
Housing First Elements Facilitating Resilience in Clients with Addictions in the Hábitat Programme: a Qualitative Study

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- **Abstract** *Four years after launching Hábitat Housing First programme, some questions arise from the intervention. As Housing First principles state, dealing with addiction crises at home allows service users to reduce harm in a safe place. The aim of this paper is to identify personal and interpersonal skills, as well as strategies to deal with addiction crises. Three case managers, two service evaluators and the technical director of the programme participated in a qualitative research, based on a focus group discussion, to share their views about three cases of the programme representative of clients' strategies to confront a recidivism crisis. Results show that several Housing First components foster an empowering climate that facilitate managing addictions. Policy recommendations include offering person-centred and housing based services to people with addiction issues in order to promote self-efficacy and develop individual skills to deal with relapses. Overall, this paper illustrates that non-coercive interventions are effective to reduce substance abuse while addressing homelessness.*
- **Keywords** *Housing First, resilience factors, harm reduction, substance abuse*

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Introduction

The Spanish Comprehensive National Strategy for the Homeless reported an estimate of 33,275 homeless people in Spain. According to the Strategy, 23,000 of those individuals were using the support services provided for the homeless, while the other 10,000 slept rough, an estimate based on the night counts conducted by municipalities across the country (MSSSI, 2016). According to data presented in the Strategy on substance use among people experiencing homelessness collected by the National survey to homeless people in 2012, 44% (n=10,120) of homeless people used alcohol (from drinking a little to drinking excessively) and 37% (n=8,567) used drugs (Instituto Nacional de Estadística, 2012). This survey is only applied to people using the support services, so it is probable that the actual number as well as the percentage of people using substances among the 10,000 rough sleepers are higher.

Over recent decades, the main responses to homelessness in Spain have been based on a “*Linear Residential Treatment system of care*” (hereinafter, *LRT*). The general aim of this system of care is to “rehabilitate” people experiencing homelessness by promoting gradually what is considered greater individual autonomy and thus providing less professional control over service users’ lives. This solution emphasizes the containment of people and provides systematic re-housing of service users through their participation in a continuum of programmes geared towards independent living. In this containment logic, alcohol or drug use is one of the commonly cited reasons for the expulsion of service users from support programmes. As an example, a study carried out by RAIS about homelessness and the social welfare system in the Spanish region of Andalusia showed that 52% of the services had expelled people because of substance use (RAIS, 2017). Other existing research shows that even when the containment logic can deliver positive results for some, the insistence on abstinence can be an insurmountable barrier for many people experiencing homelessness (Tainio and Fredriksson, 2009).

The Housing First model

The Housing First model appeared at the beginning of the 1990s as a radical transformative proposal from professionals and researchers who believed that a change of paradigm in support services for homeless people was needed. The fact that the existing support system was leaving the most chronic profiles of homelessness behind was the main reason for this current of change. The Housing First model proposed immediate access to housing and supports based on a set of key principles, which included a harm reduction and non-coercive approach and service users’ control over the service.

Housing First considers people experiencing homelessness as active individuals with rights and dignity (Tsemberis, 1999). Housing First considers the correlation between the support needs, the context and the characteristics of individual. This approach encourages people to discuss addiction problems without the risk of losing their house or support services, in order to help the whole person. Housing First's growing body of research has shown that the use of this methodology is related to significant improvements for people experiencing homelessness, specifically in housing retention and access to health care. It has also shown positive results in mental health, addiction and quality of life indices (Bretherton and Pleece, 2015). The final aim of Housing First regarding substance use is to offer the best potential conditions in which participants with substance addictions can develop greater resilience capabilities, which are known to help individuals overcome adverse (internal or external) stimuli and to respond better to crises associated with addictions (Southwick *et al.*, 2014).

Results of Housing First on substance use

The Housing First model is grounded in the idea that harm reduction is an effective approach to tackle problematic drug and alcohol use. Although this model has been mainstreamed in many Northern European countries, it is still not commonly implemented across Europe. Previous research has demonstrated that harm reduction can be more effective with people experiencing homelessness with multiple needs than traditional services that require abstinence or promote detoxification (Pleece, 2008). It is posed that "a holistic intervention addressing all the causes and consequences of drug and alcohol use is central to the harm reduction philosophy. Equally, harm reduction seeks to persuade and support people to modify drug and alcohol use that causes them harm" (FEANTSA, 2016).

However, the corpus of research on the results of Housing First for individuals that have substance use problems remains limited (Mericle and Grella, 2016; Cherner *et al.*, 2017), especially research projects based on a longitudinal randomised controlled trial methodology. Research that includes a comparison group generally finds little or no differences between Housing First and Traditional Care Treatments addiction outcomes (Tsemberis *et al.*, 2004; Padgett *et al.*, 2006; Tsai *et al.*, 2010; Tsai *et al.*, 2012; Stergiopoulos *et al.*, 2015; Aubry *et al.* 2016; Cherner *et al.*, 2017). However, some studies have found a reduction in substance use (Padgett *et al.*, 2011), and a decrease in the number of days of alcohol use (Kirst *et al.*, 2015). Other Housing First studies –without a control group– found improvements in outcomes both for alcohol (Larimer *et al.*, 2009; Collins *et al.*, 2012) and drugs use (Mares and Rosenheck, 2010). However, there is still scarce research on individual processes and factors operating behind these results. The

vast majority of studies centre on quantitative methodology and fidelity outcomes, but there is hardly any research on specific interventions beyond general principles of the model (e.g., Clifasefi *et al.*, 2016).

Description of the Hábitat programme and Research on Substance Use

RAIS launched the Housing First *Hábitat* programme in 2014 with 28 clients in Malaga, Barcelona and Madrid. At the beginning of 2018, *Hábitat* provides individual housing and support to over 200 clients in several cities across eight Spanish regions.

Hábitat aims at people experiencing chronic homelessness and presenting concurrent exclusion factors: mental health issues, addictions or disabilities. 72.1% (n=20) of the initial clients of the service were referred as having an addiction issue. *Hábitat* uses a harm reduction approach and its clients are not obliged to adhere to sobriety or abstinence nor to adhere to a substance use treatment. Only with their agreement, would the ICM team facilitate their starting a treatment in a suitable service existing in the community.

The programme is currently being evaluated through a randomized longitudinal evaluation, including an experimental group (EG) and a control group (CG) using LRT services (Bernad *et al.*, 2016a; 2016b). The comparative results of a pilot trial evaluation conducted with the initial group, showed an improvement and better results in most of the evaluated areas for the EG than for the CG. An example relevant for this research, while at month 0, 46.2% (n=12) of clients in EG and 48.0% (n=27) of clients in CG referred having had a telephone contact with her/his family in the previous month; at month 24, only 34.6% in the CG had had a telephone contact, while the amount had increased to 64.0% among *Hábitat*'s clients. Similarly, at month 0, only 8.0% (n=2) of service clients and 19.2% (n=11) of people in the CG had spent some time with someone from her/his family in the previous month. At month 24, 36.0% of service clients had spent some time with a relative in the previous month, while only 15.4% of people in the CG had done it.

Aiming at exploring specific areas of the Housing First model, RAIS carried out a research between 2016 and 2017 with the support of the Spanish National Plan for Drugs, to investigate the ways in which the Housing First model could better promote skills to confront addictions crises and particularly the development of resilience among Housing First service users (Bernad *et al.*, 2017). This paper presents the main qualitative results of this research.

Research questions and objectives

The general aim of the study was to identify personal and interpersonal skills, as well as strategies to confront addiction crises. Resilience skills and their development (Kotliarenco *et al.*, 1997) were the base for conceptualizing the research framework, and the research questions were:

- Does a Housing First intervention favour the development of resilience skills and abilities that promote the recovery processes of people with substance use issues?
- Is access to and stability of housing in a Housing First intervention a driver to abstinence and/or harm reduction processes?

Based on the research questions, the specific objectives of the study were:

- To analyse personal and interpersonal skills and strategies which clients in the *Hábitat* programme used to confront recidivism crisis; and
- To analyse the elements of the Housing First model which may promote the use of resilience skills towards achieving abstinence and/or to confront relapses or harm reduction processes.

Methodology

The research was conducted using a qualitative design based on the collection and analysis of information about the processes of clients who were active users of alcohol or other substances when entering the *Hábitat* programme. The information was collected and discussed on a focus group as explained below.

Selection of research cases and participants

The programme intervention team (n=9 case managers) together with the programme technical coordinator, who led the research, selected in a meeting three out of a total number of twenty cases of clients who had an active addiction when entering the programme. The cases were selected as being the most representative (Gobo, 2004) of: 1) different strategies used by clients, and of 2) levels of success in managing a recidivism crisis. The selected cases, characterized in table 1, were:

- AHAH – Abstinence after approximately 30 years using alcohol,
- RAZA – Ongoing alcohol abuse on a harm reduction situation,
- ANHU– Coping with a recidivism crisis during a 12-months abstinence period.

Table 1. Sociodemographic characteristics of the participants.

Participant	Gender	Age	Nationality	Homelessness trajectory (years)	Months in the programme when crisis occurred	Outcome of crisis management
AHAH	Male	54	Bulgaria	8	22	Extinction
RAZA	Male	54	Lithuania	8	4	Harm reduction
ANHU	Male	35	Pakistan	5	7	Confronted relapse

As per the focus group, it was composed by: the Technical director of the service (who facilitated the discussion), the three case managers of the selected cases, and two Research and evaluation officers responsible for the evaluation of the service (n=6).

Research instruments

An ad-hoc designed instrument called *EACA* (Strategies to Confront an Addiction Crisis) was used to collect pre-post information and experiences of clients who confronted an addiction crisis. The *EACA* was built considering the usual resilience factors mentioned in the scientific literature, specifically on people experiencing homelessness, and also the intervention and crisis management skills of the service professionals. The *EACA* collects and structures the information on several **Individual development factors** (self-determination; identity; stigmatisation; internal locus of control; ability to use own resources; satisfaction with achievements; humour; contact with people experiencing homelessness; building new social relationships; helping other peers) and also **Supportive programme factors** (active, non-judgemental listening; proportional support; provision of housing and coverage of basic needs; intervention strategies on addictions). This instrument is available upon request.

Information about the evolution of the 3 clients collected through their individual intervention follow-up instrument (RQR) was also used. The RQR focuses on 8 different areas: health (consciousness and management of health state; identifying and avoiding behavioural risks), leisure activities (identifying and expanding interests and hobbies, participation in leisure activities at individual, group and community level), personal development (self-control and relational skills), functioning and dependence (functional autonomy in daily life such as the ability to make decisions and organization skills), education and employment (labour abilities, education and skills, employment situation, performance at employment); socio-relational (development of social skills and family relations), access to basic needs (access to resources and economic benefits), citizenship and participation (relations with social environment and community network).

Procedure

The case managers for the three selected cases completed an *EACA* questionnaire per case. Participants of the focus group received the *EACA* of the three cases and also the evolution of the three clients and team intervention details as collected in the *RQR* instrument. They were asked to identify the Individual development factors and Supportive programme factors as previously detailed which may have operated in the processes and strategies used by clients and case managers to confront the crisis. The discussion of the focus group was structured based on those factors. It was audio-recorded and data confidentiality was ensured.

Data analysis

Emerging themes from the focus group discussion were coded and analysed by the research leader (the programme Technical director) through a thematic analysis based on the categories of the *EACA* questionnaire as seen in table 2. This analysis was then shared and discussed with one of the Research and evaluation officers who participated in the focus group in a discussion.

Table 2. Individual and programme factors categorization

Categories	Factors
Individual development factors	self-determination identity stigmatisation internal locus of control ability to use own resources satisfaction with achievements humour contact with people experiencing homelessness building new social relationships helping other peers
Supportive programme factors	active, non-judgemental listening proportional support provision of housing and coverage of basic needs intervention strategies on addictions

Quantitative data from the programme's aforementioned randomized trial were also used to support the interpretation of the several factors. The quantitative data will be not presented in this paper since its focus is on the findings of the qualitative research, but they can be found in the final report of this research (Bernad *et al.* 2017) or other publications (Bernad *et al.*, 2016a; 2016b).

Results of the qualitative research

The analysis of the focus group discussion resulted in the identification of a group of common relevant resilience factors operating in the recovery processes of *Hábitat's* clients, and also in the most relevant factors for the three cases analysed, as seen in table 3 below.

Table 3. Main factors identified in the client's processes.

Client	Factors
AHAH	active, non-judgemental listening contact with people experiencing homelessness satisfaction with achievements
RAZA	contact with people experiencing homelessness promotion of self-determination satisfaction with achievements ability to use available resources
ANHU	building new social relationships helping other peers ability to use available resources active, non-judgemental listening

These factors need to be understood in all the complexity that a bio-psycho-social systemic logic requires. Under this perspective, we will try to explain next some of the interconnections between these individual and programmatic factors and how they operated and influenced resilience skills in the processes of *Hábitat's* clients.

Individual development factors

Individual development factors are those individual skills which Hosuing First clients will operate to navigate their recovery process. In this process, the principle "consumer choice and control" (Tsemberis, 2010) will be the cornerstone of self-determination and self-determination will be the basis of recovery (Greenwood *et al.*, 2005). Self-determination has been defined as being the "primary causal agent in one's life and to make choices regarding one's actions free from undue external influence or interference" (Wehmeyer, 1992, p.305). Self-determination was identified in this research as one of the most relevant individual factors when confronting a relapse. ANHU's case manager explained self-determination in taking decisions and the support of the service to promote it like this: *I believe that the first choice he (ANHU) made was calling his brother. The second one was calling us (staff members). And, then, he made some decisions, but it was really difficult for him, I mean, we had to propose a range of options and then made a decision.*

Self-determination allows an internal locus of control of the recovery process (as defined in Rotter, 1966), which was identified in the focus group discussion as a crucial factor to confront the relapses and also as a differentiating factor between a Housing First intervention and a traditional one. More institutionalised support services, would lead people experiencing homelessness to develop an external locus of control or a “false internal locus of control”. In those services, even the smallest decisions, such as what time the client will take a shower, are defined by the service. On top of that, a person fighting an addiction will be probably more prone to experience learned helplessness and low self-efficacy expectations and to relapse when facing the instability and unpredictability of the addiction. The de-institutionalising nature of a Housing First service allows that clients take charge of their own lives, promoting the development of a true internal locus of control.

This is reinforced by the unconditionality of a Housing First support, which implies that service users will not expect a reward/punishment from the staff members upon an action. Instead, users will need to assume that it is their own decisions which will generate good or bad consequences for themselves. This characteristic of the programme was mentioned as having significant relevance in the case of ANHU when he decided to maintain abstinence after a period of alcohol use.

In line with this, another factor outlined in the discussion was the satisfaction with achievements. In general, the ability to recognize successes and focusing on those rather than on failures was identified as a resilience factor favouring addiction-related improvement processes. The identification and self-recognition of achievements – even the small ones – rather than an intervention based solely on success or failure, was mentioned as a facilitator within the clients’ strategies to confront the addiction relapses and to allow the definition of a positive identity. As his case manager put it: *Regarding his individual process, he (RAZA) admitted being satisfied and he was celebrating every step forward on his recovery process.*

The case manager explained that these celebrations helped RAZA to take relevant decisions favouring harm reduction, such as joining a counselling group. In doing so, RAZA showed the ability to use his own resources. However, as his case manager put it, he needed to receive “*emotional support too [...] to reduce his feeling of guilt.*”

Reducing feelings of guilt by giving unconditional support to the service user will contribute to foster an empowering climate. The team members of the Hábitat programme acknowledged some strategies developed by clients to avoid these feelings when fighting the addiction. As AHAAH’s case manager explained: *I think that he (AHAAH) anticipated everything what was coming: he gives his money to S. (a friend of him, and a services user too) to contain himself.*

On the other hand, it was noted as relevant the fact that RAZA did not develop new social relationships and kept in contact with previous acquaintances among people experiencing homelessness. RAZA referred avoiding contact with those acquaintances firstly, but since he had not developed new relations, he ended up experiencing feelings of solitude in his new home. When those feelings became too strong, he would return to drinking alcohol in company of previous friends, and that covered up those feelings. In RAZA, the tensions of the process of rebuilding a self-identity were very present. This tension was explained like this by his case manager: *He (RAZA) kept in touch with homeless people he knew, in fact, he invited some of them to stay at home for a while. Once he started an abstinence process, he has told us that he didn't want to keep in touch with them anymore because they prompt him to drink.* This tension was accentuated by the lack of meaningful activities or of new social relations that substituted previous ones linked to his addiction. RAZA's case manager mentioned that the trustful relation with the team members was one of the main supporting resources that the client used during that process.

In contrast to RAZA's strategies, AHAH expressed that avoiding contact with people experiencing homelessness was one of the main facilitators for abstinence. He decided to avoid contact when he stopped drinking alcohol. AHAH found powerful motivators for maintaining abstinence in new social relations that he established in the community and becoming friend with a service client who had successfully confronted an addiction. As expressed by his case manager: *I think that S. (the other service client) has been a motivator for him (AHAH).* On top of that, the case manager mentioned that AHAH's objectives of travelling to Bulgaria and taking care of his dental health had been two essential drivers for achieving abstinence.

Helping other people was mentioned as an effective instrument to develop a positive identity which will help to confront relapses and to build relations in the community. AHAH reported admiring his friend S. because of his ability to help people in a worse situation. He also outlined that this characteristic was crucial to gain control over his addiction and to create new goals to achieve in his life.

These same elements were discussed for the case of ANHU. Although he kept in touch with services for the homeless, he assumed a different role compared to his homeless trajectory: he started volunteering for other people experiencing homelessness. ANHU had assumed the responsibility of migrating and supporting his family financially, but since his arrival to Spain, he had only interacted with people experiencing homelessness. This led him to building a new identity based on negative assumptions about himself. ANHU told his case manager that he had found a powerful motivator not only to fight the addiction but to rebuild an identity in a new romantic relationship with a neighbour.

ANHU articulated these supporting resources to confront his crisis. His case manager explained that when he relapsed ANHU first called his brother in Greece looking for help (his brother subsequently came to stay with him) and then called the service team. Once those supports were assured, he also joined psychotherapy and sought support from his neighbour throughout the process. These actions had never been done before by ANHU when coping with a relapse, and are a good example of how the ability to use and control the client's own available resources.

Supportive programme factors

Supportive programme factors would be those elements of a Housing First service that facilitate the strategies developed by clients themselves to navigate their recovery process. The possibility of being listened without feeling judged in an active listening space was mentioned as one of the most important factors.

Service professionals highlighted the genuine relationship established between the clients and their case managers. The weekly visits of case managers to clients were conceptualized as moments characterised by healthy, adult and open relationships. This type of relationship based on an active, non judgemental listening was exemplified by the case of ANHU as explained by the case manager: only after confronting the addiction relapse 7 months after entering the service, he revealed a stressful vital event from the past. The team had been building a safe active listening space from ANHU's admission to the service. When the relapse occurred and he noticed that the team did not judge him, he felt like sharing that traumatic past experience with them, which would be a key element to work on for his recovery process.

The case managers also identified that active listening was important not only to provide support to confront the relapse, but also to validate the clients' emotions. ANHU's case manager said: "*Clearly, the most important support we gave to ANHU was respecting the times of his individual recovery process*", while RAZA's case manager said: "*I think that RAZA has connected (with his emotions) because he saw that there was another person to validate his feelings*".

Active listening was important to develop what was described as a horizontal relationship with the client. That allowed to personalize support to be proportional to the level of autonomy of the client. Providing support proportional to the client's capacities was mentioned as important factor to promote self-determination in managing the addiction and the recovery process. The case managers explained that *Hábitat* is based on the client's exploration and identification of their individual needs and strengths, therefore avoiding standardized responses and any unnecessary support. Building on that, professionals based their interventions on the "actions" that the person made to address (or not) an addiction.

The team members explained that the proportional support started by respecting the clients' pace in their own processes, and that they were consistently supported by being heard at all times. This implied that clients did not receive support based on prearranged itineraries. As RAZA's case manager explained, being attentive to the client's process indicated when to increase or decrease the number of visits in accordance with his skills and needs: *"The number of visits increased a lot when he (RAZA) began to attend a drug addiction centre and, then, in relapses or crises, phone calls increased a lot"*. Other strategies were used by the team to complement proportional support, so for example motivational interviewing was mentioned as a helpful instrument to help RAZA find the best way to address his needs and make decisions when he felt tired. These complementary approaches promote client's leadership and self-determination and facilitates the reconstruction of the identity and vital purpose.

Within this "proportionality" framework, promoting the clients' ability to use their own resources was discussed as a fundamental intervention strategy. Service professionals explained that their purpose was to generate an empowering environment in which the clients operated their own resources to address their needs. The intervention aims at helping the client to identify individual skills and competences (e.g. persistence, social abilities, etc.), allies in his/her support network (family, friends, neighbours, etc.), and other support resources in the wider community (e.g. health care or addiction treatment services, leisure opportunities, etc.).

All these elements are understood by the service as a system of resources with which the client can continuously and simultaneously interact to confront an addiction crisis. The support from AHAH's partner and his family and from ANHU's brother and larger family were basic elements in their strategy to cope with the crisis, which his case manager remarked: *"ANHU maintains weekly contact (with his family), even more than once (a week)"*. In the case of RAZA, the appointments with the family doctor, the therapeutic community and the support groups were essential for his harm reduction process. His case manager explained that: *"He began paying attention and going to his medical appointments at the addictions' treatment centre"*.

Another important factor of the Housing First model mentioned by the group was the security provided by the home and coverage of basic needs. The ontological security provided by a home and the coverage of the basic needs allow people to dedicate their resources and energy on other issues that they consider necessary to solve (Busch-Geertsema, 2014). As the case managers expressed:



“Yes, he (AHAH) clearly says that he couldn’t quit drinking or start a recovery process while being homeless.”

“(ANHU) says that if he had been homeless, the crisis would have lasted longer because now he has a security zone, a place to rest when needed.”

In this sense, one of the challenges that team members had to confront was to make clients understand that they did not need to “gain” their home by being abstinent or committing to a medical treatment. This is important because clients tended to reproduce the same patterns they used when they were homeless. Instead, the Housing First model entails an intervention that gives responsibility back to the users (Bernad *et al.* 2016; Bernad *et al.*, 2017). This was not the case for RAZA and may have also had an impact in the process of fighting the addiction. As his case manager noted: *“I observed that he (RAZA) understood that housing was unconditional, he was never worried about that [...] it was not necessary to remind this to him”*.

From a broader perspective, having a home allows not only a sense of stability and ontological security, but also the emergence of citizenship awareness and the rebuilding of the person’s social network. As shown in a study by Ornelas *et al.* (2014), it is usual that Housing First clients start using other community resources after entering the service, such as local health centres, local social services, neighbourhood organisations and local city councils. Being able to participate in the community and to establish social relations that provide comfort and support in daily life will promote the beginning of a new life and the development of a vital purpose. This transformative process encourages the transition from being “in a lodging resource” to being citizens that draw relationships from his or her environment.

As explained by his case manager, *“after entering the (Hábitat) programme, ANHU continued to attend frequently – twice a week – the day centre where he was before, and he followed the same pattern, that is, he said that he was attending (the day centre) to use the computer, having some companionship, etc.”*. But after confronting the relapse, he moved onto a different role and started volunteering at the service.

Using an ecological and recovery-oriented point of view, participation in a community and integration involves helping service users to move out of their “patient roles”, treatment centres, segregated housing arrangements, and isolation. This sense of “fitting in” the community and a “normalized” access and use of community resources, as any other citizen would do, encourage the effective integration of the person, allowing to build relations with neighbours, and other connections with the wider community. This new approach aims to promote independence, illness self-management, and a new life for people (Carling, 1995; Nelson *et al.*, 2001).

Conclusions

The objectives of the present study were twofold:

- To analyse personal and interpersonal skills and strategies which clients in the *Hábitat* programme used to confront recidivism crises; and
- To analyse the elements of the Housing First model which may promote the use of resilience skills towards achieving abstinence and/or to confront relapses or harm reduction processes.

The *Hábitat* programme has allowed formerly homeless people to experience improvement in their individual dignity, human rights and self-perception. From the group discussion, the programme seems to work well due to its holistic and ecological perspective. In line with previous research (Tsemberis, 1999; Tsemberis, 2010), having stable access to a home and receiving flexible and proportional support from the service promote clients' development their self-determination and self-efficacy.

Consequently, the supportive programme factors provided by the Housing First service would be positively influencing the recovery process and their ability to confront the addictions through the improvement of individual skills and development factors (MacLeod, 2014).

From an ecological perspective, *Hábitat* creates an empowerment and recovery oriented transformational system, where the individuals are not only introduced to the community, but where they have the possibility to become an integral part of their environment (Nelson *et al.*, 2014). This is a complex community intervention that promotes multiple components and sectors across different ecological levels (e.g. system, community, programme, individual).

The "permanent supported housing" solution provided by the *Hábitat* programme, as in other Housing First programmes, is the cornerstone which allows service users to start a new life. As clients pointed out, the (re)building of support networks and fighting complex situations such as an addiction could not be accomplished without being at home. Likewise, the (re)establishment of these connections triggers a feeling of participation in the community that helps people to reclaim their own life's goals. Moreover, the promotion of independent scattered site housing fosters the creation of a link between the person and the community. These factors are fundamental to enhance self-determination and users' quality of life (Carling, 1995; Nelson *et al.*, 2001).

On the other hand, the process of identity reconstruction promoted in Housing First is surely one of the most delicate processes in people's recovery, especially when they are in situations of chronic homelessness with problems of addiction. Through

the elimination of some elements of traditional services (Tainio and Fredriksson, 2009), the Housing First model favours an active and real commitment of the person to fighting the addiction and to the recovery process. Housing First professionals foster the creation of an empowering environment which allows the client to take over his or her recovery process. In this sense, the Housing First Service provides users with personalised support that is inversely proportional to the degree of autonomy for the achievement of their objectives.

Considering these results, we want to highlight some conclusions related to the approach to addictions and homelessness with interventions based on a Housing First model:

- The principles of the Housing First model encourage the development of skills and abilities of the clients, which are essential to fight an addiction and for their general recovery processes.
- The support provided by the *Habitat* programme –based on self-determination and control of the person– enables users to stay at home independently of their consumption (controlled or problematic), as has been demonstrated in earlier research (Patterson *et al.*, 2013).
- Housing access and stability by themselves encourage the initiation and development of people’s recovery processes to a greater extent than traditional homelessness services (De Vet *et al.*, 2013; Tsemberis, 1999; Tsemberis, 2010).

Of course, the present paper is not free of limitations. Firstly, generalisation of results should be taken cautiously given the chosen methodology. Causal inferences cannot be drawn since it is not an experimental methodology, although it must be noted that generalisation was not our main goal. Implementing a qualitative methodology enable us to understand the complexity underlying a recovery process, including how a person develops his or her coping strategies. Secondly, it is worth mentioning that sample size was configured following specific criteria of staff members in accordance with research purposes. It is possible that a larger sample would have been useful to draw wider conclusions. However, “theoretical legitimacy” can be achieved even in non-probability samples (Gobo, 2004). Thirdly, designing an *ad-hoc* questionnaire for this research entails a methodological challenge because it is not still validated. Although this issue must be accounted for in future research, it should be noted that this instrument was only implemented to collect preliminary data about clients which facilitated the discussion of the focus group.

Based on these conclusions, and considering limitations, we believe that this study can be used as a helpful guide to understand resilience factors in clients of a *Housing First* programme. But, above all, substance use is shown not to be a valid

reason for eviction (United States Interagency Council on Homelessness, 2016). This research has demonstrated that individuals with problems of substance use are people just like anybody else, that can fight their addictions while living autonomously.

In the same vein, results offer some insights in designing future policy recommendations for people experiencing homelessness. Specifically, a harm reduction approach encourages service users to gain control over his or her situation and, therefore, they are more prone to develop resilience factors to prevent future relapses. Housing First approaches have consistently shown that providing a house and person-centred support services is an effective (and efficient) way to treat addiction problems. All this suggests that it would be interesting to promote further research on housing-led and person-centred services in programmes for the treatment of addictions.

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