Housing First or Last Resort? [1] Managing the Dilemmatic Positions of People Experiencing Homelessness who Use Illicit Drugs in Social Service's Team Meetings

Johan Lindwall

University of Gothenburg, Sweden

Abstract_ *The current study adopts a bottom-up perspective to analyse how Housing First is implemented by street-level social workers within municipal social services in the context of Sweden's restrictive drug policy. The specific focus is on how social workers discuss and construct Housing First as an intervention for people who use drugs who do not want treatment for their drug use. The study draws on discursive psychology to analyse meaning-making processes in decision-oriented team meetings. The results show how a dilemma arises for social workers when the restrictive drug policy requires them to actively counter clients' drug use, while the rights-based philosophy of Housing First urges them to emphasise clients' choice and control. It is shown how the decision-oriented discussions are permeated by the idea of an obligation to work toward drug abstinence if clients are perceived as changeable, while Housing First is promoted only when clients are perceived as non-changeable. The idea of an obligation to work toward drug abstinence functions as a barrier to faithful implementation of Housing First. Consequently, Housing First is constructed as a kind of 'dispreferred intervention', only acceptable for clients where continued drug use is deemed something that needs to be accepted.*

[1] An early proceeding of this research was presented orally in 2021 at the IV ISA Forum of Sociology, Alegre, Brazil. The presentation was titled "Housing First or Last? On the Dilemmatic Representations of Homeless Drug Users in Swedish Social Work Discourse". An abstract of the presentation was published in the Book of Abstracts.

ISSN 2030-2762 / ISSN 2030-3106 online

Keywords_ *Homelessness, substance use, Housing First, social services, team meetings, discursive psychology*

Introduction

In Sweden, homelessness is a growing challenge (Socialstyrelsen, 2021). Although the population of people experiencing homelessness is heterogeneous, a considerable number also have problems related to illicit drug use (Socialstyrelsen, 2017). People who use drugs (PWUD) pose a particular challenge for social work with homelessness. PWUDs have long been subject to society's typified characterisations, moral judgements, and interventions. Often, they are positioned in the crossfire between conflicting ideas linked to drug policy, legislation, science, morality, and common sense, that in turn justify society's responses. Sweden is characterised by a restrictive drug policy including a zero-tolerance approach to illicit drugs. An overarching goal is to achieve a society free from drugs (Skr. 2021/22: 213). In line with this, all handling of illicit drugs – including consumption – is criminalised. In accordance, the Social Services Act (SSA, SFS 2001: 453) prescribes an *imperative for action* (Lindwall, 2020) for public sector social workers in municipal social services, meaning that they are obliged by law to counteract drug use among citizens, and *actively* work to ensure that PWUDs get the help and support they are deemed to need to become drug-free. Within such a discursive frame, PWUDs are positioned as *objects for change,* and interventions aimed at abstinence are justified as first-hand interventions. But, at the same time, ideas linked to human rights, harm reduction, and public health are gaining ground in drug policy debate and practical social work with PWUDs internationally, but also in Sweden. Human rights and equal access to care are highlighted along with notions of user involvement and self-determination (Socialstyrelsen, 2011; 2013; SOU, 2021: 93). On an interventional level, Housing First (HF) is an example of this movement (Pleace et al., 2019). In social work with PWUDs experiencing homelessness, HF ideally offers clients a permanent and independent housing as a primary and unconditional intervention. A flexible and person-centred support is offered for as long as needed, but whether clients want treatment for their drug use is their own decision. Abstinence from drugs is not a requirement (Tsemberis and Eisenberg, 2000). Core principles in HF philosophy are housing as a human right, but there is also an emphasis on clients' choice and control (Tsemberis, 2010). Permanent housing is viewed as a prerequisite for integration, health, and recovery. Within such a discourse, PWUDs are positioned, not as objects for change, but as *right-bearing subjects* with the same rights of choice and control as others.

It's not hard to conclude that the HF philosophy may collide with the restrictive drug policy's goal of a drug-free society as well as the obligation imposed on social workers. This conflict causes a dilemma for social workers to handle; on one hand PWUDs experiencing homelessness are positioned as objects for society's interventions for individual change, on the other hand they are to be viewed as rights-bearing and sovereign subjects with the right of choice and control. The conflict becomes particularly apparent when HF comes to the fore as a potential intervention for PWUDs experiencing homelessness who show no preparedness to change their drug use. The focus in this study is on municipal social workers' approaches to this dilemma in decision-oriented team meetings when discussing HF as a potential intervention for clients who are considered to belong to this group, that is, in meetings where eligibility decisions for HF are made. It could be argued that this is an exceptional or particularly problematic group, and that social work with this group is a kind of special case work that is not representative of social work with homelessness. While it is true that the group is not representative of all people experiencing homelessness, it is still the case that many PWUDs who have contact with the social services need social services' help to exit homelessness, even if they do not want treatment for their drug use. As Juhila (2003) says, there is also a particular value in focusing on the 'problematic clients', as they are often the ones who make the institution and its rules visible.

The implementation of Housing First

HF was developed during the 1990s in the US, initially for people experiencing homelessness with psychiatric problems (Tsemberis, 2010). Soon, HF came to include other groups experiencing homelessness with complex problems, such as PWUDs. As a method to combat homelessness, HF has strong support in research (Busch-Geertsema, 2014; Padgett et al., 2016; Cherner et al., 2017; Pleace et al., 2019; Knutagård and Kristiansen, 2019). Today, HF is a recommended policy and often promoted as a first-hand intervention by supervisory authorities, including in the EU, and specifically in Sweden (Padgett et al., 2016; Folkhelseinstituttet, 2016; SBU, 2018; Baptista and Marlier, 2019; Socialstyrelsen, 2021; SOU, 2021: 93). The Swedish implementation and scaling up of HF, however, has not developed at a pace that is on par with the method's support (Knutagård and Kristiansen, 2013; Wirehag, 2019; Carlson Stylianides et al., 2022; SOU, 2023: 62). HF was introduced in Sweden in 2010, but by 2021, only 19% of the municipalities reported that they could offer HF (Socialstyrelsen, 2021). There are indications that the number of HF apartments is increasing in these municipalities (Socialstyrelsen, 2021), but many municipalities are deviating from the core principle of providing a first-hand contract upon moving in (Wirehag, 2019). Overall, the implementation varies significantly among different municipalities and fidelity to the core principles is low (Knutagård and Kristiansen, 2013; Uhnoo, 2019; Wirehag, 2019), even though high fidelity is

associated with positive outcomes (Rae et al., 2018). Carlsson Stylianides et al. (2022) note that interventions that are based on clients' preferences, choice, and control have generally been difficult to implement in Swedish welfare institutions. Research and evaluations on the implementation of HF have identified a number of barriers, such as a general shortage of housing (SOU, 2021: 93), property owners' high thresholds for who should be granted a housing contract (Boverket, 2010; Wirehag, 2021), the structure and organisation of the everyday work (Knutagård and Kristiansen, 2019), and multi-agency difficulties among the involved actors, linked to conflicting organisational logics (Carlson Styliandes et al., 2022). Knutagård and Kristiansen (2013) write about a 'path dependency' resulting in HF tending to be implemented according to already established housing models, such as the so-called 'staircase model'. The staircase model is based on the idea that clients should deserve increasingly independent housing by submitting to treatment or refraining from drugs. Despite HF's strong support in research, the staircase model is still the most common first-hand intervention for homeless users of illicit drugs (Knutagård and Kristiansen, 2013; Wirehag, 2022). At the local level, Hansen Löfstrand (2012) has shown how HF can be implemented as a last-resort solution, a way to provide special housing and palliative care for those deemed to be suffering from an 'incurable' condition, while those considered 'curable' are managed within the staircase model.

In two recent Government Official Reports (SOU, 2021: 93; 2023: 62), the importance of a public health perspective is emphasised, along with a need to accelerate the implementation of HF and harm reduction interventions. Simultaneously, the restrictive drug policy and the significance of countering drug use is underscored from a political standpoint, and the dilemmas that the two perspectives can give rise to continue to be disregarded in governmental policy documents or strategies.

While previous research to a high degree has focused on implementation barriers at a structural or organisational level, this study adopts a bottom-up perspective to highlight public sector social workers' struggles to implement HF as a concrete intervention in their daily practice. Leaning on Lipsky (2010), the study proposes that our understanding of social work interventions remains incomplete if only policy is studied as implemented 'from above'. Ultimately, policy is made when street-level social workers deal with contradictions and dilemmas permeating their everyday work. It is in street-level social workers' everyday struggles that policy becomes manifested as actual social work interventions.

Aim and Research Questions

At the centre of the study is municipal social workers' collective meaning making processes in decision-oriented team meetings. The aim is to contribute to knowledge about how social workers discuss and construct HF as an intervention for PWUDs who express no preparedness to change their drug use. The focus is on contradictory elements in social workers' client representations and on how they rhetorically proceed to arrive at agreement. How are arguments for and against HF designed to appear justified? How are clients represented, and which underlying ideals can be discerned in social workers' justifications? And lastly, how is HF – as consequence – constructed as a social work intervention for PWUDs experiencing homelessness who do not seek treatment for their drug use? Against the backdrop of these research questions, the implementation of HF is critically discussed from a bottom-up perspective. Even though the study is situated at three social service units (see Methods and Materials) in a Swedish restrictive drug policy context, and although differences in municipalities' access to and organisation of HF impact decision-making processes, it is arguable that the results have generalisability to other contexts at a higher level of abstraction as it addresses universal social work issues linked to perceptions of how clients' presumed needs for interventions should be balanced against central liberal core values such as integrity, autonomy, and choice.

The Organisational Context

The social services are responsible for both managing homelessness and substance use problems in Sweden. The Social Service Act (SSA), which regulates social work for all municipalities, is a framework law that leaves a relatively large space for local interpretation and social workers' discretion. Hence, the local social service's view and everyday handling of clients is crucial and, to a large extent, decisive for what help people get. Alongside the SSA, there is also the Care of Substance Abusers (Special Provisions) Act (SFS 1988: 870), which assigns a legal power and responsibility to social services to intervene with coercion against individuals' substance use if certain criteria are met. Social work with people experiencing homelessness, as with PWUDs, is usually organised under social services' individual and family care, which in turn falls under the responsibility of a politically appointed social welfare board. The organisation of the individual and family care can vary among municipalities, but often the work with PWUDs is carried out in special units which also manage housing issues for their clients. This means that it is often the same social worker, or the same team of social workers, who assess clients' rights to and needs for both substance use treatment and housing.

Social service's housing solutions for PWUDs experiencing homelessness have often been intertwined with – or even conditioned by – substance use interventions. The staircase model (Knutagård and Kristiansen, 2013) is an example of this. Clearly, in positioning the client as an object of society's interventions and for change, the staircase model stands in strong contrast to HF. On the other hand, the staircase model harmonises well with Sweden's restrictive drug policy and social service's obligation to counteract drug use.

Decision-oriented team meetings

The municipal social welfare committee can delegate decision-making rights concerning individuals to team leaders or social workers at the street-level within social services. Regardless of where the decision-making authority lies, social workers with direct contact with clients normally discuss the decisions that they want to propose with team leaders. Often, such discussions take place at the unit's team meetings. Team meetings are recurring meetings at social service units, where social workers and team leaders collectively discuss individual clients in the latter's absence. Previous research has described team meetings as central to how the practical social work is carried out within human service organisations (Niknander, 2003; Petersson, 2013; Lindwall, 2020). Although discussions at team meetings do not always lead to formal authority decisions, they are decision oriented. Often, discussions concern questions such as which responses or strategies of actions are appropriate in relation to clients' situations. Typically, a case worker initiates a team discussion by describing a client and his or her situation. Sometimes the case worker has a proposal for a decision, other times the case worker more openly seeks the guidance of the team. When the case worker has produced the initial description, other team participants usually ask clarifying questions, and a discussion takes place. The discussion often leads to a conclusion either on how to proceed with the client or alternatively that more information is needed to take a position on the matter.

Analytical Framework

Discursive psychology (DP) is used to analyse social workers' discussions. DP puts situated language use in focus, as well as the discursive resources and rhetorical devices speakers make use of (Potter and Wetherell, 1987). The focus is on what talk *accomplishes* in interactions. In this section, central DP-concepts will be introduced. Also, Emerson's (1981) concepts *first-resorts, dispreferred responses,* and *last-resorts* will be presented. These concepts will be used to analyse and discuss how HF is constructed as an intervention.

Justifying decisions in a dilemmatic context

Dilemmas, from a DP perspective, occur when "socially shared images, representations and values can be seen to conflict" (Billig et al., 1988, p.14). These shared elements in a society are considered the foundational components shaping our social world. Billig contends that they form a society's *lived ideology*, representing the collective common sense and encompassing our everyday contradictory perceptions, values, and assumptions. To handle dilemmas in decision-making, a delicate rhetorical work is required. As both sides of a dilemma are considered true, they normally both need to be accounted for. Unilaterally advocating one side risks questioning and jeopardises the argument's credibility, as the other side is also valid. *Rhetoric* plays a central role when dealing with dilemmas in decision-making. Rhetoric, in a DP perspective, encompasses all communication that promotes a certain view on a phenomenon (Potter, 1996). All descriptions of a phenomenon possess a rhetorical dimension, representing a stance on a version of reality that simultaneously conceals or challenges alternative versions. Therefore, rhetoric extends beyond persuasive speech, constituting an inherent aspect of language, or a "pervasive feature of the way people interact and arrive at understandings" (Potter, 1996, p.106).

For decisions to gain consensus in team meetings, they must appear *justifiable*. Previous research emphasises the centrality of client descriptions in justifying decisions in social work (Hall et al., 2003; Järvinen and Mik-Meyer, 2003; Petersson, 2013; Lindwall, 2020). Client descriptions concern the client's identity. DP conceptualises identity in terms of *subject positions*. In talk, dynamic positions emerge for the speaker, the person being addressed, and for others the conversation concerns (Harré and van Langehove, 1999; Wetherell, 1998). Positions encompass moral and personal attributes, linked to rights, obligations, and responsibilities, and assumptions about the person. Attributes and expectations associated to positions are shaped by interactional rules, but also of culturally shared images, categorisations, and narratives (Wetherell, 1998).

A key concept in this context is *interpretative repertoires* (Potter and Wetherell, 1987). The concept denotes a recurrent way of talking about a phenomenon that creates a certain recognisable version. Interpretative repertoires can be defined as "a limited range of terms used in particular stylistic and grammatical constructions" that is often "organized around specific metaphors and figures of speech (tropes)" (Potter and Wetherell, 1987, p.149). Interpretative repertoires are shared discursive resources used to make sense of phenomenon, events, ourselves, and others, distributing certain subject positions. They function as "the common sense which organizes accountability and serve as a back-cloth for the realization of locally managed positions in social interaction" (Wetherell, 1998, pp.400-401). Since interpretative repertoires are shared resources, a mere allusion to a specific repertoire

leads others to draw certain conclusions. Hence, by drawing on certain interpretative repertoires, social workers dynamically create versions of clients in their descriptive practice. Rhetorically, interpretative repertoires can be said to *advocate* certain client versions, silencing alternatives and framing specific responses as preferable. Thus, interpretative repertoires are deeply involved in justifying decisions at team meetings. However, credible client descriptions require gradual construction in social workers' team meetings. Constructing credible client descriptions involves various linguistic practices, often addressing issues such as 'how much/ how little', 'good/ bad' or 'normal/abnormal'. Potter (1996) writes in this context about *extremisation/minimisation devices* and *normalisation/abnormalisation devices*, highlighting how speakers strategically use rhetorical resources to convey a sense of normality, abnormality, danger, or deviation.

Constructing Housing First as a social work intervention

How HF is constructed as a social work intervention concerns matters such as who it is considered to be for and what goals it is intended to achieve, but also whether it is a recommended response to a social problem or if it advisable only in exceptional cases. Emerson (1981) distinguishes between three typical societal responses to undesirable social phenomena: *first-resorts*, *dispreferred responses,* and *last-resorts*. First-resorts are responses that are preferred and considered optimal for specific problems, while last-resorts, being a certain kind of dispreferred responses, are generally avoided because they are considered to bring negative consequences. Last-resorts are distinct from other dispreferred responses. While many dispreferred responses can be considered as one of several available options, and occasionally chosen for pragmatic or situational reasons, last-resorts are justified as the sole available option within an "idiom of *necessity*" (Emerson, 1981, p.4), positioning the response as necessary and the only available option against a backdrop of "normal remedies" (Emerson, 1981, p.5). The construction of an intervention is closely tied to its justifying decision logics. Emerson identifies two decision logics associated with last-resorts, each linked to distinctive justifying procedures. The first includes establishing that normal remedies are inappropriate, positioning the client as an unusually 'serious case'. The second includes creating a narrative that establishes a history of the client, asserting that all normal remedies have been tried and failed. Successful justification hinges on establishing that normal remedies were adequately attempted and failed, making necessary to resort to last-resort responses. Therefore, the justifying procedure serves as an account of the decision logic and the necessity, and last-resorts can be described as socially constructed *outcomes* achieved through these justifying procedures (Emerson, 1981).

Methods and Material

The article builds on material that is part of a larger corpus of data generated during an ethnographic fieldwork at three Swedish social service units in 2017.[2] One was located in a small town, the other two in metropolitan areas. The units worked with clients categorised as PWUDs. The social workers at the units were responsible both for providing substance use treatment and housing for their clients. The units included 12, 15, and 17 (n=44) social workers (33 women and 11 men) respectively, team leaders and managers included. Observations (about 250 hours) were carried out in a variety of settings, including the units' team meetings, meetings between single social workers and team leaders and between social workers and clients. In addition, in-depth interviews with staff (n=38), team leaders (n=7), as well as focus group interviews with staff (n=3), were carried out.[3] All the material and its analysis underpin the findings in this study, but in focus in the current article is material collected from the units' team meetings. A total of 13 team meetings were observed (about 20.5 hours). From the position of an onlooking observer (Patton, 2015), the interactions and conversations of the social workers were documented through fieldnotes and audio recordings. Audio recordings enable transcription in high detail and allows the researcher to document non-verbal communication through field notes at the same time (Silverman, 2011; Fangen, 2005). The material was transcribed verbatim in high detail and read over and over again. Discussions that touched on PWUDs' right to housing, and discussions that regarded HF as an intervention, were selected and analysed in more detail. Using ideological dilemmas, positioning, interpretative repertoires, extremisation, and abnormalisation as analytical concepts, the selected material was analysed with a focus on dilemmatic elements in the discussions, how arguments for or against HF were formulated, how clients were represented, and how HF was constructed as an intervention in the discussions. In the latter, Emerson's concepts *first-resort*, *dispreferred responses,* and *last-resort,* was also used.

The study's research questions, as well as its theoretical and methodological approach, require detailed linguistic analysis. Attention is paid to communicative elements that often pass as trifles, such as word choice, small pauses, emphasis, and hesitations, which on closer analysis can turn out to be significant communicative acts. Some transcriptions markers, derived from Jefferson's (2004) list, therefore need explanation:

---

2 The study was approved by the Regional Ethical Review Board of Gothenburg (892-16).

3 For a more detailed material and method discussion, see Lindwall (2020).

Underlining	**Signals emphasis**
(1.5)	Specifies pauses in seconds
Hyph-	Marks a cut-off
=	Indicate no gap between utterances
((text in double brackets))	Indicates clarifications inserted by the author
SW	Social worker
TL	Team leader

The study's analytical focus on interactional processes and details means saying 'a lot about little' rather than the other way around. Therefore, only a limited selection of the collected empirical material can be presented in the article. The presented material is selected because it represents recurring ways of reasoning when social workers in the collected material as a whole talk about or discuss HF in relation to PWUDs experiencing homelessness who are considered lacking a readiness to commit to treatment for their drug use.

Results

In this section, the study's results are presented and discussed. Two examples of excerpts from team discussions are presented and analysed. The first example is an excerpt from a discussion where a case worker argues against proposing HF for a client. The second example is an excerpt from a team discussion where a case worker promotes offering HF to a client.

Case 1: "We're not there yet"

In the following excerpts, justifying arguments for not offering HF to a client are produced. When we enter the conversation, a case worker (SW1) is in the process of describing a meeting that she and another social worker at the unit had with a client the day before: a woman experiencing homelessness who is relatively new to the unit. According to SW1, the woman told them that she has been homeless for a couple of years. Lately she has lived in a basement storage. She has also told SW1 that she suffers from anxiety and drug addiction. The reason for her contact with social services, however, is not the drug problems or her mental health, but her situation as homeless. According to what she told SW1, she has never received treatment for her drug addiction.

01 SW1: So (0,5) eh this woman that we met yesterday (1.2) she comes here because she has an illness, she says. Anxiety and a drug addiction. And what does she want? (1.5) An apartment.

02 SW2: To treat the-=

03 SW1: =Yeah. And I tried to bring up like detox and discuss some sort of treatment plan, but she strongly rejected. She only wants an apartment.

In the first turn in the excerpt, SW1 produces a client description in which the client appears to position herself as ill (anxiety and a drug addiction). It is worth noting how homelessness is not included in this problem description. SW1 then describes what the client wants: an apartment. With the rhetorical question "and what does she want?", the just-produced problem description is linked to the client's application for an apartment, whereby an apartment appears as the client's own (bad) proposal for a solution to her illness. In turn three, SW1 provides some clues as to what client position is normatively desirable of a client of this kind: someone who is prepared to detoxify and submit to a treatment plan. At the end of the turn, this is set in sharp contrast to what is described as the client's actual position. In the description, SW1 makes use of a *narrative contrast structure* (Smith, 1978) as an abnormalising device (Potter, 1996), where a description of how the client is said to be is contrasted to hints of what is normatively desired. Through this, a notion of abnormality is added to the client description. Abnormalisation can be used rhetorically in conversations to justify arguments (Potter, 1996). Here it functions by countering arguments for HF by making such an idea seem abnormal, while at the same time justifying the idea that the client needs to work on her drug problems first. SW2 then asks a question:

04 SW2: So eh (0,7) so she had no substance problems or what? ((ironic tone))

05 SW1: Well, obviously, living in a basement storage room won't help her, but she- well eh- she wasn't prepared <u>at all</u> to do something about her problems. (0.7) And it's not like we have a load of apartments just to hand out.

06 ALL: ((laughter))

In turn four, SW2 confirms the just-produced abnormality in wanting to solve an illness (now merely formulated as a drug problem) with an apartment, which shows that this is a recognised way of reasoning at the unit. But what happens next is of interest. In turn five, SW1 says that it doesn't help the client to live in a basement storage, but then she quickly returns to the previous line of argumentation and emphasises the client's unwillingness to do something about her substance use problems. As Billig et al. (1988) say, when reasoning concerns dilemmas, both sides of the dilemma must normally be addressed since they are both held to be true. By first addressing the other side of the issue, that an apartment can also be seen as helpful for people in vulnerable situations, she shows that she already has taken that side into account. By this, she avoids criticism for being unaware of that side of the issue or for being insensitive. SW1's utterance functions as a disclaimer (Hewitt and Stokes, 1975) that makes it easier for her to proceed with the argument

that the client should express a will to do something about her drug use. The phrasing "do something about her problems" clearly shows that it is the drugs, not the homelessness, that should be considered the main problem in need to be solved first. Note also how *limited resources* is brought in as a rhetorical resource to back up the argument against HF. The wording "a load of apartments just to hand out" is formulated in an extreme way and as a truism hard to argue against. Truisms and extremisations (Potter, 1996) are commonly used as rhetorical devices to convince. At the same time the expression obscures the fact that there may be *some* apartments to hand out to *some* clients. However, despite the assent and affirmative laughter of several colleagues, SW3 picks up this obscured opportunity to carry on the discussion:

07 SW3: Well, that is only half true, isn't it? It is for a fact the housing first way of thinking, that=

08 SW1: =Yeah, but obviously we can't get to that point so quickly=

09 TL: =No.

10 SW3: No, of course. I'm just saying that's the housing first idea, that you need a stable ground before being prepared to engage in other things.

11 SW1: Yeah, but if we just gave an apartment to everyone who- (0,5) completely unconditional- (0,7) I mean, if the drug use doesn't have <u>any</u> consequences at all, and if we don't require <u>anything</u> in return, then how should they be motivated to do something about their drug use? Why change something that's okay? We might get there ((to HF)), but we have to try other things first. Or else I feel we let her down.

SW3's turn (turn seven) makes clear that there is another side of the issue to consider. SW1, however, interrupts before SW3 develops his reasoning. The interrupting utterance "Yeah, but obviously we can't get to that point so quickly" is interesting in several ways. The very fact that SW1 interrupts before SW3 has finished speaking, also with the word"yeah", shows that SW1 already has a clear idea of how SW3 is going to develop his turn. In other words, SW3's way of looking at the matter is well known in the group. The fact that SW1 uses the word"obviously" is therefore also of interest."Obviously" is an epistemic adverb that refers to shared knowledge, that is, something the other participants already are expected to know (Heinemann et al., 2011). By presenting the opinion that "we can't get to that point so quickly" as common knowledge, it becomes more difficult to argue for HF, since it epistemically positions the other team participants as expected to possess this "knowledge". This is indicated by SW3's response (turn 10), where he explicitly confirms the correctness of SW1's reasoning and clarifies that his input in the discussion should not be regarded as a proposal on how to proceed, but rather as

a neutral account of"the housing first idea". SW1 then launches a relatively exhaustive justification in which the underlying logic becomes clear: If clients get an unconditional apartment, they will be deprived of reasons to work on their drug problems. This, in turn, would mean "giving up" on clients' individual changeability. Therefore, it is justified not to propose HF, and instead proceed with interventions aiming at abstinence.

A first thing to notice in SW1's justification is, again, the extremisations"to *everyone*","*completely* unconditional" and"require *anything* in return". These *extreme case formulations* (Pomerantz, 1986) contribute to producing an extreme version of the apparently present idea of housing as an unconditional right. Rhetorically, the extremisations strengthen SW1's argument by having a convincing function (Potter, 1996), while at the same time they obscure the possibility that some clients may be offered HF as well as that more nuanced responses are possible. A second thing to notice is how the justification is grounded in an *interpretative repertoire of obligated abstinence.* This repertoire has a one-sided end-goal of achieving abstinence from drugs, and the social worker is obliged first and foremost to work toward this goal. The lines "we have to try other things first. Or else I feel we let her down" indicate that the work should primarily aim to get the client abstinent from drugs and that there is an obligation of 'help' from the social worker to the client – however, an obligation that the client has not signed up for. The client is positioned within the repertoire as 'someone not to give up on' while the social workers are positioned as 'facilitators of individual change'. Echoing the overarching Swedish restrictive drug policy discourse, the client's individual changeability is placed at the centre. The client position entails that the client is potentially changeable (cf. 'curable', Hansen Löfstrand, 2012), but – at the same time – an object for societal interventions rather than a rights-bearing subject.

HF is not constructed as a first-resort response in the team discussion. Wordings such as "we might get there ((to HF)), but we have to try other things first" indicate the presence of a set of local 'normal remedies' that would need to be established as inappropriate before turning to HF. This, in turn, indicates a construction of HF as a kind of dispreferred response. However, no explicit narrative that all normal remedies have been tried and failed is produced to justify HF in the discussion. So, while it can be ruled out that HF is constructed as a first-resort response in the team discussion, it cannot be concluded that the decision-making logic fully resembles that of last-resort procedures.

Case 2: "We have exhausted our resources"

In the following excerpts, arguments are developed to justify HF for a client. The team discussion concerns a man in his mid-50s, homeless with a well-documented long-term use of illicit drugs. The case worker (SW1), who has worked at the unit

for many years, has had long-standing contact with the client, even though the client has also "been absent" from social services intermittently. According to SW1, the client has submitted himself to treatment for his drug use several times over the years, however often without fully seeming to commit to or completing the treatments, and always without achieving abstinence from drugs. Today, he expresses no desire for more treatment according to SW1, and is currently residing in a communal housing shelter with other PWUDs experiencing homelessness. During SW1's last meeting with the client, the possibility of the client obtaining more independent housing was raised, which is the reason why the client is being discussed at the team meeting. When we enter the discussion, SW1 is in the process of describing the client to the team:

01 SW1: He's been homeless for- (0,3) well he has never had a home of his own as far as I know. Drug problems since he was a young teenager, in and out of treatment all his life. (1) Nothing has helped.

02 SW2: Mm.

First, it's worth noting how SW1, just like the case worker in the previous team discussion, extremises the client description (Potter, 1996). With extreme case formulations (Pomerantz, 1986) such as "*never* had a home", "in and out of treatment *all* his life" and "*nothing* has helped", SW1 paints a convincing picture of a client that is particularly difficult to help which positions the client as exceptionally hard to change. The description implicitly counters the idea that they should keep pushing for treatment and lays a justifying foundation for a new course of action. SW2's "mm" confirms the client description. Whether SW2 is familiar with the specific client is not known, but in either way, SW2's response signals that this is a well-known way to describe a client category. The confirming"mm" encourages SW1 to proceed:

03 SW1: I think eh- (0,2) maybe it's time we look at some other sort of solution, like a more long-term solution (0.7) like housing first or something like that.

In turn three, SW1 launches the idea of HF, but note the high prevalence of hesitations and softening hedges in the turn ("I think", "eh", "maybe", "like", "or something like that"). Promoting HF for a client who uses illicit drugs might implicitly mean accepting the drug use, which stands in sharp contrast to the drug-free ideal of the restrictive drug policy. The hesitations and softening hedges show that the launching of this idea is treated as a delicate matter (van Nijnatten and Suoninen, 2014). But by treating it as such, SW1 also signals an awareness of the deviance from the ideal of abstinence as well as having already seriously considered the

option of continuing to push for treatment. This signals the presence of two contradictory ideas which SW1 is balancing through delicate rhetorical work. The TL then takes the floor and formulates a request for an account:

04 TL: Mm. (2.5) Mm. What have we- what help has he received lately? (1.2) How have we worked with him?

05 SW1: Well, for the last couple of years we've helped him with different short-term housing solutions, and eh- (0,7) well you know (0.3) pushed for treatment. (2) But eh- (0,7) I don't think he- (0,5) maybe he's one of those people who just won't- maybe he will never commit fully to a treatment programme or never become free from drugs completely. I feel that (0.3) he has tried everything, and eh (0.7) to be honest eh- he's not getting any younger.

The lengthy paus after TL's first "mm" in turn four indicates that SW1's idea touches on a delicate matter (van Nijnatten and Suoninen, 2014), and the following request for an account of how SW1 has worked with the client shows that HF cannot be proposed too lightly for a client of this sort but requires a more developed justification. In turn five, SW1 responds to TL's request and describes the orientation of the work with the client the last couple of years. The description itself constitutes a strong argument for not pushing for further treatment, and thus implicitly promotes a change in strategy. Self-initiated, SW1 then develops the description of the client in which he is portrayed as someone who assumably might lack the potential to achieve abstinence from drugs. Some elements in the description are particularly worth noting. Again, SW1's language use indicates that the issue is being treated as very delicate, there are plenty of hesitations and softening hedges. Also, note the expression "one of those people" which implies that the client represents a well-known and established client category. The category is used as a discursive resource in the discussion to rhetorically construct the client as a special kind of client; one who most certainly belongs to a well-known category, but nevertheless deviates from the norm. This constitutes a solid argument for a change in strategy, as it both refers to an established way of thinking about clients and at the same time justifies handling the client as an exception. In a delicate way, SW1 can get the message through that it is time to give up the idea of abstinence without having to spell this out too explicitly. SW1's reasoning also constitutes a subtle move toward the last resort decision logic (Emerson, 1981).

Another thing to note is how the argument, just like in the team discussion in case 1, revolves around perceptions of the possibility of abstinence and the client's changeability. Here, however, the social workers make use of an *interpretative repertoire of abstinence as unachievable*. Wordings such as "pushed for treatment" and "tried everything" surely reflects both the restrictive Swedish drug policy discourse and the municipal social workers' obligation to counter drug use, but

here the client does not occupy a position as changeable but as *non-changeable*, and thus 'someone to give up on' when it comes to abstinence and individual change (cf. *incurable*, Hansen Löfstrand, 2012). This effectively counters the idea of pushing for more treatment. The position as non-changeable, and hence the built-up justification, is rhetorically strengthened, partly by the extremising formulation "he has tried *everything*", partly by making the client's (high) age relevant.

The team then continues to talk about the client in a similar way. No one challenges the produced client description. The discussion confirms and establishes the view that it is time for a change in the course of action and that HF might be an adequate intervention. After a while, TL takes the floor:

06 TL: Yeah (1.7) yeah, maybe that is the right way to go? (1.5) Maybe we have exhausted our resources (1.2) eh- maybe he should have one of our ((housing first)) apartments? (2) With good support, maybe it'll give him a chance to achieve a fair standard of living. What do you say? ((turns to the other social workers in the team))

07 (2)

08 ALL: Mm.

TL seems to buy the built-up justification. With the utterance "exhausted our resources", he strengthens the argument that it is time to change the strategy since "exhausted resources" implies that nothing more can be done to get the client abstinent from drugs. In the context of the discussion, this justifies HF. However, interestingly, once the client has been positioned as non-changeable, TL brings in"a fair standard of living" as a rhetorical resource to justify HF. This indicates a discursive shift. "A fair standard of living" as a discursive resource is rather linked to an *interpretative repertoire of basic rights*. However, it is worth noting that "a fair standard of living" is being used as a justifying resource only *after* the client has already been positioned as non-changeable. This indicates that the interpretative repertoire of obligated abstinence, supported by the overarching restrictive drug policy's promoting of individual change, takes precedence in the discussion, while the interpretative repertoire of basic rights is only seriously invoked when change is represented as non-achievable.

Concluding Discussion

In this section, the results from the analysis of the two cases above are first summarised. In a concluding way it is then discussed how HF is constructed as a social work intervention for PWUDs who show no preparedness to undergo treatment. Finally, the implementation of HF is critically discussed from a bottom-up perspective.

In the two cases above, it has been analysed how social workers rhetorically handle a dilemma that arises when HF is considered as a potential intervention for PWUDs who show no preparedness to undergo treatment. The dilemma is related to two conflicting ways of representing and positioning clients; as objects for interventions and individual change, versus as rights-bearing subjects. It has been demonstrated how the team discussions are permeated by an *interpretative repertoire of obligated abstinence* in which clients' changeability becomes primary, but also how a repertoire of basic rights is present where clients' entitlement to a decent standard of living is made relevant. However, it has been shown how the latter repertoire is employed only after the client has been positioned as non-changeable, that is where abstinence is constructed as unachievable, which can then justify HF as an intervention for this type of client.

HF is not constructed as a first-resort in social workers discussions. Clearly, this is evident in the first case, but also in the second case. The decision-making logic that can be discerned produces anything but an image of HF as the best way to handle the type of problems associated with this group of clients. Instead, the analyses of the two cases indicate that HF is constructed as a kind of dispreferred response. However, the decision-making logic that can be discerned in social workers' discussions does not fully indicate that HF is constructed as a last-resort in an Emersonian sense. Indeed, it's evident that HF is justified against the background of "normal remedies" (Emerson, 1981, p.5), which in this case refer to interventions aimed at achieving drug abstinence. The decision-making logic also resembles that of last-resort procedures in that it involves producing a narrative that all normal remedies have been tried and failed, and that normal remedies no longer can be considered adequate. In the first case, this narrative is not produced (though it is indicated that "we might get there") and accordingly HF is not seen as adequate. In the second case, this narrative is produced and in line with this HF seems justified for the client. However, according to Emerson, the justifying decision logic associated with last-resorts also often involves the construction of an unusually 'serious case'. At this point, the decision logic that justifies HF for PWUDs who have no preparedness to undergo treatment differs in that the 'seriousness' is absent. Certainly, the client is constructed as a special case, but rather than a 'serious case' it is the positioning of the client as particularly *non-changeable* that is of importance. Mirroring the absence of seriousness, the related *idiom of necessity* that characterises the justifying procedure for last-resorts is also absent. Instead, here there is a discursive shift where the repertoire of basic rights enters the justification process. Consequently, HF cannot be said to be constructed either as a first-resort or last-resort response for PWUDs who show no preparedness to undergo treatment (cf. Hansen Löfstrand, 2012). Rather, the analysis suggest that it can be described as a *dispreferred resort of acceptance*. It should be noted that

this characterisation of HF is from the perspective of social work practice, which is what is analysed in the study. From the clients' perspective it might very well be described as a preferred resort of relief.

The results also demonstrate the importance of studying implementation processes from a bottom-up perspective. The study highlights social workers' struggles to implement HF in their everyday work with PWUDs and shows how not only organisational and structural barriers need to be addressed if we are to understand the implementation process of HF. We must also take into account what can be described as barriers linked to social workers' lived ideology in DP's terminology. Such barriers consist of the socially shared images, representations, and values that permeate social work. These are created and maintained – but can also be changed – in human interaction processes. The analyses have shown how the interpretative repertoire of obligated abstinence – that social work with PWUDs should primarily aim at abstinence and individual change – affects the implementation of HF. This repertoire's precedence over the notion that PWUDs experiencing homelessness have the right to independent housing, regardless of whether they request treatment, can be described as a concrete implementation barrier that has practical consequences for both clients and social workers.

References

Baptista, I. and Marlier, E. (2019) *Fighting Homelessness and Housing Exclusion in Europe: A Study of National Policies* (Brussels: European Commission).

Billig, M., Condor, S., Edwards, D., Gane, M., Middleton, D., and Radley, A. (1988) *Ideological Dilemmas: A Social Psychology of Everyday Thinking* (London: SAGE).

Boverket (2010) *Trösklar till Bostadsmarknaden: Om Hemlöshet Som Ett Bostadsmarknadsproblem* [Barriers to the Housing Market: Homelessness as a Housing Market Problem] (Karlskrona: Boverket).

Busch-Geertsema, V. (2014) Housing First Europe: Results of a European Social Experimentation Project, *European Journal of Homelessness* 8(1) pp.13-28.

Carlsson Stylianides, K., Bejerholm, U., Denvall, V., Knutagård, M., and Johansson, S. (2022) Implementation Structures at Work: Exploring Implementation and De-Implementation Attempts Regarding Housing First and Individual Placement and Support, *Social Policy and Administration* 56(4) pp.617-631.

Cherner, R., Aubry, T., Sylvestre, J., Boyd, R., and Pettey, D. (2017) Housing First for Adults with Problematic Substance Use, *Journal of Dual Diagnosis* 13(3) pp.219-229.

Emerson, R. (1981) On Last Resorts, *American Journal of Sociology* 87(1) pp.1-22.

Fangen, K. (2005) *Deltagande Observation [Participant Observation]* (Stockholm: Liber).

Folkhelseinstituttet (2016) *Effectiveness of Interventions to Reduce Homelessness: Systematic Review* (Oslo: Folkehelseinstituttet).

Hall, C., Juhila, K., Parton, N., and Pösö, T. (Eds.) (2003) *Constructing Clienthood in Social Work and Human Services: Interaction, Identities and Practices* (London and New York: Jessica Kingsley Publishers).

Hansen Löfstrand, C. (2012) Homelessness as an Incurable Condition? The Medicalization of the Homeless in the Swedish Special Housing Provision, in: L. L'Abate (Ed.) *Mental Illnesses – Evaluation, Treatments and Implications*, pp.106-126. (Croatia: InTech).

Harré, R. and van Langenhove, L. (Eds.) (1999) *Positioning Theory* (Oxford: Blackwell Publishers Ltd.).

Heinemann, T., Lindström, A., and Steensig, J. (2011) Addressing Epistemic Incongruence in Question-Answer Sequences Through the Use of Epistemic Adverbs, in: T. Stivers, L. Mondada, and J. Steensig (Eds.) *The Morality of Knowledge in Conversation* pp.107-130. (Cambridge: Cambridge University Press).

Hewitt, J. and Stokes, R. (1975) Disclaimers, *American Sociological Review* 40(1) pp.1-11.

Järvinen, M. and Mik-Meyer, N. (Eds.) (2003) *Att Skabe en Klient: Institutionelle Identiteter i Socialt Arbejde* [To Create a Client: Institutional Identities in Social Work] (Köpenhamn: Hans Reitzels Forlag).

Jefferson, G. (2004) Glossary of Transcript Symbols with an Introduction, in: G. Lerner (Ed.) *Conversation Analysis Studies from the First Generation* pp.13-31. (Amsterdam: John Benjamins).

Juhila, K. (2003) Creating a 'Bad' Client: Disalignment of Institutional Identities in Social Work Interaction, in: C. Hall, K. Juhila, N. Parton, T. and Pösö (Eds.) *Constructing Clienthood in Social Work and Human Services: Interaction, Identities and Practices* pp.83-95. (London and New York: Jessica Kingsley Publishers).

Knutagård, M. and Kristiansen, A. (2013) Not by the Book: The Emergence and Translation of Housing First in Sweden, *European Journal of Homelessness* 7(1) pp.93-115.

Knutagård, M. and Kristiansen, A. (2019) Scaling Up Housing First Pilots: Drivers and Barriers, Nordic *Journal of Social Research* 10(1), pp.1-23.

Lindwall, J. (2020) *Handlingsimperativets Dilemma: Om Frihet och Kontroll i Socialtjänstens Arbete med Klienter Som Använder Narkotika* [Dilemmas of the Imperative for Action: On Freedom and Control in Social Services' Work with Clients Who Use Illicit Drugs] (Gothenburg: University of Gothenburg).

Lipsky, M. (2010) *Street-Level Bureaucracy: Dilemmas of the Individual in Public Services* (New York: Russell Sage Foundation).

Nikander, P. (2003) The Absent Client: Case Description and Decision Making in Interprofessional Meetings, in: C. Hall, K. Juhila, N. Parton, and T. Pösö (Eds.) *Constructing Clienthood in Social Work and Human Services: Interaction, Identities and Practices* pp.112-128. (London and New York: Jessica Kingsley Publishers).

Padgett, D., Henwood, B., and Tsemberis, S. (2016) *Ending Homelessness, Transforming Systems, and Changing Lives* (New York: Oxford University Press).

Patton, M. (2015) *Qualitative Research and Evaluation Methods* (Thousand Oaks: SAGE).

Petersson, F. (2013) Excusing Exclusion: Accounting for Rule-Breaking and Sanctions in a Swedish Methadone Clinic, *International Journal of Drug Policy* 24 pp.99-104.

Pleace, N., Baptista, I., and Knutagård, M. (2019) *Housing First in Europe: An Overview of Implementation, Strategy and Fidelity* (Brussels: Housing First Europe Hub).

Pomerantz, A. (1986) Extreme Case Formulations: A Way of Legitimating Claims, *Research on Language and Social Interaction* 33(4) pp.347-373.

Potter, J. (1996) *Representing Reality: Discourse, Rhetoric and Social Construction* (London: SAGE).

Potter, J. and Wetherell, M. (1987) *Discourse and Social Psychology: Beyond Attitudes and Behaviour* (London: SAGE).

Rae, J., Samosh, J., Aubry, T., Tsemberis, S., Agha, A., and Shah, D. (2018) What Helps and What Hinders Program Fidelity to Housing First: Pathways to Housing DC, *European Journal of Homelessness* 12(3) pp.103-128.

SBU (2018) *Insatser för att Minska Hemlöshet för Personer med Missbruk, Beroende och Psykisk Ohälsa* [Interventions to Reduce Homelessness for Individuals with Substance Abuse, Addiction, and Mental Illness] [online]. Available at: http://www.sbu.se/2018_04.

SFS (1998: 870) *Lagen om Vård av Missbrukare i Vissa Fall* [Care of Substance Abusers (Special Provisions) Act] (Stockholm: Socialdepartementet).

SFS (2001: 453) *Socialtjänstlag* [The Social Services Act] (Stockholm: Socialdepartementet).

Silverman, D. (2011) *Interpreting Qualitative Data* (Los Angeles: SAGE).

Skr. (2021/22: 213) *En Samlad Strategi för Alkohol-, Narkotika-, Dopings- och Tobakspolitiken samt Spel om Pengar 2022-2025* [A Comprehensive Strategy for Alcohol, Drug, Doping and Tobacco Policy and Gambling 2022-2025] (Stockholm: Socialstyrelsen).

Smith, D. (1978) 'K is Mentally Ill', *Sociology* 12(1) pp.23-53.

Socialstyrelsen (2011) *Metoder för Brukarinflytande och Medverkan inom Socialtjänst och Psykiatri: En Kartläggning av Forskning och Praktik* [Methods for User Involvement and Participation in Social Services and Psychiatry: A Survey of Research and Practice] (Stockholm: Socialstyrelsen).

Socialstyrelsen (2013) *Att Ge Ordet och Lämna Plats: Vägledning om Brukarinflytande inom Socialtjänst, Psykiatri och Missbruks- och Beroendevård* [Giving the Floor and Making Space: Guidance on User Involvement in Social Services, Psychiatry, and Substance Use Care] (Stockholm: Socialstyrelsen).

Socialstyrelsen (2017) Hemlöshet 2017: Omfattning och Karaktär [Homelessness 2017: Scope and Character] (Stockholm: Socialstyrelsen).

Socialstyrelsen (2021) *Förebygga och Motverka Hemlöshet: Analys och Förslag för Fortsatt Arbete inom Socialtjänsten* [Preventing and Countering Homelessness: Analysis and Proposals for Continued Work within Social Services] (Stockholm: Socialstyrelsen).

SOU (2021: 93) *Från Delar till Helhet: En Reform för Samordnade, Behovsanpassade och Personcentrerade Insatser till Personer med Samsjuklighet, Delbetänkande av Samsjuklighetsutredningen* [From Parts to Whole: A Reform for Coordinated, Needs-Adapted, and Person-Centered Interventions for Persons with Comorbidity, Interim Report by the Comorbidity Inquiry] (Stockholm: Socialdepartementet).

SOU (2023: 62) *Vi kan bättre! Kunskapsbaserad Narkotikapolitik med Liv och Hälsa i Fokus* [We Can Do Better! Knowledge-Based Drug Policy with Life and Health in Focus] (Stockholm: Socialdepartementet).

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

Tsemberis, S. and Eisenberg, R. (2000) Pathways to Housing: Supported Housing for Street-Dwelling Homeless Individuals with Psychiatric Disabilities, *Psychiatric Services* 51(4) pp.487-493.

Uhnoo, S. (2019) *Bostad Först: Utvärdering av Verksamheter i Göteborg* [Housing First: Evaluations of Facilities in Gothenburg. (Malmö: Égalité).

van Nijnatten, C. and Suoninen, E. (2014) Delicacy, in: C. Hall, K. Juhila, M. Matarese, and C. van Nijnatten (Eds.) *Analysing Social Work Communication: Discourse in Practice* pp.136-153. (London and New York: Routledge).

Wetherell, M. (1998) Positioning and Interpretative Repertoires: Conversation Analysis and Post-Structuralism in Dialogue, *Discourse and Society* 9(3) pp.387-412.

Wirehag, M. (2019) Counting and Mapping Local Homeless Service Systems in Sweden, *European Journal of Homelessness* 13(1) pp.159-180.

Wirehag, M. (2021) Gatekeeping, Managing Homelessness and Administrating Housing for the Poor: The Three Functions of Local Housing Services for the Homeless in Sweden, *European Journal of Homelessness* 15(1) pp.83-105.

Wirehag, M. (2022) *Hantering av Hemlöshet: En Kartläggning och Analys av Organiseringen av Lokala Hemlöshetssystem i Sveriges Kommuner* [Ending Homelessness or Managing the Homeless] (Gothenburg: University of Gothenburg).