Money, Drugs, and Voluntary Trusteeship; Applying Harm Reduction to Money Management Programs for People Who Use Substances

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Abstract

The objective of this research is to explore whether the Harm Reduction Trustee Case Management program at St. Stephen's Community House is reaching its objectives by improving overall quality of life for clients who are actively using substances and have a history of homelessness. Methods: A qualitative, non-experimental approach was used. Eighteen (18) retrospective pre-test-post-test questionnaires were completed. Questionnaires sought information pertaining to whether improvements in stability in terms of housing, financial, substance use, and overall quality of life were identified by clients. Results: All program outcomes measured, indicated improvements based on client responses. Post- test results indicated that 100% of clients are housed and maintaining their housing. One hundred percent (100%) of responses indicate that clients are practicing safe using strategies in terms of using substances since joining the program; and 78% of responses indicate improvements in terms of budgeting skills. Conclusion: The program evaluation has demonstrated that the Harm Reduction Trustee Case Management program it meeting its objectives and offering support that improves housing retention/stability as well as improving overall quality of life for clients enrolled in the program.

Chapter 1: Introduction

People who use substances are overrepresented in the homeless population and face multiple barriers to accessing and maintaining housing. Money is often a trigger for people who use substances; The inability to manage their money successfully results in people facing eviction or remaining homeless, and increases the risk of negative health consequences related to binge use behaviour. The major research question is: Do money management programs improve street level substance users' stability and quality of life?

During the past 9 years working for the Housing and Homeless Department of St. Stephen's Community House, I have noticed that people who are homeless or under housed, and using substances face barriers in accessing services and maintaining housing. These factors result in a chronic reliance on public (emergency) services. It is a fundamental principle of St. Stephen's Community House Voluntary Trustee Case Management Program that people who use substances in "harmful" ways have a right to the same access to basic needs (e.g.* housing and health care) as the general population. Applying the principles of Harm Reduction to Case Management and Trusteeship programming at St. Stephen's Community House has demonstrated that access is improved. We also, believe it encourages clients to engage in a more meaningful way with the program and their Trustee Case Manager. This in turn, provides the opportunity to work with individuals to improve access to other needed services, as well as to work towards the goal of improving overall quality of life.

A research project evaluating St. Stephen's Community House Voluntary Trustee Case Management Program has the potential to demonstrate effectiveness of harm reduction based

money management programming; offering evidence that may support wider application of the technique in general; and in particular, an increase in municipal funding to expand the available programming within the city of Toronto. Furthermore, this program evaluation will offer St. Stephen's Community House essential feedback to indicate what is or is not working within the existing program, as well as suggestions for ensuring that the program is meeting the needs of the clients and achieving its intended outcomes.

Chapter 2: Literature Review and Theoretical Framework

This study explores existing literature pertaining to money management programs specifically working with people who experience homelessness, mental health and active substance use challenges. The literature reveals a number of themes: First, money has been shown to trigger the population to acquire and use substances as a priority over other actions or acquisitions. Second, the major overarching goal of the research reviewed on money management programs was to reduce levels of substance use with underlying values connected to "socially acceptable" spending habits, and the expectation of abstinence as the ideal outcome. Third, community treatment approaches were identified as a precursor to people receiving money management supports. The addition of money management programming, demonstrated consistent outcomes indicating a reduced level of days on the streets or in shelter. Fourth, “housing first” models were identified as an appropriate housing model for working with this population. Themes and definitions will be discussed in detail below.

There was no single definition for the homeless population. The literature was consistent in identifying members of the studied population as people who are transient or without a

primary address; who experience a high level of insecurity, isolation, marginalization, and social exclusion; and whose mental health or substance use results in negative health consequences (Norman & Pauly, 2013, p. 136; Rowe, 2005, p. 47; Caton, Dominguez, Schanzer, Hasin, Shrout, Felix, McQuistion, Poler & Hsu, 2005, p. 1753).

Literature pertaining to people who experience homelessness also mentioned lack of choice and opportunity as an impact of homelessness. This was discussed in relation to having a voice in terms of developing policy and programs to appropriately address their needs and in terms of accessing services and resources (Norman & Pauly, 2013, p. 137; Gremier, Barken, Sussman Rothwell, Bougeois-Guerin & Lavoie, 2016, p. 31). One study also suggested that people who are without housing, compared to people with housing, are often less likely to access 'required' services (Caton, Dominguez, Schanzer, Hasin, Shrout, Felix, McQuistion, Poler & Hsu, 2005, p. 1753). This may be attributed to lack of knowledge or education on available services, the fact that finding a place to rest overshadows other needs, or because of a perceived and expressed stigma attached to people who experience homelessness.

A disproportionate rate of drug use amongst the population is consistently mentioned when describing characteristics of people who experience homelessness. The literature suggests that drug use is both a precursor and a coping strategy (Rowe, 2005, p. 48; Caton, Dominguez, Schanzer, Hasin, Shrout, Felix, McQuistion, Poler & Hsu, 2005, p. 1753; Gremier, Barken, Sussman Rothwell, Bougeois-Guerin & Lavoie, 2016, p. 30). A lack of choice and opportunity coupled with persistent substance use could very well limit one's decision-making ability or options, including how or on what they spend their money.

“Housing first” models appeared to be the preferred choice or “best practice” housing model when working with the homeless populations, and specifically people with mental health

and substance use challenges, in order to secure and maintain housing. The housing first model does not require treatment compliance as a precursor to obtaining housing (Henwood, Stanhope & Padgett, 2011, p. 79; Bullen & Fisher, 2015, p. 930; Padgett, Gulcer & Tsemberis, 2006, p. 75; Tsemberis, Gulcer & Nakae, 2004, p. 651). It values consumer choice, self-efficacy, person-centred care, and views housing as a basic right (Henwood, Stanhope & Padgett, 2011, p. 79; Bullen & Fisher, 2015, p. 930; Padgett, Gulcer & Tsemberis, 2006, p. 75; Tsemberis, Gulcer & Nakae, 2004, p. 651).

The literature suggests that money is a trigger for people who use substances and who experience mental health issues; furthermore, managing funds or making financial decisions were noted as “challenging” for the population. (Rosen, Rosenheck, Shaner, Eckman, Gamache & Krebs, 2002, p. 995; Rosenheck, Lam & Randolph, 1997, p. 707; Rosen, Rounsaville, Ablondi, Black & Rosenheck, 2010, p. 800). By challenging, they mean money was not spent in a socially acceptable way. The literature consistently suggested the appropriate use of money was determined based on whether the spending of money was on basic needs such as housing and food as opposed to the individual’s substance of choice (Rosen, Rounsaville, Ablondi, Black & Rosenheck, 2010, p. 707; Rosen, Rosenheck, Shaner, Eckman, Gamache & Krebs, 2002, p. 996; Luchins, Hanrahan, Conrad, Savage, Matters & Shinerman, 1998, p. 1218). The literature assumed that spending decisions were solely individualistic and connected to one's mental health status or substance use, rather than exploring external or systemic reasons (for example, a lack of affordable housing or a lack of choice and opportunity) for not spending money on rent (Rosen, Rosenheck, Shaner, Eckman, Gamache & Krebs, 2002, p. 996; Rosen, Rounsaville, Ablondi, Black & Rosenheck, 2010, p. 707). These social assumptions essentially blame the individual for their perceived lack of skill in making 'healthy' or socially responsible choices for themselves

rather than attributing any responsibility to our social and political systems. Nevertheless, the expectation is that individuals who avoid or exit homelessness will have a higher quality of life.

Thinking critically about the literature, there seems to be an underlying assumption: people who use substances chose to spend their money on drugs or alcohol rather than basic needs - an individual ‘choice’. I would suggest that there are additional factors affecting one's inability to cover basic needs, such as a lack of affordable housing, and social assistance payments at a level that keeps people living under the poverty line. Such systemic factors coupled with “addiction issues” create a very complex problem that cannot be easily changed. Additionally, when using substances is someone’s only coping strategy, it is not surprising that purchasing drugs or alcohol takes precedence over anything else. Therefore, although systemic factors are present and certainly have an impact on the individual’s ability to exit homelessness or to afford basic needs, there still exists a need for external support to help individuals to develop healthier budgeting skills to improve access to housing or to afford food and clothing.

Implicitly, the desire for -- or self-identified need for -- a money manager was present in the research. This was demonstrated through the fact that clients chose to join money management programs or research aimed at evaluating the impact of money management programs on their substance use levels. A client's willingness to participate could be interpreted as a level of awareness that they experience challenges with this skill and are open to improving them. (Rosen, Rosenheck, Shaner, Eckman, Gamache & Krebs, 2002, p. 996; Rosen, Rounsaville, Ablondi, Black & Rosenheck, 2010, p. 708; Black & Rosen, 2010, p. 126). Furthermore, the literature highlighted assessments completed with clients as demonstrating that there was a common theme of clients reporting they did not have enough money to cover basic needs and that clients identified this as an area for improvement (Luchins, Hanrahan, Conrad,

Savage, Matters & Shinerman, 1998, p. 1218; Elbogen, Teigreen, Vaughan & Bradford, 2011, p. 223).

Money management, or the inability to manage funds 'appropriately', can have negative impacts on housing retention or outcomes for people who are homeless. The literature establishes that substance use can diminish available funds to cover rent, a precursor for eviction or loss of housing (Kirst, Zerger, Misir, Hwang & Stergiopoulos, 2015, p. 25; Rowe, 2005, p. 48). Research pertaining to the impact of money management programs on substance use levels has indicated secondary outcomes that include an increase in client stability in the community. This means, for example, fewer days in hospital or jail and a reduction in homelessness (Rosenheck, Lam & Randolph, 1997, p. 804; Luchins, Hanrahan, Conrad, Savage, Matters & Shinderman, 1998, p. 1220). Though the primary focus of the literature reviewed was to determine whether money management programs would reduce substance use. The implicit assumption was that the research participants would then be in a position to afford or to access basic needs (housing, food, and clothing).

The most meaningful information gathered through the literature was that clients in such programs tended to gain a level of stability despite substance use, leaving me questioning whether the goal of money management programs are worthwhile social supports, and whether or not they reduce substance use, since they improve quality of life and social stability.

Money management programs in the literature were also referred to as “advisor-teller” money management programs. The focused their efforts were members of the homeless population who experience persistent substance use challenges. Money management programs were summarized as offering training on budgeting, and reducing triggers related to money and substance use. They were offered in the community, provided advocacy, and worked towards

stabilizing the client by monitoring income flow, which they hoped would reduce substance use (Luchins, Hanrahan, Conrad, Savage, Matters & Shinderman, 1998, p. 1218; Rosen, Rounsaville, Ablondi, Black & Rosenheck, 2010, p. 707).

Not all of the literature discussed how money was managed, or program delivery specifics, but many spoke of paying rent as a built in facet of the program (Carpenter-Song, 2012, p. 49; Reis & Comtois, 1997, p. 333). Some money management programs followed a constrictive delivery model where case managers/money managers led shopping trips to ensure money was not being spent on drugs or alcohol. Others provided guidance but allowed clients to have a higher level of autonomy over their spending decisions (Ries & Comtois, 1997, p. 333; Serowik, Bellamy, Rowe & Rosen, 2013, p. 149; Carpenter-Song, 2012, p. 49). In the research conducted on programs that placed a higher value on promoting autonomy, discussions included reflections in terms of protecting trust within the professional relationship and being aware of potential coercion (Carpenter-Song, 2012, p. 49; Serowik, Bellamy, Rowe & Rosen, 2013, p. 149).

A number of studies discussed *behavioural economic* models of understanding spending habits and discussed the idea of delayed discounting. Behavioural economic models informed understandings of how and why spending decisions are made. Offering the idea that developing budgeting skills will reduce the cues associated between money and the individual's substance of choice (Chivers & Higgins, 2012, p. 9; Rosen, Rounsaville, Ablondi, Black & Rosenheck, 2010, p. 707; Rosen, 2012, p. 3). Further, shifting focus from immediate gratification to longer term goals through planning for future rewards (Chivers & Higgins, 2012, p. 9; Rosen, Rounsaville, Ablondi, Black & Rosenheck, 2010, p. 707; Rosen, 2012, p. 3). Though this understanding may in fact be valid in some situations, there are many additional factors to consider when trying to

understand why people continue to spend money on substances that affect negatively on their quality of life. For one, addiction is very complex and though plans are in place to save for rent or food, this is often not enough to counter the desire to use one's substance of choice. Therefore, budgeting or improving one's ability to disassociate money from their substance of choice is likely not enough to remove all the other factors that contribute to the individual's desire to use the substance. Additional therapeutic supports are required to holistically address the complex experience of people who struggle with addiction and experience homelessness.

Money management programs were often an adjunct to existing community treatment services, often referred to as case management services or therapeutic supports. The research did not go into detail about all the services being provided through these supports but did touch on housing assistance; skills development to support a shift to greater independence; and counselling supports (Serowik, Bellamy, Rowe, & Rosen, 2013, p. 138; Rosen, Ablondi, Black, Serowik, & Rowe, 2014, p. 271; Luchins, Hanrahan, Conrad, Savage, Matters, & Shinderman, 1998, p. 1219; Rosenheck, Lam, & Randloph, 1997, p. 801; Rosen, Rounsaville, Ablondi, Black, & Rosenheck, 2010, p. 707). Noteworthy was the indication that when attaching money management programming to existing community treatment programming, a higher level of attendance or adherence to treatment plan/programming occurred (Serowik et al., 2013, p. 138; Rosen et al., 2010, p. 709; Luchins et al., 1998, p. 1219). It is assumed that a higher level of attendance could result in better therapeutic outcomes and a reduction in crises that were preventable with early intervention.

The literature on money management programs inherently implied assumptions around drug use and problematic substance use. Abstinence/12 step models were implicit in the literature reviewed. The researchers did not explicitly state that they were using abstinence

theories though the research was focused on determining whether the management interventions reduced or better yet eliminated substance use amongst participants.

The research reviewed also sought to determine whether money management interventions would have any impact on how participants spent their income security cheques or better yet, prevented the misuse of funds (Rosen, Rosenheck, Shaner, Eckman, Gamache & Krebs, 2002, p. 995; Rosenheck, Lam & Randolph, 1997, p. 800; Black & Rosen, 2010, p. 125; Rosen, Rounsaville, Ablondi, Black & Rosenheck, 2010, p. 707). The abstinence theory has built-in assumptions about right and wrong and assumes that spending priorities should be based on mainstream values. It is my opinion that these implicit assumptions can have long lasting impacts for substance users and may reduce their willingness to seek support for fear of judgement. This may have been a limitation to prior studies and may have neglected a particular group of people who were pre-contemplative in terms of wanting to make changes to their substance use.

The literature on money management programs also implied psycho-educational models as a component of program delivery. A number of studies discussed the inclusion of skill development in terms of budgeting, financial planning, and planning for longer term goals (Rosen, 2012, p. 4; Carpenter-Song, 2012, p. 52; Black, & Rosen, 2011, p. 127). The Carpenter-Song (2012) study suggested "...providing opportunities for clients to articulate their perspectives on how and why they spend money the way that they do." (p. 52) and suggested that one approach to service delivery is not sufficient for all clients (p. 52). This highlights an important point: education aimed at teaching better financial planning skills should rely on providing client-directed care and allowing the client to be an active partner in the process of identifying their own financial goals.

Research participants were recruited through outreach initiatives or because they were already accessing some level of supports through counsellors, case managers, psychiatric inpatient units or from an assertive community care team (Rosen, Rosenheck, Shaner, Eckman, Gamache & Krebs, 2002, p. 996; Rosenheck, Lam & Randolph, 1997, p. 801; Serowik, Bellamy, Rowe & Rosen, 2013, p. 138; Reis & Comtois, 1997, p. 332; Luchins, Hanrahan, Conrad, Savage, Matters & Shinderman, 1998, p. 1219). Throughout the literature reviewed, individuals included in the research all had active substance use challenges and many were considered to have a concurrent diagnosis (mental health diagnosis as well as diagnosed substance use challenge) (Rosen, Rosenheck, Shaner, Eckman, Gamache & Krebs, 2002, p. 996; Rosenheck, Lam & Randolph, 1997, p. 801; Serowik, Bellamy, Rowe & Rosen, 2013, p. 138; Reis & Comtois, 1997, p. 332; Luchins, Hanrahan, Conrad, Savage, Matters & Shinderman, 1998, p. 1219). Most were homeless or had a lengthy history of homelessness, and most were receiving social assistance although some were receiving pensions (Rosen, Rosenheck, Shaner, Eckman, Gamache & Krebs, 2002, p. 996; Rosenheck, Lam & Randolph, 1997, p. 801; Serowik, Bellamy, Rowe & Rosen, 2013, p. 138; Reis & Comtois, 1997, p. 332; Luchins, Hanrahan, Conrad, Savage, Matters & Shinderman, 1998, p. 1219).

Though not stated, it was apparent that all of the research participants were living in poverty to some degree. Some of the discourse pertaining to individuals included in the studies used language including such phrases as “ability to function responsibly”, “mismanaged funds”, “incapable of managing their funds”, “misuse of funds”, etc. (Luchins, Hanrahan, Conrad, Savage, Matters & Shinderman, 1998, p. 1219; Rosen, Rosenheck, Shaner, Eckman, Gamache & Krebs, 2002, p. 996; Serowik, Bellamy, Rowe & Rosen, 2013, p. 137; Reis & Comtois, 1997, p. 332). Discourse has powerful effects on how we interpret overall messages or meanings. The

phrases listed perpetuate a deficit based model or blaming the individual for their "irresponsible or poor money management" and as a result their "unacceptable" use of substances. However, I doubt it was the researchers' intent, language reinforces stereotypes and has the ability to maintain stigma and to perpetuate discrimination.

Research methods varied among the studies reviewed. A number of the studies were quantitative in design and used questionnaires or surveys to determine changes in money management skills, substance use, admissions to emergency services, housing status and mental health status (Black & Rosen, 2010, p. 126; Rosen, Rounsaville, Ablondi, Black & Rosenheck, 2010, p. 708; Rosenheck, Lam & Randolph, 1997, p. 801; Rosen, Rosenheck, Shaner, Eckman, Gamache & Krebs, 2002, p. 998). Other studies reviewed took a qualitative approach. These studies explored changes in substance use, money management skills, housing status, health and mental health outcomes but were also interested in client's perspectives around how they experienced the intervention (Rowe, Serowik, Ablondi, Wilber & Rosen, 2013, p. 117; Serowik, Bellamy, Rowe & Rosen, 2013, p. 142). A common theme within these studies was a sense of esteem that came along with developing financial responsibility or financial mindfulness (Rowe et al., 2013, 117; Serowik et al, 2013, p. 114). Another approach taken in the research was to gather data from case notes and case managers' rating of client functioning. These studies explored changes to clients substance use, housing status, health outcomes etc., but also explored how clients were referred, by case managers, to money management programs and how the programs were administered (Luchins, Hanrahan, Conrad, Savage, Matters & Shinderman, 1998, p. 1219; Ries & Comotis, 1997, p. 332).

Research outcomes had mixed results in terms of the impact money management interventions had on substance use. In some cases, abstinence rates improved while other studies

suggested that the intervention did not reduce substance use (Rosenheck, Lam & Randolph, 1997, p. 802; Rosen, Rounsaville, Ablondi, Black & Rosenheck, 2010, p. 709; Black & Rosen, 2010, p. 127). In instances where substance use was not reduced, there was little discussion about any change in safe using practices. Harm reduction was not discussed and the goal of the research was simply to *reduce or eliminate substance use rather than to improve health outcomes*. Incorporating harm reduction practices could offer a platform for honest discussion about whether money was going to be spent on drugs or alcohol. This could also lead to conversations around safe using practices, in turn improving health outcomes, educating clients and creating a safe and honest professional relationship free of judgement.

Some of the literature raised the concern or potential for ethical issues inherent in managing another individual's money. Of primary concern was the potential for money managers to coerce clients, perhaps unintentionally, to follow treatment plans or in other words, to use money as a leverage or a reward for "desired" behaviour or choices (Rosen, Rounsaville, Ablondi, Black & Rosenheck, 2010, p. 712; Elbogen, Tiegreen, Vaughan & Bradford, 2011, p. 225).

Arguments pertaining to client's rights to autonomy or self-determination were also raised. Questions around who has the right to decide how one spends their money and when is it appropriate to restrict a client's right to make these decisions for themselves, were evident in the literature (Luchins, Hanrahan, Conrad, Savage, Matters & Shinderman, 1998, p. 1221; Ries & Comtois, 1997, p. 337). Ethical concerns could have, and arguably should have, been raised in all of the literature reviewed if we are approaching client care from an anti-oppressive and critical lens.

The power dynamics that exist between worker and client and furthermore, the unique and enormous power dynamics/imbalance between money manager and client, requires acknowledgement and active reflection on behalf of the worker. Client centred care requires the inclusion of the client's voice and should promote self-determination and autonomy. In cases where there are obvious power imbalances, there needs to be some acknowledgement of this so that workers can be aware of their power and how their power influenced people with whom they are supporting. Awareness on the workers' behalf will, hopefully, promote client care practices that seek to promote more relationships that are neutral, promote self-determination and value autonomy, while acknowledging that there is in fact a power imbalance. Reflecting on biases and assumptions is necessary to ensure they are not impeding service delivery. Considering the literature's focus on assisting clients to spend their money in a more "socially responsible" way, it would be worthwhile to reflect on where these values and from where assumptions are coming. Are they based on improving quality of life or are they based on judgements about substance users' life styles?

Some of the literature made explicit recommendations that more staff training was necessary in order to offer appropriate money management interventions (Rowe, Serowik, Ablondi, Wilber & Rosen, 2013, p. 118; Serowik, Bellamy, Rowe & Rosen, 2013, p. 150; Elbogen, Teigreen, Vaughan & Bradford, 2011, p. 229). Training was discussed in the context of focusing on recovery principles and client centred care. The trainings explicitly focusing on ensuring collaboration between worker and client, developing and maintaining trust within the professional relationship, and promoting client choice with an overall goal of supporting clients to gain independence (Rowe, Serowik, Ablondi, Wilber & Rosen, 2013, p. 118; Luchins, Hanrahan, Conrad, Savage, Matters & Shinderman, 1998, p. 1222; Serowik, Bellamy, Rowe &

Rosen, 2013, p. 150). One study went further, suggesting that anyone working with people, who access psychiatric services, should incorporate financial skill development into service delivery because it is seen as a "...cornerstone of independent functioning..." (Elbogen, Tiegreen, Vaughan & Bradford, 2011, p. 229).

A consistent limitation mentioned in the literature on money management interventions or research studies, was the sample size or characteristics of participants. Study results were hard to validate because there remained questions pertaining to people who agreed to participate versus people who did not. It is possible that people who did not agree to participate were avoiding judgement pertaining to their substance use or because they were not ready or willing to make changes to their current substance use practices. Unknown to the researchers was whether people who agreed to participate had higher or lower levels of substance use; were in a different stage of change in their recovery; viewed money management positively; and/or explicitly wanted assistance with financial management or skill development (Rosen, Carroll, Stefanovics & Rosenheck, 2009, p. 503; Rosen, Rosenheck, Shaner, Eckman, Gamache & Krebs, 2002, p. 1000; Serowik, Bellamy, Rowe, & Rosen, 2013, p. 150; Rosenheck, Lam & Randolph, 1997, p. 805).

Experiences (mental health status, substance use challenges, experiences of trauma, experience of homelessness, etc.) differ from one person to the next and therefore understanding why money management is beneficial to some and not others remains difficult to attribute to specific factors. The literature seems to solely rely on the clients' willingness and desire for money management interventions. One can assume that money management interventions, like other therapeutic interventions, will offer the best results in terms of improving clients' quality of

life, if/when they focus on promoting and supporting client choice, self determination and valuing client autonomy.

Gaps in the literature existed. The "Harm Reduction" model, a widely accepted approach for working with people who use substances, was not a guiding principle for the money management programs reviewed in the literature. Harm reduction is best understood as a "...philosophy or set of strategies that proposes a value neutral shift towards drug use in policy and practice." (Pauly, 2007, p. 6). Harm reduction practices seek to reduce the harms associated with using substances while valuing people who use drugs and recognizing and promoting substance users' rights to have equitable access and opportunities (Tinderington, Stanhope & Henwood, 2012, p. 71; Pauly, Reist, Belle-Isle & Schactman, 2013, p. 285). A major focus of the harm reduction philosophy is to address deep rooted social and economic inequities that continue to marginalize people who use substances (Roe, 2005, p. 245; Norman & Pauly, 2013, p. 137). Tenets of harm reduction include; meaningful participation, non-judgemental, supportive, humanistic, valuing lived experiences and the voices of people who use substances (Rowe, 2005, p. 48; Norman & Pauly, 2013, p. 137; Pauly, 2008, p. 6).

The scope in the reviewed literature was narrow; research was primarily focused on increasing levels of abstinence rather than exploring the individual's life holistically and measuring overall changes in quality of life. Secondary outcomes did, in some research, indicate improvements in housing and health status, though it was not the goal of the research. Voices from service users were not present in the majority of the research and it would be interesting to hear their experience of money management programs. As the Coordinator of the Trustee Case Management program at St. Stephen's Community House, I have the opportunity to review a harm reduction based voluntary trustee case management program.

The Harm Reduction Trustee Case Management Program Description

The Harm Reduction & Trustee Case Management Program (HRTCM) is an intensive case management program which adds financial trustee supports. The program employs four (4) fulltime Trustee Case Managers and provides service to 92 clients. The target population are people who use drugs and/or alcohol and are homeless or have a history of homelessness. The primary long term goal of this program is to improve clients' overall quality of life by offering holistic Trustee Case Management supports from a Harm Reduction perspective. Primary short and medium term goals focus on reducing binge drug and/or alcohol use and safer substance use through education on harm reduction practices and financial budgeting. In addition, the HRTCM program seeks to support people who actively use substances to maintain their housing while addressing complex physical and mental health concerns. This program is voluntary on behalf of the clients and they can self-discharge at any time.

This program operates out of the Corner Drop-in Centre where there is low barrier access to a nurse, doctor, psychiatrist, harm reduction supplies, housing workers, showers, and meal programs. Abstinence is not a required goal for clients though for some it may be a personal goal. Trustee Case Managers support clients through a harm reduction case management perspective and focus on developing an open and trusting relationship, supporting self-determination and working with clients "where they are at". Case Management activities include navigating the social service and health systems, advocating for and with clients to gain access to appropriate services including legal, health, housing, social recreational, mental health and trauma supports, substance use services, harm reduction services or support, dentistry, peer work or other meaningful employment, food security and financial services. Trustee Case Managers offer off site/in community support and provide accompaniments and home visits as per

individualized care plans.

Trustee services are offered on weekdays. Clients can access a pre-budgeted amount of money daily between the hours of 8 am and 11:30 am. Afternoon hours provide the opportunity for Trustee Case Managers to work offsite with clients on case management goals and/or activities. The client and Trustee Case Managers develop budgets. Support is given to the clients to help them follow their budget for the month after which point they can create a new budget if desired. For those clients who find the drop-in centre triggering or for those who have developed a higher level of stability, Trustee Case Managers will work with them to open bank accounts and will do weekly deposits of pre-budgeted amounts. The Trustee Case Manager will pay clients' bills and rent at the beginning of each month. This maintains the program goal of supporting clients to maintain housing by eliminating the risk of evictions based on non-payment of rent and ensures the clients are in good financial standing with other bill payments.

Chapter 3: Research Design

I intend to complete a summative (outcome) program evaluation and am particularly interested in how money management programs improve overall quality of life, regardless of whether the client continues to use substances. Though the overall goal of the research reviewed was to eliminate or help individuals stop using substances through money management interventions; I will be taking a harm reduction approach. My approach will focus on changes (not necessarily reduction) of substance use as well as whether quality of life measures have changed for people who are accessing the St. Stephen's Community House Trustee Case Management Program.

St. Stephen's Community House has a strong belief that the Trustee Case Management

Program is of value to clients based on the observed length of time clients stay in the program, and the informal feedback we receive from clients, as well as the number of referrals that we receive for clients wanting trusteeship supports. Through a summative program evaluation, I will explore how a Harm Reduction based Voluntary Trusteeship program, offered at St. Stephen's Community House, impacts the lives and well-being of people who use substances.

The purpose of my evaluation is twofold. The primary goal is to determine whether a harm reduction trusteeship, combined with case management services, improves overall quality of life for people who use substances and experience homelessness. According to Harris, M.J. (2010) outcome evaluations focus on how effective the program is in terms of reaching its intended outcomes (p. 94). Therefore, the outcome evaluation will demonstrate any related changes occurring in the lives of people enrolled in the program. It will also achieve the secondary goal of this evaluation: to generate knowledge and evidence to support the need and efficacy of harm reduction based trustee case management services in the sector. Furthermore, this program evaluation will offer a guide to any agency wishing to implement a similar program for this population.

Evaluation Methods

This summative evaluation is a quantitative, non-experimental approach. The objective is to determine if and how the Trustee Case Management program is achieving its intended outcomes. This is the best methodological approach given the time frame and the programs outcomes, which are based on improvements in housing stability/eviction prevention and improvements to overall quality of life/stability.

It became apparent, in designing this program evaluation, that research on specific programs or interventions is heavily influenced by stakeholders or funders - and furthermore, by political agendas. Because programs are usually funded to address specific problems or needs within a community, that are valued by society or funders, the outcomes measured are usually based on measures that demonstrate "effectiveness" from a funder's perspective. This means that program evaluations must focus on demonstrating improvements or changes, which are often captured through measurable data (numbers) rather than through anecdotal or qualitative means. Therefore, this program evaluation will specifically focus on-whether program outcomes are being achieved rather than exploring client's experience of being in the program. Furthermore, I will be adding to knowledge by evaluating a Harm Reduction based money management program.

According to the literature, program evaluation "... should be based on systematic reviews of evidence aimed at showing the relationship of the intervention to particular outcomes and an explicit process for translating the evidence into recommendations..." (Briss, Zaza, Pappaioanou, Fielding, Aguero, Truman, Hopkins, Mullen, Thompson, Woolf, Carande-Kulis, Anderson, Hinman, McQueen, Teutsch, & Harris, 2000, p. 36). The theoretical assumption guiding this evaluation will be based on summative evaluation principles. The purpose of a summative evaluation is to demonstrate program effectiveness (Fraser Health Authority, 2009, p. 11). In this case, program effectiveness will be demonstrated if there is an observed improvement in overall quality of life for clients after being enrolled in the trustee case management program.

Key outcome evaluation questions will include:

1. Did a level of stability in substance use improve?
2. Did quality of life improve for clients enrolled?
3. Did housing stability improve?
4. Did financial stability improve?

These outcome questions are based on pre-designed program outcomes, which are geared to meet the requirements of the funders. The value of the program rest solely upon improvements in the specified areas, which would be limiting if, we were not measuring quality of life. It would be more client-centred to have had the program designed to measure outcomes identified by people who use the program. As mentioned in the literature review, language is very powerful and I can recognize that there are potential assumptions and subjective language within the evaluation questions. For example, 'stability' and 'improved'. Both of these words leave room for interpretation of their definition and may have impacts on how results of the evaluation are interpreted.

Summative evaluations are appropriate for evaluating programs that have been in place for some time and which are relatively stable (Fraser Health Authority, 2009, p. 11). Given that the goal of this evaluation is to determine if the program is reaching its intended outcomes, and since it has been operating for over 12 years, a summative program evaluation will produce the data required to evaluate program effectiveness.

Methods used for the outcome evaluation will include a retrospective pre-test-post-test questionnaire. This method is best suited since there is not consistent baseline

information available for all program participants. Furthermore, since the program has expanded and funding priorities have changed over the years, the intended outcomes have developed and changed based on funding priorities as well as the sector's move towards evidence based practices.

This questionnaire will incorporate the Quality of Life Enjoyment and Satisfaction Questionnaire (Endicott, Nee, Harrison & Blumenthal, 1993). This questionnaire is a standardized tool, which takes approximately 5 minutes to administer (Endicott, Nee, Harrison & Blumenthal, 1993). This tool "addresses the degree of enjoyment and satisfaction experienced by individuals in various areas of daily functioning." (Endicott, Nee, Harrison & Blumenthal, 1993, p. 3). Secondly, the Adverse Consequences of Substance Use questionnaire (Centre for Addiction and Mental Health, 1997) will be included. This tool "focuses on determining the negative impact of the client's substance use over a range of life areas" (Centre for Addiction and Mental Health, 1997). Answers to these questions will provide a thorough understanding of whether a level of stability in substance use has been reached when considering pre-enrollment and post-enrollment in the program.

To ensure information pertaining to all outcome questions are addressed, questions pertaining to housing status, primary care, harm reduction knowledge and behaviour, financial stability and budgeting skills will be included. Participation by respondents will be encouraged by keeping the survey short. The full survey was intended to be a total of 15-20 minutes in length. Paid research assistants will administer the surveys with participating respondents to ensure clients do not feel pressured to answer the questions in any biased way.

(See Appendix A & B)

An ethics review was submitted and approved by York University's Ethics

Review Board. Administrators will make every effort to do no harm and will offer thorough explanation of evaluation intentions and use. Staff will be available to debrief with participants that feel triggered after completing the questionnaire and survey. Participation is completely voluntary, and recruitment of participants will occur via in-office postings and signage requesting that any interested clients volunteer to participate in the evaluation. Benefits to participants include providing feedback that will be taken into account and will contribute to quality of program delivery to ensure it is meeting their needs. Sample size will depend on how many clients volunteer to participate. Informed consent is required. All participants will receive a written and detailed explanation of the purpose and intention of this review and students/volunteers will go over this information verbally with participants before they sign consent forms. Confidentially and anonymity will be maintained by excluding any identifiable information.

Evaluation Implementation

The participants in this research were current clients of the Voluntary Trustee Case Management Program at St. Stephen's Community House: Housing and Homeless Services. Program participants are 18 years of age and older, are of all genders and have a history of homelessness and substance use challenges.

The original recruitment plan included the use of posters in the office space. Posters asked those interested in participating to contact the Researcher (Michelle Dixon, Program Coordinator). There was no response from this signage. This could in part be due to the many other posters and flyers around the drop-in and in offices. It was then hypothesised that clients

may have become accustomed to them and are not taking the time to read them. This lack of attention has also been noted in the past with signage about closures or program changes. Due to the strict time-frame associated with this research project, staff began asking clients if they were willing to participate in the program evaluation process by answering a brief questionnaire. Clients who agreed were then directed to a placement student who was not associated with the Trustee program. The placement student reviewed the Informed Consent Form (*See Appendix C*) with them and asked research participants to sign the Informed Consent agreement before administering the questionnaire.

Informed Consent Forms outlined the purpose of the research, indicating that the primary goal of the research was to determine whether the Trustee Case Management Program is achieving its intended outcomes and to determine what changes, if any, are occurring in the lives of the program participants. It outlined what was being asked of them as research participants, outlined benefits of the research and potential benefits to them to give feedback pertaining to whether the program is in fact improving their quality of life.

Risks and potential discomforts were identified in the consent form. Potential risks may have included a research participant feeling triggered after completing the questionnaire. There were resources available on-site to support any research participant that felt triggered from participating in this program evaluation. Research assistants also had on hand a resource list of after-hours crisis support services should the participant require support after-hours.

The informed consent form also discussed voluntary participation; withdrawal from the study, how confidentiality would be maintained and contact information for myself (Primary Researcher), Wilburn Hayden (Professor and assigned Research Advisor).

The research plan was to administer as many questionnaires as possible at the beginning of the month when income cheques arrived. The beginning of the month was chosen because it is the busiest time in the program. A number of clients only access the program at the start of the month with little or no contact during the second half of the month. The questionnaires used were the same as intended and identified in the research proposal. They included Adverse Consequences of Substance Use questionnaire (Centre for Addiction and Mental Health, 1997), the Quality of Life Enjoyment and Satisfaction Questionnaire (Endicott, Nee, Harrison & Blumenthal, 1993) and a page of questions pertaining to housing status, and harm reduction knowledge and practices. Because this was a retrospective pre-test-post-test design, both standardized tools were included twice and asked respondents to answer both based on their memory of how they would have scored themselves before joining the program and then how they would rate themselves based on the past week. The last page of the questionnaire asked about housing status & harm reduction knowledge and practices before joining and after joining the program to get a sense of how these areas may have changed.

As previously stated, a retrospective pre-test-post-test was used to determine whether the Trustee Case Management program had impacts on clients' overall quality of life, substance use practices, financial stability, and most importantly, housing stability/retention. Because the program has expanded over the past 12 years, and there are now multiple funders, the outcome goals have changed and developed over the years and client baseline information from 10 plus years ago is either not accessible, or does not ask questions that would be required to determine changes in these areas. Given the lack of available or sufficient baseline information, I hoped that a retrospective baseline would still offer some insights as to how people's lives have changed since being in the Trustee Case Management program.

I am aware that a limitation of this type of design leaves room for memory error or distortions. Secondly, it has been observed by staff that a number of the clients consistently demonstrate challenges in accurate recollection of past events. This may be a result of prolonged substance use or simply because their fight to live and access basic needs overshadowed their attention to what was really going on for them in terms of quality of life.

A benefit to using a retrospective pre-test-post-test is to avoid the "...shift-response effect by clearing up misconceptions before participants are asked to make assessments." (Harris, 2005, p. 18). Typically, this method is used for a single intervention, for instance a one day workshop to develop skills or knowledge. In this case, I thought this method would be useful to determine whether clients reported an increased level of knowledge and applied practice of harm reduction strategies connected to their substance use. For example, injection drug users often believe they are practicing safely by not sharing needles but later learn that sharing "cookers" (spoons) can also be a source of HEPC transmission. This is an example of where someone may rate their level of harm reduction knowledge and practice as "good" until they receive education on additional risks factors for transmission of infections.

Evaluation questionnaires were kept short so that clients would agree to participate. I also wanted to ensure all respondents would complete the questionnaire, since a common theme amongst our clients is that they get distracted or disinterested quickly. I did not want the process to be a source of stress or to elicit frustration. Our clients have been paid to complete surveys and asked about compensation to complete the questionnaire. Unfortunately, this research did not involve material incentives for those who chose to participate.

A total of 18 clients participated in the program evaluation. I had hoped for 20-30 completed questionnaires. This proved challenging, possibly because of the chaotic nature of a

drop-in centre. I only had one person administering questionnaires at a time. When she was not available in the moment, clients were not willing to wait or would agree to wait and then when she finished with the first person, they were nowhere to be found.

The research design and questionnaire asked questions that required respondents to rate their knowledge, or level of enjoyment in different areas of their lives. The goal was to see if clients reported changes to their wellbeing (substance use, quality of life, housing status) and if so, this would be interpreted as though the program is meeting its objectives/projected outcomes.

As mentioned above, quantitative methods were used, primarily because funders are interested in evidence indicating efficacy of programs through percentages. For example, number or percent of people who maintained their housing while enrolled in the program or demonstrating a zero percent eviction rate.

Feedback from the research assistant indicate that research participants found the Informed Consent Form too long and as a result were not interested in reading the full form before signing it. This population is particularly accustomed to having to answer a number of questions or assessments. Unfortunately, funders require data and prescribe tools/assessments that must be administered on an ongoing basis to secure or maintain funding. Secondly, this population is also used to completing intake assessments upon every intake to service. I mention this because it is not surprising that those who agreed to participate were not overly concerned with the fine print about the research because they are used to answering personal questions as a formality to receiving service. This is a troubling reality - it seems the more marginalized, the more you are required to share your personal information. Without doing so, you may not be eligible to receive the support you need in order to survive.

The research assistant also noticed that some of the language was confusing for research

participants. For example, the Quality of Life Scale asks: "What is your future vision" which was often interpreted as a question around their eye sight as opposed to outlook on life. Furthermore, the research assistant noted that going back and forth from thinking about the research participant's past and comparing it to their future was difficult for some. Continual reminders were required to support respondents to answer the question based on the past and not just the present. Lastly, she reported that a few participants found the questions restrictive -- they expressed not being able to choose an item on a scale to sum up their true experience.

Chapter 4: Research Analysis and Findings

Some surveys were not complete. Originally, I had decided I would not include incomplete surveys however, I have decided to include them because there is still data for analyzing specific questions rather than overall ratings. This is particularly true in relation to the Quality of Life scale when analyzing unique categories.

Data from the surveys was analyzed and organized using an Excel spreadsheet. All responses from each unique indicator were tracked separately to get a more concise picture of where changes were occurring and to what degree. Once data was organized, the sum of all responses for each indicator was divided by the number of responses and multiplied by 100 to get a percentage thus, indicating the degree of change.

Adverse Consequences of Substance Use Questionnaire

Data from the Adverse Consequences of Substance Use were analyzed first. This data from the tool was used to determine whether the program was meeting outcome measure number

1: Did a level of stability in substance use improve?

The first indicator asked about physical health problems connected to substance use (including overdose). The data showed a 21% decrease in reported health problems from before joining the Trustee Case Management program to present. This is interpreted as a positive outcome. Furthermore, this strong improvement invites further study to establish more specific relationships between the program components and the results. Do client's believe that money management helps to reduce binge use behaviour and therefore, health has improved?

The second indicator asked about memory problems (including blackouts and difficulty thinking). The data showed a zero percent change. This may be explained because of continued substance use.

The third indicator asked about mood changes including substance induced psychosis or changes to personality. The data indicated a 5 % decrease. The improvement is welcome, and the fact that it is low is not surprising considering the fact that clients are still actively using and the mood baseline they are referring to is one when they were using.

The fourth indicator asked about relationships and whether there are problems because of one's substance use. There was an 8 % decrease in relationship problems. Usually by the time a client enters the Trustee Case Management program, they are estranged from friends and family or have extremely strained relationships. It is not a surprise that this area would remain consistent. Although, it is also encouraging that there was a slight decrease reported with respect to problems in relationships. Indicating that for some, relationships have improved between clients and friends and family. Perhaps this is a result of an increase in overall stability but this cannot be confirmed and would be better understood via qualitative inquiry.

Overall results from the Adverse Consequences of Substance Use questionnaire indicate small but significant improvements in all indicators. This suggests that there has been a decrease in adverse consequences related to substance use experienced by respondents before joining the program to present. Furthermore, this could be interpreted as being caused by an increase in the level of stability in terms of substance use clients have achieved while receiving services in the Trustee Case Management program.

Consistent with the literature reviewed, people do not stop using substances with the addition of money management programming. The goal of this Trustee Case Management program is not to stop people from using substances but rather to improve quality of life for clients while they continue to use substances. Therefore, if clients continue to use substances, it is not surprising that there is only a small reduction in adverse consequences related to their substance use. Furthermore, the longer people continue to use, the more susceptible they become to negative health consequences. The length of respondents' substance use history was not measured so it is hard to determine whether the minimal changes are a result of prolonged use despite the support received from the Trustee Case Management program. Alternatively, these results could be interpreted as that the improvements, though minimal, are connected to a reduction in binge use behaviour because of improved budgeting or limited amounts of money available daily.

Quality of Life Enjoyment and Satisfaction questionnaire

Data from the Quality of Life Enjoyment and Satisfaction questionnaire was analyzed second. Responses were based on a five point rating scale which included; very poor, poor, fair, good, and very good. The data was organized and analyzed using an Excel spreadsheet for

determining outcome s 2: Did quality of life improve for clients enrolled?

The first indicator asked about *physical health* and revealed a 14% increase. This was consistent with a reported increase in physical health from the Adverse Consequences of Substance Use questionnaire.

The second indicator asked about mood and revealed a positive outcome with an 11% increase. This indicator was also consistent with the responses from the Adverse Consequences of Substance Use questionnaire's responses to *changes in mood* from before entering the program to present. Both scales demonstrated improvements.

The third indicator asked about *work* and revealed an 11% increase in the scores. In the last few years St. Stephen's Community House introduced a paid Peer Training and Development program as well as peer employment opportunities. It is difficult to determine if life improved for our clients resulted from the Trustee Case Management program or opportunities mentioned above. Regardless of the root cause, it is encouraging to notice that some clients have experienced improvements.

The fourth indicator asked about *household activities* and revealed a 15% increase in scoring. This is an interesting question given that a number of clients entered the program without housing or soon after being housed. Results could speak to the fact that before the program they did not have a place to live.

The fifth indicator asks about *social relationships* and revealed a 6 % increase in scoring. This seems consistent with reports I have heard from clients over the years about their friends. There is a common belief that their friendships are tied to their substance use which may not be "real" friendships. I am not surprised that there is no significant increase in social relationships

for those who are still using substances and living in poverty. Both living in poverty and using substances results in experiences of discrimination and stigmatization which creates a barrier to seeking friendships with people from higher socio-economic status.

The sixth indicator asks about *family relationships* and revealed a 5 % increase in scoring. This is fairly consistent with the responses from the Adverse Consequences of Substance Use tool. As previously mentioned, family relationships are strained or broken before entering the Trustee Case Management program. It is not surprising that there is little improvement in this area.

The seventh indicator asks about *leisure activities* and revealed a 3% increase. Respondents rated leisure activities as 60% enjoyment before entering the program and as 63% enjoyment after enrollment. There are two things to consider. Firstly, as social services in Toronto has little funding allocated for social activities; it is not surprising that this indicator had almost no change. Funding in Toronto is geared towards short term, evidence based approaches that seek to develop healing of some sort or to encourage independence. Unfortunately, social/leisure activities have not been a priority for funding because they are generally understood as privileges. However, if we are thinking holistically, social and leisure activities can have the potential to improve mental health and isolation and increase one's network of friends. Secondly, overall scoring of before and after are not dangerously low which indicates that respondents may well be satisfied with how they spend their leisure time. This question does not ask whether time is spent in a "socially acceptable" way but rather if one is happy with this area of their life.

The eighth indicator asks about *ability to function in daily life*. The data indicated a 9 % increase. Retrospective pre-test scores were at a 56% rating; the post test scores showed 65%

rating. This question is subjective because responses reflect one's meaning of "function". If function means accessing food and getting to appointments, etc. this reality is very different from pay my mortgage, maintain employment, pick up kids, etc. Regardless, an increase is a positive outcome because the most important information is whether clients are experiencing improvements in their lives according to their personal world view.

The ninth indicator asks about *sexual drive, interest and/or performance*. Results indicated a 7 % increase. Retrospective responses indicated a 56% rating in satisfaction in this area and post tests indicated a 63% satisfaction rating. In my experience administering assessments, questions of this nature are often met with a high degree of discomfort on behalf of respondents. It is a speculation of mine that clients rated this area higher than what they are really experiencing in order to "save face". Social influences can make it difficult for men to report to a younger woman that they are not experiencing a desirable sex life.

One respondent sought me out after the questionnaire and said that he felt embarrassed by that question especially since he was not familiar with the research assistant, stating that he would have felt better answering that question with me since we have worked together for years. I had to remind this client that due to ethical boundaries with respect to research, I could not administer the questionnaires.

The tenth indicator asks about *economic status*. Results indicated a 30% increase in how respondents rated this area of their life. Retrospective pre-test results showed an overall rating of 44% satisfaction and post test results indicated a 74% satisfaction rating. This area demonstrates the highest improvement which is not surprising since the goal of the program is to help support clients to pay their bills and to stretch their money out longer throughout the month. These results indicate very significant benefits related to the impact of budget management.

The eleventh indicator asks about *living/housing situation*. Results indicated an 18% increase in how respondents rated this area of their life. Retrospective pre-test results showed an overall satisfaction rating of 57 % and post test results showed a 75% satisfaction rating. These results are likely in part due to an initiative that was rolled out after a number of clients joined the program, which offered subsidized housing for people with problematic substance use. It was based on a housing first model, which was discussed in greater detail in the literature review.

A number of the clients in our program were housed through this initiative and receive housing support workers as well as their Trustee Case Managers to help them to maintain their housing and to work on other self-identified goals. This initiative not only moved people off the street and into housing but also moved some clients from rooming houses to independent bachelor and one bedroom apartments. Another reason for the improvement is likely connected to the fact that as a result of the Trustee Case Management program paying the clients rent, they are at a zero risk of losing their housing due to non-payment of rent. This is a very positive and encouraging outcome and also speaks to the third outcome question: Did housing stability improve?

The twelfth indicator asked about one's *ability to get around physically without feeling dizzy or unsteady or falling*. Results indicated a 6 % increase in this area. Retrospective pre-test results indicated a 67% overall rating in this area and post results indicated a 73% overall rating. This could be attributed to a reduction in binge use behaviour or a more stabilized use pattern.

The thirteenth indicator asked about one's *vision* specifically in terms of ability to do work or hobbies. Results indicated a 5% decrease in this area of life. Retrospective pre-tests showed a 70% overall satisfaction rating and post tests showed a 65% overall rating. Considering the feedback from the research assistant; clients were often confused by this question and

thought it had to do with their eye sight, it is not surprising that this question may be speaking to eye sight as well as life-vision. It is hard to say that this indicator has any real insights considering the consistent misconception in terms of meaning.

Life vision, which I would interpret as a sense of hope, is something that is not well encouraged. Our discourse and societal stigma have very real impacts on individuals' sense of hope for a different life. This can leave individuals who experience multiple oppressions feeling as though there is a "glass ceiling" so to speak on what they can achieve in life, based on their social status. Therefore, I would hypothesize that even if this question was not misinterpreted; it is likely that one's sense of hope or vision of a different life may remain relatively unchanged over time.

The fourteenth indicator asked about *overall sense of wellbeing*. Results indicated a 9% increase overall. Retrospective pre-test results showed a 56% overall rating and post tests showed a 65% overall rating. This change demonstrates perceived improvements in overall wellbeing.

The last two indicators on the Quality of Life Scale are stand alone questions but did yield some important information. In terms of indicator 15, which asked about *medication*, retrospective pre-tests indicated a 30% satisfaction rating, which improved overtime to 41% based on the post-test results. This is an 11% improvement but still a low overall rating, indicating a need for improvement.

The final question asked respondents to rate *their overall life satisfaction*. Retrospective pre-test results showed an overall scoring of 52% satisfaction rate. This improved by 16% according to the post-test results, which indicated a scoring of a 68% satisfaction rate.

Out of 18 questionnaires, 15 were complete and did not have any missing data. Only the

complete questionnaires were included in scoring for the total overall enjoyment and satisfaction in terms of Quality of Life Scale.

The Quality of Life Enjoyment and Satisfaction Questionnaire has a scoring rubric which:

> "...involves summing only the first 14 items to yield a raw total score... The raw total score is transformed into a percentage maximum possible score using the following formula:
>
> $$\frac{\text{(raw total score - minimum score)}}{\text{(maximum possible raw score - minimum score)}}$$
>
> The minimum raw score on the Q-LES-Q-SF is 14, and the maximum score is 70. Thus the formula for % maximum can also be written as (raw score-14)/56. The table below converts total raw scores into % maximum scores." (*See Appendix D*). (Endicott, et al., 1993, p. 326).

The total scores from all 15 questionnaires were added up and then divided by 15 to get overall raw scores. Total raw score was then converted into percentages according to the assigned scoring rubric.

Retrospective pre-test results showed an overall score of 46% quality of life enjoyment and satisfaction compared to post test results which showed an overall score of 61% quality of life enjoyment and satisfaction rating. This indicates a 15% improvement over time.

Although we cannot determine whether improvements are a direct result of money management, we can however assert that these improvements are a result of the program as a whole (combination of case management support and money management). The literature reviewed had noted that money management improved attendance or treatment compliance rates.

That was not measured in this study; however, it is hypothesized that because clients engage more readily when money management is a component of service delivery, there is a greater opportunity to address other life areas through case management support before they become critical.

Housing, Finances, and Harm Reduction Questionnaire

The last component of the questionnaire, sought further information pertaining to housing, finances and harm reduction knowledge and practice. This section was used to gather additional information to determine whether the program was meeting outcome questions 1, 3 and 4: Did a level of stability in substance use improve?; Did housing stability improve?; and Did financial stability improve?

Responses were organized and analyzed using an Excel spread sheet. The total sum from each question was divided by the number of responses and then multiplied by 100 to get a percentage. Percentages were used to indicate the degree of change within each category.

Results showed that out of 18 respondents, 44% were homeless when they joined the Trustee Case Management program and currently 100% of those same respondents were housed. This is a very positive outcome and demonstrates that the program in addition to the ‘housing first’ initiative helps participants access and maintain housing. These results indicate an improved level of housing stability.

Less compelling results indicated that only 44% of respondents believed they were receiving all the benefits in which they were entitled. This could be a result of individuals believing that they should be able to access certain benefits but not matching the eligibility

criteria. For example, transportation allowance is based solely on the number of medical appointments you attend a month. This must be confirmed by a medical professional and funds will be issued based on the number of visits required each month. In my experience, most clients believe they should be issued travel allowance in order to be able to visit the drop-in centre, meal programs, probation appointments etc. Unfortunately, these visits are not eligible for travel allowance according to Ontario Disability Support Program legislation.

The next question asked about budgeting skills to gather an understanding of whether respondents felt their budgeting had improved since joining the program. Thirty-three percent of respondents answered "yes" when asked if "they were able to manage their money effectively before joining the program" compared to 78% of respondents who answered "yes" when asked if "they were able to manage their money effectively, after joining the program". This is a positive result, and demonstrates a level of financial stability in overall program responses. Although there are noticeable improvements in clients' perceptions pertaining to budgeting, it would be interesting to understand why 22% of clients do not believe their budgeting has improved. Further research should investigate what is missing or what could be improved to better support those clients who do not believe the program is meeting their needs in terms of improving budgeting skills.

The last section of the questionnaire asks about safe using (harm reduction) knowledge and whether people are practicing safe using strategies. There was a four point rating scale (1- strongly disagree, 2- disagree, 3- agree, and 4- strongly agree). Because the primary goal is to improve clients' knowledge and application of harm reduction or safe using practices, the following discussion will focus on responses that indicated 'agree' or 'strongly agree'.

Responses indicated that 31% *strongly agreed* that they knew a lot about safe using

practices before joining the program compared to 69% of responses, which indicated they *strongly agreed* after joining the program. Additionally, 25% *agreed* that they knew a lot about safe using practices after joining the program. Therefore, 94% of responses indicated 'agree' and 'strongly agree'.

Responses also indicated that 18% *strongly agreed* that they practiced safe using strategies before joining the program compared to 44% who indicated *strongly agree* after joining the program. Additionally, 56% *agreed* that they practice safe using strategies after joining the program. Therefore, 100% of responses indicated 'agree' or 'agree strongly'. This seems consistent. If knowledge pertaining to safer using strategies improved so would safer using practices. Most notable, according to responses, is that clients are using substances safely and are not sharing equipment.

Harm reduction was not measured in the existing literature on money management program and is likely better understood by reviewing case management supports. That being said, the Trustee Case Management program has noted money management as a tool to opening up more in depth conversations pertaining to where people are spending their money and when discussions centre on substances, this provides an opportunity to discuss safe using practices and provide access to sterile equipment regularly.

Chapter 5: Discussion and Recommendations

It is my intention to develop literature that will support the need for more voluntary trustee and case management programming and/or funding priorities in the City of Toronto.

According to all the findings the Trustee Case Management program has positive effects in terms of improving overall quality of life for clients. For all four outcome measures, improvements were identified to various degrees.

The Trustee Case Management program creates a schedule for clients by requiring that they attend on weekday mornings if they want to withdraw money. Perhaps, having somewhere to be and checking in with staff with whom they have developed, presumably, trusting relationships has contributed to clients' perceived level of life satisfaction. They may have a sense of purpose and increased level of self-worth as they become better at managing/sticking to their budgets, while also achieving additional self identified goals (medical, education, employment, housing, etc.).

Did a level of stability in substance use improve?

There were noticeable improvements in overall responses pertaining to safe using knowledge and practices. This increase indicates an improved level of stability in terms of substance use for some clients in the program (Outcome measure 1). The ideal outcome would be for 100% of clients to be practicing safe using strategies. This is an area for improvement and staff should be revisiting conversations with members about how to make their using practices safer. However, there are multiple factors that influence one's ability for consistently practice safe using strategies. For example, sterile equipment is only available when services are open, so preplanning to ensure they have extra equipment at home or with them is one step to remove this barrier. However, many clients do not want to have supplies when they are trying not to use, seeing it as a trigger. The problem with this is that they cannot always predict a relapse and if sterile equipment is not easily accessible, they often rely on using unsterile equipment or sharing

supplies.

Small improvements in adverse consequences related to substance use were identified. This is consistent with the literature in the sense that substance use patterns, in most cases, did not significantly change with the introduction of money management interventions. Therefore, while clients continue to use it may be unrealistic to assume that general adverse consequences would improve drastically. Prolonged use may and likely does have negative consequences on people's health despite improvements in safe using practices.

Additionally, with societal and internalized stigma impacting people's perceptions and the shame connected to their substance use, it is hard to determine how this influences their self-rating in these areas. More importantly, addiction has unpredictable cycles and without context as to what their substance use was like before joining the program compared to what it is like now; it is hard to determine why there is little improvement.

Did quality of life improve?

Results indicated an overall improvement was a 15% increase in the level of life satisfaction and enjoyment. These results demonstrate that when looking holistically at whether money management coupled with case management has any impact on people's lives, the answer is "yes". Life satisfaction as defined for each individual, by each individual, in this case is interpreted as meaningful because it is hypothesised that this signifies a personal sense of purpose and value.

Overall scoring of post enrollment *overall life satisfaction scoring* was 68% satisfaction rate. It was expected that there would have been more consistency between *overall life satisfaction* results and the responses from *overall wellbeing* question which showed a 9%

improvement with a post score of 80%. I had assumed that wellbeing would be connected to, or improve, life satisfaction. Upon reflection, I am left with questions around what the key factors are for life enjoyment and what would it take to improve overall life satisfaction? One tentative conclusion is that people can identify as healthy and have all their basic needs met, but live in poverty. This could explain why *life satisfaction* rating was low and yet *wellbeing* ratings were moderate to high.

Did housing stability improve?

Results indicated major improvements in terms of the number of clients in the Trustee Case Management program who are housed. Of those participating in the evaluation 100% had either maintained housing or had secured and maintained housing (44% were homeless upon service initiation) since joining the program. It is assumed that money management coupled with case management support that provided advocacy and housing follow up assistance is an effective strategy to prevent evictions and reduce homelessness rates. Housing is a basic right and in many cases, an expressed requirement for clients before they are open to addressing other needs. Results also indicated that there was an increase in the level of enjoyment and satisfaction with housing/living situation. The number of respondents securing housing since joining the program may have influenced this increase. Regardless of why there is an improvement in housing placement, it is safe to say that the Trustee Case Management program has achieved its outcome by improving and maintaining housing status and stability for those within the program.

Did Financial Stability Improve?

Overall satisfaction in terms of economic status improved significantly according to results from the quality of life enjoyment and satisfaction scale. This could, in part, be related to the fact that clients have moved from Ontario Works (social assistance) to Ontario Disability Support Program, which offers a higher level of financial assistance as well as increased level of benefits. Since the Trustee Case Management Program helps people budget and stretch their money out longer throughout the month, while also paying all bills on time, it is not surprising that significant improvements were identified.

Many clients find it very challenging and frustrating to connect with their income support worker. It is possible that when Trustee Case Managers manage the communication piece(with income support workers, it reduces stress for clients and their overall perception of finances improves. It would be interesting to explore how clients' stress levels pertaining to coordinating income support payments, influences their satisfaction and perceived financial wellbeing.

Seventy-eight percent of clients also reported that they are able to budget their money effectively after joining the program. This was a 45% increase compared to responses from the retrospective pre-test. Unfortunately, these results do not demonstrate that they feel they can manage their money independently. Future evaluations should be more specific and ask whether clients feel they have developed the skills to manage their money independently. If not, what are the anticipated challenges? One assumption is, while clients continue to use substances, they are less likely to feel they can manage their money independently without resorting back to binge spending or using behaviour. This ultimately puts their health at risk as well as putting them at greater risk of eviction if they fail to pay their rent. If nothing else, it is very encouraging to learn that clients report experiencing such an increase in their perceived economic status and a noticeable improvement in their ability to budget their money more effectively.

Limitations

The major limitation of this quantitative evaluation is that there is no context to peoples' responses. Without hearing their story, the relevance of their scoring or improvement is hard to connect specifically to the Trustee Case Management Program. There are a number of variables that are not being controlled and therefore significance is hard to determine. For example, in terms of improvements in housing stability, it would be more valuable to have knowledge of how long they were homeless, prior to joining the program, to provide context: how meaningful is it that they are now maintaining housing? Or for which of them was housing placement a result of a change in policy? Despite a lack of understanding the significance, clients *are* maintaining housing, which is a goal of the program.

Secondly, there were minimal improvements in terms of adverse consequences of substance use and without context; it is hard to say that the program only has minimal impacts. For example, without context we are unaware of whether someone joined the program straight out of treatment and has since started using again. This could result in what appears to be a decline since joining the program. Knowing this information would help make sense of what else might be affecting the client's situation. Given the nature of addiction and relapse, it is difficult to determine efficacy of a program unless the pre test and post test are both measured during times within a client's addiction cycle that are comparable. The cycle of substance use is complex and there are generally multiple factors that contribute to peoples' use patterns. Therefore, it is hard to determine improvement or lack of improvement solely on a narrow, quantitative evaluation.

Another limitation is that retrospective tests leave room for memory distortions.

Retrospective base lines are less accurate and therefore it is challenging to determine the relevance of the results. On the other hand, it is positive that overall responses identified improvements. The actual change/improvement in terms of percentage rating may be inaccurate but I can determine that clients have identified improvements to some degree in all outcome measures.

Another approach could have been to ask respondents to rate before and after on the same page rather than first answering all questions based on their recollection of the past and then on a separate page answering the same questions based on their current experience. Allowing respondents to see more clearly how their response changed (if it did), may have offered a more accurate picture. Based on this idea, it also could have been effective to score respondents' quality of life scales with them so that they could confirm whether their answers reflected change or lack of change consistent with their experience.

Chapter 6: Conclusion

There was an overall consensus of improved quality of life after joining the program. This program outcome evaluation demonstrated an increased level of overall stability in the lives of the clients enrolled. This is meaningful to the program, the funders, and to me personally because I place value on knowing that I am providing service that clients value and believe is supporting them to make changes that they believe to be positive.

A Trustee Case Manager's job is very complex and, at times, challenging. As a Case Manager, working from a harm reduction perspective, the goal is to support self-determination

and work with clients "where they are at". Adding money management to this role comes with additional challenges. Most importantly, it creates an even bigger power imbalance that has the potential to impede the therapeutic relationship. It would be interesting to do further research to determine clients' experiences of working with Case Managers who also act as Money Managers/Trustees , as well as understanding how this impacts the Case Managers' ability to provide service in line with social work values and client centred care.

As previously mentioned, this evaluation could be improved by using a qualitative or a mixed methods approach. Significance of results would be more meaningful if there was context to better understand the complex realities of clients' perceived improvements or unique experiences of how the program has impacted their lives (positively). A qualitative approach may have elicited a more accurate picture of whether or not clients of the Trustee Program valued the support and felt that it was making a difference in their lives. Furthermore, a qualitative or a mixed methods design may have provided a better platform for respondents to describe or demonstrate any changes they have experienced or noticed as a result of joining the Trustee Case Management program. For example, it may have been more effective to include questions that asked respondents to rate their perceived change in particular areas on a scale of one to ten and then allow for comments. This approach would have allowed for numerical data on perceived changes (improvements or declines) which funders required.

Future evaluations of this type would benefit from having two or three research assistants to prevent losing clients who were willing to complete the questionnaire but who were not able or willing to wait 15 minutes for the research assistant to be free.

This process has been very helpful for me professionally. Funders, more and more, are requiring evaluations demonstrating how outcomes are being met, in order to secure and

maintain funding. As the Coordinator of the program, I will be responsible to draw connections between data collected and how it demonstrates effectiveness. My major take away however, is that program evaluation is a very distinct skill, particularly in terms of ensuring that your measures will give you useful results with few limitations.

My recommendation to next year's PRP class, is to narrow down your research as much as possible. For anyone planning to do a program evaluation, I suggest focusing on one outcome measure. Most importantly, plan for deadlines and schedule in time every week.

Appendix A

Program # ____________

Counsellor: ____________

Client Name: ____________

Date: ____________

ADVERSE CONSEQUENCES OF SUBSTANCE USE

(Note to Assessment Therapist: Code only the most severe level of consequences for each problem.)

As a result of your substance use, have you experienced:

(8 = Refused, 9 = Missing)	Before Joining	After Joining	**Comments:**
a. Problems with your physical health (including overdose but not neurological problems unless neurological damage has been diagnosed) 0 none 1 self-identified/other person concerned 2 health care professional's health warning 3 medical treatment for physical problem (illness or accident) related to substance use	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 8 ☐ 9	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 8 ☐ 9	If Ever, When:
b. Blackouts or memory problems, forgetting, confusion, difficulty thinking 0 none 1 5 or fewer occasions 2 more than 5 occasions	☐ 0 ☐ 1 ☐ 2 ☐ 8 ☐ 9	☐ 0 ☐ 1 ☐ 2 ☐ 8 ☐ 9	If Ever, When:
c. Mood changes, personality changes, substance-related psychoses, flashbacks when using 0 none 1 minor (impairment had no serious consequences on daily functioning) 2 major (impairment had adverse on daily functioning)	☐ 0 ☐ 1 ☐ 2 ☐ 8 ☐ 9	☐ 0 ☐ 1 ☐ 2 ☐ 8 ☐ 9	If Ever, When:
d. Problems in relationships (including friendships, family of origin, partner/spouse,etc.) 0 none 1 minor (strains and arguments) 2 major (relationship broken off or about to be broken)	☐ 0 ☐ 1 ☐ 2 ☐ 8 ☐ 9	☐ 0 ☐ 1 ☐ 2 ☐ 8 ☐ 9	If Ever, When:

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Name:______________________________ Date:______________

Quality of Life Enjoyment and Satisfaction Questionnaire – Short Form
(Q-LES-Q-SF)

Taking everything into consideration, the week before joining the program how satisfied were you with your.....

	Very Poor	Poor	Fair	Good	Very Good
.....physical health?	1	2	3	4	5
.....mood?	1	2	3	4	5
.....work?	1	2	3	4	5
.....household activities?	1	2	3	4	5
.....social relationships?	1	2	3	4	5
.....family relationships?	1	2	3	4	5
.....leisure time activities?	1	2	3	4	5
.....ability to function in daily life?	1	2	3	4	5
.....sexual drive, interest and/or performance?*	1	2	3	4	5
.....economic status?	1	2	3	4	5
.....living/housing situation?*	1	2	3	4	5
.....ability to get around physically without feeling dizzy or unsteady or falling?*	1	2	3	4	5
.....your vision in terms of ability to do work or hobbies?*	1	2	3	4	5
.....overall sense of well being?	1	2	3	4	5
.....medication? (If not taking any, check here ______ and leave item blank.)	1	2	3	4	5
.....How would you rate your overall life satisfaction and contentment during the past week?	1	2	3	4	5

*If satisfaction is very poor, poor or fair on these items, please UNDERLINE the factor(s) associated with a lack of satisfaction.

Name:______________________________ Date:______________

Quality of Life Enjoyment and Satisfaction Questionnaire – Short Form
(Q-LES-Q-SF)

Taking everything into consideration, during the past week how satisfied have you been with your………

	Very Poor	Poor	Fair	Good	Very Good
…..physical health?	1	2	3	4	5
…..mood?	1	2	3	4	5
…..work?	1	2	3	4	5
…..household activities?	1	2	3	4	5
…..social relationships?	1	2	3	4	5
…..family relationships?	1	2	3	4	5
…..leisure time activities?	1	2	3	4	5
…..ability to function in daily life?	1	2	3	4	5
…..sexual drive, interest and/or performance?*	1	2	3	4	5
…..economic status?	1	2	3	4	5
…..living/housing situation?*	1	2	3	4	5
…..ability to get around physically without feeling dizzy or unsteady or falling?*	1	2	3	4	5
…..your vision in terms of ability to do work or hobbies?*	1	2	3	4	5
…..overall sense of well being?	1	2	3	4	5
…..medication? (If not taking any, check here _____ and leave item blank.)	1	2	3	4	5
…..How would you rate your overall life satisfaction and contentment during the past week?	1	2	3	4	5

*If satisfaction is very poor, poor or fair on these items, please UNDERLINE the factor(s) associated with a lack of satisfaction.

Housing:

1) Were you housed before joining the program? Y____ N____

1b) If you answered no, how long were you homeless?
0-6 months___ 1 year___ 1-2 years___ 2-3 years___ 3+ years___

2) Are you housed now? Y____ N____

2b) If you answered yes, how long have you had your housing?
0-6 months___ 1 year___ 1-2 years___ 2-3 years___ 3+ years___

Finances:

3) Are you receiving all the financial benefits you are entitled to? Y ___ N___

4) Before joining the program, were you able to budget your money effectively? Y___ N___

5) After joining the program, are you able to budget your money effectively? Y___ N___

Harm Reduction practices:

6) Before joining the program, I knew a lot about safer using practices.
Strongly Disagree___ Disagree___ Agree___ Strongly Agree___

7) Before joining the program, I practiced safe using strategies.
Strongly Disagree___ Disagree___ Agree___ Strongly Agree___

8) After joining the program, I know a lot about safer using practices.
Strongly Disagree___ Disagree___ Agree___ Strongly Agree___

9) After joining the program, I practiced safe using strategies.
Strongly Disagree___ Disagree___ Agree___ Strongly Agree___

APPENDIX B

OUTCOME EVALUATION MATRIX

Generating Outcome Evaluation Questions and Methods

Outcome Evaluation Questions What do you want to know about this program?	**Link to outcomes from your logic model** (What outcome does the evaluation question relate to?) E.g. This could be linked to one of the twenty Stepping Up outcomes	**Indicator(s)** What are measurable forms of this?	**Data Collection Method(s)** What data collection method will be used to measure the indicator? e.g., Survey, focus group, interview, document review, etc.	**Data Collection Tool(s)** What specific tool will be used?	**Respondent(s)** Who will provide the information needed? For example, Youth participants, program staff, etc.	**Person(s) Responsible for Data Collection** Who is responsible for ensuring the data are collected?	**Timing of Data Collection** When will the data be collected?
Did a level of stability in substance use improve?	Improved level of stability related to substance use	-Has knowledge on safe using practices increased? -Has practices of safe using strategies increased? -Has negative health outcomes decreased?	*Retrospective pre-test-post-test*	Adverse Consequences in Substance use tool (Centre for Addiction and Mental Health, 1997).	*Clients*	*Administrator(s)*	*March 15- April 15, 2017*
Did quality of life improve for clients enrolled?	Improved quality of life	-Did emergency room admissions decrease? -How many clients have primary care? -Do clients report a reduction in social isolation? -Do clients report a reduction in	*Retrospective pre-test-post-test*	Quality of Life Enjoyment and Satisfaction Questionnaire (Endicott, Nee, Harrison & Blumenthal, 1993)	Clients	*Administrator(s)*	*March 15- April 15, 2017*

		mental health crisis?					
Did housing stabili improve?	Improved housing stability	-How many clients have permanent housing? -What is the average length of housing status? -How long were they homeless before entry to the program?	*Retrospective pre-test-post-test*	Questionnaire	Clients	*Administrator(s)*	*March 15-April 15, 2017*
Did financial stability improve?	Improvement in financial stability	-Are clients receiving all financial benefits they are entitled to? -Do clients have outstanding debt? -Are clients able to budget their money more effectively?	*Retrospective pre-test-post-test*	Questionnaire	Clients	*Administrator(s)*	*March 15-April 15, 2017*

Appendix C

Informed Consent Form

Study Name:
Money, Drugs and Voluntary Trusteeship: Applying Harm Reduction to money management programs for people who use substances

Researcher:
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Purpose of the research:
The purpose of this program evaluation is to determine whether the St. Stephen's Community House Trustee Case Management program is achieving its intended outcomes and to determine what changes, if any, are occurring in the lives of the program participants.
The program evaluation will be conducted on-site at St. Stephen's Community House and participants will be asked to complete a retrospective pretest post test (two surveys). Responses from the surveys will be analyzed and presented back to respondents through a presentation (attendance is also voluntary). Data obtained from the program evaluation will also be shared with management and program staff of the Trustee Case Management program and will be used to determine whether program changes should be made to ensure the program is continuing to meet its intended outcomes.

What you will be asked to do in the research:
By agreeing to participate in this program evaluation you will be asked to complete two surveys. Each survey asks the same questions but one should be answered based on your memory of what your answers would have been before joining the trustee program and the second survey should reflect your present state. The total time commitment should be approximately 20 minutes.

Risks and Discomforts:
Some of the questions in the surveys pertain to mental health, substance use and other personal areas of one's life. These questions have the potential to trigger uncomfortable feelings. If this should occur, there will be staff onsite who can provide support. Alternatively, crisis phone numbers will be available for participants to take with them should they require crisis support

after hours.

Benefits of the research and benefits to you:

By being part of this survey, you will help us measure how the Trustee Case Management program is working. This research will help us identify areas of the program that may not be meeting your needs or the programs intended outcomes and require improvement. Also, this research has the potential to increase the certainty of being able to continue offering this support to you and others.

Voluntary participation:

Your participation in the research is completely voluntary and you may choose to stop participating at any time. If you choose to participate, you have the right to not answer any questions you deem inappropriate.

Your decision not to volunteer for this research will not influence the relationship you may have with the researchers or the research/program staff or the nature of your relationship with York University and/or St. Stephen's Community House either now, or in the future.

Withdrawal from the study:

You can stop participating in the study at any time, for any reason, if you so decide. Your decision to stop participating, or to refuse to answer particular questions, will not affect your relationship with the researchers, York University, St. Stephen's Community House, or any other group associated with this project. In the event you withdraw from the study, all associated data collected will be immediately destroyed wherever possible.

Confidentiality:

Confidentially and anonymity will be maintained by excluding any identifiable information. Participants will be issued numbers to avoid the use of names or any identifiable information. Data will be collected via surveys and will be compiled and organized using Excel sheets. Once all data is organized via excel spread sheets, it will be evaluated using a paired T test or Wilcoxon Signed Rank test depending on the distribution of the questionnaire results.

Hard copy data will be securely stored in a locked filing cabinet and electronic data will be securely stored on the St. Stephens Community House server. Access will be password protected. Only the researcher will have access to the raw data.

Hard copy and electronic data will be stored for 2 years at which point it will be destroyed. Hard copy data will be shredded and electronic data will be deleted by the Agency's Information technology department.

Confidentiality will be provided to the fullest extent possible by law.

Questions about the research:

If you have any questions about the research/ program evaluation in general or about your role in the research you can contact Michelle Dixon or Wilburn Hayden. Wilburn Hayden PhD, Professor, School of Social Work, York University can be reached at 416-736-2100, ext. 20467 or via email whayden@yorku.ca. You may also contact the York University, graduate program office at 416-736-2100 ext. 55521.

This research has been reviewed and approved by the Human Participants Review Sub-Committee; York University's Ethics Review Board and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines.

Legal rights and signatures:

I, ____, consent to participate in the research project entitled: *Money, Drugs, and Voluntary Trusteeship; Applying Harm Reduction to Money Management Programs for People Who Use Substances* conducted by Michelle Dixon. I have understood the nature of this project and wish to participate. I am not waiving any of my legal rights by signing this form. My signature below indicates my consent.

____

Signature Participant Name Date

____

Signature Researcher Name Date

Appendix D

Scoring the Quality of Life Enjoyment and Satisfaction Questionnaire – Short Form (Q-LES-Q-SF)

The scoring of the Q-LES-Q-SF involves summing only the first 14 items to yield a raw total score. The last two items are not included in the total score but are stand-alone items. The raw total score ranges from 14 to 70. The raw total score is transformed into a percentage maximum possible score using the following formula:

$$\frac{\text{(raw total score} - \text{minimum score)}}{\text{(maximum possible raw score} - \text{minimum score)}}$$

The minimum raw score on the Q-LES-Q-SF is 14, and the maximum score is 70. Thus the formula for % maximum can also be written as (raw score −14)/56. The table below converts total raw scores into % maximum scores.

Raw Score	% Maximum	Raw Score	% Maximum	Raw Score	% Maximum	Raw Score	% Maximum
14	0	28	25	42	50	56	75
15	2	29	27	43	52	57	77
16	4	30	29	44	54	58	79
17	5	31	30	45	55	59	80
18	7	32	32	46	57	60	82
19	9	33	34	47	59	61	84
20	11	34	36	48	61	62	86
21	13	35	38	49	63	63	88
22	14	36	39	50	64	64	89
23	16	37	41	51	66	65	91
24	18	38	43	52	68	66	93
25	20	39	45	53	70	67	95
26	21	40	46	54	71	68	96
27	23	41	48	55	73	69	98
						70	100

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