. Participants who are considered stable and independent are followed monthly.

3.4 Interview Process and Data Collection Procedure

Data was collected through semi-structured and in-depth qualitative interviewing. This is a common method employed in qualitative research to understand the meanings accorded by participants to their life experiences (Van Den Hoonaard, 2012). Semi-structured qualitative interviews were used during the focus group with intervention workers, as well as with HF residents. The semi-structured design of the interviews allowed to ask pre-determined open-ended questions and to probe further when clarification or further details were needed (Van Den Hoonaard, 2012). All participants were given the opportunity to enrich the process by going more in-depth with information that they considered relevant to the question.

A consent form and confidentiality agreement[5] was signed with each participant in the study, including intervention workers. The interviews were conducted in a private location. Intervention workers were met at a conference room provided by one of the partner organizations offering the HF program. The focus group lasted two hours and as mentioned before all workers read and signed consent forms. As for the HF residents, the interviews were conducted in their own dwelling, except for one, which was conducted in a private group meeting room at the Université de Montréal. Each interview lasted between 45 and 60 minutes. The interviews were conducted in French except for one of them that was conducted in English as per the interviewee preference.

[5] All supporting documents can be found in the annexes. Confidentiality agreement Annex I

Before starting the interview, each participant was informed about the purpose of the study as well as their rights as a research participant. A consent form was read aloud, and some extra time was granted for the person to read and sign it. In addition, participants were invited to ask questions at any given point before, during or after the interview.

All interviews were digitally recorded and transcribed. The transcripts and all audio files related to the research have been securely saved on a cloud platform that requires my ID and password to be accessed. Documents that were signed such as consent forms have been saved in a drawer with key at my home office. All documents will be saved for five years and then they will be sheered and erased from the cloud. Furthermore, these documents will not be used for any other purpose other than for this thesis. The areas covered during the interviews include the transition from homelessness into the HF program, the understanding and use of HR, the relationship between residents and intervention workers, their perception of substance use, and their experiences related to social reinsertion and community integration.

3.5 Methodology of Qualitative Data Analysis

After completing the data collection process, all the audio recordings from the interviews as well as the audios from the focus group were transcribed word by word into a Word document. At this stage, I started to familiarize myself with the content and started to organize the data using **Thematic analysis.** A method commonly used within qualitative research to identify and interpret patters of meaning or themes surfacing from the collected data. As per Guest, MacQueen and Namey (2012) thematic analysis is a metatheory methodological framework "focus[ed] on identifying and describing both implicit and explicit ideas within the data, that is, themes. Codes are then typically developed to represent the identified themes and applied or linked to raw data as summary markers for later analysis" (p. 9).

I first created case summaries of each interview to obtain demographic information and to compare the interviews for the purpose of coding and theme extraction. These summaries will be presented in the next chapter to contextualize the findings. I then slowly read each transcript and started labelling phrases and paragraphs. In a second review of the text, labels were used to create codes,

and these were recorded and highlighted in the margin of the text. These codes were compared and placed together based on their relationship to each other and themes started to emerge. Then themes were refined, organized and categorized using the broader concepts of the research. In other words, themes related to the individual experiences of homelessness, housing, substance use, relationship with the intervention worker, HR, recovery, autonomy and community to name a few. In a similar way, data from the focus group was refined using codes and then themes were organized based on their relationship to the broad concepts of the study. This process allowed me to congregate similar ideas as well as to compare the differences in the discourse of residents and workers.

The substantial and grounded relationships among themes were used to produce the final thematic model. The themes and subthemes were reviewed several times, both against the coding as well as the entire data set, to select the ones that better responded to the research questions. The results were organized thematically in a way that was consistent with the findings of each group (the individual interviews with HF residents and the focus group with intervention workers). For the analysis the themes were organized in a way that fit with the proposed conceptual framework and in a way that was coherent with the trajectory of HF residents as well as the story told by intervention workers. Themes and subthemes were placed strategically to demonstrate how HR is used by workers and residents of HF, but also to highlight the power within the individuals to surpass difficult situations like homelessness.

3.6 Pertinent Ethical Considerations

Institutional approval was granted by the Université de Montréal Ethics Committee (#CERAS-2017-18-075-D). The consent form was presented in a clear and accessible way, it was read aloud and then given to the participants to read and sign. The research objectives, the themes addressed in the framework of the interview, the psychological risks surrounding the interview process, the related benefits of participation and the measures taken to ensure confidentiality were also presented in the consent form. In addition, participants were informed that, if a question made them uncomfortable, they did not have to answer and could stop the interview at any time. The interviews were conducted in a location chosen by the respondents and compensation of $20 was offered to participants, while no compensation was offered to case workers. Other measures taken to ensure confidentiality included not using the name of the respondent or the names of people

cited during the focus group. In the presentation of the results, special attention was given to avoid the identification of respondents and to ensure anonymity.

3.6.1 The Role of The Researcher

In qualitative research, data is produced through the human instrument (Carey, 2012). The researcher prepares the questions and probes further to gain a deeper understanding and meaning of the experiences lived by the subjects in question. To fulfill this role, researchers need to be aware of their own biases, experiences and values and how this can impact the research process. These reflections are described by Hsiung (2008) as a "process that challenges the researcher to explicitly examine how his or her research agenda and assumptions subject locations, personal beliefs and emotions enter into their research" (p. 212). As an intervention worker carrying out this research, it was important to consider the impact of my experience in the field as well as the assumptions that are embedded in my work and that are part of the values of the organization I work for, such as biases with regards to HR. Working at a Christian organization that applies the staircase model and that upholds abstinence and sobriety as a goal for participants, my thought process was impregnated by certain preconceptions such as the belief that it must be difficult to have a good quality of life for a person suffering with addictions or the best way to attain well-being is by maintaining sobriety. Both of these beliefs were challenged through the research when the discussion with the individuals who consumed substances gave deeper insight into their relationship to the substance as well as the purpose of the use. Seeing the realities of the participants challenged my thoughts and assumptions as well as my values and provided a deeper and more meaningful view of harm reduction. As a Christian, I was able to interpret HR from a grace perspective. Grace is about loving and showing love to those who are unloved or excluded. For HF residents grace is similar to HR in that people are welcomed instead of being excluded due to substance use, while housing could be considered a place to rest from homelessness. My job as a researcher was to bring these realities to light by including and using the individual and collective experiences of participants and workers in a narrative that allows the reader to understand the context of people who use drugs and the role of harm reduction in their lives. However, HR and HF may not be interpreted in the same way by the residents or workers. It is important for me to recognize this potential for inherent bias in the way that I approach the data and mobilize it.

Being an intervention worker and having experienced working at one of the biggest shelters for homeless people in Montreal helped me to shape the questions I asked. For example, my experience interviewing clients for different programs as well the countless hours I have spent doing follow-ups with clients allowed me to probe further when asking a question. I knew that using a semi-structured interview format would give me enough flexibility to shift the question in different directions. Besides, I was also able to use tools such as attentive listening and avoiding interrupting the participant when he was telling his story. However, I nonetheless focused on refocusing the discussion if the person strayed too far from the question.

In the focus group, my experience as an intervention worker helped me to feel comfortable with the group. However, looking back, feeling too comfortable might have been the reflection of wearing the colleague hat instead of the researcher's hat. This could have been problematic if I had lost my ability to investigate further. Luckily, the structure of the interview and the format created a space in which workers were leading the conversation and I was facilitating the topics or questions. As the workers described their experience with HR, I realized that the information they were giving me was new to me, and it was not necessarily comparable with my work experience. The methodology, approach, and the services they use in their work versus the services I provide in my work were completely different. Fortunately, these differences allowed me to better position myself as a learner and not as an expert.

Finally, my experience as an intervention worker truly helped me in the development of the study as well as in the analysis of the results. Coming from the traditional services offered to homeless men, I wanted to know more about emerging services such as HF and HR. I wanted to understand better why HF is becoming a popular approach in Canada. I also wanted to know the specifics of how HR is used and understood by workers and residents in this program. Having witnessed the trajectory of many homeless men, it was vital for me to analyze the collected data in a humanistic and dignifying manner, especially given the marginalization substance users are often subject to. As a result, the next two chapters, results and discussion, will provide answers to above mentioned questions highlighting the pragmatic and humanistic aspects of HR.

CHAPTER 4

Results

Thematic analysis revealed several themes regarding the use and understanding of the HR approach within a HF project. This first part of this chapter portrays the HF residents accounts and experiences with an emphasis on their trajectory **from homelessness to housing stability**. Participants described the transition out of homelessness, including elements of **the working alliance and the accompaniment** they received to access housing and maintaining it. Information about the challenges experienced by residents during the transition period is given as a prelude to draw attention to the importance of the long-term support offered to them by the intervention workers as well as the need for participants to **reclaim independence.** The theme **understanding of substance use** describes the relation between substance use and **traumatic experiences**, the residents' perception of substance use including **the benefits and disadvantages of substance use**. Moving forward the findings present the participants knowledge about HR which included the themes of **defining vs doing harm reduction, practicing harm reduction, mitigating risk and avoiding trouble as well as substance use goals.** The residents accounts section is buckled with their experience of social reinsertion in which the themes of **reintegrating society, cutting ties with the homeless community and fighting isolation** represent a space in which substance use plays an important role.

The second part of this chapter portrays the HF workers' accounts and experiences related to housing and HR. An emphasis is given to the practice of HR through **long-term support , the nature of accompaniment** and the challenges workers face when **dealing with crisis, mistrust and resistance from residents**. In addition, this section presents the workers insights of their understanding and perception of substance use as well as how they intervene in the prevalence of risk associated to drug or alcohol consumption as present in the residents' lives. This chapter ends with the presentation of the findings related to the practice of HR and the inclusion of principles of **empowerment and self-determination** from the workers part.

Residents' Accounts and Experiences

4.1 From Homelessness to Housing Stability

4.1.1 "When I Was Homeless"

Although people become homeless for different reasons, the experience of living on the streets had many commonalities among the HF residents that participated in this study. The majority of them disclosed feeling discriminated against, unsafe, unworthy and unsupported. Even more shocking a few participants had a prominent and haunting feeling of being dead (numb or invisible) or that their life was coming to an end. Leo experienced stigmatization and discrimination due to his sexual orientation while Manuel and Carl spoke about the dangers and poor conditions of the shelters in the city. Guy reported deterioration in his mental health from high levels of anxiety and long periods of depression. Finally, Dan spoke of his desire to have a home and regain his dignity. All of the participants lived on the streets for longer than a year. Bellow are the contextuel descriptions from the interviews.

> Je me suis fait écœurer tout le temps que j'étais là parce que je suis gay, je me suis fait gausser par des gars de la rue qui me disaient toutes sortes d'affaires. Je n'étais pas fait pour être dans la rue. J'étais en train de mourir dans la rue – Leo

> In the street you are never safe, there is always danger, people cannot be trusted, so you have to be always alert and always suspicious, you are always tired and you never rest, even when you sleep in the missions, at night things happened and you are never safe – Manuel.

> La rue-là, je ne sais pas comment y font les gars pour survivre, j'étais près de mourir, vouloir absolument pas aller coucher dans une mission, lâche la drogue un peu, paye-toi un appart pis reprend ta dignité un peu – Dan

> I am getting older, it's not good for me to sleep on the streets, the cold and violence are terrible. Some kids kicked me in the back of my head while I was sleeping once – Carl

These accounts describe the dehumanizing experience of being homeless. During this time participants report having experienced social harms such as discrimination and stigma, mental and emotional harms such as anxiety, depression, loss of dignity, and physical harms such as lack of safety and violence. Therefore, it is important for this research to understand the background of HF participants and their context of homelessness in order to recognize the importance of housing as a first step to reduce harm.

4.1.2 Benefits and Challenges of Housing First

Residents reported several benefits of obtaining housing through a HF project. First of all, low-threshold admission was described as an important benefit of HF as it allows for easy access to housing in comparison with other services for the chronically homeless. Participants described the process of obtaining housing as fairly simple. In this process, workers would reach out to people over fifty that were continuously using the shelter services. In some cases it was the participants who would reach out to the intervention workers to inquire about the program. After a short interview, participants would be informed if they met the criteria to obtain housing through the program or not. In the following statements Dan and Guy describe their experience entering to the program.

> Ben […] il se promenait à la Mission, il cherchait des candidats. C'est eux-autres qui sont venus nous voir – Dan

> J'avais entendu parler du Projet puis c'est ça j'savais pas trop trop c'était quoi. J'avais entendu dire que les gars étaient placés dans des logements, pis ça allait très bien. Faque j'étais assis dehors, j'étais assis dehors, sur la chaise de la Mission, pis là j'ai vu une intervenante, et je lui ai demandé si je pouvais être un candidat. Pis elle a dit : « j'penserais pas, on n'en prend plus. » Mais elle a dit : « attendez un peu, je vais aller voir la coordonnatrice. Je vais lui en parler, elle a dit, vous avez l'air très très gentil. Elle a dit, peut-être qu'elle va vouloir. » Faque elle a dit oui, pis elle est venue me dire oui t'es accepté pis on va faire des démarches pour que t'aies un logement – Guy

Dan's account clearly shows the practice of outreach embedded a key principle of HR intervention which is meeting people where they are both geographically, as well as where they are in their life trajectory. As per Guy's account, there seems to be an interesting power dynamic from the part of the worker who states first that there are no places available in the program, but then tells him that

because he is a nice person, the coordinator might want to give him a place. In this dynamic, Guy is depicted as deserving of housing because of his personality or behaviour which is not congruent to HF philosophy as the approach espouses housing as a primary need and a human right.

Another important benefit described by participants was exiting homelessness and housing affordability. As per Carl, paying low rent allows him to have enough financial freedom to provide for his basic needs, as opposed to paying for housing in the private market but not being able to buy food or anything else.

> First benefit is not being on the streets. Second: Rent is cheap. – it's better than giving landlords all of your check and having nothing to eat or not buy cigarettes for the rest of the month – Carl

Besides having a place to live that, to an extent, is protected by a governmental subsidy, most participants expressed finding benefits related to their mental and emotional health, as well as recovery and stability. For instance, Guy experienced alleviation from his depression:

> J'étais en dépression à la Mission, je ne suis plus en dépression, c'est fini, je suis dans mon appartement, je suis bien, je suis heureux, j'ai même pas le gout de sortir, quand je suis arrivé ici la dépression a disparu – Guy

As per Manuel, having a place to live has helped his transition from homelessness by giving him hope, security and a place to recover.

> It took a few months to feel better and to get rested. I sleep a lot because you are tired from living on the streets. Now I feel more secure living in an apartment, it gives me hope – Manuel

> When you have a stable environment, you don't have to worry about where to go or how to survive. You can start to deal with your issues and find solutions for your problems – Manuel

As per Carl, one benefit of HF is having stability. This stability is not only gratifying and rewarding but brings value to him as a person, but it also uplifts his self-esteem. In addition, he comments on the aspect of privacy and highlights that his apartment is a place where he can be safe from any form of persecution or intimidation.

> Housing stability is rewarding as it provides value for people in that they are able to have a place to live, clean their apartment, cook their own food – Carl

> I rest, I live better because I have a place that is safe, where I can go to bed every day. I am comfortable and I have a space [where] no one can come to harass me – Carl

It is clear that for HF participants, having a physical place to live not only changes their social status, but also produces significant changes in their well-being. As shown in the declarations of the participants, most people find that the benefits of housing come from having a place to live, having privacy, and having stability. These findings demonstrate that ontological security can help people improve their mental health status, improve outcomes of life such as feeling hopeful, and reduce social harms such as harassment. Most importantly the provision of housing for homeless people can improve their self-esteem, opportunities for recovery and autonomy.

When comparing HF to other programs available to homeless individuals, participants preferred HF as opposed to the services using the staircase model. In contrast to reinsertion programs in the city, participants obtain better outcomes from HF such as more privacy, freedom, and opportunities for change. Guy stated that the reinsertion program he was part of would not allow him to have visitors and had stringent rules to the point he felt like he was in prison; while Dan stated that people use these programs only as a place to sleep but not as a place that can help them produce lasting changes to their consumption or their behavior.

> C'est parce que, c'était pas pour moi, t'sais, ben j'avais pas le droit de visite, ben j'avais le droit, mais y fallait que j'ouvre ma porte. J'avais pas le droit d'amener de filles chez moi. Dans ce temps-là j'avais une copine pis elle pouvait pas venir. Les règlements étaient sévères, très très sévères, pis moi j'étais pas capable, je me sentais en prison. J'me sentais emprisonné – Guy

> [les programmes de réinsertion], c'était juste pour que t'ailles une place pour crasher, c'était juste ça. La plupart des gars continuaient sur la… ils restent là mais j'dirais que 80% ils continuaient encore dans le même pattern [référence à la consommation] – Dan

Although for most participants, life improved dramatically as soon as they had access to housing, the transition process has proven to bring about various challenges for several residents. For instance, Manuel reported that for the first months, he continued to feel homeless; he felt nervous, scared, and afraid to be alone in the apartment. Carl stated that it took a few months for him to feel

safe, while Leo described his living environment as turbulent, his statement reflecting a lack of a feeling of safety in the building and concerns with regards to his neighbors.

> Il a tellement de rock and roll ici, y'a des viols, y'a toutes sortes d'affaires. Une fille s'est fait tuer dans l'appartement juste en bas ici – Leo

Leo also stated that he wishes he can be relocated because the apartment he originally chose no longer meets his needs.

> Je suis plus capable de monter les escaliers, j'ai 62 ans, j'ai mal aux genoux, en plus mon accident qui vient d'arriver. Je suis démuni, je peux plus rien faire, je peux pas bien marcher, qu'est qui va arriver ? – Leo

Not being able to relocate leaves this participant feeling trapped in the "deal." On the one hand, he wants to be transferred but states that the administrators of the program won't let him. On the other hand, if he leaves the apartment, he will have to renounce the government subsidy, in which case he will have to return to the streets as he will not be able to pay rent and other bills with his income.

> J'essaie de partir, mais ils me forcent à rester ici. Ils ne veulent pas me relocaliser, si je débarque, je perds la subvention puis je me retrouve dans la rue encore. Ça fait partie des petites choses que j'aime pas de ce projet – Leo

Another challenge or limitation of HF is that it is not a permanent program. The accounts of some residents contradict the notion of permanent housing that is often put forward by HF programs. Carl explains that his program only lasts two years, and after that, he will be without shelter unless he is eligible for social housing without supports.

> I was explained by my worker that I have to leave the apartment because the program is only 2 years and I am hoping I will go to HLM (Habitation à loyer modique) – Carl

An important component of HF is the long-term support offered to residents by the intervention team. In the following section, I will provide the findings related to the dynamics of the relationship between workers and participants

4.2 Receiving Support

4.2.1 The Resident-Worker Relationship

To investigate the dynamics of the client-intervention worker relationship I asked participants to describe their relationship with the worker. Most participants (n:3) described their relationship as one based on trust and long-lasting support. These participants appreciate having someone they can talk to, who visits them and helps them with tasks related to housing, social and health services. In accounts from the participants, their relationships with their intervention workers were described as follows:

> Elle est super, on se comprend beaucoup, on parle beaucoup, puis elle est vraiment correcte – Guy

> Elle (mon intervenante) est là, il m'accompagne toujours...j'ai tendance à m'isoler, si ce n'était pas Alfa il y a personne qui viendrait ici, Alfa c'est ma bouée, c'est mon fort, c'est ma lumière de la société – Dan

Dan's statement highlights the reality of many HF participants who tend to live isolated lives and for whom the intervention workers are frequently their only visitor. Hence, the theme of isolation will be further explored later on in this chapter.

Leo spoke about his relationship with his intervention worker in a colloquial manner and described a different kind of professional relationship, one that seems intimate and genuine.

> On rit, on a du fun, on écoute une émission de télé, il me donne un coup de main pour faire mon ménage, etc.. Il est vraiment cool, c'est un bon gars, un bon jack. Il me fait ben rire – Leo

> Ce gars-là, y est bénéfique pour moi, vraiment, il m'écoute, il me comprend, il me brasse… tu sais, il est naturel, il a les cheveux pas placés, tout croche, la casquette croche, les shorts coupés, tout déchirés, c'est correct, y est naturel, y est lui-même, c'est pour ça que ça fonctionne bien, il m'aide à revenir sur la terre, parce que des fois je m'en vas-là et je vais loin – Leo

When discussing the role of the intervention worker in the transition into and maintenance of housing, one participant stated that he needed the worker's help to enter HF, retake control of his life and undertake the necessary tasks to organize his life. Another participant stated that he received strong initial support which was important to help him settle into his apartment and navigate the new neighborhood. During the first few months, he had follow-ups twice a week, but then it changed to once a month. In addition, a participant highlighted that he no longer feels judged in the way he used to feel with other intervention workers at the shelter.

> Ben, j'me sens pas jugé, j'me sens pas prisonnier, pis quand elle me parle, elle me parle comme y faut, t'sais, j'me sens pas abaissé, tandis que là-bas j'me sentais abaissé t'sais, j'me sentais comme une proie t'sais. Faque non je n'étais pas bien – Guy

Motivation, encouragement and flexibility were three key components of accompaniment identified by the participants. Two participants have been motivated and encouraged by their worker in multiple areas of their lives. One participant stated that he received support from his worker when he felt down or when he did not want to leave the house:

> Il me motive, il m'encourage à le faire, ou j'ai des commissions à faire, il vient avec moi, pendant que je fais mes commissions, lui il joue avec Daisy (son chien) – Leo

When it comes to flexibility, some workers go beyond their mandate to accommodate clients. For instance, one participant mentioned that he had a medical appointment and his intervention worker offered to transport him in his personal vehicle, however, these types of arrangements could be both a benefit and vice, since this is not part of the standard services offered to clients it could be seen as favoritism.

> Elle a dit qu'elle va prendre sa voiture et qu'elle va venir avec moi, elle dit 'je n'ai pas l'habitude de prendre ma voiture, mais elle dit je vais faire une exception, je vais prendre ma voiture – Guy

The alliance between clients and workers, as described by the participants, has two aspects embodying the pragmatic and humanistic aspects of HR. One is the relational, which is humanistic in nature as it entails the fit between worker and client, trust development and counseling. The other is the practical, which entails support and accompaniment through the transition from

homelessness to being housed, as well as the process of social reinsertion. These aspects enable us to better understand the impact of the worker's support in helping homeless individuals' transition into, and maintain, housing as well as in the autonomy, self-determination and empowerment that comes from encouraging participants to take an active role in addressing their needs and solving their problems.

In the following statement, Dan states his understanding of the conditions necessary to obtain housing as well as psychosocial support from workers:

> Il faut que tu aies un suivi en quelque part, un suivi médical, que tu sois accompagné, en suite que tu veux t'en sortir de la rue, parce qu'il y en a qui ne veulent pas sortir – Dan

Dan's statement reflects the understanding most clients have about what it means to be supported by a HF intervention worker. It shows four components that are necessary or conditional to participating in HF. First is to accept to be followed up on by a worker, then to accept to be connected to other services and resources, to receive accompaniment and support through different stages and finally to have a desire to exit homelessness. This brings into question the notion of unconditional support often proclaimed in the HF philosophy. Two of the participants appeared reticent about having a follow up with an intervention worker. In their opinion, they are autonomous and don't need the support of the worker.

4.2.2 Reclaiming Independence: I don't Need Follow up

The homeless experiences of the participants reflected dependency on the services. For instance, access to shelter depends on whether a facility has enough beds to sleep in at night and their food and clothing is often provided by the shelter. Psychosocial support is also given through the social services, and their income depends mostly on the provision of welfare checks.

> When you go to the missions all you do is follow the rules, you line up for Souper, line up for a bed and in the morning you line up for breakfast and then you are kicked out on the street, and you are on your own till the next day – Manuel

Some programs manage the participant's finances which in turn reduces the person's autonomy to manage their own money.

> T'sais je n'étais pas d'accord avec ça, j'étais sur la fiducie, pis là encore la t'sais y prenait mon argent, pis j'avais droit à tant par semaine, pis je n'étais pas capable, les règlements étaient trop sévères – Guy

HF provides an opportunity for many residents to reclaim their independence. In effect, one way in which participants reflect self-determination is by choosing their apartment, decorating it and making it their own space. Another way is by managing their own finances and by deciding how often they want to receive follow-ups from intervention workers.

> Ce n'est pas elle qui va dire, ça va être 1 semaine, 2 semaines, c'est moi qui dis, ok une semaine, pis elle dit correct – Guy

However, for some participants having a follow-up represents a threat to their autonomy. At least three of the participants stated that they don't need a close follow up because they are autonomous.

> Support is based on trust. But I don't really need it now. I am autonomous and responsible – Carl

In Manuel's case, he feels that people who have addiction problems required a closer follow-up, since it is not his case and since he feels independent and autonomous, he does not think he needs to be followed by an intervention worker.

> Some people have a real problem and need more follow up, but I can live on my own, I was once married, and I took care of my mom. I can take care of myself – Manuel

Furthermore, he stated that he felt supported at the beginning of the transition but once he was settled in, he felt that he did not receive much more help from the intervention worker. He says:

> They (IW) just look at stuff on the internet, they tell you to go here or there, but I have a phone and I can look at those things myself … I guess they want you to [do] things on your own – Manuel

In the previous statement Manuel acknowledges that part of the worker's job is to provide resources, but also to encourage the person's autonomy, by motivating them to do things on their own. However, not all people in the HF project feel the same way. For some reclaiming their independence requires that they start slowly taking action on the things they are able to do and acknowledging that in certain areas they need help. For instance, Guy talked about the support he receives with some of the tasks that might be more difficult to him such as dealing with paperwork or calls related to public services:

> Elle s'occupe des fois de mes papiers, elle fait des démarches pour moi, elle appelle ou elle me dit il faut que tu appelles là…c'est moi qui fais les démarches, mais elle m'aide beaucoup… quand c'est trop compliqué c'est elle qui le fait, comme Hydro-Québec puis ces choses-là – Guy

This is an example of intervention work that promotes autonomy through support and education, by continually and gently nudging the person towards being more independent.

4.3 Understanding Substance Use from the Perspective of Consumers

4.3.1 Substance Use and Trauma

The results of the study show that all participants consumed some kind of substance prior to being homeless and in all cases the onset of consumption was before eighteen years old. At least four participants associated consumption with childhood trauma. Carl states that he started to consume because he was abused as a child, while Manuel states that childhood abuse moved him to consume alcohol alone to avoid trouble with others.

> Getting rid of addiction is something I have been trying to do for years. Multiple therapies help me to understand what makes me use and why I use over and over again. Once, I found out why I didn't feel comfortable with myself, I knew it was because my father beat me when I was 2 years old – Carl

> I was abused as a child, so I avoid trouble – Manuel

In the case of Leo, his childhood trauma was severe as shown below in the verbatim, but it was a rape episode that cause him to stop using alcohol.

> T'sais y' a ben des choses qui se sont passées dans mon enfance pis mon adolescence pis j'me suis fait abuser… Moi j'suis venu au monde d'un viol. Ma mère s'est fait violer par son beau-père. […] C'était un peu compliqué pour le vrai mari de ma mère là, il ne m'aimait pas pis il me battait, pis c'est ça il me maltraitait, pis l'autre, le beau-père de ma mère il m'a abusé pendant 10 ans de temps. Dès l'âge de 4 ans jusqu'à l'âge de 14 ans pis ça a continué après ça avec d'autres personnes qui savaient que j'étais vulnérable – Leo

> L'alcool, ça fait 37 ans que je n'ai pas touché à une goutte d'alcool. J'ai arrêté à 25 ans. Pile. Pourquoi? Parce que je me suis fait agresser sexuellement. Je me suis dit, si j'avais été totalement conscient, 0 goutte d'alcool dans le sang, les 2 gars n'auraient pas été de taille. C'est… c'est ça, c'est une autre traumatisme ça – Leo

Dan had a problem with drug use and was often consuming cocaine and other hard substances since he was young. He associated substance use to negative experiences in his childhood as well as to his parent's background and drug consumption.

> C'est un euphémisme. Je l'sais pas pourquoi, ben y'avait [des drogues] à la maison, je l'sais pas si c'est à cause de ma cellule familiale, ma mère était danseuse, mon père était son pimp, j'ai vu ça jeune, jeune, jeune – Dan

4.3.2 Substance Use: Before and After Housing

Participants described substance use as a determinant factor leading to homelessness. In three cases, homelessness was directly linked to divorce and substance abuse. As mentioned previously, Guy's wife left the household due to his drinking problem which caused him to be in and out of homelessness for thirteen years. Dan's divorce triggered an emotional decline that resulted in him losing his job which lead him to spending the savings he had accumulated during five years on drugs and other vices. In Manuel's case alcohol consumption led to divorce and subsequently to homelessness. For Leo, the passing of his mother triggered an emotional downfall that led to higher consumption of hard drugs, such as crack, cocaine and others. The excessive use of these drugs resulted in the loss of his savings and left him homeless. For Carl, the uncontrolled use of crack cocaine led him to lose his job and brought about his eviction from his apartment which resulted in homelessness. In most cases it seems that substances help people to cope with emotional challenges (separation, loss of employment, death) or mental health issues (anxiety, depression) or other issues that might not have been named by participants. In some cases, substance abused

exacerbates the already difficult situation by placing individuals in situations of financial difficulty.

It is important to note that most participants reduced their consumption and consequently the risks of harm related to substance use were also reduced after receiving housing through HF. There are several reasons for this change, including living in a different and more stable environment (housing vs homeless), having new priorities and having a greater consciousness about the health and social impacts of drugs and alcohol.

Guy stated that after obtaining his apartment, his consumption of alcohol reduced dramatically and became stable. Leo stopped using hard drugs and currently uses painkillers and cannabis, while Carl continues to use crack-cocaine several times a month. However, in Carl's case, he no longer spends a lot on drugs because he considers it a waste of money due to the short duration of the effect and also because he has other priorities such as buying food and clothing.

> Crack is very expensive. It costs 300$ per day and the effect is not very long. You have to do illegal activities to come up with the money "[mais] je vais pas commettre des crimes pour consommer" [in addition] on the streets you are feed while at home you have to pay your rent and make groceries, this does not leave a lot of money for consumption – Carl

Dan stated that there was a reduction in his use of hard drugs and a stabilization of his use of soft drugs, such as speed and cannabis, but he saw an increased use of alcohol. It is not clear why Dan's alcohol consumption increased despite his negative feelings about being drunk.

> J'ai commencé à boire un peu plus, avant je ne buvais pas. Pis là j'prends, genre 2 Smirnoff, 2 Poppers, j'prends pas de bière, des fois j'm'achète une bouteille de vodka, mais j'déteste être saoul – Dan

For Dan, consuming at home is much less stressful and less expensive. He can also have more control over his use as well as choosing a dealer

> Ben, beaucoup moins de risques, aussi ça coûte ben moins cher. Plus de contrôle. Aussi c'est de pas se faire entrainer, par les autres. Et… qu'est-ce que je pourrais te dire d'autre… T'sais c'est moins stressant. Y'a moins de stress… plus de contrôle aussi sur qu'est-ce que t'as, sur la dope que t'achètes. C'est plus de stabilité avec ton fournisseur – Dan

Interestingly, for Manuel life on the streets required him to be sober and alert, therefore, his consumption decreased during homelessness, but increased after having a place to live.

> On the streets it's never safe to drink, there is always dangers, people cannot be trusted, you have to be alert and suspicious, plus you are tired because you never rest – Manuel

> I still drink occasionally in the program but not excessively – Manuel

The next section will provide substantial data on the participants descriptions of their experiences regarding the use of drugs or alcohol as well as the befits and disadvantages they named.

4.3.3 Benefits and Disadvantages of Substance Use

This section describes the perceptions individuals have about substance use, the positive and negative aspects of consumption and the difference between use and harmful use. Participants in this research do not perceive drugs or alcohol consumption as something negative or positive, but as something useful. In essence, participants described using substances for different reasons, including emotional regulation, coping with everyday challenges, reducing stress and anxiety, improving sexual performance and pain management. Most participants explained that they do not generally abuse drugs or alcohol, instead they have an adaptive use of substances that alleviates certain day to day difficulties.

According to Guy, Dan and Leo their substance use does not always bring about negative consequences. Instead, they explained that their consumption reflects more of a dependency. In other words, they need to use drugs to function well and they will experience negative effects if they don't. Guy reported drinking a beer every two hours helps to control his anxiety, otherwise he feels miserable and stressed. Dan said he consumes cannabis three to four times daily and uses amphetamines occasionally on weekends. According to this participant, methadone affects his sexual performance and he has to take 'speed' to counteract this secondary effect. Leo stated that he consumes painkillers and cannabis every day for pain management.

> [Je prends] plus de 6 Motrins 600 mg par jour parce que sinon j'serais pas capable de marcher du tout là. Faut que je sorte mon chien, elle fait des gros besoins, je ne voudrais pas qu'elle fasse ça dans la maison – Leo

This last participant mentioned that he can stop his use, but he does not want to because it helps him. This participant reported that when he does not smoke cannabis, he can become compulsive. In his words, not smoking leads to engaging in compulsive behaviour:

> Quand je ne fume pas du pot, je remplace par la dépendance d'acheter de façon compulsive … dans la vraie vie, si je ne fume pas, je suis hyper actif, donc, fumer ça fait juste comme balancer un peu mon niveau de stress puis ces choses-là – Leo

> Autrement dit pour affronter la vie ça me prend une béquille – Leo

In Manuel's case, he does not drink regularly, but binge drinks every once in a while. He understands his drinking pattern as being triggered by loneliness and stress and stops when he concentrates on other things. In addition, Manuel states that another reason not to consume is that it is costly, and he cannot afford it.

> I think I am an alcoholic but [it] is triggered by depression and sadness, however, when I am busy, I don't usually drink – Manuel

> I use it [alcohol] to feel better or numb but I cannot always afford it, maybe once a month – Manuel

Carl also states that the change in circumstances has led him to reduce his consumption. Specifically, he reported that living in a home requires many expenses compared to living on the streets and therefore the lack of financial resources contributes to consuming less.

> On the streets you are fed, at home you have to pay your rent and buy groceries, this does not leave a lot of money for consumption – Carl

Carl consumes crack-cocaine several times in a month and marijuana every day. In his view, drugs help him numb his emotional pain. However, he is able to acknowledge that cocaine is a very destructive drug.

> I consume 4 to 5 times a month. Usually when I talk to my kid, I get down and then I consume. It makes me forget and it helps me move forward. (FR) La cocaïne est un produit néfaste, la marijuana, c'est n'est pas si pire et je peux la trouver gratuite – Carl

When confronted by the addictive nature of crack-cocaine and the fact that he said he only consumes four or five times a month, Carl said that he waits for the desire to consume to go away and he moves on. This reflects the fact that Carl has a good knowledge of the drug and its effects. Moreover, It shows that Carl has developed different coping strategies to face his addiction, which in turn challenges the social perception of drug users who are unable to control their urges to consume. Accounts from other participants corroborate that they all have an important level of awareness and control with regards to their consumption.

The accounts of the participants show that they make clear distinctions between substance use and substance abuse. Clients who have learned to manage their consumption, give an account of having a stable dosage, consuming in a planned manner and including their consumption expenses in their budget. According to some clients their choice of dosage allows them to obtain benefits without disrupting their day-to-day functionality. Most participants feel that as long as they are able to meet their responsibilities, such as paying bills, preparing meals and taking care of pets, their consumption is not considered problematic. When I asked Guy if he thought his alcohol consumption was problematic, his reply was no.

> Je ne pense pas. J'ai payé mes dettes, j'ai payé mon loyer, j'fais mon ménage, je fais ma bouffe – Guy

Carl described some of the negative effects of using substances include being stigmatized and portraying a negative image. Carl states that he does not consume outside of his house because he does not want to be labelled as a drug addict. However, he does acknowledge the damaging effects that drugs bring to his health.

> Crack-cocaine damages your brain function, your teeth, your bones. You are going to eat less, you forget to drink water and become dehydrated, but it has not killed me yet. But you spent money for nothing, because the buzz lasts five minutes – Carl

Understanding consumption patterns and reasons has led participants to find less harmful ways to use substances which in turn has reduce some of the negative effects related to its use. The next section explores how participants define and practice HR and how they mitigate risk.

4.4 Defining Versus Experiencing Harm Reduction

The HF residents' account about their understanding of HR reflects that it is not always necessary to know how to define a term in order to carry it out. When I asked participants about the term HR, most participants (n=3) were not familiar with the concept or its meaning while the other two were able to provide a personal definition of the concept.

One participant defined Harm Reduction as:

> Apprendre à dealer avec une partie de toi, apprendre à dealer avec tes envies et tes impulsions…parce que je sais que je n'arrêterais jamais – Dan

This statement reflects two key principles of HR: accept that substances are part of the individual's life indefinitely and understand that substance use is complex and behaviour management is part of reducing the harmful effects of consumption. Another participant stated:

> I do a lot of harm reduction – (FR) je m'arrange pour ne pas commettre de méfaits . Je vais pas commettre des crimes pour consommer – Carl

For Carl, harm reduction is about taking responsibility and control of his actions to avoid activities that can result in negative effects for his life such as committing crimes. In addition, Carl demonstrate that having boundaries and using one's ability to reason beyond the desire to consume are key to reduce the adverse consequences of substance use.

Although the other three participants were unable to define the term "Harm Reduction" their accounts demonstrate that not knowing the term does not equate to not using the approach. In fact, when explained with different questions substance use and misuse as well as the methods they use to reduce the negative effects that might come with it, most participants demonstrated important awareness about themselves, their habits and their behaviour.

4.4.1 Practicing Harm Reduction

Self-awareness and introspection seem to be an important aspect related to harm reduction. For instance, participants displayed deep knowledge about their motives to consume, the negative effects of consumption and how to manage their consumption as well as the other coping mechanisms that help them keep their substance use stable. Here I present some of the verbatim answers that reflect their awareness and reflections.

Understanding the Reasons to Consume:

> I think I am an alcoholic triggered by depression and sadness, if am busy I don't usually drink. Alcohol puts me to sleep but I don't get violent – Manuel
>
> When I talk to my kid, I get down and then I consume. It makes me forget and it helps me move forward – Carl
>
> La méthadone… me cause des problèmes du coté sexuel, pis avec des speeds ça me permet de rencontrer des gens, je n'ai pas besoin de te faire un dessin, pis c'est ça, c'est la seule raison pourquoi j'en prends – Dan
>
> J'ai une grosse tolérance à l'alcool. C'est quand je n'en ai pas que j'vais pas bien. J'ai d'la misère, j'aurais d'la misère a vous parlez t'sais. J'serais anxieux, nerveux… – Guy

Negative Effects of Ssubstance Use :

> La cocaïne a changée tout ma vie, c'est qui a fait que je reste célibataire, que je perde mes emplois, que je vois pas mon enfant – Carl
>
> l'isolement [est une conséquence]. On perd nos amis, on perd aussi notre fierté, ensuite on fait des choses qu'on croirait jamais qu'on pourrait faire… C'est ça, disons qu'on perd tout – Dan

Substance Use Management :

> If you stay calm and wait, it will pass – Carl
>
> J'bois à la maison, ben j'bois, j'prends un verre à la maison pis quand ça commence à trop tourner ben j'men va m'étendre pis c'est tout – Dan

Coping Mechanisms :

> I cope by watching TV, walking or going for a bike ride – Manuel

> I have stopped using drugs many times but when situations get hard, I cope with drugs – Carl
>
> I walk up to six hours a day – Guy

The above statement reflects that residents understand the impact of substances in their own lives, have learned to consume accordingly to what they feel is appropriate without engaging in problematic behaviour. In addition, residents demonstrate important knowledge about substance use management and coping strategies that are beneficial to them, without renouncing the use of substances.

4.4.2 Mitigating Risk and Avoiding Trouble

Participants described using several strategies to mitigate the risks associated with substance use as well as to stabilize consumption in order to keep their lives running, stay out of trouble and most of all, stay housed. One strategy is consuming at home instead of consuming on the streets, which in their words is less expensive, less stressful and there is a lower risk of engaging in fights. One participant drinks at home to avoid trouble. For another participant having a single substance provider gives him more control over product quality.

> Ouais. Je n'ai pas commencé à boire encore à l'extérieur, parce que j'ai peur des fois de… comme à mon party de Noël c'était l'année passée, j'suis allé au party pis là y'a fallu que j'parte à 9h30 parce que y'avait trop de monde qui était sur le party, pis c'est ça je voulais arriver chez moi, je ne voulais pas me faire entraîner quelque part – Dan

Dan's statement shows that fear is an important motivator used by participants to reduce problems related to substance use. In this case, fear of drinking outside, staying late at parties and engaging in fights made the participant return home early avoiding any possibility of running into trouble.

Dan highlighted an important negative effect of substance use for men which is loss of pride, dignity, self-esteem, inability to "keep it together." In contrast, for Carl reducing risks related to drug use is a matter of identity, self-esteem and pride.

> I am not going to get caught doing a crime and go to jail. I am not a criminal, I am not homeless anymore, I dress nicely, I have a good jacket and people tell me I don't look homeless when I ask for money – Carl

> Change is about pride, self-esteem and freedom – Carl

Carl does not identify as a criminal or as homeless. He has positioned himself as a citizen, despite continuing to panhandle, and he is not willing to compromise his freedom by engaging in criminal activities to buy drugs. While, for Manuel, reducing harm also includes being aware of one's influence as well as one's weaknesses.

> Drink occasionally is fine, but I don't drink with people who have a problem with drinking because I don't want to encourage them to drink and I don't want to drink in excess – Manuel

4.4.3 Substance Use Goals

Having goals related to consumption is one way to reduce harmful substance use and its consequences. Participants' goals vary between dosage stability, choosing less harmful substances, using substance substitutes, behavior change and risk prevention. In this study, none of the participants stated abstinence as a desirable goal and most participants felt satisfied with their consumption habits. Some participants see stable consumption as a more realistic goal compared to sobriety.

> I want to have a stable consumption because I don't believe in sobriety – Carl

> I want to be more responsible with myself, like buying groceries and not using everything on drugs – Carl

For one participant, his main goal of reducing the negative effects of injecting heroine is by staying on methadone. In his view, substitution of substances has helped him achieve stability and acceptance over his addiction.

> Le gros du travail a été fait, je me suis mis sur la méthadone, je me suis stabilisé, ma vie est comme ça, j'aime bien comme elle est – Dan

Most participants spoke about taking an adequate dose and the amount that works for them. Leo, for example, stated that he takes just the right amount to fulfill his needs without compromising his stability and functioning. He is aware of the negative consequences if he consumes more than he should:

> Le soir quand je suis rendu à deux, je m'arrête là parce que ça nuit à mes médicaments aussi…quand je fume trop le lendemain matin je me lève puis je suis encore buzzé…puis je ne veux pas ça le matin parce que j'ai des responsabilités, faut que je donne à manger à mon chien, elle a aussi des médicaments – Leo

For Carl, accepting himself as an addict and recognizing that substance use has caused damage in many areas in his life is a step to move forward.

> Accepting that I am a drug addict, acknowledging that it causes many problems for me such as loneliness, poor relationship with others, losing jobs, feeling different than the rest of the family and difficulty having romantic relationships – Carl

Many of these goals are set by the individual based on their own self-awareness, understanding of substance use and knowledge about the negative effects of using drugs or alcohol without limitations. However, when asked about the role of the intervention worker in helping participants creating goals or manage their substance use, most participants stated that the topic of substance use is not something they often discuss with their intervention worker.

4.5 Reintegrating Society

According to Dan, reconnecting with society requires behaviour awareness. He emphasizes that there is a difference between street behavior and the behavior that is expected in society. For him consumption of marijuana helps him to behave in a way that is in accordance with society's standards.

> Ça (marijuana) me permet de me calmer mes impulsions, comme on dit j'ai été longtemps dans la rue, fais que des fois j'ai des tendances à remettre les gens à leur place assez rapidement, puis ça se fait pas dans la société – Dan

> Going to church helps me with recovery, it helps me to have a community and a support system, and maybe find a woman – Manuel

> My quality of life is better but is not perfect. Ideally, I would like to have a full-time job, do more activities and have more friends, and find a nice girlfriend – Manuel

Other barriers experience by residents include difficulties finding employment, settling into a new community and feeling isolated. Although some participants have had 'little jobs here and there', none of the participants have been able to obtain employment stability. Factors such as having a criminal record, being unemployed for a long period of time and lack of training are among some of the reasons HF residents have been unemployed after being housed.

4.5.1 Cutting Ties with the Homeless Community

For some clients adapting to a new lifestyle required reconnecting to mainstream society while slowly disconnecting from the homeless community. At least three participants expressed their need to cut ties with the homeless community, as an important step in their social reintegration process. However, leaving the streets had left some participants feeling alone. Two participants expressed their desire to live far from other program residents because they considered them to be 'problematic'. In some instances, the reasons for cutting ties with the homeless community were related to the management of substance use. For instance, Dan decided to separate himself from the social network that he had on the streets to protect himself, as he felt that he was easily influenced by people who consume, and he wanted to remain stable.

> J'ai coupé tout mon réseau, je n'avais pas le choix…. Que ça soit mon réseau de conso, mon réseau des amis ou mon réseau de n'importe quoi, j'ai complètement tout fermé puis maintenait j'ai laissé quelques personnes rentrer dans ma vie, mais il ne faut pas qu'y consomment mes amis…je fais ben attention au monde autour de moi parce que même après cinq ans on ne sait jamais quand est-ce que ça va nous frapper [talking about relapse] – Dan

Leo is also reluctant to have friends who were previously homeless and describes other program members as problematic. He finds his building environment unsafe and wants to be separated from it, allowing only a few old friends into his life. In addition, he does not maintain a relationship with his family or the gay community he once was a part of. Dan chooses not to have contact with

his family, but he does engage in sporadic romantic relations. Manuel mentions that he often feels alone, and although he likes to go to church, he does not go often for fear of being judged.

4.5.2 Fighting Isolation

In some cases, cutting ties with the homeless community means disconnecting from people who have been close during a difficult period of time. By making this choice, I found that some of the participants are facing isolation. Carl believes that his circumstances have changed, and he no longer sees as a many people as he used to on the streets. In addition, he stays at home alone when he does not have money to go out. However, Manuel states that although he is aware of some of the activities provided by the program these are not interesting to him and therefore, he does not participate.

> On the streets lots of people help you, even strangers, but when you are in an apartment, you no longer have that – Carl
>
> I spent two weeks without going out because I don't have any money – Carl
>
> I could use more friends. The program organizes some activities, but I don't really like music and many activities are geared to that. I will go to Christmas dinner – Manuel

For most of the participants, HF intervention workers are their main social support and sometimes their only visitor. Depending on their stage in the transition process (beginning or more advanced) residents will experience different degrees of isolation and their attitudes towards socializing and creating a new community change. For instance, Manuel and Dan reported feeling lonely while they are still adapting to their new neighborhoods. At this stage, they value creating a safe and stable environment for themselves more than creating a new social network. In Manuel's case, he likes to have a place to sleep at night and not having to worry about how to survive. Leo and Guy have been in the program for longer and are continually making choices about how to socialize with others and what kind of social circle they want to form.

Workers' Perspectives On Housing and Harm Reduction

This section presents the main findings from the focus group done with five workers at a HF project based in Montreal. To better reflect the results, this part of chapter 4 is organized by themes that explore the way HR based interventions are carryout by the workers. First, housing is portrayed as an HR tool to help residents achieve stability. Then long-term support encompassed themes such as *accompaniment from homelessness to housing*, *financial support, and the nature of accompaniment* as well as how they handle mistrust and resistance from workers. This is followed by the perception of workers concerning substance use and their experiences with residents who consume different types of substances. In addition, this section presents data on how workers intervene to reduce the adverse effects of substance use. Finally, this chapter is closed by describing how workers understand HR and how they use tools such as empowerment and self-determination to implement HR based interventions.

4.6 Housing as Harm Reduction Tool

Workers estimate that for people experiencing homelessness, housing provision is HR in its most pragmatic form. According to Lana, simply giving homeless people with addictions access to housing reduces some of the risks associated with consumption. This is because housing provides two basic needs that the person is denied during homelessness: security and stability. Workers have observed that when a person no longer has to cope with life on the streets, consumption often decreases.

> Moi j'ai remarqué que, le fait d'avoir un logement réduit les méfaits de la consommation. Je ne sais pas comment l'expliquer, mais ça crée un environnement plus sécuritaire. C'est un grand mot, mais j'ai un exemple en tête. J'ai quelqu'un que depuis qu'il a son logement, après presque […] à peu près 25 ans d'itinérance, il réussit de plus en plus à consommer de l'alcool, de façon plus modérée – Lana

In fact, the sense of safety and stability provided by having a place to live changes the dynamics of consumption and the risk individuals are willing to take. For instance, workers noticed that most clients enjoy having a place of their own and, therefore, do not want to jeopardize their housing.

The apartment gives them the motivation to control their consumption habits and avoid risks that could potentially disrupt that new-found stability.

> Les clients pensent, j'ne veux pas tout perdre ça, donc je vais mettre en place des choses pour réussir à contrôler (la consommation) de plus en plus. En fait, le logement est un excellent levier pour créer de la sécurité pis des fois ce besoin de sécurité-là était tellement pas comblé que par la consommation – Sara

According to another worker, residents feel relief to have a place to come back after a long day and it is this feeling that creates both an attachment and a goal. Workers notice that clients feel attached to their apartment but also that maintaining their apartment is one of their main goals. Similarly, the workers main goal is also to help "maintain people in their apartment" by means of offering multiple types of support including psychosocial and financial support.

> … (dans la ressource), c'est vraiment la philosophie où on met les gens dans une situation de logement, pis dans le fond le Projet fait les efforts nécessaires avec les participants pour les maintenir en logement – Ed

Workers reported that housing stability creates positive changes that are reflected in other areas of the person's life, such as improved hygiene and spending habits as well as improvements in their lifestyle such as cooking, biking, and decorating their space.

4.7 Long-Term Support

Lana states that homeless individuals do not often have access to stable, continuous and long-term support that assists them before, during and after homelessness until they become fully independent. Instead, this underserved population experience multiple forms of exclusion and barriers embedded in unrealistic conditions when they try to obtain housing through the traditional staircase/ treatment first programs:

> Normalement, ils se font dire les conditions en premier…il ne faut pas que tu manques plus que telles nombre de rencontres, ne faut pas que tu sois intoxiqué…ils se font dire « tu dois prendre ça sinon t'es exclu ». T'sais comme les limites peuvent se créer au fur et à mesure en fonction des besoins des gens, mais ce n'est pas les conditions… en tout cas, ici il n'y a pas de conditions – Lana

In contrast this HF project concentrates on providing housing without preconditions of sobriety as they work at the individual's pace to help him develop boundaries that are according to their needs. In other words, it is the client who dictates their own goals, which may or may not include substance treatment.

Intervention workers consider that long-term support, as well as easy access to housing, are key to reducing homelessness and attaining housing stability:

> Je pense que c'est la notion de soutien inconditionnel. Peu importe le problème auquel on est confronté, si la personne perd son appartement, on va lui en trouver un autre – Tim

Interestingly the term "unconditional" was brought up several times when referring to the support offered to residents. This term seems to arise from the comparison of the HF philosophy with other services for homeless people using the Treatment First philosophy. As Lana mentioned previously clients have often experienced exclusion from shelters or reinsertion programs when they consume substances. HF workers instead support clients thought relapse and failures as well as through good and bad decisions as expressed by Sara:

> Dans un sens c'est la vision dans laquelle ça s'inscrit le projet, au lieu d'y aller par étape où l'arrivée en logement est vue, c'est comme, la somme de travail sur soi et de stabilité et tout, dans le fond, avec le projet, l'accès au logement est vu comme un pas inconditionnel, qui est là, qui dès le départ, t'es là, t'es installé en appartement, en logement. J'trouve que ça change toute la dynamique que t'as avec la personne, parce que, on part de ce droit-là qui est inaliénable et parce qu'il n'y a pas de conditions – Sara

Both Lana and Sara reported that there are no conditions to access housing thought HF and that this changes the dynamics between the client and the worker. However, it is known that the program does have several conditions and requirements that are not necessarily related to substance use.

Finally, as mentioned previously, long-term support is provided principally to help clients maintain their apartment despite any issues they might have, whether that is eviction, problems with the landlord or any other problem that can put housing stability at risk. This protects participants' right to housing in all cases. This means that, if they are evicted, they will find another apartment for

them. If a client violates the terms of their contract, they will no longer be part of the program which means no longer receive support from intervention workers, but they can keep their apartment and the subsidy from the social housing program.

4.7.1 Support from being homeless to being housed

While moving to an apartment would seem like a desirable goal for a person experiencing homelessness, the transition can bring about multiple challenges. Intervention workers agreed that some program participants require more intense and more frequent support during the transition period than others. Moreover, the support increases according to the needs of the clients.

> C'est vraiment intéressant, y'en a qui nécessite un suivi un peu plus important, un peu plus régulier, comme par exemple j'en ai un moi qui n'est pas capable de lire, donc tout ce qui est administratif on l'accompagne là-dedans, pis y'en a d'autres qui sont beaucoup plus autonomes – Ed

Ed stated that transitioning from homelessness to being housed brings about several situations that the person has to confront, such as adjusting to a new environment, leaving behind their street-involved community and coping with isolation. Tim added that during the transition period, clients need more psychosocial support to adapt to their new reality.

> Y'en a qui arrive en appartement, ils étaient prédisposés déjà mentalement, logiquement à être en appartement, fait que cette personne-là est devenue autonome plus rapidement, tandis qu'y en a d'autres que ça fait déjà quelques mois, un an, qu'ils sont en appartement, pour eux la transition entre la rue, l'esprit de communauté, l'isolement, être tout seul à l'appartement, souper tout seul, dormir tout seul, c'est quelque chose qui demande vraiment un soutien psychologique plus personnel, probablement un petit peu intense, fait qu'on est là aussi pour les accompagner là-dedans – Ed

Lana finds the transition period to be a slow but natural process in which clients engage more in behaviours that have a positive impact on their lives. In addition, Lana stated that clients who spend part of the day outside in the streets, or who maintain contact with their old community have an easier transition to being housed than those who want to cut all ties with the homeless community. Tim gave an example of what the transition period was like for one of her clients

> Un de mes participants s'ennuie terriblement de sa vie dans la rue. Il est allé à sa place depuis il y a quelques semaines et c'était la première fois depuis quelques mois qu'il se sent comme lui. Il est reconnu, tout le monde lui parle et il a comme un certain statut – Tim

Despite the intervention workers efforts to help their clients have a smooth transition and keep their apartment, Sara states that the transition can be difficult for some people, to the point that they give up their apartment and go back to living on the streets because they were unable to adapt to their new environment. As per the workers, one of the reasons for this is a problem with belonging; workers describe that some clients do not feel that they belong to the streets anymore, but they also do not feel like they belong in their new community either.

4.7.2 Financial Support

HF residents are offered two types of financial support. The first is mandatory and consist on the program receiving the client's welfare cheque, paying the landlord the person's rental fees, and returning the remaining money to the resident's account. This form of support is a protective measure to ensure private landlords always receive the rent payment and to avoid residents returning to homelessness for not paying their rent on time or fully. The second form of financial support is available to residents who desire help to manage their finances. This is provided through the fiduciary program that acts as a bank where people can save money. Residents can request their money any time and can access as much of their savings as they want. According to Ed, the fiduciary program helps people manage their budget better as it gives them the opportunity to save while being accountable to their intervention worker. Finally, support is given through budgeting education and accompaniment. This type of support has helped some clients break their consumption habits by using their money on other necessities, while others have learned to manage their resources to ensure they have enough money at the end of the month to buy drugs and alcohol. As per workers accounts, all forms of financial support contribute significantly to reducing harm for the client.

Specifically, workers can use budgets as a HR tool to educate and create consciousness about the cost of substances and the problems that arise from spending too much on them. The goal is to figure out how to include substances in their budget while still respecting the allocations for food, bills, medical expenses and other financial obligations.

> On discute de toutes les manières de réduire. On regarde le budget parce qu'on essaie de la mettre dans le budget, combien tu dépenses sur ça pour qu'il puisse voir d'une façon concrète combien ça coûte cette activité-là. Parce que de temps en temps c'est hyper irréaliste et c'est ça qui cause tous les autres problèmes. Ce n'est pas parce qu'il consomme, c'est parce que c'est un passe-temps qui coûte trop cher. Ça peut être un élément pour discuter, de prendre une drogue moins sévère, moins dure, soit de la prendre moins souvent, ou en plus petite quantité. – Tim

As per Ed, helping people manage their finances is important because the less resources they have, the higher the chances they will engage in criminal acts when they feel the need to consume and don't have the money to do it. Lila agrees :

> …je crois que ça vient réduire les méfaits… quoiqu'ils retournent dans leurs vieux patterns quand ils n'ont plus d'argent à la fin du mois mais pendant un certain laps de temps dans le mois je pense que ça vient réduire de beaucoup les problèmes, entre autres. – Ed
>
> Discuter, avec lui, en fonction de c'était quoi son but lui en mettant de l'argent de côté au début du mois comme ça, son but étant d'avoir de l'argent jusqu'à la fin du mois, sinon là il devient vraiment anxieux et les comportements délinquants augmentent beaucoup, parce qu'il est en sevrage et qu'il a besoin de plus de substances – Lila

Intervention workers noticed that substance use is costly and takes a substantial amount of their resident's income. In turn, lack of financial management and budgeting can have serious impacts on their stability and social integration.

4.8 The Nature of Accompaniment

Accompaniment is described by intervention workers as a partnership: a relationship characterized by working side by side, with the participants providing long-term personalized support that responds to the client's needs. In the view of workers, accompaniment has to be offered unconditionally.

> On fait l'accompagnement autant dans les bons coups que dans les échecs, autant dans les réussites que dans les rechutes, c'est plein de bonnes décisions, de mauvaises décisions, puis on 'go through' dans les décisions avec eux autres – Ed

Accompaniment also entails helping residents understand their own needs, for instance, when choosing an apartment, do they need a place close to the metro, or where pets are allowed? According to Tim, giving options and choices to people experiencing homeless is validating and empowering because it offers them the opportunity to express their preferences as well as the opportunity to exercise their power and agency by taking an active role in making decisions pertinent to their process.

> Ce n'est pas nous qui choisissons l'appartement, c'est les participants qui les choisissent, on fait des recherches d'appartement et la première fois que tu demandes « qu'est-ce que tu veux » il le sait même pas. Est-ce que tu veux un balcon, est-ce que tu es un fumeur, est-ce que tu préfères être au centre-ville, est-ce que t'as besoin d'être à côté des services, est-ce que t'as besoin d'être à côté d'un métro, est-ce que t'as des problèmes de mobilité. Y'a beaucoup de choses. Un petit bâtiment, un grand bâtiment, quoi que ce soit, mais ils ne sont si pas habitués que quelqu'un s'intéresse à leurs préférences qu'ils ont perdu l'habitude de les exprimer, de penser à ça, qu'on les prenne au sérieux s'il dit « moi je veux telle affaire ». C'est une grande expérience, ça. – Tim

Other examples of accompaniment brought up by the workers include going to medical appointments with clients, going on walks, attending community events, and assisting clients with home or administrative tasks. As described by the workers, this type of unscripted support allows them to foster trust and strengthen their relationship with residents. Lana stated that it is when helping clients with day-to-day activities that open and honest dialogue occurs.

> Donc, ça lui a permis aussi d'aller chercher un traitement pour l'hépatite C, et d'aller chercher d'autres trucs, puis par le côté informel qu'on a, ben, je peux l'accompagner au niveau de ses rendez-vous, pour la santé, donc ça me permet aussi de travailler différentes sphères, d'avoir une approche plus globale. Donc c'est bien – Lana

Beyond the flexibility, workers reflect their capacity to truly listen to and acknowledge what the client is saying. Validating the person's requests and needs versus hearing them and then pursuing the workers priorities makes a big difference for the clients and allows for a truly trusting and therapeutic relationship to build.

Workers also highlight the importance to bring clients to propose solutions to their own problems. Their goal is to empower the client and encourage him to be autonomous as they gain problem solving skills and find new coping mechanism that can potentially reduce their need to use

substances. As per Tim's reflection, it's necessary to wait until the person is ready to name his problems or difficulties regarding substance use or abuse in order to address these. However, Ed says that when clients realize that many of their problems are related to their consumption, they become more aware about their substance use habits and its repercussions on their lives.

> Ça c'est très très très important, choisis ton moment, dans un moment où il est très calme, je suppose que dans ce moment-là il est très confortable avec moi et là on peut discuter : qu'est-ce que tu penses que tu peux faire pour essayer de traiter ce problème avec le crack – Tim

Workers realise that putting pressure on clients is not a good strategy as it often results in them becoming defensive. Therefore, they use a non-directive approach as well as the motivational interviewing approach to deal with crisis mistrust and resistance.

4.8.1 Dealing with Crisis, Mistrust and Resistance from Residents

Working with an individual undergoing major changes in their life does not come without challenges. Intervention workers described how they manage crises, mistrust and resistance in order to support their clients unconditionally and maintain their relationship with them.

According to Ed, in times of crisis, clients sometimes make rash decisions - for instance returning to the streets - because it is hard to cope with being housed, even if housing was an expressed desire. When this happens, Ed reported that his intervention focuses on ensuring a close accompaniment by visiting or calling clients several times a day to ensure that they are managing the situation. In these cases, the worker allows clients time to reflect on their choices and decide for themselves what they want to do while clarifying that whatever it is, they will support them. Ed will use words like, "we are all in" with the client, even if the client's decisions cause them to lose their apartment or if the client chooses to leave the program. Showing the client support without giving specific directions allows the client to develop strategies to find solutions for their own problems.

According to Tim, clients often use resistance as a defense mechanism. When this happens, intervention workers respond by accepting and embracing the resistance. Tim reported that some

clients use insults or make hurtful comments to incite a reaction from their intervention worker or create conflict. Intervention workers do not take these behaviors personally. Instead, they understand this type of resistance as a reflection of an internalized pattern of anger and mistrust towards the system:

> J'pense que ça arrive souvent que, dans mon cas à moi anyway, qu'il y a des participants avec cette approche-là, ils ne savent pas quoi faire s'il y a pas une résistance de la part de l'intervenant, mais il va chercher la résistance…il cherche, soit t'insulter pour avoir une réaction, pour avoir une confrontation, parce qu'il y a le pattern qui est très bien installé chez la plupart des gars avec le système, c'est qu'il y a l'escalade puis c'est la rupture totale. Donc on essaie d'éviter la rupture totale - Tim

Intervention workers try to avoid the escalation of a discussion or conflict because they do not want to break the alliance they have with the client. Instead, workers aim to support clients despite their choices by showing respect for the client's right to self-determination. According to Lisa, respect and a non-judgmental approach are key to having open dialogue with clients.

Workers find it difficult to offer individualized services to clients whose needs, abilities, competencies, emotional triggers, and addiction problems are different from one to another. Furthermore, workers must deal with the unexpected, be comfortable with the unknown, and understand the many layers of the client's life and their difficulties. Most workers find it challenging to intervene when clients are heavily intoxicated. According to Lana, when a client consumes substances for many consecutive days, communication becomes very difficult because the substance has altered the person's ability to reason.

Ed expressed that helping clients with diverse needs, levels of independence and substance use habits makes his work interesting but also exhausting. Therefore, it is pertinent to recognize that case management is inherently challenging, as there is no magic formula for offering support but continued long-term support that is not conditional on client's substance use choices and that this seems to be key to help residents incrementally improve their situation.

Finally, most of the factors that favor trust between the workers and clients are inherently part of the HR approach and include: respect, non-judgemental interactions, having open dialogue,

offering unconditional accompaniment, using a non-moralistic and non-directive approach as well as offering pragmatic interventions that are realistic and appropriate to the clients timing and pace.

> Où il y a du respect pis il y a du non-jugement à la base, donc ça peut ouvrir des dialogues, puis, comme en lien avec l'approche de réduction des méfaits ça ne se veut pas moralisant, ça se veut plutôt pragmatique, après ça on ne va pas moraliser la personne, on va l'accompagner pis on a un dialogue le plus ouvert possible, je pense que c'est ce qui favorise la création d'un lien de confiance pis de dialogue ouvert par rapport à ça – Lana

4.9 Understanding Substance Use and Risks

In the workers' experience consumption is often used by their clients as a coping mechanism for different issues (such as reducing anxiety). Most workers recognise that drugs and alcohol have a place in the person's life and this acknowledgment helps them to validate and understand their client's emotional needs, their coping strategies as well as their strengths. Workers state that they often work on raising awareness of the effects of drug use and helping their clients find alternative coping mechanisms that are safe.

> Le client prenait de l'alcool, entre autres, pour simplifier sa situation, mais quand il est très anxieux ça devient un moyen de se calmer. Pis, il avait des médicaments et tout il avait peur de les prendre, alors l'approche ça a été plus de voir, ok ben, peut-être qu'on peut regarder c'est quoi tes médicaments, peut-être qu'on peut essayer de convenir si tu peux les prendre pour gérer ton anxiété d'une façon qui soit plus saine pour toi que de prendre de l'alcool sans arrêter de complètement prendre de l'alcool, mais de reconnaître cette dimension-là, où l'alcool lui sert à quelque chose aussi qui est de gérer son anxiété pis si c'est possible d'apaiser cette partie-là de lui en faisant de l'éducation auprès d'autres moyens qu'il a en sa possession. Ça devient un levier qui est important, de susciter lui, sa propre motivation. Parce que moi je peux lui dire « fais ça » mais ça ne sert à rien, je ne détiens pas la vérité. Fait que, de voir ce qui lui veut. – Tim

According to workers some clients have an idea about how to stop consumption but for the most part, abstinence is not part of their goals. Nonetheless, workers state that clients who do want to stop using will most likely do it on their own and without therapy. This reflects the need for the client to be autonomous in his decisions and to reclaim the power and control over his life and choices.

> …ils ont des idées de comment arrêter eux-mêmes, soit ils ne veulent pas arrêter, soit ils veulent arrêter mais ils ont l'idée qu'ils peuvent le faire d'une façon autonome. Pour certains c'est faisable, mais pour d'autres ce n'est pas faisable, ils veulent être capable de le faire eux-mêmes ils ne veulent pas l'aide de l'extérieur – Lila

4.9.1 The Prevalence of Risk

A HR intervention strategy is to help clients understand how substance abuse can lead to engagement in high-risk behaviors which can, in turn, create problems that affect the person's quality of life. For instance, Tim stated that, for one of her clients, the problem is not crack consumption in itself, but the problems that arise when the person engages in dangerous behaviors, such as trading services to obtain crack. As explained by the worker, one of her clients was serving as a security guard at a crack house. In this case, he was at risk of being abused by the distributors who took advantage of his addiction by promising drugs in exchange for doing a dangerous job. Additional potential repercussions also included being caught by the police. In this case, Tim asked the client to limit their consumption on the streets, and to consume at home instead.

> Ça reste qu'ils continuent des fois à avoir des comportements délinquants comme pas payer, là, moi je suis vraiment surpris à quel point il y a beaucoup de gens qui ne paient pas leurs billets d'autobus, moi j'ai été confronté à ça plus que je croyais, mais bon. Ils se rendent à la maison pareil, pis ils sont moins en train de traîner partout, ça fait une bonne différence je pense – Ed

ED used the term "direct consequences" to describe the problems that come from substance use that affect the lives of his clients. One of his clients was intoxicated with alcohol, when he was caught stealing beer from a convenience store and was badly beaten by the store owner. The client ended up with a few broken ribs and was in pain for three weeks. According to the worker, one positive outcome out of this situation was that the client was able to realize that his behavior was triggered by his consumption and that his behavior not only put his health at risk, but also brought about negative consequences that affected his daily activities:

> T'sais un moment donné quand t'as un gars qui est tellement saoul il arrive au dépanneur, pis y va prendre dans le frigidaire, y va prendre une grosse [bière, en général format de 1 litre] pis y s'en va avec ça eh !! Parce qu'il est tellement intoxiqué qu'il se fait prendre sur le fait à voler, il se cache plus – Ed

In general, clients who abuse substances would find beneficial to their security to consume in their apartment as it can reduce risks they might take when intoxicated. For instance, some make it a goal to only consume at home to avoid troubles. Others avoid spending the night on the streets while intoxicated for fear of criminal attacks. By having a home to go to, clients also avoid getting tickets for jaywalking, lying down in the metro, or drinking in public spaces. However, having housing does not reduce the risk associated with substance use entirely. In fact, workers report that many clients continue to take risks by engaging in dangerous activities such as stealing, selling drugs, trading services, and loitering.

Nevertheless, workers reported seeing positive changes in some of their clients. According to Lana, some of her clients look forward to having a quieter life while Julie has noticed how clients evolve as they engage less and less in risky behaviors and are more thoughtful about their decisions.

> J'avais noté les vols, je pense qu'il y en a un de mes gars en particulier, il vole moins, il vole moins dans le dépanneur pour de la bière ou pour autre chose parce que t'sais, il a un frigo – Ed

4.10 Practicing Harm Reduction Intervention

In practice, workers demonstrate a deep understanding of the client's relationship to substances, the risks associated with consumption, and the endangering behavior patterns clients engage in while using substances. Workers use HR interventions and strategies to reduce the harmful effects of substance use. These entail the use of ambivalence, which consists of leading the client to question their own risk behaviors and consumption habits. Additionally, workers try to create consciousness through open discussions about dangerous situations that arise from substance use and how these can affect the individual in multiple areas of their life.

> Mais c'est vraiment pas à répétition et il faut sélectionner ton moment, ou il faut peut-être attendre que lui soulève le sujet, ce qui arrive, ça arrive aussi, parce que s'il a eu beaucoup de problèmes ils sont tous reliés à son problème de consommation et inévitablement à un certain moment dans la conversation, il va soulever la question et là je peux poser des questions pour que lui développe des suggestions – Tim

When using ambivalence as a method of intervention, workers can help clients to question their consumption methods, as well as the amount and type of substances they use. In addition, workers try to find discrepancies around clients' thoughts and ideas about consumption habits and the risks associated with them.

> Je pense que de par le projet, justement, il n'y a pas de critères d'exclusion fixes, l'idée d'utiliser comme tu dis l'approche motivationnelle qui met au centre l'ambivalence et tout c'est l'essentiel de ce que tu peux faire, d'accompagner la personne où elle est rendue puis de, sans être dans le jugement, de refléter que toi aussi t'es tanné d'être dans cette situation-là – Lila

Ed stated that he tries to encourage his clients to consume at home as it is less risky than consuming on the streets. For instance, those who inject at home are safer and have less risk of using contaminated needles, hence less chance of blood-borne diseases. In a similar manner, Lila told us that one of her clients is more conscious about not picking up used cigarettes form the streets but instead buys his own cigarettes to avoid the transmission of viruses. Workers emphasized that discussions about harmful habits can only happen through open dialogue which in turn requires trust building, genuine concern and having a non-judgmental attitude.

> J'ai un utilisateur de drogues injectables que dans son logement il consomme chez lui, donc il y a beaucoup moins de risques d'échanges de seringues, de transmission, c'est des choses qui pouvaient être problématique avant, mais là c'est de moins en moins fréquent, c'est un moyen en soit de réduire les méfaits – Ed

> Un autre exemple que je pourrais avoir, c'est pas de la réduction des méfaits dans le sens qu'on parle pas de drogues dures mais des cigarettes, moi j'ai des gars que quand ils sont arrivés en logement ils gardaient les habitudes d'aller ramasser des botchs dehors, parce qu'ils n'avaient pas assez d'argent pour s'acheter des cigarettes et tout, là tranquillement tandis que la vie au complet se stabilise ils peuvent s'acheter, bon, des cigarettes indiennes, mais il n'y a plus de ramassage de botchs dans la rue, de fumer les, tu sais en terme de transmission, d'hygiène et tout, il y a quand même… – Lila

4.10.1 Empowerment and self- determination

In the focus group, workers reflected on what constitutes a respectful intervention that upholds HR principles such as self-determination and empowerment. In addition, workers stated that being

self-aware and knowing that they don't own the truth or have solutions for everything is important to implement a non-directive and non-judgmental approach to HR. In Tim's words :

> Je ne suis pas là pour suggérer des choses, mais je suis là pour poser les bonnes questions, pour que lui suggère des choses – Tim

Intervention techniques included: listening and allowing the person to vent before starting a dialogue or addressing an issue, avoid moralizing, seeking out pragmatic ways to help the client, and asking open questions about the situation without judgment or putting too much pressure on the client, which can cause them to become defensive. In addition, workers emphasized the importance of discussing difficult topics when it is appropriate and when the client is calm and comfortable. Allowing the client to make the choice to talk when he is ready. Taking the time to discuss the problem by focusing on the process and not the solution. Furthermore, the motivational interviewing approach is used by the worker to ask the right questions so that the client can untangle their thoughts, see their problems from a broader perspective and find solutions to their problems.

Respect for self-determination is one of the most important principles in HR. Workers take this principle seriously and advocate for clients to make their own choices even when respecting clients' choices goes against what the worker believes is right for the client.

> Il y a aussi beaucoup le respect des choix du risque, des choix de la personne, puis comme ce n'est pas seul, dans le sens où c'est Logement d'abord, les choix de la personne ne vont pas à l'encontre des conditions, par rapport au projet, pis on va l'accompagner en respectant ses choix. Tant au niveau de la consommation que d'autres sphères. Je pense que c'est vraiment ça les valeurs de base – Tim

For instance, Ed had a client who needed to go to the doctor but did not want to go. Although, ED was concerned about the client's health, he respected his decision, but he also made a plan with the client to protect his safety in case of a medical emergency. This situation made the worker question how far respect for client self-determination should extend, especially when client choices entail a risk to their health or quality of life. When there is such a concern, accompaniment may involve helping the client make a better judgement by considering other perspectives on their situation as well as to make informed decisions.

As per workers, empowerment starts with helping the client find their own voice. Workers believe that homelessness has silenced many clients to the point that they have lost the habit of expressing their wants, needs and preferences. According to Tim, clients are not used to someone caring about their preferences because the system has more often than not told them what to do. Lana stated that clients have been forced to accept what is given to them without question or accept impositions to avoid losing the benefit of having shelter for a night. In contrast, HF allows clients to choose an apartment based on their needs and preferences. This in itself is a validating and empowering process for the residents. Julie stated that it is great to experience when the client is able to say, "I want that." Another form of empowerment is allowing the client to propose their own solutions to their problems. For instance, a client that felt incapable of managing his money was given tools to him help take on that responsibility. Through the fiduciary program, the client was able to put money aside, while staying accountable to his intervention worker. According to ED, this type of intervention has helped many clients reach their financial goals. Nonetheless, workers are cautious not to engage in paternalistic practices that can take away their client's autonomy.

The next chapter offers a detailed analysis of how HR in which the transition from homelessness to housing in a HF context is understood, from HF residents' perspectives and workers. Using thematic analysis as a methodology, I was able to isolate the main themes that arose both from residents' interviews as well as the workers' focus group. These themes are organized in a timeline fashion that describes the process from homelessness to housing stability, long-term support, the residents' and workers' perceptions of substance use, their understanding of HR and the resident's process of social reinsertion. Finally, these themes followed the proposed conceptual framework entailing the aspects of ontological security, accompaniment, substance use, and social reinsertion.

CHAPTER 5

Discussion

The interviews with residents and workers permit to uncover how HR is understood and deploy within a HF project from multiple perspectives. The data analyzed brought up several themes that provide answers to the main research questions proposed in this thesis: 1) How is the concept of HR understood and perceived by workers and residents of HF? 2) What factors facilitate or hinder the practice of HR with HF residents from the workers' perspective? 3) How do HR practices reduce, limit or prevent the negative consequences of substance use from the perspective of workers and residents? 4) How do residents and workers understand substance use and mitigate risk-taking behavior? and 5) How do HR principles, strategies and practices contribute to HF goals of community integration?

In this analysis the research questions are explored through the lens of humanistic and constructivism theory and the person-centered approach which generally guides modern social work intervention. Featured in this chapter are the tensions found in the individual interviews and the focus group when contrasting the workers' and residents' experiences. These are then juxtaposed with the literature and the conceptual framework to seize the incongruities in an attempt to conceptualize them. With this goal in mind, the thematic analysis methodology serves to closely examine the data identifying common and repeated themes while making the research more organized, meaningful and connected to the concepts related to the practice of HR in HF. The themes below are then organized in a story telling manner in which the reader gets a close-up of the transition from homelessness to housing, the experiences of giving versus receiving support from the workers' and residents' perspectives, an understanding about substance use versus abuse and the benefits or risks associated to consumption, a brief about the practice of HR intervention and finally the experience of fighting isolation while finding a place in society.

The first theme represents the path **from homelessness to housing stability**. The subthemes describe HR practices that facilitate access to housing to individuals who have been deemed hard-to-reach. Housing is then described as a HR tool that helps reduce some of the negative risks

associated with consumption. This section also challenges the notion of permanency put forward in HF literature. The subtheme **stable but not permanent housing** shows that lack of permanency and stability can ultimately affect individuals' ontological security and can potentially increase harms for individuals who have previously experienced homelessness. In the next section, I discuss **the experiences of giving** versus **receiving support** and the practices that facilitate and hinder the use of HR in HF. Among these practices, I found **that long-term does not always mean unconditional support**, especially when housing support is contingent to the residents' abidance to HF conditions.

Mandatory practices such as follow-ups can potentially become harmful by threatening residents' autonomy which in turn creates **mistrust** and **resistance**. In the next section, I debate residents' and workers' understanding of substance use and the HR approach. The subject of substance use is addressed from the perspective of **use** versus **abuse** and **benefits** versus **risk**. This leads to a discussion about the differences between **defining** versus **practicing harm reduction** as perceived by both workers and residents. I also provide an analysis of how residents and workers minimize the harmful effects of substance use, **manage risk**, and how some HR **practices can be empowering or disempowering**. Finally, I provide insight into life after homelessness and the role of HR in helping residents who are **fighting isolation while finding a place in society**.

5.1. From Homelessness to Housing Stability

5.1.1 Reaching the "hard-to-reach"

Among the homeless population, people who experience chronic homelessness are often labeled "hard-to-reach". However, the findings from this study reveal that when HR methods such as low-threshold services, paired up with a non-judgemental approach that treats people with respect and compassion they are more likely to accept services. Moreover, the results confirm that HR principles that center on the person's primary needs prior to discussing substance use breaks the paradigm of the deserving and undeserving and dignifies people granting them equal access to services instead of punishing them for their consumption.

Most participants had lengthy periods of homelessness due to multiple barriers. Besides individual and interpersonal challenges, they also experience the structural and systemic barriers found in the literature including poverty and lack of affordable housing, marginalization and exclusion, as well as scarcity of social supports and services (Buckland et al., 2001). Despite having access to shelters and traditional staircase programs, participants were not able to find stable or permanent housing through them. As per Tsemberis et al. (2004) staircase programs "are incompatible with consumers' priorities and restrict the access of consumers who are unable or unwilling to comply with program terms" (Tsemberis et al., 2004, p. 651). In addition, models with "low tolerance for addictions create significant barriers for homeless individuals making them live on the streets for long periods of time" (Collins et al., 2012).

Workers remark that having low barriers for this population results in higher chances for them to be housed. This is partly because abstinence is not a requirement and partly because substance consumption is not held against residents. As per workers, their clients have been excluded from obtaining access to housing multiple times due to their drug or alcohol use. Unfortunately, organizations that exclude individuals from their services based on substance use create a double bind for their clients who constantly battle with their addictions and their housing needs. Instead, the exclusion of individuals based on substance use reflect society's beliefs about who is deserving and undeserving of help. A construct that is often internalized by individuals who do not feel worthy of having a place to live. Furthermore, people that have been excluded from services based on their consumption might become distrustful against other services for homeless individuals, which can result in longer periods of homelessness and further disenfranchisement (Dorvil & Boucher, 2013).

The HR approach accepts that people consume for different reasons including trauma, emotional distress, and to cope with difficult circumstances; nevertheless, HR asserts that substance use should not bring upon this group social exclusion. The intervention practices used in this particular HF project, reflect several pragmatic strategies that are congruent with HR principles that seek to eliminate access barriers that arise for substance users hence reducing the rate of people experiencing chronic homelessness. HF workers consider that HF offers a straight-forward process to obtain housing and psychosocial services as well as financial support without substance use

contingencies. In their view, HR within HF facilitates access to services that have been denied to people because of their consumption and provides a way for individuals to focus first on their primary needs and then on their substance use problems if they wish to do so.

The paradigm change from treatment to care has brought a different focus of approach for workers. The findings of this research show that workers and residents emphasize practices that place the individual at the core of intervention. When workers present the program to participants, they make them feel safe, are interested in the person's preferences, and give them a voice by taking into account what they want and need regarding their apartment. Residents state that they appreciate workers' attitude and support with bureaucratic tasks, including agreements with private landlords. Therefore, it is denotable that workers are not initially enquiring about substance use or mental health problems. Instead, workers aim to inquire and understand people's needs, demonstrating empathy drifting from preconceived ideas about what the problem is, or how to help the client and refraining from imposing treatment.

5.1.2 Housing as a Harm Reduction Tool

Interviews with participants revealed the hard reality of living chronically homeless. Their accounts highlight dehumanizing experiences and multiple forms of harm related to living on the streets including discrimination and stigma as well as increase anxiety and depression. Last but not least, participants described lack of dignity, lack of safety and lack of support as part of the negative experiences they endured during this period. Even though the literature also describes harms related to substance abuse which include severe diseases like HIV, Hepatitis, and TB (OHTN Rapid Response Service, 2009) none of the participants in this study disclosed such health factors. Instead, this study centered on the harms that were endured and openly described by participants.

Henwood et al. (2014) suggest that HR effectively uncouples housing from treatment requirements which makes housing a component of therapy, as it is more challenging to keep substance use goals when people do not have stable housing. HF workers agree that providing housing to people in homelessness is the first step to reduce the negative effects of both homelessness and substance

use. Workers have observed that simply giving people experiencing homelessness and addictions access to housing reduces some of the risks associated with consumption. Similarly to Denning and Little (2012), Workers indicate that when a person no longer has to cope with life on the streets, consumption often decreases. For residents, housing provision and housing affordability are described as the two major benefits of HF. Receiving a rent subsidy form the government allows residents to afford their basic needs whereas paying private market prices will significantly affect their quality of life as they would not be able to afford food, transportation and other needs.

Housing generally addresses two basic needs that a person is often denied during homelessness, security and stability. As per workers, the sense of safety and stability provided by having a place to live changes the dynamics of consumption and the risk individuals are willing to take. Workers observe that residents find it motivating to have a place to live and they don't want to jeopardize that new-found stability. From a HR perspective, this motivation can result in substance use stability as "consumers make choices about their drug use that do not necessarily threaten their housing status" (Tiderington, Stanhope & Henwood, 2013, p. 72). Workers also reported that housing stability creates positive changes that are reflected in other areas of the person's life, such as improved hygiene and spending habits as well as improvements in their lifestyle such as cooking, biking, and decorating their space.

The workers accounts are congruent with the residents' who found privacy, stability and a sense of security after being housed. Some have seen an improvement in their mental health and the diminution of substance abuse. In addition, having a place to live has helped participants improve other positive life outcomes such as feeling hopeful, reducing stress and reducing social harms such as harassment. Participants also demonstrated that housing has helped them improve their self-esteem, has given them opportunities to recover, and has provided them a place to exercise their autonomy. These findings are similar to other reports of people in HF which described an "increased feelings of privacy, independence and freedom" (Yanos et al., 2004), as well as housing being perceived as a place of safety, self-worth, a symbol of citizenship, and a place for social encounters (Coltman et al., 2015).

Although for most participants, life improved dramatically as soon as they had access to housing, the transition process has proven to bring about various challenges for several residents. Leo in particular described his living environment as turbulent. This statement reflects a lack of safety in the building. Leo's case shows that one of the risks of scattered housing is that is not always safe housing. Leo describes that there have been rapes and even a murder in the apartment block where he lives. This is concerning to him and has affected negatively his perception of the place provided by HF.

According to Sounders (1990) home is a source of ontological security "where people feel in control of their environment, free from surveillance, free to be themselves and at ease" (as cited in Hiscock et al., 2001, p. 50). Padgett (2007) indicates that obtaining permanent housing promotes the realization of ontological security by having control and self-determination, a routine in daily life, a sense of intimacy and allow the repair of broken identities. When these conditions are not met, participants' quality of life is affected and their vulnerability to return to the streets can increase.

5.1.3 Stable But Not Permanent Housing

As per Gaetz, Scott and Guilliver (2013), HF gives immediate access to housing which refers to the process of obtaining "safe, secure and permanent housing" (p. 5). While most workers and residents agree that housing provides both safety and security, the permanency part is arguable. As per workers, once the three-year program ends participants will be able to continue to obtain the housing subsidy, however, funding is not guarantee which can put housing stability at risk for some. In addition, the accounts of some residents contradict the notion of permanent housing that is often put forward by HF programs. Carl explains that he only has two more years in the program, and after that, he will be without shelter unless he is eligible for social housing without supports. There seems to be misinformation about whether or not participants will be able to continue to be eligible for social housing once the tree year program ends. As per Leo, the request he made to be relocated to another apartment where he does not have to use the stairs, has been declined and he feels trapped in the "deal." In his words, if he leaves the apartment, he will have to renounce the government subsidy and he will have to return to the streets as he will not be able to pay rent and other bills with his income. Without permanent housing, ontological security is uncertain because

individuals will no longer have the confidence in the continuity and constancy of their new environment (Giddens, 1991, as cited in Hiscock et al., 2001, p. 50), or the services intending to serve them. Several studies also attest that unstable housing has been associated with hopelessness, eviction, and substance use problems (Patterson et al., 2013). Finally, lack of stability could be detrimental for the practice of HR as it elevates stress, worry and uncertainty which could result in higher intake of substances or taking stronger drugs to cope with distress.

5.2 The Experiences of Giving Versus Receiving Support

5.2.1 Long-term Support Does Not Always Mean Unconditional Support

Overall, the majority of residents find multiple benefits from having a supportive person throughout the transition of moving from the streets into their new living space. Through this therapeutic relationship, residents experience motivation, encouragement and flexibility. Residents also appreciate the company from workers as well as their counselling. From the workers' perspective their approach is both pragmatic and humanistic. In essence, their work support HR intervention by helping residents both with trivial as well as complex tasks, placing the residents and their needs at the center of their intervention.

HR practice advocates for ongoing support to HF participants to help them develop healthier behaviors and delivers educational guidance about harmful substance use and its consequences while maintaining a focus on recovery (Mancini & Wyrick-Waugh, 2013). Workers in HF generally offer long-term support, usually for three years, with the goal of helping individuals maintain their housing despite any problems that might be related or not to substance use or abuse. One of the workers, Ed, refers to this type of support as unconditional, meaning that they will support the residents in good and hard times, despite good or bad choices and without passing judgments.

Even though HF programs are more accepting and have less barriers for chronically homeless individuals when compared to staircase programs, their support still is conditional to residents being able to meet the few requirements the programs does have. These conditions include accepting follow-ups with the intervention workers and being part of the fiduciary program that

manages the payment of the rents with private landlords. This accompaniment in the form of follow-ups can sometimes be seen by residents as an imposition as residents cannot opt-out. Being obliged to accept follow-ups is contradictory to the discourse and perception many workers have about offering unconditional support or being a program without conditions or requirements.

Previous research show that using HR principles in intervention can lead to "improved workers and consumer relationships because consumers could be open with the staff about their problems without fear of being judged" (Watson et al., 2013, p. 169). However, this research shows the conditions of the program can create barriers that limit the resident's autonomy which in turn creates friction in the alliance between workers and clients, and may develop distrust, dissatisfaction, and disempowerment.

5.2.2 When Protective Measures Become Harmful

According to Oshana (2005), to be autonomous a person must be able to act on his own behalf and have the capacity to do so. As per the author "an autonomous individual must not in fact be affected […by social institutions…] in ways that render him incapable of self-control and of living a self-directed life" (as cited in Taylor, 2005, p. 184). Analyzed from this perspective, follow-ups and financial support can be looked at as a form of control by the HF institution. In this sense, some practices continue to be a reflection of traditional social intervention approaches, where control is exerted by the social worker. Autonomy is not always expected or accepted from the residents because the worker knows what's best. Hence, little autonomy to make choices makes residents subject to accept conditions and that they might not be comfortable with in order to benefit from different services. Although both of these measures are perceived as protective by the HF project, they do not always settle well with all residents. In fact, some perceive these measurements as paternalistic and even threating their autonomy and self-determination which can be harmful in terms of self-efficacy and self-esteem as well as for the recovery of individuals.

Follow-ups are weekly or biweekly visits in which workers discuss with residents about their needs or goals, review their process and progress and inquire about the challenges and hurdles clients might be having. This research revealed that residents are not always satisfied with this practice. In fact, I found out that this is a polarized topic among participants of the study, while some felt a

strong need to connect often to their worker, others did not. To further explore this nuance, I look at the participant's perception of their relationship with their worker and whether they feel follow-ups are helpful or not.

At least three of the participants describe the relationship in a positive manner. They appreciate what workers bring to the table such as good listening, authenticity, reflective counselling, understanding and their non-judgmental empathic approach. These participants explicitly state feeling motivated and encouraged by the worker when they don't feel well emotionally or when they feel inadequate to complete a task. For example, Leo appreciates the flexibility workers have when it comes to helping out with ordinary activities such as playing with a dog or running errands while Guy appreciated when his worker offered to transport him to his medical appointment when he had difficulty walking. However, two other participants interviewed for this study described a different experience. They seem to view support as pejorative and not as helpful as the other three residents. In their verbatim account, participants explained that they are autonomous, and they know how to obtain the resources they need.

These views reflect reluctance to accept the follow-ups as if this practice threatens the recovery of participant's full autonomy. In the past, HF residents had lost their autonomy due to an inability to provide for their financial needs on their own, difficulty finding housing by themselves and difficulty in recovering their citizenship status. For many, housing represents a change in their social status but also an opportunity to reclaim their independence. Nevertheless, as long as they are in a program like HF their choices are still limited when it comes to being fully autonomous and managing their own finances.

In a similar way, financial support is given in three different forms. First, a federal subsidy is provided to pay part of their rent. Without this subsidy most HF residents will not be able to afford their apartment. Second, residents accept to participate in a fiduciary program within the project which pays the rents to private landlords. And third, residents receive help to create and maintain a budget that allows them to cover their expenses including allocations for substances. In essence, these can be view as protective measures to help individuals fulfill their responsibilities and maintain their housing. From a HR perspective financial support is imperative for residents' stability and social integration goals. However, it is imperative to question the effects of these

imposed practices on people trying to reach full autonomy. In addition, the question can be asked if these practices are legitimizing prejudices and stereotypes with regard to previously homeless individuals and substance users being unable to manage their own finances. This could also reflect the power dynamics that professionals or programs often exercise over vulnerable populations in the name of helping them. These practices can be harmful for some as they deny residents the ability to actively participate in their reinsertion process and thus jeopardize their self-esteem and autonomy.

5.2.3 Resistance and Mistrust

As per workers, supporting clients entails effectively responding to moments of crisis, mistrust or resistance from the part of the residents. In these cases, workers demonstrate using HR principles by providing support through a non-judgmental, non-directive approach. They understand that resistance is often a product of mistrust against the system workers represent. In order to minimize resistance, workers try to make effective use of the therapeutic alliance by building a relationship outside of the normative professional style to include flexible boundaries. This is demonstrated when workers engage with residents in their ordinary day-to-day activities. According to Gagnon et al. (2011) accompanying requires getting a person out of the indifference, anonymity and loneliness by getting involved and not working in an impersonal way or routine manner but always adapting to the situation, putting in time, energy and imagination. For a population that has been disenfranchised, marginalized and left out by multiple systems within society, being present and ensuring accompaniment all along the process might be the only thing that can help them reconnect to society, feel included and ensure better recovery outcomes while avoiding homeless relapses.

Marlatt et al. (2012) state that people are more receptive to interventions when these are empowering and non-directive instead of confrontational, paternalistic and restrictive (p. 25). Regrettably, resistance towards follow-ups can have a negative effect on the relationship between workers and clients hindering the transition process by decreasing opportunities to build trust and to gain insight on the client's truest needs. Mistrust could be related to the unequal balance of power between vulnerable populations and workers that reflects their previous experiences with social services. For a long time, the services offered to individuals experiencing homelessness was based on the treatment first philosophy in which they were treated in a controlling manner and

were told that abstinence was the best for them. The power dynamics imposed by traditional services play an important role inhibiting trust building between workers and residents. These old power dynamics continue to deny access to service users to participate in the development of policy and procedures for programs that are meant to address their needs which is in itself counterproductive to the practice of HR. In addition, power dynamics between the individuals and caseworkers, often reflected a goal setting and decision-making process that is affected by the values of practitioners and institutions (Gagnon et al., 2011). In contrast, accompaniment rejects the perceived 'superiority' of professionals calling for a more egalitarian relationship, in which individuals are allowed to exercise control over their life, choices and decisions, while continuing to receive support in finding solutions to their problems in their own way. Unfortunately, HF is not the exception when it comes to exercising power and control over chronic homeless individuals by imposing practices that often create tension and mistrust incapacitating the therapeutic alliance and potentially reducing opportunities of positive influence that ultimately have an effect in reducing multiple forms of harm.

5.3 Substance Use vs Abuse: Benefits and Risks

The HR approach challenges established beliefs about substance use as well as users, one of them being that all substance use is problematic. The collected data suggest that this is not necessarily the case for everyone. Denning and Little (2012) argue that the motivation for substance use is not self-destruction but rather self-care. In effect, I found that most residents experienced some benefits from substance use, and when managed appropriately, substance use does not disturb their functionality. Nevertheless, it is imperative to analyze the difference between use and abuse from the user's perspective since these two terms are often conflated in the literature on addiction.

In the HR literature, benefits and harms are often used to describe substance use in terms of measuring effects and consequences. HF participants find more positive than negative effects in substance use. Among the benefits participants described were the use of alcohol to reduce anxiety, speed to counteract sexual dysfunction, marijuana to reduce stress and to control hyperactivity, and crack-cocaine to cope with emotional distress. The findings in this research are congruent with Khantizian (1985) who argues that people use drugs or alcohol for purposes such as self-medication. For example, they use "opiates for aggression, stimulates for depression and alcohol

and sedatives for anxiety" (as cited in Marlatt et al., 2012). Even though substance use plays a positive role in the participants' mental health and emotional stability, this research shows that participants will experience negative effects if they stop using. Some participants describe feeling miserable, hyperactive, and stressed when their consumption patterns are disturbed. In this case, there is a double bind, because using drugs can bring long-term harms but not using them can disrupt their short-term functionality.

As a matter of fact, HF residents differentiate between the terms use and abuse based on their level of functionality. In other words, substance users are described as those who are able to remain functional while those who abuse substances are not. Participants assess functionality based on their ability to meet responsibilities such as paying bills, preparing meals, walking their dogs, watering their plants and keep medical appointments. What participants described is congruent with the literature on abuse and dependence in which a dependent person needs the substance to function normally, while a person who abuses a substance is considered to have problematic use patterns that lead to significant impairment and distress (APA, 2013, p. 490).

Despite the benefits described by residents, workers observe that some residents continue to engage in risky behavior such as selling and trading services as well as sharing pipes. As a result, they employ HR to raise awareness as well as to deal with immediate and short-term risks. However, short-term risks cannot be assessed without considering long-term risks as well. Research on addiction have demonstrated that substance users are at a high risk of experiencing long-term negative effects. Veach and Moro (2018), prompt us to reflect on the fact that although some alcohol users are not diagnosed with substance use disorder high levels of drinking can be damaging to health, well-being and longevity. Furthermore, health risks augment when substances are combined, such as the case of some of the participants who use marijuana and prescription drugs, marijuana and speed or crack-cocaine and alcohol. Therefore, while HR practices tackle short-term risks, participants who consume psychoactive substances on a daily basis are still subject to long-term health and social risks and consequences that can be detrimental to their well-being in the long run. As per Marlatt et al. (1988) addictive behavior increases the risk of disease and personal and social problems" (as cited in Griffiths, 2005, p. 192). In addition, given the moral and political climate about substance use, participants have started to experience negative social

impacts such as difficulties in finding a job, creating social networks and engaging in meaningful activities within their neighborhood which in the end can limit their opportunities to reinsert into society.

5.4 Defining Versus Practicing Harm Reduction

5.4.1 Defining Harm Reduction

When questioning residents and workers about the definition of HR, it was surprising to find out that most HF residents were unable to articulate the definition or meaning of these terms, reflecting a lack of understanding of the approach HF uses as a tool to support them. This lack of knowledge prevents individuals from participating in a wide variety of practices, such as peer support, that can further help them. Furthermore, it goes against the practice of HR in itself which advocates for substance users to be educated about the principles of the approach and the inclusion of users in program development and improvement (Marlatt et al., 2012; Pauly et al., 2013). This form of exclusion reduces the chances that drug users have in HF to get involve in the shaping of the programs and policies that serve them.

Although some participants were unable to define the term “Harm Reduction” their accounts demonstrate that not knowing the term does not equate to not using the approach. In fact, when explained the concept through examples, most participants demonstrated important awareness and knowledge about how to reduce the negative effects of substance use. For instance, some participants described using several strategies to mitigate the risks of consumption. These include, consuming at home instead of consuming on the streets, which in their words is less expensive, less stressful and there is a lower risk of engaging in fights. Additionally, some residents mentioned that consuming at home, avoiding trouble and having a ‘trusted’ dealer were also HR strategies they use.

The findings show that participants are intrinsically using pragmatic ways to reduce risk related to substance use. In some cases, residents believe that reducing harm requires them to have a reduced and stable consumption while others believe that staying on drug substitutes such as methadone is

as a way to reduce harm. These findings are consistent with HR principles that view drug users as the primary agents to reduce harm (Marlatt, 1996).

Participants strongly demonstrate that self-awareness regarding their body, substance risks and adequate dosages, constitute a powerful tool to minimize dangers. One of the residents, Dan, highlighted an important negative effect of substance use for men is loss of pride, dignity, self-esteem, and an inability to "keep it together." In contrast, another resident, Carl, states that reducing risks related to drug use is a matter of identity, self-esteem and pride. Therefore, self-awareness and introspection seem to be important aspects related to HR. Participants displaying deep knowledge about their motives to consume and the negative effects of consumption seem to be better equipped to manage their consumption and to maintain substance use stable.

By comparison, workers demonstrate a great understanding of the term "Harm Reduction" not only in definition but also in practice. Workers report using the approach in multiple ways but highlight the use of ambivalence and open-informal discussions. Both of these practical techniques serve to educate and support clients to use substances in a safe manner, while at the same time motivate them to think about making changes with regards to consumption patterns as well as negative behavioral patterns that arise as consumption increases.

5.4.2 Applied Harm Reduction Principles in Intervention

While workers described different approaches to help clients open up about substance use, this research revealed inconsistent results from the residents' sample. Unexpectedly, most residents report that discussions about substance use with intervention workers are limited. This is surprising since one of the areas in which workers using the HR approach support individuals in is their substance use. There could be a few explanations for this discrepancy. One is that since most interviewed participants stated to have a stable consumption, the need for discussions about the topic is not as frequent or as necessary. Another possibility is mistrust from residents who binged drink or consume hard-core substances who might feel ashamed of disclosing an increase in consumption or fearful of having negative consequences that affect their housing. The analysis of this discrepancy prompts me to further examine how workers report using HR. During the focus

group workers report that HR provides support to help people to solve emerging problems, whether related to drugs, adaptation or behavior, and to create awareness about how substance use affects multiple areas such as health, finances and relationships. All of these forms of support can reduce the negative effects of consumption indirectly, especially when most residents use substances to manage stress, loneliness, low self-esteem and emotional pain. Therefore, by addressing all of these issues, workers are ultimately accompanying their clients in reducing their consumption. They are not just seeking to hear about the person's substance use or trying to define their clients use as problematic when the individual does not share this perception, if they were, they would be aligning with the simplistic models of treating consumption as a problem, and not as a symptom. Instead, they are halting situations at early stage that can potentially represent risk for increased consumption.

5.4.3 Risk Management

HR is grounded in the acknowledgment that some people are unable or unwilling to renounce illicit drug use. Therefore, it targets urgent priorities, such as avoiding deaths, reducing the harms of drug laws and policies, and offering alternative paths seeking to prevent or end drug use (HRI, 2019). In HF programs the HR approach begins by reducing the harms associated with substance use and homelessness by providing stable housing and long-term support. However, once the person is housed, HR evolves from pragmatic interventions such as housing provision to multiple forms of awareness about choices, behaviours and risk prevention. Workers state that raising awareness about the effects of drug and alcohol use and helping individuals find alternative and safer coping mechanisms is part of practicing HR.

For workers, helping individuals understand how substance abuse can propitiate high-risk behaviors that affect the person's quality of life is a HR intervention strategy. One of the workers spoke about the importance of reflecting with residents about the direct consequences of substance use. For his client it was understanding that by stealing beer from a convenience store his health was put in danger as he was beaten up and suffered multiple rib fractures. While for another resident the intervention was geared towards creating awareness about the risks of working in exchange for drugs and the dangers that come with it, like being abused by gang members or being

prosecuted and charged for the illicit sale of drugs. As per workers, further reflection on the negative consequences of drug and alcohol use and risky behaviour leads to a positive outcome when individuals are able to realize that risk-behavior is triggered by consumption and that taking dangerous risks not only affects their health but disturbs their stability.

For residents like Carl, HR is about taking responsibility and control of his actions to avoid activities that can result in negative effects for his life such as committing crimes. In addition, Carl demonstrates that having boundaries and using one's ability to reason beyond the desire to consume are key to reducing the adverse consequences of substance use. HR also means learning to manage their desires and impulsions as in the case for Dan. Unfortunately, workers report that many of their clients continue to take risks by engaging in dangerous activities such as stealing, selling drugs, trading services, and loitering. Tiderington et al. (2013) agree that in circumstances where harmful behavior gets out of control, "the harm reduction approach breaks down and case managers find themselves overriding consumer self-determination" (p. 76).

5.4.4 Empowering and Disempowering practices

In a similar way, certain interventions can either empower or disempower clients based on their capacity to do things on their own. For instance, some clients are encouraged to make their own choices, find solutions to their problems and think critically about their behaviour and the risks they take. For other clients, this type of intervention can be disempowering when capacity building could be done with anyone, at their own pace and within their limits. This research shows that clients with learning disabilities have more difficulty communicating over the phone with different entities such as banks, government and health services, due to their complicated and bureaucratic systems. Therefore, workers that support residents by making calls for them or reading and explaining letters from the government reduce unnecessary frustration, stress and anxiety which could potentially lead to an increase in consumption. This reflects the HR principle of meeting the client where they are at.

Even though, the use of empowering practices might not seem directly related to substance use or HR in itself, some studies show that "prevention, intervention, policy education and advocacy that

is more client-driven may be more acceptable, feasible, and empowering than approaches that involve predetermined goals based on researchers' and treatment providers' own values norms and interest" (as cited in Marlatt et al., 2012, p. 25). Therefore, fostering empowerment and self-determination based on clients' needs and capacities and taking into consideration the person's level of autonomy can set the stage for interventions targeting substance abuse and high-risk behavior.

Pauly and colleagues (2013) suggest that HR is optimized through social inclusion, which requires the participation of people who use drugs and alcohol in the development of policies and programs to address their needs. The authors argue that effective HR strategies need the involvement of substance users because it breaks the stigma, improves services, and increases individual control over health determinants. Unfortunately, during this research I observed that residents are not necessarily included in the development of programs or activities targeting specifically HR. On the contrary, it seems like residents are less heard when voicing some of their needs, as it was the case of Leo who seeks to move to another apartment but whose request has been unaddressed, putting him in a vulnerable position.

5.5 Fighting Isolation While Finding a Place in Society

The HR approach acknowledges that substance abuse brings on negative consequences for individuals, communities, and society as a whole (Brisson, 1997). Nevertheless, others suggest that for people with a history of chronic homelessness, addressing substance use might be the least of their worries, when compared to taking care of "criminal justice entanglements, poverty, unemployment, housing problems, [stigma], trauma histories and other complications" (Padgett, et al., 2008, p. 333). The research revealed that for most residents addressing substance use is not necessarily a priority. In fact, when asked about current goals and substance use goals most people highlighted their need to break isolation, find employment and staying out of trouble more so than changing their current consumption habits.

Service providers have identified isolation as an essential target of intervention, especially when taking into account that social interactions and networks can lead to positive or harmful outcomes within the homeless population (Padgett et al., 2008). In a similar way, employment has been

historically seen as imperative for social inclusion and social reinsertion (Castel, 1994). Moreover, labor is often inherently a form of breaking isolation, which might influence directly or indirectly substance use and risk factors for criminal behaviour. Nevertheless, "physical environment is only one aspect of the environment and its impact on risk factors for problematic drug use will depend upon other contextual factors such as the social and policy environments" (Spooner and Hetherington, 2004, p. 174).

Studies addressing social and community integration for HF participants establish that social networks and reestablishing links with family are positive evidence of social reinsertion (Padgett et al., 2008). As per Hogan and Carling (1992) scattered housing can be conductive to consumer community integration (as cited in Tsemberis & Henwood, 2016). However, during the interview process, most residents were located far from the city's downtown core where they had been living for the past three to four years. Relocating individuals outside of their habitual neighborhoods can produce isolation by moving them away from known services and places towards isolated areas where they need to familiarize themselves with the area and must try to build a new community. That said, some residents found that moving away from the downtown community is best for them. Partly for fear of falling into patterns of consumption, partly because some consider this population to be problematic and partly because they no longer identify with this community. Workers state that some of their clients get extremely bored and miss their old friends while others are afraid of the stigma related to substance use. As is the case of Carl who described some of the negative effects of using substances including being stigmatized and portraying a negative image. Carl states that he does not consume outside of his house because he does not want to be labelled as a drug addict. Gowan, Whetstone, and Andic (2012) state that "stigmatization of the illicit drug user as "powerless" to a drug is considered an obstacle to employing HR strategies in one's life" (as cited in Boucher et al., 2017, p. 2). Therefore, focusing on destigmatization and incremental control creates the preconditions for social inclusion and social citizenship (Gowan et al., 2012).

5.6 Implications for practicing Harm Reduction in Housing First projects

The practice of HR in HF projects goes beyond providing safe consumption kits to individuals at risk. In a broader scope, practicing HR ought to ensure secure and stable environments where

people's basic needs are met. The findings of this thesis reveal that housing is a tool for motivation to change, review consumption habits, and evaluate risks related to substance use for the interviewed residents and workers. In addition, HF services such as long-term psychosocial and financial support, act as protective measures that help individuals stay housed and rebuild social structures after homelessness while addressing mental health and substance use problems. However, it is essential to acknowledge that people enduring or having experienced homelessness have individual needs that require different levels of care and services.

The person's degree of autonomy plays a vital role in the way residents perceive and receive long-term psychosocial and financial support. While some residents require more assistance due to their level of education or ability to navigate the health system and social services, others prefer to have more autonomy and be less dependent on the program structure. For the latter, continual support can be perceived as derogatory and impairing to their independence and self-determination. Since housing is conditional to accepting these services, not abiding by them will result in a higher risk of homeless relapse, thereby increasing harm instead of reducing it. Imposed services can also create constraints in the therapeutic alliance by decreasing the ability workers have to connect with residents. Therefore, the practice of social work using the HR approach in community settings must guarantee interventions that respect people's levels of autonomy, acknowledge the place substances occupy in the lives of residents, and creates opportunities for residents' participation in HR measures. In addition, HF based projects using the HR approach need to consider how long-term support can affect the individual's worth, self-determination, and social responsibility. These are central principles in the person-centered approach (Greene, 2008).

The study also revealed a low involvement of interventions targeting drug use directly. The HR approach specifically applied in community-based programs such as HF, seems underused, although not unexplored. The research shows limited knowledge about the approach and little education conducted regarding its model and its tools. Alternatively, this could indicate that workers need to be better trained to use the approach with all participants regardless of their consumption level since abusive patters can erupt sporadically. Several studies suggest that lack of understanding of the term HR, lack of fidelity to its guidelines, and lack of training on the approach represent significant barriers to HR's implementation within HF programs (Watson et al., 2017; Pauly et al., 2013).

In social work practice, HR ought to be recognized and use to improve outreach, the fostering of substance user groups, the involvement of residents in the development of programs, education and risk awareness. Used in this way HR can help social workers to address the stigma of substance use and advocating for the rights of those who use illicit substances (Friedman et al., 2007). Since these practices are not being implemented in the HF project under study, the approach is not used to its full potential. Finally, using the HR approach should call for higher education about treatment programs considering the long-term health and social effects of substance use. This could reduce common social harms faced by HF residents which include unemployment and difficulty forging social networks with non-substance users, often leading to isolation.

Despite the lack of education about the HR approach, residents demonstrate that they have learned from experience how to reduce the harmful effects of substance use. Some have reduced or stabilize their consumption, others are using drug substitutes, and others are just avoiding engaging in dangerous activities. Contrary to common assumptions, participants engaging in HR demonstrate an exceptional level of self-awareness about drug use, their reasons to consume, and how to take care of themselves. Most residents want to reduce risk simply because they don't want to experience the adverse effects of uncontrolled substance use; instead, they use self-regulation to control substance use. For the practice of social work, HR interventions can be optimized when workers use the inherent person's capacity to have emotional regulation and self-efficacy to help the propose different ways to address substance use problems. Participants' ability to self-reflect, to regulate, to change, and to want better things for themselves represent intrinsic HR tools. Therefore, it is evident in this research that HR is not only achieved through ontological security or psychosocial support; instead, it comes from an individual's realizations, knowledge about substance use, and capacity to make choices that are beneficial for themselves.

Conclusion

The practice of HR implemented under the HF framework, plays an important role in reducing chronic homelessness, fostering housing stability and avoiding homelessness relapse. Housing provision and stability is the first step and most important step towards reducing social, health, psychological and economic harms for individuals who previously experienced chronic homelessness. These findings are similar to those seen in previous studies which demonstrate that housing provides a stable environment that reduces several adverse risks related to substance use. Nevertheless, the fact that HF cannot guarantee permanent housing can be detrimental to the participant's ontological security and achievement of HR goals in the long term by creating stress and uncertainty which could result in an increase of substance use to cope with distress.

From a humanistic perspective, the HR approach is used to upend practices that portray individuals in homelessness as undeserving and perpetuate their status by making access to housing contingent on substance use treatment. By favouring low-barrier access to housing while offering long-term support, HR helps the fostering of a therapeutic alliance between workers and clients. Financial and psychosocial support helps residents maintain stability while avoiding the risk of engaging in criminal activities due to lack of resources. However, imposed HF conditions such as follow-ups and the fiduciary compliance can hinder the resident's autonomy and self-determination because residents cannot opt out. In this case, the use of empowerment and respect for self-determination as a tool to facilitate HR interventions require careful consideration of the person's needs, capacities and level of autonomy.

This research findings about the practice of HR in HF challenged established beliefs about substance use as well as substance users. The collected data suggests that contrary to popular beliefs, residents do not necessarily perceive substance use as problematic. Instead, the experiences described by both workers and participants help to recognize the value individuals find in substance use as well as the disadvantages that stop using will bring to those with substance dependency. Clearly, the practice of HR in HF programs require a deep understanding of the role of substances in individual's live and their experiences with regards of consumption needs to be acknowledged and legitimized. In addition, HR interventions addressing HF residents need to be

understood within the larger context of short and long-term risks to help reduce mortality rates, health deterioration and other social harms such as isolation and stigmatization.

This study revealed that HF residents have poor knowledge of the HR approach in comparison to HF workers. The findings show that there is a lack of education with regards the approach. This puts the effectiveness of the approach at risk, denying clients vital opportunities to actively shape and inform the program that serves them.-Nevertheless, participants recognize using HR tools even if they are unable to define the terms. For instance, residents practice HR by having dosage stability, choosing less harmful substances, using substance substitutes and changing their behaviour based on the acknowledgment of the negative consequences that come with abusing substances.

Several limitations exist in this research due to the nature of the study. First of all, the residents' sample is not representative of the ensemble of the program residents. Therefore, their responses are not generalizable to the rest of participants of HF projects in Montreal. In fact, some of the reports received from resident's clash in several ways to the reports I obtain from workers, specifically with regards of consumption goals and risk behavior. One of the blind spots in this research resulted from having limited data from the focus group. Instead of collecting data from five workers individually, which would have amounted approximately to five hours of information, I am drawing on data from a one-hour focus group. The intent of doing a focus group with workers was to explore their understanding and interpretation of their use of HR in intervention. However, time constraints limited the possibility to investigate the role of HR in helping residents reinsert into society. Therefore, while there was a good amount of data on this subject from the residents' perspective, it was difficult to contrast it to the workers experience related to this topic.

In addition, the experiences of workers and participants are considerably different, as only five HF residents were recruited. Whereas, the workers accounts reflected their experiences with over 90 clients, considering that each worker has a caseload of about 18 clients. While residents reported seeing improvements in substance use, risk management and self-awareness, these seems to be only true for a small percentage of cases. Workers report that many of their clients do not practice HR, have problematic substance use and often engage in high-risk behaviours.

It was difficult to conceptualize the aspect of social inclusion that was mobilized in the conceptual framework. The initial intention was to explore the role of HR in promoting social inclusion for people who are often marginalized and stigmatized due to substance use and how these forms of social harms interfere with the process of social reinsertion for HF residents. Unfortunately, the collected data did not provide vast information on this aspect, other than highlighting the lack of HR education and inclusion of residents in the development programs and initiatives to address their needs. This gap in the results reflect perhaps a lack of intention in the way the methodology was deployed, that is concentrating the questions more on housing and HR and less on social integration. Therefore, more research needs to be developed with regards of HR specifically within the context of housing programs in order to better understand its role in social reinsertion. It would also be interesting to inquire about the perception of HF landlords with regards to HR and how this affects the search for housing. Finally, further investigations need to be done to assess the role of HR in social inclusion for people who are active substance users.

Conclusively, the study of HR interventions within the HF context provide three important lessons. First of all, the approach needs to be actualized by positioning it within a framework in which people who use substances are educated and knowledgeable about HR in order to maximize the benefits of this approach. Second, workers need to be better trained and the organizations that supervise HF programs need to be accountable to provide clear protocols that are committed to HR vision and values. Third, HR needs to be practiced within a broad social work framework that not only focuses on reducing the risk associated with substances but fosters empowerment and self-determination to people in accordance to their needs, capacities and level of autonomy.

It is evident that people who use substances have the inherent capacity to make positive changes and to reduce harm associated with drug use when they are empowered to be autonomous in their choices, decisions and goals, and have structural and systemic supports that promote social inclusion. However, questions remain. Are previously homeless people, now HF residents, seen as primary agents of HR ? if they are, why is the program not inviting them to transfer that knowledge with others ? How can social workers in the field help thwart structural barriers affecting the use of HR with individuals in HF ?

References

About-affordable-housing-in-canada. (2018) Canada Mortgage and Housing Corporation (CMHC) Retrieved August 21, 2018, from https://www.cmhc-schl.gc.ca/en/Developing-and-Renovating/Develop-New-Affordable-Housing/Programs-and-information/About-Affordable-Housing-in-Canada

Alcoholics Anonymous World Services (2019). What Is A.A.? Retrieved from https://www.aa.org/pages/en_us/what-is-aa

Allman, D. (2013). The Sociology of Social Inclusion. *SAGE Open*. https://doi.org/10.1177/2158244012471957

Aranguiz, M., & Fecteau, J. (2000). L'école de la précaieté : Vagabonds et Errants à Montréal au tournant du siècle. In D. Laberge (Author), *L'errance urbaine* (pp. 11-27). Québec, Canada: Editions MultiMondes.

ASAM, American Society of Addiction Medicine. (2011). Definition of Addiction. Retrieved from https://www.asam.org/resources/definition-of-addiction

Barry, C., Sherman, S., Stone, E., Kennedy-Hendricks, A., Niederdeppe, J., Linden, S., & McGinty, E. (2018). Arguments supporting and opposing legalization of safe consumption sites in the U.S. *International Journal of Drug Policy, 63*, 18-22. doi:10.1016/j.drugpo.2018.10.008

Beaudoin, I. (2016). Efficacité de l'approche « logement d'abord » : une revue systématique. *Drogues, santé et société*, *14*(2), 43–69. https://doi.org/10.7202/1037732ar

Bellot, C,. & Sylvestre, M. (2017). La judiciarisation de l'itinérance à Montréal: les dérives sécuritaires de la gestion pénale de la pauvreté. Revue générale de droit, 47, 11–44. https://doi.org/10.7202/1040516ar

Bergheul, S. (2015). *Regards croisés sur l'itinérance*. Québec (Québec): Presses de l'Université du Québec.

Bossé, Y. (1998). Introduction à l'intervention centrée sur le pouvoir d'agir . *Cahiers de la recherche en éducation, 5*(3), 349-370. doi:10.7202/1017126ar http://id.erudit.org/iderudit/1017126ar

Boucher, L.M., Marshall, Z., Martin, A. *et al.* (2017) Expanding conceptualizations of harm reduction: results from a qualitative community-based participatory research study with people who inject drugs. *Harm Reduction Journal. p.* 14-18 doi:10.1186/s12954-017-0145-2

Brisson, P. (1997). *L'approche de réduction des méfaits : sources, situation, pratiques*. Comité permanent de lutte à la toxicomanie (CPLT). 109 pages. Retrived from http://www.santecom.qc.ca/BibliothequeVirtuelle/CPLT/2550325826.pdf

Brooks, F., & McHenry, B. ((2015). *A Contemporary Approach to Substance Use Disorders And Addiction Counseling*(Second ed ed.). Alexandria, VA: American Counseling Association.

Bui, N., Y. (2014). How to Write a Master's Thesis. 2ed. Los Angeles: SAGE

Carey, M. (2012). *Qualitative research skills for social work: Theory and practice*. Farnham Surrey, England: Ashgate.

CMHC, Canada Mortgage and Housing Corporation. (2011). The Evolution of Social Housing in Canada. Retrieved from https://www.francinetracey.com/documents/CMHC-2011.pdf

Collins, S., Clifasefi, S., Dana, E., Andrasik, M., Stahl, N., Kirouac, M., . . . Malone, D. (2012). Where harm reduction meets housing first: Exploring alcohol's role in a project-based housing first setting. *International Journal of Drug Policy, 23*(2), 111-119. doi:10.1016/j.drugpo.2011.07.010

Collins, S. E., Clifasefi , S. L., Logan, D. E., Samples, L. S., Somers, J., & Marlatt, A. Current Status, Historical Highlights, and Basic Principles of Harm Reduction. (2012) In *Harm Reduction: Pragmatic Strategies for Managing High-Risk Behaviors*(2nd ed.). Guilford Publications.

Collins, S. E., Grazioli, V. S., Torres, N. I., Taylor, E. M., Jones, C. B., Hoffman, G. E., et al., (2015). Qualitatively and quantitatively evaluating harm-reduction goal setting among chronically homeless individuals with alcohol dependence. *Addictive Behaviors,45*, 184-190. doi:10.1016/j.addbeh.2015.02.001

Collins, S. E., Malone, D. K., Clifasefi, S. L., Ginzler, J. A., Garner, M. D., Burlingham, B., et al., (2012). Project-Based Housing First for Chronically Homeless Individuals With Alcohol Problems: Within-Subjects Analyses of 2-Year Alcohol Trajectories. *American Journal of Public Health,102*(3), 511-519. doi:10.2105/ajph.2011.300403

Collins, S. E., Malone, D. K., & Larimer, M. E. (2012). Motivation to change and treatment attendance as predictors of alcohol-use outcomes among project-based Housing First residents. *Addictive Behaviors,37*(8), 931-939. doi:10.1016/j.addbeh.2012.03.029

Culhane, D. P., Metraux, S., & Hadley, T. (2002). Public service reductions associated with placement of homeless persons with severe mental illness in supportive housing. *Housing Policy Debate,13*(1), 107-163. doi:10.1080/10511482.2002.9521437

Davidson, N. (2006). "Housing First" for the Chronically Homeless: Challenges of a New Service Model. *Journal of Affordable Housing & Community Development Law, 15*(2), 125-136. Retrieved from http://www.jstor.org/stable/25782781

Denning, P. (2000). Practicing harm reduction psychotherapy: An alternative approach to addictions. New York: Guilford Publications.

Denning, P., & Little, J. (2012). Practicing harm reduction psychotherapy: An alternative approach to addictions. 2nd edition New York: Guilford Press.

DiClemente, C.C., & Scott, C.W. (1977). Stages of change: interactions with treatment compliance and involvement. In L.S. Onken, J.D. Blaine, & J.J. Boren (Eds.), Beyond the therapeutic alliance: Keeping the drug-dependent individual in treatment (National Institute on Drug Abuse Research Monograph 165). Washington DC: U.S. Government Printing Office.

Dolbeare, C.N., (1996). Housing Policy: A general consideration. In Baumohl, J., & National Coalition for the Homeless (U.S.). *Homelessness in America*. pp 34-37 Phoenix, Ariz: Oryx Press.

Dorvil, H., & Boucher, S. (2013). *Le logement comme facteur d'intégration sociale pour les personnes itinérantes aux prises avec des problèmes de santé mentale participant au Projet Chez Soi à Montréal* (pp. 1–129). Montreal, QC: UQAM -Faculté de sciences humaines. Retrieved from https://www.cremis.ca/publications-et-outils/toutes-les-publications/rapports-de-recherche/le-logement-comme-facteur-dintegration-sociale-pour-les-personnes-itinerantes-aux

Dyb, E. (2016). Housing First or no housing? Housing and homelessness at the end of alcohol and drug treatment. *International Journal of Drug Policy,36*, 76-84. doi:10.1016/j.drugpo.2016.07.003

Exclusion : UNESCO . (2017). Retrieved from http://www.unesco.org/new/en/social-and-human-sciences/themes/international-migration/glossary/exclusion/

Forte, J. A. (2014). *Skills for using theory in social work 32 lessons for evidence-informed practice*. Abingdon, Oxon: Routledge.

Friedman, S. R., de Jong, W., Rossi, D., Touzé, G., Rockwell, R., Des Jarlais, D. C., & Elovich, R. (2007). Harm reduction theory: Users' culture, micro-social indigenous harm reduction, and the self-organization and outside-organizing of users' groups. International Journal of Drug Policy, 18, 107-117. doi:10.1016/j.drugpo.2006.11.006

Gaetz, S., Dej, E., Richter, T., & Redman, M. (2016). The State of Homelessness in Canada 2016. Toronto: Canadian Observatory on Homelessness Press. Retrieved from

https://homelesshub.ca/sites/default/files/SOHC16_final_20Oct2016.pdf

Gaetz, S. Barr, C. Friesen, A, Harris, B. Hill, C. Kovacs-Burns, K. Pauly, B. Pearce, B. Turner, A. Marsolais, A. (2012). Canadian Definition of Homelessness. Toronto: Canadian Observatory on Homelessness Press. Retrieved from https://www.homelesshub.ca/sites/default/files/COHhomelessdefinition.pdf

Gaetz, S. (2012). The Real Cost of Homelessness: Can We Save Money by Doing the Right Thing? Toronto: Canadian Homelessness Research Network Press. Retrieved from https://www.homelesshub.ca/sites/default/files/attachments/costofhomelessness_paper21092012.pdf

Gaetz, S., Donaldson, J.,Richter, T,. Gullivert, T. (2013). The State of Homelessness in Canada 2013. Toronto, CA: Homeless Hub. Canadian Homelessness Research Network Press. Retrieved from http://homelesshub.ca/sites/default/files/SOHC2103.pdf

Gaetz, S., Gullivert, T., Richter, T. (2014). The State of Homelessness in Canada 2014. Toronto, CA: Homeless Hub. Canadian Homelessness Research Network Press. Retrieved from https://www.homelesshub.ca/sites/default/files/attachments/SOHC2014.pdf

Gaetz, S., Scott, F., & Gulliver, T. (Eds.) (2013): Housing First in Canada: Supporting Communities to End Homelessness. Toronto: Canadian Homelessness Research Network Press. https://www.homelesshub.ca/sites/default/files/HousingFirstInCanada.pdf

Gagnon, É., Moulin, P. & Eysermann, B. (2011). Ce qu'accompagner veut dire. Reflets, 17(1), 90–111. https://doi.org/10.7202/1005234ar

Galea, S., & Vlahov, D. (2002). Social determinants and the health of drug users: socioeconomic status, homelessness, and incarceration. *Public health reports (Washington, D.C. : 1974)*, *117 Suppl 1*(Suppl 1), S135-45.

Gaudreau, P., (2016). 3000 ou 30 000 sans abri ?. *L'itinierance a Montreal au-delà des chiffres, RAPSIM.* Montréal, QC. Retrieved from http://www.rapsim.org/docs/Itin%C3%A9rance%20%C3%A0%20Montr%C3%A9al-version%20pdf.pdf

Goering, P., Streiner, L., Adair, C., Aubry, T., Barker, J., Distasio, J., Hwang, S. W., Komaroff, J., Latimer, E., Somers, J., … Zabkiewicz, D. M. (2011). The At Home/Chez Soi trial protocol: a pragmatic, multi-site, randomised controlled trial of a Housing First intervention for homeless individuals with mental illness in five Canadian cities. *BMJ open*, *1*(2), e000323. doi:10.1136/bmjopen-2011-000323

Goering, P., Tolomiczenko, G., Sheldon, T., Boydell, K., & Wasylenki, D. (2002). Characteristics of persons who are homeless for the first time. *Psychiatric Services (washington, D.c.), 53*(11), 1472-4

Goffman, E. (1987). *Stigmate- les usages sociaux des handicaps.* Edition de minuit.

Greene, R. (2008). Human Behavior Theory and Social Work Practice. New York: Routledge, https://doi.org/10.4324/9781351310369

Griffiths, M. (2005). A 'components' model of addiction within a biopsychosocial framework, Journal of Substance Use, 10:4, 191-197, DOI: 10.1080/14659890500114359

Grinman, M. N., Chiu, S., Redelmeier, D. A., Levinson, W., Kiss, A., Tolomiczenko, G., Cowan, L., … Hwang, S. W. (2010). Drug problems among homeless individuals in Toronto, Canada: prevalence, drugs of choice, and relation to health status. *BMC public health*, *10*, 94. doi:10.1186/1471-2458-10-94

Guest, G., MacQueen, K. M., & Namey, E. E. (2012). *Applied thematic analysis*. Thousand Oaks, CA: SAGE Publications, Inc. doi: 10.4135/9781483384436

Harm reduction International (2019). What is Harm Reduction. Retrieved from https://www.hri.global/what-is-harm-reduction

Harris, S. R. (2006). Social Constructionism and Social Inequality: An Introduction to a Special Issue of JCE. Journal of Contemporary Ethnography, 35(3), 223–235. https://doi.org/10.1177/0891241606286816

Heather, N., (2017). Q: Is Addiction a Brain Disease or a Moral Failing? A: Neither. *Neuroethics*, *10*(1), 115-124. doi: [10.1007/s12152-016-9289-0]

Henwood, B. F., Padgett, D. K., & Tiderington, E. (2014). Provider views of harm reduction versus abstinence policies within homeless services for dually diagnosed adults. *The journal of behavioral health services & research*, *41*(1), 80-9. doi: 10.1007/s11414-013-9318-2

Henwood, B. F., Stanhope, V., & Padgett, D. K. (2011). The Role of Housing: A Comparison of Front-Line Provider Views in Housing First and Traditional Programs. *Administration and Policy in Mental Health and Mental Health Services Research,38*(2), 77-85. doi:10.1007/s10488-010-0303-2

Heyman, G., M., (2013). Addiction and choice: theory and new data. *Frontiers in psychiatry*, *4*, 31. doi:10.3389/fpsyt.2013.00031

Hohman, M. (2012). *Applications of motivational interviewing. Motivational interviewing in social work practice.* Guilford Press.

Hsiung, P., C. (2008). Teaching Reflexivity in Qualitative Interviewing. Teaching Sociology, 36(3), 211–226. https://doi.org/10.1177/0092055X0803600302

Hwang, S. W. (2000). Mortality among men using homeless shelters in Toronto, Ontario. *The Journal of the American Medical Association*, 283(16), 2152-2157. Retrieved from https://jamanetwork.com/journals/jama/fullarticle/192620

Institute of Medicine. (2007). *Preventing HIV Infection Among Injecting Drug Users in High-Risk Countries: An Assessment of the Evidence*. Washington, DC: The National Academies Press. https://doi.org/10.17226/11731.

Kertesz, S. G., Crouch, K., Milby, J. B., Cusimano, R. E., & Schumacher, J. E. (2009). Housing first for homeless persons with active addiction: are we overreaching?. *The Milbank quarterly*, *87*(2), 495-534. doi: 10.1111/j.1468-0009.2009.00565.x

Kertesz, S., Larson, M., Horton, N., Winter, M., Saitz, R., & Samet, J. (2005). Homeless chronicity and health-related quality of life trajectories among adults with addictions. *Medical Care, 43*(6), 574-585. doi:10.1097/01.mlr.0000163652.91463.b4

Koegel, P. (2004). Causes of homelessness: overview. In D. Levinson (Ed.), *Encyclopedia of homelessness* (Vol. 1, pp. 51-58). Thousand Oaks, CA: SAGE Publications, Inc. doi: 10.4135/9781412952569.n21

Kraus, D., Serge, L. & Goldberg, M. (2006). Housing and services for people with substance abuse and mental health issues. Prepared by the Social Planning and Research Council of BC (SPARC BC) for the Housing and Homelessness Branch, Human Resources and Social Development Canada.

Landry, M., & Lecavalier, M. (2003). L'approche de réduction des méfaits : Un facteur de changement dans le champ de la réadaptation en toxicomanie. *Drogues, Santé Et Société,2*(1), 1-13. Retrieved from http://droguess.whc.ca/wp-content/uploads/2012/10/vol2_no1_7.pdf

Langer, C., & Lietz, C. (2015). *Applying theory to generalist social work practice*. John Wiley & Sons.

Larimer, M. E., Malone, D. K., Garner, M. D., Atkins, D. C., Burlingham, B., Lonczak, H. S., et al. (2009). Health care and public service use and costs before and after provision of housing for chronically homeless persons with severe alcohol problems. *Journal of the American Medical Association*, 301, 1349–1357. doi:10.1001/jama.2009.414.

Lassiter, P. S., & Spivey., M. (2018). Historical Perspectives and the Moral Model. In P. S. Lassiter & J. R. Culbreth (Authors), *Theory and practice of addiction counseling*. Thousand Oaks, CA: SAGE Publications.

Latimer, E., MacGregor, J., Méthot, C., & Smith, A. (2015). I Count MTL 2015: Count and Survey of Montreal 's Homeless Population on March 24 , 2015 . 1-81. Retrieved March 15, 2017, from http://ville.montreal.qc.ca/pls/portal/docs/page/d_social_fr/media/documents/I_Count_MTL_2015_report.pdf

Latimer, E., Bordeleau, F. (2019). Je compte MTL 2018: Dénombrement des personnes en situation d'itinérance sur l'île de Montréal le 24 avril 2018. 1-143. Retrieved from https://jecomptemtl2018.ca/wp-content/uploads/2019/04/rapport-montral-rvision-8-avril-2019.pdf

Lesemann, F. & Martin, C. (1992). Prendre soin : liens sociaux et médiations institutionnelles. International Review of Community Development / Revue internationale d'action communautaire, (28), 7–11. https://doi.org/10.7202/1033799ar

MacNeil, J., & Pauly, B. (2011). Needle exchange as a safe haven in an unsafe world. *Drug and Alcohol Review,30*(1), 26-32. doi:10.1111/j.1465-3362.2010.00188.x

Maison l'Exode. (n.d.). Réinsertion sociale progressive à Montréal - Retrieved from http://www.maison-exode.org/reinsertion-sociale-progressive/

Mancini, M. A., & Wyrick-Waugh, W. (2013). Consumer and Practitioner Perceptions of the Harm Reduction Approach in a Community Mental Health Setting. *Community Mental Health Journal,49*(1), 14-24. doi:10.1007/s10597-011-9451-4

Marlatt, G. (1996). Harm Reduction: Come as you are. *Addictive Behaviors, 21*(6), 779-88. https://doi.org/10.1016/0306-4603(96)00042-1

Marlatt, G. A., Latimer, M. E., & Witkiewitz, K. (2012). *Harm Reduction, Pragmatic Strategies For Managing High Risk Behaviours* (2nd ed.). New York: Guilford Press.

Ménard, J., & Simard, M. (2013). Toxicomanie et itinérance : Un modèle d'intervention intégrée. *Domrémy-de-la-Mauricie / Centre-du-Québec, 25*(1). Retrieved December 3, 2016, from http://www.domremymcq.ca/fichiers/Documents/info-toxico_avril-2013.pdf

Milby, J. B., Schumacher, J. E., Wallace, D., Freedman, M. J., & Vuchinich, R. E. (2005). To house or not to house: the effects of providing housing to homeless substance abusers in treatment. *American journal of public health*, *95*(7), 1259–1265. https://doi.org/10.2105/AJPH.2004.039743

Ministère de la Santé et des Services Sociaux. (2014). *Politique nationale de lutte à l'itinérance - Ensemble pour éviter la rue et en sortir.* Publication no : 13-846-03F Retrieved from https://publications.msss.gouv.qc.ca/msss/document-000174/

Neukrug, E. (1994). *Theory, practice, and trends in human services: An overview of an emerging profession*. Pacific Grove, CA: Brooks-Cole.

Ninacs, W. A. (1995). Empowerment et service social : approches et enjeux. *Service social, 44*(1), 69. polysémie d'un mot », L'Année sociologique 2008/2 (Vol. 58), p. 299-318. doi:10.7202/706681ar

OHTN (2009). *Housing and Harm Reduction*. Rapid Response Service. Rapid Review no 7: Toronto. Retrieved from: http://www.ohtn.on.ca/Pages/Knowledge-Exchange/Rapid-Responses/Documents/RR07-2009-Housing-Harm-Reduction.pdf

OHTN (2012). Public Perception of Harm Reduction Interventions. Rapid Response Service. Toronto, ON: Ontario HIV Treatment Network; Retrieved from http://www.ohtn.on.ca/wp-content/uploads/rapid-response/RR63-2012-Public-Perception-HR-Interventions-1.pdf

Padget, D., K. Gulcur, L., Tsemberis, S., (2010). Housing first services for people who are homeless with co-occurring serious mental illness and substance abuse. In K. Van Wormer & B. Thyer (Eds.), *Evidence-based practice in the field of substance abuse: A book of readings*. (pp.248-260)Thousand Oaks, Calif.: Sage.

Padgett, D. K., Henwood, B., Abrams, C., & Davis, A. (2008). Engagement and retention in services among formerly homeless adults with co-occurring mental illness and substance abuse: Voices from the margins. *Psychiatric Rehabilitation Journal,31*(3), 226-233. doi:10.2975/31.3.2008.226.233

Padgett, D. K., Henwood, B. , Abrams, C. and Drake, R. E. (2008), Social Relationships Among Persons Who Have Experienced Serious Mental Illness, Substance Abuse, and Homelessness: Implications for Recovery. American Journal of Orthopsychiatry, 78: 333-339. doi:10.1037/a0014155

Padgett, D. K., Henwood, B. F., & Tsemberis, S. J. (2015). Paradigm Shifts and Systems Change. In *Housing First: Ending Homelessness, Transforming Systems, and Changing Lives*(pp. 1-19). Oxford Scholarship Online. D 10.1093/acprof:oso/9780199989805.001.0001

Padgett, D. K., Stanhope, V., Henwood, B. F., & Stefancic, A. (2011). Substance Use Outcomes Among Homeless Clients with Serious Mental Illness: Comparing Housing First with Treatment First Programs. *Community Mental Health Journal,47*(2), 227-232. doi:10.1007/s10597-009-9283-7

Parekh, R. (2017) What Is Addiction? Retrieved from https://www.psychiatry.org/patients-families/addiction/what-is-addiction

Pathak, V., Jena, B., & Kalra, S. (2013). Qualitative research. *Perspectives in clinical research*, *4*(3), 192.

Pauly, B., Reist, D., Belle-Isle, L., & Schactman, C. (2013). Housing and Harm Reduction: What is the role of harm reduction in addressing homelessness? *International Journal of Drug Policy,24*(4), 284-290. doi:10.1016/j.drugpo.2013.03.008

Paugam, S. (1998). Les formes contemporaines de la pauvreté et de l'exclusion. Le point de vue sociologique. Genèse, 31, pp. 138-159.

Payne, M. (2014). *Modern social work theory* (4th ed.). Chicago, Illinois: Lyceum Books.
Shebib, B. (2011). *Choices: Interviewing and counselling skills for canadians*(4th ed.). Toronto: Prentice Canada.

Pearson, C., Locke, G., Montgomery, A. E., & Buron, L. (2007). *The applicability of Housing First models to homeless persons with serious mental illness: Final report* (Department of Housing and Urban Development., Office of Policy Development and Research.)Washington, D.C.: U.S. Retrieved from https://www.huduser.gov/portal/publications/hsgfirst.pdf

Pleace, N. (2013). Consumer Choice in Housing First. *European Journal of Homelessness*, *7*(2), 329-339. Retrieved from https://www.feantsa.org/download/np_response6502075727440568644.pdf

PLM. (2017). Projet Logement Montreal, Qui sommes-nous ? Retrieved from http://www.projetlogementmontreal.org/services

Pomeroy, S. (2005). *The Cost of Homelessness: Analysis of Alternate Responses in Four Canadian Cities*(pp. 1-30) (Canada, National Secretariat on Homelessness). Focus Consulting. Retived from https://www.homelesshub.ca/sites/default/files/attachments/Cost_of_Homelessness_Pomeroy_English.pdf

Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change: Applications to addictive behaviors. *American Psychologist, 47*(9), 1102–1114. https://doi.org/10.1037/0003-066X.47.9.1102

Quilgars, D., & Pleace, N. (2016). Housing First and Social Integration: A Realistic Aim? *Social Inclusion,4*(4), 5. doi:10.17645/si.v4i4.672

Réseau d'aide aux personnes seules et itinerantes de Montreal (RAPSIM). (2003). *Comprendre l'itinerance. http://www.rapsim.org/docs/comprendreLitinerance.pdf*

Rhoades, H., La Motte-Kerr, W., Duan, L., Woo, D., Rice, E., Henwood, B., Harris, T., & Wenzel, S. (2018). Social networks and substance use after transitioning into permanent supportive housing. *Drug and Alcohol Dependence, 191*, 63-69. Doi.org/10.1016/j.drugalcdep.2018.06.027

Rhodes T. (2009). Risk environments and drug harms: a social science for harm reduction approach. *The International journal on drug policy*, *20*(3), 193–201. https://doi.org/10.1016/j.drugpo.2008.10.003

Riley, D. (1994). The harm reduction model: Pragmatic approaches to drug use from the area between intolerance and neglect. Ottawa: Canadian Centre on Substance Abuse.

Roy, S. (1995). « L'itinérance : forme exemplaire d'exclusion sociale? ». *Lien social et Politiques, 34*, 73-80. http://dx.doi.org/10.7202/005232ar

Rubin, J., & Rubin, I., (1995) Qualitative Interviewing: The Art of Hearing Data. 2nd Edition, Sage Publications, London.

SAMHSA. (2015). Substance Use Disorders. The Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/disorders/substance-use

SAMHSA. (2018). Treatment for Substance Use Disorders. The Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/treatment/substance-use-disorders

Segaert, A. (2012). The National Shelter Study: Emergency Shelter Use in Canada 2005-2009. Ottawa: Homelessness Partnering Secretariat, Human Resources and Skills Development Canada. Retrieved from

https://homelesshub.ca/sites/default/files/Homelessness%20Partnering%20Secretariat%202013%20Segaert_0.pdf

Snoek, A., & Matthews, S. (2017). Introduction: Testing and Refining Marc Lewis's Critique of the Brain Disease Model of Addiction. *Neuroethics*, *10*(1), 1-6. doi: [10.1007/s12152-017-9310-2]

Social Development Canada. (2018). Final report of the Advisory Committee on Homelessness. Retrieved from https://www.canada.ca/en/employment-social-development/programs/homelessness/publications-bulletins/advisory-committee-report.html

Souleymanov, R., & Allman, D. (2016). Articulating Connections between the Harm-Reduction Paradigm and the Marginalisation of People Who Use Illicit Drugs. *British journal of social work*, *46*(5), 1429–1445. doi:10.1093/bjsw/bcv067

Sylvestre, J., Klodawsky, F., Gogosis, E., Ecker, J., Polillo, A., Czechowski, K., . . . Hwang, S. (2018). Perceptions of housing and shelter among people with histories of unstable housing in three cities in canada: A qualitative study. *American Journal of Community Psychology, 61*(3-4), 445-458. doi:10.1002/ajcp.12243

Tainio, H. & Fredriksson, P. (2009) The Finnish Homelessness Strategy: From a 'Staircase' to a 'Housing First' Approach to Tackling Long-Term Homelessness, *European Journal of Homelessness* 3 pp.181-199. Retrieved from http://www.bawo.at/fileadmin/user_upload/public/Dokumente/Europa/FEANTSA/Berichte_Studien/FEANTSA_finnish_stragtegy_09-12.pdf

Tatarsky, A., & Marlatt, G. A. (2010). State of the art in harm reduction psychotherapy: An emerging treatment for substance misuse. *Journal of Clinical Psychology*. doi:10.1002/jclp.20672

Taylor, J. S. (Ed.). (2005). *Personal autonomy: New essays on personal autonomy and its role in contemporary moral philosophy*. Retrieved from https://ebookcentral.proquest.com

Tiderington, E., Stanhope, V., & Henwood, B. F. (2013). A qualitative analysis of case managers use of harm reduction in practice. *Journal of Substance Abuse Treatment,44*(1), 71-77. doi:10.1016/j.jsat.2012.03.007

Tsemberis, S. (2010). *Housing First: The Pathways Model to End Homelessness for People with Mental Illness and Addiction Manual*. Center City: Hazelden.

Tsemberis, S., Gulcur, L., & Nakae, M. (2004). Housing first, consumer choice, and harm reduction for homeless individuals with a dual diagnosis. *American Journal of Public Health,94*(4), 651-6. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1448313/

UNAIDS. (2014). *Global AIDS response progress reporting 2014: Construction of core indicators for monitoring the 2011 UN political declaration on HIV/AIDS.*(Switzerland, Joint United Nations Programme on HIV/AIDS). Geneva. Retrieved from http://www.unaids.org/sites/default/files/media_asset/GARPR_2014_guidelines_en_0.pdf

UNODC, (2009). United Nations Office on Drug and Crime, Reducing the adverse health and social consequences of drug abuse: A comprehensive approach. *Human Rights Documents Online,*1-7. Retrieved from https://www.unodc.org/docs/treatment/Reducing_the_Adverse_Health_and_Social_Consequences_of_Abuse.pdf

Van Den Hoonaard., K. (2012). *Qualitative research in action: A Canadian primer*. Don Mills, Ont.: Oxford University Press Canada.

Watson, D. P., Shuman, V., Kowalsky, J., Golembiewski, E., & Brown, M. (2017). Housing First and harm reduction: a rapid review and document analysis of the US and Canadian open-access literature. *Harm reduction journal*, *14*(1), 30. doi:10.1186/s12954-017-0158-x

Watson, D., Wagner, D. and Rivers, M. (2013) Understanding the Critical Ingredients for Facilitating Consumer Change in Housing First Programming: A Case Study Approach, Journal of Behavioral Health Services & Research 40(2) pp.169-179. doi: 10.1007/s11414-012-9312-0

Watson, J., Crawley, J., & Kane, D. (2016). Social exclusion, health and hidden homelessness. *Public Health, 139*, 96-102. doi:10.1016/j.puhe.2016.05.017

WHO. (2017) Substance abuse. Retrieved from http://www.who.int/topics/substance_abuse/en/

Woodhall-Melnik, J., Dunn, J. R., Svenson, S., Hamilton-Wright, S., Patterson, C., Waterfield, D., Kirst, M., & Matheson, F., (2017) *Finding a Place to Start: Exploring Meanings of Housing Stability in Hamilton's Male Housing First Participants*, Housing, Theory and Society, 34:3, 359-375, DOI: 10.1080/14036096.2016.1266382

Young, A. S., Grusky, O., Jordan, D., & Belin, T. R. (2000). Routine Outcome Monitoring in a Public Mental Health System: The Impact of Patients Who Leave Care. *Psychiatric Services,51*(1), 85-91. doi:10.1176/ps.51.1.85

Appendix A

Formulaire D'information et de Consentement Pour Intervenants

« Perception et utilisation de l'approche réduction de méfaits au programme Projet Logement Montréal (PLM) »

Chercheuse étudiante :	Marysabel Moreno, étudiante à la maîtrise, École de Travail social, Université de Montréal
Directeur de recherche :	Sue-Ann MacDonald, Directrice de recherche, École de Travail social, Université de Montréal

Vous êtes invité à participer à un projet de recherche. Avant d'accepter, veuillez prendre le temps de lire ce document présentant les conditions de participation au projet. N'hésitez pas à poser toutes les questions que vous jugerez utile à la personne qui vous présente ce document.

A. RENSEIGNEMENTS AUX PARTICIPANTS

---

1. Objectifs de la recherche

Ce projet vise à mieux comprendre la perception des intervenants sur l'approche de réduction des méfaits tel qu'utilisée dans le Projet Logement Montréal (PLM). Pour ce faire, nous comptons recueillir les points de vue de cinq travailleurs d'intervention du même programme.

2. Participation à la recherche

Votre participation consiste à participer à un groupe de discussion (focus group) dans lequel le chercheur vous posera plusieurs questions par rapport à votre perception et expérience avec la réduction de méfaits en relation à votre travail avec des individus avec problèmes d'alcool et ou toxicomanie. Cette entrevue sera enregistrée, avec votre autorisation, sur support audio afin d'en faciliter ensuite la transcription et devrait durer environ 60 minutes. Il aura aussi une personne de l'équipe de recherche qui prendra les notes pendant la discussion.

3. Risques et inconvénients

Il n'y a pas de risque particulier à participer à ce projet. Il est possible cependant que certaines questions puissent raviver des souvenirs liés à une expérience désagréable. Vous pourrez à tout moment refuser de répondre à une question ou même mettre fin à l'entrevue. Il suffit simplement d'informer l'interviewer.

4. Avantages et bénéfices

Il n'y a pas d'avantage particulier à participer à ce projet. Vous contribuerez

cependant à une meilleure compréhension sur la toxicomanie et la réduction de méfaits dans un contexte de logement avec soutien.

Confidentialité

Les renseignements personnels que vous nous donnerez demeureront confidentiels. Aucune information permettant de vous identifier d'une façon ou d'une autre ne sera publiée. De plus, chaque participant à la recherche se verra attribuer un code et seuls la chercheuse pourra connaître leur identité. Les données seront conservées dans un lieu sûr. Les enregistrements seront transcrits et seront détruits, ainsi que toute information personnelle, 7 ans après la fin du projet. Seules les données ne permettant pas de vous identifier seront conservées après cette période.

5. Droit de retrait

Votre participation à ce projet est entièrement volontaire et vous pouvez à tout moment vous retirer de la recherche sur simple avis verbal et sans devoir justifier votre décision, et sans conséquence pour vous. Si vous décidez de vous retirer de la recherche, veuillez le dire à l'interviewer.

À votre demande, tous les renseignements qui vous concernent pourront aussi être détruits. Cependant, après le déclenchement du processus de publication, il sera impossible de détruire les analyses et les résultats portant sur vos données.

B) CONSENTEMENT

Déclaration du participant – Intervenant

- Je comprends que je peux prendre mon temps pour réfléchir avant de donner mon accord ou non à participer à la recherche.
- Je peux poser des questions à l'équipe de recherche et exiger des réponses satisfaisantes.
- Je comprends qu'en participant à ce projet de recherche, je ne renonce à aucun de mes droits ni ne dégage les chercheurs de leurs responsabilités.
- J'ai pris connaissance du présent formulaire d'information et de consentement et j'accepte de participer au projet de recherche.

Signature du participant : _____ Date : _____

Nom : _____Prénom :_____ _____

Engagement du chercheur
J'ai expliqué au participant les conditions de participation au projet de recherche. J'ai répondu au meilleur de ma connaissance aux questions posées et je me suis assurée de la compréhension du participant. Je m'engage, avec l'équipe de recherche, à respecter ce qui a été convenu au présent formulaire d'information et de consentement.

Signature de la chercheuse : _____Date : _____
(Ou de son représentant)

Nom : _____Prénom : _____

Pour toute question relative à l'étude, ou pour vous retirer de la recherche, veuillez communiquer avec Marysabel Moreno

Pour toute préoccupation sur vos droits ou sur les responsabilités des chercheurs concernant votre participation à ce projet, vous pouvez contacter le Comité d'éthique de la recherche en arts et en sciences

Toute plainte relative à votre participation à cette recherche peut être adressée à l'ombudsman de l'Université de Montréal.

Appendix B

Formulaire D'information et de Consentement pour Participants/ Résidents

« Perception et utilisation de l'approche réduction de méfaits au programme Projet Logement Montréal (PLM) »

Chercheuse étudiante :	Marysabel Moreno, étudiante à la maîtrise, École de Travail social, Université de Montréal
Directeur de recherche :	Sue-Ann MacDonald, Directrice de recherche, École de Travail social, Université de Montréal

Vous êtes invité à participer à un projet de recherche. Avant d'accepter, veuillez prendre le temps de lire ce document présentant les conditions de participation au projet. N'hésitez pas à poser toutes les questions que vous jugerez utile à la personne qui vous présente ce document.

B. RENSEIGNEMENTS AUX PARTICIPANTS

---

6. Objectifs de la recherche

Ce projet vise à mieux comprendre votre perception sur l'approche de réduction des méfaits tel qu'utilisée dans le Projet Logement Montréal (PLM). Pour ce faire, nous comptons recueillir les points de vue de cinq participants du programme PLM.

7. Participation à la recherche

Votre participation consiste à accorder une entrevue au chercheur qui vous posera plusieurs questions par rapport à votre perception et expérience avec la réduction de méfaits en relation à votre consommation soit de substances ou d'alcool. Cette entrevue sera enregistrée, avec votre autorisation, sur support audio afin d'en faciliter ensuite la transcription et devrait durer environ 60 minutes. Le lieu et le moment de l'entrevue seront déterminés avec l'intervieweur, selon vos disponibilités.

8. Risques et inconvénients

Il n'y a pas de risque particulier à participer à ce projet. Il est possible cependant que certaines questions puissent raviver des souvenirs liés à une expérience désagréable. Vous pourrez à tout moment refuser de répondre à une question ou même mettre fin à l'entrevue. Il suffit simplement d'informer l'interviewer.

9. Avantages et bénéfices

Il n'y a pas d'avantage particulier à participer à ce projet. Vous contribuerez cependant à une meilleure compréhension sur la toxicomanie et la réduction de méfaits dans un contexte de logement avec soutien.

10. Confidentialité

Les renseignements personnels que vous nous donnerez demeureront confidentiels. Aucune information permettant de vous identifier d'une façon ou d'une autre ne sera publiée. De plus, chaque participant à la recherche se verra attribuer un code et seuls la chercheuse pourra connaître leur identité. Les données seront conservées dans un lieu sûr. Les enregistrements seront transcrits et seront détruits, ainsi que toute information personnelle, 7 ans après la fin du projet. Seules les données ne permettant pas de vous identifier seront conservées après cette période.

11. Compensation

Pour vous remercier de votre participation et votre temps, une carte cadeau de valeur 10$ pour McDonald's vous sera remis à la fin de l'entrevue.

12. Droit de retrait

Votre participation à ce projet est entièrement volontaire et vous pouvez à tout moment vous retirer de la recherche sur simple avis verbal et sans devoir justifier votre décision, et sans conséquence pour vous. Si vous décidez de vous retirer de la recherche, veuillez le dire à l'interviewer.

À votre demande, tous les renseignements qui vous concernent pourront aussi être détruits. Cependant, après le déclenchement du processus de publication, il sera impossible de détruire les analyses et les résultats portant sur vos données.

B) CONSENTEMENT

Déclaration du participant

- Je comprends que je peux prendre mon temps pour réfléchir avant de donner mon accord ou non à participer à la recherche.
- Je peux poser des questions à l'équipe de recherche et exiger des réponses satisfaisantes.
- Je comprends qu'en participant à ce projet de recherche, je ne renonce à aucun de mes droits ni ne dégage les chercheurs de leurs responsabilités.
- J'ai pris connaissance du présent formulaire d'information et de consentement et j'accepte de participer au projet de recherche.

Signature du participant : _____ Date : _____

Nom : _____Prénom :_____ _____

Engagement du chercheur
J'ai expliqué au participant les conditions de participation au projet de recherche. J'ai répondu au meilleur de ma connaissance aux questions posées et je me suis assurée de la compréhension du participant. Je m'engage, avec l'équipe de recherche, à respecter ce qui a été convenu au présent formulaire d'information et de consentement.

Signature de la chercheuse : _____Date : _____
(Ou de son représentant)

Nom : _____Prénom : _____

Pour toute question relative à l'étude, ou pour vous retirer de la recherche, veuillez communiquer avec Marysabel Moreno

Pour toute préoccupation sur vos droits ou sur les responsabilités des chercheurs concernant votre participation à ce projet, vous pouvez contacter le Comité d'éthique de la recherche en arts et en sciences.

Toute plainte relative à votre participation à cette recherche peut être adressée à l'ombudsman de l'Université de Montréal.

Appendix C

Demande D'autorisation d'Effectuer une Recherche Dans une Organisation

Projet Logemement Montreal a été approchée pour participer au projet de recherche suivant :

« Perception et utilisation de l'approche réduction de méfaits à Projet Logement Montréal (PLM) »

Ce projet est réalisé par Marysabel Moreno qui étudie à la maîtrise à l'université de Montréal.

Ce projet est réalisé sous la supervision du Sue-Ann MacDonald directrice de recherché et professeure agrégée, Faculté des arts et des sciences.

Ce projet vise à mieux comprendre la perception des utilisateurs et des intervenants sur l'approche de réduction des méfaits tel qu'utilisée dans le Projet Logement Montréal (PLM). Pour ce faire, nous comptons recueillir les points de vue de cinq travailleurs d'intervention et cinq participants. Les renseignements recueillis au cours de ce projet seront utilisés pour la préparation d'un document qui sera rendu public. Les informations brutes resteront confidentielles, mais le chercheur utilisera ces informations pour son projet de publication.

Les renseignements personnels demeureront confidentiels. Aucune information permettant d'identifier un participant ne sera publiée. De plus, les données seront conservées dans un lieu sûr. Les enregistrements seront transcrits et seront détruits, ainsi que toute information personnelle, 7 ans après la fin du projet. Chaque participant aura à remplir un formulaire de consentement.

Nous vous demandons l'autorisation d'effectuer notre collecte de données dans votre projet. La mention du nom de PLM dans le projet de publication ne peut être faite sans l'autorisation de la direction à cet effet. Nous vous demandons l'autorisation de dévoiler le nom du projet PLM dans la publication d'un document qui sera rendu public.

Pour toute question en matière d'éthique, vous pouvez communiquer avec le secrétariat du Comité d'éthique de la recherche CERAS .

J'accepte que cette recherche soit conduite dans PLM, projet que je dirige.

☐ **Oui**

☐ **Non**

J'accepte que le nom de mon entreprise soit dévoilé lors de la diffusion des résultats de cette recherche.

☐ **Oui**

☐ **Non**

Nom du projet	
Adresse	
Nom et fonction du ou des signataires autorisés	
Numéro de téléphone	
Courriel	
Signature	

Résumé du projet de recherche :

Problématique

Des milliers de personnes à Montréal vivent sans logement stable et dépendent de refuges et de programmes sociaux pour répondre à leurs besoins fondamentaux. L'itinérance est un phénomène aux causes et aux conséquences diverses. Parmi les facteurs les plus communs qui provoquent l'itinérance se trouvent les « problèmes financiers, la dépendance aux drogues ou à l'alcool et l'éviction par le propriétaire » (Latimer et al., 2015 : 25). Les individus qui présentent à la fois des problèmes d'itinérance et de toxicomanie sont exposés à un risque accru d'itinérance chronique et aux dangers potentiels liés aux dépendances. Selon Landry et Lecavalier (2003), la consommation problématique de substances peut avoir des répercussions aussi graves que la mort accidentelle et la contraction de maladies transmises par le sang en raison de comportements sexuels à risque ou d'échange de seringues. Les autres conséquences liées à la consommation de drogues comprennent : l'incapacité de travailler ou de rester à l'école, les relations rompues avec la famille, les amis et les membres de la communauté ainsi que les problèmes avec la justice. Cependant, la relation entre l'usage de substances et l'itinérance est complexe, nous ne pouvons donc pas affirmer que l'une est la cause principale de l'autre.

À Montréal, les sans-abris font face à de multiples défis dans la recherche d'un traitement qui les aidera à gérer leurs dépendances à leur propre rythme. La plupart du temps, les maisons d'hébergement traditionnelles et les programmes de réinsertion exigent que la personne sans-abri soit sobre ou promette de le devenir pour qu'elle puisse avoir accès à des services de logement. Ce type des services basés sur l'abstinence rend parfois impossible pour un individu en situation d'itinérance d'avoir accès à des traitements complets et holistiques pour leur dépendance ou même de contrôler leur consommation et réduire les risques qui lui sont associés. En fait, les programmes de réinsertion sont connus pour placer la barre trop élevée que «souvent ne implique pas les résidents et ne pas répondre pleinement à leurs besoins complexes » (Collins, 2012 : 1). En conséquence, les décideurs politiques ont appelé à « l'élaboration de programmes de logement d'accès facile qui pourraient impliquer plus efficacement les personnes sans abri, les loger et répondre à leurs besoins » (Collins, 2012 : 1).

Pour traiter la dépendance et éradiquer l'itinérance, deux approches sont devenues prioritaires dans les politiques publiques québécoises : le modèle Logement d'abord (*Housing First model*) et la réduction des méfaits. Chacune de ces approches prétend aborder deux problèmes différents et essentiels à traiter pour aider la population itinérante. D'une part, les programmes Logement d'abord fournissent un logement stable aux sans-abris, indépendamment de tout problème de toxicomanie ou de santé mentale, sur la base du principe que le logement est un droit de la personne. Quant à la réduction des méfaits, elle vise à réduire le risque et les conséquences négatives associées à la consommation problématique de substances.

La réduction des méfaits a été utilisée dans les programmes de Logement d'abord comme une approche innovante qui diverge des approches traditionnelles du logement, selon lesquelles les clients sont tenus de suivre un traitement pour leurs problèmes psychiatriques ou d'utilisation de substances et de s'engager dans des programmes basés sur l'abstinence. Cependant, Landry & Lecavalier (2003) mentionnent que les approches de réduction des méfaits et de Logement d'abord négligent l'aspect de la prévention de l'utilisation de substances et de la dépendance elle-même. Ce qui pourrait conduire les sans-abris à parcourir le cycle complet de l'itinérance à nouveau par la perte de leur logement et, potentiellement, un retour à la rue. Les conséquences de ces interventions, pourtant en faveur des sans-abri avec problèmes de consommation, peuvent donc s'inscrire en contradiction des valeurs des organisations fournissant les services. En d'autres termes, les intervenants enclins à travailler avec leurs clients en matière de prévention, de réhabilitation et de sobriété peuvent trouver difficile de travailler simplement pour réduire les risques, les dangers et les conséquences de la consommation, sans cibler le problème réel de la dépendance à la drogue ou à l'alcool. Ce potentiel paradoxe dans le domaine de l'intervention m'amène à m'intéresser à l'élaboration d'un projet de recherche sur le sujet.

Objectifs généraux et spécifiques

1. Comprendre à la fois la perception des residents et des intervenants du concept de réduction des méfaits en tant qu'approche utilisée dans HF
2. Comprendre comment les principes de réduction des méfaits sont utilisés un programme basé sur l'approche Logement d'abord.

(A) Pour connaître la compréhension des travailleurs et résidents par rapport à l'approche de réduction des méfaits
(B) Étudier les défis et les effets des interventions en utilisant des principes de réduction des méfaits
(C) Étudier la manière dont la relation des travailleurs d'intervention et ses clients influencent l'application des pratiques de réduction des méfaits
(D) Savoir si les interventions de réduction des méfaits influent dans la vie des personnes hébergés par Projet Logement Montréal (PLM)

Question de recherche

Cette recherche vise à explorer: comment les résidents et les travailleurs comprennent, négocient et mettent à jour l'approche de réduction des méfaits? Les questions suivantes seront explorées: 1)

comment le concept réduction des méfaits est-il compris et perçu par les travailleurs et les participants de HF? 2) Quels facteurs permettent ou défient la pratique de la réduction des méfaits dans le projet HF? 3) Comment les pratiques de la réduction des méfaits réduisent-elles les conséquences négatives de la consommation de substances du point de vue des travailleurs et des résidents? 4) Comment les participants et les travailleurs comprennent-ils la consommation de substances? 5) Comment la réduction des méfaits contribue-t-elles aux objectifs de réinsertion sociale décrite par les programmes HF?

Échantillon :

Le recrutement se fera sur une base volontaire parmi les travailleurs d'intervention de Projet Logement Montréal. Les intervenants seront invités à informer leurs clients de la possibilité de participer à la recherche. Tous les participants recevront une carte-cadeau de 20 $.

Critères d'inclusion et de sélection des participants : 5 Hommes vivant sur l'île de Montréal, âgé de 18 à 65 ans, souscrit au programme Projet Logement Montréal, suivi au moins une fois par mois par un travailleur d'intervention affilié au programme. La personne doit s'identifier comme utilisateur ou dépendre de substances psychoactives ou d'alcool. Il peut être ou non à la recherche d'un traitement de toxicomanie. Les participants pourraient souffrir de problèmes de santé mentale pas sévères, tels que l'anxiété ou la dépression diagnostiquée ou pas, mais nous éviterons de préférence ce type de participants à moins qu'ils démontrent de l'intérêt pour la recherche et qu'ils aient l'air bien durant l'entrevue.

5 travailleurs d'intervention du projet logement à Montréal dont leurs clients présentent des problèmes de dépendance

Critères d'exclusion :

Les travailleurs d'intervention travaillant pour Projet Logement Montréal (PLM) mais embauchés par la MISSION BON ACCUEIL seront exclus pour éviter les conflits d'intérêts en raison du fait que la responsable de la recherche est également employée de MISSION BON ACCUEIL.

Les clients ayant des problèmes de santé mentale graves impliquant généralement des psychoses telles que la schizophrénie, le trouble bipolaire et la dépression maniaque seront exclus, car ils peuvent se trouver dans un état de santé vulnérable. Cette mesure a pour objectif de protéger la santé des clients, éviter de contribuer à des épisodes de psychose potentiels et finalement éviter le jugement nuisible (par l'intervenant ou par les clients) possible par la maladie lors de la réponse aux questions.
Les clients âgés seront exclus pour des raisons éthiques et pour éviter des processus plus longs liés au consentement.

Processus d'entrevue :

Les travailleurs d'intervention seront dans un premier temps contactés par le chercheur et les clients seront ensuite contactés par leur travailleur d'intervention pour se renseigner sur le désir de participer à l'étude. (À accorder avec la direction de PLM)

Le processus d'entrevue sera guidé par un questionnaire semi-structuré et aura une durée de 60 à 90 minutes. Des questions ouvertes seront posées aux participants. Les entrevues seront effectuées par le chercheur sans assistance. Les participants seront informés que l'entrevue sera enregistrée avec leur consentement.

Appendix D

Interview questions for participants

Identification Sheet

Sex:

Age:

Level of studies:

Civil status: married ___ Divorced ___ Single ___ widow ___

Financial status: Employment insurance ___ welfare _____ Employed ___ Unemployed

Employment type:

Criminal record: Yes ____ No ____

Product of consumption:

Duration of consumption:

Evolution of consumption in the past year:

Interview questions

1. Can you tell me a little bit about yourself, how you came to PLM?
    a. if you were homeless for how long?
    b. Why did you decided to join PLM?

2. Can you describe your relationship with your intervention worker?
    a. How often do you see the intervention worker?
    b. Are you presently working on a specific plan or have a specific goal with your intervention worker?

3. Have you or do you consume alcohol or any other substance or drug?
    a. what substances do you consume ?
    b. Can you tell me how you came into contact with drugs or alcohol in first place?
        i. Why do you think you began to consume?
    c. What is your preferred method of consumption?
        i. Have you ever use a needle syringe program (if relevant)?

4. Can you tell me about any negative effects or consequences you have experience that are related to your consumption?
    a. What are some of the strategies that you use to reduce those negative effects?

5. In your experience does your consumption have an effect on your physical or mental health?

6. what are some of the changes you have noticed in your consumption since you moved into your apartment?

7. What are some of the differences have noticed between consuming on the streets as opposed to consuming in your own home (if you consume at home)?

8. What would you like to change about your consumption?
    a. do you have any goals regarding your consumption?
    b. Where do you see yourself in one year from now?

9. Have you heard of the term harm reduction? If so, what does it mean to you, what is your understanding of the notion? If not, what do you think it refers to?

10. Does your intervention worker intervene with regards to your consumption?
    a. If they do, how?
    b. What are the advantages or disadvantages of this type of intervention?

11. Have you been stigmatizing or discriminated for your consumption habits?
    a. If so, how?

12. Have you seen any changes in your life since you moved into the apartment (for example, family, relationships, health, etc.)

13. In your opinion what are some of risks related to your consumption (if any) for you or for others ?

14. What are some of the measures you take to reduce any risk associated with your consumption (ex: not driving if you have drink)

Questions d'entrevue pour les participants

Fiche d'identification

Sexe :

Âge :

Niveau d'études :

État civil : marié(e) ___ Divorcé(e) ___ célibataire ___ veuf/veuve ___

Situation financière : assurance-emploi ___ aide sociale _____ en emploi ___ sans emploi

Type d'emploi :

Casier judiciaire : Oui ____ Non ____

Produit de consommation :

Durée de consommation :

Évolution de la consommation au cours de la dernière année :

Questions d'entrevue

1. 1. Pouvez-vous me parler un peu de vous, comment vous êtes arrivé au PLM?
    a. Si vous étiez sans abri, pour combien de temps ?
    b. Pourquoi avez-vous décidé de rejoindre PLM ?

2. Pouvez-vous décrire votre relation avec votre intervenant ?
    a. À quelle fréquence voyez-vous votre intervenant ?
    b. Travaillez-vous actuellement sur un plan spécifique ou avez-vous un objectif spécifique avec votre travailleur d'intervention ?
3. Avez-vous ou consommez-vous de l'alcool ou autre substance ou drogue ?
    a. Quelles étaient ou quelles sont vos substances préférées ?
    b. Pouvez-vous me dire comment vous avez été en contact avec les drogues ou de l'alcool en premier lieu?
    c. Pourquoi pensez-vous que vous avez commencé à consommer ?
    d. Quelle est votre méthode de consommation préférée ?

4. Pouvez-vous nous parler des effets négatifs ou des conséquences que vous avez subies en lien à votre consommation ?

    a. Quelles sont les stratégies que vous utilisez pour réduire ces effets négatifs ?

5. Sur la base de votre expérience, votre consommation a-t-elle un effet sur votre santé physique ou mentale ?

6. Avez-vous remarqué une modification de votre consommation depuis votre déménagement dans votre appartement ?

7. Pouvez-vous nous dire si vous avez noté une différence entre le fait de consommer dans la rue plutôt que de consommer dans votre propre maison ?

8. Que voudriez-vous changer à propos de votre consommation?

    a. avez-vous des objectifs concernant votre consommation?
    b. Où vous voyez-vous dans un an à partir de maintenant?

9. Avez-vous entendu parler du terme réduction des méfaits? Si oui, qu'est-ce que cela signifie pour vous, quelle est votre compréhension de cette notion? Sinon, à quoi pensez-vous qu'il se réfère ?

10. Votre intervenant agit-il en ce qui concerne votre consommation ?

    a. S'il le fait, comment ?
    b. Quels sont les avantages ou les inconvénients de ce type d'intervention ?

11. Avez-vous déjà été stigmatisé ou discriminé pour vos habitudes de consommation ?
    a. Si c'est le cas, comment ?

12. Avez-vous observé des changements dans votre vie depuis que vous avez déménagé dans votre appartement (par exemple avec la famille, vos relations avec les autres, votre santé, etc.)

13. Selon vous, quels sont les risques liés à votre consommation (le cas échéant) pour vous ou pour les autres ?

14. Quelles sont les mesures que vous prenez pour réduire les risques associés à votre consommation (ex: ne pas conduire si vous avez bu)

Appendix E

Interview questions for Intervention workers

1. How long have you been working at PLM?
2. What is your degree or intervention background?
3. How often do you see your clients?
4. How would you have described your relationship with your clients?
5. What is your understanding of harm reduction?
6. Does your intervention approach towards harm reduction include abstinence?
7. What are your thoughts of people who consume?
8. What is your approach to help reduce harmful behaviors related to consumption that your clients might engaged in?
9. Have your interventions help your clients to reduce negative consequences related to consumption?
10. In your experience, moving into an apartment increases or decreases your client's consumption?
11. Can you tell us if your clients have already contributed to the creation of harm reduction strategies to reduce negative consequences of their consumption?
12. In your experience has harm reduction strategies empower or disempower your clients
13. In what way does harm reduction contribute to the recovery process of your clients
14. What are some of the factors that affect your client's capacities to effectively dealing with drug consumption related harm?
15. What are some of the dangers, related to drug or alcohol consumption that your clients might be exposed to?
16. What are some of the risky behaviors your clients engage in when they are intoxicated?

17. Are your clients more in control of their consumption and its effects living in their apartments as opposed to living on the streets or in shelters?

18. Is abstinence a realistic goal for your clients?

Questions d'entrevue pour les travailleurs d'intervention

1. Depuis combien de temps travaillez-vous chez PLM?
2. Quel est votre diplôme ou votre parcours d'intervention ?
3. À quelle fréquence voyez-vous vos clients ?
4. Comment décririez-vous votre relation avec vos clients ?
5. Quelle est votre compréhension de la réduction des méfaits ?
6. Votre approche de l'intervention sur la réduction de méfaits comprend l'abstinence ?
7. Quelle est votre perception sur les personnes avec des problèmes de toxicomanie ?
8. Quelle est votre approche pour aider à réduire les comportements nuisibles liés à la consommation de vos clients ?
9. Comment vos interventions aident-elles vos clients à réduire les conséquences négatives liées à la consommation ?
10. Selon votre expérience, déménager dans un appartement peut-il augmenter ou diminuer la consommation d'un client ?
11. Pouvez-vous nous dire si vos clients ont déjà contribué à la création de stratégies de réduction des méfaits pour réduire les conséquences négatives de leur consommation ?
12. Sur la base de votre expérience, les obstacles à la réduction des méfaits contribuent à autonomiser ou à déresponsabiliser vos clients
13. De quelle manière la réduction des méfaits contribue-t-elle au processus de rétablissement de vos clients?
14. Pouvez-vous nommer quelques facteurs qui influent sur les capacités de votre client à traiter efficacement les dommages liés à la consommation de drogue ou d'alcool ?
15. Quels sont certains des dangers liés à la consommation de drogue ou d'alcool auxquels vos clients pourraient être exposés?

16. Quels sont les comportements risqués auxquels vos clients s'engagent lorsqu'ils sont en état d’ébriété ?

17. Vos clients maîtrisent-ils davantage leur consommation et ses effets négatifs lorsqu’ils sont en appartement par opposition à quand ils se trouvent dans la rue ou dans des abris ?

18. L'abstinence est-elle un objectif réaliste pour vos clients ?