Article

Improving Harm Reduction Services: A Qualitative Study on the Perspectives of Highly Marginalized Persons Who Inject Drugs in Montreal

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Abstract

Harm reduction (HR) is an alternative to the moralization of drug use and a pragmatic public health approach aimed at minimizing harms associated with use. This study sought to gain the perspectives of persons who inject drugs (PWID) on the adequacy of services provided by HR organizations in Montreal. Twenty-two semi-structured interviews and two focus groups were conducted with 30 participants. Some of the key advantages of HR perceived by participants include access to injection equipment, psychosocial support, and reduced social isolation. However, many wanted more opportunities for social insertion and greater value to be placed on their knowledge and life experiences (e.g., experiential knowledge of the street scene, drug use, sex work, or homelessness). This study suggests that PWID who access HR services in Montreal are interested in paid work opportunities in environments that promote power sharing, and activities that are conducted and managed by and for them.

Keywords

persons who inject drugs, health, harm reduction, social integration

Introduction

The present study was conducted to gain the perspectives of people who inject drugs (PWID) on harm reduction (HR) services in Montreal provided by community-based organizations. In Montreal, Canada's second-largest city, HR services (e.g., providing clean injecting material) are

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mostly government-funded and managed by professionals, a model which is different to that traditionally associated with the origins of the HR approach.

The Harm Reduction Approach

In the early 1980s, movements of drug users emerged in Europe. For example, *Junkiebond* in Rotterdam formed an underground needle and syringe exchange program. This group aimed to fight against police repression on drugs and criminalization, and advocate for the rights of people who use drugs to access sterile injection equipment and health care (Cohen, 1997; Roe, 2005; Souleymanov & Allman, 2015; Toufik, 1997). These demands inspired the development of HR policies in the Netherlands and elsewhere in Europe (Friedman et al., 2015). Since then, HR has been advocated as a philosophy and intervention framework for PWID in many countries, including Canada. According to Harm Reduction International (n. d.):

> Harm reduction refers to policies, programs and practices that aim to minimize negative health, social and legal impacts associated with drug use, drug policies and drug laws. Harm reduction is grounded in justice and human rights. It focuses on positive change and on working with people without judgement, coercion, discrimination, or requiring that they stop using drugs as a precondition of support. […] Approaches such as these are cost-effective, evidence-based and have a positive impact on individual and community health. (para. 1–3)

HR is an alternative to the moralization of drug use (Marlatt, 1996), and is also considered a pragmatic public health approach (Harm Reduction International; Massé, 2013; Southwell & Durjava, 2017). It is primarily aimed at minimizing harms associated with drug use, such as overdose—the leading cause of death for PWID. In Canada, between January 2016 and December 2021, 29,052 people died of overdoses mostly involving toxic synthetic opioids such as fentanyl and carfentanyl, as well as stimulants (e.g., amphetamine-type stimulants and cocaine) (Belzak & Halverson, 2018; Special Advisory Committee on the Epidemic of Opioid Overdoses, 2022).

Persons who inject drugs (PWID) are also at risk for several other health problems (e.g., abscesses, ulcers, phlebitis, endocarditis) which sometimes result in fatal outcomes (Brothers, Lewer, Bonn, Webster, & Harris, 2021; Visconti et al., 2019). In Quebec, blood-borne infections are a major concern as 13.0% of PWID are living with HIV, and 62.6% are have contracted hepatitis C virus (HCV) (Leclerc et al., 2021). Suicide is the second leading cause of death among PWID (Gjersing & Bretteville-Jensen, 2014; Nambiar et al., 2015). Mental health problems are prevalent among PWID and may precede, be exacerbated or induced by drug consumption (Reddon et al., 2018). Furthermore, a web of other complex and interrelated factors are associated with drug use and dependence including: seeking freedom from oppressive social conformity (Fernandez, 2010, 2014), seeking pleasure, a high, or relief from the demoralization for instance linked with joblessness loss of purpose, or medical conditions, such as chronic pain (Archambault, Bertrand & Perreault, 2022; Friedman et al., 2020).

HR services provide many benefits for highly marginalized PWID, such as reducing the incidence of multiple associated harms and facilitating linkage to health care and drug addiction services (Boyd, Carter, & MacPherson, 2016; Strike et al., 2021). The philosophy of HR is one that strives to redress social inequalities faced by PWID, and will incorporate advocacy work, social reintegration (e.g., through work or housing programs) as well as social and peer support (Klein, 2020). Another significant principle of HR for people with lived experience of substance use is that there should be "nothing about them without them," considering the stigma that surrounds drug use, and their need for social recognition (Denis-Lalonde, Lind, & Estefan, 2019; Boyd et al., 2016). It has been demonstrated that combining HR interventions is more successful

in reducing health risks for PWID than one intervention alone (e.g., syringe exchange program), all the more so when actions address the socio-structural causes of risks, such as drug laws and drug policies (e.g., criminalization, repression) (Klein, 2020; Park et al., 2020). Also, governmental, societal, political, legal, and ideological positions on drugs can modulate risks, and in some instances, exacerbate them, through structural violence directed at PWID (Cooper et al., 2009; Gartry, Oviedo-Joekes, Laliberté & Schechter, 2009; Rhodes, 2009). Consequently, PWID may reuse or share injection equipment in order to avoid the experience of possible stigma or police repression during attempts to obtain equipment from HR services (Bourgois, 1998).

Critiques of Harm Reduction Approaches

The way HR has been implemented in many countries has been criticized for its depoliticization, straying from its original aim to defend the rights of persons who use drugs, and centering of programs primarily around risk minimization and individual responsibility toward one's health and that of others (Brothers et al., 2021; Friedman et al., 2020; Hyshka et al., 2017; Souleymanov & Allman, 2015).

From a public health perspective, HR can also consist of identifying people at risk of harm and of transmitting infections with the result that at risk clientele may be perceived as dangerous (Lupton, 1995; Poliquin, 2017). Under this model of self-empowerment, public health interventions can be perceived as "pathologizing" (Harris & Rhodes, 2011) and guilt-inducing (Bourgois, 2002; Roy, Nonn, Haley, & Cox, 2007). This strong social stigma shapes the sociocultural, socio-political, and geospatial environment of PWID that can be understood through the lens of the "risk environment," a concept developed by Rhodes (2002). This concept refers to environmental factors, exogenous to PWID, that increase their risk of harm, which may be outlined as follows: (1) micro or interpersonal level factors related to social norms; (2) meso-level factors that pertain to the responses of institutions and organizations; and (3) macro level factors, situated at most distal level, regarding decisions made about laws and policies that contribute to social inequality (Rhodes & Simi'c, 2005).

As avoidable deaths and harms occur, many effective HR strategies are not being fully deployed in Canada or in other parts of the world, including drug checking; overdose prevention sites; supervised consumption services involving different modes of consumption (e.g., injection, inhalation, or oral consumption); injectable opioid agonist treatment (iOAT); and a safer, legally regulated drug supply (Oscapella, 2012; Strike et al., 2021; Strike & Watson, 2019). Although there was much progress and innovation in HR intervention in Canada during the COVID-19 pandemic (e.g., telehealth for OAT, a 24-hour overdose prevention line, accommodation in hotels for people experiencing homelessness), public health measures had a detrimental effect on the most vulnerable of PWID (Bertrand, Désilets, Ngo Ngué, & The GID-COVID Research Team, 2021). Mitigation measures such as physical distancing and lockdowns greatly hindered the HR approach and threatened the human rights of PWID. COVID-19 mitigation measures have contributed to increased social exclusion and drug-use-related harms due to decreased access to regulated drug supply and formal or informal income generating activities, food, sanitary and health care services, shelters, day centers, and supervised injection services (SIS) (Bertrand et al., 2021; Brothers et al., 2021).

A study by Bastien et al. (2007), conducted in Montreal, highlights how focusing on biological aspects of health diverts from acting upon the social determinants of health. This study explored how street and outreach workers reinterpret public health prevention messages in their daily work with people who are socially vulnerable, such as people who use drugs. The authors concluded that public health strategies are deployed in an essentially non critical manner, which they explain using three contextual elements: (1) the "sanitization" of the social, which is said to be generated

by persistent social inequalities in health, leading outreach workers to intervene more with people excluded from health care services; (2) the crisis of public finances influenced by neoliberal currents and a technocratic logic of efficiency and profitability, which means community organizations are funded according to governmental priorities and their capacities to respond to the imperatives of evidence-base medicine; and finally (3) the socialization and politicization of the medical field, which calls into question the structuring of action by a limited set of health problems identified by experts (e.g., HIV, HCV, drug dependence), rather than by the individuals who are receiving the services (Bastien et al., 2007).

Upstream intervention necessitates advocacy work, healthy public policies addressing the social determinants of health, and concrete action to tackle the structural causes of social inequalities, social marginalization, and exclusion (Boyd et al., 2018; Friedman et al. 2015). Yet, collective action aimed at solving complex problems that shape the everyday life of people who use drugs such as homelessness, criminalization, law-enforcement and social exclusion is often lacking (Friedman et al., 2020; Goodyear, 2021; Lamarre, Mineau, Larochelle, 2006). As sociologist Castel (2012) points out, the freedom enjoyed by individuals is based on solidarity, social ties, social capital, and social rights: "An individual does not have within himself, by himself, this capacity to ensure his independence. He must be given basic conditions in order to behave as a responsible subject" (Castel, 2012, p. 47). These basic conditions (e.g., work and income, housing, access to services, dignity) are central issues for the various groups advocating for the rights of persons who use drugs (Boyd, Carter, MacPherson, 2016; Denis-Lalonde, Lind, Estefan, 2019). Taking this critical stance, this research sought to gain the perspectives of PWID on the adequacy of HR services provided in Montreal.

Methods

Study Design

This study is based on a previous constructivist qualitative study that more broadly investigated the perspectives of PWID on the meaning of health and taking care of self, as well as on the changes that can be made to improve their living conditions and the services provided to them (Poliquin, 2018). The methods of this study have been described previously (Poliquin, 2022; Poliquin et al., 2021). The present study aimed, more specifically, to gain the perspectives of PWID on the adequacy of services provided by HR organizations in Montreal, Quebec using individual semi-structured interviews, focus groups, and participant observation.

Setting

Given the importance of trust in contacting target participants, this research built on partnerships between potential participants and workers from three Montreal community-based HR organizations (A, B and C) that provide services to PWID and other socially marginalized individuals, including people who use crack and other substance users. These organizations provide resources such as safe consumption equipment, a safe place to connect with others, access to HR workers and other affiliated professionals, amongst others. Partnerships had already been established between these three HR community-based organizations and HP's research supervisor and last author (KB) through projects funded by the Canadian Institutes of Health Research (CIHR) and the Fonds de recherche du Québec-santé (FRQ-S).

Theoretical Framework

This study takes a constructivist epistemological approach which privileges the building of knowledge to gather the perspectives of the people with lived experience of the subjects under study (Guba & Lincoln, 2005). The theoretical framework of symbolic interactionism guided data collection and analysis (Blumer, 1969). Within this framework, people make sense of and give meaning to their realities and experiences in light of their social interactions, living conditions and positions held in society (Blumer, 1969). Symbolic interactionism also focuses on the ability of individuals to disengage from forms of social regulation or domination, particularly through negotiation between social actors and reinterpretation of rules of conduct (Mead, 2008; Musolf, 1992). This perspective facilitates the understanding of the links between social exclusion and the self (Anderson & Snow, 2001) and is meant to provide an account of broader social representations constructed and reproduced by institutions, power relations, and ideologies (Musolf, 1992). Thus, a fundamental question that cuts across all work from this perspective is that of understanding "how people create meaningful social realities" such as within social microcultures (Anderson & Snow, 2001; Musolf, 1992). This epistemological perspective also favors face-to-face encounters with participants (Musolf, 1992).

Sampling

For both the individual interviews and the focus groups, convenience sampling was used to recruit 30 participants with various socio-demographic profiles and characteristics (e.g., age, gender, type of drugs consumed, living conditions) in order to obtain a diversity of views (Saldaña, 2015). Inclusion criteria were: having injected drugs in the past month; being over the age of 18; and being able to provide free and informed consent.

Recruitment and Data Collection

Data collection took place from June 2014 to June 2015. Participant observation was conducted by HP in various settings of social interaction (e.g., injection material distribution sites, workshops, street cleaning activity sites, collective kitchens) within three Montreal community-based HR organizations that offer services to people who use drugs. Participant observation took place throughout a period of 12 months for a total of 90 hours. This allowed for several informal interviews to be conducted with participants. Some of them had already participated in a formal interview, while others had not. In a naturalistic manner, HP was approached by individuals who expressed interest in her research project, and what health and taking care of oneself meant to them, among other topics. No observation grid was used during participant observation, however, three types of note-taking were completed during these periods: descriptions of the environment and interactions; content focused on the research questions; content that is theoretical in nature with reflections leading to preliminary data analysis (Arborio & Fournier, 2008; Peretz, 2004).

Participant observation activities in three collaborating Montreal HR organizations (A, B and C) greatly facilitated recruitment of participants for the individual interviews which were also done by HP. Many of those who wished to participate in the research contacted HP directly and were subsequently subject to an assessment of eligibility on the spot, or over the phone. Once deemed eligible, interview with the participant either took place immediately or was scheduled to take place in the following days. HR workers themselves also facilitated the recruitment process by talking about the study and sometimes organizing initial meetings between potential candidates and HP. Six participants were also recruited using the "snowball" method (Poupart, 2011) which

consisted of asking participants to tell their friends and people around them about the study. This resulted in the recruitment of 6 of the 30 participants.

Individual interviews were held in locations deemed most convenient for the participants (e.g., HR organizations; public places, such as parks and university halls; private residences or supervised housing). Twenty-two in-depth one-on-one interviews (with an average duration of two hours), and two focus groups (two hours each; one with women and one with men) were conducted by HP with the assistance of a moderator for each focus group (one with research supervisor and one with a postdoctoral fellow). The moderators took notes and carried out a debriefing immediately after the focus groups. The two focus groups took place in December 2014 (after 20 individual interviews had already taken place). All those who participated in an individual interview were invited to attend the focus group and were reached by phone, in person or through research participants who informed others of the upcoming focus groups. Six people who had not participated in the individual interviews beforehand took part in the focus groups. Certain participants facilitated the recruitment of four new participants to the focus groups by inviting them to attend.

In total, 30 participants (12 women and 18 men) participated in this study (see Table 1 for more details). Different interview scripts were used for the individual interviews and the focus groups, with both scripts touching on subjects of HR services. For example, participants were asked how satisfied they are with HR services, how they feel about them, what they value most, and what they think could be improved in order to meet their needs. While detailed and personal information was gathered in individual interviews, the completion of the focus groups added further richness to the data; common problems encountered in HR organizations, as well as perceived solutions, could be identified. All individual interviews and focus groups were recorded and transcribed verbatim in full and verified for accuracy by the first author.

Data Analysis

Symbolic interactionism (described above) was used as a framework to guide the thematic analysis (Miles, Huberman, Saldaña, 2014). The data, which consisted of the verbatim from the individual interviews and focus groups, and notes from participant observation; was codified using NVivo 9 software, with a mixed grid of pre-established themes (from the interview grid) and emerging themes. Briefly, Miles et al.'s (2014) method of data analysis involves identifying as many themes as possible, without first grouping them together with tight line-by-line coding of the verbatim. Thus, verbatim excerpts are grouped by theme or theme categories. The same verbatim excerpt can be classified using NVivo 9 software under several themes. Another important step of the process is to identify the interactions between the identified patterns, their meanings, the roles held by the actors, the power relationships, etc. One main goal is to identify recurring events or phenomena (emerging patterns) and the interactions between them.

The themes were refined with analysis notes and a written "metamemo," which consists of all the notes produced while coding data paired with verbatim excerpts (Miles et al., 2014). Study credibility and validity were enhanced by strict and transparent processes: keeping a logbook; full transcription of verbatim and full coding of data by themes (with NVivo 9 software); recoding of several interviews; multiple listening and replaying of several interviews; writing numerous memos; and regular discussions with research supervisors (KB and MP) concerning the analytical steps (Miles et al., 2014). Also, during participant observation, HP informally discussed research findings with study participants and other PWID present at these sites, which contributed to deepening the data analysis and served to informally validate findings.

Table 1. Descriptive Variables.

Participant pseudonym	Sexe: Male (M) / Female (F)	Age	Participated in: An individual interview	Participated in: A focus group	Participated in: Number of different encounters during participant observation	Living arrangement at time of study	Age at first injection
Brigitte	F	41		x	0	SA	26
Caroline	F	41	x	x	3+	SA	21
Chantal	F	43	x	x	2	SA	18
Denis	M	46	x	x	3+	H	40
Dominic	M	55	x		3+	A	17
Gabrielle	F	20	x		2	H	17
Émilie	F	38	x		3+	SA	21
Francis	M	28	x		0	H	21
François	M	56		x	0	A	17
Jérémie	M	59		x	0	A	18
Judith	F	48	x		3+	A	27
Julie	F	42	x		3+	H	36
Kevin	M	30		x	3+	A	17
Linda	F	56	x	x	3+	A	21
Loïc	M	24	x		0	SA	16
Louise	F	43			0	SA	16
Marc-Antoine	M	31	x		0	A	21
Mike	M	50	x	x	3+	A	14
Nadine	F	27	x		3+	H	15
Nicolas	M	33	x	x	3+	H	14
Normand	M	49		x	3+	H	41
Patrick	M	42	x		2	R	24
Philippe	M	44	x		0	SA	15
Pierre-Luc	M	50	x		2	H	20
Richard	M	46		x	3+	A	45
Sébastien	M	44	x		0	A	15
Simon	M	33	x	x	3+	H	20
Sophie	F	43	x	x	1	R	18
Sylvain	M	50	x	x	3+	H	26
Valérie	F	37	x	x	3+	A	17
Yvon	M	51	x	x	3+	A	20

A = Own apartment; H = Homeless; R = Living at relatives' home; SA = Subsidized accommodation (apartment or room).

Ethical Considerations

The research project was approved by the Ethics Committee of the Centre hospitalier universitaire de Sherbrooke (Project #2015–755, 14–025). Individuals gave written consent to participate and were informed that they could withdraw from the study at any time. Participants that took part in an individual interview also gave written consent to be contacted again to participate in a focus group. Each participant received a compensation of CAN$40 for participating in an individual

interview or focus group. Names have been replaced with pseudonyms and any other information that could be used to identify individuals has been removed.

Results

Sociodemographic Characteristics of the Sample

The 30 study participants were between 20 and 59 years of age and had been actively injecting drugs for 4–30 years, mainly opioids (such as morphine or hydromorphone), heroin, and cocaine. Some participants were also injecting crystal methamphetamine. Most were also using different psychoactive substances by methods other than injection. For instance, they would smoke, inhale, or take orally other drugs such as amphetamines, cannabis or alcohol. Many participants reported low incomes and very precarious living conditions; 9 participants (7 men and 2 women) lived or had lived on the street in the previous 6 months. All participants reported some involvement with the criminal justice system for offenses such as shoplifting, illegal sale of drugs, unpaid tickets, and sex work-related activities. Most had been previously incarcerated. Participants cited other experiences that affected them throughout their lives, especially social isolation and adverse childhood experiences. See Table 1 for descriptive variables.

Results are presented in three sections pertaining to participants' perspectives on (1) access to injection equipment and other health services within HR organizations; (2) psychological and social support within HR organizations; and (3) social recognition and reintegration within HR organizations.

Access to Injection Equipment and Other Health Services Within Harm Reduction Organizations

Increased Accessibility of Injection Equipment and Other Related Services. Some of the main reasons participants gave for accessing HR organizations were to obtain new injection equipment (syringes, Maxicups®, sterile water, alcohol swabs, sharps containers, etc.) to practice safer injections and thus avoid harms such as HIV, HCV, or abscesses. Many appreciated the distribution of injection equipment in the streets, back alleys, parks, by outreach workers. The first author spent time with "messengers", that is, outreach workers with lived experience of drug use. She witnessed the trust established among the workers and the people they were interacting with. All study participants, like Yvon, voiced their appreciation of HR services while also expressing desire to get increased access to injection equipment in Montreal, preferably at all times:

> Because we have new syringes, we have… you know, food sometimes. There's always someone available to listen to us. But, they're not there 24 hours a day. That's the main problem. Yes, because it closes… The last one closes at 4:00 a.m. From 4 o'clock to 9 o'clock, there, 9 and a half hours, where you can't get anything anywhere! (Yvon, male, fifties)

Since participants often feel strong urges to use drugs or effects of withdrawal, they largely want access to injection equipment at all times. However, access is perceived to be insufficient or too frequently interrupted for varied reasons (e.g., staff meetings, holiday closures, frequent changes in opening hours).

> It makes me sick. There, at the beginning, here [HR organization C] it was open … I don't know, five days a week, and after that, that… five days a week but spread over the week, and it was open on Saturday. That's five, four. Now, it's four […]. And, through this, they find days for consultations: the door is locked here,

> and everything. And, where are they? Supposedly together thinking about something, or I don't know what! But Christ, the door is locked all the time, here. (Sébastien, male, forties)

Since injection equipment is unavailable at night or on holidays and weekends in most HR services, some participants longed for injection equipment vending machines downtown and in the city outskirts, where free equipment is hard to find. Some participants commented that some drug stores charge $1 or $2 for a few syringes, an amount they often do not have. They also recommended that sharps containers be placed where people often use drugs (near certain parks for instance) to avoid accidental pricks with soiled equipment and community complaints related to injecting equipment being left behind.

Nurses' presence within HR organizations was appreciated by many participants though many of them also complained that the number of hours for which they are available (a few hours a week) is insufficient. Many participants wanted greater access to health services within HR organizations to address minor health problems, get health screenings and check-ups for sexually transmitted and blood-borne infections or cancer, and obtain referrals to other services (e.g., medical appointments, hepatitis C treatment, opioid agonist therapy, addiction therapy).

More Comprehensive HR Services: "Like in Vancouver". Many participants compared Montreal's HR organizations and overall services to those of other Canadian cities, such as Vancouver and Toronto, and sometimes to other European countries. They mostly perceived that the inadequacy of HR services provided in Montreal was due to the ongoing social discrimination faced by "drug addicts" (in their words). For instance, many participants mentioned that injectable opioid agonist treatment (iOAT) was unavailable in Quebec at the time of interview, despite numerous studies demonstrating the benefits for both individuals and society at large. Many, like Nicolas, were eagerly awaiting the opening of supervised injection services (SIS) in Montreal (which did open in 2017):

> I think it's a shame that it … it's taking way too much time. […] I don't understand why it's not there yet. In Vancouver, they fought for it a long time ago and they have it. Really! It's almost impossible that in Quebec, we don't have that [SIS]. With all the health resources, the system we have, it's tough. (Nicolas, male, thirties)

Participants also perceived the resources allocated to help PWID to be insufficient, especially for individuals they see as most vulnerable (e.g., homeless, young, living with HIV or mental health problems). A few participants were also concerned that women may avoid injection equipment distribution sites for fear of social judgment, or worse, having their children taken away from them. Therefore, they suggested that HR programs be developed to include peer-to-peer support for women, including those who are injecting drugs or living with HIV.

Psychological and Social Support Within Harm Reduction Organizations

Desire to Feel Welcomed, Considered and Cared For. Several participants stressed how much they value low-threshold HR organizations, which are places where they can access information on varied HR topics and resources are made available to them. They greatly appreciated simply being able to talk with HR workers or peers and taking part in various activities offered on-site (e.g., workshops, collective cooking, breakfast). Small acts of kindness—kind words, a simple smile, coffee or food—are very important in the lives of most participants. Many described feeling welcomed and cared for in HR services and how that contributes to their self-esteem and motivates

them to initiate positive changes in their lives. Sylvain, who sleeps rough in a downtown park enjoys moments spent in HR organizations:

> [in HR organization A], I like it. On Thursday nights, we go to the back terrace, there is a movie with… There's food, coffee, soft drinks and so on. Then at the same time, we talk a little bit with outreach workers there. They're good people [HR organizations A and C]. Very good people! (Sylvain, male, fifties)

A simple "How's it going?" or friendly advice from outreach workers, public health nurses, psychosocial workers, or peers can be very meaningful to many participants; with most individuals living in marginalized and socially isolated conditions: "Yeah, it's really like, at least there is someone interested in how you're doing. It's always nice to see that!" (Loïc, 24, male). Émilie needed support to break through isolation and very much valued the help provided in one specific HR organization:

> [HR organization C], it's really a haven for me… as much when I'm all alone, because I'm a person who isolates a lot, whether I'm using or not. [HR organization C] offers free activities there. You do arts and all kinds of activities, and I think it's fun. You meet people. Also, community workers are on site. If you want to talk, you can talk. […] Sometimes, I'm not feeling well and I won't tell anyone. I will keep it inside. But they notice and they'll say, well, "Things aren't going well for you?" And it's like as if they open a door for me to express myself (Émilie, female, thirties)

Many participants named a specific person, worker, or professional (e.g., counselor, nurse) within a HR organization with whom they have created a meaningful bond and who had helped them to cope with challenges, open up, and access much needed resources. Sylvain (male, forties) stated that one HR worker helped him a lot just by being kind and caring: "She was telling me to be careful with my drug use." As for Dominic, he was grateful to one social worker in HR organization C who had helped him find a family doctor to begin hepatitis C treatment. She accompanied him to his first medical appointments: "It took a day! I had a doctor's appointment. […] And she came… She came with me, because at first, I was worried. She did a follow-up with me, she accompanied me" (Dominic, male, fifties).

Requests for Better Adapted Psychosocial Support and Services. Many participants expressed the desire for more psychosocial support within HR organizations. Many believed it was better to talk to someone who had either "gone through" drug use or lived in the street and who could also "speak their language" believing this person could better understand what they are experiencing (e.g., drug addiction, trauma, stigma, injustices, remorse, difficulties, emotions). Others stated they would rather talk to professionals, such as psychologists, that unfortunately, are almost inaccessible, either because they are unaffordable, or due to long waiting lists in the public system (as much as 3 years). It was felt that psychosocial needs are not sufficiently met within HR organizations.

> But like, these people [people who use drugs] it's as if they're complaining about their fate. But, I don't know, maybe they just need to feel that someone will listen to them somewhere […] Sometimes I get the impression that in Montreal there's a lot of focus on public health, public health. "Give new syringes" "Don't catch diseases!" We don't focus on people's well-being. Who cares! It's like, not that we don't care, but it's not a priority. The priority is not to get hepatitis C! And that we don't get AIDS so we don't have to be a burden on the health care system, and we don't cost the government money in treatment, and blah, blah, blah! That's the priority for public health, it's not people's well-being! (Nadine, female, twenties)

Participants sought to be better informed about resources for drug users and a variety of other topics (e.g., hepatitis C, reintegration programs, safer injection techniques), expressing that this type of information is not sufficiently circulating within HR organizations. For instance, Richard and another participant believed for a long time that the skin at the site of injection needed to be disinfected after the injection rather than before: "But, if I'd been told before, maybe… If I'd been told to clean myself before, I might have done it and avoid getting endocarditis. But it affected my lungs, my endocarditis" (Richard, male, forties).

For the most part, participants were seeking support but did not want others telling them what to do. As this participant pointed out: "We know what to do!" Many highlighted the kindness and benevolence of HR workers. Others, especially those over 40, voiced their frustration about being given advice by young, newly graduated individuals who have little or no experience with drug use or homelessness, but are nonetheless employed within HR organizations. Linda (female, fifties) saw herself as being one step ahead of many employees who did not possess her knowledge or experience: "Yes, yes, they've been to school, but it's not that important."

Most participants reported having taken part in workshops or having done volunteer work in HR organizations. Those activities proved to be very meaningful to several of the participants. Most were proud of their contribution, such as Sophie (female, thirties) who was once a street messenger and Nadine (female, twenties) who once joined a group to advocate for the opening of supervised injection sites in Quebec. However, quite a few participants expressed some dissatisfaction with the HR programs available to them. One main dissatisfaction was that the staff of HR organizations seemed to be playing more of an "entertainer" role rather than a psychosocial support role. Some male participants expressed dissatisfaction with the staff, who were mostly young women offering activities "for women", and not stimulating enough: "We're coloring like children". Others said that they purposely avoided some HR programs because a lot of people attending appeared depressed or mentally ill and being around them was depressing or draining. It appears that high staff turnover is disconcerting for some individuals. For instance, Nadine hesitated to get reinvolved with HR organizations because the people she knew were no longer there.

Social Recognition and Reintegration Within Harm Reduction

Tackling Unemployment and Homelessness within Broader Harm Reduction Approaches. The majority of participants seemed to want more chances to reintegrate into society with the help of HR organizations' programs and activities including linkage to housing, employment, training, art, empowerment, or advocacy. Participants saw themselves as individuals who were marginalized, stigmatized, and discriminated against for reasons far beyond their drug use, such as being poor, experiencing homelessness, and being unemployed. According to Mike, who had traveled across Canada (as had a few other participants), compared to other Canadian provinces, "Montreal really doesn't get it!" Most study participants were aware of HR programs available elsewhere and thought Montreal could do better. Many wished for a large downtown HR walk-in center for people who use drugs or who are experiencing homelessness, much like what is currently available in British Columbia (BC). As Francis said

> They should do, in my opinion, what they're doing in BC and then they should be doing it here. There, they're really taking them off the street. They have a big project, big projects, then the buildings they build to get people off the street, they have programs: to help people find a job, go back to school, volunteer. You know, give them self-esteem, give them hope, show them there's light at the end of the tunnel. Help them! (Francis, male, twenties)

Although some participants expressed the desire to continue living in the street and pursue their current occupations (e.g., temporary work, squeegee, panhandling, collecting cans, shoplifting), many said they wanted to "get a good job", "get a steady job", "go back to school", or get involved in volunteer work. The participants associated these latter activities with better health, autonomy, social recognition and self-fulfillment. Many participants spoke of PWID as individuals with very low self-esteem. For most participants, appart from being a source of income, work is related to hope and building self-esteem. Therefore, many wanted more comprehensive HR programs whose objectives include linking service users to job opportunities, such as in agriculture:

> I don't think they're being informed enough. Worse, they may feel too disgusted with themselves, maybe? They don't feel valued. "Ah! It's not for me, going to spend the day in the sun." You know, it's $80, spending the day in the sun! (Dominic, male, fifties)

Although they mentioned that they did not expect everything be given to them by the government or other organizations, participants definitely wanted more support and programs to get out of precarious living conditions. Finding work, housing, and increasing their income, were the main incentives to engage with HR organizations. Some participants suggested new social programs for people who use drugs, for instance, housing maintenance with direct deductions for rent from social assistance checks, or post-secondary education programs that recognize lived experience of drug use.

> You know, programs like messengers, it's great and everything, but it would be fun if there was something for people to aim for once they're more stable. Like to have a full-time job! [swears] That their life experiences are of use for that. (Kevin, male, thirties)

Also, most participants were seeking occupations adapted to their realities and difficulties of meeting standard labor market requirements (full working days, limited breaks, punctuality, attendance, need for concentration). Some suggested the adaptation of schedules to their lifestyles and drug consumption (e.g., three-to four-hour shifts) and flexibility when they are under the influence of substances at work or need to inject several times a day to avoid opioid withdrawal. Many participants wanted to be employed by HR organizations. Some expressed the desire to do more manual jobs (e.g., street and park cleaning) or temporary cash-based jobs (working at festivals). Many participants thought that being employed in homelessness or HR settings such as shelters or walk-in centers could increase access to the resources and reduce the impact of closures on weekends and holidays:

> "We don't work, it's a holiday!" Well [swears] if you see a person who stands out because he has the skills to provide services to users and to his colleagues, well, find him a position [swears]! What does it cost to try? The thing is, community organizations are run like businesses. (Mike, male, fifties)

Increased Responsibilities Tailored to the Realities as Drug Users. Many participants voiced dissatisfaction regarding how HR organizations are managed and power relations between staff and service users. For instance, some participants questioned the objectives and functioning of HR organizations as well as wage inequity. They perceived a lack of transparency in resource allocation; some asserted that managers' and employees' high salaries were unjustified given the number of people who benefit from HR services and programs. Also, some participants, including Mike, argued that HR organizations often unfairly favor hiring people that do not have lived or living experience of drug use or homelessness.

I was involved there, and then I saw administration people come down and take away hours of work from participants [people who use drugs] to get their buddies in. Do you understand? (Mike, male, fifties)

Quite a few participants deplored having to follow many rules within HR organizations and felt that their opinions are not considered, except for trivial issues such as "choosing the brand of coffee." They also pointed out that HR organizations should be empowering and be run by and for users. Several participants expressed wanting more responsibilities tailored to make use of their experiences as active drug consumers. In the following exchange between Kevin and Nicolas (both males in their thirties), it is interesting to note that management`s occupancy of the second floor of the building, or "at the top", was viewed as a sign of their superordinate status compared to service users, "the people from below":

Kevin: Well, I think it's at the level, well generally speaking, that it's at the management level that it sucks!

Other participants: Yes

Kevin: Off the bat, I just want to give an example, I want this to be kept between us. But, I think it's completely ridiculous that a place like (in HR organization B), that the management is on the second floor, and then that it has no more contact with the people …

Nicolas: The people from below

Kevin: With the people below. Whether those people are messengers or any kind of people. […] where I work [name of organization], supposedly we are by and for […] that it's the inverted triangle… that it's the users who decide, and all. But other than deciding which brand of coffee you buy, or stuff like that…

Nicolas: Yes, that's true!

Kevin: They put you in front of decisions that have already been made. And the management is not even by and for.

While participants expressed a great deal of satisfaction in helping others within HR organizations, some perceived that peer-support activities and other work they do is not valued enough, or sometimes even underappreciated. It appears that getting involved with HR organizations elicits widespread feelings of being taken advantage of, due to low wages, poorly defined responsibilities, and a lack of opportunities for advancement. Many participants also mentioned feeling controlled to the point of being infantilized. Chantal (female, thirties), on social assistance due to a mental illness, enjoyed doing HR outreach work, especially since that otherwise, she felt that the likelihood of her getting a job is rather low. However, with a meager $10 stipend per day's work, Chantal felt exploited. All participants wanted to increase their income and mentioned that economic benefits are very important to them. Participants also deplored having to be "docile" to take part in social integration activities that often offered little advancement and were limited in time. This made some participants, like Jérémie, weigh the pros and cons of pursuing programs or activities offered by HR organizations.

So, there's no chance of advancement? (interviewer, female, forties)

> Absolutely nothing! If you like doing projects and want to continue, you'll pick yourself up at (HR organization B). Worse, it's like he says, you'll get nothing from them that will allow you to move forward in this. It's going from one place to another while staying in the same situation! (Jérémie, male, fifties)

Promoting Activities By and For Persons Who Use Drugs. Several participants mentioned wanting to engage in projects that value their knowledge and lived experiences (e.g., experiential knowledge of drug and alcohol use, sex work or homelessness). Many used the term "by and for" to describe desired activities, that is, activities that are developed, conducted, and managed by people who use drugs. To obtain a paid position within a HR organization, whether as a peer or in another capacity, the person is required to have significantly reduced their drug consumption. Several participants mentioned that there is even stigmatization of drug use within HR organizations. In fact, some women participants sought reassurance that their participation in this study would not be disclosed to HR staff for fear of losing respect, trust, and especially their income from peer work. To tackle the root causes of their exclusion from social and labor markets, many participants requested more flexible and inclusive HR programs. Some HR organizations have successfully adapted their programs to better fit the needs of people who consume drugs:

> I worked as a messenger at (HR organization D). And, the messenger team we had there, we were users the whole gang, and it often happened that people didn't show up to work because they were too high. You know, we'd call and say, "Okay, look, today I've been using, I'm not coming to work, and all." Well, just too bad. She'd try to give us two hours at another time, and then we were peers! So, they understood what was going on. Well, there are many places where the peers they're going to hire, they're going to hire people that haven't been using drugs in the last five years. What for? Because it's easier to have them for two or three hours! (Kevin, male, thirties)

Participants' main requests are summarized in Table 2.

Discussion

A qualitative study involving 30 participants who inject drugs was conducted to gather information on their experiences and expectations regarding HR services. Recruitment was facilitated by the first author's presence within HR community-based organizations as well as the collaboration of HR workers and users. Results offer an insight into the experiences of highly marginalized individuals (many participants were homeless or living in very precarious conditions) with HR services provided by low-threshold organizations in downtown Montreal. The results of this study confirm many of the findings of previous similar studies on harm reduction. This study adds to existing knowledge by offering an in-depth analysis of the motivations of PWID for using HR services and providing valuable information about the resources available in Montreal. The broader social, political, and cultural environment of HR in Canada, and some of its variation by province and city, were also described. These are essential factors to consider when guiding HR interventions (Fischer et al., 2005, 2016).

Access to Harm Reduction Services in Montreal

One of the main findings is that participants were highly preoccupied with the availability and coverage of consumption and protective equipment (syringes, Maxicup®, condoms, etc.). While participants greatly appreciated being able to access clean equipment, they considered opening hours to be limited. Beyond the quantity of injection equipment distributed O'Keefe et al. (2019), recommend using additional indicators, such as opening hours in order to assess the supply

Table 2. Key requests from participants pertaining to harm reduction.

Key requests from participants pertaining to harm reduction services, programs and policies
• **Improve harm reduction services**
• Increase opening hours preferably to 24/7 access
• Implement supervised injection services (SIS), to which several other services would be linked
• Introduce injectable opioid agonist treatment (iOAT) as an option
• Within HR organizations, provide more information and education on a variety of topics including low-risk injection practices, HIV and HCV
• Provide specific HR services, including for women who inject, have children or live with HIV, as well as for street youth, people with mental health problems or who are experiencing homelessness
• Place injection equipment vending machines in strategic neighborhoods and locations
• Place additional sharps containers (to dispose of injection equipment) in varied locations and neighborhoods
• **Recognize the knowledge and potential of people who use drugs**
• Focus more on empowerment through HR programs by and for users such as PWID rather than on hierarchical structures
• Promote peer-led activities and social reintegration through work
• Give more decision-making powers, responsibilities and advancement opportunities to users of HR services
• Make it easier to find jobs within HR organizations
• Foster and encourage back to school programs and job opportunities by facilitating entry and recognizing experiential knowledge of drug use
• **Make adequate, safe and affordable housing more accessible to people who use drugs**
• Increase access to housing and supervised housing
• Design programs where rent would be paid for in advance by subsidy programs

coverage of injection equipment and HR services in order to tailor them to the needs of PWID. Many participants were also envious of services available elsewhere in Canada. However, disproportionate access to HR services is partly due to the fact that the overdose crisis impacts some Canadian jurisdictions more than others, namely the western provinces (British Columbia and Alberta) and in Ontario. For instance, around the time of this study (in 2016) per 100,000 inhabitants, British Columbia was registering 985 overdose deaths, with Ontario and Quebec registering 867 and 140, respectively (Belzak & Halverson, 2018).

Nonetheless, some participants believed Montreal was lagging in many ways in terms of its offer of HR services. For example, many wanted access to injectable opioid agonist treatment, as offered in some other cities (Eydt et al., 2021). While this service was not available in Montreal at the time of interview, it is now offered in a Montreal hospital and has been in place since 2020. Also, new HR services and programs have emerged in Montreal in recent years, such as access to naloxone prevention kits, training to reverse opioid overdose, as well as supervised injection sites (which opened in 2017) (Health Canada, 2021). That being said, the COVID-19 pandemic and mitigation measures (e.g., closure of several businesses, health and social resources, curfews, restrictions on social gatherings) have laid bare the health inequalities affecting people who use drugs or are experiencing homelessness (Leblanc, Bertrand, & Loignon, 2020; Vasylyeva, Smyrnov, Strathdee, & Friedman, 2020). During the pandemic, risks of fatal overdoses and mental distress increased, and many marginalized PWID were more susceptible to COVID-19 infection due to underlying medical and social conditions such as homelessness, and inhabiting unstable or overcrowded shelters (Vasylyeva et al., 2020). Therefore, even if this study has been conducted in 2014–2015, many findings

are still relevant today as they emphasize the need for holistic HR services that are led by and for people who use drugs themselves.

Need Expressed for a More Comprehensive Response

Another important finding is that many study participants felt HR services in Montreal were deficient in many aspects compared to more HR-proactive cities in Canada (e.g., Vancouver, Toronto, and Ottawa) or in European countries (e.g., Netherlands and Switzerland) and associated resources (e.g., medical clinics, drop-in centers, outreach and advocacy groups) (Paul et al., 2020). This deficiency can be partly explained by a HR approach in Montreal that is mainly focused on the prevention biological risks and much less so on human rights (Roe, 2005), social policies, programs, and actions to promote social inclusion and overall health and wellbeing of PWID (Bastien, 2013; Massé, 2013; Mondou, 2013). Criticism voiced by participants in our study raises questions of solidarity, equity, and social justice for those left behind. While HR interventions present many benefits for individuals and their families as well as for society, these services are demonstrated to be most effective when integrated into a comprehensive basket of measures aimed at improving overall health and social inclusion of people who consume drugs (Strike et al., 2021).

Our study suggests that PWID interact with HR organizations to meet basic needs, be treated with dignity, connect with peers and HR workers, reduce feelings of isolation, find work, and attain shelter and food, results which are similar to those found in other studies (Boucher et al., 2017; Crabtree, Latham, Bird, Buxton, 2015; Crabtree et al., 2018; Lee & Petersen, 2009). Given PWID's social vulnerability as well as the multiple and complex problems they often face, accessing health care and social services can be a real challenge. Many participants also expressed needing help to reach personal goals (connecting with people, reducing their drug consumption) and that services offered by community-based HR organizations were invaluable to them. However, similar to previous critiques of HR services in Quebec (Bastien, 2013; Lachapelle, Archambault, Blouin, Perreault, 2021; Massé, 2013), participants found that services in Montreal could be more holistic and were lacking in terms of meeting the multiple needs of PWID, and the specific needs of certain subgroups such as young people, persons experiencing homelessness, persons living with HIV or with a mental health problem, and women with children. One example of an adapted service for women who fear child protective services when accessing HR resources is "Logis Phare", a non-profit organization in Montreal that has taken a holistic approach for expectant mothers or parents with children who are undergoing OST to facilitate their social integration by providing shelter and support as an alternative to placing children in foster care (Logis Phare, n. d.; Moura et al., 2018).

Social Stigma and Oppression

Many participants linked the inadequacies of HR services to stigma and oppression. As pointed out by previous authors, characteristics such as injecting drugs, engaging in sex work, experiencing homelessness, and being mentally ill not only can be associated with great suffering, they are also morally laden and can constitute barriers to accessing health care and social services (Boucher et al., 2017; Poliquin, 2018). Thus, it is all the more troublesome that dynamics of oppression, inequity, and stigma also pervade within HR organizations, as reported in previous studies (Austin et al., 2021; Green et al., 2021; Lee & Petersen, 2009). According to Mead (2008), one of the founders of symbolic interactionism, human action must be seen above all as a communication. Therefore, communication represents an opportunity to create and transform meanings "on the basis of an opportunity of identification with another" (Le Breton, 2008, p. 34). Thus, future research should examine how HR organizational structures and programs may

reinforce feelings of inferiority in PWID. For example, the study participants were dissatisfied that their knowledge was insufficiently valued within HR services, while "others" with college or university degrees were recognized; and gave advice without having gone through the struggles of drug addiction or homelessness. Many participants perceived that professional knowledge is imposed upon them, which contributes to the perception that their offer of knowledge and life experiences are undervalued.

Our findings show that, to variable extents, HR community-based organizations reproduce some patterns of social differentiation and exclusion, as illustrated by symbolic distinctions made between "users" of HR services (drug users) and "others" providing services (employees, managers). This has the potential to pathologize PWID (i.e. portray them as sick and vulnerable) and contribute to their social marginalization (Austin et al., 2021; Greer, Buxton, Pauly, & Bungay, 2021; Souleymanov & Allman, 2015). Peer-workers can feel undervalued when their work is poorly defined and positive representations of experiential knowledge of drug use is lacking (Greer et al., 2021). According to Amartya Sen (1999), charitable organizations that assist people can also give the impression that the people they help are incapable of self-determination, which "inevitably affects the respect recipients have of themselves and the respect that society will show them" (Sen, 1999, p. 183). Bastien (2013), sees the limitations of the HR approach applied in Quebec, a province known for its generous social programs (e.g., universal access to health care and social services, affordable education), as evidence of the erosion of social protection measures for the most vulnerable individuals throughout the last four decades. As pointed out by Bibeau, (2008) as cited in Bastien (2013), "social protection programs have become a disciplinary management of the lives of the poor and excluded" (p. 141). Many participants in our study reported feeling controlled and infantilized within HR organizations, sentiments which were mirrored in the findings of another Montreal study conducted by Lachapelle et al. (2021).

Better Access to Paid Work and Peer-Led Activities

Finally, work - as well as being the primary means by which to make money and a widely recognized determinant of health - is also an established means of emancipation and social recognition (Castel, 2012). Our study suggests that quite a few PWID who access HR services want opportunities to work, as well as work and income-related advancement tailored to their needs to be available within HR organizations. These organizations are among the few places where participants can hope to take on valued roles and build bridges towards social and economic integration and attain social recognition and a sense of purpose; points which were also made by Bardwell et al. (2018), whose study demonstrated that making low threshold jobs available to PWID in HR reduces their feelings of stigma. Also, it has been shown that providing low-threshold job opportunities is correlated with decreased involvement in criminal activities thus providing support for policies that favor such programs (DeBeck et al., 2011).

Participants believed that better use can be made of their experiences and knowledge of the realities of drug use, sex work, or homelessness, for example through peer-led activities and by informing HR programs generally. Advantages of peer-led work in HR services include increased uptake of these resources, increased self-esteem and empowerment for people who receive support from peers, and mutual support and network building among people who use drugs (Greer et al., 2021; Marshall, Piat, & Perreault, 2018). Indeed, peers can foster trust and the uptake of HIV, HCV, and opioid dependence treatment programs (Kennedy et al., 2019; Treloar, Rance, Dore, Grebely, & ETHOS Study Group, 2014). Peer work is correlated with increased reaching out of PWID at greater risk of adverse health outcomes, decreased deaths by overdose (e.g., with peer-administered naloxone), and decreased HIV transmission (e.g., by distributing safe injecting material) (Faulkner-Gurstein, 2017; Hayashi, Wood, Wiebe, Qi, & Kerr, 2010). Therefore, people

with lived and living experiences of drug use are invaluable allies to shape and deliver HR services such as naloxone programs (Faulkner-Gurstein, 2017) as well as shelters, housing, or HIV and HCV treatment programs (Greer et al. 2021). People who use drugs may derive many benefits from partaking in peer-led activities, such as raised self-esteem, feelings of usefulness (Crabtree et al., 2015; Greer et al., 2021; Kerr et al., 2006), acquisition of new knowledge and skills, and greater structuring of their daily lives (Labbé et al., 2013). A study with 874 PWID from Vancouver, Canada found that if they had the choice, 48% of participants would rather take a low threshold job than resort to other money-generating activities such as panhandling, drug dealing, or sex work (Debeck et al., 2011).

However, a crucial issue that has been raised in other studies is the need to review wage and working conditions for people with lived experience of substance use working in HR organizations (Bardwell et al., 2018; Debeck et al., 2011; Greer et al., 2019). Peer workers were at the frontline during the COVID-19 pandemic yet were not recognized as essential workers (Olding, Barker, McNeil, & Boyd, 2021). Their work conditions in HR services can be very precarious, with nonstandard or casual work arrangements, minimal security and stability, low wages, and poor social benefits (Greer et al., 2020; Olding et al., 2021). The development of organizational competence, knowledge, and capacity is greatly needed to support the contribution of peers and avoid tokenistic use of people with lived experiences of drug use (Greer et al., 2021).

Harm Reduction Organizations Run By and For Users

The present study suggests that some aspects of HR resources are particularly appreciated by PWID (i.e., being listened to, having a space to interact with others, receiving assistance for basic needs). However, internal power imbalances can also accentuate stigma and social vulnerability (Souleymanov & Allman, 2015). PWID who participated in this study perceived having very few opportunities to speak and be heard, even within HR organizations. Yet, PWID's active involvement in HR organizations' management, decisions, and activities is key to providing services that correspond to their needs (Komaroff & Perreault, 2013).

Participants have repeatedly mentioned that HR services should be by and for them. They request the right to access work, quality health care and housing, and to use drugs and be treated as deserving citizens. Leece et al. (2019), evaluated HR action plans in Canada and the United States; they recommend that stigma and barriers to care and services experienced by users may be better addressed by strengthening partnerships with people who use drugs. Tremblay & Olivet (2011), who have looked at social reintegration and the rights of opioid users, conclude that there are too few spaces where persons who use drugs can express themselves and negotiate with health and psychosocial professionals. This scarcity is due to the reluctance of professionals and institutions to share their power, or because they are set in their ways and reluctant to change. It must be noted that people viewed as overindulging in pleasures are still subjected to social disapproval, a moral judgment that can undermine the recognition of the legitimacy of PWID's claims to be treated as deserving citizens (Tremblay & Olivet, 2011). Participants in our research are not without dreams, willpower or abilities, quite the contrary. However, the willingness of PWID to be consulted and take an active part in health and community programs appears to be a lever not sufficiently exploited in Montreal's HR organizations where participants of this study were recruited. One way to increase engagement with PWID is to collaborate with organizations run by drug users who highly value their own experiences and voices. One example is Metad'ame, a peer-run organization in Montreal since 1999 that hires and trains people with lived experience of drug use. For instance, across 14 of Quebec's administrative regions, it conducted a fatal overdose prevention training program involving naloxone administration (Perreault et al., 2021). Another example is the Vancouver Area Network of Drug Users (VANDU) (Kerr et al., 2006), a group that contributed

to the creation of pop-up safe consumption and overdose prevention sites in Canada (Klein, 2020; Pauly et al., 2020). A similar group is the Association for the promotion of the health of drug users in Quebec (AQPSUD, 2022), which promotes the health of drug users and advocates for increased access to health services, the right to use drugs, and decriminalization of possession for personal use and drug use.

To improve HR service experiences, participants wanted more empowering approaches that espouse the "nothing about us without us" philosophy which inspired many drug-user rights groups to claim their rights to act on their lives and choose for themselves (Boyd et al., 2016; Denis-Lalonde et al., 2019). A recent initiative is the PROFAN program in Quebec that involves training offered by persons with lived drug use experience on how to reverse an opioid overdose with naloxone administration (Perreault et al., 2021). Another example is the advocacy of the International Network of People Who Use Drugs (INPUD) to keep people safe worldwide during the COVID-19 pandemic (International Network of People who Use Drugs, 2021). These types of programs embrace the spirit of Freire's empowerment theory and pedagogy of the oppressed through seeking knowledge which "must be developed with the oppressed and not for them, whether men or peoples, in their ongoing struggle to recover their humanity" (Freire, 1974, p. 2). Our findings support the conclusions of previous studies such as those made by Boucher et al. (2020), where a sample of PWID also wanted more peer-led HR services within an anti-stigmatizing space and non-judgmental, non-discriminatory social support. Moreover, the "de-stigmatization" of persons who use drugs can be adopted as a framework for interventions geared toward the promotion self-esteem, self-efficacy, confidence, and a sense of competence to act on one's life (Lee & Petersen, 2009). Finally, increasing dialogue with PWID within HR organizations is key to ensure services are better aligned with the former's needs and aspirations. Further research could also be conducted to document the experience of PWID (e.g., inclusion, stigma, work opportunities) within HR community-based organizations, including those that now offer supervised injection and drug checking services in Montreal, ideally, with the active participation of PWID.

Conclusion

This article takes a critical look at the way HR services are provided and perceived by PWID in Montreal. While HR organizations provide PWID with respite from some conditions that contribute to their social marginalization, it seems these organizations often fail to meet the needs and aspirations of the people who participated in our study. The main finding of this study is that despite active drug use, participants do not want to be excluded from society. By accessing HR organizations, they seek various forms of assistance, including housing and work, but also want to take on various social roles and advocate for their rights, such as access to health care services. While participants felt that HR organizations were very supportive in many respects, they also denounced power dynamics and poor access to certain services and social integration programs. Participants made suggestions such as increased access to injection equipment, education, consultations with various professionals, and more social reintegration initiatives. Also, results suggest that PWID in Montreal want to have greater opportunities to design HR programs and collaborate with HR organizations that are destigmatizing and consider the strengths and challenges faced by people who inject drugs.

Limitations

This study has several limitations. First, despite efforts to diversify the sample, the study does not account for the diverse realities of all PWID (e.g., ethnocultural minorities, Indigenous peoples,

people from the LGBTQ2+ community, etc.). Additionally, most participants were socially marginalized and had very low incomes, nine of them were homeless and some had mental disorders, which limits the transferability of results. Even if the methods used did allow for in-depth understanding of the research questions from the perspectives of PWID, the present research team did not include PWID; their inclusion could have helped to refine analyses and improve the credibility of the findings. The fact that most participants were not seeking recovery at the time of the interviews also influences their perspectives on HR services. However, this study provides a rare insight into the realities of persons who are actively using drugs, as they are seldom interviewed compared to PWID in treatment or in recovery. Finally, beyond the production of knowledge, this study allowed individuals to share their life experiences, thus contributing to increase PWID's awareness of their capacity to take action in their lives (Denzin & Lincoln, 2005; Kincheloe & Mac Laren, 2003). Some participants pointed out that taking part in the study provided a rare break to reflect on their health, aspirations, and life in general.

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