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The European Journal of Homelessness provides a critical analysis of policy and practice on homelessness in Europe for policy makers, practitioners, researchers and academics. The aim is to stimulate debate on homelessness and housing exclusion at the European level and to facilitate the development of a stronger evidential base for policy development and innovation. The journal seeks to give international exposure to significant national, regional and local developments and to provide a forum for comparative analysis of policy and practice in preventing and tackling homelessness in Europe. The journal will also assess the lessons for Europe, which can be derived from policy, practice and research from elsewhere.

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Content

"A Multi-Country Study of the Fidelity of Housing First Programmes": Introduction

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Introduction

The concept of "programme fidelity" refers to the extent that a programme is delivered as planned by programme developers (Caroll *et al.*, 2007). Reaching a high level of fidelity has emerged as an important area of research focus for evidence-based interventions like Housing First (HF) because of its demonstrated relationship to programme outcomes such as achieving housing stability and improvements in quality of life (Davidson *et al.*, 2014; Gilmer *et al.*, 2015; Goering *et al.*, 2016). A challenge associated with the international dissemination of HF (e.g., in Europe) is how the approach is adapted to different populations and policy milieus without compromising its effectiveness.

In the context of this growing diffusion of HF across North America and Europe, the purpose of this special issue of the *European Journal of Homelessness* is to present findings from a multi-country study of fidelity of HF programmes located in 9 countries. In conducting the research on fidelity, participating programmes followed a common research protocol that included conducting a self-assessment of programme fidelity. This was followed by qualitative interviews with programme managers and staff, intended to identify factors facilitating high programme fidelity and factors contributing to areas of low fidelity.

In this introductory article, we begin with a brief overview of Housing First. We then present relevant research on the fidelity of evidence-based programmes from the field of implementation science. Next, we review the growing body of research on HF programmes and fidelity. Finally, we describe the common methodology used to collect data in the multi-country study and provide brief descriptions of the articles.

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Brief description of Housing First

Developed initially in the early 1990s by a community agency in New York City known as Pathways to Housing, HF is an approach that combines the delivery of housing and support to help people with chronic histories of homelessness to become permanently housed (Tsemberis, 2010; Padgett *et al.*, 2016). According to Tsemberis (2010), there are three major components making up Housing First: (1) Practice values centered on consumer choice that guide service delivery, (2) permanent scattered-site housing, and (3) community-based portable support services typically in the form of Assertive Community Treatment or Intensive Case Management. Padgett and her colleagues (2016), noting that there are no preconditions required to qualify for HF such as sobriety or participation in treatment, identified the adoption of a harm reduction philosophy as a fourth component.

Nelson *et al.* (2012) defined four key theoretical principles behind the HF model: (1) Immediate offer of housing and consumer-centered services, (2) separation of housing and support services, (3) delivery of supports guided by a recovery orientation, and (4) focus on the achievement of community integration. HF was modelled on the "supported housing" approach in community mental health services wherein individuals with severe and persistent mental illness were provided with the necessary support in the community to live as tenants in regular housing (Blanch *et al.*, 1988; Ridgway and Zipple, 1990; Carling, 1995).

HF, as an approach to assist people with serious mental illness who are chronically homeless, began to draw attention in the U.S. and internationally because of research findings that showed that a majority of individuals were able to successfully become stably housed (Tsemberis, 1999; Tsemberis and Eisenberg, 2000; Tsemberis *et al.*, 2004). An accumulation of evidence showing the effectiveness of HF in assisting individuals to leave homelessness, including in a large multi-city trial in Canada, has established the approach as being evidence-based with the development of HF programmes found now throughout North America and in many European countries (Aubry *et al.*, 2015).

Programme Fidelity and Implementation Science

Definitions of programme fidelity

In the case of "evidence-based programmes" the achievement of fidelity to a set of defined standards is important in order for a programme to produce the same outcomes demonstrated in research (Aarons *et al.*, 2017). Programme fidelity is referred to "adherence" from the standpoint of content (i.e., active ingredients) and frequency, duration, or coverage, which has also been defined as "dosage" in the implementation science literature (Caroll *et al.*, 2007). Blakely *et al.* (1987) date the first mention of fidelity in the programme evaluation literature to a book chapter by Sechrest *et al.* (1979). It was spawned by the realisation that "black box" evaluations on programmes fail to recognize critical ingredients and produce findings that are difficult to interpret, consequently limiting the dissemination of these programmes to other contexts (Moncher and Prinz, 1991; Mowbray *et al.*, 2003; Bellg *et al.*, 2004; Fixsen *et al.*, 2005).

In line with these definitions, Gearing and her colleagues (2010), in a review of meta-analyses of studies and review articles focused on programme fidelity, identified its central elements. These include the theory, goals, structure of the programme and the services it delivers. Often these are defined in a programme manual. According to Gearing and her colleagues (2010), training is essential for helping programmes achieve fidelity. The combination of training with technical support helps ensure that the critical ingredients of interventions are delivered, and that programme drift is avoided. Based on their review, they note a lack of uniformity in how fidelity is defined in the research literature. In this context, they argue that greater attention needs to be given to fidelity in programme development and its execution, and that fidelity assessment should be built into programmes as a routine activity to assist with programme improvement.

Moderators of programme fidelity

Carroll and his colleagues (2007) proposed a conceptual model of programme fidelity that included specification of its potential moderators. The moderators included intervention complexity with achieving fidelity being more difficult in more complex programmes, training and support strategies (e.g., initial training, ongoing technical support, existence of programme manuals) that are intended to optimise implementation fidelity, the extent programme delivery is in line with goals, and the engagement of programme providers and recipients.

In another theoretical paper, Aarons *et al.* (2011) also identified factors moderating programme fidelity. They grouped them as being either in the "outer context" (i.e., external to the programme) or in the inner context (i.e., internal to the programme). Factors in this outer context included public policies, funding opportunities, client

advocacy, and inter-organizational networks that interface with the organization in which a programme is located. Factors in the inner context of effective leadership, an organizational culture of openness to change and learning, the availability of programme champions, the fit of the programme with the structure and ideology of the organization, valuing of innovation, commitment to evidence-based practices, fidelity monitoring, and ongoing training and support were identified as contributing to effective implementation.

In a review of research studies, Durlak and Dupre (2008) examined factors affecting the implementation of programmes. Their findings mirror those of the previously mentioned studies. Specifically, the factors they identified included: community level elements (e.g., funding and policy), provider characteristics (e.g., perceived need and benefits by providers, skill level), characteristics of the innovation (e.g., compatibility of programme to organization's mission and values, adaptability of the programme to fit organizational practices and community needs), organizational capacity (e.g., positive work climate, organizational norms relating to change and risk-taking, shared vision about the innovation, coordination with other agencies, effective communication channels, leadership), and the support system (i.e., availability of training and technical assistance). It can be expected that the moderators identified in theoretical and empirical implementation science research will be relevant to influencing the achievement of fidelity in Housing First programmes.

Balancing fidelity and adaptation

There has been a debate in the fidelity research literature about the balancing of replication with adaptation. Replication if often termed "scaling up" in which a very similar intervention is delivered to a similar population (Aarons *et al.*, 2017). The need for flexibility and openness to adaptation would seem to be particularly important with regard to complex interventions with multiple components like Housing First.

Moreover, the diffusion of a complex intervention such as Housing First to contexts with different social service and health care systems or to different populations, which is also known as "scaling out", inevitably requires adaptation of the programme model (Aarons *et al.*, 2017). An important consideration in the adaptation of a programme to different contexts is ensuring that the core elements of the intervention that produce the outcomes remain in place (Damschroder *et al.*, 2009). Pleace (2011) argues for the importance of conducting research on the variation in Housing First programmes that are based on the Pathways model.

Programme fidelity in HF programmes

Stefancic *et al.* (2013) developed and validated a fidelity measure for HF programmes. The researchers defined the items in the measure by examining the HF model's guiding principles and ingredients, reviewing the research literature and relevant fidelity scales, conducting interviews with HF programme managers, and surveying HF service providers.

A panel of five HF experts developed two versions of the scale, one to be used with HF programmes that include an Assertive Community Treatment (ACT) team to deliver support and another one for programmes with Intensive Case Management (ICM). The two scales were very similar with differences on a small number of items related to the delivery and structure of services on which ACT and ICM differed. The final measure included items taken from the Permanent Supportive Housing KIT (8 items; Substance Abuse and Mental Health Services Administration [SAMSHA], 2010), the Dartmouth Assertive Community Treatment Scale (DACTS) (5 items; SAMSHA, 2008), the Tool for Measurement of Assertive Community Treatment (TMACT) (10 items, Teague *et al.*, 1998), and the Programme Characteristics Measure (3 items; Williams *et al.*, 2001). The final measure produced by this initial set of steps included 38 items for both versions.

In pilot testing, the new measure was administered as part of a fidelity assessment conducted with 13 programmes in the At Home / Chez Soi demonstration project and 20 programmes in the California Full Service Partnership (CFSP). The CFSP programmes were not full-fledged HF programmes but had many aspects of the model. The conducted fidelity assessments were composed of a full-day visit to the programme by a small number of individuals (i.e., 4-6 for the Canadian study and 3-5 for the Californian study) who were knowledgeable of the HF programme model. These visits included staff meeting observations, interviews with staff and programme managers, consumer focus groups, chart reviews, and reviews of programme documents. Information provided through these means was used to formulate consensus ratings of visiting experts on the fidelity measure.

Pilot testing found the items to vary across programmes, with most items showing a range of scores from 1 to 4. Results from the 20 Californian programmes demonstrated good internal consistency in four of five domains: Housing Choice and Structure (.80), Separation of Housing and Services (.83), Service Philosophy (.92), and Service Array (.71). Stefancic and her colleagues (2013) noted that the fifth domain of programme structure was not defined as a homogeneous construct, but rather reflected a set of items intended to capture good operations across programmes (e.g., low participant /staff ratio and frequent meetings).

The Canadian programmes that explicitly followed the HF model and received training and technical support in this direction demonstrated higher fidelity than the Californian programmes that were not specifically based on the HF model. The Canadian programmes scored significantly higher on the items in the Housing Choice and Structure, Separation of Housing and Services, and Service Philosophy domains.

Based on the original HF fidelity scale (Tsemberis, 2010) used by external evaluators, Gilmer *et al.* (2013) developed and validated a self-administered survey measure of fidelity. Researchers reconfigured the original scale so that programme staff could evaluate a HF programme by completing a 46-item survey. The survey was administered to 93 full service partnerships (FSPs) located in California that combined integrative supportive housing and team-based treatment models for people with serious mental illness who were homeless or at risk of becoming homeless.

Items in the survey also fell into the five previously mentioned domains. Certain items required one response from a range of alternatives reflecting low to high levels of fidelity, while others allowed multiple choices that included some items in line with HF and others that were antithetical to the model. The multiple choice responses were scored by either summing responses or scoring the chosen alternatives as either showing different levels of fidelity or not reflecting fidelity at all.

Exploratory and confirmatory factor analyses produced a two-factor solution made up of 16 items. One factor (8 items) comprised items relating to the domains of Housing Process and Structure, Separation of Housing and Services, and Service Philosophy. The other factor (8 items) was composed of items relating to the domains of Service Array and Team Structure. Both factors showed acceptable internal reliability (i.e., >.70).

Gilmer and his colleagues (2013) concluded that the self-report survey completed by programme staff provided a useful and expeditious alternative to on-site fidelity assessment by an external team. They noted its potential utility as a programme development tool serving to identify areas for technical assistance. At the same time, they recognized the limitations of this form of fidelity assessment, notably related to social desirability and the brevity of some of the items to capture programme standards, thereby affecting their reliability. The studies conducted in the different countries and reported in this special issue used a revised version of the Gilmer *et al.* (2013) measure of fidelity.

Research on Programme Fidelity of Housing First Programmes

European study

Greenwood *et al.* (2013) reported findings from key informant interviews on the fidelity of the implementation of HF programmes based on the HF model in six countries, namely Portugal (Lisbon), France (Lille, Marseilles, Paris, Toulouse), Netherlands (Amsterdam), Scotland (Glasgow), Ireland (Dublin), and Finland (multiple sites). They reported that their interview data suggested that the programmes in the six countries achieved a high level of fidelity with many key ingredients of the HF model. These included access to permanent independent scatter-site housing with portable and separate support services, no expectations concerning housing readiness or participation in treatment, consumer choice in service, delivery harm reduction approach to services, and multidisciplinary support services teams.

On the other hand, there was variability in achieving fidelity to other key ingredients, namely housing choice, housing availability, intensity and range of supports, and consumer involvement in programme planning and policy. Service Array was the domain on which fidelity was lowest across the programme in the six countries. A combination of the newness of many of the programmes and limited resources contributed to this area characterized as having a low level of fidelity by key informants.

Canadian At Home /Chez Soi study

As part of the At Home / Chez Soi demonstration project that tested the effectiveness of HF in five Canadian cities, two fidelity assessments were conducted by an external team on 10 HF programmes of which five provided support through an ACT team and five delivered support through an ICM team (Nelson *et al.*, 2014; Macnaughton *et al.*, 2015). Depending on the site, the external team conducting the fidelity assessments consisted of clinicians, researchers, housing experts, and a consumer representative with expertise in the HF model.

The fidelity assessments occurred over the course of a full day visit with data including observation of programme staff meetings, interviews with programme staff, chart reviews, and focus groups with consumers. Nelson and his colleagues (2014) reported that the Canadian programmes demonstrated a high degree of fidelity after 9-13 months of operation, with 71% of the items on the fidelity scale scored by the external teams as equal to or higher than 3.5 on a 4-point scale. In fact, scores on the items showed a skewed distribution with most falling at the positive end of the scale. The high scores were found on items in the domains of

Separation of Housing and Services (3.90), Service Philosophy (3.60), and Housing Choice and Structure (3.59). Relatively lower scores were evident on the items in the domains of Programme Structure (3.11) and Service Array (2.84).

Fidelity assessments were followed by qualitative interviews with programme managers and psychiatrists and focus groups with programme staff and consumers with the objective of identifying factors facilitating or impeding programme fidelity to the HF model. In line with the previously cited implementation science research on programme fidelity, factors facilitating programme fidelity in this early stage of programme development included delivery system factors, notably community capacity (i.e., existing services, partnerships with government agencies and landlords), organizational capacity (i.e., leadership, programme staff, organizational structure and governance, partnerships with consumers), and support system factors in the form of training and technical support that was available to programmes. Impediments to achieving programme fidelity included a lack of available affordable housing in communities because of low vacancy rates, challenges associated with integrating peer support and consumer input into programmes, and a paucity of services in some of the communities.

Macnaughton *et al.* (2015) reported on the second set of fidelity assessments of the Canadian programmes that were conducted at 24-29 months of operation at which point programmes were at capacity. Improvements in fidelity were apparent, with scores 3.5 or higher, representing high fidelity, achieved on 78% of the items in the programme fidelity measure. Moreover, the average scores on items for four of the five domains increased, namely the domains Separation of Housing and Services (3.95), Service Philosophy (3.63), Programme Structure (3.51) and Service Array (3.39). The average score of items in the Housing Choice and Structure domain (3.59) remained the same as the first fidelity assessment.

Key informant interviews and focus groups with programme staff and consumers found that programme staff's commitment to the work and its values, along with their learning and growing expertise, partnership with services in the community, organizational culture that included strong leadership within the programme, and ongoing training and technical support facilitated programme fidelity. In contrast, staff turnover in some programmes, frequent rehousing of a small number of programme participants, social isolation of participants, and limited employment or educational supports were identified as obstacles to achieving programme fidelity.

In interpreting findings on programme fidelity from two different points of programme development in five different cities, Macnaughton and his colleagues (2015) noted that they demonstrated the adaptability of the model. A high level of programme fidelity achieved in different contexts with different populations,

including a site with a high proportion of Indigenous participants and another site with a high proportion of participants from minority ethnoracial backgrounds. High fidelity to the HF model was also achieved in a project that delivered HF in a small city and an adjoining rural region (Ecker *et al.*, 2014; Aubry *et al.*, 2015).

Approximately two years after the end of the At Home / Chez Soi demonstration project, Nelson *et al.* (2017) conducted an assessment of programme fidelity on nine of the original 12 HF programmes that were sustained, using the self-report measure. The methodology involved having members of the programme staff complete the measure independently followed by a meeting of programme staff facilitated by a researcher who assisted them to arrive at consensus ratings. Based on the benchmark of 3.50 or greater reflecting a high level of fidelity, seven of the nine programmes continued to demonstrate high levels of fidelity in their total scores.

Factors that facilitated programme sustainment with a high level of fidelity included dissemination of research findings from the project, alignment with the emerging policy context, partnerships and support by key people in the community, continuation of strong programme leadership, and ongoing training (Nelson *et al.*, 2017). Factors that blocked sustainability and fidelity included a lack of alignment between HF and existing provincial policies, the difficulty of working across housing and health ministries, competition for shrinking resources for health and housing services, staff turnover and loss of programme capacity (Nelson *et al.*, 2017).

Overall, the research on programme fidelity conducted in European countries and in Canada suggests that HF programmes can be developed and implemented with good fidelity in a wide range of contexts. Moreover, similar moderators that are external (e.g., social policies) and internal (e.g., organizational values) to programmes in the different countries serve to facilitate and impede programme fidelity. The group of studies presented in this special issue build on this nascent research area related to HF programmes.

Description of Study

Background

The international fidelity study was conceived through the International Network of Housing First, an informal body that spawned the First International Conference on Housing First held in Lisbon, Portugal in 2014. The objectives of the study were twofold: (1) Investigate the fidelity of Housing First programmes in different countries in Europe and North America, and (2) identify the factors that facilitate or impede achieving a high level of programme fidelity. The Research Ethics Boards at the University of Ottawa in Canada and the University of Limerick in Ireland provided

ethical approval for the study of programmes in Canada, the United States, and Ireland. Formal ethical approval was not required for participation in the study by programmes in other European countries.

A total of 10 different Housing First programmes located in 9 different countries participated in the study. Eight of the programmes were in European countries, namely Belgium, France, Ireland, Italy, Norway, Portugal, and Spain. Two other programmes were in Canada and the United States. Some of the programmes were situated in multiple sites (i.e., Belgium, France, Italy, Spain) while the programmes in other countries were single site (i.e., Canada, Ireland, Norway, and Spain).

Given the wide range of countries and the fact that Housing First programmes were at different stages of development, the study was viewed as a rich opportunity for examining both the commonalities of Housing First programmes and the adaptations of the programme model located in different contexts. In addition, capitalizing on the International Network of Housing First, the cross-country study was conceptualized as an opportunity for programme improvement, with staff in Housing First programmes learning from their participation in a fidelity assessment on their own programme and from one another.

Methodology

The methodology consisted of two separate but related steps: (1) A self-assessment of fidelity by programme staff producing consensus ratings on items of a Housing First fidelity scale, and (2) a set of semi-structured interviews or focus groups with programme staff querying about factors facilitating or impeding programme fidelity.

Fidelity self-assessment

A 37-item fidelity self-assessment measure was administered to programme service providers who had been working in the programme for at least 6 months. They completed the survey independently without discussion. The measure was based on the previously described 46-item measure developed by Gilmer and his colleagues (2013). It was revised and shortened by Nelson and his colleagues (2017) and this version was used for the study.

Subsequently, service providers who completed the survey met to arrive at consensus ratings of fidelity for the programme on the measure. Depending on the country, the meeting was facilitated by collaborating researchers, national technical coordinators, or managers in the programme's organizations. At this meeting, an item-by-item review was conducted with service providers as they discussed their item ratings. In cases where there was consensus on item ratings across all service providers, the rating was taken as the final fidelity rating for that item.

In cases where there were differences in item ratings among service providers, the focus group facilitator facilitated a discussion in which service providers explained the rationale behind their ratings. Discussion continued until a consensus rating was obtained. This consensus rating became the final fidelity rating for that item. The final consensus ratings were summed and totals for each fidelity rating domain as well as a total score were calculated for the programme.

Semi-structured interviews / focus groups with programme staff

Semi-structured interviews and focus groups began with a review of programme fidelity scores. A common protocol was followed by all of the participating programmes. The focus was on items that reflected either high or low fidelity. The interview/focus group questions focused on facilitators and barriers to programme fidelity in each of the domains.

Next, each site conducted a qualitative analysis to identify themes and sub-themes regarding facilitators and barriers to programme fidelity. Participating sites agreed to a deductive approach that organized factors into three levels: systemic (external to the programme), organizational (within the organization in which the programme was located), and individual (relating to individual staff and programme participants). The grouping mirrored previous research conducted by Nelson and his colleagues (2014) and Macnaughton and his colleagues (2015).

Description of Special Issue Papers

The Special Issue presents the results of programmes in 9 countries that represent a rich variety of administrative/policy backgrounds and Housing First operational configurations. These include an original Pathways Housing First programme (Washington, DC), single programmes in some countries (Canada, Ireland, Norway, Portugal, Spain), and multiple programmes in other countries (Belgium, France, and Italy). Some of the programmes have been launched by government, while others were initiated by non-governmental agencies.

Jennifer Rae and her colleagues present the findings of the Pathways to Housing DC programme located in Washington, DC. This programme is part of the first generation of HF programmes in the United States and serves as a gold standard reference point in the group of Special Issue papers. The study findings show the important contribution of organizational factors in the context of a mature programme that has high fidelity.

Jonathan Samosh and his colleagues present results on programme fidelity of a unique programme located in Ottawa, Canada that serves individuals with problematic substance use. Programme adaptations included a programme partnership that separated the delivery of housing services from support services.

Roberto Bernad and his colleagues present the results of the fidelity assessment conducted in three sites of the Habitat programme in Spain, that serves people with mental health, addictions or disability issues. The paper describes both barriers and facilitators found in an early implementation phase of the HF programme, which started one and a half years before conducting the fidelity assessment. Service Philosophy and Housing and Services domains show a high fidelity to the model, while a moderate fidelity appeared in the other domains. The main challenges for introducing the HF model in the Spanish welfare system configuration are also discussed.

Rachel Manning, Ronni Greenwood, and Courtney Kirby present results on fidelity in a programme located in Ireland's capital city, Dublin. This was the first Housing First programme established in Ireland and remains the largest to date. Among other findings, their investigation highlights the importance of relationships with landlords and other community resources, as well as commitment to the model among service providers.

Anne Bergljot describes results of a fidelity assessment of a small HF programme in Bergen, Norway that was serving 30 participants. Norway's well-developed welfare system that provides housing subsidies and access to health and social services was cited as an important systemic factor contributing to programme fidelity. Challenges faced by the programme included programme staff lacking systematic training combined with not having previous experience with HF.

Pascale Estacahandy presents the fidelity assessment findings associated with the four HF programmes that were part of the national demonstration project in France known as "Un chez-soi d'abord". All of the programmes delivered support through an Assertive Community Treatment team. Overall, the programmes were assessed as having high levels of fidelity and most notably in the domains of Housing Process and Structure, Separation of Housing and Services, and Service Philosophy. Lower levels of fidelity were identified in the areas of Service Array and Team Structure and Human Resources.

Teresa Duarte and her colleagues describe the programme fidelity of Casas Primeiro, the first HF programme developed in Portugal in 2009. The programme was assessed as having a high level of fidelity in all of the domains with the exception of Team Structure / Human Resources. A combination of systemic factors (including the policy context and health and social services systems in

place) along with organizational factors (the alignment of HF philosophy with the host agency's values, collaboration among team members, and integration of supported education and supported employment programmes) were viewed as playing a significant role in facilitating this high fidelity.

Adela Boxados and Maria Virginia Matulic from Barcelona University and their colleagues at Arrels Fundacio report findings from a fidelity assessment of the Housing First programme developed by Arrels Foundation, in Barcelona, Spain. By 2016, the programme provided services based on a HF approach to 243 individuals, both in congregate and individual accommodations. The self-assessment yielded a total fidelity score reflecting moderate fidelity, with the highest fidelity observed in the Housing and Services domain and the lowest fidelity shown in the Service Array domain. Key facilitators of model fidelity included access to quality community-based services and staff members' expression of HF philosophy in their practice. Key barriers to model fidelity included the challenges of a tight housing market and cultural resistance.

Coralie Buxant from Housing First Belgium presents the fidelity assessment results of the multisite Housing First Belgium demonstration project. This project started as eight independent programmes led by local organizations in different Belgian cities that were later pooled under the umbrella of the Federal Service for Social Integration, which provided technical assistance, training and a longitudinal outcome evaluation. The paper presents some of the main challenges for those HF programmes and discusses some of the innovative solutions proposed to address them, such as the "housing locator" team member to help sourcing dwellings for HF tenants.

Marta Gaboardi, Massimo Santinello, and Marco Iazzolino from fio.PSD (Italian Federation of Organizations for homeless people) present the findings of the fidelity assessment conducted on four HF pilots of the HF Italy network, which are managed by different organizations and serve different profiles of service users, including families, refugees and single people. The different background and configuration of the projects allows the identification of common challenges for the implementation of Housing First in Italy and also some specific barriers and facilitators to fidelity that the different organizations found at the local level.

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Building A Way Home: A Study of Fidelity to the Housing First Model in Dublin, Ireland

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Abstract_*In Ireland, the numbers of individuals recorded as 'out of home' increases annually. In 2011, the government committed to ending long-term homelessness and the need to sleep rough. As part of this, Dublin City Council implemented a Housing First Demonstration Project with the goal to house and support 30 chronically homeless individuals. In 2015, a consortium of two homeless service organisations expanded and restructured the programme. At the time of data collection for this project, Dublin Housing First had 16 employees and served 76 homeless individuals. Results from a fidelity self-assessment of the team are described in the present paper. Team members and team leaders (n = 12) completed a fidelity self-assessment. Five weeks later, a conciliation focus group met to discuss and agree self-assessment scores. The programme demonstrated higher fidelity on Housing Process & Structure, Separation of Housing & Services, and Service Philosophy domains, and lower fidelity on Service Array and Team Structure domains. Five key stakeholders took part in a second focus group to discuss facilitators of and barriers to fidelity in each domain. Thematic analysis identified facilitators and barriers to fidelity across systemic, organisational, and individual ecological levels and yielded nuanced insights into the establishment of social innovations such as Housing First.*

Keywords_*Housing First, programme fidelity, enablers, barriers*

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Introduction

In Ireland, homeless individuals have "no accommodation that they, and the people they normally live with or who they might reasonably be expected to live with, can occupy" (The Housing Act, 1988). They may sleep rough, stay in homeless hostels, B&Bs or hotels, with friends or family, or in a squat. The number of homeless adults residing in homeless accommodation increased by over 80% between June 2014 and October 2016, an increase of nearly 100% in Dublin and 60% outside of Dublin. Between December 2014 and August 2017, the number of rough sleepers in Dublin increased from 127 to 184 (O'Sullivan, 2016; Factcheck, 2017; Peter McVerry Trust, 2017). These counts may underestimate homelessness because they exclude asylum seekers and people living in domestic violence refuges, institutions like prisons and hospitals, or inadequate circumstances like overcrowded flats. While some people still attribute homelessness to individual problems such as addiction or mental illness, most now agree that rising rents and a social housing system that does not meet demand fuel the homeless crisis (Peter McVerry Trust, 2017).

In 2009, Dublin City Council sought to reverse the homeless trend by reconfiguring services to end long-term homelessness and the need to sleep rough (Dublin City Council, 2009). The *Pathway to Home* document described resources and strategies that would support a 'housing-led' approach. As part of this approach, SLÍ, which is an acronym for to 'Support to Live Independently', and also means "path" in Irish, was established. SLÍ was a visiting service to help people with moderate support needs "move out of homelessness by sustaining independent living and reintegration in the community" (Dublin Regional Homeless Executive, 30 April 2012). The plan, however, did not offer services for adults with high support or more complex needs (Homeless Agency, 2008). To fill this gap, Dublin's leadership moved to implement Housing First.

Housing First is guided by a philosophy of self-determination; that is, homeless individuals are believed to be competent to make their own decisions, with support if required. Housing First provides immediate, affordable, permanent, scattered-site housing. There are no sobriety, psychiatric stability, or transitional housing requirements. There is, however, a focus on harm reduction, assertive engagement, and person-centered planning. Conditions are minimal and flexible (e.g., meet a support worker; pay 30% of income toward rent). Housing First teams emphasise choice and the pursuit of various recovery goals, should service users choose, including mental and physical health, integration, employment, education, and meaningful activities. Importantly, Housing First consistently shows better outcomes than traditional services, particularly in relation to housing

stability and better outcomes in some studies in terms of quality of life (Greenwood *et al.*, 2005; Greenwood *et al.*, 2013; Stergiopoulos *et al.*, 2015; Aubry *et al.*, 2016; Padgett *et al.*, 2016).

A Housing First Demonstration Project launched in Dublin in April 2011. It drew resources from existing homeless services and had an initial target to house 30 adults with significant histories of homelessness and complex support needs. The Outreach Team identified individuals who were high risk because they slept rough in cold winter weather conditions. An Approved Housing Body (AHB) supplied the team leader and the first four apartments. Two part-time key workers, a psychiatric nurse specializing in alcohol and drug abuse counselling, and an education and job specialist were provided from other community services. As a key ingredient of Housing First, a programme evaluation by an external team commenced at the same time to assess programme fidelity and client outcomes (Greenwood, 2015). In the evaluation, the Demonstration project evidenced higher fidelity in Housing Choice and Structure, Separation of Housing and Services, and Service Philosophy domains, and lower fidelity in the domains of Service Array and Team Structure.

As a "microsystem of recovery" (Manning and Greenwood, 2018), it is important to understand the ways in which particular aspects of the ecology affect the implementation of Housing First programmes. Multiple aspects of ecology affect model fidelity, an observation reported by Housing First evaluators in other contexts, too (e.g., Nelson *et al.*, 2017). Landlords' willingness to offer accommodation, as well as stakeholders' appraisals of the team as responsive, proactive, and attuned to their concerns, facilitated fidelity, while a significant housing shortage, caused by the interrelated economic and mortgage crises, was a barrier. Individual barriers included gatekeepers' reluctance to let units to clients in locations with low neighbourhood-person fit. Stakeholders' preferences for staircase or continuum of care services, and scepticism that Housing First could deliver the necessary supports were also barriers to fidelity in the Demonstration project phase. The evaluation also yielded a number of recommendations that led to a reconfiguration of the team (Greenwood, 2015). In April 2014, a consortium of two organisations that provide continuum of care services in the region was awarded a three-year contract to deliver the service. In September 2014, the Demonstration Project became Dublin Housing First (DHF).

DHF is the largest provider of Housing First in Ireland. It has a multidisciplinary team of intake workers who engage with clients and follow them through to housing, addiction workers, a counsellor, and a nurse. Clients are offered independent, long-term, scatter-site homes procured from social and private rental markets. It takes between two and four weeks to house a client, but the wait can be longer for people with long histories of rough sleeping. It can also take longer to obtain social housing

than private rented housing. To be eligible, an individual must have a significant history of rough sleeping or use of emergency services and complex support needs. In the initial tender, DHF was to house 100 clients by the end of 2017. At the time of writing this paper (August 2017), DHF had progressed significantly toward this target by supporting 76 clients and employing 16 staff. Approximately 88% of clients were housed in the programme for the past 12 months, while 89% were housed at 1-year or 2-year follow-up. It is worth noting that in 2016, the Government of Ireland launched an Action Plan entitled 'Rebuilding Ireland' wherein it promised to increase Housing First tenancies from the original target of 100 to 300. This significantly increased target was to still be achieved by 2017. During the research period, informal conversations with Housing First staff suggested that meeting the new target was challenging primarily due to its 'unexpectedness', which did not afford consideration to the usual challenges of accessing housing, as well as the time it takes to build relationships with homeless individuals.

The present study

DHF underwent significant expansion and reorganization since the Demonstration project was replaced, particularly as most, but not all, of the team left the project. In the present study, we assessed the extent to which the current DHF team evidenced fidelity to the Housing First model and identified the facilitators and barriers that affect model fidelity. Because we have the fidelity findings from the original demonstration project, we also had the opportunity to compare the two assessments and to look for similarities and differences in both periods. Thus, in Autumn-Winter 2016, we conducted a fidelity self-assessment and focus groups with current DHF team members and leadership.

Method

The fidelity assessment

Measure. The self-assessment is a programme-based, self-administered survey used to evaluate fidelity to the Housing First model. Respondents rate programmes on key domains (Housing Process and Structure, Housing and Services, Service Philosophy, Service Array, and Team Structure). Items including: "What types of psychiatric services, if any, are available to participants?", "Which life areas does the programme systematically address with specific interventions?", and "What is the programme's approach to substance use among participants?" are coded on a 4-point scale. Some items have only one answer, while others have several. A total score is calculated as well as a score for each of the 5 domains.

Procedures. A member of the research team (RMG) met with all interested DHF team members who at that point had served on the team for six months or more. RMG explained the self-assessment tool and the scoring procedure. She distributed information sheets, informed consent forms, and copies of the self-assessment. Team members completed the self-assessment anonymously and individually without discussion with their colleagues. The team leader collected and returned the completed self-assessments to RMG, who then compiled the scores to identify areas of convergence and divergence.

About five weeks later, RMG met with members of the team to conduct a conciliation focus group. The meeting was attended by team members who did complete the self-assessment and some who did not. The scores for each fidelity item were presented to the team and they discussed each item for which there was not initially consensus, until they agreed a final score. The meeting lasted about 2.5 hours and was a lively discussion of the meaning and applicability of the fidelity items to the Dublin context. RMG entered agreed scores into an Excel sheet that calculated average scores for each domain.

At a third and final meeting, the domain scores were presented to a focus group of five managers representing both organizations in the consortium. RMG used the fidelity scores to guide a conversation about facilitators and barriers of fidelity. This meeting lasted approximately two hours. Both meetings were digitally recorded and a research assistant transcribed them verbatim.

Participants. Members of outreach, support services, and housing teams completed the self-assessment tool (n = 12). Most, but not all, of those who completed the self-assessment, plus other team members, participated in the conciliation meeting. This included the Housing First Manager, Housing First Project Leader, members of the outreach team, intake team, and housing and support services teams. The focus group comprised of managers from each organization, including the Housing First team leader (n = 5).

Data analysis

In this study, a programme developed by Roberto Bernad (and reported in Bernad *et al.* 2018, this volume) was used to calculate the self-assessment score. We used thematic analysis (Braun and Clarke, 2006) to code the two focus groups into relevant and meaningful segments of information. Working from Nelson *et al.*'s categorization scheme (2017), a postdoctoral researcher (RMM) and an undergraduate research assistant (CK) identified factors that either facilitated or impeded fidelity (See Table 2). Within these two categories, subordinate systemic, organizational, or individual level (with possibility of overlap between categories retained) were identified. The coders also took an inductive approach to the transcripts to identify additional factors

that seemed relevant, which resulted in a third code, "methodological concerns". RMM collated the independent coding and discussed the codes with RMG and CK until they reached 100% agreement. All discrepancies resulted from one coder identifying a text chunk missed by the other, rather than from disagreement.

Results

Fidelity assessment

Table 1 presents the standard scores for each item, the average domain scores, and the total score. Previous research has set an overall total of 3.5 or higher as the "benchmark" for high fidelity (Macnaughton *et al.*, 2015). It was agreed by researchers participating in the international Housing First project that a score of 3.0 or less reflected low fidelity. In Ireland, the total programme fidelity score was 3.4, indicating that overall the programme had close to high fidelity (i.e., 3.5 or higher, Macnaughton *et al.*, 2015).

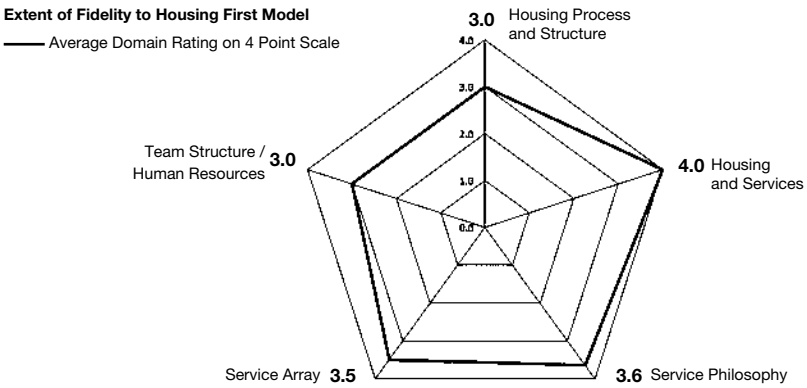
Table 1. Fidelity Assessment Item Scores and Domain Means

Domain / Item	Domain Mean / Standard Item Score (Out of 4)
Housing Process and Structure	**3**
1. Choice of housing	3.0
2. Choice of neighbourhood	3.0
3. Assistance with furniture	4.0
4. Affordable housing with subsidies	3.0
5. Proportion of income required for rent	4.0
6. Time from enrollment to housing	1.0
7. Types of housing	3.0
Separation of Housing and Services	**4**
8. Proportion of clients with shared bedrooms	4.0
9. Requirements to gain access to housing	4.0
10. Requirements to stay in housing	4.0
11a. Lease or occupancy agreement	4.0
11b. Provisions in the lease or agreement	4.0
12. Effect of losing housing on client housing support	4.0
13. Effect of losing housing on other client services	4.0
Service Philosophy	**3.6**
14. Choice of services	4.0
15. Requirements for serious mental illness treatment	4.0
16. Requirements for substance use treatment	4.0
17. Approach to client substance use	4.0
18. Promoting adherence to treatment plans	3.5
19. Elements of treatment plan and follow-up	2.0
20. Life areas addressed with programme interventions	4.0
Service Array	**3.5**

21. Maintaining housing	4.0
22. Psychiatric services	4.0
23. Substance use treatment	2.4
24. Paid employment opportunities	4.0
25. Education services	4.0
26. Volunteer opportunities	4.0
27. Physical health treatment	4.8
28. Paid peer specialist on staff	1.0
29a. Social integration services	3.2
Programme Structure	**3**
31. Client background	2.7
33. Staff-to-client ratio	4.0
34b. Frequency of face-to-face contacts per month	4.0
35. Frequency of staff meetings to review services	4.0
36. Team meeting components	2.7
37. Opportunity for client input about the programme	0.7
Total	**3.4**

Figure 1 shows average ratings per fidelity domain according to the standardized four-point scale. The highest score was in the Separation of Housing and Services domain (4 out of 4), which includes access to housing, rights, and responses to tenancy loss. Scores were also high in the Service Philosophy domain (3.6 out of 4), which includes choice and client-led practice, and in the Service Array domain (3.5 out of 4), which includes housing and support. Scores were lower in the Housing Process and Structure domain (3 out of 4), which includes type of housing, rent subsidies, and neighbourhood. Scores were also low in the Programme Structure domain (3 out of 4), which includes the programme's target population, client contact and meetings, and opportunities to give feedback or to hold paid positions or seats on governing bodies.

Figure 1. Average scores for five fidelity domains



Facilitators of Housing First fidelity.

The main facilitators of fidelity to the model are summarized in Table 2.

Table 2. Summary of Facilitators for Achieving Housing First Fidelity

Systemic	Organizational	Individual
• Mortgage crisis & economic downturn access some cheaper houses;	• Commitment to the philosophy, incl. client-centred, recovery-oriented care; • Work to build landlord relationships; • "accommodation finder"; • Relationships with community services; • Pilot/ Demonstration project successes	• Sense of reward/witnessing success

Few *systemic-level* facilitators of model fidelity were identified in either focus group transcript. Surprisingly, the mortgage crisis was the one systemic facilitator of fidelity that participants mentioned, and that was in relation to the housing process and structure domain. One team member described how they were able to "seize thirty houses… [that offer] pretty secure tenancy…". Key Stakeholder 3 noted that they "… wouldn't have gotten as many [houses] if the market had been much freer and easier". As a consequence, the team was able to quickly house many new clients.

Most of the facilitators of fidelity identified were at the *organizational level.* Commitment to the Housing First philosophy of client-centred, recovery-oriented care was discussed extensively. In relation to the housing process and structure domain, Team Member 1 described commitment to the model in this way: "Housing First, [it's] core… everything circles around that, being and doing Dublin Housing First as… an ethos [not just] a name of a service." Team members also described how they worked to "meet clients where they are at" and to encourage them to develop adaptive, self-regulatory behaviours and build relationships with people in their neighbourhoods.

When discussing factors that affected fidelity in the Separation of Housing and Services domain, Key Stakeholder 3 noted how team members were "very clear that… sobriety, mental health… were [not] a condition in respect of accommodation". Emphasizing this point, Team Member 4 talked about their clients who are unable, or unwilling, to engage in face-to-face meetings. Instead of punishing these clients by taking them "out [of housing]", the team used alternative or more creative strategies, including "phone calls to link in some shape or form".

The importance of focusing on client-led goals and client-led responses was also mentioned in discussions about the Service Philosophy domain. Noting the challenges involved in providing a client-led service, Key Stakeholder 4 described how clients "find it hard to think beyond getting a home" and work on any other goals before they are housed. However, once they are "in housing," clients are "much more able to communicate [about] their [other] goals". This stakeholder illustrated the kinds of client-led interventions the team employed with a story about a client who was "banging the tables and… making noise", which caused his neighbours to complain. The team increased their visits to this client to "twice a day…", they "put carpet down… got slippers", and linked him to "different counsellors". He added that in this case, the team did not "go in and… say stop banging the tables and stop making noise". Instead, they worked with the client to help him understand that "if you do that [the neighbour will get annoyed] so maybe it's better to be… on carpet or… put some slippers on." The team member concluded the story by saying, "it's not about stop doing what you're doing, but it's about how to manage it."

The different ways that the programme works to build relationships with landlords were also discussed. The "accommodation finder", whose responsibility is to obtain housing by building positive relationships with landlords, was mentioned in regard to Separation of Housing and Services and Housing Process & Structure domains. Key Stakeholder 4 described the accommodation finder as someone who "knows the language… knows what to say [to landlords], things like 'your house won't be destroyed'". Key Stakeholder 2 added that landlords know that clients are not required "to be… housing ready or any of that", but that the team is "looking for homes for people who are on the streets [and that they] have a support team". He felt that "honesty… gives credibility… and [helps]… within the local authorities and the private rented [landlords]". Key Stakeholder 1 noted that this work fostered a reputation that Housing First will "manage the apartment for you" if you are reluctant "to get into the property business."

Building positive relationships with landlords is a responsibility taken up by all members of the team, though, not just the accommodation finder. In discussion of factors that facilitated fidelity in the Separation of Housing and Services Domain, for example, Key Stakeholder 1 described how the programme strengthens relationships with housing sources through activities such as end-of-year "welcome mornings". Activities to build relationships with landlords were also viewed as important to fidelity in the Housing Process and Structure domain. For example, Key Stakeholder 3 described how they do "a 'roadshow', trying to get people to understand the level of support that is with this programme, so that people [landlords] can take a risk or a chance on housing someone".

Positive relationships with community-based services were also identified as important facilitators of fidelity to the model in the Service Array domain. Key Stakeholder 1 described their existing connections in the community as "well-matured", which provided sources of education, volunteering, and social integration services for their clients. Some team members noted that these brokered services are not accessible to all their clients, but that those who do engage with them are afforded opportunities for increased community integration.

Key Stakeholders also noted the groundwork done by the Demonstration team was an important facilitator of fidelity in the Housing Process and Structure domain. The achievements won by the Demonstration team meant the current team "were working off the back of an awful lot of work and engaging [with community partners]." Key Stakeholder 4 described how the Demonstration team's achievements were "successes that we can evidence" and that they were "pushing an open door in as much as you possibly can." The team's success sustaining and building relationships, as well as their clients' positive outcomes, were identified as facilitating fidelity in the Team Processes and Structure domain. For example, processes and procedures help new team members learn how to deliver services to clients in accordance with Housing First philosophy and principles. Key Stakeholder 1 described their "buddy system" in which new members are paired with experienced team members for the first three months on the job. Through this kind of shadowing and learning-by-doing, the team builds cohesion and mobilizes commitment to the Housing First model.

Although focus group participants did not mention many *individual-level* facilitators of recovery, they did briefly note the sense of reward they get from working in a Housing First team, compared to working in more traditional services. Despite the challenges they face, the team does witness successes among their clients, which sustains their engagement, motivation, and creativity, even in difficult times. As Key Stakeholder 5 noted:

> "the outcomes are so positive… there's nowhere near the same reward for staff having worked with them handing them their key and then seeing them in their own place and whether they are doing well or not, they are there in a stable surrounding and they have what they want."

Barriers to Housing First fidelity

Barriers to achieving Housing First fidelity are summarized in Table 3.

Table 3. Summary of Barriers to Achieving Housing First Fidelity

Systemic	Organizational	Individual
• Economic down turn, mortgage crises, increased rental prices;	• Conflicting client-led practice & duty of care; • Relatively young organisation;	• Clients' stages of change

In the previous section, we noted that some focus group participants identified the economic downturn as a *systemic-level* facilitator of fidelity because it opened the team's access to some housing units. At the same time, as Ireland emerged from the economic and mortgage crises, the housing market tightened and rental prices spiked again, closing access to other sources of housing for new clients. Quite simply, demand for housing outstripped supply. As Key Stakeholder 5 succinctly said, "the number of rough sleepers is increasing and the availability of housing is decreasing". In discussion about the "housing process and structure" domain, Team Members 2, 3, and 4 explained how the chronic housing shortage limits clients' choices in housing:

> "they don't really have a choice… we haven't got the option to give people two or three choices… if they say no, when is the next one to come up? They have a choice to turn it down but the alternative [e.g., rough sleeping; emergency accommodation] is usually enough to make them take it…"

The economic downturn was also associated with reduced tenancy security. For example, Key Stakeholder 4 said:

> "up until two years ago the security there was just not there for anybody -- not just anybody who had problems, [but] for anybody -- because within a year… rent would go up so there's no security at all. So, anybody living in private rented in Ireland never felt secure or unless they actually had a nice wad of money to support."

Respondents identified the tight housing market as a barrier to fidelity in the Service Philosophy domain, because it negatively affected the team's ability to re-house clients after housing loss. For example, Key Stakeholder 1 described how the "really bad" housing market made it difficult to move clients when a housing situation became unstable. Further, the tight market put the team in a position where they felt they needed to encourage clients to take the first available unit and prevented clients from being able to say "that's not the right house for me". As a result, clients often had to choose flats or neighbourhoods that lacked

the characteristics clients preferred. The team worked to overcome the challenges caused by the housing market by trying to convince private "landlord[s] to lease the apartment to [them so they could] convert [the lease to a] social housing lease [that gives] the choice of location and the quality [with] social housing security" (Key Stakeholder 1).

To a lesser extent, participants noted some *organisational-level* barriers to fidelity in Service Philosophy domain, particularly conflicts between client-led practice and their duty of care. Participants described how clients' behaviours that threaten tenancies can set "alarm bells… ringing [because it might be] due to… poor mental [health, which is] under the contract of a duty care [because clients could be] harming themselves or others" (Key Stakeholder 3, Key Stakeholder 4).

Participants also identified organizational barriers to fidelity in the Service Array domain. This domain includes clients' opportunities for meaningful participation in the programme, perhaps by means of employment as paid peer specialists. Focus group participants felt that that the programme scored lower on items in this such as, *Does the programme have a paid peer specialist on staff who provides services directly to participants?* because the organisation was still young. Key Stakeholder 1 said that these programme elements are only supposed to "kick in… around now", suggesting that, if the assessment been completed at a later time, then the programme might have scored higher in this domain. According to participants, the programme does not offer many avenues to service users' input into the programme operations and policy. When asked to comment on the barriers to fidelity on this item, Key Stakeholder 3 responded that "we are too young as a partnership or as a project to have that fully implemented, and I think the longer we go on, the more you get aspects that [service user input] creeping in to the programme".

Key Stakeholder 1 also added that there are also *individual-level* barriers to service user input and suggested that "the nature of the customer group" means that they need intensive case management and are not ready to participate in programme operations. Key Stakeholder 2 suggested that the programme leadership believed that, at this stage, service users' integration into their communities was more important than their input into the programme.

Participants noted some *individual-level* barriers to fidelity in the Service Array domain, particularly the availability of education, volunteering, and social integration supports. They noted that a number of their clients are not yet ready to engage in these areas, suggesting that clients' early stages of change (Prochaska *et al.*, 1994) explains the programme's lower fidelity in this domain. Acknowledging the longitudinal and often non-linear nature of client recovery, Team Member 4 described how "it takes somebody that has been living on the street for twenty years… more than six months before they decide, 'actually I want to be a doctor'".

Although their clients might not necessarily be prepared to work toward those kinds of goals just yet, Key Stakeholder 3 was optimistic, suggesting that "over the next year, two years, three years [they] would have stuff like that coming in".

Methodological Concerns

Some methodological challenges arose during data collection. For example, for Item 7, a programme evidences 'high fidelity' if 60% or more clients are in "independent apartments rented from community landlords with outside support". Our participants found it difficult to answer this question because, in the Dublin context, private rented apartments are not always the best option:

> … [with] a private rented apartment [the] big worry is this 'is a home for life?' If we get through the… first 6-months… you get some security of tenure for the next three and a half years… 99% of the time… if we had an independent apartment rented from community landlords and a social housing apartment rented from local authority housing body… the citizen would choose the social housing," (Key Stakeholder 1).

Individually, team members' responses to Item 18, which measures the extent to which the programme uses coercion to encourage treatment compliance, suggested that clients were required to attend daily meetings with the team. In the conciliation meeting, however, Key Stakeholder 3 explained that meetings provide "more intensive support" when a client's "mental health is maybe deteriorating or… an addiction [is] really escalating. Meetings were to encourage clients to "re-engage" or for the team to gain insight into what might be going wrong. Key stakeholder 1 further explained, "there isn't a real consequence" when clients choose not to meet with the team. Therefore, it seems that these meetings are a form of assertive engagement and not punishment or coercion. The team also struggled with the wording 'systemic interventions' in Item 20, suggesting that this does not reflect their work because client-led care cannot be done according to a fixed plan or system. Finally, for Item 29, the team were unsure if the social skills and training they provided informally on a day-to-day basis counted as 'social integration' services.

Discussion

Overall, the team evidenced a moderate to high degree of fidelity in each of the five domains, with scores ranging from 70% to 100% (i.e., 3 to 4 on the 4-point scale). Results indicate that despite being a relatively young programme working in a challenging housing market, the programme embodies the key principles and practices that define the Pathways Housing First model. In order to achieve this result, the programme benefitted from a number of facilitators and overcame a number of barriers across different ecological levels.

Commitment to core aspects of the Housing First philosophy, as well as the team's relationships with landlords, were identified as important organisational facilitators of fidelity, while the relative newness of the team and conflicting duty of care were identified as organizational barriers. The main systemic barrier identified by our participants was access to housing, which limited client choice and security of tenancy. Individual-level facilitators or barriers were rarely mentioned, although the limiting influence of clients' stages of change on Service Array was noted. Findings indicate that most of the items in the self-assessment tool (Gilmer *et al.*, 2013) were applicable in the Dublin context, but that the North America-centric terms used in some items were ambiguous and were the source of some disagreement among the team about the extent of programme fidelity on some facets of some domains.

By identifying facilitators and barriers to fidelity across ecological levels, our findings replicate and extend knowledge about fidelity to the Housing First model. Housing First can also be conceptualized as an innovative health and social care model, and so, more generally, our findings contribute to understanding of fidelity in these contexts, too (Greenwood, 2015; Nelson *et al.*, 2017). At the organisational level, we found that commitment to the model was particularly important, which reflects Nelson and colleagues' (2017) findings, who noted the importance of 'organisational champions' who enhance organisational learning, performance, and transformation (Ferlie and Shortell, 2001). Together, team members are a stronger lever for change than one individual, and so programmes should strive to maximise team commitment (Maton, 2008).

Our work also builds on previous findings from the area of homeless service delivery that highlight the importance of sharing evidence of programme effectiveness with community partners such as landlords and other services on an ongoing basis (Steadman *et al.*, 2002; Nelson *et al.*, 2017). We know innovation involves stages of sharing knowledge and evidence, persuasion, decision, implementation, and confirmation (Rogers, 2003). That is, innovators learn about a new programme, are persuaded by evidence of effectiveness, and then decide to implement it and see if it works in their local contexts. In Dublin, the stages of innovation were not linear; instead, the team delivered their programme, shared their knowledge of success

as evidence (e.g., "the level of support that is with this programme") and persuaded landlords to buy-in, all in a cyclical, iterative process (Swan and Newell, 2000). This process of evidence sharing also contributed to a positive reputation in the community. As such, evidence sharing is an important component of broader innovation processes.

Interestingly, individual-level factors did not feature strongly in our findings. This finding differs from those reported by Nelson and colleagues (2017), who noted that staff turnover and change are important influences on fidelity. A number of individual-level barriers to fidelity were, however, identified at the phase of the Demonstration project when staff turnover was high and disrupted team functioning. In fact, in the early days, staffing was such a significant barrier to fidelity that substantial reconfiguration of the team and its management was recommended (Greenwood, 2015). It would be wrong, then, to say that Housing First in the Dublin context has been immune to individual-level barriers to fidelity. Rather, the current programme is delivered with a clear structure, strong leadership, and effective management and oversight, so staffing barriers did not feature in this particular assessment. The finding that barriers and facilitators change over time makes sense, given that Housing First is a dynamic and adaptive programme model. Overall, assessments at regular intervals might be useful to monitor and understand current facilitators and barriers to fidelity, and also to assess effectiveness of activities intended to increase or maintain fidelity, and to guard against threats to fidelity such as model drift or dilution.

Comparing the present findings to the Demonstration evaluation (Greenwood, 2015) offers further insight into the relationships of systemic, organizational, and individual facilitators and barriers to fidelity. As in the Demonstration, higher fidelity was shown in Housing Choice and Structure, Separation of Housing and Services, and Service Philosophy domains in the present study. Areas of lower fidelity were found in the Service Array and Programme Structure domains. Also, as in the Demonstration, participants in the present study repeatedly mentioned the importance of landlords. However, the Demonstration team identified their pro-active responsiveness to landlords as a facilitator of fidelity, while the current team emphasized the importance of maintaining relationships with landlords. This suggests that, over time, Housing First has established a positive reputation with landlords which must now be maintained and capitalised on.

Some barriers to fidelity that were observed in the earlier Demonstration programme evaluation were also observed in the current evaluation, especially the systemic problem of housing shortages and low neighbourhood-participant fit. Other barriers that were observed in the Demonstration evaluation included key stakeholders' preferences for traditional homeless services over Housing First and scepticism

about the Housing First model (Greenwood, 2015), were not found in the present study. The fading influence of these factors on fidelity indicates that key stakeholders in Dublin have become more convinced about the efficacy of Housing First. However, since this study did not include interviews with private landlords, representatives of approved housing bodies, or local authorities, we cannot draw any firm conclusion about changes in attitudes over time.

Practical contributions

Most decisions to implement Housing First are "top-down" policy decisions, and are sometimes met with resistance from those who feel the model is being imposed on them. However, bottom-up, employee-led participation is important to implementation success and sustainment, because commitment to the model and its philosophy is embedded in and enacted through providers' daily practices (Ferlie and Shortall, 2001). The Dublin Housing First team's practices, such as their "buddy system," serve to empower staff to participate fully in a programme that has certainly influenced the wider community. These findings reflect the broader literature on mentoring, which is described as a means to share power and develop leaders (Maton and Salem, 1995; Maton, 2008). Mentoring creates empowering settings that motivate team members to participate in actions and decisions (Peterson and Zimmerman, 2004). Empowering settings, in turn, can exert influence over the wider community and society. As such, shared leadership and mentoring, as a route to empowering and empowered settings, should be an important consideration for the development and running of Housing First programmes.

Like Nelson and colleagues (2017), who emphasized integrated knowledge translation strategies, we note the importance of evidence-sharing in our study. It is widely acknowledged that evidence for promising innovations, such as Housing First, is often difficult for practitioners and providers to access because it is published in specialized outlets, written in technical language, or without the level of detail necessary for implementation in practice. These issues make effective translation of findings critical to a programme's success. In Dublin, evidence of Housing First's efficacy was transmitted via word-of-mouth, the media, and the team's accommodation finder. Information about how Dublin Housing First manages apartments was crucial for landlord buy-in, even more so than evidence of clients' recovery outcomes or public savings. These are just some real-world examples of how evidence can be synthesized and attuned to the priorities and concerns of potential community partners for effective programme dissemination and implementation.

Further considerations and future research

We believe our findings offer important insights into the facilitators and barriers to Housing First fidelity. However, readers should keep certain aspects of the methods and procedures in mind when drawing inferences from our findings. For example, the order in which domains were presented for discussion may have resulted in different emphases on the various aspects of the context of implementation (Shaughnessy *et al*., 2002). Participants did not, for example, mention access to housing when talking about separation of housing and services, although independent, scattered-site housing can be presumed essential for fidelity in this domain. Because participants had already discussed housing at length in relation to the housing process and structure domain, which was discussed first, they may have felt they had already exhausted this topic. Researchers should be aware that the order of topics may influence the extent to which participants emphasize or discuss information that is relevant to a range of topics over a long interview or focus group.

Participants' familiarity with some topics may have led them to emphasise on certain facilitators or barriers over others. For example, participants spent much more time discussing organizational-level factors than systemic-level or individual-level factors. It may be that organizational factors were the most important facilitators in Dublin, or it may be that these factors were simply most salient to our participants. Although they received little attention from our participants, systemic and individual facilitators are often critical to programme fidelity. In the case of Housing First, political will to solve homelessness (Nugent and Rhinard, 2015) and public willingness to help (Toro and McDonell, 1992; Agans *et al*., 2011) are critical. We may have obtained different findings had we used a differently structured interview that probed deeper into systemic and individual factors, with different sets of stakeholders (e.g., service users, landlords), in different stages of programme development, or in a different context. Comparison of Dublin's findings with other international programmes and with programmes at different developmental stages will shed additional light on this topic.

Finally, ecological forces may exert bi-directional influences on fidelity. Kidd and colleagues (2007), for example, showed that vicarious exposure to homeless youths' trauma led to burnout among service providers. Our findings also indicate that there are links between facilitators and barriers across ecological levels. For example, commitment to client-led care, as an organisational facilitator, is likely to reflect positively on the team's reputation and, in turn, enhance relationships with landlords, both of which are systemic facilitators. Future research will need to confirm this conclusion, but we believe that our findings indicate that, rather than being mutually exclusive, facilitators and barriers of fidelity influence each other across multiple ecological levels in iterative, cyclical, and non-linear ways. In future,

researchers might examine these relationships more closely. We recommend that programme leaders and team members also consider the ways in which the actions and choices they take to affect fidelity at one level may have either positive or negative consequences for fidelity at another level.

Cross-national implications & generalizability

We believe our findings are applicable and relevant to Housing First stakeholders across different contexts. First, our findings, alongside the evidence for the spread of Housing First internationally, show that successful innovation in homeless service delivery is possible when policymakers and programme leaders consider, develop, and implement plans for long-term positive change. Key to the programme's success were their responsiveness to early staffing challenges and their sustained efforts to build community relationships. An unstable team and doubt about change to the status quo are often features of any change processes. Thus, our findings about the importance of building a cohesive team that is committed to the model philosophy, as well as establishing positive relationships with community partners, particularly landlords, are most likely to be critical to success in any context.

The prevailing challenge for DHF nowadays is structural in nature, namely a lack of affordable housing. Again, homeless services across contexts are all working to manage similar challenges. Thus, our findings highlight the importance of anticipating and planning for challenges related to housing shortages. Moreover, our findings should be taken as direction to activism in the relevant arenas, particularly toward lobbying for the provision of adequate and affordable housing. Overall, the fidelity research presented here, particularly the nuanced insights into barriers and challenges, is a crucial precursor to effectively disseminating the Housing First model and establishing a strong evidence base in the European context (Greenwood *et al.*, 2013).

Summary and Conclusions

In sum, our findings suggest that higher fidelity to key aspects of the Housing First model in Dublin was facilitated by commitment to core aspects of the philosophy, as well as the team's positive relationships with landlords. Our findings also provide practical examples of how these facilitators can be embedded in organisations (e.g., coffee mornings with landlords, buddy systems for new staff). At the same time, fidelity was challenged by housing shortages, an issue that is not unique to Ireland. Shortages in affordable housing make it difficult to find homes for new or existing clients. Programme implementers should not assume "if we build it [Housing First], they will come [housing units]". Securing pathways to housing should be an important preparatory step in the implementation of any new Housing First programme. Overall, we hope that by identifying facilitators and barriers to Housing First fidelity, the current study findings, combined with those from others in this special issue, will provide direction and inspiration for innovators in homeless and other human service contexts.

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Fidelity Assessment of a Canadian Housing First Programme for People with Problematic Substance Use: Identifying Facilitators and Barriers to Fidelity

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Abstract_*This article presents the findings of a fidelity assessment conducted with a Housing First programme in Canada that supported clients with problematic substance use. A mixed-methods (quantitative and qualitative) evaluation design was used. A fidelity assessment survey, fidelity rating conciliation session, and interviews were conducted with programme staff and management to identify facilitators and barriers to the programme's fidelity to the Housing First model. Data analysis identified areas of high and low fidelity originating at systemic, organizational, and individual levels, with an overall high level of fidelity found. Factors supporting fidelity included the availability of government-funded rent supplements and organizational commitment to the principles of Housing First. Factors limiting fidelity included a lack of affordable housing and limited client and peer involvement in programme decision-making. Programme adaptations implemented for local relevance were also identified, including a novel programme partnership between two community agencies that helped to partition the delivery of housing services from support services. Implications of the results both locally and globally are discussed.*

Keywords_*Fidelity assessment, homelessness, Housing First, intensive case management*

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Introduction

At least 235,000 Canadians experience homelessness every year, with approximately 35,000 homeless each night (Gaetz *et al.*, 2016). Beginning in the 1970s in Canada, deinstitutionalization of patients from psychiatric hospitals into the community was implemented (Aubry *et al.*, 2015a). The slow development of community mental health services in response to deinstitutionalization contributed to housing challenges faced by people with serious mental illness across the country (Kirby and Keon, 2006). In the 1980s and 1990s, changes in the Canadian government's social and housing policies led to further increases in poverty and reductions in affordable housing (Gaetz, 2010). The legacy of this history remains today, with high levels of homelessness present in Canada, though the development of community mental health services (including housing initiatives) is now underway to address it (Nelson, 2010).

The Pathways to Housing programme, developed in the 1990s in New York City, implemented a new "Housing First" approach to end chronic homelessness of people with serious mental illness (Tsemberis, 1999; Tsemberis, 2010; Padgett *et al.*, 2016). The programme provides immediate housing to clients, maintains a separation between housing and clinical services, works from a recovery orientation, and facilitates community integration (Tsemberis, 2010; Padgett *et al.*, 2016). Tsemberis (2010) described how Housing First utilizes either intensive case management (ICM; in which case managers individually assist their own caseload of clients) or assertive community treatment (ACT; in which teams of healthcare professionals collaboratively care for all programme clients) based on client need. Aubry *et al.* (2015a) provided an in-depth analysis of the Pathways approach to Housing First, including a programme logic model for its theory of change – linking overarching theoretical principles, programme activities, and immediate-, medium-, and long-term outcomes. This model is now followed in various North American and European countries (Greenwood *et al.*, 2013; Padgett *et al.*, 2016). For a more detailed summary of the history of the Pathways Housing First model, its spread around the globe, and research on its effectiveness to assist individuals with histories of chronic homelessness achieve housing stability, see Padgett *et al.* (2016).

Implementation science now requires programmes that are evidence-based to specify their critical ingredients (Carroll *et al.*, 2007). As a result, research is now beginning to define these critical ingredients relative to the Pathways Housing First model, largely by defining a set of fidelity standards (Tsemberis, 2010). Fidelity standards can provide "guidelines to ensure that programmes implement housing, support, and treatment services, and practice philosophy that is consistent" with the Housing First model (Tsemberis, 2013, p.236). Gilmer *et al.* (2013) developed a

self-report measure to assess Housing First programme fidelity based on five domains: Housing Choice and Structure, Separation of Housing and Services, Service Philosophy, Service Array, and Programme Structure (also see Stefancic *et al.*, 2013). Research has shown that clients in Housing First programmes with higher fidelity to the Pathways model used more outpatient mental health services (Gilmer *et al.*, 2015), were more likely to retain housing (Gilmer *et al.*, 2014), and less likely to report using stimulants or opiates at follow-up (Davidson *et al.*, 2014).

Housing First in Canada

Housing First has also been implemented in Canada. Most visibly, the Canadian federal government funded the Mental Health Commission of Canada with $119 million in 2008 to conduct the At Home / Chez soi (AHCS) Demonstration Project – a randomized-controlled study comparing Housing First services to existing services for individuals with serious mental illness and histories of homelessness in five cities across the country: Vancouver, Winnipeg, Toronto, Montreal, and Moncton (Goering *et al.*, 2011). In accordance with the Housing First approach, AHCS offered services through either ICM for those with a moderate level of need or ACT for those with a high level of need. Various implementation evaluations, outcome evaluations, and fidelity assessments took place over approximately five years of AHCS. Housing First was found to produce better housing outcomes than existing services and produced rapid and greater client improvement in terms of community functioning and quality of life (Aubry *et al.*, 2015a).

In terms of AHCS fidelity assessments, fidelity was found to be related to outcomes of housing stability, community functioning, and quality of life (Goering *et al.*, 2016). Further, given differences in the five cities involved in the AHCS project, the programme was often adapted to its local context in terms of the ethnoracial characteristics of participants, community size, and availability of community mental health services. Such adaptations in the AHCS sites were implemented while still maintaining fidelity to the formal Housing First model, which was important to ensure programme success, consistency, and local relevance (Stergiopoulos *et al.*, 2012; Keller *et al.*, 2013; Nelson *et al.*, 2014; Aubry *et al.*, 2015a; Macnaughton *et al.*, 2015).

Housing First has also been implemented on a smaller scale through a variety of new programmes across Canada. At the same time the Canadian federal government was funding the AHCS project in 2008, the Ontario provincial government's Ministry of Health and Long-Term Care provided $16 million over three years to fund 1,000 housing units for the Supportive Housing for People with Problematic Substance Use Programme, "designed to provide rent supplements and support services such as helping people acquire the skills to retain their housing" (Office of the Auditor General of Ontario, 2010, p.290).

The Sandy Hill Community Health Centre

Funding from the Supportive Housing for People with Problematic Substance Use Programme was allocated to a programme site in Ottawa, Canada. Approximately one million dollars in annualized funding starting in 2010 was allocated to support 120 people in the Ottawa area through a Housing First programme jointly operated by the Sandy Hill Community Health Centre (SHCHC) and the Canadian Mental Health Association's Ottawa Branch (CMHA). The SHCHC Oasis programme provided the ICM support services to clients while a CMHA housing coordinator provided the housing services to programme clients, all within the Housing First model (Cherner *et al.*, 2014; Cherner *et al.*, 2016). This combined SHCHC and CMHA Housing First programme was the focus of the current fidelity assessment and is referred to here as the "SHCHC Housing First programme."

The SHCHC Housing First programme served clients 18 years of age or older who were homeless or at risk of homelessness, with problematic substance use and complex needs based on various factors including past substance use treatment, daily or binge alcohol or drug use, injection drug use, substance use significantly impacting daily functioning, mental illness significantly impacting daily functioning, physical health conditions (typically HIV/AIDS, hepatitis C, and liver disease), no family physician, use of hospital services, use of emergency services, use of justice services, and being barred from other community organizations for disruptive behaviour (Cherner *et al.*, 2017). Clients were accepted into programme services following assessments selecting for the most complex individuals with the above characteristics.

Kertesz *et al.* (2009) noted that the demonstrated effectiveness of Housing First in research may not be generalizable to people with substance use problems. To date, the research on outcomes for people with substance use problems is equivocal, with one study showing similar levels of achieved housing stability compared to abstinent individuals (Edens *et al.*, 2011), and another showing reduced housing tenure for tenants with a dual diagnosis (i.e., mental health and substance use problems) compared to tenants without a dual diagnosis (Tsemberis and Eisenberg, 2000). Only two studies to date have shown Housing First to achieve better substance use outcomes than treatment as usual (Padgett *et al.*, 2011; Kirst *et al.*, 2015). The precise relationship between Housing First and problematic substance use remains unclear.

However, an implementation evaluation of the SHCHC Housing First programme in the past reported positive findings, with the programme serving the intended population and delivering the intended ICM services (Cherner *et al.*, 2014). An outcome evaluation found that programme clients had better housing outcomes than a comparison group who received the usual services available in the community.

Within a 24-month period, programme clients spent 76% of their time housed and became housed on average within 105 days of entering the programme (compared to 51% of time housed and being housed within 173 days of entering the programme for the comparison group). In the last six months of the study, 81% of clients were housed for the full six months while 8% were not housed for any of the six months (compared to 55% and 25% respectively for the comparison group; Cherner *et al.*, 2016). A prior fidelity assessment at SHCHC conducted in 2012 by an external team found high fidelity on four of the five fidelity domains, with the exception of moderate fidelity in the domain of Service Array (Stefancic *et al.*, 2012).

The current study

A prior fidelity assessment at SHCHC was conducted by Ana Stefancic, Sam Tsemberis, and Juliana Walker from Pathways Housing Inc. to support programme development and improvement in its first year of operation and before caseloads reached capacity (Stefancic *et al.*, 2012). This earlier fidelity assessment did not assess the potential facilitators and barriers that might affect the SHCHC programme's capacity to meet fidelity standards. The purpose of the current study was, therefore, to conduct an internal fidelity assessment with SHCHC programme staff and management at a later stage of programme development and with caseloads at capacity, and to explicitly investigate facilitators and barriers of fidelity to the Housing First model that might be influencing the fidelity of the SHCHC programme. The following research questions guided this fidelity assessment:

RQ 1: Does the SHCHC Housing First programme demonstrate fidelity to the standards of the Pathways Housing First model?

RQ 2: What are the factors that facilitate a high level of fidelity to the Pathways Housing First model at SHCHC?

RQ 3: What are the factors that impede attainment of a high level of fidelity to the Pathways Housing First model at SHCHC?

Method

In accordance with other studies of Housing First programme fidelity in various North American and European locations, the current study utilized a mixed methods approach to the evaluation of the SHCHC's Housing First programme. First, a quantitative assessment of fidelity facilitated by external research team members was completed by programme staff to measure the fidelity of the SHCHC Housing First programme using the self-administered fidelity survey (Gilmer *et al.*, 2013; Stefancic *et al.*, 2013). This was followed by qualitative key informant interviews with programme staff to identify factors that contributed to the areas of high and low programme fidelity.

Description of the SHCHC Housing First programme

The SHCHC programme was funded with rent supplements for 116 housing units, while the programme served approximately 120 clients. Clients were supported by 12 programme professionals: 10 case managers, one housing coordinator, and one programme manager. Each case manager (typically social workers) provided ICM services to a case load of 12 clients. The programme served clients from the Ottawa area who were homeless or at risk of homelessness and had problematic substance use and serious mental illness. The clients were housed primarily in scattered-site, private-market units (n = 99), with one client living in a public housing unit. The remainder of clients were not housed due to reasons such as searching for new housing following an eviction, imprisonment, or challenges with mental health or substance use symptoms. Clients received rent supplements so that no one paid more than 30% of their income towards rent.

The fidelity assessment

Procedure and sample

First, the 37-item self-administered survey (Gilmer *et al.*, 2013) was completed individually by programme staff. A subsequent conciliation meeting facilitated by members of the research team was held with staff, during which an item-by-item review was conducted with all staff present sharing their self-assessed fidelity ratings. In cases where there was consensus on item ratings across all participants, this rating was taken as the final quantitative fidelity rating for that item. In cases where there were differences in ratings, a discussion was held among participants to explain the rationale for their ratings. Discussion continued until a consensus was reached among staff and this consensus was taken as the final quantitative rating for the item. The self-administered fidelity survey was completed individually by 10 programme staff members who had each been working with the SHCHC Housing First programme for at least six months. All programme staff and management members who were interested in participating

were invited to complete the survey. Eight case managers, one housing coordinator, and one programme manager participated. They completed the survey between June 22, 2016 and July 27, 2016. The staff conciliation meeting with the same individuals was held on July 27, 2016.

Measures

Gilmer *et al.*'s (2013) 37-item self-administered survey was completed by participating programme staff members to answer Research Question 1. The survey was composed of separate sections to assess each domain of Housing First fidelity (Housing Process and Structure; Separation of Housing and Services; Service Philosophy; Service Array; Programme Structure). Many survey items were ranked by participants on a scale of 1 (low fidelity) to 4 (high fidelity). Other items were ranked on scales with varying score ranges that were subsequently standardized to the 4-point scale. Sample survey items included "What types of psychiatric services, if any, are available to participants?" and "What percent of participants share a bedroom with other tenants?"

The fidelity assessment survey was implemented as intended, with one exception related to the comprehension of one survey item. Item 18 in the self-administered fidelity survey asked if programme staff engaged in "*quid pro quo*" behaviours to promote client adherence to treatment plans. *Quid pro quo* is Latin for "this for that," referring to an exchange in which the receipt of one thing is contingent upon giving something in return. In the Housing First context, one example could be if a case manager were to offer bus tickets to a client in exchange for the client taking medication. This would affect the client-directed nature of the service and reflect a reduction of fidelity to the Housing First model. However, many participants in the SHCHC fidelity assessment did not know what *quid pro quo* meant and were confused by the item. The meaning of *quid pro quo* was subsequently provided to participants during the conciliation meeting and a consensus was achieved on item 18 based on this understanding.

Data Analysis

Following the conciliation meeting, item ratings were averaged to produce total scores for each Housing First domain. Each domain score was also combined to produce a total fidelity score. Scores below 3 indicate low fidelity, scores between 3 and 3.5 reflect moderate fidelity, and scores between 3.5 and 4.0 reflect high fidelity (Macnaughton *et al.*, 2015).

Key informant interviews

Procedure and sample

The qualitative key informant interviews were conducted individually with SHCHC Housing First programme staff in-person or by telephone. Key informants were provided a copy of the conciliated fidelity assessment results prior to interviews. The interviews were conducted individually with seven programme staff (many of whom had also participated in the fidelity survey) between October 13, 2016 and November 7, 2016. However, all programme staff and management members who were interested in participating were invited for a key informant interview. The group of participating staff included four case managers, the housing coordinator, the programme manager, and the executive director. Their responses to interview questions were used to investigate Research Questions 2 and 3.

Materials

The qualitative interview protocol included questions investigating factors that contributed to either high or low fidelity in each Housing First domain. The interview protocol was semi-structured, with open-ended questions followed by optional probes to be used as deemed necessary by the interviewer. Participants were also queried throughout the interview to provide any additional information they believed to be relevant to programme fidelity that had not been raised by the interview protocol. Sample interview questions included: "What factors helped implement these aspects of the programme with high fidelity?" and "What barriers prevent the programme from achieving a higher level of fidelity in this area by not engaging in any of the activities identified in this item?"

Data analysis

Interviews were audio-recorded, transcribed, and then coded using QSR NVivo software. Working from the categorization scheme used by Nelson *et al.* (2017), data coding was conducted deductively by categorizing identified factors as either facilitators or barriers of Housing First fidelity. Within these two categories, subordinate coding also identified data deductively as originating from either the systemic, organizational, or individual level (with possibility of overlap between categories acknowledged). This structure provided a guide to then inductively code the data into relevant and meaningful segments of information for the fidelity assessment.

Prior to coding key informant interview transcripts, four members of the research team independently coded two transcripts for all systemic, organizational, and individual facilitators and barriers of Housing First fidelity. The four research team members compared and discussed coding results for one of these interviews over several meetings, in which they reconciled all differences in results, agreed to general coding terminology, and developed a strategy to complete coding of all

transcripts. Three research team members then coded all transcripts, with each member responsible for coding a separate set of factors (either systemic facilitators and barriers, organizational facilitators and barriers, or individual facilitators and barriers). The research team then reviewed all coding to verify the quality of the data analysis and integrate the findings.

Results and Discussion

Fidelity assessment

Table 1 presents standard scores of all fidelity assessment survey items, average domain scores, and the overall programme fidelity score on a 4-point scale. High levels of fidelity were found on 67% of items. Low levels of fidelity were found on 17% of items. The remaining 17% of items reflected moderate levels of fidelity. The overall average programme fidelity score was 3.5, indicating that the programme has a high level of fidelity to the Housing First model.

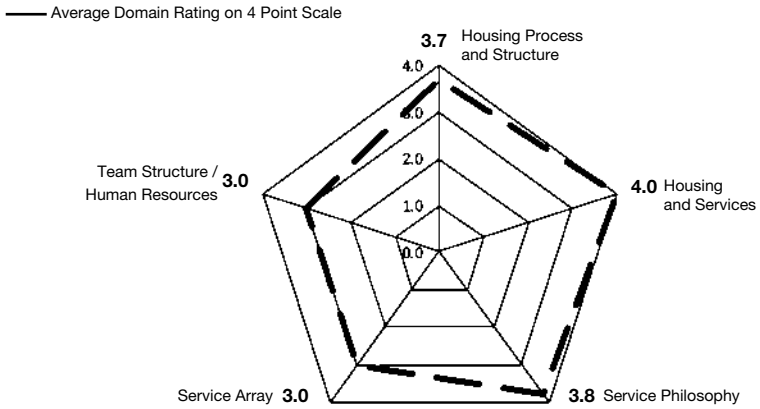
Table 1. Fidelity Assessment Item Scores and Domain Means

Domain / Item	Domain Mean / Standard Item Score (Out of 4)
Housing Process and Structure	***3.7***
1. Choice of housing	4.0
2. Choice of neighbourhood	4.0
3. Assistance with furniture	3.0
4. Affordable housing with subsidies	4.0
5. Proportion of income required for rent	4.0
6. Time from enrollment to housing	3.0
7. Types of housing	4.0
Separation of Housing and Services	***4.0***
8. Proportion of clients with shared bedrooms	4.0
9. Requirements to gain access to housing	4.0
10. Requirements to stay in housing	4.0
11a. Lease or occupancy agreement	4.0
11b. Provisions in the lease or agreement	4.0
12. Effect of losing housing on client housing support	4.0
13. Effect of losing housing on other client services	4.0
Service Philosophy	***3.8***
14. Choice of services	4.0
15. Requirements for serious mental illness treatment	4.0
16. Requirements for substance use treatment	4.0
17. Approach to client substance use	4.0
18. Promoting adherence to treatment plans	2.5

19. Elements of treatment plan and follow-up	4.0
20. Life areas addressed with programme interventions	4.0
Service Array	***3.0***
21. Maintaining housing	3.0
22. Psychiatric services	4.0
23. Substance use treatment	3.2
24. Paid employment opportunities	0.8
25. Education services	3.2
26. Volunteer opportunities	4.0
27. Physical health treatment	4.0
28. Paid peer specialist on staff	1.0
29a. Social integration services	4.0
Programme Structure	***3.0***
31. Client background	3.3
33. Staff-to-client ratio	4.0
34b. Frequency of face-to-face contacts per month	4.0
35. Frequency of staff meetings to review services	2.0
36. Team meeting components	2.7
37. Opportunity for client input about the programme	2.0
Overall Mean	**3.5**

Average fidelity scores varied across the five Housing First domains, as illustrated in Figure 1. The average scores for the Housing Process and Structure, Separation of Housing and Services, and Service Philosophy domains were 3.7, 4.0, and 3.8, respectively, indicating high fidelity in these areas. The score for the Housing Process and Structure domain indicated particularly high fidelity in terms of valuing client choice in housing and in its delivery of rent supplements. Separation of Housing and Services averaged 4.0 on all fidelity survey items, indicating that the programme is strong in its delivery of the housing portion of the programme and that the loss of housing does not affect the delivery of further housing or support services to clients. The programme also evidenced high fidelity in the Service Philosophy domain, especially in terms of client choice in services and minimal requirements imposed on clients to receive services. All items in this domain were scored as 4.0, except for Item 18 with a score of 2.5. This lower score indicates that programme staff engage in transactional behaviours to promote client adherence to treatment plans, such as cautioning the withholding of client services or engaging in *quid pro quo* exchanges, which are inconsistent with fidelity standards.

Figure 1. Average Housing First Fidelity Ratings by Domain



Scores on items in the Service Array and Programme Structure domains were mixed. Average scores in both domains were 3.0, on the border between low and moderate fidelity. The Service Array domain evidenced this level of fidelity because of a limited availability of services to support clients interested in paid employment opportunities, and because there are no paid peer specialists on staff. In this programme's first external fidelity assessment, Stefancic *et al.* (2012) recommended introducing peer support workers to the programme. However, incorporating peer support can be a challenge for Housing First programmes. Canadian programmes that offer ICM services typically have not included peer support (Nelson *et al.*, 2014), or have experienced challenges doing so (Macnaughton *et al.*, 2015). Further, the SHCHC programme demonstrates high fidelity in the Service Array domain on several other indicators, including availability of psychiatric and physical health services, services to connect clients with volunteer opportunities, and services that target and increase clients' level of social integration.

Programme Structure domain scores fell into the low-fidelity range on three main items. These scores reflect a relatively low frequency of staff meetings per month and minimal opportunities for client input into the programme. In the first fidelity assessment, Stefancic *et al.* (2012) recommended increasing the frequency of staff meetings and introducing a client advisory council; however, this reassessment found that these aspects of implementation have not yet been addressed. Two items in this domain attained high-fidelity scores and indicate that the programme maintains a low staff-to-client ratio and frequent face-to-face contacts between staff and clients. Overall, the fidelity self-assessment indicates that the SHCHC Housing First programme operates at a level of high fidelity and adheres to most of the standards associated with the Housing First model.

Key informant interviews

Facilitators of Housing First fidelity

Key informants identified various factors that facilitate high fidelity to the Housing First model for the SHCHC programme. In the following section, these facilitating factors are organized by their origin at either the systemic, organizational, or individual level, and are summarized in Table 2.

Table 2. Summary of Facilitators for Achieving Housing First Fidelity

Systemic	Organizational	Individual
Client priority to receive community services	Commitment to Housing First philosophy	Staff member values
Complementary services available in community	Commitment to re-housing	Staff member expertise
Housing availability	Partnership for programme delivery	
Landlord support of clients	Structural separation of housing and services	
Programme reputation	Traditional lease contracts	
Rent supplements		

Systemic factors

The most important facilitator emphasized by key informants is the substantial government-sponsored rent supplements that provide financial support to programme clients. The rent supplements facilitate housing success because they are: (1) portable, allowing for client choice and re-housing as necessary; (2) large enough, when combined with client income, to cover rent for a one-bedroom apartment in a wide range of neighbourhoods; and, (3) administered with a traditional lease arrangement between the client and landlord, which contributes to clients' sense of pride, accountability, autonomy, and responsibility. Key informants described rent supplements as critical facilitators of Housing First fidelity. One key informant noted, "the number one thing that contributes to it [our success] is the fact that we have subsidies [rent supplements]. Without subsidies, we couldn't do it. That's the biggest thing." This finding is consistent with previous research, which found that funding was critical to the sustainability of Housing First programmes across Canada (Nelson *et al.*, 2017).

Characteristics of both clients and landlords were also identified as important facilitators. For clients, complex support needs such as homelessness, substance use, and mental and physical illness mean that they are often prioritized for services in the Ottawa area, which enhances the array of services and choices available to them. One key informant noted that, "what happens are our clients being considered the most complex, usually they have the easiest access to services." Regarding landlords, key informants noted a "network of landlords who were friendly and favourable to Housing First and experienced with Housing First programmes" in

Ottawa, which bolsters SHCHC's ability to maintain fidelity by making housing more available. Prior research investigating landlord perspectives identified not only various concerns about renting to Housing First tenants, such as poor unit maintenance and conflict with other tenants (Aubry *et al.*, 2015b), but also some landlords' "desire to give back to the community and to help individuals with mental health challenges" (MacLeod *et al.*, 2015, p.8). In the current study, key informants recognized the importance to fidelity of supportive landlords who make housing available to Housing First clients. Because these client and landlord characteristics reflect population-level descriptions of each group, we include them here as systemic-level fidelity facilitators, rather than as individual-level facilitators.

The SHCHC Housing First programme's reputation in the Ottawa community is another facilitator of Housing First fidelity, because it creates opportunities for the programme to find and maintain client housing. For instance, one key informant summed up the value of the programme's reputation as follows: "We have clients who have been housed and their landlord is like 'Oh you're with Sandy Hill, come on in.' And they actually went two months without getting rent and they're like, 'Yeah… you guys will pay me,' so you know, our reputation does help." Some key informants also identified various complementary services in the Ottawa area as being important facilitators of Housing First fidelity. These allow SHCHC to connect with a broader array of services and ensure their clients receive the support they desire. These complementary services particularly relate to the relationship between SHCHC and CMHA, but also extend to other health care agencies. However, other key informants felt that more could be done to provide an even broader range of services to clients. Finally, some key informants identified the availability of housing in the Ottawa area as a facilitator of Housing First fidelity. Although limited housing options were identified as a barrier by other informants as explained below, some still felt that "there is enough housing in Ottawa that we can get into an area and ultimately the decision is [the client's] in terms of whether they want it."

Organizational factors

Key informants also identified important facilitators of Housing First fidelity at the organizational level. Key informants described a high degree of organizational awareness and formal commitment to the philosophy of Housing First. The organizational approach aligns closely with Housing First principles such as client autonomy, client choice, client-directed service, harm reduction, and access to low-barrier housing. One key informant stated: "We are, I guess you could say, almost Housing First purists." Key informants recalled Housing First principles being reinforced during recruitment, hiring, and training processes, staff meetings, and conferences. One said "I think the structure of the programme, in that we are a client-directed programme, it's a part of the philosophy. People are hired with that intent and we consciously discuss that concept." Several key informants also

pointed out that the programme is embedded in two established organizations that already adhered to a well-entrenched harm reduction approach and client-directed service delivery model before the SHCHC programme began, making this a rich and appropriate context within which to establish a strong Housing First programme.

Key informants also emphasized that the programme's commitment to re-housing clients – usually necessary because of an eviction or a client's decision to move – is a notable facilitator of fidelity. Key informants explained that this commitment to re-housing could be attributed to staff members' levels of experience, their understanding of Housing First, and why it works. Re-housing is framed as an important learning experience and a necessary and expected step towards housing stability. One key informant said: "Some places you have like a 'three-strike model,' you know?… And then you don't get a rent sup[plement] anymore. Well, we don't work that way. Because sometimes it takes more than one housing attempt for them to be successful."

Further, the unique partnership between the two agencies (one a community mental health agency and the other a community health centre) contributes to the array of services available to clients. Clients are well-supported by two different agencies, each offering a broad range of supports. As one key informant explained: "We provide an integrated model of care and so we're able to wrap a whole bunch of services around this for people who choose to use it… We want people to use as many of our services here as possible." This partnership is particular to the SHCHC programme and reflects a local adaptation from the Housing First model in the Ottawa area that allows two community organizations to work together to enhance housing and treatment services for clients. This partnership between SHCHC and CMHA also contributes to the ability of the programme to connect with landlords in the community. One key informant explained that CMHA has previous experience working with landlords and has established a "network of landlords who were friendly and favourable to Housing First and experienced with Housing First programmes…" Key informants discussed the importance of working closely with landlords, being responsive to landlord calls, ensuring that rent is paid directly to landlords, and having a dedicated housing coordinator to lead in these areas, thereby promoting high fidelity to the Housing First model.

Differentiated staff roles at each organization (housing services from CMHA and treatment services from SHCHC) provide a distinct structural separation of housing and services, especially with the creation of the dedicated housing coordinator position at CMHA. Indeed, the separation of dedicated housing staff from other programme service staff is a central element of the Housing First model (Tsemberis, 2010), because shared responsibility over client tenancy leases can blur distinctions between housing and services, and thereby constrain client choice. In contrast, the SHCHC programme's use of traditional lease contracts that confer all

the standard rights *and* responsibilities of a tenancy onto programme clients under Ontario law facilitates the separation of housing and support services, and consequently enhances client-directed service and autonomy.

Individual factors

Key informants identified the primary individual-level facilitators of Housing First fidelity as follows: many individual staff members and leaders have personal values and expertise that support the Housing First mandate. Key informants spoke about how this helps build client-staff relationships, facilitates client-centered services, and thus promotes high fidelity. Key informants spoke about how their own knowledge and expertise developed through working in the field and how this is important to clients' housing success. This expertise allows them to maintain relationships with landlords, clients, and community resources, which assists in finding and maintaining housing for their clients. Housing First programme staff, particularly frontline case managers, are the foundation upon which the work of Housing First gets translated from theory into practice. Having case managers that are qualified, committed, and trained appropriately therefore appears crucial to the success of the Housing First model, particularly given the often complex and difficult situations which staff must navigate with a degree of independent discretion (Clifasefi *et al.*, 2016; van den Berk-Clark, 2016).

Barriers to Housing First fidelity

Key informants also identified various barriers that affected fidelity in certain areas of the Housing First model, which are summarized in Table 3. Key informants sometimes disagreed about whether certain factors were barriers or facilitators of fidelity. Thus, some of these barriers are similar to some of the facilitators described above and reflect nuanced understandings of how some factors can facilitate fidelity in one context but detract from it in another.

Table 3. Summary of Barriers to Achieving Housing First Fidelity

Systemic	Organizational	Individual
Client complexity	Commitment to Housing First philosophy	Staff member values
Complementary services unavailable in community	Lack of client voice and input in programme	Staff member approach to practice
Housing availability	Limited partnerships with landlords	
Landlord requirements	Programme communication and decision-making processes	
Lack of funding	Service provision without rent supplements	
Stigma towards clients and programme	Supervision practices	
Coordination with other agencies		

Systemic factors

Various systemic factors were identified as barriers to Housing First fidelity at SHCHC. One of the most frequent themes identified in our analysis was the characteristics of programme clients. SHCHC's clients are often in crisis, have complex histories and challenging physical and mental health profiles. Although these clients often receive higher priority access to community services, key informants felt that there can be "ethical concerns related to people who may have repeatedly trashed units, and/or who may have been threatening towards superintendents… they can be challenging in terms of offering them housing." For instance, if clients engage in problematic behaviours on an ongoing basis, programme staff sometimes feel that they have no choice but to deviate from the Housing First model to protect their clients, other people, and property, while attempting to maintain client housing and avoid burning out landlords. Thus, the complexity of clients in this programme can sometimes constrain the provision of housing and services, which can reduce Housing First fidelity.

Further, the SHCHC client population experiences significant substance use problems. Research on Housing First for people with problematic substance use has shown mixed results. Previous research with SHCHC's client population showed that the majority of clients with substance use problems receiving Housing First services can achieve housing stability; however, other clients provided with standard community care may have more success addressing substance use concerns (Cherner *et al.*, 2017). Thus, it is important to consider the varied needs of different client groups when developing Housing First programmes.

Key informants also explained how stigma sometimes operates as a barrier to fidelity for the SHCHC programme. For instance, one key informant noted that "I have one fella who anytime we go anywhere in [Ottawa neighbourhood] applying for housing, [landlords] know who he is and they judge him on past behaviours and there is no way he is going to be housed." While some landlords are supportive of programme clients, and so facilitate fidelity, others have many requirements for rental applications and high expectations of tenants, which function as barriers to fidelity by restricting access to housing for some SHCHC clients. Further, some landlords increase their rent costs to prohibitive amounts, while others have had negative experiences with SHCHC tenants and thus avoid renting to new SHCHC clients.

These barriers are further compounded by a lack of funding. While the availability of rent supplements is the core of this programme, these subsidies do not increase when rent costs increase. This reduces client choice of housing type and neighbourhood. Pricing competition from post-secondary students and government employees in the Ottawa area leads to further increases in rental costs that are

difficult to meet with SHCHC rent supplements. Insufficient funding also affects other areas of fidelity. For example, the programme has no funding to hire a peer support worker and limited funding to cover repair costs to damaged rental units. Some key informants also expressed concern that there is a lack of new rent supplements being provided to the programme; thus, they are unable to offer rent supplements to new clients (a broader concern also raised by Nelson *et al.*, 2017). Further, even when funding is adequate to supplement clients' rent, more is needed to support them to achieve goals beyond housing stability, namely obtaining health services and participating in meaningful community activities (Kumar *et al.*, 2017).

The housing context in Ottawa was identified by some key informants as another barrier to fidelity. In particular, one key informant stated: "I'll tell you a huge issue right now is the availability of housing. It's not there." Key informants noted significant difficulties finding housing, particularly affordable housing, in Ottawa. Given that Housing First promotes client choice in housing location, low availability created a barrier across Ottawa, especially within the more popular neighbourhoods where availability was notably low. As described above, other key informants saw the housing context as a facilitator of fidelity, and it remains unclear why opinions are mixed on this issue. These differences may reflect staff members' varied experiences sourcing housing with different landlords and different clients.

Another barrier to fidelity identified by key informants is restricted availability of certain support services in the Ottawa area. For instance, key informants noted limited employment support options and difficulty finding psychiatrists to assist clients. This concern is compounded for Housing First programmes like SHCHC that are organized around the ICM model of programme delivery which relies on the availability of community-based services (Tsemberis, 2010; Somers *et al.*, 2013). This concern is eased slightly for the SHCHC programme because of its connection to CMHA (which provides other services in the Ottawa area that are identified as facilitators of fidelity above), but the struggle to find a broad array of services was still highlighted by key informants. Even when services are available, key informants found it difficult to coordinate with other agencies, "because everybody has their own stats to be accountable for, so I don't feel like we are working as a system on this." As a result, making referrals to other agencies is sometimes difficult and limits fidelity in the array of available services. Indeed, this may reflect a broader system-level challenge to health care agencies trying to manage various and competing institutional demands (Scheid, 2008), which may impede development of a more efficient and integrated system of service delivery.

Organizational factors

Although key informants identified a strong programme commitment to Housing First philosophy as a facilitator of fidelity, on occasion it could also undermine fidelity. For instance, the Housing First values of client choice and client-driven services sometimes prolong the processes of finding housing for clients and engaging clients with treatment services. One key informant explained: "I think the delays [in finding housing] are really, for the most part, self-imposed by each client. It's where they're at, what they're working on, what they're willing to do."

Some operational procedures within the programme were described as interfering with programme fidelity. The programme has begun to shift toward discharging clients from services and accepting new clients without offering them a rent supplement, due at least in part to insufficient funding. This shift raised concerns among case managers, one of whom felt it represented the development of "a façade… We're still calling ourselves Housing First, when, are we really?" Because of this shift, case managers find that they need to advocate for their clients to stay in the programme rather than being discharged, to maintain client access to services. This advocacy has become the focus of some case managers' time spent in supervision, rather than focusing on clients' support needs, goals, and treatment planning.

Client input is also not well-supported by current operational procedures and this diminishes programme fidelity. According to key informants, clients are sometimes excluded from discussions about re-housing or discharge, no client advocacy groups or client committees have been established, peer support is not a component of the programme, and formal client grievance processes are not well-developed. One case manager remarked: "The formal grievance process? I don't know what that is. My clients don't know." However, client involvement and choice is valued in the Housing First model (Tsemberis, 2010), and the absence of some client feedback mechanisms at SHCHC is notable.

SHCHC's approach to supervision was identified by many key informants as a positive local adaptation used by their programme, however some of them also recognized that it is technically a barrier to the programme's fidelity. The supervision that case managers receive from the programme manager occurs during regular weekly team meetings and monthly one-on-one meetings, as well as additional phone, text, and email communications. A supervision tool is used to keep track of case managers' work with each client. Key informants generally described this approach as working well and expressed a preference for communicating as needed via technology, rather than frequently holding formal meetings to discuss client treatment planning in person. Key informants felt that this use of technology was a more modern, efficient, and effective approach to communicate, because they can obtain information about client issues faster, when needed, and without

requiring travel to the office for meetings that take time away from direct contact with clients. However, the formal Housing First fidelity assessment does not consider these kinds of communication strategies to be facilitators of fidelity (Gilmer *et al.*, 2013). Rather, the absence of more frequent in-person meetings is rated as low fidelity. Still, it represents a local adaptation from the Housing First model used and preferred by the SHCHC programme to meet less in person and communicate more often in a virtual fashion. It is unclear if this adaptation has affected the SHCHC programme's ability to assist clients to achieve goals beyond housing stability.

In terms of SHCHC's limited service array for Housing First clients, the programme makes various services available to clients, but still lacks important components like vocational support, peer support, and direct access to a psychiatrist. Reasons for this limited service array include: lack of funding; management priorities (e.g., favouring other services over peer specialists); team members' perceptions of client need (e.g., questioning whether clients are ready for vocational pursuits); difficulty filling positions (e.g., finding a psychiatrist to replace one who left the organization); and the size and stage of the programme's development (e.g., a relatively young and small programme working with complex clients).

Difficulty maintaining partnerships with landlords was also identified as a barrier to accessing housing for clients. Some landlords were described as reluctant to rent to Housing First clients, especially those with histories of evictions. Key informants stated that the programme should cover property damages caused by clients and should have a team member whose role is dedicated to cultivating relationships with landlords on a regular basis. One case manager explained that the programme has not done enough to maintain relationships with landlords and that programme fidelity has suffered as a result.

Individual factors

At the individual level, variability among SHCHC staff members' personal values and approach to practice was identified as negatively affecting programme fidelity. While staff members' individual approaches can foster fidelity, as explained above, others' individual approaches may undermine it. For instance, some key informants described how they have effectively used *quid pro quo* approaches in other settings and still use them when supporting clients at SHCHC. While they stated that *quid pro quo* is perhaps not a frequent or first-line approach, "we have this as a tool in our tool box" as needed, despite its misalignment with Housing First standards. Key informants also mentioned individual programme members' values, such as limited support for introducing peer support positions to the programme, as negatively affecting programme fidelity.

General discussion

The SHCHC Housing First programme

Various recommendations for the SHCHC Housing First programme to maintain and develop strong fidelity follow from these results. First, the partnership between SHCHC and CMHA is a unique local adaptation that helps concretize the separation of housing and services in the programme and provide clients with access to resources from both agencies. This valuable partnership should continue. Further, involving programme clients and individuals with lived experience of mental illness in Housing First is a core element of the model and should be introduced to the programme. Previous findings suggest that peer support services can enhance supports available to clients (Bean *et al.*, 2013; Mahlke *et al.*, 2014). A client advisory council or other mechanism for obtaining client feedback could increase client voice and input into guidance of the programme.

The programme's schedule of team meetings is less frequent than recommended for typical Housing First programmes. This adaptation increases time spent in the community in direct contact with clients, but it also decreases the team's opportunities to formally confer about client issues and treatment planning on a more regular basis. SHCHC staff may wish to continue using their alternative communication methods (e.g. texting and email), but should consider supplementing these with more frequent in-person meetings to ensure an appropriate amount of time is spent discussing client progress on a more frequent basis and in a more structured and consistent manner (Tsemberis, 2010). Overall, however, the SHCHC Housing First programme demonstrates a commendable level of high fidelity. Improvements should focus primarily on the areas of client voice, peer inclusion, supervision meetings, and team communication.

Housing First around the world

The current findings suggest recommendations for Housing First programmes around the globe. Most notable is the importance of rent supplements as a source of sustainable funding. Rent supplements are crucial for creating and maintaining Housing First programmes. At the same time, since these rent supplements are ideally provided to clients on an open-ended basis (and in some cases over the course of a lifetime), they limit the ability to fund a larger number of programme clients' housing over time. How to fund and manage Housing First programmes in light of this tension between lifetime supplements and assisting as many clients as possible is a challenge for many programmes and comes with a high risk of programme failure if not managed carefully (Nelson *et al.*, 2013; Busch-Geertsema, 2014).

The results also point to the relevance of stigma related to clients and Housing First programmes. While positive client and programme reputations can help reduce stigma, many Housing First programmes serve clients with complex

needs that can present real challenges for landlords. In these common scenarios, serving clients may not be enough; rather, Housing First programmes may need to foster relationships with landlords as well, support them when faced with tenant problems, and do their best to prevent landlord burnout. Results suggest that providing this kind of support might not only increase landlords' tolerance for Housing First clients, but also encourage them to rent more units to programme clients (Aubry *et al.*, 2015b).

Finally, partnerships with other organizations and services can bolster the success of Housing First programmes. The collaboration between SHCHC and CMHA provides for a structural separation of housing and services. It also provides a notable increase in service array that would otherwise be much more difficult to offer programme clients. This can serve as a partnership model for other Housing First programmes, particularly in regions such as Europe, where fidelity concerning the breadth and intensity of services available to clients is variable (Greenwood *et al.*, 2013). Further, promising research has indicated that programme clients with substance use problems may be able to retain housing under Housing First conditions (Busch-Geertsema, 2014). At the same time, many programme clients are still affected by problematic substance use even after being housed, suggesting that more substance use-related services would be valuable in these contexts (Cherner *et al.*, 2017). Particularly in an ICM-based Housing First programme, partnering with other organizations to offer these kinds of options can serve to further support clients (Tsemberis, 2010).

Conclusions

This article reported on a Housing First fidelity assessment in Ottawa, Canada. The results reflect a single case study in a mid-sized Canadian city and thus should not be overextended. Further, the results reflect the Canadian context in which Housing First programmes tend to rely on private market housing. Other regions can have distinct welfare systems and some, such as Scotland and Denmark, can rely more on social housing for programme clients (Aubry, 2014; Busch-Geertsema, 2014). Still, the results have notable implications for enhancing the fidelity and success of Housing First programmes both locally and globally. While various systemic, organizational, and individual factors can be facilitators or barriers to fidelity, it is possible for Housing First ventures like the SHCHC programme to adapt locally and maintain fidelity. This is particularly the case when Housing First programmes are provided with sustainable funding for rent supplements, when they support and foster relationships with landlords, and when they partner with other community organizations to enhance their capacity to support programme clients.

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Assessment of Fidelity to the Housing First Principles of the HÁBITAT Programme

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RAIS. Hogar SÍ

Abstract_*This article presents findings from a fidelity assessment of the Housing First Hábitat programme in Spain in its three initial sites, Madrid, Barcelona and Málaga. A fidelity self-assessment, qualitative interviews, and a focus group with key informants were conducted. Good fidelity was demonstrated in the Service Philosophy domain. Lower fidelity was observed in the Housing Process and Structure, Team Structure and Human Resources domains. Several barriers and facilitators to fidelity were identified. Barriers to clients' access to social and housing benefits and to community-based services were found at the systemic level. Lack of experience delivering Housing First and some aspects of the organizational culture were identified as barriers at the organizational level. Facilitators at the organizational level included the organization's vision and commitment of leaders and programme staff to the model. At the individual level, clients' and professionals' learning processes fostered adherence to the programme and facilitated adherence to Housing First principles. Implications of these findings for programme sustainment and fidelity are discussed, including lobbying activities to address systemic barriers, further separation of Housing and Support services, and support to team members.*

Keywords_ *Homelessness, housing first, Spain, fidelity assessment, implementation science*

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Introduction

The first Spanish Comprehensive National Strategy for the Homeless, approved by the Council of Ministers in November 2015, reported that there were approximately 33,275 homeless people in Spain. Approximately 23,000 of these individuals frequented the support services provided for homeless people, such as shelters and soup kitchens, while another 10,000 slept rough, according to night counts conducted in several municipalities across the country (MSSSI, 2016).

Historically, support services for the homeless population in Spain followed the *Continuum Linear Treatment* model (*CLT*). In this system, homeless people are offered a continuum of services beginning with low-threshold, emergency resources, progressing to more permanent housing and support services. Clients need to demonstrate their ability to meet increasing demands at the different steps in order to be considered "housing ready" (Nelson and Macleod, 2017).

The Spanish welfare system offers a wide array of public services to Spanish residents, including social, healthcare, education, and employment. Administratively, although the national ministries have input, the main responsibility for policy design and service provision is devolved to the 17 regions and to local governments. In practice, varying structures produce differences in access to public services across the different regions. The homeless services sector is composed mostly of small regional or local non-profit organizations. A few non-specialized state or multi-regional homeless organizations also operate in the country, such as the Red Cross, Caritas, and Saint John of God. Recently, several private companies were awarded tenders to deliver homeless services. RAIS, which runs the *Habitat* Housing First programme, is an exception in the sector because it is a specialized, private, state-level, non-religious, non-profit organization that has operated in the homelessness sector since 1998.

The main funding sources for homeless services in Spain, and in the social sector in general are: 1) regional or local tenders for the management of public services and 2) grants from several national, regional or local administrations. There is little philanthropic tradition in the country, although some private donors, corporate social responsibility schemes, and NGO members' fees provide some additional funding to some organizations. This funding structure is challenging for the sector because it is diverse (i.e., there are several small funders), unstable (i.e., grants have to be renewed annually), restricted in source (i.e., dependent mainly on public funding), and constricted (i.e., limited to the funding priorities and activities set by public authorities via calls of proposals). Dependence on public funding also limits organizations' lobbying and advocacy capacities because they have to do it

"against" their funders. Some umbrella organizations and networks have traditionally been key players in political dialogue, although the specific umbrella organization for homeless organizations in Spain dissolved in 2016 due to internal tensions.

All these elements have shaped homeless policies and services in Spain, which focus on managing homelessness instead of implementing the kinds of structural changes that could eventually end it. In general, homeless policies across Spain are still firmly rooted in paternalistic approaches that stem from the religious history of the social sector. Homeless services have traditionally addressed local emergency situations, provided for homeless people's basic needs, and followed a staircase approach (Alemán, 1993).

Social housing and some types of housing subsidies are available at the state, regional, and local levels. However, homelessness is not an eligibility criterion for these support schemes, so people in a homelessness situation are not entitled to any housing support if they do not also belong to another vulnerable group. Moreover, there are long waiting lists for social housing, and it can take years for a person in homelessness to receive social housing. Taken together, these factors make it very difficult for a Housing First programme to grant immediate access to housing for any client or to mobilize the finances needed to maintain their tenancies.

Introduction of the Housing First Model into the Spanish Context

Around 2012, some social organizations began to advocate for the introduction of the Housing First model into Spain (Uribe, 2016). RAIS established a dialogue with the Ministry for Health, Social Services and Equality at the state level, and with several regional and local administrations, with the objective to launch a Housing First programme that could demonstrate its effectiveness in the Spanish context.

The resulting Housing First service run by RAIS was called *Hábitat* and opened in 2014 in the cities of Madrid, Barcelona, and Málaga (Bernad *et al*., 2016a). *Hábitat* started with 28 housing units and one support team in each site. It was designed as a social experiment, as defined by the European Commission (EC, 2011), with a 24-month randomized trial evaluation, inspired by the successful outcomes of other Housing First demonstration programmes such as the *At home/Chez-soi* project in Canada (Goering *et al*., 2014), *Un chez-soi d'abord* project in France (DIHAL, 2017) and the *Housing First Europe* project (Busch-Geertsema, 2014). In 2018, more than 300 clients received housing and support services from *Hábitat* in several cities in the regions of Galicia, Asturias, Basque Country, Aragon, Catalonia, Comunidad Valenciana, Balearic Islands, Andalusia, Canary Island and Madrid. The launch of the *Hábitat* programme, combined with ongoing advocacy work of a few other key

organizations, sparked several regional administrations' interest in implementing the model, which resulted in the first public Housing First service in the country, *Primer la Llar,* which was opened by the municipality of Barcelona in 2015.

Increased public awareness about homelessness policies and the debate around Housing First impacted on policy making too. In late 2015, the Council of Ministers approved the first National Strategy on Homelessness, in which Housing First appeared as one of the strategic lines for service provision. However, the regional governments are not obligated to implement the national strategy, nor do they receive any national funding to pay for its implementation.

Since Housing First was only recently introduced in Spain, very little research based on Housing First local practices has been completed. University researchers who are external to the Housing First programmes are currently evaluating both the *Hábitat* and the *Primer la Llar* Housing First programmes. At the time of writing, only one article had been published on the *Hábitat* programme (Bernad *et al*., 2016b). Other preliminary outcomes of the *Hábitat* evaluation and findings of the fidelity assessment have been presented in international conferences in Madrid (Bernad, 2015, 2016c, 2016d, 2017). It is maybe worth noting that programme evaluation has never been one of the strengths of the Spanish social services system and, in fact, the introduction of Housing First in the country has brought a wider awareness of the need to generate evidence to inform policy-making processes.

In this context, RAIS identified the need to conduct a fidelity assessment of the *Hábitat* programme with the following objectives: 1) to encourage implementation of new Housing First Programs in Spain with high fidelity to Housing First principles, and 2) to identify and improve any areas of low model fidelity in the *Hábitat* programme. The fidelity assessment method proposed in the cross-country research allowed the identification of facilitators and barriers to programme fidelity at the systemic, organizational and individual levels (Aubry *et al*., 2018). RAIS considered this research framework useful for the advocacy on social services and housing policies (systemic level), programme management (organizational) and service delivery (individual level).

Method

RAIS followed the fidelity assessment method used by the programmes participating in the cross-country research project (Aubry *et al*., 2018). The assessment process was composed of the following steps: 1) translation and adaptation of the 36-item self-administered survey (Gilmer *et al*., 2013); 2) administration of the self-assessment survey and analysis of results; 3) interviews with key informants, 4) coding of qualitative interviews and 5) analysis of results. The methodology followed

in the cross-country fidelity project received ethical approval from the University of Ottawa (Aubry, *et al*, 2018). Specific local ethical approval was not sought for the present research because it is not required for research on the social services sector in Spain.

Description of the Habitat Programme and Clients

Hábitat targets individuals with histories of chronic homelessness with high support needs. Eligibility criteria are: 1) being 18 years old or older; 2) being in a roofless situation at programme entry (ETHOS categories 1 and 2; see FEANTSA, 2005); 3) having a significant history of homelessness (e.g., 3 years in ETHOS 1, 2 or 3; or more than 1 year in ETHOS 1 or 2); 4) having one or several of the following concurrent social exclusion factors: a mental health issue (whether diagnosed by a doctor or as assessed by the clients' social worker), a substance abuse problem and/or a physical disability. At the time of the fidelity assessment, 38 clients (80% men, 20% women) were enrolled in the programme. On average, clients of the *Hábitat* programme were 48.5 years old and had been homeless 9.5 years. Most (72%) had a substance use problem; a smaller proportion had a mental health issue (40%) or a physical disability (29%).

Clients are referred to the *Hábitat* programme by local organizations that provide outreach or emergency services for people experiencing homelessness. An experimental group (its size is determined by the number of houses available in each city) and a control group (double the size of the experimental group) are constituted through a random assignment among all the referred cases which meet the inclusion criteria. The only requirements for clients to keep their housing and social support are: 1) accept at least one weekly visit by the HF team; 2) pay 30% of their income toward rent (if the person has no income, the programme will cover rent and basic needs such as utilities, food, and hygiene); 3) adhere to basic social norms in the neighbourhood; and 4) complete an evaluation interview every 6 months for two years.

Clients in *Hábitat* receive independent, scattered-site housing rented from the public or private housing market, depending on availability and on agreements with regional and local administrations. Support team configuration is based on the ICM model. Most team members are social workers, who link clients to the community-based services they need. Due to the lack of specialized housing associations and the structure of the organization, the support teams were originally in charge of both housing and support services. An alliance with the specialized housing association *Provivienda* was established in 2016 to create stronger separation of housing and services. The housing outcomes for the initial group of clients, who accessed the programme between 2014 and 2015, showed that 100% of participants (n = 38) were housed in the programme on a regular basis for the past 24 months. Two

relocations occurred during that period; two people died; and one programme user moved into a rented room after 12 months but continued to receive support from the Housing First programme.

Initially, some people waited up to four months for housing after being told they were selected for the programme, which caused frustration and mistrust. Today, clients are not told they are accepted to the programme until one or several housing units are available. Usually, move-in occurs two weeks after clients are told they have been accepted onto the programme.

The fidelity self assessment

Procedure and Sample. The self-assessment survey was first translated from English to Spanish independently by four different native Spanish speakers with knowledge of the homeless sector. The translators compared and discussed the four Spanish versions at a conciliation meeting and agreed on a final version that best reflected the configuration of the Spanish welfare system and services. Discussions with Prof. Aubry and Prof. Greenwood, coordinators of the cross-country fidelity research and with the fidelity research teams which translated the survey into other European languages, and a pilot administration to two programme staff members contributed to the development of the final version of the survey. The Spanish-language version of the survey was shared with the research group and is available on demand by any individual or organization.

The survey was administered in the initial sites of the programme: Madrid in March 2016, and in October 2016 in Barcelona and Málaga. Each team member and site coordinator completed the assessment individually (Madrid n = 4; Barcelona n =3; Málaga n = 2). Staff conciliation meetings facilitated by the research team were held independently in Madrid (April 2016), Barcelona, and Málaga (October 2016). In these meetings, an item-by-item review was conducted, and participants discussed differences in item ratings until a consensus was agreed and taken as the final rating for the item.

Data Analysis. Following the conciliation meetings, the item ratings were summed up to produce a score for each Housing First domain and a total fidelity score for each of the three sites independently. All the item ratings were converted to a 4-point scale following the more recent developments of the self-assessment methodology (Macnaughton *et al*., 2015) and an average score for the three sites was calculated. Scores of 3.5 or higher on an item or domain indicate a high level of fidelity while scores below 3.0 are interpreted as reflecting a low level of fidelity.

The key informant interviews

Procedure and Sample. A focus group with key informants (n=3) and an individual interview (n=1) were conducted for qualitative assessment of the Madrid site in June 2016. For the Barcelona and Malaga sites, individual interviews were conducted with key informants (n = 6) either in person or by video-conference between December 2016 and January 2017. Key informants were selected to represent a range of roles within the organization and the Housing First programme.

The scores per item and per domain for each site were sent to all key informants two weeks before the sessions. In the interviews and focus groups, which were audio-recorded, the researcher followed the structured guide to discuss the scores provided by the cross-country research coordinators (Aubry *et al*., 2017). Conversations explored factors identified as facilitators or barriers to programme fidelity.

Data Analysis. Following the procedures agreed for the cross-country project (Aubry *et al*., 2018), the interview and focus group data were coded by the main researcher into two basic categories: 1) factors acting as facilitators or barriers and 2) factors at the systemic, organizational or individual level (Nelson *et al*., 2014). This coding was then checked by two evaluation officers with knowledge of the *Hábitat* programme.

Results of the Assessment

Findings of the fidelity assessment

The quantitative findings from the self-assessment survey showed a moderate to high programme fidelity to the Housing First model. As seen in Table 1, moderate fidelity was observed in the domains of *Housing Process and Structure*; *Service Array*; and *Team Structure and Human Resources*. Lower scores in these domains included limited choice of clients in housing and decoration; barriers to housing subsidies; lack of a regular tenancy agreement and limited separation of housing and services; lack of peer support workers, poor support provided or lack of public services in some areas; lack of time in coordination meetings; and low client participation.

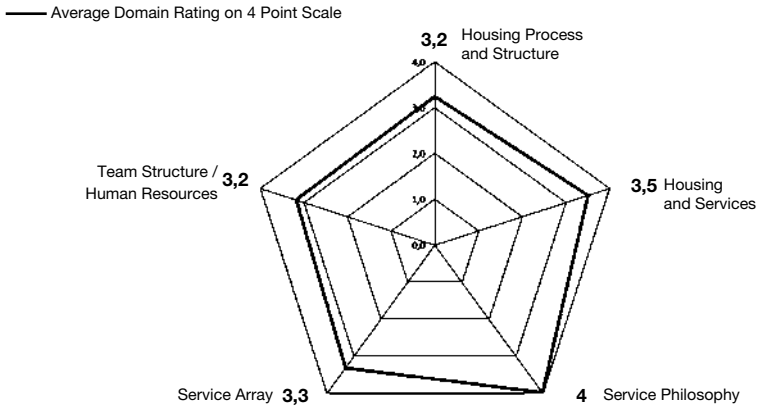
Table 1. Fidelity Assessment Item Scores and Domain Means Per Site and Average

Domain / Item	Domain Mean / Standard Item Score (Out of 4)			
	Madrid	Barcelona	Málaga	Mean 3 sites
Housing Process and Structure	***4.0***	***3.1***	***2.6***	***3.2***
1. Choice of housing	*4.0*	*3.0*	*2.0*	*3.0*
2. Choice of neighbourhood	*4.0*	*3.0*	*2.0*	*3.0*
3. Assistance with furniture	*4.0*	*4.0*	*4.0*	*4.0*
4. Affordable housing with subsidies	*4.0*	*1.0*	*2.0*	*2.3*
5. Proportion of income required for rent	*4.0*	*3.0*	*1.0*	*2.7*
6. Time from enrolment to housing	*4.0*	*4.0*	*4.0*	*4.0*
7. Types of housing	*4.0*	*4.0*	*3.0*	*3.7*
Separation of Housing and Services	***3.1***	***3.1***	***3.7***	***3.5***
8. Proportion of clients with shared bedrooms	*4.0*	*4.0*	*4.0*	*4.0*
9. Requirements to gain access to housing	*4.0*	*4.0*	*4.0*	*4.0*
10. Requirements to stay in housing	*4.0*	*4.0*	*4.0*	*4.0*
11a. Lease or occupancy agreement	*4.0*	*2.0*	*4.0*	*3.3*
11b. Provisions in the lease or agreement	*2.7*	*4.0*	*4.0*	*3.6*
12. Effect of losing housing on client housing support	*2.0*	*4.0*	*2.0*	*2.7*
13. Effect of losing housing on other client services	*1.0*	*4.0*	*4.0*	*3.0*
Service Philosophy	***3.9***	***4.0***	***4.0***	***4.0***
14. Choice of services	*4.0*	*4.0*	*4.0*	*4.0*
15. Requirements for serious mental illness treatment	*4.0*	*4.0*	*4.0*	*4.0*
16. Requirements for substance use treatment	*4.0*	*4.0*	*4.0*	*4.0*
17. Approach to client substance use	*4.0*	*4.0*	*4.0*	*4.0*
18. Promoting adherence to treatment plans	*4.0*	*4.0*	*4.0*	*4.0*
19. Elements of treatment plan and follow-up	*3.6*	*4.0*	*4.0*	*3.9*
20. Life areas addressed with programme interventions	*4.0*	*4.0*	*4.0*	*4.0*
Service Array	***3.5***	***3.5***	***3.0***	***3.3***
21. Maintaining housing	*3.0*	*3.0*	*3.0*	*3.0*
22. Psychiatric services	*4.0*	*4.0*	*4.0*	*4.0*
23. Substance use treatment	*4.0*	*3.2*	*2.4*	*3.2*
24. Paid employment opportunities	*4.0*	*4.0*	*4.0*	*4.0*
25. Education services	*3.2*	*4.0*	*3.2*	*3.5*
26. Volunteer opportunities	*4.0*	*4.0*	*4.0*	*4.0*
27. Physical health treatment	*4.0*	*4.0*	*2.4*	*3.5*
28. Paid peer specialist on staff	*1.0*	*1.0*	*1.0*	*1.0*
29a. Social integration services	*4.0*	*4.0*	*3.2*	*3.7*
Programme Structure	***3.3***	***3.2***	***3.0***	***3.2***
31. Client background	*2.7*	*3.3*	*2.7*	*2.9*
33. Staff-to-client ratio	*4.0*	*4.0*	*4.0*	*4.0*
34b. Frequency of face-to-face contacts per month	*4.0*	*4.0*	*4.0*	*4.0*
35. Frequency of staff meetings to review services	*4.0*	*4.0*	*4.0*	*4.0*
36. Team meeting components	*3.3*	*2.7*	*2.0*	*2.7*
37. Opportunity for client input about the programme	*2.0*	*1.3*	*1.3*	*1.6*
Total	***3.6***	***3.5***	***3.3***	**3.4**

High levels of fidelity (scoring 3.5 points or more on a 4-point scale) were found on 61% of the items while moderate (3.0 to 3.4) or low levels of fidelity (below 3.0) were found on 39% of the items. As illustrated in Figure 1, the five Housing First domains varied in their average fidelity scores, with the highest average scores being 4.0 for *Service Philosophy* and 3.5 for *Separation of Housing and Services*. The scores for the other three domains were 3.3 for *Service Array* and 3.2 for both the *Housing Process and Structure* and the *Team Structure/Human resources* domains.

Some variation in scoring was observed across sites, and the difference between the *Housing Process and Structure* scores in Madrid and Malaga is especially notable. The discussions in the consensus meetings suggested that participants in Madrid, whose office was in the RAIS headquarters building, answered those items with greater understanding of systemic barriers due to their knowledge of programmes' operations. Both the Madrid and Malaga teams identified similar barriers to *Housing Process and Structure*, but the Madrid team seemed to have greater insight into the challenges the organization faced in implementing the model. The Malaga team identified more barriers related to migrants' access to social or housing rights.

Figure 1. Average Housing First Fidelity Ratings by Domain (Mean rating calculated for the 3 sites)



The consensus meetings conducted during the self-assessment phase and the focus group and interviews during the qualitative assessment allowed the identification of barriers and facilitators for the fidelity of *Hábitat* to the original Housing First model as well as some key elements of the programme that have an impact on clients' recovery outcomes.

Findings from the key informants' sessions

Systemic facilitators and barriers

At a general level, political and social momentum in the years prior to the launch of the *Hábitat* programme facilitated the implementation. The emergence of two new parties in the political arena, combined with a strong social awareness about housing issues resulting from numerous high-profile evictions, fostered political openness to new solutions to homelessness. The visibility of the evictions crisis in the media and the rise of several relevant political figures linked to anti-eviction social movements around the country drew the media's attention to the issue of homelessness and to the *Hábitat* programme. All of these factors indirectly facilitated the programme's operations. For example, the municipality of Madrid sourced social housing units with the required characteristics to be allocated to the programme. Some professionals from community-based services developed an interest in the Housing First principles and began to collaborate with the programme teams.

Political forces and dependence on public funding are challenges to programme sustainability for many social services in Spain. *Hábitat* depends mainly on different public sources of funding or public housing entities, through grants or agreements, which must be renewed yearly in most cases, and are subject to political whims and pressures. As one of the site coordinators put it: "… the strategy is that the municipality progressively assumes the cost of the programme over time, and although we had their commitment two years ago, the fact is that they are not assuming it".

In all three sites, some of these pressures came from other organizations in the homelessness sector, which have advocated against RAIS or against the Housing First model in a fight to maintain the sector *status quo* and retain their funding. A key informant noted: "We cannot burst into this city saying: 'we are bringing in something better that what you have been doing, so give me money for that'", while another said: "There is not a culture of evaluation in the sector. If a City Council says: "this (Habitat's evaluation) is what should be done", they would be losing votes". These elements put constant pressure on the programme to ensure that the service will not be interrupted, and that risk management adopted by RAIS will not affect the recovery processes of clients.

Housing First's innovativeness and principles were identified as key motivations for adherence to the programme and commitment to the recovery process for clients and professionals. The sense of being offered a service completely different to the one traditionally delivered, in which clients are the main actors in their recovery process, was perceived as essential to the commitment of the service users to the service and to establish a trusting relationship with the intervention team. One key

stakeholder expressed it this way: “There is a great motivational element in this (programme). People can access a home for themselves, which you tell them is not limited in time, and that they have to accept very basic commitments for that”. On the professional side, team members felt motivated by being part of an innovative programme and felt more comfortable with a Housing First intervention approach over traditional services.

Key informants expressed that both the public and private social housing markets provide facilitating elements for programme adherence and recovery processes, but they also pose some barriers to programme implementation and for clients’ recovery. As in most of the European countries in which the Housing First model has been introduced, the housing market in Spain is tight and housing policies do not assure the right to housing in practice. This is, in fact, one of the main structural challenges for the *Hábitat* programme and for any other Housing First programme in Spain.

In terms of housing costs, one key informant said: “in many cases, the clients’ 30% income contribution would not even cover half of the rental, so their graduation from the programme seems unrealistic”. The public housing market is cheaper than the private housing market. For example, the average monthly rent in Madrid for social housing was around €200, compared to an average of €520 per month in the private market (Fotocasa, 2015), which in many cases can make the difference between clients being able to cover the monthly rent or not.

Professionals in the Madrid focus group also mentioned that landlords in the public market often have an altruistic attitude towards tenants and, therefore, they are usually more committed to clients’ recovery and more collaborative when difficulties arise. This also appeared as a barrier in some cases, since public housing landlords would be used to intervening in the recovery processes and would do it from a more traditional, “patronizing” approach, having difficulties in respecting clients’ own processes. One key informant noted: “… [the local social housing agency] will call you and tell you: “You must intervene in this situation”, while we think we shouldn’t”.

In contrast, sourcing houses in the private market may facilitate clients’ choice about neighbourhood and features of their home such as size and configuration. Dwellings in the public market tend to be larger and to be in neighbourhoods with a larger concentration of people experiencing social exclusion. One key informant said: “[the local social housing agency] provided the first units available, and although we tried, it was not possible to negotiate [some of the features of the apartments]”.

Barriers for access to social housing, support services, and social benefits were identified in all sites, especially in the case of migrants, who would not be entitled to those benefits. As one key informant noted: "The good thing is that services exist in the communities; the problem comes because clients have barriers to access them. A house is the first facilitator, since people can register there, and that would entitle them to access services. But this doesn't work for people in an irregular situation".

Access to social housing was especially challenging for homeless people in Barcelona and Málaga, since they are not an identified priority group in terms of the eligibility criteria for social welfare. As one key informant noted: "there is social housing available, but homelessness is not an access criterion, so clients wouldn't qualify for it". The sometimes challenging and long administrative processes to access social benefits or social housing were also identified as negatively affecting programme sustainability, client choice, and their commitment to the recovery process.

The Spanish welfare system offers a wide array of public services which, according to several key informants, adequately address their clients' support needs. The choice to broker existing public services was a strategic decision taken in the design of the programme, which was motivated mainly by the will to: 1) optimize the HF model so that it would not duplicate existing services, and 2) promote normalized use of the public services by *Hábitat* clients as another community integration tool. As a key informant from the management level stated, "the aim of the programme is to grant Hábitat clients with exactly the same access to services as the rest of the population would have". As in other European countries with similar welfare systems, ICM configuration of intervention teams was chosen in order to create and capitalize on links with existing public services networks (Busch-Geertsema, 2014).

However, the configuration of public services in Spain also created barriers to programme fidelity. Regional governments have control over social, health, education or employment services in Spain. This results in (sometimes wide) differences in the support services available to *Hábitat* clients in different regions. For example, the quality of mental health services provided in the different sites varied from good to poor. As stated by one staff member: "the support services exist in the community; now, the quality of those services is something different…". Some health and social services needed by *Hábitat* clients would be not sufficiently covered or not covered at all by the Spanish welfare system, such as dentistry or specific community integration services.

The current configuration of the system for social support to people experiencing homelessness may hinder the *Separation of Housing and Services*, since municipalities' outreach teams or emergency services are officially responsible for providing support to people experiencing homelessness who are not enrolled in any type of housing support service. As one key informant noted: "nowadays, the provision of social support to homeless people (not linked to any type of accommodation) is the exclusive responsibility of the local social services". This would imply that clients losing their home would be obliged to receive social support from those local services, not by the *Hábitat* programme.

The international Housing First community developed from European and North American programmes has facilitated Housing First fidelity in the *Hábitat* programme. As one key informant put it: "Being able to discuss the way we did things with people with longer experience with the model validated certain aspects of how we were doing things and guided us in confronting others".

Table 2. Summary of Systemic Facilitators and Barriers for Achieving Housing First Fidelity

Facilitators	Barriers
Political momentum open to new ideas and social awareness on evictions crisis	Regional distribution of competencies for delivering social, health, education and employment services in Spain
Inherent innovation of the HF model as a motivator for users and professionals	Programme dependence on political whims
Both public and private housing have (different) positive elements	Weakness of funding structure and sources of the social sector and services
Spanish welfare system provides a wide array of services and social/housing benefits	Opposition from some organizations within the homelessness sector
Learnings and relations with international community; HF momentum in Europe.	Availability and affordability of housing
	Existing barriers for access to social benefits and public services and unstable social benefits
	Non-existing or non-adequately covered services by the public networks

Organizational facilitators and barriers

Several elements linked to the lack of previous implementation experience with Housing First were mentioned as challenges to the Housing First model fidelity. Some strategic decisions were taken to mitigate possible barriers to implementation in the first stages of the programme, which limited model fidelity on some dimensions such as inclusion of peer support workers. For example, although including peer workers on the team was seen as a valuable element in the recovery process of clients, their inclusion was postponed so that potential management

challenges were avoided. As one key stakeholder expressed it: "the launch of the Hábitat programme was difficult enough to add another challenge such as the integration of a peer worker in a team of two people".

Risk management and an insufficient number of individual housing subsidies were reasons for the decision for RAIS to serve as the lessee on clients' housing units. In a tight and competitive housing market, it is difficult to convince private landlords to sign a contract with a homeless person with high support needs. The administrative procedures for social housing allocation are protracted and make it difficult for clients to access social housing units. As one team member explained the functioning of the local benefits: "it would usually take up to nine months for someone to start receiving social benefits, and they would receive them for a maximum period of one and a half years. Then he/she would have to apply again, so there would be another nine months with no income at all".

Lack of experience delivering a Housing First service led to some misinterpretations of the model and omissions in the design of the *Hábitat* programme. Unlike the rest of the services in RAIS, the intervention procedures for *Hábitat* stated that clients' goals were not to be set forth in writing. The reason for this was that "we wanted to make it clear that this was a radically different programme where clients had total control over the service, and it should not resemble anything of what we did before". After an initial period of time, the team realized that this decision created problems in the *Service Philosophy* domain, since it created too much subjectivity in what it meant to respect clients' choices. The intervention procedures were revised so that service providers began to record clients' goals.

Similarly, one key informant described how unfamiliarity with the programme led to practices that deviated from the model in *Separation of Housing and Services* domain. For example, after 12 months, a service user expressed the intention to leave his home for a rented room that was not covered by the programme, yet he wanted to continue receiving social supports from *Hábitat*. That would add a new client to the service, who would use the empty house, but early exits from the programme had not been anticipated by the programme developers, and therefore, they had not budgeted the provision of supports outside a housing unit. As one of the informants with technical responsibility expressed it: "we did not expect that we were asked to provide social support once a client left the house provided by the programme".

Key informants identified some core organizational elements that played an essential role in preventing programme drift from the original Housing First model. First, RAIS' traditional vision and system of values aligned closely with the Housing First person-centred, rights- and recovery-based approach. As a key informant expressed it: "The Housing First values were already in the organization before even

learning about the existence of Housing First". Consequently, there was a clear commitment of the RAIS Board to the Housing First model and to implementation of the *Hábitat* programme, which cascaded down through the different leadership levels in the organization. Leaders were actively involved in relevant processes of the programme. As one key informant recalled: "We had a situation of domestic violence with one of the clients. The City Council asked us to immediately expel the client from the service, and it was the General Director who answered and claimed that the client was not to be judged by the programme, but that he should be sued and respond to legal consequences".

Resulting from this multilevel engagement, several informants remarked on the importance of Housing First principles throughout the whole project cycle (programme design, resourcing, delivery and evaluation). This was a facilitator to fidelity in the *Service Philosophy* domain. As one key informant noted: "whenever we found unsolved challenges, we would go to the principles in Sam's [Tsemberis, 2010] book to find the solution". The programme design was based on making the Housing First principles operate efficiently in the Spanish context, with close observation of model principles, while also flexibly adjusting to the Spanish welfare system, funding sources, and culture. Staff members explained how teams faced fewer challenges to service delivery in areas where interpretation of the Housing First principles had been easier, since there were clearer responses to those challenges.

Informants also identified some barriers to programme fidelity in the organization's culture, especially regarding client participation in programme governance, hindering higher fidelity of the *Programme Structure* domain. One key informant said: "Is client participation in *Habitat* different to the participation in other RAIS' programs? No. Is it something we should address? My opinion is that we should. But this decision should be probably taken by the Board of Directors or the Board of Trustees". Although as one key informant said: "this is not an issue for this programme, but (…) a usual thing within the social sector in Spain".

A specific independent structure for the *Hábitat* programme that depends on a national technical coordination was a key facilitator for *Service Philosophy*. This structure provided *Hábitat* with a development framework separate from other services that are based on a staircase model, which are also managed by RAIS. As one key informant said: "the existence of a global technical figure has been important to ensure a coordinated intervention, with respect to the model, training…". Training sessions and inter-territorial meetings held twice a year were also introduced to improve programme staff understanding and application of Housing First principles and philosophy.

Nevertheless, the territorial structure and the deployment of the programme across geographical distances created some challenges to Housing First fidelity, especially for the domains of *Housing Process and Structure* and *Separation of Housing and Services*. As a key informant put it: "Had we have had the possibility of having 80 clients per site, the client choice options would have been much higher". Some of these challenges came from within the organization, from technical staff in other services or site coordinators who were reluctant to implement the programme, fearing that Hábitat would take over the existing services and professionals.

The small size of the programme in each site, which was determined by political support and the resources that RAIS managed to obtain, hindered clients' capacity to choose the neighbourhood and house where they will live. As one key informant expressed it: "We only had 10 houses, so the first client could choose amongst those 10 units, but the last client necessarily had to take the one left". The programme funding structure also limited the control and election options of clients over the furbishing and decoration of their homes and affected the *Housing Process and Structure domain*.

The small size of the teams in each site and limited resources also implied that the task of sourcing and managing the housing units was assigned to the ICM teams members. This generated an extra burden for members of staff who didn't have competencies in these areas. It also put strain on client-staff relationships, since the same person that provided the support was also the one who came to talk about housing issues. This was seen as an obstacle for a higher fidelity on the *Separation of Housing and Services* and the *Service Array* domains. A key informant said: "we definitely realized that we needed to introduce the figures of good cop and bad cop, assumed by site coordinators, when clients were breaching commitments. This may affect the intervention, but still it is the best way I can think of to do it".

The small size of the teams also implied that the professional working in the smallest site shared her time with other RAIS' services operating with a staircase model approach. When discussing that situation, key informants expressed an added difficulty to quickly take up the Housing First approach, with comments such as: "it is not the same to have to work part-time in an emergency center and part-time in the Habitat programme than having exclusive dedication for Habitat. (…) That generates some bipolarities in the staff that affect their capacity to have the HF model in mind".

The lack of mental health professionals on the ICM teams was mentioned by several informants as a barrier to an adequate service delivery in that area. They described how difficult it was for team members to manage clients' mental health crises and how difficult it was to access public mental health services. As discussed in the

section on systemic facilitators and barriers, the provision of mental health services through the community was a conscious decision of the programme to promote integration. To address the gap, a technical coordinator with expertise in mental health services was hired to provide supervision and support to service professionals in that field.

Team members also mentioned that there was insufficient time for case review during the weekly meetings. As one of them expressed it: “Coordination meetings become very long because there are a lot of cases. Therefore, we have to focus on the crisis and we don’t have the time in the end to discuss prevention or less urgent cases”. To improve this, specific intervention tools have been developed to increase the efficiency of weekly team meetings by structuring the agenda and share case information before the discussions.

When the programme launched, RAIS operated other services different from the *Hábitat* programme and had offices in two of the three programme sites, so the team members had other colleagues from the organization on-site. Today, RAIS operates other services only in approximately half of the sites where Housing First is implemented, so some of the teams have no direct contact with the organization on a regular basis. Team members working in sites where RAIS does not operate expressed a greater sense of solitude and a stronger sense that clients identify individual team members with the whole organization. As one team member put it: “A sense of solitude in professionals is inevitable given the structure of the programme”; “We are the same as RAIS and *Hábitat* for them (the clients). We are the only real thing they see from the organization”.

Team members described this situation as emotionally challenging and affecting their relationships with clients, therefore hindering fidelity on the *Team Structure and Human Resources* domain. Some of these team members felt “abandoned” by the organization, which combined with the high emotional demands of the intervention, may lead to staff burnout. These feelings may also help to explain opposing views regarding care of the team: Some team members complained of “a lack of training and good working conditions. Salaries are higher in other similar services”, whereas others noted that “the organization has made a greater investment in the professionals of Hábitat than that we could afford on other services”.

Several key informants identified procedural changes that were introduced to mitigate structural limitations. For example, to increase choice in housing, team members now show clients a dossier of available homes before visiting the apartments or visit the different neighbourhoods so that clients can make informed choices. It is important to note that, while participants in management roles focused on mitigating factors at the organizational level, intervention team members identi-

fied them mostly at the individual level (e.g., competencies and personal characteristics). In any case, it was clear that, for all informants, the organization strives to mitigate effects of these structural factors on model fidelity.

Some staffing and human resources elements were identified as facilitators of programme fidelity and clients' recovery. Several key informants noted that the programme's staff selection process was very effective. Staff competencies, skills and personal characteristics such as resilience, flexibility and empathy were mentioned as key factors that facilitated fidelity to Housing First principles. As one key informant with managing functions said: "the competences and the motivation of the service professionals has been key elements for the launch of the programme. It is important to have staff with good technical competences and experience but who are open to reset how they apply them". Again, the international element appeared to facilitate programme fidelity. Several informants mentioned the involvement of the organization in the Housing First international community as a facilitator of Housing First fidelity and a source of motivation for team members.

Table 3. Summary of Organizational Facilitators and Barriers for Achieving Housing First Fidelity

Facilitators	Barriers
Vision and values aligned with HF principles	No previous experience or reference to HF implementation in the country
Commitment to and observation of HF principles	Pressure on programme to demonstrate the validity of the HF model in Spain
Commitment of leaders to programme	Limitations of the organizational structure and disruption of and independent programme structure
Independent structure for the HF programme within the organization with an own technical coordination	Internal concerns with the model or its deployment within the organization
Attention to learnings and measures to mitigate structural limitations	Structure and size of the programme (small teams scattered in several sites across Spain)
Good profiling and selection of staff	Sense of solitude and lack of organizational care in professionals
Good competencies and personal abilities of professionals	Lack of some specific competencies within the team structure (housing, mental health)
Cohesion and training measures	
Investment in relations with external agents (networks, media, international community)	

Individual facilitators and barriers

Different facets of disruption caused by the Housing First model itself linked to most of the facilitators and barriers for programme fidelity and for the recovery process at the individual level. Regarding clients' factors, several informants mentioned that clients' understanding of choice and control over the service was a key facilitator

for recovery. In many cases, initial client mistrust was transformed into engagement with team members. Based on their experiences of traditional services, new clients worried they would be expelled from the programme if the team members found out they used drugs or alcohol, got involved in a fight, or had issues with the police.

When clients began to understand that these activities would not get them expelled from the programme, both their relationship with the service and their own recovery process improved. However, after some time in the programme, some clients began to get annoyed by visits from team members. Key informants quoted clients saying: "This cannot be forever, I am starting to get tired of these visits" and "Since I do not have to report you on anything I wouldn't like to, I am not telling you not to come, but… why do you come?" Several key informants also mentioned that clients who did not have an income and did not contribute towards the programme felt less engaged with their homes and with the programme. In contrast, those who were further along in their recovery processes took on peer support roles with other clients.

Service professionals' adaptation to the Housing First model was also identified as relevant to programme fidelity. One site manager said that professionals "felt more comfortable with the new intervention approach", which probably helped align the service with the original model. At the same time, it was difficult for some team members to manage several emotional aspects of delivering the new programme, such as the need to be flexible and resilient. One team member noted, "It is difficult to manage when you have been up until 6am because your client's mother died and then you have to get up at 8am because you have an appointment with another client". Others felt they lost professional skills, competencies, and values in the client-oriented context of Housing First. One person described relationships as blurred, "the line between personal and professional in this programme is weak, and that is emotionally exhausting".

Informants also mentioned difficulties with the Housing First approach in interactions with professionals from other services, such as those who referred clients to the programme. These professionals had difficulties in understanding the model, with questions such as: "Well, then if there are no requirements for clients, what will you do with them?" In cases where external services did not accurately explain Housing First to new clients, it affected clients' perception of the *Separation of Housing and Services*. Professionals from community services such as health, addictions, and employment were reluctant to respect clients' choice in services, such as a family doctor who refused to provide medication to clients who were not abstinent.

Key informants described the leadership style as flexible, and empathic, and thus contributing to team cohesiveness. They said they regularly share their views and daily learnings with other colleagues and have discussions about the work they do and how they do it, which fostered shared belief in the model, as expressed by one team member: "I truly believe the model works". Combined with the team cohesion, the personal commitment and competencies of programme staff also facilitated management of complicated and emotionally difficult situations. As one of the team members put it: "this is all about respecting the clients' processes, and impatience and frustration come easily, and some personal skills have been essential to maintaining an adequate response".[1]

Table 4. Summary of Individual Facilitators and Barriers for Achieving Housing First Fidelity

Facilitators	Barriers
Users learning process on election and control of the service	Difficulties in users in understanding this new approach (mistrust)
Individual leaderships of some staff and team cohesion	Professionals' difficulties with the HF approach (feeling of losing competencies, emotionally demanding and requiring resilience and flexibility)
Staff commitment with users and shared belief in the HF model	Professionals' difficulties with external services and networks with the HF approach
	Administrative issues in some service users hampering income and bonding to house

Discussion

The fidelity assessment findings seem to reflect the programme's early stage of implementation and are more closely linked to elements related to design and implementation rather than to client outcomes, as seen in other studies (Nelson *et al*., 2014; Macnaughton *et al*., 2015). These findings highlight some actions that the *Hábitat* programme can take to promote and maintain model fidelity. First, some action to remove barriers to benefits and social housing is needed. Lobbying actions directed toward improving the welfare system may be important to removing these barriers. Second, further developing the separation of housing and services

[1] Other external elements at the individual level were mentioned as facilitators to the recovery process. For example, some neighbours developed helping relationships with clients, which facilitated their recovery process. In some cases, service professionals had to advocate on their clients' behalf to help their new neighbours overcome their prejudices. Clients' community integration has also been facilitated by having pets that they take to the park, where they meet other members of the community. As one key informant noted: "That thing with dogs is incredible. There are two clients in Madrid for which the dogs have been key facilitators to building relations within the community".

through the alliance with *Asociación Provivienda* would facilitate higher fidelity in the *Housing Process and Structure*, *Separation of Housing and Services* and *Service Array* domains. Third, actions aimed at supporting the small intervention teams scattered across the Spanish geography and that foster greater technical cohesion would facilitate higher fidelity in the *Programme Structure* domain and help maintain a high fidelity in the *Service Philosophy* domain.

As in other European implementations of Housing First, this grassroots implementation of a "disruptive" model faced many obstacles at the systemic level (Lancione *et al*., 2017). Systemic barriers to programme fidelity included housing policies that would not prioritize homeless people's access to benefits, unstable funding schemes, and barriers to accessing public services and social benefits.

Challenges at the organizational level came mainly from the disruption generated by the introduction of a radically different intervention approach within the organization. This resulted in a learning-by-doing process of the service design and implementation in which some mistakes were made, and some successes were achieved. The Housing First principles played an essential role in guiding the organization towards an effective programme implementation. Most adaptations were related to the configuration of services and social benefits available in the Spanish welfare system. The key informants' general perceptions were that these adaptations did not undermine *Hábitat* programme's capacity to adhere to key principles, a finding consistent with previous research (Pleace and Bretherton, 2013).

Few facilitators of fidelity were found at the systemic level. The Housing First model's innovative character was mentioned as an essential motivational factor for clients, professionals, and for the organization. Motivation fostered engagement and commitment of the different players with the programme and with the clients' recovery processes. At the organizational level, values and leadership contributed to fidelity and facilitated effective responses to challenges in ways that accorded with Housing First principles. At the individual level, commitment of the service professionals to the model, and the learning processes of both the clients and the staff facilitated model fidelity and helped staff members overcome systemic and organizational difficulties.

The *Hábitat* programme experienced barriers and facilitators to programme fidelity similar to those found in other fidelity assessments (Greenwood *et al*., 2013; Macnaughton *et al*., 2015; Lancione *et al*., 2017). As in these other studies, *Hábitat* reported a high housing retention rate and increased levels of quality of life for its clients (Bernad *et al*., 2016b). The findings of this study would indicate that Housing First works even when adapted to different political and social systems, as long as the model's key principles are adhered to.

Some systemic barriers identified in the fidelity assessment invite us to consider whether systems need to change for Housing First implementations to work in new contexts. For example, the obstacles that RAIS encountered in obtaining housing for its clients were caused by not only by a lack of affordable housing, but also by structural and policy barriers which, if transformed, could redress the housing crisis in Spain.

Limitations

Some issues in the survey translation and adaptation process may have affected the results of the fidelity self-assessment. Most of these issues arose from difficulties in identifying Spanish equivalence to North American terms, such as "promising practice", "supported education in the community," and some language used to describe housing subsidies. Solutions were identified through discussion with the research coordinators. Challenges to interpretation also arose in the conciliation meetings, especially in regard to colloquialisms such as 'quid pro quo'. These challenges were reconciled by the facilitator, who defined and explained the English colloquialisms to participants. Some participants from the intervention teams expressed concerns that the survey did not adequately capture the nuances of their daily work.

Despite these methodological challenges, the assessment process was a valuable opportunity for the organization to reflect on programme fidelity and to identify systemic, organizational and individual factors that affected programme implementation and clients' recovery experiences. The use of a common assessment methodology and instruments in this research has sparked discussions among different international programmes and will advance our understanding of the different adaptations of the Housing First model across Europe. At this early introduction stage, the possibility of benchmarking the *Hábitat* programme with other European implementations has been very useful for identifying contextual features that affect fidelity and client outcomes.

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What Helps and What Hinders Program Fidelity to Housing First: Pathways to Housing DC

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Abstract_*Homelessness continues to be a pressing concern across the United States. On a given night, 564,708 people are either sleeping outside, in an emergency shelter, or in a transitional housing bed (National Alliance to End Homelessness, 2016). The Pathways Housing First model, which combines immediate access to permanent housing with community-based support, has gained recognition as an effective approach to ending homelessness for individuals with complex needs. As Housing First is more widely adopted, maintaining fidelity to the philosophy and practice of the model is essential for achieving optimal outcomes. This paper reports on a fidelity self-assessment of the Pathways to Housing DC program located in Washington, DC. The Pathways Self-Assessment survey (Gilmer et al., 2013; Stefancic et al., 2013) was completed by program staff (n = 7) who subsequently participated in one-on-one qualitative interviews to discuss their responses. Results indicated that overall, Pathways to Housing DC achieved a high level of fidelity to Housing First, with an overall score of 156 points (out of a possible 169) on the Pathways Self-Assessment, representing 92 percent fidelity. Themes that emerged from the qualitative interviews included organizational culture, commitment to Housing First values, operational processes, the separation of housing and clinical services, and team structure and human resources. The findings of this study offer valuable insights into the factors that facilitate or hinder program fidelity of a high-functioning Housing First program.*

Keywords_ *Fidelity assessment, homelessness, Housing First, Assertive Community Treatment*

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Introduction: Homelessness in the United States

Federal data indicate approximately 564,708 people experiencing homelessness – sleeping either outside, in an emergency shelter, or in transitional housing – across the U.S. on any given night. The U.S. has one of the highest per capita rates of homeless among Western countries, with 17.7 people per 10,000 residents in the general population (National Alliance to End Homelessness, 2016). Data from the national Homeless Management Information Systems show that in 2015, 1.48 million people used emergency shelters or transitional housing programs (HUD, 2016). Fifteen percent of the overall homeless population is composed of individuals termed chronically homeless; those who have a disabling condition and have been continuously homeless for one year or more, or have experienced four or more episodes of homelessness in the last three years (HUD, 2016).

Housing First as a response to homelessness in the United States

A linear treatment continuum – called the staircase model – has been the predominant approach to addressing homelessness. This approach is based on the premise that people need to proceed through a series of interventions (i.e. steps) to address underlying clinical conditions before being 'ready' for permanent housing (USICH, 2015). The Pathways Housing First (PHF) model, developed in New York City in the 1990s, offers an alternative (Tsemberis, 2010). Housing First (HF) provides people who are homeless and have disabling conditions immediate access to permanent housing in the form of scattered-site apartments. Housing is coupled with community-based support consistent with either an assertive community treatment (ACT) or intensive case management (ICM) model (Tsemberis, 2010).

After years of advocacy and research, HF is recognized as an effective approach to ending homelessness for this population. Today, HF is endorsed by the U.S. Department of Housing and Urban Development and the U.S. Interagency Council on Homelessness (USICH) as a "best practice".[1] The US federal government advocated for HF as part of a systems response: the HF model is a prominent feature of the federal strategic plan to prevent and end homelessness (USICH, 2015).

Experimental and quasi-experimental studies have compared PHF to the staircase model and have documented the effectiveness of PHF programs in ending home-

[1] The definitions of HF used by HUD, USICH, and the Homelessness Partnering Strategy (HPS) in Canada are not the same rigorous definition of PHF used by the developers of the model, in research studies, or in the U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administrations' National Registry of Evidence-Based Programs and Practices (USICH, 2015; NREPP, 2007). Variations in definitions used by federal agencies may have implications for program fidelity and program drift.

lessness. The program reduces homelessness, increases housing retention, and decreases emergency room visits and hospitalization (Rog *et al.*, 2014; Benston, 2015; Woodhall-Melnik & Dunn, 2015). One of the most methodologically rigorous studies of the PHF program was the At Home/Chez Soi study, a multi-site randomized controlled trial in five Canadian cities. Two-year findings indicated that PHF participants entered housing more quickly, spent more time in stable housing, and had more positive perceptions of housing quality than participants in treatment as usual (Aubry *et al.*, 2016).

Fidelity to the PHF Model

The PHF model is now in practice throughout the U.S. and internationally in Canada and New Zealand and across Europe, in both urban and rural contexts with diverse populations (Greenwood *et al.*, 2013; Keller *et al.*, 2013). Questions about variations in the implementation and interpretation of the model, and the potential for program drift, have arisen (Padgett, 2013; Pleace, 2011; Pleace and Bretherton, 2012). In response, researchers developed a program fidelity scale to systematically assess the extent to which programs adhere to the PHF model (Stefancic *et al.*, 2013). High fidelity is predictive of positive client outcomes like housing stability, quality of life, and community functioning (Davidson *et al.*, 2014; Gilmer *et al.*, 2015; Goering *et al.*, 2016). Measures of fidelity can determine whether program outcomes are indicative of problems inherent to the original model, or rather, its application in a novel setting (Schoenwald *et al.*, 2011). Successful programs deliver critical components that contribute to positive outcomes while adapting to local conditions. When replicating an evidence-based intervention like PHF, fidelity is best coupled with flexibility to ensure the integrity of the intervention is maintained but adapted to fit with contextual factors (Chambers and Norton, 2016). The topic of fidelity, fit, and adaptation in relation to PHF is explored in more detail in the introductory article of this issue (Aubry *et al.*, 2018).

Pathways to Housing in Washington, DC

The focus of this paper is the Pathways to Housing program located in Washington, DC. Washington, DC has the highest rate per capita of homelessness of any city in the United States, with 124 homeless people for every 10,000 residents in the general population (US Conference of Mayors, 2016). A point-in-time count found 7,473 people experiencing homelessness on a single night (District of Columbia, 2017). Among adults using emergency shelters, over 50% of individual adults in emergency shelter experience chronic homelessness and over 50% report chronic substance abuse, severe mental illness, or a dual diagnosis (District of Columbia, 2017). In 2008, the DC government adopted HF as the citywide model to address chronic homelessness (Pathways to Housing DC, 2014).

Pathways to Housing DC was founded in 2004 as a satellite program by the same practitioners that developed the original Pathways program in NYC. The DC program uses an ACT team[2] to support adults experiencing severe and persistent mental illness and/or co-occurring disorders, identified as benefiting from community-based services to prevent the recurrence of homelessness or long-term hospitalization. Although homelessness is not an eligibility requirement, most service users have recent experiences of homelessness. In 2012, the program received a contract from the Department of Veterans Affairs to provide housing and services to 50 veterans with complex needs experiencing chronic homelessness (Pathways to Housing DC, 2014).

Forty-eight professionals (including a psychiatrist, a nurse, social workers, certified addictions counsellors, employment specialists, and peer health specialists) are organized into four ACT teams serving approximately 350 service users. Each ACT team supports 80 service users. Service users receive a housing voucher (funded through local and federal government programs) to supplement the cost of rent in scattered-site apartments. Service users hold a standard lease and contribute 30% of their monthly income toward rent. The program reported consistently high rates of housing stability outcomes: 97% of service users remained housed at one-year follow-up and 84% remained housed at two-year follow-up (Tsemberis, Kent and Respress, 2012).

The present study

This paper examines the extent to which one of the Pathways to Housing DC program ACT teams demonstrates fidelity to the PHF model. Program fidelity was evaluated using the Pathways Self-Assessment survey and qualitative interviews with staff. Factors that facilitated or impeded fidelity were explored. This program is an interesting case study for an examination of fidelity because it is closely tied to the original Pathways HF program in NYC. As a first-generation adaptation and operationalization of the model, the program presents an opportunity to explore the transferability and adaptability of PHF in a new environmental and bureaucratic context. As HF is scaled up and spread in increasingly diverse contexts across Europe and elsewhere, practitioners and policy makers must understand factors that impact fidelity in order to implement PHF effectively in new settings.

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2 A detailed description of the ACT model is available elsewhere (SAMHSA, 2008).

Method

Procedure and participants

Pathways Self-Assessment survey

The Pathways Self-Assessment survey was developed and described by Stefancic *et al.* (2013) and Gilmer *et al.* (2013). The survey measures fidelity across the five domains of PHF: 1) housing process and structure (e.g. the availability of rent subsidies, degree of participant choice, proportion of participant income paid toward rent, immediacy of access to housing); 2) separation of housing and services (e.g. scattered-site housing, no treatment preconditions for housing, standard lease, commitment to rehouse); 3) service philosophy (e.g. participant choice and rights, service type and intensity, harm reduction approach); 4) service array (e.g. services meet client needs, nursing, psychiatric, educational and vocational services available); and 5) team structure (e.g. case load ratios allow sufficient service intensity, frequency of team meetings, frequency of contact with clients, opportunities for client feedback).

The Pathways Self-Assessment survey consists of 37 quantitative items scored with a range of values typically from 1 through 4. On each item, respondents are asked to "report the percentage of program participants in certain categories or to select one or more response options that qualitatively describe the program operations" (Gilmer *et al.*, 2013; p.912). In developing and validating the tool, Gilmer and colleagues (2013) administered the survey to 93 supported-housing programs and conducted exploratory and confirmatory factor analyses which determined that the survey items and two factors demonstrated a reasonable model fit (CFI=.95 and RMSEA=.044) and an acceptable level of internal consistency (Cronbach's α=.72 and.78, respectively).

The Pathways Self-Assessment survey was completed independently by seven staff members of the Pathways to Housing DC program, including ACT team service providers and a program manager. These same staff members then participated in a conciliation focus group facilitated by two external researchers. This focus group was approximately 90 minutes in duration and consisted of an item-by-item discussion of the completed fidelity surveys to arrive at consensus-based ratings agreed upon by the entire team. The survey was completed between April 25th and May 7th 2016, and the conciliation focus group took place on May 10th 2016.

Qualitative interviews

Seven staff members participated in one-on-one qualitative interviews. Interviews included questions about the factors that contributed to areas of high fidelity in each domain, followed by questions about each specific item scored as having low or moderate fidelity. For these items, participants were asked about the barriers

that prevented the program from achieving a higher level of fidelity, and how these barriers could be best addressed going forward. The interview protocol placed particular emphasis on the discussion of barriers to fidelity, rather than facilitators.

The roles of participating staff members were as follows: Mental Health Rehabilitation Services Clinical Director, Director of Quality Improvement, Service Coordinator, Team Manager (Former), Peer Support Specialist, ACT Clinical Supervisor, and Program Coordinator. Interviews were conducted via telephone by external researchers and were approximately 60 minutes in duration. Interviews took place during a three-month period from December 2016 to February 2017. Interviews were audio recorded and transcribed verbatim.

Data analysis

Pathways Self-Assessment survey

The conciliated survey results were scored using the calculator developed and described by Bernad *et al.* (2018, this volume). The calculator converted all items to a 1-4 scale and produced a total score across the 37 items and subtotal scores for the five different domains. Two-way random effects intraclass correlation coefficient (ICC) for absolute agreement with average measures was calculated to provide a measure of interrater reliability among program staff survey responses.

Qualitative interviews

Data analysis was guided by an overall coding framework adopted from a previous study of PHF conducted by Nelson *et al.* (2017). The framework had two overarching categories (facilitators and barriers) with each category subdivided into three ecological levels: systemic factors (e.g., funding, policies), organizational factors (e.g., leadership, organizational support), and individual factors (e.g., capacities of service providers).

Within this overall coding framework, data were analyzed using a general inductive approach to coding (Thomas, 2006). Four researchers independently open-coded two key informant interviews. The researchers then met to discuss and reconcile codes. One researcher assembled the reconciled codes into a preliminary coding manual using QSR NVivo software.

Three of the researchers then conducted the coding. Each researcher was responsible for coding one of the three sets of ecological levels (systemic, organizational, and individual). The preliminary coding manual was modified to add new codes and group codes together, producing a finalized coding framework.

Results

Fidelity assessment survey

The ICC analysis of interrater reliability on the Pathways Self-Assessment survey was 0.85, indicating a high level of agreement among program staff. The Pathways to Housing DC program achieved a high level of fidelity to the PHF model, with an overall survey score of 156 (out of 169), or 92% fidelity. Table 1 presents the overall and domain-specific scores. Table 2 presents item-specific scores, the average domain-level scores, and the total program fidelity score, all on a 4-point standardized scale, with a score of 4 representing the highest possible fidelity and a score of 1 representing the lowest. The total program fidelity score was 3.8, indicating a high-fidelity PHF program. High levels of fidelity (scores of 3.5 or higher) were found on 87% of items. Low levels of fidelity (scores less than 3.0) were found on only 5% of items.

Table 1. Domain Summed Scores

Domain	Maximum Score	Site Score	Fidelity (%)
Housing Process and Structure	28	28	100
Housing and Services	28	28	100
Service Philosophy	41	34	83
Service Array	42	41	98
Team Structure/Human Resources	30	25	83
Total Scoring	169	156	92

Table 2. Fidelity Assessment Item Scores and Domain Means

Domain/Item	Domain Mean/Standard Item Score
Housing Process and Structure	***4.0***
1. Choice of housing	4.0
2. Choice of neighbourhood	4.0
3. Assistance with furniture	4.0
4. Affordable housing with subsidies	4.0
5. Proportion of income required for rent	4.0
6. Time from enrolment to housing	4.0
7. Types of housing	4.0
Separation of Housing and Services	***4.0***
8. Proportion of clients with shared bedrooms	4.0
9. Requirements to gain access to housing	4.0
10. Requirements to stay in housing	4.0
11a. Lease or occupancy agreement	4.0
11b. Provisions in the lease or agreement	4.0
12. Effect of losing housing on client housing support	4.0
13. Effect of losing housing on other client services	4.0
Service Philosophy	***3.5***
14. Choice of services	3.0
15. Requirements for serious mental illness treatment	4.0
16. Requirements for substance use treatment	4.0
17. Approach to client substance use	4.0
18. Promoting adherence to treatment plans	3.5
19. Elements of treatment plan and follow-up	2.0
20. Life areas addressed with program interventions	4.0
Service Array	***3.9***
21. Maintaining housing	3.0
22. Psychiatric services	4.0
23. Substance use treatment	4.0
24. Paid employment opportunities	4.0
25. Education services	4.0
26. Volunteer opportunities	4.0
27. Physical health treatment	4.0
28. Paid peer specialist on staff	4.0
29a. Social integration services	4.0
Team Structure/Human Resources	***3.4***
31. Client background	4.0
33. Staff-to-client ratio	4.0
34b. Frequency of face-to-face contacts per month	4.0
35. Frequency of staff meetings to review services	4.0
36. Team meeting components	3.3
37. Opportunity for client input about the program	1.3
Total	**3.8**

Only two items scored in the low fidelity range. Item 19, in the Service Philosophy domain, assesses elements of the treatment plan and follow-up. Respondents indicated that client treatment plans may include goals chosen by staff or automatically set by the program. In a high-fidelity HF program, treatment plans should only include goals chosen by the client. Item 37, in the Team Structure/Human Resources domain, assesses opportunities for client input and participation. Respondents indicated that persons of lived experience are employed in regular staff positions, but there is a lack of opportunity for client input and participation in program operations and policy setting. In a high-fidelity PHF program, clients should have the opportunity to give feedback and input to the program and participate in planning/implementation committees, advisory boards, governing bodies, and/or staff positions.

Three items scored in the moderate fidelity range. Item 14, in the Service Philosophy domain, assesses how the program determines the type, frequency and sequence of services. Respondents indicated participants have some say in choosing, modifying or refusing services, but staff preferences may prevail. In a high-fidelity PHF program, participants choose, modify, or refuse services and supports at any time, with the exception of one mandatory face-to-face visit per week. Item 21, in the Service Array domain, assesses services offered to help maintain housing. Respondents indicated that although some services are provided to help participants maintain housing, the program does not offer ongoing property management services, assistance with the process of paying rent, or cosigning of leases. A high-fidelity HF program would offer these kinds of housing support services. Lastly, Item 36, in the Team Structure/Human Resources domain, assesses the use of team meetings. Respondents indicated that although staff meet regularly for some program purposes, they do not meet to review the long-term goals of all clients on a regularly scheduled basis. In a high-fidelity HF program, staff would regularly conduct a review of each client's long-term goals.

Qualitative Interviews

Factors identified by key informants as either facilitating program fidelity or acting as a barrier to program fidelity are presented in detail below. A summary can be found in Tables 3 and 4.

Table 3. Summary of Facilitators of Housing First Fidelity

Systemic	Organizational	Individual
- Availability of complementary services in the community - Favourable government policy - Reliable funding	- Commitment to Housing First values: *agency culture, originators of the model, hiring practices* - Housing process and structure: *portable rent supplement, rehousing, separation of housing and clinical services* - Team structure and human resources: *ACT model, communication* - Consumer involvement - Partnerships: *community health organization, legal clinic, landlords*	Staff fit

Table 4. Summary of Barriers to Housing First Fidelity

Systemic	Organizational	Individual
- Complex client characteristics - Funder requirements - Limited funding - Local housing context	- Commitment to Housing First values: *client choice, transactional relationships* - Housing process and structure: *delays, inspections, rehousing* - Operational processes: *treatment plans, representative payeeships, intake* - Limited service array: *social/recreational programming* - Team structure and human resources: *training, burnout and self-care, turnover*	Client characteristics

Systemic facilitators of fidelity

Availability of complementary services in the community. Key informants highlighted the array of services available, including health, substance abuse treatment and social services. Fidelity was enhanced because services met clients' needs and allowed for client choice. One key informant stated, "The Washington D.C. metropolitan area, we are just very blessed in that we are an extremely services-rich area. There are over 50,000 non-profits within a 22-mile radius."

Favourable government policy. Key informants explained that local government policy included a mandate to end homelessness and specific rental and service dollars were provided to support the HF approach.

Reliable funding. The program and other local services were stably funded. One key informant said, "I think that the funding is strong enough that there can be multiple different agencies and you're not just going to be refused services because there's too many people there." Stable funding supplied "a large number of [rent] vouchers" to support clients in housing.

Organizational facilitators of fidelity

Commitment to HF values. Key informants described a high degree of organizational commitment to the philosophy, values and practices of the PHF model like client choice in housing and services, harm reduction, and no barriers to housing. One key informant explained, "It's kind of become second nature."

As an agency, Pathways to Housing DC was founded to operate the PHF program in Washington. Some staff of the original program remain on the team. One key informant said, "I think that we just started out working… with that mission and that philosophy and we just very much make it a point to adhere to that."

The agency's hiring practices were another facilitator. Job interviews focused on behavioural questions and understanding the candidates' compatibility with program values (e.g. What would you do in this situation? What do you think the client should do?). Candidates "shadowed" team members in action to determine if this way of working was a good fit for them. According to one key informant:

> I think the culture has come from when they hire. Pathways specifically hires people that understand the model and in the hiring process they ask a lot of questions… they are able to get a sense about if a person would even be comfortable working within a HF framework.

Housing process and structure. The availability and portability of a rent supplement, or 'housing voucher', contributed to high fidelity. One key informant said, "That flexibility allows us to match the client to the apartments that they want, so that we can essentially use our vouchers intelligently… And give people the space to engage in the housing process like they were an independent tenant."

Clients were re-housed as needed. One key informant said, "If a client loses their housing, we work with them right away to try to get them re-housed. That's our policy and our process. As many times as it takes. We are able to re-house fairly quickly."

Housing and clinical services were separate. One key informant explained, "We have a Housing department at Pathways that is completely separate from mental health or any Case Management services that a client might be receiving… In each ACT team we have a Housing specialist or Housing liaison that works directly with the Housing department."

Clients signed independent leases with landlords and were free to decline all clinical services while remaining eligible to receive a housing voucher or rent supplement to stay housed. One key informant explained, "[The client] agreeing to

do psych or take medication, or have his finances managed by a payee, none of those things affect his ability and his right to be housed. So, I do think that we do a very good job of separating our clinical and mental health services [from housing]."

Team structure and human resources. The program adhered to the ACT team model – which requires frequent, structured meetings among staff to keep track of each client – and is evaluated annually by the Department of Mental Health. The team communicated through multiple channels: daily in-person team meetings; a once-weekly two-hour case review meeting; a scheduling board that displays all team appointments, client goals and the amount of time spent with each client; and "constant" electronic communication. One key informant said:

> There is a meeting typically every morning where the entire team gets together… We are able to discuss the intervention and the services we provided the day before and update on any services we need to provide for that day… So, we are able to co-ordinate every single day.

Service array. ACT team members have a variety of specialties, allowing them to provide an array of services directly, including vocational, educational, peer support, psychiatry and nursing. The program also provided social integration services, budgeting support, and a representative payee program.

Consumer involvement. The program had established consumer involvement initiatives considered to be a strong asset. Examples included inviting clients to speak at an "*open doors*" event, fundraising events, and all-staff meetings; involving people with lived experience in the interviewing process with new staff; and conducting anonymous client satisfaction surveys on a bi-annual basis.

A consumer advisory board existed previously but had "died down because of staff turnover." After a hiatus, the advisory group was now "in the process of being restarted." This board was described as "made up by consumers and run by consumers", though meetings were also attended by senior staff. One informant remarked, "We really try to make sure individuals with lived experience are at the table and contributing."

People with lived experience were also included as Peer Specialists on ACT teams. One key informant said of their experience as a peer, "I know at our agency, my team accepted me… Some agencies don't really know how to use their peers, but I think Pathways does."

Partnerships. The program was partnered with a community health organization providing physical health care to clients through a low-barrier service delivery model. A nurse practitioner was available on-site at Pathways two mornings per

week. Another external partnership with a legal clinic helped clients expunge their criminal records, which was described as being instrumental in opening up more housing and vocational opportunities.

Successful partnerships were in place with many landlords in the community. The program appealed to landlords because of the guaranteed, direct rent payments and the high level of support provided by the ACT team and Housing Specialists.

The program had created a full-time Director of Housing position dedicated to building relationships with landlords. One key informant discussed the importance of having this position, saying:

> [The Director of Housing] will go out and do the real meet and greet and build a relationship with [the landlord] and really work towards leveraging that landlord… we just want to be that person that next time they have another vacancy they think, "Oh, I'm having such a good relationship with Pathways, let me call them first."

Individual facilitators of fidelity

Staff fit. The personal values held by staff fit well with the values embedded in the PHF model, contributing to a high level of commitment to the work. One key informant said, "I think that the reason people stay is because they believe in the model and they believe in HF." Another key informant commented, "We can teach anybody to write a progress report or develop a treatment plan or whatever, but we generally cannot teach an employee values, attitudes and ethics, right?"

Systemic barriers to fidelity

Complex client characteristics. Clients of the program had complex needs, including "serious cognitive deficits" and criminal records. According to one key informant, client complexity was so challenging that mortality was a serious concern, and was hard to reconcile with the notion of positive program outcomes: "A lot of our consumers who are coming off of being homeless have not been to a doctor and we've found that they haven't had a chance to rest, and so the first moment that they get to rest they end up passing away because they've been in defence mode for so long."

Funder requirements. As a primary funder of the program, the Washington DC Department of Behavioral Health imposed strict requirements on funding. Funding mandates influenced some aspects of client treatment plans, limiting client autonomy and choice. Staff struggled to describe their work with clients in a way that would ensure reimbursement for service. One key informant said, "It's not really about the client focusing on a few things they really want to work on… It's catered towards Medicaid billing, it's not catered to the client voice…. It's about, we need to get paid for the things that we need to do with this person."

Conditions imposed by the Housing Authority, which provides the rent supplements or housing vouchers, sometimes contributed to delays in housing clients. Conditions included a time-consuming approval process; "bureaucracy"; a requirement that clients first need to have identification cards; and a mandatory unit inspection at move-in and then annually thereafter. One key informant said:

> Paperwork has to be submitted to [District of Columbia Housing Authority], you have to make sure they process them, give you an answer, and then after you find a unit and they [have to] approve the unit, then you have to wait for the unit to be inspected.

If a unit failed an initial inspection, the landlord would be required to address the issue. The unit would then be inspected by a different inspector, who may identify new issues. Long delays could result in a client disengaging from the program or a landlord giving up and renting to someone else. Overall, a key informant estimated that, "best-case scenario we can get somebody [housed] in about two months, worst-case scenario can be up to six months or longer." On the Pathways Self-Assessment survey, a top score for "time to house" is one to two months.

Limited funding. One key informant remarked, "Because we are a younger organization we do have a small donor base." Most funds raised were from government and came with a narrowly-defined use. Additional funding was required for apartment repairs, re-locations and furniture.

Housing context. In the Washington, D.C. area, rental costs were rising, background checks and other onerous rental requirements were becoming common, and housing availability was limited, especially during times like the start of the academic year because of an influx of students renting the same kind of housing. Fidelity was compromised because client choice and ability to re-house was limited. One key informant stated:

> I will say it's not something that I'm very proud of in the way that we do things… When someone is in a unit and they want to move, but there are not major issues with the unit that they are in, then we really try to orient them to the housing situation and how tough it is to come by housing now.

Organizational barriers to fidelity

Commitment to HF values. Organizational commitment to PHF values was thought to contribute to barriers in other areas of program fidelity. One key informant described how adhering to a client choice model could interfere with recovery by saying, "I believe in being able to show both sides, being able to allow our partici-

pants to be able to see what recovery can look like for them. And I don't think that we are able to do that as much with consumer choice." This key informant suggested "incentivizing" participation in some aspects of treatment.

Some participants thought that for clients to be housed without delay, client choice had to be limited to a reasonable degree. One key informant said, "We try to respect client choice as much as possible but we also want to get them housed quickly. So, we try to be realistic about the options and set them up for success in applying for places that will actually take them."

One key informant explained that adhering to a client choice approach was problematic when working with some clients who were described as "low functioning", because it could result in housing loss or harm to the client, saying,

> On those clients where you're concerned about their well-being, and their hygiene and it's bordering on self-neglect, and we want to keep the housing, well then those are the clients who are not getting much say…. I think for the lower functioning clients it becomes – you end up back at not giving them choice, in order to keep them housed.

Deviation from HF values. The program had drifted from core PHF values in some instances. Some staff adopted a quid pro quo or transactional approach to working with clients. Examples included offering food, cigarettes, or access to cheques in exchange for a client attending a medical appointment, taking medication, or agreeing to meet with staff. One key informant recalled "essentially bribing someone into getting an injection."

Using a transactional approach was part of "trying to pull out whatever is in the arsenal" to encourage a client to do something that staff thought to be beneficial to the client's well-being. Transactional approaches were considered to be well-intentioned, quick, and effective. One key informant said, "It's helpful because without it we wouldn't be able to see people at times… I don't in any way think that anyone abuses it."

The transactional approach was described as a "moral struggle", an "ethical issue", and a tactic that could "tarnish our ability to be clinical with clients because we're using that power so freely." One key informant said, "We have clients that are incredibly vulnerable and that will say yes to anything… I think a lot of it is about ensuring that the client understands that they are potentially being manipulated and [staff] could potentially be a source of that manipulation."

Housing process and structure. During evictions and re-housing, it was difficult to balance the interests of the landlord with those of the client. One key informant said:

> Housing (is) interested in maintaining relationships with landlords, where me as a case manager, I'm interested in the interests of my client. I'm like, "I know my client destroyed that other unit and got evicted, but I still want him to move into this unit." And that's when you have this back and forth with Housing and they are like, "Oh no, we don't want any clients with destructive histories in this building because we don't want to lose the relationship with this landlord."

Clients who lost their security deposit due to damages may not receive another security deposit from the program. Some staff raised questions about whether clients who had lost housing were "stable" enough to be housed again or whether independent housing is "appropriate" for them. One key informant said:

> I think substance abuse and cognitive deficits that are not repairable; those would be the main barriers to re-housing… Where people have demonstrated failure and they're not in a clinical space where they are doing better and we cannot honestly say that they're ready for it.

Operational processes. Client treatment plans were described as "*inflexible*", time consuming, and not client-directed. Treatment plans were generally regarded as an administrative task, not a clinical tool. Treatment plans were often completed without client input, sometimes by a staff member unfamiliar with the client. Medicaid billing contributed to this culture of formality and expediency. Key informants suggested additional training; a better system for tracking documentation and determining when treatment plans were due; reducing the length or scope of the plans; and a focus on harm-reduction and the stages of change, rather than an abstinence-based approach to goal setting.

Another barrier to fidelity was the role the program played in managing clients' finances. The program was serving as representative payee for a "*considerable*" number of its clients. This arrangement compromised client choice. Some staff engaged in "*cautioning the withholding of the participants' income*" or used access to money as a bargaining chip. One key informant described a situation where staff said to a client, "*I* need you to sit with me and do your treatment plan and if you're able to do that then we can talk with Finance about getting $50." Another key informant said:

> We run into the issue of running into a road block with clients of how much we can get them to do with what resources or interventions that we have, so I think the one area that we can and do control with our clients is in their finances…. So that's what we rely on.

Key informants suggested the payee role should be given to a separate agency or department. One key informant said, "There should be a larger disconnect between financial management and mental health services in housing." Another said, "It's a

conflict of interest." One key informant described representative payee arrangements as blocking clients' engagement with services: "A client could be incredibly fixated on their finances and unable to, or unwilling to engage with us because they're mad about money."

Lastly, the intake process was a barrier to fidelity by contributed to delays in housing clients due to being demanding, invasive, repetitive, and in some cases, incomplete. One key informant said:

> Within the first 30 days the client needs to see the psychiatrist, the client needs to have an initial assessment, the client needs to do certain small things like apply for Medicaid… You have to figure out a time to get vital documents and talk about where a client wants to live and then see if a client can even be approved for an apartment.

Service array. Social and recreational supports were not readily available to clients. Clients who were housed reported having nothing to do and nowhere to go. One key informant explained, "Once you have been decently stable and successful in the community, the next step of actual recovery and re-integration is another issue."

Team structure and human resources. Further training was needed to orient staff toward PHF principles and a client-driven approach. Additional training needs included maintaining professional boundaries with clients, engagement strategies, motivational interviewing, and working on longer-term interventions with clients.

Burnout and lack of self-care of program staff were also identified as barriers to fidelity. Short-staffing and heavy caseloads were sometimes a problem. Some staff took on extra responsibilities outside their role, came to work sick, and took work home with them. High staff turnover could be an issue, compromising client-staff relationships. One key informant explained: "That comes back to the human connection and how it can be really hard for consumers and for staff, to be working so closely with someone to be so involved and care so much about their life and then you move on." One key informant remarked that staff turnover was typical of the transient nature of work in the non-profit sector.

One key informant at the management level held a different view of staffing issues in the program, saying, "Our supervisors here, we have what's known as a good work and home-life balance. We like to make sure that people are taking care of themselves and taking time off if they need to. We ask people not to work after hours."

Individual barriers to fidelity

Maintaining professional boundaries. Some individual staff members became overly invested in their clients on a personal level, and subsequently found it difficult to adhere to PHF program philosophies. Some staff recalled feelings of personal disappointment when clients engaged in harmful behaviours. In these situations, staff struggled to promote client choice and client-directed treatment planning. Instead, they felt compelled to intervene and do what they considered to be in the best interest of their clients, based on a sense of ethical and humanistic responsibility.

Discussion

This paper presents findings from a HF fidelity assessment of Pathways to Housing DC, one of the first satellite programs established by the original developers of the HF model. Overall, the program demonstrated a high degree of fidelity on the Pathways self-assessment fidelity measure. Only minor areas of low fidelity were identified, specifically in the service philosophy and team structure domains. The overall high level of fidelity of the program is impressive. High fidelity programs produce better client outcomes such as greater housing retention, reduction in substance use, engagement in treatment, and healthcare utilization (Blakely *et al.*, 1987; Durlak and DuPre, 2008; Bond *et al.*, 2009; Davidson *et al.*, 2014; Gilmer *et al.*, 2014; Gilmer *et al.*, 2015; Goering *et al.*, 2015). Future research should explore new methods for weighting items in the Pathways Self-Assessment survey to reflect those domains that are most closely associated with positive program outcomes.

In qualitative interviews, key informants of Pathways to Housing DC described both facilitators and barriers to program fidelity. The discussion of barriers reflects the reality that even programs with a high degree of fidelity can still have areas of improvement to be targeted. This is not unusual. The pragmatism inherent in harm reduction programs requires that staff and clients make difficult choices. For example, staff must make practical decisions about when and how often to re-house a client. Such decisions may be at odds with program principles, but pragmatic considerations are essential if the program is to succeed in the real world of complexity, and not just as an ideal program model. In the present study, interviews revealed the moral and ethical dilemmas faced on a day-to-day basis when staff resort to transactional exchanges, bargaining and other practical and street-wise approaches that compromise the higher program principles and values but effectively help people with long histories of homelessness and complex problems remain stably housed. These tensions, contradictions, and situations without a clear answer are stressful for both clients and staff but they should also be understood as being an integral part of operating the PHF program (Tsemberis, 2010).

Some of the qualitative data solicited may have been the result of the structure of the interview protocol. As previously noted, interview questions were more heavily focused on barriers and areas of challenge, despite the program's high degree of overall fidelity. Interview findings were also primarily concentrated on factors affecting fidelity at the organizational level, rather than the systemic or individual levels. This does not necessarily mean that organizational factors are more critical to program fidelity. Rather, they may be more obviously relevant to the day-to-day work of key informants.

Key informants of the Pathways to Housing DC program described a high degree of organizational commitment to HF values. Previous literature on HF programs highlighted the importance of agency culture to implementation, particularly having staff with philosophy, values, and skills consistent with the PHF model (Greenwood *et al.*, 2013; Stefancic *et al.*, 2013; Nelson *et al.*, 2014; Macnaughton *et al.*, 2015). Additionally, past research on community programs, including both HF programs and ACT programs, demonstrated that staff from high fidelity programs are more likely to value tolerance, empathy, and commitment to consumer choice, and to incorporate these values into hiring practices (Mancini *et al.*, 2009; Macnaughton, *et al.*, 2015; Gilmer *et al.*, 2013; Henwood *et al.*, 2013; Kertesz *et al.*, 2017;).

When discussing housing process and structure, key informants emphasized the importance of separating housing and clinical services. In the HF literature, this separation entails practicing harm reduction techniques and removing any clinical provisions or preconditions for housing such as sobriety, medication or treatment compliance to receive or keep housing (Stefancic et al, 2013; Davidson *et al.*, 2014; Kertesz *et al.*, 2017).

In Pathways to Housing DC, key informants explained that when clients lost housing, they were generally rehoused, which was made easier by the portability of the housing vouchers used in the program. HF programs that incorporate these client-centered practices can evoke positive change in clients and have been found to have higher rates of retention of a traditionally difficult-to-house population compared with abstinence-based programs (Davidson *et al.*, 2014; Gilmer *et al.*, 2014; Macnaughton *et al.*, 2015). Although re-housing was a program priority, key informants explained that it was often difficult to balance the interests of clients and landlords, a finding consistent with previous research (Aubry *et al.*, 2015).

One of the most significant dilemmas discussed at length by key informants from Pathways to Housing DC pertained to the use of transactional approaches when working with clients. Some considered this approach to be a necessary means to engage reluctant clients, while others considered it manipulative and unethical. The power associated with managing client finances in a representative payeeship relationship was of particular concern. Previously, researchers noted that

assertive engagement techniques can become problematic with some clients (Stefancic *et al.*, 2013). ACT practitioners have been criticized for using engagement and retention practices such as behavioural contracting or close monitoring of medication compliance. However, programs that show high levels of fidelity to the ACT model are associated with lower client perceptions of coercion (Salyers and Tsemberis, 2007).

Consistent with past findings, program structure, teamwork and frequent communication among Pathways to Housing DC staff facilitated program implementation (Stefancic, *et al.*, 2013; Nelson *et al.*, 2014). Consumer involvement and peer-driven initiatives were important to the success of the program, and have been previously identified as positive contributors to program implementation (Salyers and Tsemberis; 2007; Nelson *et al.*, 2014). Similarly, partnerships beyond the immediate scope of the program are considered essential to mobilizing resources of the wider community (Macnaughton *et al.*, 2015). For the Pathways to Housing DC program, partnerships with community health and legal clinics broadened the array of services available to clients. Partnerships with landlords were also important. Research has shown that having a successful partnership with landlords can help to resolve issues through negotiation and mediation, rather than notification of police or eviction (Nelson *et al.*, 2014).

One area of low fidelity identified by key informants was a limited service array for clients who had achieved stable housing. Specifically, lack of social supports and recreational opportunities may pose barriers to recovery and community integration. There are concerns that HF programs are equipped to deal with crises, but struggle to provide effective education or employment support or proactive long-term goal planning (Macnaughton *et al.*, 2015). Other areas of low fidelity identified by key informants as limiting client choice and contributing to housing delays include high levels of bureaucracy and red tape imposed by the program funders (Kertesz *et al.*, 2017).

Limitations

One limitation to this study that should be considered is the use of a self-report tool to measure program fidelity. In developing the tool, Gilmer and colleagues (2013) acknowledged these limitations, saying, “A combination of social desirability, limitations of self-assessments, and the need for brevity may make some items more reliable than others” (p.914). It is possible that participants in this study reported a more positive view of program fidelity than may have been obtained through other methods, such as a site visit by a neutral observer. However, it is important to note that this study did include multiple perspectives of fidelity – including the perspec-

tives of peer workers, front-line staff, and management – and that the final fidelity scores reflected a consensus view among the group. Further, the present study included one-on-one qualitative interviews with key informants as another source of data beyond the self-report survey. In all, key informants seemed open and honest about the strengths and weaknesses of the program and made constructive suggestions for improvement. Future research on program fidelity would benefit from the inclusion of diverse stakeholders, such as service users, landlords, and community partners, to triangulate results and offer a more fulsome picture of the program and the local context.

Conclusions

Our findings offer valuable insights into the systemic, organizational and individual-level factors that facilitate or present barriers to a high fidelity, first-generation PHF program. Results indicate that the PHF model is indeed transferrable to new contexts and can be implemented with a high degree of fidelity in new settings, offering support for scaling up and spreading the model in Europe and elsewhere. Pathways to Housing DC is a useful example for other HF programs to follow. The program achieved high fidelity overall while demonstrating unique adaptations. Nevertheless, the present study also documented some challenges faced by the program, such as maintaining commitment to HF values, avoiding transactional relationships with clients, protecting against staff burnout, and providing social and recreational supports to clients. These areas may benefit from ongoing attention and adaptation (Durlak and DuPre, 2008).

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Fidelity Findings from the Arrels Foundation Housing First Programme in Barcelona, Spain

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Abstract_*Arrels Foundation is one of the oldest homeless service organisations in Barcelona, and is one of the main promoters of Housing First in Catalonia. The programme was launched in 2015 and one year later, Arrels Foundation evaluated programme fidelity for the first time using the self-assessment approach (Stefancic et al., 2013) and one-to-one structured interviews with key stakeholders. Nine staff members participated in the first phase and eleven took part in the qualitative phase. Results indicated higher fidelity scores in the Separation of Housing and Services domain and lower scores in the Service Array domain. Barriers to fidelity were identified in the domains of Services Provision, Team Structure, Housing Processes and Structure. These barriers appeared to be linked to systemic challenges of a difficult housing market, small public sector housing supply, and cultural resistance to the model. Facilitators of fidelity included the quality of public health and mental health services; organisational commitment to the consumer-led, recovery-oriented HF philosophy; and the stability and long-term dedication of Arrels Foundation's workers and volunteers. Analysis also underlined the benefits of local adaptations for programme fidelity. These findings provide context and perspective for comparison with other Housing First implementations and demonstrate how the programme is sufficient, sustainable, and effective in improving quality of life for adults with histories of homelessness and complex support needs.*

Keywords_*Homelessness, Housing First, Arrels Foundation, evaluation, fidelity*

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Introduction

A 2017 homeless count conducted on a single night by a network of public services and social initiatives called Attention to Homeless People (XAPSLL) found that 3,383 people were homeless in Barcelona, of which 962 (28.4%) were sleeping rough, 2,006 (59.3%) were in municipal and social care facilities, and 415 (12.3%) were in settlements (Guijarro, Sales, Tello and De Inés, 2017, p.18). Settlements are public or private spaces that are occupied by people who spend the night in warehouses (factories or abandoned buildings) or plots of land with precarious housing structures (shacks, caravans, trucks….) that are maintained over time (Àrea d'Hàbitat Urbà, 2012, p.5).

Since 1985, Barcelona has had a Local Programme of Social Support for Homeless People (Ajuntament de Barcelona, 2005). In 2005 XAPSLL was created. XAPSLL is a network composed of 33 public and private organisations in the city, including Arrels Foundation, a founding member. In 2006, the Barcelona City Council published the Citizens' Agreement for an Inclusive Barcelona (Ajuntament de Barcelona, 2006).

In Barcelona, both the staircase approach and Housing First (HF) models are employed to address homelessness. Traditionally, programmes in Barcelona followed the staircase approach, an intervention model characterized by the gradual setting of goals with programme participants to help them become ready for independent living, both in terms of resources provision and social intervention (Matulič, Cabré and García, 2016, p.69). In recent years, programmes have begun to adopt the Housing First approach. In December 2014, the Arrels Foundation delivered the first conference on Housing First in Catalonia (Universitat de Barcelona, 2014). Professionals and academics from France and Portugal shared their knowledge and experiences. Over the following years, Arrels Foundation has continued to champion the HF model and, along with other organisations and municipalities in Catalonia, to disseminate the model to other towns and cities in the region. Catalonia's government works closely with other organisations, including Arrels Foundation, to prepare the Comprehensive Strategy for tackling Homelessness in Catalonia, which includes the implementation of Housing First programmes (Generalitat de Catalunya, 2017).

A more recent document (Xarxa d'Atenció a Persones Sense Llar Barcelona, 2017a) of the council's Plan for Fighting Against Homelessness 2016-2020 was released and described an intervention strategy for addressing homelessness. Housing First is one of the strategies presented in this plan. The City Council also created a process through which local authority agents consult with homeless services users who make suggestions for support services based on their own experiences. In 2015, Barcelona City Council's Social Rights Department launched a housing

service based on HF principles with 50 scattered housing units (Ajuntament de Barcelona, 2015). Arrels Foundation decided not to participate in this project in order to retain control over the organisation's philosophy and practice.

Most social and clinical services are brokered from public providers such as Barcelona City Council Social Services Centre and the Catalan Health Service, which includes general practitioners, specialists, and the city's mental health network. The Mental Health Team for Homeless People (ESMES) is composed of psychiatrists, nurses, and case managers that are integrated into the public mental healthcare sector as a pioneering project in the Spanish State. ESMES was created in 2005 after a pilot project launched in 1998, in which Arrels Foundation participated. The teams provide services on the ground to address the serious mental disorders or co-occurring mental disorders and addictions of individuals who have not yet received a diagnosis or dropped out of the mental health services.

Arrels Foundation

Since 1987, Arrels Foundation has had three main goals: to support homeless people, to raise public awareness about homelessness, and advocate for political change. Arrels Foundation was created by volunteers and, since the organisation's beginning, it has delivered support services to rough sleepers in Barcelona, especially the most vulnerable. One of Arrels Foundation's principles is the involvement of volunteers in all its programmes, services, and participation levels. Currently, around 397 volunteers collaborate one morning or afternoon at least once a week in one of the different services and departments (Arrels Fundació, 2017). All volunteers receive specific training on issues related to people experiencing homelessness and, on the values, and principles of the organisation. Of Arrels Foundation's budget for 2016, 70% came from private funds raised by 4,300 donors (Arrels Fundació, 2016). This allows the organisation to be self-governing and innovative.

In January 2015, Arrels Foundation's leadership made an important structural shift in the decision to implement Housing First. This transformation represented an important challenge for the organisation and required commitment to a culture of innovation, a reconfiguration of programmes and services, and the application of a client-centred approach (Uribe, 2014; Matulič and De Vicente, 2016). The Housing Support team and the Social Work department were restructured into Individual Support service, composed of three individual support teams that offer housing and client-led supports. The Arrels Foundation's open centre, the outreach service, and the care home Llar Pere Barnés were retained. These HF programme streams include volunteers, programme participants, and case managers.

Additionally, in January 2017, Arrels Foundation opened a new accommodation facility called "Flat Zero", a flexible and low-threshold resource for individuals who live on the street, fail to adapt to the HF model, and are unable to find a place in any other resource. It is designed to provide a safe, secure, and clean shelter for the most vulnerable programme participants when they run out of other options. Approximately 20% of Arrels Foundation's programme participants fall into this category. Flat Zero has 10 beds and is open only at night.

Description of the Arrels Foundation Housing First Programme

In 2016, 243 programme participants were enrolled in the Day Centre, the Outreach service, the Llar Pere Barnés care home, and the Individual Support service (218 men and 25 women). Some 90% of them were offered housing in self-contained or shared units, sub-tenancy rooms, pensions, care homes, or other accommodation centres. Regardless of the type of housing, they received social support based on the HF principles. These principles stress individual rights and provide person-centered supports.

The HF programme's teams use a care plan based on the Intensive Case Management (ICM) model, a team-based approach that supports individuals through case management and public social, physical health, and mental health services. The principal aspects of the ICM model are: recovery-oriented supports with particular emphasis on education and employment, a ratio of 20 programme participants per case manager, centralized case management allocation; 12-hour coverage, seven days a week; monthly case management meetings; and support with medical appointments and paperwork (Macnaughton, Goering and Nelson, 2012). The current ratio in Arrels Foundation is 16 programme participants per case manager. Ten volunteers assist each team in providing support to programme participants.

Of the 243 participants of the HF programme, 89.7% (n=218) are male and 83.9% are older than 50. Seventy-three percent (n=178) are of Spanish nationality and 7% (n=17) are people who have immigrated without documentation. Of the 243 programme participants, 57.2% (n=139) earn less than €500/month and 13.6% of them (n=33) have no income. Based on contact with programme staff, it is estimated that 70.4% (n = 171) suffer some mental disorder although, of these, only 37.9% (n = 92) have been formally diagnosed. Regarding addictions, 82.7% (n = 201) suffer alcoholism and 28.8% (n = 70) suffer some substance abuse.

Objectives

This paper explains how Arrels Foundation reconfigured its programmes and services into a Housing First programme in Barcelona. In order to share our experience and serve as an example to other organisations, this paper describes the results of a fidelity assessment of the HF programme, identifies factors facilitating or impeding programme fidelity, and presents local adaptations to the programme.

Method

After 18 months, an evaluation was warranted to assess the new programme's success in implementing Housing First. The assessment was conducted using a mixed methods approach (quantitative and qualitative). This method was agreed upon with other Housing First programmes in various North America and European locations that were members of an international Housing First network. First, a quantitative self-assessment of fidelity was completed using the 38-item Pathways HF Fidelity Scale measure (Stefancic *et al.*, 2013). Following this, a focus group was conducted to arrive at a consensus among programme staff on fidelity scores. The evidence suggests that a higher level of model fidelity is associated with more positive client outcomes (Stefancic *et al.*, 2013; Davidson *et al.*, 2014; Gilmer *et al.*, 2014). Finally, a qualitative phase was conducted by key informant interviews identifying facilitators and obstacles to achieving a high level of fidelity. The methodology is detailed below.

The fidelity assessment

Procedure and sample

The self-assessment fidelity survey was translated from English into Catalan by professional translators and was checked for accuracy by two independent Housing First experts. To facilitate programme participants' understanding of the instrument, a supplementary, detailed document was created that expanded and contextualized some items.

The self-assessment of fidelity was carried out between June and July 2016. The aim of the quantitative phase was to assess model fidelity with the Housing First Fidelity Survey (Stefancic *et al.*, 2013), which was completed by staff members of the HF programme. Nine staff members completed and returned the self-assessment: five women and four men. The questions are designed to assess fidelity of a programme with the original Pathways to Housing model in five domains: Housing Process and Structure; Separation of Housing and Services; Service Philosophy; Service Array; and Team Structure and Human Resources.

Next, a focus group was organized in which the survey study participants met to discuss and reach agreement on a single score for each question. All nine staff members who completed the self-assessment participated in the focus group. The meeting was moderated by one of the advocacy team managers, who collected the consensus results. Ten additional members of the organisation, both employees and volunteers, attended the feedback meeting to observe. These members did not participate in the focus group discussion. They attended in order to facilitate internal communication and to ensure transparency. The managers of Arrels Foundation did not participate in the meeting to prevent any possible skewing of the focus group discussion. The meeting lasted for 2 hours and 30 minutes.

Data analysis

The scores for items on the fidelity measure were standardized on a 4-point fidelity scale. Scores below 3 were considered of low fidelity, scores of 3.5 and above reflected high fidelity, and scores between 3 and 3.5 were considered to represent moderate fidelity (Macnaughton *et al.*, 2015).

The key informant interviews

Procedure and sample

This second phase of the research was completed between January and March 2017. The goal of this qualitative phase was to explain the scores obtained in the survey and identify the facilitators and barriers to fidelity observed in the implementation process. Eleven members of the organisation were interviewed as key informants of Arrels Foundation: five men and six women. The sample included two volunteers, two programme participants, and seven programme staff in order to ensure representation of the organisation. The semi-structured interview guide included 38 questions across seven topics to obtain information about key aspects of the Arrels Foundation HF implementation in the five fidelity domains. The researchers were particularly interested in the local coordination among healthcare and social services networks, community integration, the role of volunteers in programme delivery as an essential part of the organisation, and evidence of the effects of the programme on service users' quality of life. Two of the eleven staff members who participated in the qualitative phase also completed the fidelity assessment. The average duration of the interviews was 2 hours and 15 minutes.

Data analysis

The interviews were recorded and transcribed using the qualitative data analysis ATLAS.ti 7. In order to carry out the qualitative analysis, a coding system was created based on an initial theoretical framework and established objectives. The two researchers from Barcelona University who carried out the interviews coded the data by separating the factors identified as facilitators and barriers to fidelity. The principal categories for analysis were: system of protection; housing; transfor-

mation of the organisation; professional team; support; harm reduction; networking; incorporation of peers; volunteers; ethical dilemmas; the evaluation of services; participant profiles; stigma; collaboration of programme participants; integration into the community; quality of life of programme participants. In the following analysis section, excerpts from study participants' interviews are identified by code numbers that represent their role in the organisation: professionals as P1-P7, volunteers as V1-V2, and programme participants as U1-U2.

Results

The fidelity assessment

The overall fidelity score was 123 points out of a possible 169 (73%). Table 1 presents standard scores of all fidelity assessment survey items. High levels of fidelity were found on 45% of items. Low levels of fidelity were found on 36% of items. The remaining 19% of items indicated moderate fidelity. The results of the Arrels Foundation assessment indicate high Housing First fidelity in the domain of Separation of Housing and Services. Scores were lower in the domain of Housing Process and Structure because programme participants often cannot choose housing units in the neighbourhoods where they want to live, and must wait more than six months.

In the Service Philosophy domain, lower fidelity was observed in the area of individual rights to self-determination; although programme participants play an important role in decision-making, services are not always client-led. The lowest score was obtained in the Service Array domain, because of a lack of educational, vocational training, and employment opportunities and because peer-support workers have not yet been incorporated into the teams.

An examination of the scores in the Team Structure and Human Resources domain identifies two principal causes of lower fidelity. Firstly, there are few formal mechanisms to facilitate input from participants into the development of the programme, although some programme participants are members of the Board of Directors. Secondly, the team does not have enough time to thoroughly discuss and review ways to prevent future challenges related to living in the community (flat maintenance, problems with neighbours, etc.). The distribution of scores in the five domains is presented in Figure 1 for easy comparison to other evaluations.

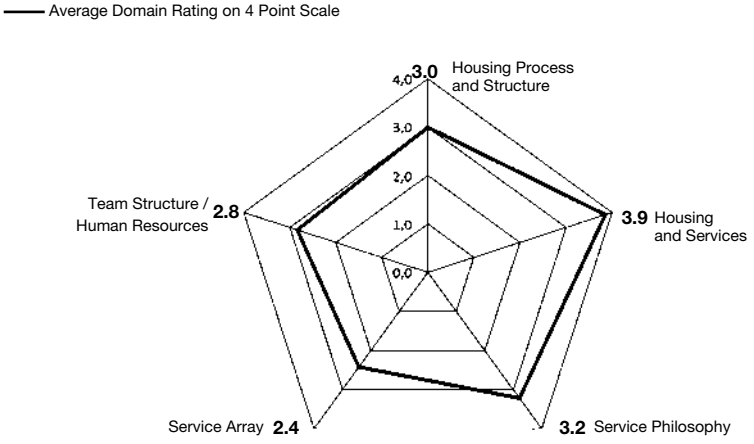
The key informant interviews

Key informants identified factors that affected fidelity in the five domains. We organized their responses as facilitators and barriers to model fidelity (see Table 2). We then organized facilitators and barriers into systemic, organisational, and individual categories.

Table 1: Fidelity Assessment Scores and Domain Means

Domain / Item	Domain Mean / Standard Item core (Out of 4)
Housing Process and Structure	**3.0**
1. Choice of housing	3.0
2. Choice of neighbourhood	2.0
3. Assistance with furniture	4.0
4. Affordable housing with subsidies	4.0
5. Proportion of income required for rent	4.0
6. Time from enrolment to housing	2.0
7. Types of housing	2.0
Separation of Housing and Services	**3.9**
8. Proportion of clients with shared bedrooms	4.0
9. Requirements to gain access to housing	4.0
10. Requirements to stay in housing	4.0
11a. Lease or occupancy agreement	4.0
11b. Provisions in the lease or agreement	4.0
12. Effect of losing housing on client housing support	3.0
13. Effect of losing housing on other client services	4.0
Service Philosophy	**3.2**
14. Choice of services	3.0
15. Requirements for serious mental illness treatment	4.0
16. Requirements for substance use treatment	4.0
17. Approach to client substance use	4.0
18. Promoting adherence to treatment plans	2.5
19. Elements of treatment plan and follow-up	1.6
20. Life areas addressed with program interventions	3.4
Service Array	**2.4**
21. Maintaining housing	4.0
22. Psychiatric services	4.0
23. Substance use treatment	2.4
24. Paid employment opportunities	0.8
25. Education services	0.8
26. Volunteer opportunities	3.2
27. Physical health treatment	3.2
28. Paid peer specialist on staff	1.0
29a. Social integration services	2.4
Programme Structure	**2.8**
31. Client background	2.0
33. Staff-to-client ratio	4.0
34b. Frequency of face-to-face contacts per month	4.0
35. Frequency of staff meetings to review services	3.0
36. Team meeting components	2.7
37. Opportunity for client input about the program	1.3
Total	**3.0**

Figure 1: Extent of Fidelity to Housing First Model



Source: exclusively elaborated for this study from Arrels Foundation database

Facilitators of Housing First fidelity

Systemic factors

Key informants singled out one key systemic factor in the Service Array domain as a facilitator of HF fidelity: the city's healthcare and mental health services. These services are public and free. Moreover, there are specific support services for homeless people, such as ESMES. As mentioned above, they provide direct support to vulnerable individuals with serious mental health issues. Currently, ESMES staff members visit patients referred by the HF programme's teams at Arrels Foundation. ESMES staff members collaborate frequently with Arrels Foundation's case managers. These interventions help to improve the quality of life of programme participants with mental health disorders.

Organisational factors

At the organisational level, various factors were identified as facilitators of HF fidelity. A strong facilitator of fidelity in the Housing Process and Structure domain is the programme's commitment to supporting people's right to housing. Interviewees emphasised that Arrels Foundation is committed to vulnerable people's right to housing, as indicated by their contributions to programme participants' rent, by their commitment to providing services through housing loss, and by their new facility, Flat Zero. Key informants also pointed to the ongoing improvement of the social and healthcare situation of programme participants as evidence for fidelity in this domain.

Table 2: Summary of facilitators and barriers

	Systemic	Organisational	Individual
Facilitators	1. Public Health Care and Mental Health services	2. Commitment to vulnerable people's right to housing 3. Partnership with Mambré Foundation 4. Arrels Foundation support people without documentation 5. The support goes on despite loss of housing 6. Local and international community networking 7. Harm-reduction approach 8. Stable and experienced staff teams 9. Specific training sessions and visits to European HF programmes 10. Volunteers participate with the teams 11. Programme participants are part of the board of directors and collaborate with Arrels Foundation's services 12. Strong relationships are built with programme participants 13. Leisure and sport activities offered	14. Personal values and expertise
Barriers	1. Private housing market crisis in Catalonia 2. Lack of public housing stock 3. Rehabilitation of housing is needed 4. Low incomes of the programme participants 5. Stigmatisation	6. Community involvement of the programme participants 7. Employment advice and occupational training are not a priority 8. Lack of peer-support workers in the services 9. A higher participant to case manager ratio entails less time intensive work 10. Non-differentiation of case manager role 11. Lack of assessment tools and services 12. Lack of external teams supervision	13. Some residual staircase practices

Key informants also identified the creation of Mambré Foundation as a facilitator of model fidelity. Mambré Foundation is a coalition of four major organisations in the city (Assís Shelter, Filles de la Caritat de Sant Vicenç de Paül, Sant Joan de Déu Hospital Order and Arrels Foundation). It contributes to the array of services offered to programme participants, such as housing supplies and employment advice. This is a local adaptation created due to the lack of private and public housing in Barcelona City. The partnership with Mambré Foundation is part of Arrels Foundation's current strategy to find and obtain housing in the area near the capital.

Since it was founded, Arrels Foundation has supported people who have immigrated without documentation and who have no access to any benefits. The beneficial effect of this local adaptation was expressed by various key informants, one of whom said, "It's worth pointing out that Arrels Foundation's position has always been extremely clear: when helping a person who is in a bad position – who has chronic problems – whether or not that person has documentation is not important" (P1).

Regarding the Separation of Housing and Services domain, key informants emphasised the benefits of knowing that their support will continue even if they lose their housing. This was a sentiment expressed by almost all the interviewees. One said: "[…] I think that housing is an important factor. However, it doesn't make any sense to only look after the house if you forget the original goal of supporting the person who lives there" (P5). The same service support in Arrels Foundation continues even if the participant goes to Flat Zero, returns to the streets, enters a rehabilitation centre, or goes to prison. Even after a participant passes away, Arrels Foundation ensures that the person has a dignified funeral.

In the Service Philosophy domain, key informants pointed to the local and international community networking as a facilitator of model fidelity. Working in a network is a strategy that favours and improves global perspectives in social intervention (Ubieto, 2007). Arrels Foundation has worked alongside European networks that implement Housing First for many years. Believing in a new and more efficient approach within an international context has provided much encouragement to the professionals who work in the organisation, which has been further strengthened by positive client outcomes. As a key informant said: "As an organisation, this decision to implicate ourselves in the international community has been beneficial; we have learned from international entities, we've developed. I think it has been a great help" (P2).

In the same domain, key informants also expressed that Arrels Foundation's experience of working in a harm-reduction model with street-dwellers facilitated their delivery of services with no pre-conditions. There was a consensus among several

interviewees that the fact that Arrels Foundation does not force programme participants to comply with treatment (for substance addiction, mental health issues, etc.) enables programme adherence.

In the Service Array domain, key informants described the teams as stable and experienced in working with homeless people, which helped to ensure an effective transition from a staircase model to a Housing First model. They also highlighted that case managers were aware of the difficulties that may arise from this cultural shift. Challenges to delivering the more client-led Housing First programme have been addressed through a variety of formative practices, including team collaboration and communication skills training sessions, international visits to HF programmes, and weekly team meetings, among others. The teams are coordinated in their service delivery and effectively support programme participants in self-regulation and relationships with neighbours.

Several key informants emphasized that the volunteers are a valuable local adaptation and an indispensable resource to the organisation and the people it attends to. Volunteers participate in support tasks alongside case managers' teams. They provide service users with a link to the community. As a key informant said: "[…] Volunteers are very important. In all the programmes, whether it's in the Housing First programme or at the centre or anywhere… They create bonds with participants and to me that is the key of all the work we do" (P2).

Key informants also identified the programme's emphasis on respect and fostering positive personal relationships as reflected in the team's cohesion and the organisation's Board of Directors' leadership style. It is important to note that programme participants are members of the Board of Directors and that some also collaborate in all of Arrels Foundation's services and departments. Arrels Foundation has worked for years to include programme participants in day-to-day tasks such as the administration and maintenance of materials and spaces, organising events and activities, and providing support to the Communication department. Although, this collaboration is not remunerated; they are not peer-support workers; it facilitates programme participants' influence on the services (Arrels Fundació, 2015). Key informants acknowledged that self-determination is crucial to recovery, a core HF principle (Gaetz *et al.*, 2013).

Several key informants highlighted the importance of building strong relationships among the volunteers, programme participants, and case managers. People engaged with Arrels Foundation have a very strong sense of belonging and consider the organisation as family. "A lot of people tell us: 'This is my family.' It's something we hear a lot. But for me it's important that this doesn't just refer to the four professionals in somebody's team, it means the whole of Arrels" said an interviewee (P3).

Key informants also identified the fact that Arrels Foundation offers both leisure and sports activities aimed at social integration within a holistic approach as a facilitator of fidelity in the domain of Service Array.

Individual factors

Key informants identified the personal values and expertise of the case managers as an individual factor facilitating programme fidelity in the Team Structure/Human Resources domain. Motivation and trust were seen as key factors that promote adherence to the programme. For professionals, this motivation is essential to team stability and to the development of workers' skills. One interviewee said: "I think in about 95% of the cases you're working with people who are animated, motivated, and who want to improve; who want to be more effective in what they do" (P1). The programme philosophy encourages team members' trust in the new approach. This is important because they are managing difficult situations with the programme participants whose complex financial, legal, and health problems can make them feel fearful and destabilize their housing situation.

Barriers to Housing First fidelity

Various factors were identified by key informants as barriers to model fidelity. These barriers are also organized according to systemic, organisational, or individual levels.

Systemic factors

The main barriers to model fidelity that key informants identified were systemic, especially in the area of access to affordable and appropriate housing in the Housing Process and Structure domain. The large number of evictions caused by the housing market crisis in Barcelona increased public awareness about the importance of the fundamental right to housing. Despite this increased awareness and the fact that homelessness is on local and regional governments' political agendas, investments have fallen short of what is needed to resolve the problem. The lack of public and private housing stock makes it difficult to access housing for programme participants.

There is an average six-month waiting period between housing unit acquisition and move-in for programme participants, mainly due to the lack of housing in Barcelona and the fact that housing units obtained are in poor conditions and require significant repairs. As a local adaptation, Arrels Foundation offers shared units or helps programme participants to rent rooms as sub-tenants. However, programme participants have few neighbourhoods to choose from.

As one key informant said: "It would be ideal to be able to choose which area to live in, but of course, if there are few flats available, the market shuts off the options you have to choose from" (P7). Another barrier identified by key informants to fidelity in this domain is programme participants' low-incomes. As stated earlier,

more than 7 out of 10 programme participants earn less than €500/month, the labour market is tight, and the number of employment services is low. Moreover, interviewees explained that their access to benefits and allowances designed to help guarantee personal autonomy is very limited. One key informant stated: "We always try and work to achieve autonomy for people. The problem we have is: can they ever really be autonomous while still receiving this income? Or are they dependent? That´s a conflict that I have struggled with" (P3).

Although Catalonia's Parliament has approved legislation for a Minimum Citizen Income of €664/month – published in the Official Journal of the Generalitat of Catalonia (Llei 14/2017, de 20 de juliol, de la renda garantida de ciutadania) – recipients at the moment only receive 80% of it and some of the eligibility requirements are difficult to demonstrate for some homeless people. Although these issues affect the personal autonomy of Arrels Foundation's programme participants, it does not hinder their access to housing, since the organisation uses its budget to pay rent even when programme participants have no income.

Key informants also pointed to the barrier of stigma around homelessness in the Service Array domain. Some key informants commented on cases in which programme participants have found themselves discriminated against by neighbours in their new communities. The stereotype of homeless people as a dangerous and unknown entity remains a force in the collective consciousness (Matulič, 2015, p.42). This is also notable in the difficulty Arrels Foundation has in finding flats to rent. As a key informant said: "I think the fact that Arrels Foundation is well known here […] in some cases it actually works against us, because people associate Arrels with people who live on the street" (P7).

Organisational factors

Various organisational factors were identified as barriers to HF fidelity at Arrels Foundation. In the Service Array domain, key informants pointed out the difficulties programme participants encounter when trying to get involved with the community and the strong feelings of loneliness that some experience when they move into individual units to live. Participants have few people in their social networks and their community engagement is low. This makes the role of the volunteers very important. One participant said: "The volunteers… are a big support. We're people who don't have a family to surround us – we're more or less alone in this life – and the volunteers cover the role that family or friends might provide, they give us company" (U2). Programme participants often find it hard to move away from the community network they created in the Arrels Foundation open centre and the neighbourhood where it is located. This is the district where the highest number of homeless people was identified in the 2017 count done by XAPSLL (Xarxa d'Atenció a Persones Sense LLar Barcelona, 2017b).

In the same domain, key informants also described how employment advice and occupational training are not, as of now, a priority for the organisation. One key informant said: “I think this barrier to accessing employment opportunities has to do with the fact that we don’t yet have a dedicated job search and insertion service, because that’s never been one of the entity’s priorities” (P4).

Although Arrels Foundation has been working for several years to increase clients’ participation in the different services and departments of the organisation, there is still scope to improve in this area. For example, peer- support workers have not yet been added to the organisation. Key informants explained that case managers and volunteers are still not fully convinced of the value of peer- support workers on the team and find it difficult to accept them as colleagues. One professional said, “We’re not at a stage yet where the participants can perform the same role as paid professionals” (P5).

Key informants identified the high participant to case manager ratio as a barrier in the Team Structure/Human Resources domain. “I think that often the participants need more support than they get. Sometimes we don’t provide it because we don’t have the resources […] but it’s not just professionals working at Arrels: we are professionals and volunteers working together” said one professional (P3). A lower participant to case manager ratio allows the case managers and volunteers to spend more time working on emotional and social aspects of the programme participants’ support needs (Matulič, 2015).

Undifferentiated housing and support roles were also identified as an organisational barrier to model fidelity that lead to situations that undermine relationships with programme participants. For example, one key informant said, “It can’t be right that the person who tells you that you have to leave your flat is also the person who is in charge of supporting you afterwards, it ends up contaminating the relationship that you have” (P1). The key informants highlighted that the fact that the Individual Support Team is responsible for ensuring that programme participants pay their rent, maintain their housing, and mediate with their neighbours in case of difficulties can result in a weakening of the bonds between case managers and programme participants.

Some interviewees also signalled the lack of a global strategy for monitoring and evaluating the services and the support provided to volunteers and case managers as a barrier to fidelity in the Service Array domain. This is compounded by the lack of established processes through which programme participants can assess the impact of the programme on their quality of life and provide insight as to how it could be improved. One interviewee said: “There is no formal evaluation system with set indicators. All the evaluation we do is subjective” (P3).

The last organisational barrier pointed out by key informants was that the organisation does not provide spaces for external supervision where case managers can deal with the difficulties and emotional consequences of working with programme participants who have challenging support needs. One interviewee said: "Obviously the implementation of supervision and training of Arrels's service teams in mediation skills is something that needs to be given more impetus and to be worked on" (P1).

Individual factors

Key informants identified one individual factor to HF fidelity, which was in the Service Array domain. The organisation has undergone significant transformation, facilitated by continuous training of volunteers and case manager teams. However, some residual staircase practices are still evident. For example, the monitoring and control of service users' activities is still common. Case managers face challenges in determining the appropriate intensity of engagement. "We try and keep some form of control over the person's life in their home… We do so respectfully, but I think it's something that has to be done. It's just not viable not to have any type of control," explained one key informant (P4). These situations highlight several ethical dilemmas linked to the autonomy and self-sufficiency of the programme participants with, in some cases, a certain amount of disagreement among volunteers and case managers. Team monitoring is not always well received and case management intensity is not always a decision made by the participant.

Discussion

Knowledge of the history of the organisation is important to understanding the context of the current programme. As Macnaughton *et al.* (2015) pointed out, the success of a new HF programme relies, in part, on the team's prior experiences, values, and commitment to the project, and on the alignment of the organisation's values with those of the HF model. Even when an organisation's members are willing to adopt an innovative, evidence-based project like HF, the transition is not always easy (Greenwood *et al*., 2013; Goering *et al*., 2014; Stergiopoulos *et al*., 2015).

Participating in this evaluation and international study has been a great opportunity for Arrels Foundation to reflect upon and discuss their daily work routines and to improve the alignment of Arrels Foundation's programme values with HF philosophy. These results confirm that, although the programme adheres closely to HF principles, there are several areas that require improvement. The strength of Arrels Foundation comes from its long tradition of working with homeless people using a philosophy similar to that of HF in terms of providing secure and permanent housing, its harm-reduction approach, and provision of flexible support for as long as is required (Pleace, 2016).

The highest fidelity scores were observed in the Separation of Housing and Services, Housing Process and Structure, and Service Philosophy domains. These findings suggest that Arrels Foundation has achieved levels of fidelity similar to those reported by other programmes, especially in the Separation of Housing and Services domain, which matched the same score obtained by Canada's *At Home/ Chez Soi* programme in their third year of implementation (Macnaughton *et al.*, 2015). Arrels Foundation's lowest fidelity score was in the Service Array domain, mirroring the results that were also reported for the first year *of At Home/Chez Soi* (Nelson *et al.,* 2014).

It is very important to maintain relationships with other services and organisations in the sector in order to collectively influence local and regional polices and increase housing access for programme participants, access to mental health services and addictions treatment. Our results indicate that strengthening the bonds between public and private institutions and getting new partners involved is important to the maintenance and diffusion of HF in Catalonia, in Spain, and in other countries (Macnaughton *et al.*, 2015). Our findings highlight the indispensability of our collaboration with the network of XAPSLL in Barcelona, of encouraging discussion and reflection about the HF model in Catalonia, and of participation in international HF networks and communities.

The results also demonstrate the importance of several local adaptations to the general success of the programme in the regional context. One of the most important has to do with the provision of housing. The provision of housing units helps the programme participants' recover their quality of life, especially in terms of material stability, restoring healthy habits, and re-establishing positive social and personal identities. These positive elements are in accordance with the results of other research projects carried out in different European countries (Bretherton and Pleace, 2015; Busch-Geertsema, 2013). As stated earlier, the partnership with Mambré Foundation plays an important role in helping the organisation to ensure the provision of housing.

Another local adaptation is that, since its beginning, Arrels Foundation has supported people who have immigrated without documentation and who have no access to benefits. Despite the evidence of the benefits of the HF model, options other than the HF model must also exist. Flat Zero, a low-threshold shelter for people who have been sleeping in the street long-term and for whom, for various reasons, it is difficult to access other resources or services in the city, is a valuable local adaptation. The cognitive deterioration caused by chronic psychiatric illnesses, loneliness, isolation, and aggressive behaviour, along with substance use,

and lack of income are examples of difficulties many programme participants face. The feeling of rejection, disengagement, and of not having access to their rights complicates their use of programmes and public services.

The large number of volunteers is an essential local adaptation that enhances programme participants' community engagement. As mentioned above, Arrels Foundation was created by volunteers, who are considered one of the driving forces of the organisation. Ramón Noró, one of the founders of the organisation who is currently the manager of the advocacy team, said that, "while volunteers help to engage individuals with the community and re-establish broken bonds, the Support Services team members ensure adequate case management is provided" (Noró, 2007, p.35). At the same time, volunteers contribute to increasing society's awareness of homelessness.

The results also confirm that the various teams that provide Arrels Foundation's services made up of case managers and volunteers are stable and have specific training and expertise in the HF model. They provide the knowledge and practical skills needed to deal with programme participants' complex situations. The commitment of the organisation's leadership to Arrels Foundation's mission is responsible in large part for the commitment of case managers and volunteers to providing long-term support to programme participants. These factors contribute to recovery orientation and adherence to individualized and client-driven support principles. It has also undertaken a significant cultural shift to adopt the Housing First model through trainings, conferences, and visits to other HF European programmes. These experiences have increased the team's sensitivity to service users' right to self-determination.

This evaluation identified several challenges to programme implementation and delivery that require attention. For example, the housing situation in Barcelona makes it remarkably difficult to obtain individual housing units at affordable prices, and therefore programme participants' choices become limited and the waiting times continue to increase. The extent of this problem complicates the adherence to the HF principle of providing immediate access to permanent housing. Without rapid growth in the public housing market, it will become increasingly difficult for Arrels Foundation to provide a solution to the housing needs of the programme participants.

The non-separation of housing and support services means that case managers must provide support services and attend to housing-related issues, and this can damage relationships between programme participants and case managers. The separation of the roles carried out by the case manager is an important aspect of the HF model (Tsemberis, 2010). The non-separation of housing and support service has not been implemented because it has not been a priority, nor has it

been a possibility due to financial restrictions. This is an important issue to which the organisation must pay special attention in order to ensure adherence to HF individualized and client-driven support principles.

The organisation needs to increase efforts to facilitate programme participants' community integration and access to the labour market in order to increase its adherence to HF principles of social and community integration. Programme participants' social isolation is also a new challenge that the organisation is addressing. As Realidades Association and RAIS Foundation state (Asociación Realidades and Fundación RAIS, 2007), an important goal and aspect of recovery is to help the programme participants create new relationships and rebuild relationships that were damaged during their homelessness. These new relationships enable new perspectives in the relations with primary welfare networks and community centres to pave the way for the process of social inclusion. The challenges that programme participants experience in building and rebuilding social connections reflect findings reported by other research on Housing First (Bretherton and Pleace, 2015; Bernad, Yuncal and Panadero, 2016; Bernad, Cenjor and Yuncal, 2016).

Limitations

There are several limitations of the evaluation in relation to the fidelity assessment and the key informant interviews. Regarding the fidelity assessment, the survey was filled out individually by staff members. Final scores were obtained from discussion in a consensus meeting. This method was used in previous evaluations (Macnaughton *et al.*, 2015). Limitations of this type of procedure include the possibility of some study participants dominating the discussion in the consensus meeting and their influence on the conclusions. Nine out of nineteen service heads and case managers from the HF programme participated in the self-assessment survey and the consensus meeting. Another methodological limitation is that ten additional members of the organisation attended the feedback meeting to observe. This fact could also have influenced the results.

Concerning the key informant interviews, we used individual interviews with key informants to gain insight into the facilitators and barriers to fidelity in the five key domains. While interviews with key informants proved valuable, focus groups could be used to ensure that more staff members, volunteers, and programme participants are heard (Macnaughton *et al.*, 2012; Macnaughton *et al.*, 2015). Furthermore, a meeting in which the interviewees discuss and compare their findings has occurred.

Conclusion

The experience of evaluating the fidelity of the Arrels Foundation HF programme provided us with an opportunity to reflect on and improve HF fidelity. In addition, this evaluation has offered Arrels Foundation a unique opportunity to evaluate its own capacities within the HF programme and to incorporate such self-evaluation into its processes. Some improvements were already implemented during the evaluation process. First, Mambré Foundation began searching for cheaper flats in the surrounding areas of Barcelona (Metropolitan Area of Barcelona) to deal with the lack of housing. Also, La Troballa, an occupational and labour workshop that promotes personal habits and skills-recovery for Arrels Foundation's programme participants who are in vulnerable situations, hired more staff and moved into a new building that is more than triple the size it once was. It is designed to provide support for the reintegration of programme participants into the labour market, provide training in practical, work, and social skills, as well as employment advice. Finally, the Arrels Foundation began to carry out external supervision sessions with the teams. It has also created a working group to study strategies around how best to include peer-support workers into the services.

The results of the Arrels Foundation HF programme also provided some recommendations for areas that the organisation needs to work on in order to improve fidelity with the HF model. These include: implement a more clearly defined separation of the roles of the case manager; promote the community integration of the programme participants; establish a formal procedure for the evaluation of organisational practices; achieve a lower participant to case manager ratio; and improve the continuous training that is currently offered to professionals and volunteers.

In sum, comparing our results with other countries has enabled us to identify common challenges and design possible strategies to overcome them. Making these evaluations in an international context contributes to the project's credibility and sustainability (Nelson *et al.*, 2017). Cross-country comparisons will allow us to identify whether the systemic barriers we encountered are also encountered in other social and political contexts.

We share a history of significant economic recession and housing crises with other Western countries. This presented difficulties in accessing housing for our programme participants through the private and public markets. In the Catalan context, social support services for homeless people have increased, but are still not enough to meet demand.

Comparisons across Western countries will illuminate similarities and differences in systemic barriers to mobilizing effective support for programme participants. Cross-country comparisons may also highlight similarities and differences in cultural shifts toward client-led, recovery-oriented services. Taken together, these comparisons will yield important information about the context of implementation and the areas in which organisations need to focus their efforts in order to implement effective programmes with a high level of model fidelity.

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Fidelity Study of the "Un chez-soi d'abord" Housing First Programmes in France

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Abstract_*"Un chez-soi d'abord" is a national pilot programme of Housing First, implemented from 2011 to 2016 in four French cities: Lille, Marseille, Paris and Toulouse. Service users in this study were single adults with severe mental illnesses and addictions, who were homeless. This article presents the results of a Housing First fidelity assessment and key informant interviews with staff members at each site examining facilitators and obstacles to achieving fidelity. The four sites showed moderate to high fidelity to the Housing First model. All of the sites showed consistently high fidelity in the Separation of Housing and Services, and in Service Philosophy domains. In the Housing Process and Structure domains, some sites had lower fidelity scores in relation to availability of affordable housing and facilitating participants' choice of neighbourhood. Lower scores in the Programme Structure and Human Resources and Service Array domains were found in two or more programmes on items relating to participant access to substance abuse treatment and employment and volunteer opportunities, participant input to programme development and improvement, and having a peer support worker on the team. Key informants identified systemic, organisational and individual facilitators and barriers to implementing the Housing First model in France. Facilitators included the guaranteeing of rent payments to landlords, holding direct lease agreements, team members' commitment to Housing First values and a positive approach to developing Housing First practices and tools. Barriers included the high cost of rental housing, landlord stigma against service users, a shortage of client choice of quality housing, lack of partnerships with complementary services, external resistance to the Housing First*

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philosophy, and low salary and training opportunities for peer workers. The paper documents the successful, innovative, and challenging implementation of Housing First for the first time in France.

Key words_*Housing First, homelessness, evidence based practices, public policies.*

Introduction

After the Second World War, France developed a comprehensive social welfare system. In recent years, however, this system has begun to show its limitations and inability to solve structural problems such as increased unemployment, growing social inequalities, and fractured families (Novella, 2010). It has not yet effectively responded to economic instability and has faced increased pressure from a large number of new immigrants and an insufficient stock of social housing.

In France, the national government is responsible for organizing support and accommodation for the homeless population. In 2007, after public protests by NGOs and civil society organisations, a law was passed ensuring the "right to housing" (Cours des comptes, 2007). Since then, national programmes that promote unconditional access to shelters and housing-led policy have been developed from large governmental financial investments. In 2017, the government invested €1.8 billion in the "social insertion and housing" policy for the homeless population (Ministère de la Cohésion des territoires, 2017a).

The government is not only in charge of organizing funding for social housing and construction, but also provides a "personalized housing income" to support housing access and maintenance for the poorest populations in the country. This provides coverage for approximately 6.5 million households. However, like most European countries, rather than fostering direct access to housing, most social programmes for people who are homeless in France still favour the staircase model, where people have to be considered "ready" for independent living before they may move into their own housing (Busch-Geertsema, 2013).

Moreover, municipalities are required to deliver building permits and are often reluctant to greenlight buildings that house people living in poverty with complex needs. The 21st Annual Report on the state of housing in France by the Foundation Abbé Pierre noted that French national housing policy is failing to address the lack of affordable housing and the poor quality of the available housing (Foundation Abbé Pierre, 2016). The report indicated that in 2016 an estimated 3.8 million people in France were poorly housed, while approximately 12 million were affected by the housing crisis.

In France, the universal health coverage system (La Protection Universelle Maladie) provides access to care for people living below the low-income threshold without a fee. However, accessing these services is difficult, especially for vulnerable populations who cannot always navigate the complex system (Archimbaud, 2013). This complexity contributes to a high percentage of people who do not access care and support for which they qualify. An estimated 20% of those who are eligible for social assistance never submit an application (Archimbaud, 2013). This is exacerbated by compartmentalization and lack of coordination between social programmes that not only results in a breakdown of the care and support, but also contributes to extra costs for public authorities (Girard *et al*., 2010).

These limitations extend to the mental health care system. Like most developed countries, mental health care in France has been deinstitutionalized and initiatives that aim to provide individualized support in the community have been implemented (Florentin *et al*., 1995). Through this process, a large number of beds in psychiatric hospitals were closed. From 1970 to 1990, approximately 88,000 psychiatric beds throughout hospitals in France were closed, and the average length of stay for psychiatric patients decreased from 250 to 57 days (Florentin *et al*., 1995). However, alternatives to hospitalization were insufficient and unequally available throughout the country (Roelandt, 2010; Coldefy *et al*., 2009). Today, the mental health system is ill-equipped to care for individuals with severe mental illness or addictions who are homeless. An increasing number of people suffering with severe mental illness, such as schizophrenia, end up living on the street for long periods of time, sometimes even for years (Damon, 2002).

In 2012, the National Institute of Statistics and Economic Studies (INSEE) estimated that approximately 143,000 people living in France were homeless, a 50% increase from 2001 to 2012 (Yaouancq *et al*., 2013). Among this population, an estimated 10% are rough sleepers. A meta-analysis of studies from 1979 to 2005 on the prevalence of major mental disorders in the homeless population, conducted in Australia, Europe, and the United States, found that 30% to 50% of people who were homeless suffered from diagnosable mental health issues (Fazel *et al*., 2014). The average prevalence of psychotic disorders across studies was 13%, while severe depression accounted for approximately 11%. Moreover, mean prevalence of alcohol dependence was 38%, while the mean prevalence of drug dependence was 24%.

A 2010 French survey conducted by Laporte and Chauvin (2010) confirmed that people suffering from severe psychiatric illnesses were at an increased risk of homelessness. This study demonstrated that individuals suffering from schizophrenia were particularly vulnerable to homelessness and were also more likely to experience verbal and physical assault. Take out compared to people who are

homeless. No epidemiological studies have been conducted in France concerning the presence of physical illnesses, but front-line social workers have observed that the health of homeless people is seriously compromised and associated with a low quality of life, with the average age of death around 45 years old (Lettre N° 3, 2013).

"Un chez-soi d'abord": Development of the Housing First model in France

A 2010 Report on Homelessness, mandated by the Minister of Health and Sports in France emphasized that being homeless is associated with much higher morbidity and mortality rates than the general population (Girard *et al*., 2010). The authors recommended the adoption of a "Housing First" (HF) model in France. This recommendation was fostered by a national law ensuring the "right to housing", lobbying by international organisations for access to housing to become a fundamental human right, as well as the positive experiences of other countries with HF. For these reasons, the government of France agreed to test this strategy in a pilot programme.

The *"Un chez-soi d'abord"* research demonstration project of HF was implemented from April 2011 to December 2016 in four French cities: Lille, Marseille, Toulouse and Paris. It focused on delivering services to people with severe and persistent mental illness and complex needs who were homeless. Based on the "Pathways HF" model, the demonstration programmes provided access to independent scattered housing directly from the street with multidisciplinary intensive support from an Assertive Community Treatment (ACT) team (including psychiatrists, general practitioners, harm reduction specialists, nurses, social and peer workers) 24 hours per day and 7 days per week (Tinland *et al*., 2013).

Flexible support was provided by the ACT team as long as needed and consumer choice over treatment was respected. The team was recovery-oriented and offered services to consumers based on a harm reduction philosophy. Once housed, professionals made regular home visits and provided support that covered all aspects of life (health, housing, employment, citizenship). In total, more than 80,000 home visits were made during the pilot period by the four sites (on average one home visit per week and person). Housing and supports were separated: people were supported even if they left their apartments and became homeless again. About 80% of the housing was provided by private market landlords and 20% by social housing providers (Tinland *et al*., 2016).

Funding for the programme came from the state for the housing side and the health insurance system for the support side. The programme was led by an inter-ministerial delegation. In each city, health care, social service, and housing operators

cooperated to manage the programme. A steering committee was formed to coordinate the different stakeholders from these three sectors. National coordination focused on ensuring fidelity to the "Pathways HF" model (Tsemberis, 2010) by offering training and assistance. As a result, the framework of the programme is quite similar in the four sites.

Alongside the pilot programme, researchers conducted a randomized controlled trial, which was the first within the community mental health sector in France (Tinland *et al*., 2013). In total, 705 people were included in the research, 353 of whom were in the *"Un chez-soi d'abord"* programme and 352 in the standard care group. The average age was 38.5 years and 82% were male. The average total amount of time homeless was more than eight years, of which 4.5 years were spent as rough sleepers. In line with the eligibility criteria for being a study participant, 100% of participants had a severe and persistent mental illness (schizophrenia 70% and bipolar 30%), and 80% had a drug abuse problem (Tinland *et al*., 2016).

The *"Un chez-soi d'abord"* programme was found to be cost effective during the two-year study period. The participants in the HF cohort experienced rapid access to housing that averaged 28 days from referral to being housed. About 85% of the HF group experienced housing retention at the 24-month follow-up. Compared to individuals in the standard care group, HF participants reported having a better quality of life, especially those with diagnoses of schizophrenia. There was also a significant reduction in health service utilization, with a 50% decrease in hospital stays, and decreased use of homeless services. The savings associated with decreased use of health and social services offset the total cost of the programme (Tinland *et al*., 2016).

The evaluation committee met in 2016 and analysed the different reports of findings. The committee concluded that the programme effectively responded to the needs of the homeless population and complied with public policy concerning this target group. It also concluded that the programme was cost-effective and delivered value-added services compared to traditional services. Moreover, it was determined that the use of resources in delivering the programme had been carried out efficiently (DIHAL, 2016; DIHAL, 2017).

As a consequence of the demonstration project's findings, HF has become a community health service under the "social action and family code named, "*Un chez-soi d'abord*" (JORF N°0303, 2016). Besides the four pilot sites, HF programmes are planned in 16 other cities in France with 2,000 people included in total by the end of 2023. The result is a new public policy to tackle homelessness for people with severe and persistent mental illness and complex needs (Estecahandy *et al*., 2018).

Fidelity Evaluation to the "HF" Model

In contrast to other European countries, France does not have a tradition of evaluating public policies. Moreover, the concept of "evidence-based policy" is not standard for informing policy decision-making, even though, since 2000, this process is gaining more importance.

"Un chez-soi d'abord" is the first study in France to test an evidence-based community mental health programme (Goering *et al*., 2012). Evaluation of model fidelity is a key process in determining the extent to which the programme was implemented in line with an "evidence-based" approach. The objective of this present study is to measure fidelity to the Pathways HF model (Tsemberis, 2010) in the four HF pilot programme sites, and to determine factors that facilitated or impeded programme fidelity.

Method

The methods consisted of a self-administered HF fidelity measure, followed by a conciliation session to reach consensus ratings on each of the fidelity items in the measure. Subsequently, semi-directed qualitative interviews were conducted with the coordinators at each of the four sites to identify factors that facilitated or impeded programme fidelity. Table 1 presents the characteristics of the four sites, the number and type of professionals who completed the survey, as well as their time working on the team and the number of national training sessions they attended.

Table 1. Fidelity Assessment Item Scores and Domain Means Per Site and Across Sites

Domain Items	Site Mean				Total Mean
	1	2	3	4	
Housing Process and Structure	**3.6**	**4**	**3.4**	**3.9**	**3.7**
1. Choice of housing	4	4	3	4	3.8
2. Choice of neighborhood	3	4	3	4	3.5
3. Assistance with furniture	4	4	4	4	4
4. Affordable housing with subsidies	3	4	3	3	3.3
5. Proportion of income required for rent	4	4	4	4	4
6. Time from enrollment to housing	3	4	3	4	3.5
7. Types of housing	4	4	4	4	4

Separation of Housing and Services	**4**	**4**	**3.9**	**3.9**	**3.9**
8. Proportion of clients with shared bedrooms	4	4	4	4	4
9. Requirements to gain access to housing	4	4	4	4	4
10. Requirements to stay in housing	4	4	4	4	4
11a. Lease or occupancy agreement	4	4	4	4	4
11b. Provisions in the lease or agreement	4	4	4	4	4
12. Effect of losing housing on client housing support	4	4	3	4	3.8
13. Effect of losing housing on other client services	4	4	4	3	3.8
Service Philosophy	**3.6**	**3.9**	**3.9**	**3.8**	**3.8**
14. Choice of services	3	4	4	3	3.5
15. Requirements for serious mental illness treatment	4	4	4	4	4
16. Requirements for substance use treatment	4	4	4	4	4
17. Approach to client substance use	4	4	4	4	4
18. Promoting adherence to treatment plans	2.5	4	4	3.5	3.5
19. Elements of treatment plan and follow-up	4	3.6	3.6	4	3.8
20. Life areas addressed with program interventions	4	4	4	4	4
Service Array	**2.6**	**2.8**	**3.3**	**3.7**	**3.1**
21. Maintaining housing	3	3	4	4	3.5
22. Psychiatric services	3	3	3	3	3
23. Substance use treatment	3.2	1.6	2.4	2.4	2.4
24. Paid employment opportunities	1.6	2.4	2.4	4	2.6
25. Education services	1.6	4	4	4	3.4
26. Volunteer opportunities	1.6	2.4	3.2	4	2.8
27. Physical health treatment	2.4	3.2	4	4	3.4
28. Paid peer specialist on staff	4	2	3	4	3.3
29a.Social integration services	3.2	4	4	4	3.8
Program Structure	**3.3**	**2.9**	**3.2**	**3.4**	**3.2**
31. Client background	4	4	4	4	4
33. Staff-to-client ratio	4	4	4	4	4
34b.Frequency of face-to-face contacts per month	4	2	2	4	3
35. Frequency of staff meetings to review services	3	3	4	4	3.5
36. Team meeting components	2	3.3	3.3	2	2.7
37. Opportunity for client input about the program	2.7	1.3	2	2.7	2.2
Total	**3.4**	**3.5**	**3.6**	**3.7**	**3.6**

Three programmes were launched in August 2011 and one in June 2012. The fidelity evaluation took place in 2016, five years after initial implementation in the case of three sites and four years after implementation for the fourth site.

Fidelity assessment

Measure

The self-administered fidelity measure was developed and validated in English (Gilmer *et al*., 2013; Goering *et al*., 2015; Stefancic *et al*., 2013). It was used by Canadian researchers in a follow-up study of the At Home/Chez Soi project that included a translation of the measure into French (Nelson *et al.*, 2014). It is composed of 36 items that assess five domains of programme fidelity in HF programmes, namely Housing Process and Structure (7 items), Separation of Housing and Services (6 items), Service Philosophy (7 items), Service Array (9 items), and Programme Structure and Human Resources (7 items). For many of the survey items, participants choose a response alternative from four choices that are scaled from 1 (low fidelity) to 4 (high fidelity). Other items have fewer or more alternatives and some items ask participants to choose all those that apply. A scoring key developed for the international fidelity study converted all scores to a standardized 4-point scale. The French version was tested in the four pilot sites in France in January 2016 to ensure translation accuracy, given the French-Canadian translation.

Procedures and sample

In each of the four sites, from February to April 2016, the National Coordinator invited all team members who had been on the team for six months or longer to complete the fidelity questionnaire. The questionnaires were left at the disposal of each team member so that he or she could respond individually at that moment or at a later time. As shown in Table 1, ten members of the programme staff completed the measure in three sites and nine members completed it in the other site. Participating programme staff represented different professional disciplines (i.e., psychiatrist, psychologist, nurse, social worker, general physician, peer support worker).

In a second stage of the study, a 90-minute meeting was conducted with the National Coordinator (in three sites) or a national research team member (in one site) and programme staff to define consensual collective scoring of each item with those service providers who had completed the self-administered survey. In one of the sites, nine members of the programme team completed the self-administered questionnaire and eight of them participated in the conciliation session. Otherwise, all individuals who completed the questionnaire participated in the conciliation session. The score for each item rated by staff was reviewed. In cases of disagreement, programme staff discussed reasons for their ratings on the measure and continued to discuss their differences with other programme staff until a consensus was reached with a final score.

Data analysis

Subsequent to the conciliation meeting, consensus ratings on items were scored using a calculator developed for the international fidelity study. The calculator converted all items to a 4-point scale and produced an average score for each domain and a total score.

Key informant interviews

Procedures and sample

As detailed in Table 1, the national coordinator conducted key informant interviews with the local coordinator of each site. In two of the sites, the team psychiatrist was also present and participated in the interviews. The national coordinator conducted the 90-minute meetings face-to-face for two sites and by telephone for two sites. The national coordinator was in possession of the consensual ratings for each site and used these to guide the discussion on items showing high and low fidelity to a HF approach. The interview also included general questions concerning challenges faced by programmes in accessing housing, hiring and integrating peer workers on the team, human resources management, factors facilitating recovery, and the relationship between housing and recovery.

Data analysis

The national coordinator took detailed notes during the qualitative interviews, which served as the qualitative database. Following the procedures agreed for the cross-country project (Aubry *et al*., 2018), the qualitative data were coded thematically for each site and categorized as being either facilitators or barriers to achieving programme fidelity. The themes were then compared across all four sites. Subsequently, the themes that were common across all four sites were identified and categorized further as reflecting factors at the systemic, organisational, or individual level.

Results

Fidelity assessment survey

Table 1 presents the domain and total item averages for each of the four sites. The average total score for the 4 sites is 3.6/4. The total scores of the sites were similar, ranging from a low of 3.4 to a high of 3.7. Given that an average score of 3.5 or greater on the measure is considered a high level of fidelity to the Pathways model (Nelson *et al*., 2014), three programmes were rated on average as having a high level of fidelity while the other programme was assessed as being close to achieving a high level of fidelity (3.4/4.0). The highest domain average scores across the four sites were apparent on items in the Separation of Housing and Services (average of 3.9/4), Service Philosophy (average of 3.8/4), and the Housing Process and

Structure domains (average of 3.7/4). The other two domains, Service Array (average of 3.1/4) and Programme Structure and Human Resources (average of 3.2/4) were assessed as having lower average fidelity scores.

Items in the Service Array domain with low average scores across the sites were the following: (1) Availability of substance use treatment at all of the sites (average of 2.4/4), (2) availability of paid employment opportunities at three of the sites (average of 2.6/4), and (3) availability of volunteer opportunities at two of the sites (average of 2.8/4).

Items in the Programme Structure and Human Resources domain with low average scores across the sites were the following: (1) Opportunity for client input in the programme had low scores for all the sites (average of 2.2/4), (2) team meetings serving multiple functions in following clients and planning services with them had low scores at two of the sites (average of 2.7/4), and (3) frequency of face-to-face contacts with participants per month had low scores at two of the sites (average 3.0/4).

As shown in Table 1, there were a small number of items specific to individual sites on which low fidelity ratings were assessed by programme staff. Specifically, these consisted of the promotion of adherence to treatment plans at site 1 (2.5/4), facilitation by the programme to physical health treatment for participants at site 1 (2.4/4), facilitation to education-related services for participants (1.6/4) at site 1, and the presence of a paid peer specialist on staff at site 2 (2.0/4).

Qualitative Interviews

Tables 2 and 3 provide a summary of the facilitators and barriers to fidelity identified in the qualitative interviews.

Table 2. Summary of Facilitators for Achieving Housing First Fidelity

Systemic	Organizational	Individual
Access to housing through direct lease agreements	Commitment to Housing First philosophy	Staff member commitment to values and approach to practice
Government social housing assistance	Team members learning through experience over time	Peer workers on teams
Guarantees of rent payment by the government to landlords	Coordination among team coordinators	
	Development of tools and best practices to gain access to housing and partnerships	
	Regular training and team building promoting HF and harm reduction principles	
	A wide awareness of the mainstream resources that can offer a large range of service	

Table 3. Summary of Barriers to Achieving Housing First Fidelity

Systemic	Organizational	Individual
High rent costs of housing	Difficulty making proactive partnerships with a large range of services	
Discrimination of landlords/ society to the profile of service users	Lack of funding for hiring full-time housing and peer support workers and training of volunteers	
	Novelty of the program and lack of experience	
Limitations on "client choice" for type of housing and location.	Resistance from social service and psychiatric professionals towards Housing First with a preference towards Treatment First	
	Low salary and lack of integration and specific training for peer workers within the team	

Systemic facilitators of fidelity

Government social housing assistance. The State and certain municipal governments helped to facilitate HF by reserving a portion of the public housing sector specifically for the roll-out of HF in the trial.

Guarantees of rent payment by the government to landlords. Key informants identified two rent payment programmes as facilitators to HF fidelity. HF clients can receive both of these supports. The French welfare system offers individual housing aid to people whose income is below a certain threshold. The allowance covers part of the rent and can be applied to both public and private sector housing and can be paid to the tenant or directly to the landlord.

The second rent payment programme is termed the "rent intermediation system" (IML), where an association receives government funding to act as a guarantor to a landlord. This system was developed to address very high private rent rates in large cities, as well as a lack of public sector housing. It began in the private sector but due to its effectiveness, the public sector also began to offer rent intermediation, although usually direct public sector leases are encouraged. The intermediation alleviates some uncertainty that private landlords report around renting directly to people who are homeless. In addition, tenants receive a form of protection because they do not sever relationships with landlords in circumstances where they have challenges paying rent. Rent intermediation must be a temporary help, usually for two years, after which time a landlord sometimes arranges a direct lease with the tenant, although it is not required. If he refuses, the client can continue to have a sub-lease but it is not an ideal situation for developing empowerment.

Access to housing through direct lease agreements. Key informants agreed that direct lease agreements between tenants and landlords were a key way the HF model was facilitated. These are most often arranged in the public sector, although some private landlords have provided them as well. Key informants observed that direct lease agreements increase security and neighbourhood integration because people are not obliged to move from the first apartment in cases of refusal from the landlord to a proposed direct lease.

Organisational facilitators of fidelity

Coordination among team coordinators. Key informants felt that the coordinated effort to implement HF across the four sites led to a more in-depth understanding of the model and its principles among team members. This coordination helps programme teams stay on track on many levels, in the form of regular inter-site meetings, through the role of a national coordinator, and local-level coordination of roles within each team. These efforts resulted in information sharing across sites about practices. Recognizing the leadership role as essential, the actual term "coordinator" was important to key informants. One noted that "… horizontal management is a key point with having a coordinator rather than a director."

Commitment to HF philosophy. Key informants also noted that coordinated support across the sites brought further legitimacy to the HF model and helped sites support each other when carrying out services consistent with the programme philosophy, particularly in difficult times and when facing criticism from other health and social services programmes in the community.

Team members learning through experience over time. Key informants referred to what they called "practical jurisprudence" to explain how the team members learned through experience. Borrowing from the judicial system, where previous court decisions guide judges' decision-making, the HF teams use the term to refer to the process of testing strategies in new situations that then turn into guidelines and common practice moving forward.

At the initial stages of the project, the model was implemented as the French team had seen it practiced in Canada and the United States. Over time, they adapted the model to the French context. Throughout this process, the team reflected on how to apply HF philosophies in particular situations, or how to target recovery in their work. As team members gained experience, their practice also developed. As a result, the four sites developed a community of practice, and thus built guidelines and a model suited to the French context.

Development of tools and best practices to gain access to housing and partnerships. One of the four sites launched the HF model before the others. Given that they had fewer financial resources before the broader implementation rolled out,

site staff needed ingenuity to adapt tools and approaches for accessing housing. They were also pushed to work closely with partners. This experience that was shared with other teams then became a facilitator of fidelity for all teams. When speaking about partnerships in particular, one key informant said, "It takes time to develop partnerships but it's as important as the individual follow-up of the client, at least in the beginning of the programme… it's the key to introduce a large range of services".

Regular training and team building, promoting HF and harm reduction principles. Key informants noted that in order to achieve high fidelity, training and coaching must be offered regularly, for both new members of the team, as well as the entire team itself. Training covered the topics of recovery, harm reduction, and motivational interviewing, and included simulations, coaching, and concrete action. Coaching involved team members going together in pairs to clients' homes, which fostered security and trust within the team. One key informant explained, "(A) community of practice decreased professional turn-over" and "the promotion of team building" was a key factor.

Wide awareness of the mainstream resources that can offer a large range of services. When the sites knew about a wide range of services available in their areas, they could provide direct support to people effectively by assisting them to access them. Fidelity related to the Service Array domain in HF programmes requires this reliance on resources from the community.

Individual facilitators of fidelity

Staff member commitment to values and approach to practice. Staff recruitment was highlighted as a particularly important facilitating factor. A key informant stated, "We need committed and engaged professionals." There was general agreement that it is more important to hire people who hold values consistent with the recovery model. In the hiring process, the coordinators particularly looked for professionals who believed in harm reduction and who had an understanding of stigmatization as a result of mental illness.

Peer workers. Similarly, a key informant noted that "… peer workers can help change other professionals' views of mental illnesses as well as facilitate clients' participation [in treatment]." Each site hired two peer workers during implementation, one-third of whom had prior training. As a result, all peer workers completed team training sessions. Key informants noted that when peer workers were well-integrated in the teams, they played a major role in facilitating recovery efforts. They helped to simplify clients' interactions with other staff members, and they positively influenced the staff teams' views of mental illness.

Systemic barriers to fidelity

High costs of housing. The high cost of rent in the private sector was described as a systemic barrier to fidelity. As previously mentioned, the national government provides individual housing allowances directly to landlords on behalf of tenants, who are required to pay the remaining difference. However, because the rent for most housing is so expensive, the remaining amount is often too high for many clients, limiting their access to housing.

Discrimination of service users by landlords/society. While rent intermediation is initially a major facilitator of getting clients housed, unfortunately, landlords mostly refuse to renegotiate the lease in the tenant's name after two years. With this system, the client continues to have a sub-lease contract and will have difficulties to feel empowered regarding his social situation.

As one key informant commented, "IML allows access to the private housing market but also limits direct leases between tenants and landlords." The IML system provides an incentive for landlords, not only through tax benefits, but more importantly, a guarantee of rent and repair of potential damages, especially with tenants who have complex needs. Without this, clients are considered "at risk", and landlords rarely enter lease contracts directly with clients.

Limits on client choice of type of housing and location. The high cost of rent in the private sector limited client choice to an extent, because much of the financially-accessible types of housing are low in quality, located in poorer and less accessible neighbourhoods with fewer public services and higher crime rates. Furthermore, client choice was limited due to social service and psychiatric professionals' resistance to HF. For example, at one site, the municipal officials put limits on the number of clients who could choose apartments closer to the city centre, even after they were informed that client choice is a critical and guiding principle of HF. As a result, team members had to propose housing in suburban areas to tenants, which as one key informant described, resulted in a "negative impact for the team in terms of increasing the time in public transportation and decreasing time with the client during home visits."

Another key informant commented that "recovery-oriented care" was not the norm in France and the conflicting model approach is "(…) difficult for the client" when on one hand, psychiatrists provide treatment without the primary goal of client involvement, while HF philosophy is oriented towards client choice and a specific aim "(…) to develop empowerment strategies".

Organisational barriers to fidelity

Lack of partnership with external complementary services. When launching the programme, team members had to move quickly to provide training, acquire housing, and integrate clients within a 36-month deadline. As a result, team members did not have sufficient time to dedicate to building partnerships, and could not adequately direct clients towards available community services. One key informant explained, "It takes time to develop partnerships, but it's just as important as following up with clients, especially in the beginning of the programme, (…) where it's important to provide them with a large range of services". Building these relationships was difficult for the team in the beginning, as one key informant described, "It takes time to understand the principles and then put them into concrete actions".

Resistance from social service and psychiatric professionals towards HF. As noted above, preference for "Treatment First" approaches among external services also made building partnerships difficult. One key informant described how they were heavily criticized in the beginning by social service and psychiatric care systems. It has been difficult to maintain relationships with external social and health programmes because the team felt pressured to remain "in the bubble" to protect itself from the social and psychiatric system's criticisms.

The HF model called into question common and accepted practices among psychiatrists, as well as other service providers caring for people who are homeless in France. Team members expressed difficulty with the pragmatic nature of the model that emphasizes building on and improving aspects of people's daily lives, rather than the psychoanalytic approach that is most of time the dominant theoretical approach present in French psychiatric services.

Novelty of the programme and lack of experience. "*Un chez-soi d'abord"* is the first HF programme in France. Team members had no prior experience with the model and were trained while simultaneously working towards acquiring housing and integrating clients into the programme. This was difficult for certain teams and some professionals resigned from teams because their approaches were not compatible with the service philosophy of the programme.

Low salary and lack of integration and training for peer workers. Key informants noted that the "low salary and lack of training for peer workers are an issue" for team integration. There were no official positions to recognize peer support workers, and some actually lost income by working for the programme rather than receiving a disability pension. In this context, it is essential that their roles are better defined and recognized within the mental health system.

Discussion

This paper describes a HF fidelity assessment of *"Un chez-soi d'abord"*. The four sites in this pilot were relatively homogenous in terms of programme staff and training. At each site there was a balance of both health care and social service professionals, as well as at least one peer worker. During the evaluation process, most professionals had about four years of experience in their fields and had attended at least one of the national training sessions.

Overall, assessment scores showed strong fidelity to the HF model at all four sites, with a total average score of 3.6 out of 4.0. Separation of Housing and Services and Service Philosophy domain scores were relatively similar at all sites and showed strong adherence to the model.

There was some variability in the Housing Process and Structure domain scores, although overall domain scores were high. Lower scores reflected differences in housing availability. Differences existed across all sites under the Service Array and Programme Structure and Human Resources domains. Service Array measures proved to be highly variable. The presence of peer support workers under this domain was very different in each site. In the Programme Structure and Human Resources domain, teams had lower fidelity particularly related to frequency of face-to-face contact with clients, team meeting components, and client input.

Qualitative interviews with key informants provided insight into some of these low and variable fidelity scores. While the fidelity measure showed overall high fidelity across sites, the qualitative data highlighted the complexities of implementing the model in France for the first time. Key informants identified several systemic, organisational and individual facilitators and barriers of programme fidelity.

Systemically, housing aid and rent intermediation were described as major facilitators of HF by fostering access to housing and promising a guarantee of rent payment. However, while rent intermediation was initially helpful, the fact that direct leases were not re-negotiated due to the stigmatization of HF tenants by landlords often acted as a barrier. These challenges were worsened by the high cost of housing, which limited client choice of type and location of housing.

In Aubry *et al*.'s (2015) study of private landlords' perceptions of HF, the provision of guaranteed rent was identified as a key landlord incentive to rent to HF tenants. While some landlords in Aubry *et al*.'s study held stigmatizing attitudes toward homeless people with severe mental illnesses, they acknowledged that renting to people in the HF programme provided them with financial and social benefits.

The re-housing of HF tenants has also been identified as a challenge in the HF literature. Re-housing in Macnaughton *et al*.'s (2015) study was framed as more of an organisational or individual barrier. HF research also identifies low housing availability as a major barrier to implementing the model. Finding good quality, affordable housing in areas that people want to live is a continuous challenge in many countries (Nelson *et al*., 2014; Macnaughton *et al*., 2015).

Looking to the fidelity literature more broadly, Aarons *et al.* (2011) divided factors that affect programme fidelity into "outer" and "inner" contexts. The systemic factors related to implementation of HF in France fit into the concept of the outer context factors, external to the programme itself. Aarons *et al.* identified public policies and funding issues within the outer context, aligning with the challenges related to lack of housing availability and rent intermediation affecting the HF programmes in France.

Organisationally, the French teams in this study were highly coordinated and committed to the HF philosophy. They had a thoughtful approach to gaining experience and developing the French HF practice, based on ongoing learning and reflection. Team members gained experience over time, received ongoing training, and worked to develop tools and practices to gain access to housing and partnerships.

Organisational factors, such as training, leadership, and coordination, are also highlighted in the HF literature as facilitators to successful implementation (Nelson *et al*., 2014; Macnaughton *et al*., 2015). In their study of HF sites in Canada, Macnaughton *et al*. (2015) described a high level of staff commitment to the HF philosophy, which drove the development of local HF practices.

These organisational factors fit within Aarons *et al*.'s (2011) concept of the inner context of moderators of fidelity. The implementation science literature consistently identifies the internal factors reported in the HF French sites: effective leadership, training and ongoing support, and staff engagement (Carroll *et al*., 2007; Durlak and DuPre, 2008; Aarons *et al*., 2011).

While the HF sites in this pilot reported organisational strengths and programme novelty, the lack of previous experience with HF by programme staff served as a barrier. The peer worker components were a facilitator to fidelity to the model but key informants reported low peer worker salaries and a situation in which the peer worker was not a recognized position in mental health services in France. These barriers are reflected in some lower fidelity ratings in the domains of Service Array and Programme Structure. The shortage of peer workers on HF teams and lack of

client input are significant because they are key contributors to programme success in the HF literature (Nelson *et al*., 2014). Macnaughton *et al*. (2015) noted challenges integrating peer workers into the programme in a meaningful way as well.

Finally, while the sites in this study reported high levels of trust and unity internally and across sites, building partnerships with external complementary services served as a major programme barrier. The programme faced resistance from social service and psychiatric professionals towards the HF philosophy, who preferred the traditional treatment-first model rather than client-centered harm reduction approaches.

External partnerships have been identified as a core driver for successful implementation of HF, highlighting the significance of this barrier in France (Nelson *et al*., 2014; Macnaughton *et al*., 2015). Inter-organisational networks are also identified as a moderator of fidelity to social service programmes in the implementation science more broadly (Aarons *et al*., 2011).

Study limitations

Researchers faced several challenges in executing this study. For example, a translated version of the HF fidelity measure was used, and even though the coordinators followed a rigorous process to validate the translation and tested the survey tool, some items were still misunderstood, such as the concept of "housing subsidy" or "treatment plan". Certain elements could not adequately capture cultural differences in the French context.

Since this study was conducted at the end of implementation of the pilot programme, staff reported on a large period of time retrospectively. Fidelity responses would have differed from the beginning of the study to the end. For example, housing availability changed over time as partnerships grew. Key informants were unsure if they should answer fidelity items based on the current context or the entire study period.

Concerning data collection, the nature of the self-administered survey may have biased responses. The national coordinator was involved in the implementation process as well as data collection and facilitation of conciliation meetings, which would have impacted the discussions and consensus process. Some staff may have been reticent to discuss and report on negative aspects of implementation in these contexts. Finally, some of the conciliation meetings were much longer than others, with some teams spending more time and going more in-depth to reach a consensus on item scores. The facilitators of these meetings were also different for some of the sites, which could have influenced the process.

Overall, the self-administered questionnaire, even if limitations were found in the translation, appears to be a sufficiently sensitive tool to measure HF fidelity in France. The French sites intend to use the measure as a quality assurance and programme improvement tool in the expansion of HF in France.

Conclusion

"Un chez-soi d'abord" was a successful pilot of a complex intervention that required high levels of training and technical support. The complexity of the HF intervention and the scaling out of HF in the French social service and health care context could have presented significant barriers to reaching high fidelity (Aarons *et al*., 2017; Carroll *et al*., 2007). And yet, all four sites reached a high level of fidelity to the HF model, while also revealing the challenges of implementing a new and innovative approach in the mainstream health care and social service system in France. National coordination, staff engagement, and a high level of motivation from programme stakeholders were key factors behind its success. As HF is currently being scaled up across France in response to the success of *"Un chez-soi d'abord"* (Ministère de la cohésion des territoires, 2017b), programme stakeholders will pay particular attention to developing awareness of the recovery model in mental health care and housing in France, adapting the role of peer workers in the HF model, and continuing to address the lack of quality, affordable housing options for HF clients.

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Assessing the Fidelity of Four Housing First Programmes in Italy

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Abstract_*This article presents the findings of a fidelity assessment conducted with Housing First (HF) programmes in four Italian cities: Bologna, Rimini, Siracusa, and Verona. These programmes are part of the 'Network Housing First Italia' (NHFI), coordinated by the Italian Federation of the Organisations for Homeless People (fio.PSD), which is composed of public and private organizations (cooperatives, mutual societies, non-profit associations and foundations) that work with homeless people. The fidelity assessment is a mixed-methods evaluation composed of a quantitative fidelity assessment survey and qualitative key informant interviews. Seventeen housing professionals participated. Data analysis aimed to identify areas of high and low programme fidelity at the systemic, organizational and individual levels. The paper describes both facilitators to fidelity, such as collaboration with Municipalities, holding frequent team meetings, and having experienced staff, and obstacles such as limited external and internal economic resources, and lack of HF expertise. These factors explain the differences that impacted on fidelity in each programme. Implications of the results are discussed as well as suggestions for improving the existing HF programmes in Italy that are at an early stage of development.*

Keywords_*Housing First, homelessness, fidelity, Italy, experimentation, adaptation.*

Introduction

In 2014, an estimated 50,724 people in Italy used homeless services as a shelter or soup kitchen, amounting to approximately 0.24% of the population. This was based on the *National Survey on the Condition of Homeless People in Italy,* conducted for the first time during 2011-2012, with a follow-up conducted in 2014. The 2014 survey showed an increase in the number of service recipients from 2011, when an estimate of 47,648 people utilized such services, suggesting that these numbers are growing over time (Istat, 2012; Istat, 2015). Moreover, these numbers may be even higher, considering that some individuals may not have gained access to services or could have been hospitalized or in jail during that time. These numbers, whether underestimated or not, shed light on a growing problem of homelessness in Italy.

In Italy, homeless services are organized in a system of local services that includes shelters, soup kitchens, public showers, and counselling and outreach services. Homeless services usually require residents to comply with rigid rules, such as abstinence from illicit substances, being registered as an official citizen or meeting other prerequisites before being considered as 'ready' to live autonomously (Consoli *et al.*, 2016). Furthermore, most of these services rely on resources that are organized within municipalities or regions. There are no national policies or programmes in Italy that regulate services for homeless people.

Italy's welfare system has been described as a *welfare mix* (Bertin, 2012), in which state resources are delegated to local organizations. These include a wide array of organizations, ranging from private cooperatives to public agencies, non-profit organizations, religious institutions, and volunteer initiatives. These programmes normally have different organizational features, missions and resources, often without any common coordination (Lancione *et al.*, 2017).

In recent years, the HF model has been growing successfully across Europe (Busch-Geertsema, 2013). Since 2012, some organizations in the Italian cities of Bergamo, Bologna, Trento and Ragusa have applied HF principles in their programmes. One programme in Bergamo, for example, tested the HF model as part of a local initiative of the region Lombardia (Regione Lombardia, 2012). This, and similar initiatives were implemented independently, without any coordination at the national level. The early successes of these bottom-up programmes, combined with concerns over the increasing numbers of homeless people in Italy, set the stage for implementation of HF at the national level.

The steering group of the Italian Federation of Organizations for Homeless People, also known as 'fio.PSD', called for a coordinated introduction of the HF model at the national level. The proposal was officially launched and named 'Network

Housing First Italia'[1] (NHFI) in March 2014 (Consoli *et al.*, 2016; Cortese, 2016). The initiative obtained large support from member organizations, with many of them committed to the HF philosophy and principles. The network members began a two-year period of experimentation (Consoli *et al.*, 2016) guided by the *Pathways to Housing* (PtH) principles.

During this period, fio.PSD provided support to participating organizations including training on the theory and methods of the HF model through summer/winter schools and webinars, supervision and evaluation of the HF experimental programmes carried out by an independent Scientific Committee, and support in advocacy actions. These advocacy actions encouraged the approval of the 2015 national *Guidelines for Tackling Severe Adult Marginality in Italy,* developed by the Ministry of Labour and Social Policy within the framework of the Europe 2020 Strategy.

The guidelines aimed to coordinate the different homeless services and provide some conceptual and practical guidelines for adequately responding to the needs of homeless individuals. One of the main goals was to implement and test sustainable projects based on the Housing First / Housing Led approaches. The objectives were to promote increased access to permanent housing, provide tailored and flexible support to beneficiaries in their homes, and promote wellbeing and community integration. The guidelines also included recommendations for public investment in HF serviced to address homelessness. For example, the *PON metro* was a call for national funding aimed at strengthening the role of big cities and their surrounding territories to achieve sustainable urban development and social inclusion.

The number of the Network Housing First Italia members had grown at the end of 2016 to 54 public, private and social economy organizations (e.g., municipalities, Caritas, social cooperatives, associations, non-profits) from 10 Italian regions with 35 HF experimental pilot programmes. The funding for the HF pilots and the fio. PSD support was provided by member organizations.

A new phase for the Housing First Italy network (NHFI 2.0) began in 2018 with the aim to provide training and supervision at three different stages: (1) organizations that want to start delivering HF services; (2) organizations in their first year of HF implementation; and (3) organizations that have delivered HF services for at least two years. The NHFI 2.0 aims to support the inevitable adaptation of the HF model to the Italian context (Lancione *et al.*, 2017), as it has been the case in other European countries (Greenwood *et al.*, 2013b).

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1 See: http://www.housingfirstitalia.org/

fio.PSD has been an active member of the HF international community, and when the multi-country HF fidelity assessment was proposed (Aubry *et al.*, 2018), fio.PSD saw an opportunity to analyse the local adaptations that impacted fidelity in the programmes. Participation in the assessment was proposed to the organizations in the network, and eventually four HF programmes participated in the fidelity assessment process.

Method

The fidelity assessment was completed in April-June 2016 by two external researchers from the University of Padua (Department of Developmental Psychology and Socialisation), and members of network's Scientific Committee using the method and tools of the multi-country HF fidelity study (Aubry *et al*., 2018).

Description of participating programmes

The fidelity assessment involved four HF programmes from four cities: Bologna, Rimini, Siracusa, and Verona. All the programmes are members of the NHFI and were selected based on the following criteria: 1) geographic location (North, Centre and South); 2) type of organization (religious/not religious); and 3) number of programme staff with at least a 6-month experience in HF (more than three). These criteria ensure that programmes selected for the project would represent the diversity of HF models in Italy. Programmes were excluded if a sufficient number of programme staff could not attend the consensus meetings. There were insufficient economic resources to conduct a fidelity assessment with all the organizations in the network.

Table 1 outlines the main characteristics of the organizations and information about the programmes. The programmes in Bologna, Rimini, and Verona served clients who were homeless or at risk of homelessness and had problematic substance use and/or serious mental illness. The programme in Siracusa targeted families who were at risk of homelessness.

Table 1: Characteristics of the Organizations and HF Services

Site		*Bologna*	*Rimini*	*Siracusa*	*Verona*
Geographical Area		Centre	Centre	South	North
Organisation		Social cooperative	Mixed (religious and social cooperative)	Religious organization	Mixed
Clients		60	9	8 families	27
Staff		6+ 1 peer	5	4	4
Funding sources	Private	50%	78%	100%	59%
	Public	50%	22%	-	41%
Nº of housing units	Scattered site units	19	9	8	4
	Congregate units	2	-	-	12
Nº of housing units	Private market units	20	9	6	16
	Public housing units	1	-	2	-
Is there a time limit for the housing?		No	Yes (2 years)	Yes (2 years)	No
Does the programme provide a rent supplement?		Yes	Yes	Yes	Yes

The teams are composed of social workers who also work in other public services, and so are neither Intensive Case Management (ICM) nor Assertive Community Treatment (ACT). Except in Bologna, most team members work part-time.

The Fidelity self-assessment

Procedure and sample. The self-administered fidelity survey was used for the quantitative evaluation (Gilmer *et al.*, 2013; Stefancic *et al.*, 2013). It was translated from English to Italian by two researchers independently. Discussions with the coordinators of the cross-country fidelity research and with the fidelity research teams that translated the survey into other European languages contributed to sorting out difficulties with the translation and to the development of the final version of the survey.

The survey was administered in each programme between April and May 2016. In Bologna, four social workers answered the survey (n = 4); the project coordinator, two social workers and two local civil servants participated in Rimini (n = 5); the project coordinator (a priest), the technical coordinator and two social workers answered the survey in Siracusa (n = 4); and the project coordinator and three social

workers in Verona (n = 4). Participants completed the survey individually and then attended a consensus meeting facilitated by a researcher to reach agreed upon programme responses to each item in the survey.

Data Analysis. The conciliated survey scores for each programme were converted to a 4-point scale following the self-assessment methodology (Macnaughton *et al.*, 2015). All final item ratings were summed up to produce total scores for each fidelity domain. Domain scores were also combined to produce a total fidelity score. Survey items were scored on a scale from 1 (low fidelity) to 4 (high fidelity). Scores below 3 were interpreted as reflecting low fidelity, while scores of 3.5 and above were interpreted as reflecting high fidelity. Scores between 3 and 3.5 were considered to reflect moderate fidelity.

The key informant interviews

Procedure and sample. The qualitative component was completed in June 2016. Individual telephone interviews with an intervention team member were conducted for each programme (n = 4). Participants were provided with a copy of the conciliated fidelity assessment results prior to interviews. During the interview, the results of the survey were conveyed to participants and they answered questions about which factors hindered or favoured the fidelity in each of the five domains. The interviews were audio recorded.

Data Analysis. Interviews were transcribed verbatim and then coded by two independent researchers using the typology of systemic, organizational, and individual facilitators and barriers to Housing First fidelity defined by Nelson and colleagues (2017). The two researchers then compared their coding and a final coding was agreed upon.

Results

Fidelity assessment

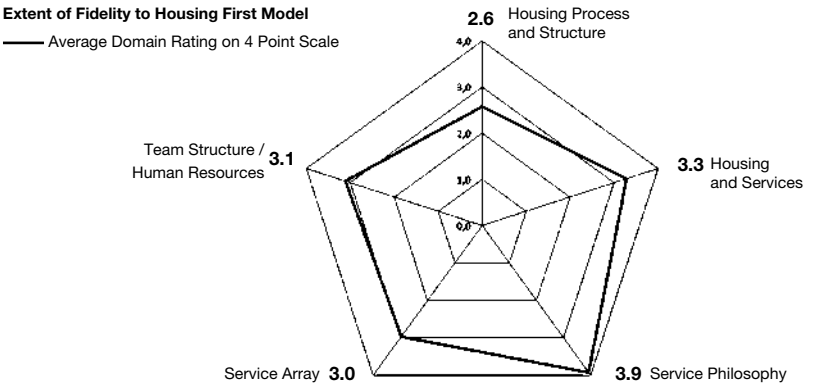
Table 2 presents standard scores of all fidelity survey items, average domain scores, and the total fidelity score on a 4-point scale for each programme. Of the four programmes, the average programme fidelity score across all the items was moderate for two: Bologna and Rimini (3.2), and lower for the other two programmes: Siracusa (2.8) and Verona (2.9). Average fidelity scores for the different domains varied from one programme to another as illustrated in Figure 1.

Table 2: Fidelity Assessment Item Scores and Domain Means

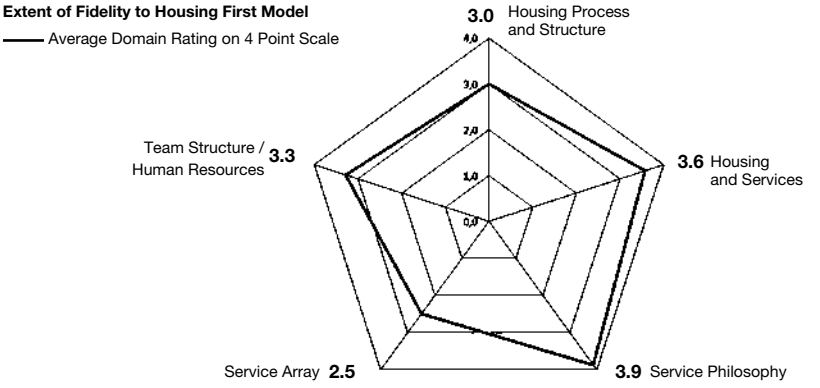
Domain / Item	Domain Mean / Standard Item Score (Out of 4)			
	Bologna	Rimini	Siracusa	Verona
Housing Process and Structure	***2.6***	***3.0***	***3.1***	***2.7***
1. Choice of housing	3.0	3.0	4.0	3.0
2. Choice of neighbourhood	3.0	3.0	3.0	3.0
3. Assistance with furniture	4.0	4.0	4.0	4.0
4. Affordable housing with subsidies	2.0	2.0	2.0	2.0
5. Proportion of income required for rent	2.0	1.0	1.0	1.0
6. Time from enrollment to housing	3.0	4.0	4.0	3.0
7. Types of housing	1.0	4.0	4.0	3.0
Separation of Housing and Services	***3.3***	***3.6***	***3.5***	***2.9***
8. Proportion of clients with shared bedrooms	2.0	4.0	4.0	4.0
9. Requirements to gain access to housing	4.0	4.0	3.3	3.3
10. Requirements to stay in housing	4.0	4.0	3.2	3.2
11a. Lease or occupancy agreement	4.0	4.0	4.0	2.0
11b. Provisions in the lease or agreement	4.0	4.0	4.0	0.0
12. Effect of losing housing on client housing support	2.0	2.0	3.0	4.0
13. Effect of losing housing on other client services	3.0	3.0	3.0	4.0
Service Philosophy	***3.9***	***3.9***	***2.1***	***3.2***
14. Choice of services	4.0	4.0	1.0	3.0
15. Requirements for serious mental illness treatment	4.0	4.0	1.0	4.0
16. Requirements for substance use treatment	4.0	4.0	1.0	4.0
17. Approach to client substance use	4.0	4.0	3.0	2.0
18. Promoting adherence to treatment plans	3.5	3.5	3.5	3.0
19. Elements of treatment plan and follow-up	4.0	3.6	1.2	3.6
20. Life areas addressed with program interventions	4.0	4.0	4.0	2.9
Service Array	***3.0***	***2.5***	***3.0***	***2.6***
21. Maintaining housing	4.0	4.0	4.0	3.0
22. Psychiatric services	3.0	3.0	2.0	3.0
23. Substance use treatment	2.4	2.4	4.0	4.0
24. Paid employment opportunities	1.6	4.0	2.4	3.2
25. Education services	4.0	0.8	4.0	0.8
26. Volunteer opportunities	2.4	2.4	4.0	4.0
27. Physical health treatment	2.4	1.6	4.0	1.6
28. Paid peer specialist on staff	3.0	1.0	1.0	1.0
29a. Social integration services	4.0	3.2	1.6	3.2
Programme Structure	***3.1***	***3.3***	***2.3***	***3.3***
31. Client background	3.3	2.7	0.7	2.7
33. Staff-to-client ratio	4.0	4.0	1.0	4.0
34b. Frequency of face-to-face contacts per month	4.0	4.0	3.0	4.0
35. Frequency of staff meetings to review services	2.0	3.0	3.0	3.0
36. Team meeting components	3.3	4.0	3.3	4.0
37. Opportunity for client input about the programme	2.0	2.0	2.7	2.0
Total	**3.2**	**3.2**	**2.8**	**2.9**

Figure 1. Average Housing First Fidelity Ratings by Domain for each Programme

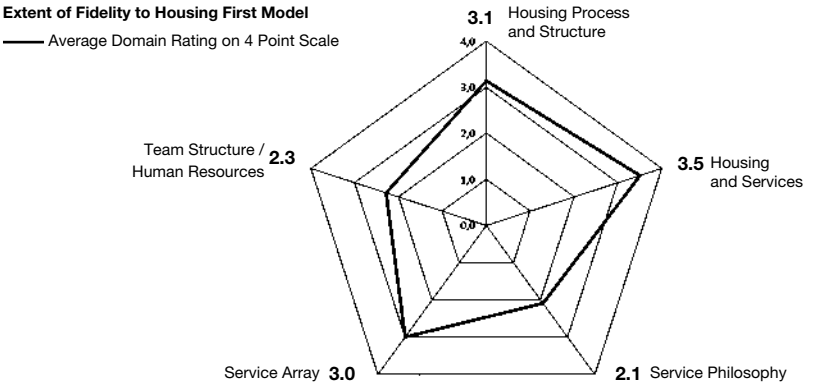
Bologna



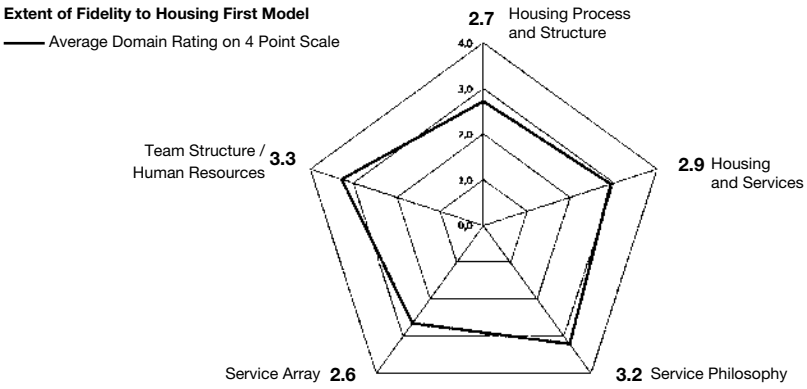
Rimini



Siracusa



Verona



Scores reflecting moderate fidelity were obtained in the *Housing Process and Structure* domain in Rimini (3.0) and Siracusa (3.1), while scores reflecting low fidelity were obtained in Bologna (2.6) and Verona (2.7). Low scores were obtained in all sites on items related to access to affordable housing by the provision of rent subsidies and the proportion of income used to pay the rent.

Scores reflecting high fidelity in the *Separation of Housing and Services* domain were obtained in Rimini (3.6) and Siracusa (3.5). Scores reflecting moderate fidelity in this domain were obtained in Bologna (3.3), and lower scores were obtained in Verona (2.9). There was considerable variability in responses to each item in this domain across the four sites.

Scores reflecting high fidelity in the *Service Philosophy* domain were obtained in Bologna (3.9) and Rimini (3.9), while in Verona (3.2) scores reflected moderate fidelity and scores reflected low fidelity in Siracusa (2.1). The *Service Array* domain received low scores, especially due to the absence of paid peer specialists on staff in the programme (excluding Bologna). The highest scores in this domain concerned the prioritization of maintaining housing.

In Bologna (3.1), Rimini (3.3) and Verona (3.3), scores indicated a moderate level of fidelity in the *Programme Structure* domain, while scores for Siracusa (2.3) reflected low fidelity in this domain. Items that received the lowest scores in this domain related to lack of opportunities for clients' participation into programme design or governance. The highest scores related to the frequency of face-to-face contacts between staff and clients per month including team meetings (topics discussed in the meetings).

Key informant interviews

In this section, we present findings from the key informant interviews in terms of facilitators and barriers identified as affecting programme fidelity at systemic, organizational, and individual levels.

Systemic level facilitators

As presented in Table 3, an important factor identified in key informant interviews to facilitate fidelity was collaboration with stakeholders such as the City Council or organizations such as the Caritas network. In Bologna and Rimini, the programmes are implemented in partnership with the City Council while Caritas manages the Verona and Siracusa programmes. These collaborations are useful for two main reasons. First, collaboration with the City Council facilitates access to funds and to social housing units for the HF services. This is particularly important because there is no funding from the national government in Italy. Second, collaboration with Caritas increases the number of housing units that are available to the programmes. As one of the informants said: '*the independent apartments are available thanks to Caritas; being part of the Caritas network allows you to have different apartments.'*

Table 3: Summary of Systemic Factors to Achieving Housing First Fidelity

Systemic	
Facilitators	*Barriers*
Collaboration with the Municipality/Caritas	Difficulty in collaboration with municipality
Networking with services available in community	Limited external economic resources
Programme reputation	Distrust landlords
Working with fio.PSD and NHFI	Expensive private housing market
	Client complexity
	Lack of minimum income

Collaborations that open access to funding were identified as positively influencing the *Housing Process and Structure* and *Programme Structure* domains by increasing choice in types of housing and neighbourhoods and by enabling an adequate staff-to-client ratio. One key informant noted: *'we were in line with the mission of the City Council and we worked together […], the local government has chosen to invest in this new type of programme'.* Collaborating with the City Council and voluntary organizations also facilitated fidelity in the domain of *Service Array* by opening access to community services such as psychiatric services, substance use treatment, educational services and physical health treatment.

Moreover, these collaborations facilitated coordination of meetings between different services representatives to discuss the needs of clients. As one key informant noted:

> *We have meetings with different specific services to understand what strategies to use with our clients'*; '*there has been a great commitment on the part of the services already informing the programme […]. The City Council has committed to analyse the outcomes of the different local services and to find out what is working for clients and what are their difficulties […] as well as creating a space for general collaboration*.

These network connections contributed positively to programme reputation in the local community. Good positioning of the organization in the community was thought to often increase cooperation with landlords and citizens. One key informant stated: '*the organization is already known both by services and citizens, and this serves as an insurance for landlords*', who know the organization will provide support to clients in their housing, such as furniture (*Housing Process and Structure*) and help them become better integrated in the community through participation in volunteering (*Service Array*).

Finally, another systemic factor that was described as fostering model fidelity, was programme membership in the *Network Housing First Italy* (NHFI), that offered training and supervision as well as comparisons with other HF programmes in Italy As one key informant noted: *'we seized all the training opportunities requests from the network, which is important for access to training opportunities for the team we could not have otherwise provided'.* Observation and collaboration with other programmes helped to better understand how to start and run a programme and which aspects to focus on: *'working with fio.PSD network is instrumental and facilitated meeting with other programmes and comparing [practices] gave us ideas for trying to something different*'. This feature was also a facilitator of the *Service Philosophy* domain.

Systemic level barriers

Table 3 presents systemic level barriers. Interestingly, collaborations with City Councils were also seen as sometimes functioning as barriers to fidelity. For some programmes, especially Siracusa, collaborating with municipal administrations was difficult. One key informant described it this way: '*the biggest obstacle was not being in the local network of social policies […] not having subsidies or a minimum universal income… it is important to have financial support, it's fundamental*'. This influenced the availability of resources and the possibility of accessing affordable housing.

The expensive private housing market was also identified as a barrier to model fidelity, especially in the domains of *Housing Process and Structure* and *Separation of Housing and Services*. In Bologna, a key informant noted: '*there is cohabitation of clients because it is too expensive to give a home to just one person, we had to choose because there were many people who needed both accommodation and support'*. This increased the proportion of clients with shared bedrooms and limited clients' choices in housing.

Lack of access to funds for programmes to cover expenses other than housing was also identified as a major barrier to model fidelity. For example, with the exception of Bologna, none of the programmes that participated in this fidelity assessment had enough funding to employ a paid peer specialist or to achieve a full complement of staff to meet recommended client to staff ratio: '*we are experiencing a peer in the team but he is not paid […] there is a need to have more staff because if you have so many people to follow you cannot spend enough time […]; there are few economic resources and a low investment on staff'.*

Another systemic barrier identified as influencing negatively the domain of *Separation of Housing and Services* was landlords' distrust. In order to provide a lease, some landlords requested assurances, such a proof of income or employment, which cannot usually be provided by clients who cannot work or have physical or mental health problems. Therefore, the organization often serves as the leaseholder, rather than the client. This affects the areas of fidelity concerned with leases, occupancy agreements, and choice over housing and neighbourhood. As a key informant noted: '*not all clients can choose their neighbourhood because of the high costs of the private housing market. Some neighbourhoods are inaccessible because of prices or because of landlords who do not want to rent their houses to this type of clients'*.

Clients' low income and inability to get and keep paid employment were identified as barriers to fidelity in regard to the proportion of income required for rent. It is difficult for clients to contribute 30% of their income to rent. This factor is exacerbated by *the lack of a minimum income* for homeless people in Italy. As a participant noted: '*it is difficult then to find further support for housing, to find a job for them*; *the percentage of contribution depends on income, and it's difficult when the contribution depends on precarious and limited work opportunities, they have no income'.*

In Siracusa, the choice to include families at risk of homelessness as a target group influenced fidelity to the model. Many aspects of fidelity, such as in the domains of *Service Philosophy* and *Service Array*, are not particularly relevant to this group. Many services needed by the typical HF participant, such as psychiatric services or social integration services, are not needed by families, or by all family members.

As reported by one key informant, '*our target is different, but we chose based on people who came to the Caritas centre, to prevent homelessness, so we do not provide some services'.*

Organizational level facilitators

The facilitators identified at the organizational level are presented in Table 4.

At the organizational level, availability of other services in the organization to HF clients, such as soup kitchens, transitional accommodation where clients can stay while their house is ready or occupational workshops were described as the most important facilitator of programme fidelity. These services are a source of support for people both before enrolment in the HF service and also when they leave the HF programme. Therefore, availability of services positively influences the *Service Array* domain. People stay in touch with the organization even if they leave the programme: '*having other services in the organization (not just HF programme) is the parachute […] to offer other housing solutions and to keep the person engaged in the organization, even through low-threshold services.'*

Table 4: Summary of Organizational Factors to Achieving Housing First Fidelity

Organizational	
Facilitators	*Barriers*
Other services in the organization	Experimentation programmes
Discussion meetings	Limited internal economic resources
External supervision	Lack of supervision practices
	Staff communication

An important organizational factor described as facilitating model fidelity was the team meetings. As one key informant stated: '*information, discussion and negotiation around the HF principles in the team meetings before the programme launched helped team members identify strategies to align practice with principles.*' These discussions facilitated fidelity in the *Service Philosophy* domain, and to the items referring to clients' choice or compliance and adherence to treatment. For the same reason, the Rimini programme noted the importance of having external supervision: *'supervision is useful to face different issues in the team […] to have an external point of view helps to see things that you might not see once in your daily relationship'.*

Organizational level barriers

Table 4 lists the organizational level barriers. Key informants also identified several barriers that affected fidelity at the organizational level. First, because these were pilot programmes, they had limited resources and limited opportunities for client involvement. For example, there were difficulties to provide an unlimited timeframe for clients' permanence in the programme. A participant explained: '*the concern is that the house will not be forever […] it is an experimental phase, but we do not know where we will end up.'* Because they were pilot programmes, the organizations invested limited internal funding. The organizations ran many other programmes, and the HF services received fewer resources than did the more established and permanent programmes. This limited investment of resources affecting the *Service Array* and *Programme Structure* domains. In fact, it was noted that there were no resources for the evaluation or the specific supervision for the programme, excluding that provided by fio.PSD at a national level: '*there is no specific supervision on HF […] but there is the risk to do a programme in a shelter style to work and this is difficult*'.

Finally, the limited funding for team members' salaries meant that, with the exception of Bologna, many worked part-time at the HF services. This resulted in a low frequency of staff meetings. Key informants explained how they used technological devices to access and communicate clients' information when needed, without having to spend time going to the office for meetings: *'there is no daily team, no time, but thanks to technology we can be contacted for emergencies, and we are always in touch thanks to emails, messages or phone calls, 24h/7'.*

Individual level facilitators

Table 5 presents the main individual factors influencing the fidelity to HF principles.

Table 5: Summary of Individual Factors to Achieving Housing First Fidelity

Individual	
Facilitators	*Barriers*
Staff expertise	Changing the way to work
Staff member values	Lack of HF expertise
Client-staff relationship	
Studying principles	

At the individual level, the main factor identified as influencing fidelity is staff expertise. Key informants explained how expertise helped build client-staff relationships and facilitated client-centered services. However, they also spoke about their own knowledge and expertise through experiences working in the field in general, not specifically in HF. Because of these previous experiences, staff members brought important skills, knowledge, and contacts with community resources to the Housing First teams.

Staff members' values were also identified as facilitating model fidelity. Believing in the HF values and principles from the outset facilitated motivation to understand HF operational practices, especially in regard to client choice and separation of housing and services. Staff members' motivation to take a new approach to change the system of services for homeless people was also an individual level facilitator of model fidelity in these domains. As one key informant said, '*the innovation of separating housing and treatment and the will to do something new […] adhere to these principles has led to making these operational choices*.' Finally, staff members' relationships with clients helped to incorporate clients' input to the programme. As one key informant said,

> *The relationship with the clients allows them to feel free to express criticisms to the programme […]. Some clients take part in some meetings expressing themselves on how they would something […]. We let us be amazed and taught by them […]; having a different vision protects you from frustrations, and comparison is important*.

Individual level barriers

Despite the fact that many team members brought considerable expertise to their programmes, many were inexperienced, especially in practice aligned with Housing First principles and philosophy. HF principles led to a change in the power dynamic between team members and clients. Some aspects of HF practice required a radical change in social workers' beliefs about clients' autonomy. As one informant stated: *'social workers in the team have difficulty to find a new mentality and a new approach with the different type of service.'*

Discussion

The results of the key informant interviews provide insights into HF model fidelity in the Italian context. Most of the factors identified as influencing fidelity were located in characteristics of Italian welfare system. The one systemic factor common to all organizations is the lack of minimum income in Italy that hinders clients' recovery opportunities. Another significant factor that influenced fidelity was the extent to which programmes collaborated with City Councils and

voluntary organizations, specifically whether these collaborations opened access to funding sources. This became especially relevant in the Italian *welfare mix* (Bertin, 2012), where state funding is delegated to local organizations. Organizations that had strong collaborations with the local government also had more resources for supervision and/or regular meetings (organizational facilitators). Local administration policies determine whether and how many resources made available to homeless organizations.

A revision of the *Guidelines for Tackling Severe Adult Marginality in Italy* beyond 2020 could be an opportunity to harmonize the different approaches of homeless services in Italy and to favour the integration of fidelity to HF principles in homeless services across the country, especially through the allocation of funding that allows adequate programme staffing and by funding technical assistance and training for HF services.

Nevertheless, the establishment of the HFI network and the role of fio.PSD prompted some facilitators at the national level. In systemic terms, the training and supervision provided by a scientific committee and the opportunity for knowledge exchange with other HF programmes at the national level both emerged as facilitators to fidelity. Training was also indirectly relevant as a facilitator on the individual level, for example through its influence on individual workers' internalization of HF principles. On the other hand, the novelty of the HF network, inexperience with delivering HF services, and having the insecure status of pilot programmes were all barriers to fidelity on organizational and individual levels.

Other factors cannot be generalized to the overall Italian context, but are specific to the structure and connections of individual organizations. Some relevant systemic factors include networking with services available in the community, programme reputation, landlords' distrust, and organizational aspects of team communication.

Finally, some individual factors included staff expertise and values, client-staff relationships, and the staff members' experience delivering a Housing First programme. These organizational factors are shaped by the organizations' management activities, like recruitment, training, and supervision.

The HF services participating in the present study found that the fidelity assessment was a useful opportunity for the organizations and their teams to reflect on their work. During the interviews, participants stated how the HF model helped them change their ways of working. In general, applying the HF principles was seen as an efficient way to change the traditional approach of homelessness services and to help building strong relationships with clients.

The differences in fidelity scores found among the four programmes reflect that the HF model can be adapted to local contexts, although it is recommended that services evaluate their outcomes to confirm that those adaptations are not hindering programme efficiency. Repeated early and later implementation fidelity evaluations will also yield insights as to which modifications are positive adaptation versus model drift (Greenwood *et al.*, 2013a).

Conclusion

The objective of this research was to measure the fidelity to the HF principles in four Italian programmes of the NHFI and to identify factors that affected implementation in each of these sites. Systemic, organizational and individual factors emerged as facilitators and barriers to HF fidelity. It is possible to draw several recommendations for the Housing First programmes in Italy, in order to develop and maintain strong fidelity when launching their programmes and over time. These recommendations are divided into three levels: systemic (external in the community), organizational (internal of the programme) and individual level.

In terms of systemic level factors, we suggest that it is important for new Housing First programmes to establish and maintain positive relationships with funding institutions, particularly with the City Councils, but also with voluntary organizations like Caritas. Such collaborations should be established before starting the programme, so that resources and cooperation with other community services are available from the beginning. Collaboration with external services can be created through meetings to introduce the HF model and its principles to key stakeholders, and through the establishment of partnerships to run the projects.

It is also important to pay attention to public support, to raise awareness about homelessness and HF programme, and to build the programme's reputation, which may be helpful for example, in winning over landlords. The NHFI has proved useful both for advocacy work and for training organizations. Networking with other community organizations can also be useful in finding different and new operational strategies. Indeed, Rapp *et al.* (2010) documented the importance of developing collaborations with the various local services in the community (e.g., social, health, justice, and employment agencies) and with the neighbourhoods where the services are to promote social integration of the clients, as well as the perception of effectiveness in the team.

In terms of organizational factors, establishing collaboration with local companies or farms could be useful to facilitate clients' access to employment, as well as to lever additional financial resources for the HF programmes and to promote community awareness. Team members should continue to use alternative commu-

nication methods (e.g. telephone, texting, email), but should complement these with more frequent face-to-face meetings to discuss the cases. External supervision regarding HF principles and training in relevant skills would also facilitate programme fidelity, while the inclusion of peer support services can also provide opportunities for face to face engagement and enhance support for clients and social workers.

We recommend programmes integrate an evaluation during implementation, to provide evidence when discussing opportunities for funding and support from stakeholders (Greenwood *et al.*, 2013b). At the individual level, it is useful to study and share the HF values and principles. The organizations included in this assessment found that individual training and providing opportunities for staff members to share and discuss the principles within the team was useful. Damschroeder *et al.* (2009) argued that work teams should not only be characterized by good professional skills, but also by a strong congruence between the values and beliefs of the staff and those that characterize the philosophy of the programme within which the social workers are inserted.

There are some limitations in this study. The four case studies may not be generalizable to the other programmes in Italy, the number of participants in the key informant interviews was limited (one per programme), and the data are cross-sectional. However, it is important to underline that this is the first research about fidelity to the HF principles in Italy, and so it serves as an important, if imperfect, benchmark.

In the future, it would be useful to adopt this mixed-methods evaluation for all organizations that have implemented a HF programme, both at the beginning and after the programme has matured. Furthermore, it would be useful to deepen the analysis of the barriers and facilitators to fidelity found by different types of organizations belonging to NHFI (private cooperatives, public agencies, no-profit organizations, religious institutions, and volunteering initiatives), so that specific features or best practices facilitating fidelity can be transferred to other sectors.

Research has shown that adherence to a model helps in achieving positive outcomes (Durlak and DuPre, 2008; Woodhall-Melnik and Dunn, 2015). This fidelity assessment is not only useful in the analysis of the status of HF programmes in Italy, but also in identifying directions for future programme development to bring them in line with the Pathways model.

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Implementation of Housing First in Lisboa, Portugal: A Fidelity Study of the Casas Primeiro Programme

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Abstract_*Casas Primeiro is the first Housing First programme implemented in Portugal and began in September 2009. The goal of the programme is to provide housing and support to homeless people with mental health problems, who may also have difficulties with substance abuse. The programme has been implemented in collaboration with AEIPS, a non-profit organization, and ISPA – University Institute, and is funded by the Municipality of Lisboa. In 2016, the programme participated in the Housing First International Cross-Country Fidelity Project that was conducted as part of the Housing First International Network. Casas Primeiro underwent a fidelity assessment intended to measure the degree to which its providers believe the programme has implemented practices that are congruent with HF standards. A mixed methods approach was used, including a self-reported fidelity assessment survey and qualitative interviews with staff to examine factors that have contributed to high or low fidelity scores. Overall, the programme achieved very high-fidelity scores. Factors that have been influential for programme implementation across the five fidelity domains were observed at the systemic, organizational and individual level. Implications for practice, policy and future research are discussed.*

Keywords_*Housing First, homelessness, Portugal, fidelity, self-assessment*

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Introduction

Casas Primeiro was the first programme implemented in Portugal with a Housing First (HF) approach. The programme was established in 2009, in the city of Lisbon, in partnership with AEIPS (Associação para o Estudo e Integração Psicossocial) and ISPA – University Institute. AEIPS is a non-governmental and non-profit organization, founded in 1987 to develop community-based supports that promote recovery and fully support community integration of people who experience mental illness (Ornelas, Duarte and Monteiro, 2014). Since the early years, AEIPS has established a collaboration protocol with ISPA-University Institute for technical assistance, training, evaluation, and research. This long-standing collaboration has been important in combining action and research within the organization and in developing innovative solutions.

The programme was established within the scope of the First National Homelessness Strategy in Portugal (2009-2015) and was funded by the Institute for Social Security, a public agency under the aegis of the Ministry of Solidarity, Employment and Social Security (GIMAE, 2009). The ENIPSA envisaged the development of innovative solutions to tackle homelessness, since at that time, homelessness services relied mainly on emergency and shelter accommodations. Thus, Casas Primeiro was implemented as a two-year pilot project (2009-2011) to test the HF approach in the national context. Evaluation of this experiment would provide the grounds that could lead to its scaling up to other cities of the country (ISS, 2017).

The positive results of the pilot project have clearly demonstrated its effectiveness (a solution that works), efficiency (a cost-effective solution) and the feasibility of the model in the national context (Ornelas *et al.*, 2012). Some years later, in 2017, in the public session for the presentation of the new National Strategy for the Integration of Homeless People (2017/2023), the Secretary of State for Social Security highlighted the implementation of the Casas Primeiro pilot project as one of the strengths of the previous strategy (MTSS, 2017). However, at the end of 2011, what could have been a smooth process towards the project sustainability, turned out to be a challenge given the political changes that occurred. After the elections held in June 2011, a new government was formed. While recognizing the project value and effectiveness, the Institute of Social Security announced that it was necessary to evaluate the National Strategy and to define policy regulations, before assuming long-term commitments. In the following years, the operationalization of the ENIPSA was put on hold, as its objectives were not translated into concrete political and action measures (Baptista, 2018).

After the two-year pilot, despite the constraints, the project has found its way to survive and be sustainable. With persistence and determination, AEIPS sought new sources of funding and environmental support. Evaluation reports and residents'

testimonies provided the foundation to advocate for the project, to negotiate and raise the interest of other community stakeholders. With a combination of public funds and donations from private foundations and companies it was possible to ensure programme sustainability (Ornelas and Duarte, in press). The most relevant source of support came from the Lisboa City Council. From 2012 to 2015, the annual grants provided by the City Council helped cover a large part of the project costs. Since 2016, the project has reached a more stable situation with its integration into the Municipal Programme for Homeless People, which recognizes HF as a key policy measure to address homelessness.

Lisbon is the capital of Portugal and has a population of over 500,000 residents. In addition, an identical number of people flock to the city on working days (Rede Social Lisboa, 2017). The City Council is the statutory authority with respect to city homelessness policy, coordinates responses to homelessness, and is the main funder of the programmes and services provided by non-governmental organizations in this field. In 2015, it was established that the NPISA Lisboa, which is a local partnership led by the City Council and composed of public and non-governmental organizations, would be given responsibility to reorganize and enhance coordination of homeless service delivery to achieve better outcomes.

To estimate the size of the homeless population, street counts on a single night were conducted in 2013 and 2015. Additional data covering the sheltered population were provided by local services. Between 2013 and 2015, some differences were observed. The 2015 count showed a decrease in the homeless population from 852 to 818, a slight increase in the sheltered population from 343 to 387, and a decrease in the number of people observed to be sleeping rough from 509 to 431 (Rede Social Lisboa, 2017). However, a separate survey conducted by NPISA at the end of 2015 found a much higher number of rough sleepers (NPISA, 2017). NPISA's estimates were based on data gathered from local services over the year, which identified nearly 700 people living on the streets or in public spaces. Most recent figures, released by the deputy mayor of social rights, based on the ongoing monitoring process that has been held by NPISA, indicate a decrease in the overall number of homeless people in the city, particularly the number of people living on the streets, which decreased from 700 to 350 (Lusa, 2018). Future NPISA reports may provide a more comprehensive explanation for this development. But the backdrop for this positive trend seems to reflect the dynamic generated by local partners, which has been pushing forward towards more housing solutions, including the two HF projects that operated in the city, which together support 80 people.

Currently, the Casas Primeiro programme provides housing and support to 50 individuals who were chronically homeless and who have a severe mental illness (80% are diagnosed with schizophrenia), often combined with substance abuse. The majority are male (76%), national citizens (82%), and aged between 23 to 72 years. Participants are housed in independent, permanent and scattered-site apartments rented from the private housing market. The programme signs the leases directly with landlords and sublets the apartments to programme participants. Currently, the programme has 46 rented apartments, 42 of which are occupied by single individuals, and four occupied by couples. The apartments are scattered throughout 20 city boroughs. The average rental cost is €400, ranging from €250 to €550. Participants contribute 30% of their monthly income towards rent, and the remaining proportion is covered by the programme.

Support services are offered by the HF team, which is composed of five professionals, including one peer-worker. One of the team members is also the team coordinator. The support provided by the team is similar to the Intensive Case Management model, with a focus on housing stability, recovery and community integration. These services include a combination of individualized support, according to individual needs and preferences (consumer-driven), peer support, and mutual help group weekly meetings. These services are provided in the apartments (at least one home visit per week, scheduled previously) and in community settings to help participants access public welfare system services, community resources and activities. All the professionals work as a team with all participants (ratio of 1 to 10). On-call 24/7 services are also available. Support is provided as long as people want, in accordance with participants' changing needs and interests over time.

Over the years, the programme has demonstrated a high housing retention rate (i.e., percentage of participants stably housed in the last 12 months), ranging from 85% to 90%, as well as a significant decrease in participants' use of emergency services and psychiatric hospitalizations, and significant improvements in quality of life and community integration (Ornelas, Martins, Zilhão and Duarte, 2014; AEIPS, 2016; AEIPS, 2017).

Fidelity Assessment of the Casas Primeiro Housing First Programme

This study is part of the HF International Cross-Country Fidelity Project conducted within the HF International Network. The study was conducted to assess whether HF programmes that have been implemented in different countries have maintained or modified the core principles and operational elements of the original model. The HF model has clearly defined a core set of principles related with housing provision and services delivery (Stefancic *et al*., 2013). Fidelity assessment can be useful in informing programme development and improvement processes and guiding efforts towards organizational change. By assessing their performance in accordance with HF principles, agencies can review areas of relative strength as well as those needing improvement in their programme.

There is an increasing emphasis on assessing implementation fidelity as the HF model has been widely disseminated around the world as an evidence-based practice. The process of translating evidence-based practices to different contexts and communities is often complex (Aarons *et al.*, 2011). Whether these new settings maintain or modify a programme's core components and activities over time affects programme capacity to produce desired outcomes and programme sustainability (Stirman *et al.*, 2012). Some adaptions may occur to respond to contextual factors without compromising programme effectiveness, if core philosophical principles and operational ingredients are preserved (Durlak and DuPree, 2008; Greenwood *et al*., 2013). However, adaptations that subtract or reverse core elements of the intervention may result in programme inconsistency or even in contradictory practices, and may fail to produce desirable outcomes (Mowbray *et al*., 2003). One meta-analysis specifically investigating the issue of fidelity on a wide range of community health and education programmes showed that sites that demonstrated closer fidelity to the original programme had effect sizes two or three times higher than sites that demonstrated lower levels of fidelity in programme implementation (Durlak and DuPre, 2008). Consistent with these findings, several studies have shown that HF programmes with higher fidelity to the model demonstrated more positive outcomes for participants (Davidson *et al*., 2014; Gilmer *et al*., 2015; Goering *et al*., 2016).

The likelihood of an innovative programme being adopted with higher fidelity in new locations is influenced by factors related to the host organization (leadership, structure and capacity), as well to the environmental support to the programme (public policies, funding, technical assistance, community stakeholders) (Durlak and DuPree, 2008; Aarons *et al*., 2011). Research on the implementation of HF in different contexts also found that these factors account for the variation of programmes fidelity to the model. In Europe, a preliminary study that examined the

implementation of HF programmes in six countries (Greenwood *et al*., 2013) found variability in adherence to core principles across countries. Issues of compatibility between HF philosophy and organizational values and current practices, as well as contextual barriers, such as local resistance or constraints in housing markets, seemed to affect the degree of fidelity by which programmes were implemented.

In a multi-site study in Canada of HF programmes, some variation in level of fidelity was found across sites but with programmes overall showing moderate to high levels of fidelity, during both early and later stages of their implementation (Nelson *et al*., 2014; Mcnaughton *et al*., 2015). Organizational factors that facilitated implementation fidelity include staff commitment to programme philosophy, staff expertise, and organization leadership. Additionally, community facilitators include collaboration with landlords and with other services, and the availability of technical assistance. Some barriers to fidelity were also identified, both at the organizational level, such as staff turnover and range of services provided, and at the community level mainly related with the housing availability (Nelson *et al*., 2014; Mcnaughton *et al*., 2015).

The purpose of the present study was to assess the degree to which practices oriented to HF principles were perceived to be implemented in the Casas Primeiro programme and to identify factors at different levels of analyses that either facilitate or hinder programme fidelity, as well as describe their influence within the intervention. The study was carried out by a research team consisting of two researchers from the ISPA University Institute and a professional from AEIPS that does not belong to the programme team. This collaborative approach to conducting research is an intentional strategy adopted by both organizations as they acknowledge the mutual benefits of working together in all phases of the research process. The collaboration of university researchers and community agencies has been increasingly valued and recognized for its validity and the utility of the knowledge generated for both academics and practitioners (Suarez-Balcazar *et al*., 2004; Trickett and Ryerson Espino, 2004; Ornelas *et al*., 2012).

Method

Research design

The study adopted a mixed methods design, which was defined for all of the programmes from participating countries within the larger study (Aubry *et al*., 2018). The first phase entailed a quantitative component comprised of an adapted version of the self-assessment survey (Gilmer *et al*., 2013) used by programmes to determine their programme fidelity. The survey is a 37-item questionnaire designed to measure the degree to which providers believe their programmes implement practices that are

consistent with HF principles. This measure covers five domains: (1) Housing Process and Structure, (2) Separation of Housing and Services, (3) Service Philosophy, (4) Service Array, and (5) Team Structure/Human Resources. Each item offers several response options with some items asking respondents to select one response option and others requesting them to choose all that apply. The scale scoring protocol generates scores for each item, ranging from 1 (low fidelity) to 4 (high fidelity). In the second phase of the study, in-depth qualitative interviews with key informants were conducted to gain additional information to identify factors contributing to high or low fidelity scores. More specifically, the qualitative interviews were intended to determine programme staff's perceptions of systemic, organizational, and individual level factors that have acted either as facilitators or barriers to programme fidelity.

Procedures

The process of translating and adapting the HF Fidelity Survey into Portuguese took into account guidelines for cross-cultural adaptation of self-report measures (Beaton *et al*., 2001). Procedures included survey translation, back translation, and pre-testing designed to maximize semantic and conceptual equivalence with the original survey.

Two steps were taken in the collection of the quantitative data. First, each staff member of the Casas Primeiro programme was asked to complete the survey individually. Secondly, a group meeting was held, where programme staff' were asked to compare and discuss their individual responses and to reach a consensus on a rating for each item which was used to score programme fidelity. The meeting was facilitated by one researcher from the university, who had received previously all the completed surveys. In the meeting, the facilitator conducted an item-by-item review. In the items where some divergence was observed, participants had the opportunity to present their own perspectives. The facilitator asked participants to provide concrete examples that could help to illustrate and explain their individual responses. Discussion continued until an agreement was reached among participants. Observations and comments produced at the meeting were recorded and included in the qualitative analysis.

In the qualitative phase of the study, on-site interviews were held with the key informants, professionals responsible for delivering the intervention, to gain more comprehensive information and discuss fidelity outcomes, which were sent to them in advance. Individual interviews were audio recorded and transcribed.

Participants

The fidelity survey was completed by the team coordinator, the four individuals that made up the programme staff, as well as by one member of AEIPS's Board of Directors. All members participated in the consensus meeting. In the qualitative

phase, the team coordinator and one team member were interviewed to examine and discuss the fidelity survey outcomes. The selection of these two members of the staff among the five was based on criteria of experience with the programme (seven and five years respectively) and gender equality, one female and one male.

Data Analysis

Analyses of the quantitative component used the scale scoring protocol and the fidelity self-assessment calculator that was developed within the larger study, which generates scores for each item as well as scores for each fidelity domain and an overall fidelity score. For the qualitative analysis, the transcripts of the interviews were reviewed by two members of the research team who identified factors influencing fidelity. These factors were initially categorized according to three different ecological levels: systemic, organizational, and individual. Subsequently, factors were coded as being either facilitators or barriers to programme fidelity (Nelson *et al.*, 2017).

Results

Fidelity scores

Table 1 presents the Casas Primeiro scores for each item, the average scores of each five domains, as well as the global fidelity score. Overall, the programme achieved a score of 3.8, which indicated a high level of fidelity to HF model.

Table 1. Fidelity Assessment Item Scores, Domain Means, and Total Mean

Domain / Item	Domain Mean / Standard Item Score (Out of 4)
Housing Process and Structure	***4.00***
1. Choice of housing	4.0
2. Choice of neighbourhood	4.0
3. Assistance with furniture	4.0
4. Affordable housing with subsidies	4.0
5. Proportion of income required for rent	4.0
6. Time from enrollment to housing	4.0
7. Types of housing	4.0
Separation of Housing and Services	***4.0***
8. Proportion of clients with shared bedrooms	4.0
9. Requirements to gain access to housing	4.0
10. Requirements to stay in housing	4.0
11a. Lease or occupancy agreement	4.0
11b. Provisions in the lease or agreement	4.0
12. Effect of losing housing on client housing support	4.0
13. Effect of losing housing on other client services	4.0
Service Philosophy	***4.0***
14. Choice of services	4.0

15. Requirements for serious mental illness treatment	4.0
16. Requirements for substance use treatment	4.0
17. Approach to client substance use	4.0
18. Promoting adherence to treatment plans	4.0
19. Elements of treatment plan and follow-up	4.0
20. Life areas addressed with programme interventions	4.0
Service Array	***3.5***
21. Maintaining housing	4.0
22. Psychiatric services	3.0
23. Substance use treatment	2.4
24. Paid employment opportunities	4.0
25. Education services	4.0
26. Volunteer opportunities	4.0
27. Physical health treatment	2.4
28. Paid peer specialist on staff	4.0
29a. Social integration services	4.0
Programme Structure	***3.4***
31. Client background	4.0
33. Staff-to-client ratio	4.0
34b. Frequency of face-to-face contacts per month	4.0
35. Frequency of staff meetings to review services	2.4
36. Team meeting components	3.3
37. Opportunity for client input about the programme	2.7
Total	**3.8**

Figure 1 – Casas Primeiro fidelity average scores by domain

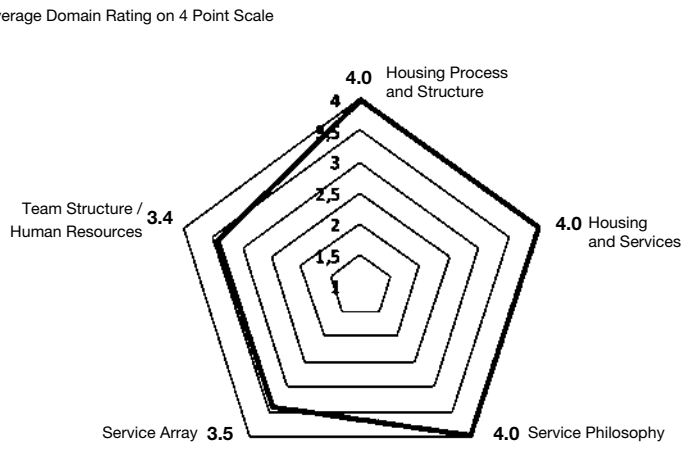

Figure 1 displays the programme average scores by domain, which ranged from 3.4 to 4. Under the Housing Process and Structure, Housing and Services, and Service Philosophy domains, the programme obtained the maximum score of 4, showing the highest possible levels of fidelity. The average score was also high on the Service Array domain (3.5). The score on Team Structure/Human Resources

was slightly lower (3.4) than in other domains. The maximum score of 4 obtained in the *Housing Process and Structure* domain reflects the programme's dedication to practices of providing independent apartments that are rented from private landlords, subsidizing the apartments rents and furniture, ensuring that participants are paying no more than 30% of their income, and promoting participants' choice over housing.

High fidelity score in the *Housing and Services* domain indicates that as well as meeting the responsibilities of a standard lease, no treatment or sobriety requirement is imposed on participants for them to access and stay in permanent housing, and if, for whatever reason participants lose their houses, re-housing opportunities are available. Casas Primeiro also obtained the maximum score in the *Service Philosophy* domain, which reflects the programme's commitment to participants' choice over services and providing individualized supports that are consumer-driven and oriented to recovery and community integration.

In the *Service Array* domain, the programme obtained an average score across the items of 3.5. Items related to the availability of services in education and employment, as well as the existence of a paid peer specialist on staff, obtained high scores (4). Items related to the provision of health or substance use treatment scored lower (2.4).

In the *Team Structure/Human Resources* domain, the programme obtained an average score of 3.4. On items related to the size of caseloads and the frequency of contacts with participants, the scores were high (4). Scores were lower on items related to the regularity of team meetings (2.4), and to participants' inclusion on governing bodies (2.7).

In the next section, we examine the fidelity outcomes by incorporating the views of programme staff on factors that can provide a deeper insight for these results. We used an ecological framework to analyse the multifaceted nature of systemic, organizational and individual level factors that seem to have been influential on programme implementation across the five fidelity domains.

Qualitative interview results

Table 2 summarizes the facilitators and barriers of fidelity to the HF model at the systemic, organizational and individual levels.

Table 2. Summary of Facilitators and Barriers Related to Achieving HF Fidelity

Summary of Facilitators for Achieving HF Fidelity		
Systemic	Organizational	Individual
Availability of housing in private housing market	Alignment between Housing First philosophy and organizational values	Participants voice and input in programme
Landlords collaboration	Collaboration with organization' education and employment programmes	Participants collaboration in political and community initiatives
Access to public health care system	Collaboration with the University	Staff member values and expertise
Complementary services available in community	Collaboration and communication between team members	Staff collaboration in political and community initiatives
Coordination with other agencies	Team involvement at all levels of the programme	
Political climate and policy validation	Peers support and participants involvement	

Summary of Barriers to Achieving HF Fidelity		
Systemic	Organizational	Individual
Constraints in the access to addiction treatment sector	Non-daily basis of team meetings	
Constraints related to immigration services	No formal procedure for participants to express concerns or dissatisfaction	
	Participants not include in the governing bodies of the organization	

Systemic factors

At the systemic level, we identified four overarching themes that appear to be influential for achieving programme fidelity: the private housing market, public health care systems, the social delivery system network, and policy approaches.

Private housing market. The private housing rental market was indicated as a vital systemic level resource that leveraged high fidelity outcomes in several domains. As professionals strongly emphasized, the private rental market not only enhances the programme's capacity to provide independent and scatter-site apartments across the city's neighbourhoods, but also offers participants more housing choices and housing environments of better quality.

> *Where one lives facilitates one's ability to access community resources. That is why we didn't use social housing that tends to be located in deprived and socially isolated areas. Conversely, we look for apartments blended into integrated neighbourhoods, where people could have access to different types of commerce, leisure facilities, transportation, health services and other community resources, which is important to community integration*. (team member 1).

The team also noted that housing environments have impact on the participants' recovery paths. "*I found in my PhD research that the quality of housing environments increases people's perceived sense of choice and control over their own lives that, in turns, is a predictor of recovery outcomes*" (team member 2).

Providing rapid access to housing is a key element of the intervention. The team found that resorting to the private market increases the odds of finding housing in a timely manner.

> *We know that to be effective and to meet the expectations raised when approaching homeless people on the streets, we cannot put people on hold for several months, but we need to provide them immediate access to housing. Within the context of social housing this would not be possible, because the waiting list is huge* (team member 1).

The team also stressed that, for the same reason, "*whenever it is needed, it is easier and quicker to re-house one participant to another apartment within the private market stock*" (team member 1). Moreover, having the programme as the leaseholder facilitates the immediate access to housing for homeless people that do not have their identity documents in order, or any source of income.

The capacity to source suitable apartments for the programme is due to the availability of private rental proprieties stock in Lisboa. One team member reported that "*even now, in a context of high demand in the rental market, with the boom of short leases for tourism, it is possible to find small and affordable apartments for the*

programme and in a timely manner" (team member 2). In addition, the team found no significant resistance from private landlords. In general, having the programme as the leaseholder was a facilitator for negotiations. The team indicated that the programme's ability to guarantee rent payments on time and the maintenance of the property, as well as the team's support to tenants is a valued proposition for private landlords.

Public health care system. Another important systemic level factor is the public health care system. The team indicated physical and mental health care, which are mostly provided by public local health centres, as an available resource for programme participants. Since the programme team does not directly provide medical, psychiatric or nursing services, the fidelity outcomes in the Service Array domain were lower than the average scores in other domains. However, team members do not consider this as a weakness, but rather as a strength of the programme, for several reasons. First, as mentioned by one of the team members,

> *… not providing these services directly does not mean that participants do not have access to health care whenever they want and need to do so. But in a city where citizens have easy access to public health care, there is no justification for overlapping services, nor would that be efficient* (team member 2).

A second argument is related to community integration: "*What is intended is that participants have access to the health services that are used by all members of the community because this is a factor of community integration"* (team member 1). Finally, the team explained that the use of public health care delivery system contributed to the separation of housing and treatment services, and for participants to experience the house as a living place and not as a place for treatment.

Nevertheless, the team also identified two barriers that may affect access to health services. One concern was regarding the addiction treatment sector for alcohol and drug abuse. Although there are several public services and publicly-funded agencies available, they usually have long waiting times. This situation contributed to some participants dropping out of the process before being admitted into these services.

Another constraint is the bureaucratic process and time-consuming process of getting residence permits for non-European Union citizens living in Portugal from the Portuguese immigration service. Although the number of non-national participants is extremely low, for those who are waiting for their residence permit, the proportion of health care costs covered by public funding is reduced. To overcome this barrier, engagement of the programme in the city social services network has been essential.

Social services network (NPISA) and other community resources. AEIPS is a member of NPISA, a formal partnership established in the city of Lisboa among public social services and organizations that are working within the homelessness sector, coordinated by the Municipality of Lisboa. From the point of view of the team, this partnership enhanced the relationships among members of the organizations, which, in turn, facilitated the referral processes between the city outreach teams and the programme. Another benefit of this partnership is that it facilitates the process by which programme participants gain access to minimum social income (RSI) and other complementary financial supports. Participants contribute 30% of their income, (usually RSI), towards the rent. Considering the expenses with the rent, the additional financial supports complement the participants' disposable monthly income, up to the limit of the maximum value of the RSI.

In addition, the team indicated that there are many community organizations in the city that provide essential goods to all citizens who need them, such as food, clothing or furniture. Community resources that may be used by programme participants also include sports or leisure facilities, educational programmes, and civic and recreational organizations.

Political climate and policy validation. From the point of view of team members, increased attention by policy makers towards homelessness has generated a favourable political climate for innovative solutions to address the problem, particularly for the HF approach. As noted, contextual factors are important but do not explain all the changes that have taken place at the policy level in recent years.

> *We have come a long way and not always an easy one. But due to the good results of the programme and the leading role of our organization in advocating for a HF policy, we have been able to take advantage of this favourable political climate and influence the formulation of new policies that expressly support and prioritize the implementation of HF programmes* (team member 1).

In particular, the team highlights the fact that the City of Lisboa has created the first public funding stream for HF programmes and has established a set of criteria for evaluating the applications based on the core principles of the model.

Organizational factors

At the organizational level, the team identified six key factors that appear to be influential for fidelity outcomes.

Alignment with organizational values and practices. The alignment between HF principles and AEIPS' values and objective practices was seen as a crucial organizational factor for programme fidelity outcomes. As it was stated, the implementa-

tion of this new programme *"… did not imply a disruption within the organization's usual operating approach. Quite the contrary, it matched smoothly with AEIPS' values and intervention principles* (team member 1).

Team members emphasized that AEIPS has substantial experience with delivering support services to people with severe mental illness with a recovery-oriented approach and through providing collaborative and empowering relationships with participants.

> *We share the same principles. We value people's strengths and experiences, and respect their choices over housing, over treatment, and over all life domains* (team member 2).

> *We focus on the goals that people set for themselves based on their own interests and preferences, and we work collaboratively with them to the attainment of these goals* (team member 1).

The team also credited AEIPS for their programme's focus on community integration. "*We do not have to create on-site services to address all of the participants' needs because this would keep them apart. Instead, we focus on solutions and resources that are available in the community for all citizens, whether we are talking about health care, fitness, employment or recreational activities"* (team member 1).

Another aspect of HF programmes that fits perfectly with AEIPS' practices is that support is provided in a person's natural environment and works towards creating pathways for community inclusion.

> *For assisting participants in housing management or developing their own wellness strategies, we need to know and work in the housing and neighbourhood contexts where they live* (team member 2).

We are not just service brokers. To facilitate people's access to material and social resources or activities that are meaningful for them, we need to be familiar with community resources, to make connections, and even accompanying participants to those activities if necessary (team member 1).

Both members explained that working with community settings is crucial to facilitate participants' access to community resources and activities, as well as to enhance the capacity of local services and communities to be more responsive to participants' needs.

Collaboration between team members. The HF programme's team is composed of five staff members, including a peer worker, with a staff/participant ratio of 1 to 10. Caseloads are shared, which means that every staff member works with all participants. The team noted that this method is beneficial for participants. "*We have*

already tried both ways and we concluded that this method works best because, whenever a staff member is not present, participants' support is not compromised. Although we share information in the team there are many nuances we would not know if we did not work with all participants" (team member 1). Moreover, the team noted that caseload sharing also prevents participants' dependency on just one staff member.

The team also explained that collaboration goes beyond case sharing and extends to all the activities the team has to accomplish in order to achieve target outcomes that are agreed as priorities at each particular time.

> *We work, in a way, as a task force and very problem-solving oriented. For example, a team member can be relieved of his/her daily routines to perform priority tasks, whether looking for new apartments or providing more intensive support to a participant in need, and this implies that the workload of the others will be heavier that week* (team member 1).

This is only possible, according to the team, because there is an environment of cooperation and flexibility, and a sense of common purpose and commitment that facilitates the team's capacity to solve problems and achieve goals.

The team meets formally once a week rather than on a daily basis resulting in the score on this item in the fidelity measure to be lower. However, the team explained that in the weekly meetings, as well as evaluating the previous week, a detailed plan of the following week is drawn up, setting daily goals and assigning daily tasks for each member. Additionally, although they are not formal meetings, team members communicate daily with their coordinator to report the most relevant information. It was also mentioned that frequent communication flows between team members throughout the week. Where necessary, the weekly plan could be adjusted to meet the needs of the participants.

Collaboration with AEIPS supported education and employment programmes. The availability of services to assist participants who are interested in accessing employment, education, or volunteer activities in the community is an important organizational level resource. AEIPS has a long history of providing these services for people with mental illness. The supported employment programme helps individuals choose, obtain, and maintain employment in the open labour market, including opportunities for job site training and negotiation with employers. The supported education programme assists people in accessing regular schools, universities, or other educational programmes, and provides support both within and outside educational settings' contexts.

Collaboration within the organization has enhanced Casas Primeiro team's capacity to offer employment and educational support, either by involving some participants in these programmes or by using the technical assistance of the AEIPS co-workers to provide these services directly. However, as both interviewees pointed out, this is a field where the team still has a lot to learn and grow.

Collaboration between AEIPS and ISPA-University Institute. Another organizational level factor is the partnership between AEIPS and ISPA-University Institute, which has been instrumental in developing a culture of continuous learning within the organization. The team described opportunities that are made available for staff members to gain knowledge, develop their expertise, and enhance their capabilities over time. This includes participation in AEIPS' weekly training programme, conferences and other scientific events, consultation and supervision, networking with teams from other HF programmes, and encouragement and support to pursue postgraduate courses.

Collaboration with ISPA – University Institute also provides opportunities for staff to be involved in evaluation and research. The most recent example is the Home_EU project. The team valued this link between research and practice. "*It is important for me to conciliate the practical work I do, with research.… To investigate what we do every day in practice I think is a very important contribution to this programme*" (team member 2). It was strongly emphasized that ongoing training, evaluation and research contributes to combining knowledge and action, which are equally beneficial to the team, the programme, and the entire organization.

Team involvement at all levels of programme development. Opportunities for staff involvement in all aspects of the programme's development, which are afforded by the organization, led to favourable remarks by a team member. "*It is an asset for the team to know everything concerning the various aspects of the programme, including its financial and administrative elements, and be involved on strategic planning, and evaluation, as well as on dissemination endeavours*" (team member 2). It has also been reported that the team has been involved in local committees within NPISA and has participated together with the organization's directors in public forums and in meetings with policy makers. The team expressed that the opportunity to be involved at all these levels of the intervention increases staff's commitment and enhances their sense of ownership of the programme.

Peer support and participants' involvement. Hiring an individual with personal experience of both mental illness and homelessness as a team member was indicated as a relevant fidelity factor in the organizational domain. It was stressed that because peer workers' lived experience plays an important role in supporting programme participants through their recovery paths, as well as bringing unique

expertise to the team. "*We have a person who has been in the team since the beginning of the project and it has been a positive experience. He can give us completely different perspectives of the situations."* (team member 1).

Moreover, opportunities for peer support are also provided in the weekly support group meetings. "*It is also important to mention the help they give each other. Some participants, as they get to know each other at meetings or other activities we provide, are building bonds, supporting each other, and doing things together in other community contexts*" (team member 2).

The organization also promotes opportunities for participants' involvement and collaboration in programme implementation and evaluation, as well as in dissemination initiatives, including conferences, university classes, study visits from other organizations, or public meetings with community stakeholders.

> *We provide information and discuss political issues related to the programme. We assist them and prepare their participation in public initiatives and defend their rights. It is important that they feel that their opinions are valued, that they have a voice, and that they can influence the change process in services' delivery and policies in this area* (team member 1).

However, despite the initiatives described above, the programme scored below average in this area because there is no formal procedure for participants to express concerns or dissatisfaction, and because the participants have not yet been included in the governing bodies of the organization. The team has ensured that a formal complaint procedure will be implemented similar to what already exists in other programmes. Additionally, the team believed that participants' inclusion in the organization governing bodies is only a matter of time as one team member stated: "*It has been a practice for many years in this organization to have participants' representatives in governing bodies. Currently, people with mental illness experience who participate in other programmes of the organization, are members of the Board of Directors and of the Fiscal Council*" (team member 2).

Individual factors

At the individual level, we also found factors that facilitate higher levels of fidelity. Specifically, these related to participants and to programme staff.

Participants. The team noted that the programme has been successful in reaching individuals who are homeless, a subgroup which is considered as high priority, in accordance with HF principles. Participants who are receiving housing and support services in the Casas Primeiro programme are those with severe mental illness, who frequently have concurrent alcohol or drug addiction disorders, and have

experienced long-term or repeated homelessness. Everyone has a history of rough sleeping and most have had several incidents of psychiatric hospitalizations. Some of them also used night shelters, but only for short periods of time.

Participants have contributed to the programme's implementation through various forms. Participant' feedback regarding housing and support services is a valuable resource to monitor the programme's fidelity and improve the quality of the intervention. "*When expressing their appreciation or criticism about the way in which the programme is carried out, when making practical suggestions, as well as when describing the wellness and recovery benefits they experience, participants are helping us to realize if we are on the right track and what we need to improve*" (team member 2).

Participants' willingness to advocate for the programme in the media and in meetings with policy makers or other community stakeholders is another important individual level factor strongly emphasized by the team. "*Some participants have taken a leadership role and became strong advocates for the programme, explaining very clearly why they consider HF the best and most effective approach to tackling homelessness*" (team member 1). Participants' involvement and collaboration in political and community initiatives were described as a vital contribution for the validation, dissemination and sustainability of the programme.

Team members. Staff commitment to HF principles is an important individual-level factor for programme performance. Team members expressed that staff share the vision and principles of HF philosophy. They also stated that congruence between these principles and staff's personal values and beliefs has been critical in translating the programme's principles into concrete daily practices.

Team members also value the purpose of their work, as they see the impact of the programme on people's lives. They also value the social impact of their work. "*Because of our work, the policy makers are realizing the social return of HF investment, and public policies are incorporating HF as a priority approach, rather than an exceptional one*" (team member 1). From the standpoint of the team, all of this makes their job rewarding and helps to explain the low staff turnover.

Team members also perceive themselves as having the knowledge and experience to tackle the work.

We have learned a great deal over the years, from our own experiences and through continuous training. And all this knowledge is fundamental for us to do well what we have to do. We have to address multiple challenging issues, work in a variety of community settings, negotiate with different stakeholders, and build collaborative and trustful partnerships with participants (team member 2).

For all these reasons, the team believes that it has been beneficial for the programme to have managed to sustain its human capital.

Discussion

Results of the fidelity self-assessment indicated that the philosophy and practices of the Casas Primeiro programme are highly consistent with the principles of the HF model, with an average total score of 3.8 out of 4. Results also support the importance of attending to the ecology in which the programme operates. Reviews of empirical literature had identified several factors, at multiple levels of analysis, which have influence on a programme's sustainability (Greenwood *et al*., 2013). Our findings also describe a wide range of factors at multiple ecological levels that helps to explain fidelity outcomes. More precisely, they capture the interaction between people, organizational context and the larger social environment, and its effects on programme implementation.

Organizational factors seem to play the most important role. Research on programme implementation identified that a new programme is likely to be implemented with greater fidelity when it fits with the mission, values and practices of the host organization (Durlak and DuPree, 2008; Aaron *et al*., 2011). Our findings also support the importance of the organizational context to be compatible with and supportive of HF principles. Alignment between the service philosophy of HF and AEIPS organizational culture and practices seemed to facilitate programme implementation at a high level of fidelity. This includes participants' choice over housing and services, the separation between housing and treatment, and the hiring of people with lived experience as members of the team. Participants' choice and control over their own lives is a paramount principle of HF service philosophy. As the empowerment theory (Zimmerman, 2000) suggests, the ability of participants to make choices, engage in decision-making and develop a sense of control, depends on the extent to which they have opportunities to access, secure and manage resources, and to participate in their communities. In our study, we found that interactions between systemic and organizational level factors influence those opportunities.

Housing is a key resource. In our study, a systemic facilitator of high fidelity in the *Housing Process and Structure* domain was the availability of affordable private rental supply, which allowed for participants' choice and rapid access to independent and scattered site apartments across the city. In other studies, the lack of affordable housing was reported as a significant challenge for programme implementation (Macnaughton *et al*., 2015; Manning *et al*., 2018; Rae *et al*., 2018). In our study, programme staff also recognized the recent constraints of the rental market

in Lisboa. According to the Housing Market Observatory (Fernandes, 2018), 51.4% of the available houses for rental has rent costs below €500 per month. This is clearly insufficient since demand among renters for this housing segment (rents bellow €500) is about 74%.

Therefore, in a high demand housing market, the programme's capacity to continually find suitable apartments and maintain long lasting leases agreements seems to be facilitated by the organizational strategy of having the programme as the lease holder, and by the team's responsiveness to private landlords' concerns. Developing good relationships with landlords was also found by other programmes to be essential to overcome this challenge to programme fidelity (Aubry *et al*., 2015; Macnaughton *et al*., 2015; Manning *et al*., 2018).

On the other hand, in a context of a tight social housing stock, which only has the capacity to respond to 33% of the 9,869 families with rehousing needs in Lisbon (IHRU, 2018), the private rental market ensures that people can move more easily and quickly into housing. Additionally, it was noted by our respondents that the private rental market offers housing environments of better quality, which has been found to be a factor influencing participants' perceptions of choice and control, and recovery outcomes (Martins *et al*., 2016).

The public health and mental health care system is considered to be a community asset that should be used by HF programme participants. Not having on-site medical diagnosis and treatment was a factor contributing to low programme fidelity, in terms of available health care. However, in a setting with good quality, readily available, and affordable health care services, as is the case in Portugal, the use of this resource seems a much better option. In many HF programmes in Europe, services are provided only by ICM teams, even for those who work with homeless people with very complex health needs (Busch-Geertsema, 2014).

Collaboration among organizations has been described as a mechanism for building social capital, facilitating their capacity to attain resources to fulfil their mission (Nowell and Foster-Fishman, 2011). In our study, relationships and collaboration between the programme and other community services and organizations were described as an important organizational asset that facilitate participants' access to not only mainstream health care or social services but to a wide range of community resources, enhancing their involvement in community life and social relationships.

Supported education and employment methodologies are incorporated into the programme to better assist participants to succeed in their school projects, or work in the competitive job market. The adoption of these services by the HF programme was facilitated since the organization has been developing these types of

programmes for a long time. However, it was emphasized that in this area, the services provided by the team can be improved and developed. Further strengthening of collaborative endeavours with community organizations will foster peoples' capabilities (Sacchetto *et al.*, 2018) by both increasing the set of opportunities to which people have access, and enhancing the capacity of environments to be more responsive and inclusive.

Investment in ongoing staff training, as well as staff involvement on evaluation and collaborative research with the university, were also considered relevant organizational factors influencing fidelity. Similar results were found in Canada's At Home/ Chez Soi demonstration programme (Nelson *et al.*, 2017), where ongoing training and technical assistance also accounted for the achievement of programme fidelity. Our findings indicated that involvement in training and research increased staff perception of self-efficacy. Moreover, it contributed to staff perception of the programme's intervention from both a values and evidence-based standpoint, and to have a more comprehensive understanding of the impacts of their work on participants' individual changes, and on the broader social environment.

Our findings also indicated that staff and participants' involvement in programme development has effects at different ecological levels. We believe that peer support and opportunities for participants' engagement in programme dissemination and advocacy can contribute to individual recovery outcomes. Several studies found that peer support, as well as involvement in civic advocacy and political action are important factors to recovery processes of people with experience of mental illness (Jacobson and Curtis, 2000; Davidson *et al.*, 2005).

Involvement of staff at all levels of programme development enhanced their perceptions of self-efficacy, and commitment to the programme's mission, which may provide an explanation for the low turnover among staff. Collectively, the results suggest that the involvement of staff and participants enhances their sense of programme ownership, contributes to improve services quality and achievements, and has been crucial in influencing the political changes that have taken place.

Our findings also indicated that the interactions between systemic and organizational factors accounted for recent developments in the policy arena. Since the first years of programme implementation, AEIPS and ISPA University Institute have actively sought to influence the formulation of social policies toward the HF approach, both at a local and national levels. Evaluation and research reports were used to communicate programme effectiveness and efficiency to policy makers and other community stakeholders. Keeping the issue on the agenda and demonstrating that effective solutions are available to end long-term homelessness seems to have paved the way for increasing interest from policy makers to look for solutions that address homelessness, particularly with the HF model.

At a local level, the City Council of Lisboa launched a new programme for people who are homeless (2016-2018) and created the first public funding stream specifically directed to promote the implementation of HF programmes. Moreover, this funding stream incorporated HF principles, particularly as it relates to housing structure, providing funds specifically for rental of individualized and scattered apartments, and to services that focus on wellness and community engagement.

At a national level, the second National Strategy for Homeless People (2017-2023) was launched (ENIPPSA, 2017). One of the strategic objectives is to increase the provision of individualized and permanent housing solutions through HF programmes. Moreover, the new generation of housing policies created a programme for financing the rehabilitation, acquisition and rental of buildings to increase the availability of affordable housing, namely for the implementation of HF projects.

In addition, the President of the Portuguese Republic has called for effective solutions to tackle homelessness, and has hosted regular meetings with stakeholders, in which AEIPS and ISPA have participated. Further, on April 4th of 2017, the President declared that Portugal should end homelessness by 2023 and has called for the urgent implementation of the National Strategy.

While this study described a programme in a particular setting, we think that the findings are relevant for understanding how the interactions between multiple factors at different ecological levels could affect programme implementation. In addition, our findings highlight the presence of several facilitating factors to programme fidelity that may be useful to guide the implementation of similar processes for HF programmes in order to enhance their practices.

Some limitations are worth noting. Programme fidelity was assessed with a self-report measure, which is susceptible to some degree of subjectivity. Although the questionnaire covers many factual issues, the subjective nature of some questions may have led programme staff to evaluate the programme in a more positive way. To reduce potential biases, participants were asked at the consensus meeting to provide examples from daily practice that could support their ratings.

As well, the results on programme study in our study relied exclusively on providers' perceptions of programme fidelity. In future studies, the assessment from programme participants should also be incorporated to measure fidelity. Participants' involvement is a principle of HF philosophy, thereby it is a paradox that they were not involved in the evaluation, particularly in a study that intends to assess fidelity to HF principles. On the other hand, providers and participants may have different perceptions and eventually may rate programme's qualities differently, as individual perceptions are not only influenced by the setting's character-

istics, but also by one's social role in the setting (Linney, 2000). Therefore, having participants' perspectives and recommendations will be beneficial for assessing the programme's quality.

Future research should also move beyond the organization's experiences and seek to incorporate perspectives from different stakeholders of the broader environment in which the programme operates, including landlords, representatives of social services, health services, traditional homeless services, other community organizations, as well as policy decision makers. Taking into account these different perspectives may provide a more comprehensive understanding of the interplay between organizational and system factors on programme implementation and sustainability.

Conclusions

This study illustrated the utility of completing a fidelity self-assessment to support a reflective process in which HF providers could learn about the areas of their programme that are implemented with high fidelity to principles of the model and to build on their strengths, as well as to identify areas in need of improvement that require more attention in order to enhance their practices and procedures. In addition, the HF International Cross-Country Fidelity Project allowed programmes to share their implementation experiences and learn from each other. As HF is growing throughout several countries, collaboration and learning among programmes will help develop a sense of community practice. For this purpose, we believe that the HF International Network has much to offer.

Fidelity to the HF principles is relevant for the sustainability of the model, particularly when this approach is being scaled up across many different settings. These principles reflect the underlying philosophical values of the model and provide a guiding framework associated with the effectiveness of the intervention. International evidence has shown that HF not only delivers better outcomes for service users, but is also cost-effective (Gaetz, 2012; Goering *et al.*, 2014). Model effectiveness and long-term savings have been crucial to raise increasing interest among policy makers.

Investment in HF policies seems to be a more rational choice and a better use of available resources. However, in order to consolidate HF policies, it is critical to prevent new programmes to drift away from the core principles and compromise programmes' expected outcomes. Ongoing fidelity monitoring can help to assure a programmes' quality and its continued effectiveness. HF holds enormous potential for addressing the complex challenges of ending homelessness. By implementing the model in a consistent manner, HF programmes will be better able to fulfil this promise.

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The Challenge of Implementing the Housing First Model: How Belgium Tries to Connect Fidelity and Reality

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Abstract_*In Belgium, Housing First (HF) programmes were systematically implemented in eight cities in a two-year experimental Housing First Belgium framework. From September 2013 to March 2016, an evaluation team completed a longitudinal assessment of participants supported by Housing First teams (n=141) compared to homeless people relying on the traditional support system, 'treatment as usual' (n=237). HF programmes demonstrated efficacy with particularly high housing retention rates after three years (93%). Using the Housing First self-assessment of fidelity method developed by Pathways to Housing for the American context (Gilmer et al., 2013), average scores on Housing and Services, and Service Philosophy domains nearly achieved the maximum possible scores (Ms=3.9 and 3.8 out of 4 respectively). Moderate fidelity was found on three of the five domains (Housing Process and Structure [M=3.2], Service Array [M=3.4], Team Structure/Human Resources [M=3.0] domains). In this paper, we describe the Belgian Housing First projects and define the main barriers explaining the moderate average scores in these three domains across the programmes. This analysis allows us to question the equal weighting of the five domains. Inspired by an evidence based-approach, we open a discussion about the need to prioritize key HF principles by weighting the fidelity survey domains according to their role in the impact of HF practices on clients. We hypothesize that research and data on this issue could assist to promote implementation of HF programmes that are more effective.*

Keywords_*Housing First, homelessness, evidence-based practices, effectiveness, public policies*

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Introduction

In Belgium, the fight against homelessness is geared toward addressing social emergencies, with most public subsidies and programmes focused on various forms of temporary accommodation, especially during the winter. Independent and permanent housing is often considered the final goal of an integration process for which clients have to prove they are "housing ready". This approach is commonly referred to as the "treatment first" paradigm, in which it is assumed that, most of the time, people must resolve their personal issues, such as addictions and mental health problems, as a precondition to access temporary semi-collective accommodation and prior to being deemed "ready" for housing.

Commonly referred to as the "staircase" model, "treatment first" may be suitable for some people (Housing First Belgium, 2016), who are able to quickly orient to housing from the street or shelters with the aid of floating support. However, as observed in the US, Canada, and some European countries, it has not been successful for a subgroup of homeless people who use night shelters and/or sleep rough for years, which includes many people with mental health diagnoses and addiction issues (Réa *et al*., 2001). The conditions associated with being considered ready to integrate into regular housing in the community impede their progress (Devine *et al*., 1997; Dordick, 2002; Gulcur *et al*., 2003).

In Belgium, some pilot projects have attempted to meet the needs of specific target populations more effectively by reducing the thresholds for access (Agence Alter, 2010). However, these efforts have not sufficiently addressed the problem, and most vulnerable homeless individuals are still unable to get a foothold into the integration process. Consequently, what could be a temporary emergency turns into a long-term homeless situation in which the individual's initial problems worsen.

In comparison to traditional models of homeless services, Housing First (HF) appears to be the most efficient solution for this specific target population, an observation confirmed in several experimental trials in Canada (Goering *et al*., 2014), France (DIHAL, 2017) and Spain (Bernad *et al*., 2016). Since its launch in New York in the early 1990s, this model has been successfully tested and implemented in several European countries, with a two-year housing retention rate of at least 80% (Pleace and Quilgars, 2013). HF's success is anchored in its core principles and practices. For example, in HF, housing is not contingent upon readiness or on 'compliance', such as sobriety or medication adherence. Rather, it is a rights-based intervention, rooted in the philosophy that all people deserve housing, and that adequate housing is a precondition for recovery. Consistent with the model's focus on recovery, HF programmes provide client-led, intensive and multidisciplinary supports that are individually tailored to clients' needs.

In Belgium, HF programmes were implemented systematically for the first time under the two-year experimental HF Belgium framework (starting in September 2013). Some HF-inspired practices emerged in other locations, such as Ghent, which was also involved in the HF Europe project as a peer site (Busch-Geertsema, 2014).

The Housing First Belgium experiment

This two-year experiment was the result of what may be referred to as a "bottom-up process". The development of the Second Federal Plan against Poverty (Federal Government, 2012) created ripe conditions for the implementation of HF practices in Belgium. In preparing the plan, the Secretary of State for Social Integration and the Fight against Poverty asked for and considered input from service providers, including existing HF services. Encouraged by some private and public stakeholders' innovative proposals, Action 76 of the Federal Plan thus provided for "the implementation of initiatives inspired by the initiation of the HF approach in the country's five largest cities: Brussels, Antwerp, Ghent, Charleroi and Liege" (Federal Government, 2012; p.38).

The combined support of the Secretary of State, the Federal Public Service for Social Integration, and the National Lottery (which provided the necessary funds), permitted the experimental *Housing First Belgium (HFB)* project to begin. After the first year, in order to consolidate the initial evidence of efficacy and expedite the start of the scaling-up phase, the experimental period was renewed and included three new medium-sized cities: Hasselt, Molenbeek-Saint-Jean and Namur. As a result, HF programmes operated in eight sites during this test-phase. The objective of this experimental phase was to highlight the conditions determining the effectiveness and efficiency of HF in the specific Belgian contexts.

HF support teams selected clients who had experienced long-term homelessness in accordance to the *European Typology of Homelessness and Housing Exclusion* and were very vulnerable in the context of physical and/or mental health and/or addiction (Armore, Baker and Howden-Chapman, 2011). Traditional solutions had proven limited in their ability to improve integration for this specific target population.

A research team carried out a two-year longitudinal assessment (between September 2013 and March 2016) on a selected sample of the first HF clients *(n*=141), compared to a sample of homeless participants with the same vulnerabilities found in programmes with "treatment as usual" policies *(n*=137) (Housing First Belgium, 2016). On average, both groups had experienced five years of homelessness (with a short standard deviation of a few months and no significant variabilities between the eight sites for the experimental group). Through structured interviews, impact indicators were systematically explored and tested in domains such as

administration, well-being, health, housing, and justice. Along with France (DIHAL, 2017) and Spain (Bernad *et al*., 2016), Belgium is one of the few countries in Europe that has systematically compared HF programmes with "treatment as usual" programmes longitudinally.

Findings indicated that vulnerable individuals who have experienced long-term homelessness are able to move into houses directly from the street and maintain housing, with 93% of the participants in the experimental cohort remaining housed after the second year. For many, the use of emergency health services declined as their health stabilized or improved. Positive changes on recovery indicators were also observed. For example, many participants made new social and community links and developed stronger self-esteem and autonomy. These findings suggest that it may be time for us to do away with past prejudices and rethink the 'housing-ready' precept. Moreover, HF appears to be not only a good practice but the best practice for this specific target population; in comparison, in the 'treatment as usual' group, only 48% were in housing after two years (Housing First Belgium, 2016).

A third group was added to the research (n=100) to determine the longitudinal impact of what we could call a more traditional floating housing support. This kind of housing support is usually offered in Belgium to individuals considered "ready to be housed", who have previously lived in temporary collective accommodation and have recently moved into their own tenancy. They were less vulnerable (conditions for entering in this kind of temporary accommodation include no drug consumption), and had experienced homelessness for a shorter time (average was a year and a half). As soon as they were in rented accommodation, they received support, for as long as necessary (even if this means around one year). This support involves responding to their specific demands, applying a case management approach (support is mainly given by social workers). The two-year follow-up demonstrated the effectiveness of this floating housing support. The housing retention rate was high (86%) and positive outcomes were observed in the areas of administration and health (Housing First Belgium, 2016). Therefore, the outcome evaluation of the interventions in the three groups revealed the crucial role that housing plays in the recovery and social integration process.

All of these observations were translated into practical recommendations collated as a handbook for institutions wishing to initiate HF practices (Buxant *et al*., 2016). This document is used as a tool in a training session delivered by *Housing First Belgium – LAB*, the national framework that supports the development of the HF model in Belgium (see below).

The place of HF in the fight against the homelessness paradigm

HF has proven to be an effective practice for the most vulnerable homeless groups. A body of research from the United States, Canada and Europe attests to the success of the model (for an overall review of the HF literature, from the 1990s to 2014, see Raitakari and Juhila, 2015). More specifically, the Belgian data demonstrates how HF can be implemented effectively in the Belgian context. There are now more HF sites in Belgium than at the beginning of the experiment (11 HF support teams in total, distributed in 8 different cities including 4 support teams in Brussels and its surroundings, at the end of 2017). Most of these programmes are still considered as pilot projects that supplement traditional homelessness services (both by the governments and the social sector). The outcomes of the test phase justify re-examination of both the practical and the political approaches. The paradigm shift towards evidence-based housing-led practices is now on the stakeholders' agendas (local social services and governments included).

In Belgium, the authorities fighting homelessness mainly operate at the regional level. Since the experimental phase ended (supported by the Federal level), the three regional Governments have been in charge of the future of HF in Belgium. For the time being, progress has been very different across the three regions. In Wallonia, the three pioneer sites received financing to allow them to keep their support teams in their present state for three years. A fourth city has recently started and a fifth one is due to submit a project in the next few months. However, HF practices are still considered specific programmes, supported by yearly grants. At the same time, new night shelters have opened. Housing and social emergency services still seem to operate as separate entities.

In the Brussels Capital Region, the expansion of HF is under way. One year before the end of the experimental period, the two original programmes were continued and two new programmes were funded, including one that targets homeless youth. An official document describing how HF practices should be implemented is currently being prepared. Programmes will be obliged to fulfil the implementation requirements set in the document if they want to subscribe funding agreements with the administration. In the broader sense, this points to the need to swiftly orient homeless individuals towards housing as soon as they arrive on the streets or in emergency services. This approach would help to confront homelessness, especially since the population is growing: the results of the two latest homeless counts carried out in Brussels show an almost 100% increase in the size of the homeless population since 2008 (La Strada, 2017).

Furthermore, during winter periods, the increase in available emergency beds correlates with an increase in the number of homeless individuals recorded in the region. If these winter programmes provide shelter to those who spend the rest of

the year in public areas, they primarily attract homeless people who were overlooked in the count performed before the winter period. The next challenge for these urban areas is to move the political cursor towards sustainable integration measures. In any case, sustainable integration measures appear to be the declared intention of the Brussels sector in aid of the homeless, particularly in reaction to a recent political scandal related to mismanagement of the largest emergency services provider; the SAMU-Social (Mormont, 2017; Vanhessen *et al*., 2017).

In the Flemish region, a strategic plan to fight against homelessness was published recently. It focuses on HF practices, with a goal to significantly reduce the number of homeless people and help them avoid getting trapped in the emergency social services system.

At the federal level, the secretary of state granted a transition subsidy to the support teams and created the *Housing First Belgium-LAB*, a public structure that provides support and technical assistance to the Belgian HF services. Notably, this structure provides longitudinal monitoring and training programmes. The Federal Public Service for Social Integration presides over a platform, led by the HFB-LAB, which brings together HF participants. Finally, through this same public authority, Belgium is a member of the HF Europe Hub.

The next challenge is to get homelessness on the agenda for health care, housing and employment policies, especially for the vulnerable population for which HF is intended. In some countries, HF is considered part of healthcare policies, but in Belgium, at least for now, it is mainly the prerogative of social welfare programmes. Because of the support provided to the 11 HF teams in Belgium over nearly five years, more than 400 long-term homeless people with very significant needs in terms of physical health, mental health or addiction, are no longer living on the streets and have successfully started their recovery and social integration process.

Description of the Housing First Belgium experiment

The *Housing First Belgium* experiment referred to the Pathways to Housing model and to the *Housing First Europe Guide* (Pleace, 2016). Regional Governments, potentially ready to open new submissions for developing HF programmes, urged the existing HF services to clearly define what should be called “Housing First” according to their own expertise. The services reached a consensus for HF practices in Belgium guided by three key principles: (1) The target group is homeless adults who are least likely to have access to housing; (2) Housing is provided first, then other needs are addressed; and (3) Support is personalized. A set of criteria for programmes to qualify as HF was also defined (see Table 1 below).

Table 1. Defined Target Group, Housing, and Support Criteria of Housing First Practices in Belgium

Target group. ***The homeless people least likely to have access to housing.***	**Housing.** ***Housing is provided first, then the rest.***	**Support.** ***Personalized support.***
1. Homeless (Ethos 1 and 2).[a]	6. Unconditional access to housing.[d]	11. Mobile
2. Long term (at least for the three months prior to inclusion in the housing program or a total of 12 months accumulated in separate episodes over a lifetime). [b], [c]	7. Separation of housing and support.[e]	12. Must be able to respond to the high and complex needs of the public.[g]
3. Vulnerable (physical and/or mental health issues and/or drug addiction).	8. Individual tenancy agreement	13. Separate from housing (if necessary, support is provided even if the person is not or no longer in housing, as long as the person is accepting of it).
4. In need of intensive housing support.	9. Individual housing.[f]	14. Following the HF philosophy (with an aim to resettle, focused on individuals and their rhythm, as part of a philosophy of risk reduction, in a compassionate way).
5. Able to create entitlement to an income or already have an income.	10. Permanent housing.	15. As long as necessary.
	Other criteria considered as recommendations:[h] Signature of a tenancy agreement between the occupier and the owner. Housing distributed in the City.	

(a) Situations of homelessness, insecure or inadequate housing could be considered as long as they are temporary situations where the most likely outcome is a situation of homelessness and all other criteria related to the target group are met (e.g. admitted to hospital from the streets with an almost certain return to the streets after discharge).

(b) Please note that, on average, the participants of the HFB experiment have been homeless for of 5 years (Ethos 1 and 2).

(c) This concept must be seen in relation to the age of the group.

(d) Without access conditions other than those provided for each tenant by signing the tenancy/occupancy agreement – no obligation with regard to addressing health/addiction problems may be applied to access housing.

(e) The housing tenure is independent of the quality/frequency of the support relationship.

(f) Except if the person prefers another approach which better suits his/her profile. Because of their age and/or specific vulnerabilities, certain tenants of the Housing First Belgium experiment occupy a room in a nursing home or within the framework of a sheltered housing initiative. The recommended rationale is as follows: the housing must be best suited to the person in question AND the housing must be permanent.

(g) Either directly via an Assertive Community Treatment team (multidisciplinary team) or through external channels, via an Intensive Case Management team.

(h) Both these recommendations aim to promote the key role of housing in the social resettlement/integration process. However, considering the difficulty of access to housing, these recommendations must be put into context.

The eight HFB pioneer services participated in the fidelity assessment process undertaken in Belgium within the framework of the larger international fidelity study (Aubry *et al*., 2018). Six of the eight services use an Assertive Commitment Treatment model (teams include psychologist, nurse, social worker, specialist educator); moreover, two of them include a peer worker[1], one a doctor, and one a job coach. The other two services use an Intensive Case Management model. The caseload is six to eight clients per employee. At the time of data collection, the professionals had worked within the HF model for approximately one to two and a half years. Five of the services used a mix of public and private market housing units, while two of them used only public housing and one service used only private housing. Due to the short, fixed two-year duration of the experiment, 75 clients were housed very quickly in the first year across the first six sites (and mainly in the first six months) and 45 in the second year (with the 2 new sites involved later in the experimentation). Currently about 30% of new clients are housed every year.

1 At the time participants filled in the Fidelity Scale, only one HF support team was working with a peer.

Method

The fidelity assessment

Procedure and sample

The self-assessment survey used for the research consists of 37 items (Gilmer *et al*., 2013). Six to eight items assess fidelity in five domains: (1) *Housing Process and Structure,* (2) *Housing and Services*, (3) *Service Philosophy*, (4) *Service Array*, and (5) *Team Structure/Human Resources*. Thirty-six of these items are used to calculate an overall fidelity score and domain scores.

The coordinators of the five French-language teams read and commented on the original wording of each item. Translation was discussed with French speaking colleagues, which resulted in minor wording modifications. The same final version was used by the French programme *Un chez soi d'abord.* A professional translation was provided to the three Dutch-speaking HFB teams, based on the French and English versions.

The national coordinator of *Housing First Belgium* (and author of the present paper) conducted the research. The fidelity survey was completed individually in the summer of 2016. All team members of these eight teams participated (30 people). In each site, the team coordinator then conducted a consensus meeting to reach agreement on each item in the measure. Quantitative results were presented to them at a collective meeting (5 October 2016).

Interviews with site coordinators

A qualitative assessment phase was then conducted by the national coordinator by means of email exchanges and phone calls with each of the eight site coordinators (October 2016).

Data analysis

For the quantitative results, the agreed answers to the survey for each of the sites were scored using a grid provided by the research coordinators. The scores for each item were converted to a 4-point scale, in which scores of 2.9 or lower are considered low fidelity, scores between 3 and 3.4 are considered moderate fidelity and scores of 3.5 or higher are considered high fidelity (McNaughton *et al*., 2015). A total fidelity score and a score for each of the five fidelity domains was calculated. The national coordinator of *Housing First Belgium* then calculated the average scores for the eight sites.

For the qualitative results, the different elements identified in the discussions and email exchanges with the team coordinators and other team members were coded according to the agreed upon common analysis framework (Aubry *et al*., 2018). Initially, factors identified in the interviews were classified as facilitators or barriers

to HF fidelity. Subsequently, after this initial dichotomization, they were coded in terms of ecological level, namely as being either systemic-, organizational- or individual-level factors.

Results

Quantitative findings

Table 2 presents the individual item scores, average domain scores, and average total scores for the eight programmes. The average global score for the eight sites was 3.4. The *Housing and Services* and *Service Philosophy* domains nearly achieved the maximum possible scores (*Ms*=3.9 and 3.8 respectively). Moderate fidelity scores were obtained for the *Housing Process and Structure* (*M*=3.2), *Service Array* (*M*=3.4), and *Team Structure/Human Resources* (*M*=3.0) domains (Figure 1). Despite some exceptions, mainly due to different configurations in the services (availability of public housing for items 4 and 5; or the existence of a peer worker in item 28), a great deal of consistency was observed across the eight sites. The lowest average scores per item related to clients' participation in the services (item 37, M=1.1; item 28, M=1.4), the proportion of income required for the rent (item 5, M=2.1) and the frequency of staff meetings (item 35, M=2.5).

Figure 1. Average Housing First Fidelity Ratings by Domain (Mean rating for the 8 sites)

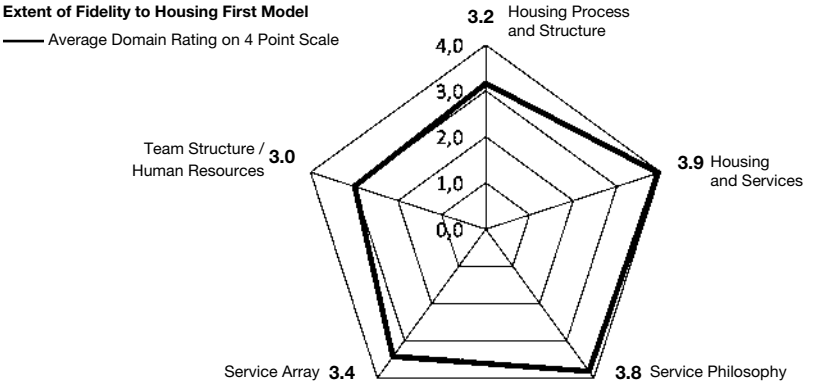

Table 2. Fidelity Assessment Item Scores and Domain Means per site and Average

Domain / Item	Domain Mean / Standard Item Score (Out of 4)								
	Site1	Site2	Site3	Site 4	Site 5	Site 6	Site 7	Site 8	Mean 8 sites (SD)
Housing Process and Structure	***3.1***	***3.6***	***2.7***	***3.3***	***3.9***	***3.0***	***3.0***	***2.7***	***3.2 (.42)***
1. Choice of housing	*3.0*	*3.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*3.8*
2. Choice of neighborhood	*4.0*	*3.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*3.9*
3. Assistance with furniture	*4.0*	*4.0*	*2.0*	*2.0*	*4.0*	*2.0*	*2.0*	*2.0*	*2.8*
4. Affordable housing with subsidies	*2.0*	*4.0*	*2.0*	*3.0*	*4.0*	*3.0*	*2.0*	*2.0*	*2.8*
5. Proportion of income required for rent	*4.0*	*4.0*	*1.0*	*2.0*	*3.0*	*1.0*	*1.0*	*1.0*	*2.1*
6. Time from enrolment to housing	*4.0*	*3.0*	*2.0*	*4.0*	*4.0*	*3.0*	*4.0*	*2.0*	*3.3*
7. Types of housing	*1.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*3.6*
Separation of Housing and Services	***4.0***	***3.7***	***3.9***	***4.0***	***4.0***	***4.0***	***4.0***	***4.0***	***3.9 (.11)***
8. Proportion of clients with shared bedrooms	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*
9. Requirements to gain access to housing	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*
10. Requirements to stay in housing	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*
11a. Lease or occupancy agreement	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*
11b. Provisions in the lease or agreement	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*
12. Effect of losing housing on client housing support	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*
13. Effect of losing housing on other client services	*4.0*	*2.0*	*3.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*3.6*
Service Philosophy	***3.6***	***3.7***	***3.9***	***3.9***	***3.9***	***3.8***	***3.9***	***3.7***	***3.8 (.12)***
14. Choice of services	*4.0*	*3.0*	*4.0*	*4.0*	*4.0*	*3.0*	*4.0*	*3.0*	*3.6*
15. Requirements for serious mental illness treatment	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*
16. Requirements for substance use treatment	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*
17. Approach to client substance use	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*
18. Promoting adherence to treatment plans	*3.5*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*3.5*	*3.9*
19. Elements of treatment plan and follow-up	*2.0*	*3.2*	*3.6*	*3.6*	*3.2*	*3.6*	*3.6*	*3.2*	*3.3*
20. Life areas addressed with program interventions	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*
Service Array	***3.4***	***3.5***	***3.3***	***3.3***	***3.9***	***3.4***	***3.4***	***3.3***	***3.4 (.19)***
21. Maintaining housing	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*
22. Psychiatric services	*3.0*	*4.0*	*3.0*	*3.0*	*4.0*	*4.0*	*4.0*	*3.0*	*3.5*
23. Substance use treatment	*2.4*	*3.2*	*2.4*	*2.4*	*3.2*	*2.4*	*2.4*	*2.4*	*2.6*

24. Paid employment opportunities	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*
25. Education services	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*
26. Volunteer opportunities	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*
27. Physical health treatment	*4.0*	*3.2*	*3.2*	*3.2*	*4.0*	*3.2*	*3.2*	*3.2*	*3.4*
28. Paid peer specialist on staff	*1.0*	*1.0*	*1.0*	*1.0*	*4.0*	*1.0*	*1.0*	*1.0*	*1.4*
29a. Social integration services	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*
Program Structure	***3.2***	***2.9***	***3.0***	***2.9***	***3.1***	***2.7***	***3.0***	***3.1***	***3.0 (.15)***
31. Client background	*3.3*	*3.3*	*4.0*	*3.3*	*3.3*	*2.7*	*3.3*	*4.0*	*3.4*
33. Staff-to-client ratio	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*
34b. Frequency of face-to-face contacts per month	*4.0*	*4.0*	*4.0*	*3.0*	*4.0*	*4.0*	*4.0*	*4.0*	*3.9*
35. Frequency of staff meetings to review services	*4.0*	*2.0*	*2.0*	*2.0*	*2.0*	*2.0*	*2.0*	*4.0*	*2.5*
36. Team meeting components	*2.7*	*2.7*	*2.7*	*4.0*	*4.0*	*2.7*	*4.0*	*2.0*	*3.1*
37. Opportunity for client input about the program	*1.3*	*1.3*	*1.3*	*1.3*	*1.3*	*0.7*	*0.7*	*0.7*	*1.1*
Total	***3.4***	***3.4***	***3.3***	***3.5***	***3.7***	***3.4***	***3.4***	***3.3***	***3.4 (.13)***

Qualitative findings

Systemic facilitators and barriers

Assistance with rental payments, (interest-free) loans for the rental deposit, and a (single) moving-in grant for any homeless person moving into accommodation from the street, were considered some of the types of public subsidies that facilitate access to housing for the most vulnerable people in Belgium. This help exists and is available independent from the HF programmes; as a result, it was thought to facilitate separation between housing and support that is promoted by the HF model.

However, these social benefits hide and try to compensate (all too often unsuccessfully) for the lack of investment in a more social housing policy. Access to affordable housing for a poor and stigmatized population clearly remains the major sticking point in the fight against homelessness (and poverty). The HF programmes in Belgium can even be considered as having more difficulties in accessing housing solutions, considering the stigmatization of the extremely fragile people they are designed for, which is reflected in the difficulty of achieving a higher score in the *Housing Process and Structure* domain of the fidelity scale.

At the time when the HF programmes in Belgium participated in the current study, they were still considered innovative pilot projects. They were developed within the framework of a fixed-term experiment, fully supported by the Secretary of State in charge of Fighting Poverty. As a result, the Regional Housing Ministers did not feel involved. To access the housing units, the HF programmes were autonomous and

powerless. Amongst the 11 HF programmes that currently exist in Belgium, only one of them has direct and priority access to public housing, and only four have a subsidy to cover late rental payments or small rental damages.

The moderate score in the *Housing Process and Structure* domain is mainly influenced by the item number 5 called "Proportion of income required for rent". Scoring high on that item means that at least 85% of the tenants should spend no more than 30% of their income on rent.

In Belgium, the Social Integration Income paid to homeless people with no other source of income is €835 per month. Accordingly, rent should cost a maximum of €250 per month, which could, in theory, be achieved in the public rental market, since income is taken into account when setting rental prices. Currently, however, there is a substantial shortage of social housing units and a long waiting list that increases each year. HF programmes negotiate access, but few of them have signed a formal partnership, so most negotiations are *ad hoc*. The obvious conclusion is unambiguous and disappointing: the policy to fight homelessness is not yet aligned with housing policy. Therefore, the average rent paid by the tenants in our HF programmes is unfortunately greater than 30% of their income (sites that work mainly or only with the private rental market – sites 3, 6, 7 and 8 – are most affected, this is reflected in item 5).

HF programmes (as do all housing-led programmes in Belgium as well as many European countries) require structural political measures such as the capping of rents, increased assistance with rent payments, refinancing of Social Estate Agencies, and the creation of new social housing (including pilot projects involving modular housing). During the launch of the experimental phase, it was important to remain optimistic, and the critical lack of housing was not considered an immediate obstacle. To maximize the duration of the longitudinal assessment within the allotted period, teams were hired and housing was found in record time. Although some teams found the pressure of the experimental study difficult to handle (see the individual obstacles mentioned below), it nevertheless provided a positive influence in the form of a catalyst. This pressure made the role of the housing department indispensable and allowed for a clear separation between housing and support, which facilitated fidelity in the *Separation of Housing and Services* domain.

All available routes to accessing housing were taken. These included: (1) collaboration with private investors who entrusted management of a renovated building to a Social Estate Agency; (2) use of a rolling rental agreement to negotiate with private and public owners and use of public funds to cover possible rent defaults or damages; (3) precarious occupation of public housing in need of renovation (with an agreement to ensure the transfer to suitable housing with a traditional rental contract); (4) feasibility study for the construction of low-cost modular housing; and

(5) long-term residences such as care homes and Protected Housing Initiatives. The only directives given by the experiment's general management team were that access to housing must be unconditional and the rental contract must be as traditional as possible (including in its duration).

As a social worker from one of our teams says: "I explain to them that the only thing we're asking them is to pay their rent, and to agree to meet with the team at least once a week. And that we're not going to ask them to undergo treatment or abstain from consuming" (Buxant *et al*., 2016; p.62). *Housing First Belgium* is a social laboratory for the entire "housing-led" sector. The huge amount of media coverage has contributed to the legitimacy of the practices tested and has reassured certain intermediaries (in particular, private landlords). However, despite this initial burst of energy from the HF teams, we have to acknowledge that, with more than 400 clients in housing, securing additional tenancies will be difficult.

The score on the *Housing Process and Structure* domain is also influenced by some poor-quality housing units. In the very high-cost and tight rental market, certain accommodation offers have been considered by some programmes as they could not be refused. As one social worker stated, "we had to start the experiment. There wasn't any housing available at the time and all of a sudden, we had 10 candidates and we had to use transitional housing, which does not fall within the HF principles". Testing the effectiveness of these different types of housing units placed the teams in a stronger position to negotiate with new housing providers because of their experience from which they could draw. In the HF implementation manual published at the end of the experimental phase, although we advise institutions looking to implement such practices to follow every lead to decent and sustainable housing, we also suggest they take the time necessary to prepare the project and build partnerships before they accept their first tenants.

Table 3. Systemic Facilitators and Barriers for Achieving Housing First Fidelity

Facilitators	Barriers
Rent supplements & move-in bonuses	High cost public rental market
Additional subsidies and interest free loans	Substantial shortage of social housing and long wait times
Separation between housing and support	Lack of funding
Collaboration with private investors	Coordination with other Agencies
Negotiation and partnerships with housing provider	Lack of structural political measures
Public and media support for the program	Yearly increases in cost of rent

Organizational facilitators and barriers

As previously discussed, the HFB programme was developed by the stakeholders themselves, who developed and piloted the project with support from (but under the control of) the Federal Public Service. Therefore, apart from some clear fundamental principles of the HF model, stakeholders were free to build the teams according to their local needs. Precedence was given, for example, to three organizations that combined their expertise to create the HFB teams integrated by specialized workers. These mixed teams favoured the development of the different skills needed to support clients and facilitated the integration of the HF practice throughout the whole HFB network. The challenge was, therefore, to ensure fidelity to HF principles while adapting to local needs. To do so required support team members to look beyond their respective institutional philosophies, which was not evident due to the lack of an initial shared training process, as well as the absence of strong leadership within some of these teams.

Whatever their composition, the HFB teams are at the core of local networks of community agencies and delegate to these agencies, helping to support clients' autonomy in the community. The HF teams physically accompany the tenant to these external services in the community providing a "warm handover". In some cases, the HF service provider delivers the support in collaboration with a colleague from another agency.

As one HF social worker explained: "We have different partners, each one is a piece of the puzzle in the fight against homelessness, but nobody is going alone. If we combine our means, work together, and are responsible together, we can have something to offer to people with complex problems who have nowhere else to turn. I think it's really important that a project starts from a field network" (Buxant *et al*., 2016; p.29). Since the HF teams do not want to view themselves (or be seen by others) as being self-sufficient, they make use of existing networks as well as their clients' own resources.

The HF teams faced some barriers to achieving high fidelity in the *Housing Process and Structure* domain, especially purchasing furniture and decorating the apartment in ways that match the client's wishes. On one hand, the teams do not have the budget to carry out this type of purchase (not at the beginning of the experiment, in any case); on the other, this is a deliberate choice. The teams ensure the presence of furniture needed to meet basic needs, but the follow-up to these purchases becomes a part of the recovery process. In other words, the team does assist participants to find furniture in the community, such as through donations. From their perspective, they view HF teams as providing support to clients so they can capitalize on their own strengths and become more independent.

This explanation given by one of the HF social workers aligns well with this philosophy:

> I think that at one point we had, by default, taken the habit of saying that we would move them in using our own funds, but actually no, I think we also have to use the external resources that exist. Sometimes, the people themselves have a lot of resources. They have a friend who comes along, who can help out. We have to be able to ask them: "But what about you? How do you think you can do it?" It's also important not to fill all the spots too quickly (Buxant *et al*., 2016; p. 66).

> We have a check-list comprising all of the tasks and things that have to be done to enter housing. We also give this list to the tenants. A lot of them are able to manage things independently, but just don't think about it because they've never lived alone before (Buxant *et al*., 2016; p. 66).

On an organizational level, some choices that were made when the teams were first set up limit programme fidelity. However, we note that fidelity in many areas is still developing as the programmes mature. When they began, HFB teams had the opportunity to select the staff themselves, and they prioritized hiring team members with expertise they deemed indispensable for their own local projects. In the beginning, these team members did not yet have expertise in HF. They gradually developed their own practices, mainly at the national level meetings coordinated by Federal Public Service for Social Integration. Moreover, HFB teams support about 20 to 45 clients each (with an average caseload of six to eight clients per employee). They are, therefore, small teams with limited budgets and two to four FTE employees. These conditions made it difficult to integrate other HF components, such as peer support workers. In programmes with high fidelity, there must at least one 1.0 FTE peer specialist for every 100 participants. In Belgium, only two teams have peer workers, and they have not been hired from the start. And even now, one is employed, while the other is still working as a volunteer due to the lack of funding.

All the HFB teams are aware of the benefits that a peer support worker could bring, especially to delivering support around substance misuse and harm reduction. However, it must be said that some team members have concerns about integrating peer workers into the HF teams. They mainly explain that when starting a HF programme, all efforts and time are put into managing and training their HF support team in providing an innovative practice and convincing the local stakeholders about their legitimacy. They all talk about having to "fight" when implementing HF. Working with peers in the field was totally new in Belgium. Team members explained that it was impossible to implement all innovations at the same time, with such an insecure framework, as they received funding for the test phase, but without any

guarantee for the period after the pilot. Moreover, the Federal Public Service in charge of the piloting asked them to implement HF in such a way that they could fulfil it even if the financial support was to stop after the test phase. This involved networking and pooling their own resources.

It seems that the framework we gave them was not secure enough for all to receive peer support from the start. More than three years later, with more confidence in the future of their HF programme, they are working with peers or seriously thinking about it. Current subsidies remain very tight in some HF programmes and don't allow the employment of new workers. However, when asked, most HF team support coordinators answer that if any financial revaluation occurs, they will prioritize the fulfilment of the part-time contracts before thinking about working with peers. From our point of view, we all still need to overcome our prejudices. Some of the crucial questions heard from social workers during the discussions were: "How are we going to manage if he decompensates? How can we be confident about his recovery?" The HF support team who has the strongest experience in working with peers has started a training programme. It could be the first step to overcoming scepticism.

Working with volunteers was also identified as challenging. Two HF teams recently began working with volunteers. These volunteers are trained and supervised, so they can accompany clients who are further along their recovery journeys to leisure activities or other appointments. This allows the teams' professionals to focus on their primary responsibilities to their most vulnerable clients. This kind of partnership with volunteers aligns well with some individual clients' needs, which only appeared at the end of the second year of our experiment. These needs are linked to loneliness and a desire for more opportunities for meaningful daily activities. Even though there are positive benefits for all stakeholders to continue these partnerships, it is important to remember that including volunteers in a professional team requires time, coordination, training, and support from the HF support team, which is not always available at the beginning of a project. In the same way, despite the teams' desire to increase clients' participation in the programme, to do so effectively takes time, training and more experience (item 37).

Team members' part-time employment status is the final organizational obstacle identified by the key informants. Part-time work makes it difficult to hold daily meetings, share, and update client information, despite the assistance of some very practical tools. In the beginning, the choice was taken that teams would be multi-organizational and that team members would return to their original organizations to help expand HF in those areas. However, HF team members increasingly favour full-time positions on the HF teams.

Table 4. Organizational Facilitators and Barriers for Achieving Housing First Fidelity

Facilitators	Barriers
Program development by stakeholders	Absence of strong leadership
Collaboration between HF teams	Lack of shared training process among support workers
Adaptation to local needs	Lack of funding for hiring full-time housing and peer support workers and training of volunteers
Strong commitment among housing first workers	Novelty of the program and lack of experience
Use of external networks and client own resources	Part-time housing workers
Partnerships with volunteers	

Individual facilitators and barriers

It appears that very few individual elements functioned as either barriers or facilitators of HF fidelity. Effective daily practice is highly dependent on this individual element, both for the workers and clients. Motivation and trust are the two facilitating assets on both sides. HF teams have time and do not have pressure to deliver immediate results, which is particularly unheard-of in the sector. Motivation can therefore be generated and honed, and trust can be earned.

The unusual offer of housing was met by some chronically homeless and vulnerable potential clients with initial suspicion:

> We often hear very specific questions about money, payment: 'What am I signing up for?' Sometimes people ask, 'Why me?', so they're distrustful. I give them time to think about it. It's really a question of getting their heads around this strange idea that 'someone's just offered me somewhere to live!' It's a big shock. Some cry, they can't believe it, and some have intense feelings of guilt regarding others (…) (Buxant *et al*., 2016; p. 62).

Housing was difficult to find for this target population. Some were more interested in the offer of housing than the offer of assistance. Some quickly put an end to the assistance despite the contact the HF teams tried to maintain, though as a consequence of the strict separation of housing and support, they remained in their homes. As a social worker described it: "Some take up the housing, but don't want the assistance. When we explain to them that we'll have to meet with them regularly, to make home visits, they tell us 'But I don't need that'" (Buxant *et al*., 2016; p. 62).

In terms of how the team works, it has become apparent that strong leadership from the manager is necessary for multi-organizational teams to work coherently and to remind them of the fundamental principles of the model. Finally, the HF teams must also constantly fight against the prejudices that still act as major obstacles, including those coming from managers of public housing. Evidence that the risks are overestimated does not seem to allay these prejudices. Without a housing policy to provide impetus by officially prioritizing this target population, the expansion of HF will be limited.

One of the major individual obstacles is that some owners change their minds at the last minute or add conditions to access the housing, demonstrating their prejudices and jeopardizing the hoped-for collaboration:

> Generally speaking, it's when the housing was promised to us with a billed guarantee for a certain date, but something goes wrong, and we get it much later. Then, it is a nightmare, because the person is in dire need, as is the team. We get harassed on a weekly basis, and there's nothing we can do. (…) And sometimes it's the professionals around this person who are more stressed than the person him/herself, and then they get resentful (Buxant *et al*., 2016; p. 63).

Table 5. Individual Facilitators and Barriers for Achieving Housing First Fidelity

Facilitators	Barriers
Motivation and trust among support workers and clients	Skepticism of the program among vulnerable homeless individuals
	Stigma towards clients and program
	Last minute changes and added conditions of housing by landlords

Conclusion

Team members who completed the fidelity self-assessment reported that the experience allowed each team to gain common understanding of their own practice and put it into perspective. Further, they have a better understanding of the actions they need to take to address systemic barriers and improve model fidelity. One of the major challenges of HF in Belgium is, for example, to generate accountability and implement housing policies in the fight against homelessness.

However, at the same time, certain doubts and questions emerged as a result of completing the survey. Some answers, although associated with a high level of fidelity to the HF model, were seen as potentially contradictory to HF practice. Some remarks can probably be explained in part, by misunderstanding of some items that lost nuanced meaning through the translation process. For example, although the teams demonstrated high fidelity in the *Service Philosophy* domain, our attention was drawn to the item that states the programme must "systematically address [different issues] with specific interventions". For this item, the average score obtained by Belgian respondents was significantly lower than for other items in the same domain. In discussion, participants said that they do not have to *systematically* cover each of these fields with *specific* interventions. These two adjectives can probably be interpreted in different ways. Our respondents stressed the facts that support is always provided on an "as-needed" basis with a client-centred approach and that a HF team does not necessarily have to meet all of an individual's specific needs. As we illustrated with some concrete examples (e.g., furnishings), our view is that a HF team, targeting the autonomy of the client as an objective, should not be expected to accomplish it on its own.

A social worker interviewed described this "tailored" support very well:

> For example, a woman I assist. In the beginning, she clearly said to me: *'I'll take care of my children. You're already giving me so much help, there's no need to worry about that'. But now, she's asked me to accompany her to the youth tribunal. I simply notice that it has changed. But it might not have changed. Others are better placed to help her than I am* (Buxant *et al*., 2016; p. 80).

The lowest fidelity average scores were observed in the *Service Array* domain. Most of our respondents maintained that the range of services offered by a HF team should not lower fidelity estimates or be used as a basis for judging whether a programme should be given the HF label. In the specific area of employment, if the client wishes, a HF team can help them to look for a job and/or training and/or any other socio-professional integration programme, depending on the available services within the network. However, the role of HF employees is to make these partners aware of the special needs of the target population and to provide assis-

tance. The objective has always been to meet the client's needs and wishes through a common law offer, with as little stigmatization as possible from their former status as a homeless person. This "return to common law" is facilitated by the HF teams' reliance and use of external resources. The HFB teams' experiences show that employment relationships and socio-professional integration in general, rarely appear at the start of the recovery process, and is relevant only to a small segment of this vulnerable population.

HF teams clearly assume a motivational role and accompany the client to see a partnered expert service, but would rarely offer the full services themselves. A major factor that allows this to work is the extensive network of local services available to our clients. These services have been stakeholders for a long time and are organized into coordinated networks. As a reminder, the fidelity scale was developed into this specific context, where it was absolutely essential to have the largest service array possible in order to cover the complex needs faced by long-term homeless individuals.

This two-year longitudinal study showed that HF programmes are effective. Keeping in mind the potential for misunderstanding of certain scale items, we question how HF practices can be effective despite a moderate score on a fidelity measure. We formulate the hypothesis that some domain sub-scales would be more statistically discriminant and more directly associated with the effectiveness of HF practices – not only in Belgium, but perhaps in other European countries. In this case, these subscales could therefore be included in the core principles of the HF model

This may be the case for the *Housing and Services* and *Service Philosophy domains*. In other words, the separation of housing and support (assessed by the separate *Housing and Services* sub-scale) and the very philosophy of the support (client-centered, choice, harm reduction, etc.) may be domains that have greater influence on HF effectiveness, compared to other domains. For example, we argue that the number of meetings taking place per week within a HF team should not be weighted as heavily as clients' unconditional access to housing.

Organizations could adapt their HF programmes in order to better fit the model as assessed through this assessment scale and gain some points on this fidelity measure. But doing so, will they significantly gain effectiveness? We recommend further research to evaluate how specific modifications to the original model affect both fidelity and client outcomes. This research may result in the adaptation of the fidelity scale by weighting items or domains based on their impact on effectiveness, assisting practitioners and policy makers in the improvement of the services they deliver.

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A Mixed Method Study of the Fidelity of the Bergen Housing Programme in Norway to the Pathways to Housing Model

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Abstract_*Housing First (HF) programmes have been implemented in Norway since 2012. An evaluation of 10 programmes conducted in 2015-2016 showed very good results when it comes to tenants achieving housing stability, having access to services, and experiencing improvement in different life-areas. None of the programmes had conducted a fidelity assessment until Bergen decided to participate in the international fidelity project. This article is based on this assessment. The fidelity assessment took place between August and November 2017 and all seven professionals in the programme team participated in the assessment. All of them also completed follow-up interviews. There are 30 individuals served by the programme. The programme showed an overall average score of 3.7 on a 4-point scale. The highest scores were in the domains of Service Philosophy and Separation of Housing and Services, while the lowest score was in the domain of Service Array. Several facilitators of programme fidelity were identified. Foremost, Norway has a strong and well developed welfare system that ensures many of the basic needs of the service users are met, such as housing subsidies and access to social and health services. Barriers to fidelity included an insufficient supply of suitable housing, a lack of essential services within the programme, and a lack of systematic training and implementation experience. Based on the usefulness of the experience for the Bergen HF programme, other Norwegian HF programmes are planning to conduct fidelity assessments.*

Key words_*Housing First, homelessness, evidence-based practices, public policies, evaluation*

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Introduction

The objective of this study was to evaluate the fidelity of a Norwegian Housing First (HF) programme and identify facilitators and barriers to achieving programme fidelity in this programme. The study was intended to show that by giving the HF projects an active part in the process of measuring certain areas of their service, it gives an ownership and commitment to further programme development and improvement. If the fidelity scale is to be implemented routinely with HF teams in Norway, it is necessary to demonstrate evidence of its utility.

The study served as a pilot to test the use of the fidelity measure in a Norwegian HF programme. The fidelity scale has not previously been used by the HF teams in Norway. Due to variations in various HF programmes, conducting fidelity assessments was viewed as way to identify commonalities and differences across them. Evaluation based on the fidelity scale provides a good indication of how the service works in the project, and will specifically show what the project has achieved and what needs to be improved. The study started the process of implementing the use of the fidelity scale as an evaluation tool for all the Norwegian HF teams.

Homelessness in Norway

There is a relatively small number of rough sleepers in Norway compared to other European countries and the USA. The Norwegian welfare state provides a safety net, and the different municipalities are obliged to find accommodation for those who need it. Homelessness is not likely to happen because of poverty since the welfare state provides both financial assistance and housing.

The definition of homelessness is quite broad in Norway: *"A person is considered homeless in Norway if he/she has no privately owned or rented accommodation and is reliant on occasional or temporary lodging, lives temporarily with friends, acquaintances or relatives, lives in an institution or in a correctional facility and is due to be released within two months without access to accommodation, or who sleeps rough/has no place to sleep"* (Dyb and Lid, 2017).

Beginning in 1996, Norway conducted several nationwide point-in-time counts of homelessness. Since 2008, the count takes place every fourth year and over the course of a specific week. The data from these counts provide information on the composition of the homeless population. The data is collected in every municipality by organizations that are in regular contact with homeless people. Housing service organizations as well as other organizations delivering health and social services participate in the point-in-time count. Table 1 provides the number of individuals who were homeless in each of the completed point-in-time counts in Norway.

Table 1. Number of Individuals Who Were Homeless in Point-In-Time Counts in Norway

Year	# of counted homeless individuals
1996	6.200
2003	5.200
2005	5.496
2008	6.091
2012	6.259
2016	3.909

As shown in Table 1, the number of homeless people increased from 2008 to 2012 (Dyb and Lid, 2017).

According to the latest point-in-time count conducted in 2016, there were 3,909 homeless people in Norway (Dyb and Lid, 2017). The significant decrease in homelessness since 2012 can be explained by a housing policy where homelessness is not only seen as a social problem, but also because housing is expensive and hard to obtain. It is also agreed that provision of housing together with follow-up support is often necessary to prevent and reduce homelessness.

Even if the number of rough sleepers is low in Norway, there remains a large group of long-term hidden homeless, who live with friends, family or acquaintances over a long period of time. The number of individuals in this subgroup was estimated to be 1,396 in the 2016 point-in-time count, and the majority of these individuals indicated that they had been homeless for a long time. Three-quarters of homeless individuals in this subgroup were men aged 25 – 44 with a lower educational background than the rest of the Norwegian population. Their income came from social benefits, disability benefits or other welfare-schemes. It has been found that people experiencing long-term homelessness are more likely to suffer from mental health issues and / or addiction problems (Dyb and Lid, 2017).

Bergen, a city with a population of 277,644, identified 486 homeless people in the 2016 point-in-time count (Dyb and Lid, 2017). As shown in Table 2, the typical person in Bergen who is homeless is a single man with a lower level of education and living on social benefits.

Table 2. Demographic Characteristics of Homeless Individuals in Bergen 2016 Point-in-Time Count (N=486)

Gender	**%**
Men	79
Women	21
Status	
Single	93
Married/ living together	3
Not specified	3
Education	
Primary school	37
Secondary school	11
Higher education/ university	3
Not specified	49
Income	
Salary from employment/unemployment benefits/ sickness-benefits	5
Old age pension/ disability pension/other	26
Other benefits from the state	22
Social relief	37
Not specified	10

National response to homelessness in Norway

Several national programmes targeting homelessness have been developed in Norway since 2000, and challenges linked to resolving homelessness have had high priority. "Project Homelessness 2001-2004" was the first national programmeme (Norwegian Ministries and Norwegian State Housing Bank, 2001). This programme was a four-year national project carried out in the largest municipalities in Norway. The conclusion of the project was that there ought to be a shift from the traditional staircase method where homeless people must qualify for a home to an understanding where homeless people have a right to a home.

The project was completed at the end of 2004, followed by the "National Strategy Against Homelessness 2005-2007" (Norwegian Ministries and Norwegian State Housing Bank, 2004). The strategy's aim was to develop methods and models to prevent homelessness, and the work took place in all municipalities. The Norwegian State Housing Bank and the Norwegian Labour and Welfare organization (NAV) was primarily responsible for implementing the strategy.

The strategy had the following objectives, to: (1) reduce evictions, (2) ensure that no one stays at an emergency shelter when released or discharged from prison or institutions, (3) ensure that emergency shelters met certain criteria, and (4) ensure that no one stays longer than three months in temporary accommodation. A subsequent evaluation of the strategy recommended development of expertise and services in the municipalities to secure a focus on the most disadvantaged homeless groups. A focus on assisting those who could not find housing themselves was also recommended.

A revision of the strategy (Revision of Housing and Services for Vulnerable Groups Document 3: 8 2007-2008) stated that the necessary services failed to reach the target group as intended. The set of regulations were difficult to understand, and there was a lack of cooperation between different political sectors. A need for knowledge and understanding about vulnerable groups and adopting a systematic approach to reaching these groups was needed to reach the goals as stated in the national strategy.

NOU 2011: 15 (Official Norwegian report) responded to this critique by recommending that municipalities be mandated to structure the political agenda for housing at the same time the state gave clear guidelines for setting national goals and strategies. The report also stated that people must be given a chance to live in their own home, regardless of the personal challenges they might face, such as substance abuse or psychiatric problems. A secure home is a fundamental ingredient in recovery, and the municipalities should assist those who need it, for instance with practical and financial advice.

Subsequently, the document “Housing for Welfare 2014-2020, A National Strategy for Housing and Support Services” was released (Norwegian Ministries, 2014). In this strategy, the Government established a set of national goals and focus areas for housing and support-services: Everyone should have a good place to live, everyone with need for services will receive assistance in managing their living arrangements and public efforts shall be broad and effective. The strategy stated that everyone needs a home, and with assistance, everyone can live in their own home. Cooperation across sectors and levels are described as necessary to achieve outcomes of housing and support-services. In this strategy, HF is presented as a model to prevent homelessness.

The first HF programme in Norway was established in 2013. Today there are 21 programmes scattered around the country, all managed by the local municipalities. A national network for all programmes was established from the very beginning in order to connect the programmes together and to guide and support programme development. The network is organised by the Norwegian National Center for

Mental Health Care, also referred to as NAPHA. Next, a brief overview of HF in Norway is provided, focusing specifically on Bergen HF, the Norwegian programme participating in the international fidelity assessment project.

Bergen HF

Bergen HF started in 2013 as a pilot project, and was implemented as an ordinary service in 2016. Bergen HF consists of seven professionals. It was developed based on the original Pathways HF model (Tsemberis, 2010). One difference is that the team does not have a doctor or psychiatrist in the multidisciplinary team, as in the original programme. Bergen HF could be described as a hybrid combination of intensive care management (ICM), where case-managers have their own caseload and assertive community treatment (ACT), where a multi-disciplinary team of professionals work together on a caseload.

The team is multidisciplinary and composed of social workers, psychiatric nurses, educational counsellors, and a carpenter who has the role of a handyman. All team members have a caseload but also have knowledge of each of the programme participants' status and service plans. Each team member provides individualized support to a maximum of 10 service users. Bergen HF takes responsibility for damages to the flat and works closely with the landlords.

Bergen HF offers a broad spectrum of services including practical assistance, financial counselling, and coordination and brokering of access to other public services in the community. The role of a broker must be seen in light of other existing public services in the welfare state. The state and local authorities have responsibility for ensuring that inhabitants have access to housing, health service and financial benefits. Bergen HF has established regular meetings with other services and procedures for discussing cases, which has resulted in a seamless process between the different services.

To be eligible to participate in the programme, one must be over 18 years of age and be experiencing absolute homelessness. The main target group is individuals with mental health issues and/or drug-addictions. When the project started in 2013, a set of eligibility criteria was agreed: (1) individuals should be homeless or living in temporary accommodation, (2) individuals are ready to be discharged from institutions such as addiction-rehabilitation or prison, or (3) individuals should be at risk of being evicted from their homes.

Participants had had an average of 2 months of homelessness before entry into the HF programme. More than 50% of the service users presented with both mental and physical health problems. Those referred to the programme usually have a complex situation and are in need of several public services in their everyday life.

Participants in the HF programme are housed in independent scattered apartments throughout the city. Most of them are rented in the private market, unlike most of the other programmes in Norway, which use public housing. Specifically, in Bergen HF, two-thirds of the participants live in privately rented homes, the rest in social housing. Moreover, the housing is located throughout the town and none of them are in so called clustered or congregate social housing (Hansen, 2016).

Nearly 40 persons have participated in the programme. As of January 2018, there were 34 participants in Bergen HF, of which five are women and 29 are men. Twenty–eight of them (82%) were living in their own flat. Seventy percent of participants in Bergen HF have retained their original housing. The reasons for evictions mostly involve complaints from the neighbours; none has lost their flats because of rent arrears (Hansen, 2016).

Study objectives

During the last year the HF teams in Norway expressed interest in participating in the international fidelity project, as a means to evaluate the HF teams, improve their services, and compare HF in Norway to programmes in other countries. Members of the International Network of HF have contributed with valuable expertise to this process. It was agreed that Bergen HF would participate in the cross-country study of fidelity of HF programmes, pilot test the self-assessment measure of fidelity, and identify facilitators and obstacles associated with achieving programme fidelity in Norway. The reason for selecting the Bergen HF programme on which to conduct the self-assessment of programme fidelity was because of its maturity. It had transitioned from being a pilot programme to becoming a fully integrated permanent community service. The study's main objective was to develop an understanding of the methods, determine the level of fidelity achieved by the Bergen HF programme, and identify the factors that facilitated or impeded programme fidelity. If the self-assessment of fidelity proved useful for the Bergen HF programme, the plan was to integrate fidelity assessment in the HF network of programmes as a tool for programme development.

Method

Procedures

The research project with the Bergen HF followed the same methods as other HF programmes in the international study, with some modifications. Initially, the project focused on workshops, dialogue, and network-meetings to get a better understanding of the fidelity scale, since it had not been used previously in Norway. It was decided that the first workshop with Bergen HF programme staff should focus

on translation, and any issues identified at this workshop would be discussed at the national HF network meeting in the fall of 2017. Researchers for NTNU (Norwegian University of Science and Technology) were invited to this conference to give further input on the use of fidelity scales. At the same network meeting, Roberto Bernad from Rais Foundation (Madrid, Spain) gave an overview of the background of the HF fidelity scale. At the network meeting, all the participating HF teams were given an overview of how the fidelity scale had been used in the United States, Canada, and Europe.

The research questions guiding the study were the following: (1) What is the level of programme fidelity of the HF programme in Bergen? (2) What are the factors that facilitate or impede the achievement of programme fidelity in a HF programme? (3) Does the method for assessing programme fidelity and facilitators and impediments to fidelity contribute to programme development and improvement of a HF programme in the Norwegian context?

Fidelity assessment

The starting point of this process was firstly to find common grounds in terms of getting a better understanding of the fidelity scale. Furthermore, the translation led to discussion on how to understand the fidelity scale in a Norwegian context on issues such as housing policies, the welfare state, organizations of services and how this could complicate the use of the fidelity scale.

Firstly, a quantitative assessment using the 37-item self-administered survey constructed by Gilmer and his colleagues (2015) was conducted. An academic advisor from NAPHA informed the team via telephone about the process beforehand. All the team members had been employed in the programme for one year or longer, and completed the survey individually without discussion. The team leader collected the forms and sent them to NAPHA to calculate the scores. The results were converted into a four-point scale via the Excel tool provided by the international team of researchers.

A consensus meeting was conducted via Skype and e-mail in November 2017. All seven team members participated in this consensus meeting. The answers that differed from each other were discussed and conciliated until full agreement was reached among all team members. After the consensus-meeting, the ratings of individuals were summed into a total score in the five different domains: Housing Choice and Structure, Separation of Housing and Services, Service Array and Programme Structure. Based on the answers, factors identifying either facilitators or barriers to fidelity were identified. These factors were grouped into systemic factors, organizational factors and individual factors.

The team's answers proved for the most part to be very consistent; some answers needed clarification before consensus was reached. One example is that the Bergen HF-team has a nurse, but the nurse does not provide healthcare as a nurse, but is rather a broker and a link to those services provided from other services within the healthcare system. The question of 30% of salary used on rent also needed clarification. In Norway, rent is often covered by the Norwegian Labour and Welfare organization (NAV), and the different municipalities have individual policies on how much rent they approve as maximum level. In most cases, the participants do not pay rent directly from their salary or benefits; at the same time the municipalities' polices play an important part in financial decisions.

Data analysis

The answers from the consensus meeting represented the final score of items from the five different domains. Subsequently, an average item score was calculated for each domain. Previous research on programme fidelity of HF programmes has set an average score on items, domain totals, and overall total of 3.5 or higher as the "benchmark" for high fidelity (Macnaughton *et al.*, 2015). It was agreed by researchers participating in the international HF project that a score of less than 3.0 reflected low fidelity.

Qualitative interviews

Next, after reaching consensus on fidelity item scores, qualitative data collection was conducted by further discussion with team members to identify factors contributing to high and low programme fidelity, until they reached agreement. The qualitative interviews followed questions presented in a protocol as detailed in a guide. This interview guide proved to be a useful tool to generate discussion and agreement about the facilitators and obstacles influencing programme fidelity.

Data analysis

The interviewer took detailed notes of the interviews. Analyses of this qualitative data involved identifying common themes across interviews in terms of facilitators and barriers to achieving programme fidelity.

Results

Fidelity assessment

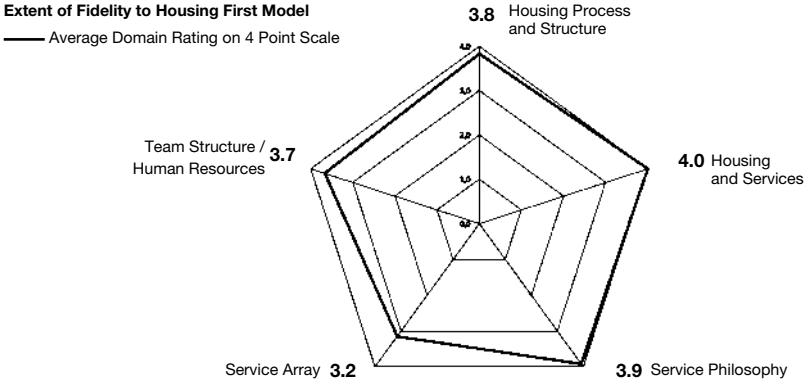
Table 3 presents the score on the individual items and domain average item score of the fidelity assessment on a 4-point scale as well as the average total score for the programme for all the items. The Bergen HF Programme was assessed overall by programme staff as having an average item score of 3.7, representing a high level of fidelity.

Table 3. Fidelity Assessment Item Scores and Domain Means

Domain / Item	Domain Mean / Standard Item Score (Out of 4)
Housing Process and Structure	***3.8***
1. Choice of housing	4.0
2. Choice of neighbourhood	4.0
3. Assistance with furniture	4.0
4. Affordable housing with subsidies	3.0
5. Proportion of income required for rent	4.0
6. Time from enrollment to housing	4.0
7. Types of housing	3.0
Separation of Housing and Services	***4.0***
8. Proportion of clients with shared bedrooms	4.0
9. Requirements to gain access to housing	4.0
10. Requirements to stay in housing	4.0
11a. Lease or occupancy agreement	4.0
11b. Provisions in the lease or agreement	4.0
12. Effect of losing housing on client housing support	4.0
13. Effect of losing housing on other client services	4.0
Service Philosophy	***3.9***
14. Choice of services	4.0
15. Requirements for serious mental illness treatment	4.0
16. Requirements for substance use treatment	4.0
17. Approach to client substance use	4.0
18. Promoting adherence to treatment plans	4.0
19. Elements of treatment plan and follow-up	4.0
20. Life areas addressed with program interventions	3.4
Service Array	***3.2***
21. Maintaining housing	4.0
22. Psychiatric services	4.0
23. Substance use treatment	3.2
24. Paid employment opportunities	4.0
25. Education services	2.0
26. Volunteer opportunities	3.0
27. Physical health treatment	3.0
28. Paid peer specialist on staff	1.0
29a. Social integration services	4.0
Program Structure	***3.7***
31. Client background	4.0
33. Staff-to-client ratio	4.0
34b. Frequency of face-to-face contacts per month	4.0
35. Frequency of staff meetings to review services	4.0
36. Team meeting components	4.0
37. Opportunity for client input about the program	2.0
Total Mean	**3.7**

Figure 1 presents the average item scores for each of the five domains. The Separation of Housing and Services, Service Philosophy, and Housing Process and Structure domains had average scores of 4.0, 3.9 and 3.8 respectively, demonstrating high levels of fidelity in these areas. In these domains, 100% of the items in the Separation of Housing and Service domain and 85.7% of items (6/7) in both the Service Philosophy and Housing Process and Structure domains were rated at the highest possible level of fidelity (M = 4.0). For the item in the Service Philosophy domain that was assessed at less than full fidelity, the programme was judged by staff as working with participants in five of possible six life areas (*M* = 3.4). The programme was also assessed as having a high level of fidelity in the Team Structure and Human Resources domain (*M* = 3.7). The sole item in this area on which it had low fidelity (2.0) related to the extent it provided opportunities for participants' input into programme operations and policy.

Figure 1. Average Housing First Fidelity Ratings by the different domains Housing Process and Structure, Housing and Services, Service Philosophy, Service Array and Team Structure and Human Resources.



The programme was assessed by staff as having moderate fidelity in the Service Array domain with an average score of 3.2. This domain caused a lengthy discussion on how to interpret the fidelity scale in a Norwegian context, mainly because of the team's role as a broker or link to other services. In terms of how Bergen HF is organized, they have procedures that secure a close connection to other services such as health care, financial assistance and services that provide job counselling and training. The team has immediate access to such services and the cooperation is described as seamless. However, they assessed their ability to make education and volunteering services available to participants as having low to moderate

fidelity (2.0 and 3.0). In addition, they also rated the programme as having a low level of fidelity on the item regarding having a paid peer specialist on staff (1.0), as there were none of these types of positions in the programme at the time of the fidelity assessment.

Facilitators of programme fidelity

Table 4 presents a summary of facilitators of fidelity emerging from the qualitative interviews and grouped into categories of systemic, organizational, or individual factors.

Table 4. Summary of Facilitators for Achieving Housing First Fidelity

Systemic	Organizational	Individual
Rent supplements. Universal health care. Wide array of services. Housing availability. Cooperation with landlords. Good reputation of program.	Follows principles of HF. Separates housing & services. Ordinary lease contracts. Facilitates re-housing.	Commitment of professionals. Personal values. Experienced team members.

Systemic factors

Through interviews with key informants, several systemic factors that were defined as facilitators were identified. The most important factor is that rent is secured through benefits. Norway's welfare system provides subsidies for rent to people with income below a certain level. Bergen HF cooperates closely with the Norwegian Labour and Welfare Administration (NAV) in the municipality, and arrangements such as budgeting and voluntary deduction for the participant's account in order to secure rent. One of the key informants stated: "My experience is that the participant feels proud when rent and other bills are paid. The feeling of shame because of unpaid rent is something many of our participants have experience with. Being able to handle one's income is empowering."

Co-operation with other public services such as health-care and financial systems were also identified as important facilitators of model fidelity. Norway's welfare system provides universal healthcare, which is a facilitator for fidelity. Bergen HF does not provide healthcare or financial aid, but works closely with the providers of such services, and so participants have immediate access to an array of services.

From the outset, Bergen HF has worked closely with the landlords. At the time of the fidelity survey, an individual who had previous experience as a service user had the prime responsibility of contacting landlords, searching the internet for flats, and so forth. This caseworker was described as both "practical and persistent", and

managed to secure many housing leases for programme participants. Through agreements with landlords, the programme has ensured that rent payments are on time and provided financial coverage when flats were damaged. They have also provided landlords with contact information in order to be reached quickly if necessary.

Since the beginning, the project had a strategy in which co-operation with private landlords is a key element. A staff member had the main responsibility to contact landlords, explain the idea behind HF, inform them about the systems that secure rent, and explain how the team will assist with repairs. Bergen HF has a webpage that answers many questions that landlords may have about the programme. It explains what HF is, how it works, and how to contact them. It also explains who pays the deposit and insurance. A key informant stated that "landlords are eager to help those who struggle, but they need to be assured there is a system that can back them up, if needed".

Over the course of its short history, Bergen HF has developed a reputation as a trustworthy service in the municipality. Working strategically with an emphasis on co-operation has turned Bergen HF into a sought after professional partner. A key informant noted, "other services trust us, and we are easy to reach either by phone or e-mail. Many services have all kinds of technical solutions to be reached that can make connection more difficult. We have phone-numbers posted on our web-site and are easy to reach".

Organizational factors

Organizational factors that facilitate programme fidelity within the HF team included programme design and structure, how the team was put together, and resources available to the programme. From its inception, Bergen HF aimed to follow the original principles of Pathways HF (Tsemberis, 2010). Bergen HF studied the original model and put together a team of members suited to the job. The service providers on the team are social workers who have training in the areas of mental health and addictions, nursing, and carpentry. Even the carpenter has education in social work. Bergen HF advertised specifically for a team member with a master's craftsman certificate when searching for team members. This person is available to address maintenance or damage issues when they arise. The team members had all the requisite professional qualifications, and the goal was to put together a team that could deliver a client-directed service. Team members were selected with this goal in mind. They are all very proud to work with HF, and have a strong commitment to the model. A key informant noted that "we hire people with warm hearts and a clear mind".

Bergen HF separates housing and services according to the principles of HF. As mentioned before, there are no sobriety or "housing ready" requirements. All participants have their own leases and they are obliged to follow the same rules and regulations as other tenants. Separating housing and services is a key element for success. We are able to keep a continuity and stability even when crises occur, the team says.

Bergen HF has no "limit" to how many times a service user can be re-housed. A key informant explained, "Participants are often positively surprised when they understand the relationship of the principles HF to client participation, decision-making and empowerment. It happens that some participants must be re-located, either because of own their own choice or if they are evicted, but most manage to keep their second apartment."

One of the team members has experience as a service user, but was not hired specifically as a peer worker. The team member is described as being an asset to the team because they are able to assist the team in working closer to the principles of HF. In many situations, they understand the participants better than those who do not have personal experience. A programme staff member described the value of having someone with user experience on staff in the following way: "Our colleague has so many unique strengths. Our colleague are able to understand our participants and uses skills the rest of us only can dream of having."

Individual factors

The team members described their commitment to HF as facilitating fidelity. A key informant said "we are a closely knit team, and we are proud to be working in HF." Those working in Bergen HF had no specific experience in working on the issue of "housing" before the project, but they all had long experience working with vulnerable groups. The combination of commitment to the principles of HF and lengthy experience working with vulnerable groups has created a culture where the team members build on participants' strengths using a recovery-perspective.

For the most part, the same individuals have been members of the team since the beginning. Trust and dialogue with the participants is paramount for Bergen HF. The service team has come to an agreement with participants where the team is allowed to keep an extra copy of participants' keys. A key informant noted that "many of the participants find it hard to trust other people, and have bad experiences with trust…. We explain to the participants that the key is not to be used to spy on or control them…. A participant thanked me because this made him believe it was possible to trust other people again and that it felt good that someone was worried about him."

Barriers to fidelity

Table 5 presents a summary of barriers of fidelity emerging from the qualitative interviews and grouped into categories of systemic, organizational, or individual factors.

Table 5. Summary of Barriers to Achieving Housing First Fidelity

Systemic	Organizational	Individual
Housing prices. Vulnerable groups are left out. Clients need coordinated services.	Lack of formal training. No advisory board.	Team is vulnerable for changes.

Systemic factors

Rental prices are high in Norway, and (smaller) affordable flats are hard to find. According to Statistics Norway (2017), 77% of Norway's' inhabitants own their own homes. Seventy-two per cent of those who do rent, rent from private landlords. Ten percent of the housing stock entails social housing owned by the municipality. The participants in HF must therefore find housing in the private rental market. Bergen HF staff described a situation where their participants often have very complex needs and a long history of housing difficulties.

Many of the participants have been receiving help from various public services for a long time. One key informant stated, "we experience that some participants are referred to HF because other services have given up on them". The team says they have to be very clear when discussing the cases with other services. A key informant stated, "HF is not meant to be a programme for those who other services have given up on." Bergen is one of the largest cities in Norway, but all the same, those who have been receiving assistance from public services for a period of time are often well-known in the city and their "troubled reputation travels before them" as indicated by a key informant.

The need for coordinated services was also cited as a barrier to HF fidelity, even if Bergen HF has managed to create structures for co-operation with other services. As described previously, the organization of the team's services led to a discussion of the fidelity scale in a Norwegian context. Bergen HF does not provide services such as healthcare, but cooperates with other professionals who do. Different professional jurisdictions, and even different understandings of what help is needed, can lead to disagreements about the course of action and support for a HF participant. It was noted that responding with immediate help was important for vulnerable individuals particularly when they are motivated. A key informant stated, "a fragmented system where a referral is needed, often followed by a waiting-list, is a barrier to recovery".

The community-based services in Norway are divided into a wide range of services, and there is often a lack of communication and coordination among them. Work-related issues are organized by the Norwegian Labour and Welfare Administration, while medical centers see patients for health concerns, and mental health concerns are addressed by local mental health centers. Programme staff viewed the lack of communication and integration of services among these different providers and the programme as an obstacle. Moreover, participation in substance use treatment programmes often requires abstinence, a qualification many of the participants in HF have problems fulfilling.

Organizational factors

The HF teams in Norway have no formal or continuous training, except network meetings and sharing of knowledge. A key informant noted "the network [members] willingly share experiences, but we would like to have a more formal system for training and evaluation." It was suggested that not having a such a system might lead to variation in how HF services are delivered, not only between the different teams in Norway, but also even within the teams.

Input from participants is supported in Bergen HF. Participants are invited to open meetings but participants are not included in advisory boards, at the time when this study was conducted. The development of a process whereby participants are included in advisory boards would strengthen the fidelity. The Bergen HF strives to prioritize clients' choice over their housing and services in the supports and services they provide, such as where to live and in what type of housing, and what type of support clients prefer. The team is very committed to HF, and strives to follow the principle of consumer choice at all times. However, there are times when providing a client with choice regarding their housing is not possible. A key informant summed up this practical reality, stating "we take the participant seriously when it comes to their choice of housing…. At the same time we must be honest, saying this flat is the best and only solution for the time being." The team members emphasized that even when a participant declines a flat, the team continues to keep in contact discussing options and being supportive.

Individual factors

Bergen HF consists of team members who have worked together for a long time. The team members' individual skills are both an asset and vulnerability. If a particular team member takes responsibility, for instance when it comes to interacting with landlords, the team is vulnerable when changes in staffing occur. There is also a risk of burn out, because the teams are small and the workload is high.

Discussion

The participation in the international fidelity study has provided an opportunity to reflect on the implementation of HF in Norway. Based on the findings in this study, some recommendations for improving the fidelity of the Bergen HF are suggested. At the moment, there is no specific training available for HF teams. Lack of formal training could be a weakness because HF as a model, at a first glimpse, seems to be a very logical and "easy to understand model", not too different from other follow-up services. One recommendation is to provide opportunities for formal training, for instance on the eight principles of HF (Pleace, 2016). In this light, the fidelity assessment is a good tool to evaluate one's own HF programme and to compare it to other programmes in Norway.

The fidelity process has been viewed positively by the Bergen HF programme staff, both in terms of being able to measure and capture the uniqueness of one's own team, and for understanding the local development of a HF programme (Nelson *et al.*, 2014; Macnaughton *et al.*, 2015). HF has attracted attention in Norway since the first projects started. An interest in using the fidelity scale as a tool for improving the services and the service users' recovery process is emerging.

In order to strengthen the recovery process for the participants, the findings suggest that there is a need for the programme to offer more intensive multidisciplinary services (ACT) to people with complex support needs, an approach that is not, for the most part, present in Europe (Padgett *et al.*, 2016). Adding paid peer-workers to the teams, and creating a committee through which participants provide can provide input into the programme would strengthen HF in Norway (Tsemberis, 2010).

The welfare state provides financial aid and healthcare, but the staircase model that focuses on treatment before housing is still very prevalent and serves as a barrier to HF in Norway. The different service systems are not working well enough together, and it is difficult to create a seamless process for people who use several public services. Discussions at network meetings also highlighted the need for a systematic way of facilitating training for HF in Norway in order to make it easier to follow the Pathways HF principles. Municipalities and different professionals agree that homelessness must be fought, but HF has not been implemented systematically as a model. "We would like a national educational programme that gives study credits", a team-member said at a network meeting.

This fidelity pilot started late autumn of 2017, and only one HF team has been assessed through this pilot. The goal of the pilot was to get a better sense of the fidelity assessment in order to implement it as a tool for all HF programmes in Norway. Research shows that stages of implementation can be challenging both

on an individual and structural level for those involved (Røvik, 2007). Not all of the HF teams in Norway operate according to the original Pathways HF model, but choose different elements from the original model; hence diversity exists between the different HF teams. There is little planned training before the teams start. There are bi-annual network meetings, but otherwise little evaluation of the projects. This situation is problematic given the relationship that has been found in HF programmes of a higher a level of fidelity with better participant outcomes (Davidson *et al.*, 2014; Gilmer *et al.*, 2015; Goering *et al.*, 2016).

There is a shift in the political view of combating homelessness across Europe that corresponds with the implementation of HF (Greenwood *et al.*, 2013). Even though there is the beginning of a paradigm shift in Norway from treatment first to HF, and evidence shows that HF yields positive results, it takes time to ultimately change practice. The debate on using a fidelity scale that was designed in North America in a Norwegian context is ongoing. However, at this point, it is agreed that the existing tool will give valuable insight to the different domains. The fidelity scale fosters the delivery of services by a HF programme that moves individuals in the direction of recovery (Tsemberis, 2010).

Since the completion of this study, Bergen HF has hired a full-time employed peer support worker. When this study took place, the team had employed a team member with user experience, but this staff member was not hired specifically as a peer worker. The team has also included participants in regular open programme meetings and is planning an advisory board. The team invites participants to open meetings where they can give feedback to the team and discuss topics of concern. These meetings have taken place only for a short time, and will probably need some time to maximize participant involvement and utility. The participants who have been to these meeting are not used to being invited to such forums where they are served food and coffee, and can express their opinions in a friendly non-judgmental atmosphere.

Conclusion

The fidelity assessment process started discussions on how to use the tool in a broader fashion in the Norwegian context. NAPHA is the main facilitator in this process along with the Bergen HF Team. The international HF network has been an important resource. During the past year, the fidelity scale has been discussed frequently in the Norwegian HF network and the interest of using the fidelity scale to improve services is a driving force in the process. Whether this type of evaluation of fidelity ought to take place on a regular basis, not only to get a picture of a specific team over time, but also to compare the teams nationally and internationally, has also been discussed.

During this process, the discussion shifted from arguments for trying to develop a fidelity scale that is unique to Norway, to an understanding that the existing fidelity assessment tool can be used, even if some of the items are difficult to interpret in a Norwegian context. When doing the fidelity assessment, it will be paramount to reflect on the domains and scores together with the team, and it does not seem necessary at this point to develop a new fidelity measure for Norwegian HF programmes. The questions in the self-assessment survey are of importance in all countries regardless of welfare systems.

The municipalities in Norway differ both in number of inhabitants and in terms of the kinds of assistance that is available. As of today, the consensus is to use the translated fidelity scale and explain low scores with differences in housing policies across borders. The experience from these discussions gives a clear indication that the HF teams in Norway agree upon the benefits of using a fidelity scale to document and analyse their work according to the principles of HF.

The understanding of a home as being essential for the recovery process is the next step for the housing policy in Norway. NAPHA suggests a national target of “zero” homelessness. If this vision can be integrated into the national strategy, this will lead to a higher degree of political action to end homelessness.

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A Study of Programme Fidelity in European and North American Housing First Programmes: Findings, Adaptations, and Future Directions

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Study Objectives and Methods

Our objectives for the multi-country study presented in this special issue of the *EJH* were to determine the fidelity of Housing First (HF) programmes to the Pathways to Housing model in different countries in North America and Europe, identify the factors that facilitate and impede fidelity in these programmes, describe unique adaptations to the model in the different contexts in which these programmes are implemented, and contribute to the development and improvement of HF programmes in the nine participating countries. The articles in this special issue have been written to present findings that are in line with these objectives.

As detailed in the introduction to the special issue (Aubry *et al.,* 2018) and again in each article, a common set of methods was followed, beginning with a self-assessment of fidelity by programme staff, followed by qualitative interviews and/or focus groups in which programme staff identified systemic, organisational, and individual factors they perceived to facilitate or impede programme fidelity. In this concluding article to the special issue, we present an overview of the findings across the participating programmes in which we compare fidelity results across the sites, synthesize common facilitators and obstacles to achieving fidelity, reflect on the various adaptations to the Pathways to the Housing model reported by the different sites, present a set of programme and policy recommendations based on the findings, and discuss limitations and future directions for HF fidelity research.

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Fidelity Assessment Results

Table 1 presents average domain item scores and average total item scores on the self-assessment fidelity measure for programmes that participated in the multi-country study. Overall, the total average item score across all of the programmes in the study was 3.5/4. This average mirrored the average item scores of the 10 programmes in the At Home / Chez Soi project after 9 – 13 months of implementation, at which point they were still in the process of admitting new clients (Nelson *et al.,* 2014).

Table 1: Fidelity Assessment Item Scores each Domains of Included Programs

Program Name *Location*	Housing Process & Structure	Separation of Housing & Services	Service Philosophy	Service Array	Program Structure	Total
Pathways to Housing DC *Washington DC, U.S.*	4.0	4.0	3.5	3.9	3.4	3.8
Arrels Foundation *Barcelona, Spain*	3.0	3.9	3.2	2.4	2.8	3.0
Un chez-soi d'abord[1] *France*	3.7	3.9	3.8	3.1	3.2	3.6
Housing First Italia[2] *Italy*	2.9	3.3	3.3	2.8	3.0	3.0
HÁBITAT program[3] *MADRID, Spain*	3.2	3.5	4	3.3	3.2	3.4
Pathways to Homes Dublin *Dublin, Ireland*	3.0	4.0	3.6	3.5	3.0	3.4
The Sandy Hill Community Health Centre *Ottawa, Canada*	3.7	4.0	3.8	3.0	3.0	3.5
Casas Primeiro *Lisbon, Portugal*	4.0	4.0	4.0	3.5	3.4	3.8
Housing First Belgium[4] *Belgium*	3.2	3.9	3.8	3.4	3.0	3.4
Bergen Housing Program *Norway*	3.8	4.0	3.9	3.2	3.7	3.7
TOTAL	3.5	3.9	3.7	3.2	3.2	3.5

1 Un Chez-soi d'abord consisted of 4 individual program sites, mean provided for across the sites

2 Housing First Italia consisted of 4 individual program sites, mean provided for across the sites.

3 Hábitat Spain consisted of 3 individual program sites, mean provided across the sites.

4 Housing First Belgium consisted of 8 individual program sites, mean provided for across the sites.

Based on a benchmark score of 3.5 or higher reflecting high fidelity, programmes located in five different countries showed high fidelity. Pathways to Housing DC, an original Pathways programme in the U.S., along with the Casas Primeiro programme in Portugal, the oldest HF programme in Europe, had the highest total average item scores (*M* = 3.8). It is important to note that relative to these two programmes, the other programmes in the current study were launched more recently. As a result, it is not surprising that they would have lower fidelity scores. The programmes in the Canadian At Home / Chez Soi project showed increases in programme fidelity from the first year (i.e., within 9-13 month) to the third year (i.e., 24 to 29 months) of implementation (Macnaughton *et al.,* 2015). Similar increases in programme fidelity are quite possible among the newer programmes in our study, particularly if they implement programme changes in response to their fidelity assessment results.

The highest average domain item scores across programmes were in the *Separation of Housing and Services* domain (*M* = 3.9), followed by average domain items scores in the *Service Philosophy* domain (*M* = 3.7), and in the *Housing Process and Structure* domain (*M* = 3.5). Again, these average domain scores were very similar to those obtained in the Canadian trial (Macnaughton *et al*., 2015). Lower average domain items scores were found in the *Service Array* (*M* = 3.2) and *Programme Structure and Human Resources* (*M* = 3.2) domains. These findings are consistent with previous research, in which fidelity scores in these domains have been lower, particularly for HF programmes that deliver intensive case management (Macnaughton *et al.,* 2015; Nelson *et al.,* 2017; Macnaughton *et al.,* 2018). Consistent with this previously observed pattern, all of the HF programmes in the present cross-national study provided intensive case management with the exception of two of the eight Belgian services, and the French and American programmes (Buxant, 2018; Estecahandy, 2018; Rae *et al.,* 2018) that delivered support through an Assertive Community Treatment approach.

Key Informant and Focus Group Results

Through focus groups and interviews with key stakeholders, researchers in each country identified factors that positively and negatively influenced model fidelity and then organised them into three categories: systemic, organisational, and individual. In turn, we identified key themes that cut across findings from programmes in the nine countries. We present a summary of facilitators in Table 2 and of barriers in Table 3.

Table 2. Summary of Facilitators Identified in Study Programmes Contributing to Housing First Fidelity

Systemic	Organizational	Individual
Belgium – Housing First Belgium		
• Rent supplements & move-in bonuses • Additional subsidies and interest free loans • Separation between housing and support • Collaboration with private investors • Negotiation and partnerships with housing provider • Public and media support for the programme	• Programme development by stakeholders • Collaboration between HF teams • Adaptation to local needs • Strong commitment among HF workers • Use of external networks and client own resources • Partnerships with volunteers	• Motivation and trust among support workers and clients • Stigma towards clients and programme • Last minute changes and added conditions of housing by landlords
Canada – Sandy Hill Community Health Centre		
• Client priority to receive community services • Complementary services available in community • Housing availability • Landlord support of clients • Programme's reputation	• Commitment to HF philosophy • Commitment to re-housing • Partnership for programme delivery • Structural separation of housing and services • Traditional lease contracts between landlords and HF tenants	• Staff member values and expertise
France – Un chez-soi d'abord		
• Access to housing through direct lease agreements • Government social housing aid • Guarantee of payment to landlords • Awareness of the mainstream resources that can offer a large range of service	• Commitment to HF philosophy • Team members learning through experience over time • Coordination among site team coordinators • Development of tools and best practices to gain access to housing and partnerships • Regular training and team building promoting HF and harm reduction principles	• Staff members' commitment to values and approach to practice • Peer workers

Systemic	Organizational	Individual
Ireland – Pathways to Homes Dublin		
• Mortgage crisis & economic downturn facilitated access to some cheaper housing	• Commitment to the philosophy including client-centred, recovery-oriented care; • Work to build landlord relationships; • Position of "accommodation finder" • Relationships with community services • Pilot / demonstration project successes	• Sense of reward/ witnessing success
Italy – Housing First Italia		
• Collaboration with the municipality • Networking with services available in community • Programme reputation	• Availability of other services in the organization • Scheduling of regular discussion meetings • Availability of external supervision	• Staff expertise • Willingness to change the way to work • Staff member values • Lack of HF expertise • Client-Staff Relationship • Studying principles
Norway – Bergen Housing Programme		
• Rent supplements • Universal health care • Housing availability • Cooperation with landlords • Good reputation of the programme	• Ordinary lease contracts • Follows principles of HF • Facilitates re-housing • Separates housing & services	• Commitment of professionals
Portugal – Casas Primeiro		
• Availability of housing in private market • Landlords' collaboration • Access to public health care system • Complementary services available in community • Coordination with other agencies • Political climate and policy validation	• Alignment between Housing First philosophy and organizational values • Collaboration with organization's supported education and employment programmes • Collaboration with university researchers • Collaboration and communication between team members • Team involvement at all levels of the programme • Peers support and participants involvement	• Participants' voice and input in programme • Participants' collaboration in political and community initiatives • Staff members' values and expertise • Staff members' collaboration in political and community initiatives

Systemic	Organizational	Individual
Spain – Arrels Foundation		
• Public health care and mental health services	• Commitment to vulnerable people's right to housing • Partnership with Mambré Foundation • Continued support despite loss of housing • International community networking • Stable and experienced staff • Volunteers participate with the teams • Participants are part of the Board of Directors and collaborate with Arrels' services • Strong relationships are built with participants • Leisure and sport activities are offered	• Team members' personal values and expertise
Spain – Habitat Programme		
• Political momentum open to new ideas and social awareness on evictions crisis • Inherent innovation of the HF model as a motivator for users and professionals • Both public and private housing have (different) positive elements • Spanish welfare system provides a wide array of services and social/ housing benefits • Learnings and relations with international community; HF momentum in Europe.	• Organization vision and values aligned with HF principles • Commitment to and observation of HF principles • Commitment of leaders in the agency to the program • Independent structure for the HF programme within the organization with own technical coordination • Attention to learnings and measures to mitigate structural limitations • Good profiling and selection of staff • Good competencies and personal abilities of professionals • Cohesion and training measures • Investment in relations with external agents (networks, media, international community)	• Users learning process on election and control of the service • Individual leaderships of some staff and team cohesion • Staff commitment with users and shared belief on the HF model
United States – Pathways to Housing DC		
• Availability of complementary services in the community • Favourable government policy • Reliable funding	• Commitment to HF values: agency culture, hiring practices • Portable rent supplement, rehousing, separation of housing and clinical services • ACT model, communication • Consumer involvement • Partnerships with community health organisations., legal clinics, landlords	• Staff fit

Table 3. Summary of Barriers in Study Programmes Impeding Housing First Fidelity

Systemic	Organizational	Individual
Belgium – Housing First Belgium		
• High cost of public rental market • Substantial shortage of social housing and long wait times • Lack of funding • Lack of coordination with other agencies • Lack of structural political measures • Yearly increases in cost of rent	• Absence of strong leadership • Lack of shared training process among support workers • Lack of funding for hiring full-time housing and peer support workers and for training of volunteers • Novelty of the program and lack of experience • Part-time housing workers	• Skepticism of the program among vulnerable homeless individuals • Stigma towards clients and program • Last minute changes and added conditions for accessing housing by landlords
Canada – Sandy Hill Community Health Centre		
• Targeted client groups' complex support needs • Complementary services unavailable in community • Lack of housing availability • Landlord requirements • Lack of funding • Stigma towards clients and programme • Lack of coordination with other agencies	• Commitment to HF philosophy • Lack of client voice and input in programme • Limited partnerships with landlords • Programme communication and decision-making processes • Some service provision with clients without being able to offer rent supplements • Supervision practices	• Staff member values and approach to practice at odds with HF practice
France – Un chez-soi d'abord		
• High cost of public rental market • Landlords' discrimination against service users • Limitations of psychiatric and municipal services on facilitating "client choice" for type of housing and location.	• Difficulty making proactive partnerships with a large range of services • Lack of funding for hiring full-time housing and peer support workers and for training of volunteers • Novelty of the programme and lack of experience among staff • Resistance from social service and psychiatric professionals towards HF	• Low salary and lack of integration and specific training for peer workers within the team
Ireland – Pathways to Homes Dublin		
• Economic downturn, mortgage crises, increased rental prices	• Conflict between client-led practice & duty of care • Relatively young organisation	• Clients' varying stages of change

Systemic	Organizational	Individual
Italy – Housing First Italia		
• Difficulty collaborating with municipality • Limited external funding • Distrust from landlords • Expensive private housing market • Targeted client groups' complex support needs • No minimum income for clients	• Demonstration experimental programme • Limited internal funding • Lack of supervision practices • Limited staff communication processes	• Difficulty Adjusting to HF approach to working with clients • Lack of HF expertise
Norway – Bergen Housing Programme		
• Steep housing prices • Vulnerable groups are left out • Clients need coordinated services	• Lack of peer workers	• Lack of vocational or educational training • Lack of inclusion of service users in governing bodies
Portugal – Casas Primeiro		
• Constraints on access to addiction treatment • Constraints on services to immigrants • High cost of public rental market • Substantial shortage of social housing and long wait times • Lack of funding • Lack of coordination with other agencies • Lack of structural political measures • Yearly increases in cost of rent	• Non-daily basis of team meetings • No formal procedure for participants to express concerns or dissatisfaction • Participants not included in the governing bodies of the organization • Absence of strong leadership • Lack of shared training process among support workers • Lack of funding for hiring full-time housing and peer support workers and training of volunteers • Novelty of the programme and lack of experience • Reliance on part-time housing workers	• Service user' scepticism about the programme.
Spain – Arrels Foundation		
• Private housing market crisis in Catalonia • Lack of public housing stock • Rehabilitation of housing is needed • Low incomes of the participant • Stigmatisation	• Lack of community involvement of the participants • Occupational training is not a priority • Lack of assessment tools and services • A higher participant to case manager ratio limits ability to provide intensive supports • Undifferentiated case manager role • Lack of external supervision	• Lack of peer-support workers in the services • Some residual staircase practices

By *systemic factors,* we refer to forces outside the programme, like political and welfare systems, network structures, strategies, and relationships with external bodies. Examples of systemic facilitators are access to medical services and positive relationships with landlords. Examples of systemic barriers include a lack of affordable housing and strict eligibility requirements for social welfare payments. By *organisational factors,* we refer to forces within the HF programme or within its parent organisation that support or limit the programme's ability to deliver the service with fidelity to the HF model. Examples of organisational facilitators include having adequate staffing and team cohesiveness. Examples of organisational barriers include lack of training or significant turnover in staff. Finally, by *individual factors,* we refer to characteristics of individual team members and individual clients that either facilitate or undermine the programme's ability to deliver services with fidelity to the HF model. For example, a specific manager's transformative leadership style could facilitate fidelity by inspiring team cohesiveness and commitment to HF philosophy. In contrast, clients' complex support needs could make it difficult for team members to effectively deliver client-led supports.

Facilitators of fidelity

Many programmes identified the availability of partnerships with complementary community-based services as a systemic facilitator, particularly in the *Service Array* and *Separation of Housing and Services* domains. One key informant from Pathways to Housing DC Programme explained how being located in the Washington metropolitan area was a 'blessing', because it is "*an extremely services-rich area*" with "*over 50,000 non-profits within a 22-mile radius*" (Rae *et al.,* 2018, p.116). The key informant described a valuable partnership with a community health organisation that has offices throughout the city and provides both walk-in services and scheduled appointments, as well as a practitioner who sees clients on-site at the Pathways DC programme offices once a week. Another external partnership is with a legal clinic that helps DC clients with their criminal records, which could expand their housing and vocational opportunities (Rae *et al.,* 2018).

Key informants from two programmes, the Casas Primeiro programme in Portugal and the Bergen HF Programme in Norway, highlighted the value of links to their countries' public healthcare systems (Duarte *et al.,* 2018; Fjelnseth*,* 2018). Links to statutory bodies that administered rent supplements, subsidies, and loans were also identified as important systemic factors that facilitated programme fidelity. For example, a key informant from the Un chez-soi d'abord programme in France explained how the French welfare system offers housing aid for people with low income (Estecahandy *et al*., 2018). Having reliable and strong links to community-based services and public healthcare was noted as important facilitators of fidelity in the *Service Array* and *Separation of Housing and Services* domains.

Having a positive reputation and receiving positive attention from the public and from the media were identified as systemic facilitators of fidelity in the *Housing Process and Structure* and *Separation of Housing and Services* domains for several programmes. For example, a key informant from HF Belgium explained how being the first housing-led programme in their sector resulted in a huge amount of positive media coverage, which legitimised their approach to addressing homelessness and reassured important stakeholders, like private landlords (Buxant, 2018). This was particularly important for programmes that relied on both public and private housing, because landlords' cooperation is especially important for HF tenants to achieve housing stability (Aubry *et al*., 2015).

Landlords' cooperation and supportive attitudes toward HF clients were identified as important systemic facilitators by several programmes. Some programmes identified standard leases as useful for maintaining programme fidelity. For example, the Sandy Hill Community Health Centre in Ottawa explained how using traditional lease contracts supported the *Separation of Housing and Services* because they consisted of standard rights and responsibilities of a tenancy available to clients under the Province of Ontario law, which enhanced their ability to deliver client-directed services and foster autonomy (Samosh *et al.,* 2018). In the Casas Primeiro programme in Portugal, the private housing market was identified as a facilitator that not only enhanced the programme's capacity to provide independent and scatter-site housing across the city, but also offered participants more housing choices and better quality of housing environments, because in Portugal, social housing tends to be located in more deprived and socially isolated neighbourhoods (Duarte *et al.,* 2018).

Commitment to HF values from both the organisation and members of staff was identified as an important organisational facilitator. Specifically, programmes described commitment to re-housing, the separation of housing and clinical services, and to client-centred and harm reduction principles as particularly important to fidelity in the *Service Philosophy and Separation* of *Housing and Services* domains. Regarding the *Separation of Housing and Services*, key informants in Barcelona's Arrels Foundation emphasised the benefits of their clients knowing that their support will continue even if they lose their housing, with one key informant saying *"[…] I think that housing is an important factor. However, it doesn't make any sense to only look after the house if you forget the original goal of supporting the person who lives there*" (Boixadós *et al.,* 2018, p. 143). Staff commitment to HF values, staff experience and expertise, as well as the client-staff relationship, were all considered as individual facilitators to programme fidelity in these domains as well.

At the organisational level, intragroup processes and dynamics were often identified as important facilitators of fidelity in the *Programme Structure and Human Resources* domain. Team building sessions, regular training, effective and frequent communication, and coordination of activities among programme staff were among the activities most often described by key informants as facilitators of fidelity across the sites. For example, one key informant from HF Italy described how effective discussions were important to the development of the programme structure: "*information, discussion and negotiation around the HF principles in the team meetings before the programme launched helped team members identify strategies to align practice with principles*" (Gaboardi *et al.,* 2018, p. 173). Related to these organisational facilitators, team cohesion and leadership were described as important individual facilitators. Collaboration with other community services and with volunteer organisations was identified as facilitating fidelity in the *Separation of Housing and Services* and *Service Array* domains. For example, the Arrels' programme in Barcelona was built on collaboration with a local volunteer programme (Boixadós *et al.,* 2018).

Finally, several programmes described how belonging to rich networks of community-based services that provide complementary supports to people in homelessness helped them to achieve effective programme implementation and therefore, good model fidelity in each domain. As one social worker from a HF programme in Belgium put it this way: "*We have different partners, each one is a piece of the puzzle in the fight against homelessness, but nobody is going alone. If we combine our means, work together and are responsible together, we can have something to offer to people with complex problems who have nowhere else to turn. I think it's really important that a project starts from a field network*" (Buxant, 2018, p.197).

Barriers to fidelity

Perhaps the most commonly described systemic barriers to model fidelity were factors that blocked a programme's access to adequate and affordable housing. High rents and limited availability of appropriate housing units made it difficult for many programmes to house clients within the recommended timeframe and in neighbourhoods of their choice. These barriers undermined fidelity in the domains of *Housing Process and Structure* and *Separation of Housing and Services*. One key informant from Dublin described how the tight housing market limited clients' choice: "*they don't really have a choice… we haven't got the option to give people two or three choices… if they say no, when is the next one to come up? They have a choice to turn it down but the alternative [e.g., rough sleeping; emergency accommodation] is usually enough to make them take it…"* (Manning *et al.,* 2018, p.43).

Weak links to important community-based services such as employment, training, education, legal aid, welfare, and healthcare were commonly identified as systemic barriers to programme fidelity in the *Service Array* domain. Across programme sites, links to community services were identified as important for clients to access needed or desired services. As mentioned previously, most of the HF programmes provided intensive case management to service users, which requires case managers to broker the services that the programme does not provide. Limited governmental or municipal funding also undermined many programmes' abilities to support their clients with the intensity and range of services recommended in the HF model. For example, limited funding for staff salaries often meant programmes either did not hire or delayed hiring a peer support worker. Many teams were understaffed, and in some programmes, HF team members worked part-time in other services. Some programmes were unable to offer 24-hour support services seven days a week (Gaboardi *et al.,* 2018; Bernad, 2018).

Some aspects of organisational management and programme functioning undermined programme fidelity in the *Programme Structure and Human Resources* domain at several sites. Inadequate funding was both a systemic and organisational barrier that affected staffing levels and supervision. Many programmes were staffed with team members who had little or no experience working within the HF model. In some programmes, such as the Hábitat programme in Spain, no team members had prior experience with HF, which sometimes led to problems translating the model into practice. For example, key workers in the Hábitat programme initially did not develop care plans for their clients as a result of a misunderstanding of the role of care planning in client-led care (Bernad, 2018).

Commitment to client choice was difficult to sustain due to a number of organisational factors in the *Service Philosophy* and *Separation of Housing and Services* domains. For example, one key respondent from the Sandy Hill Community Health Centre in Ottawa described tensions between the HF value of client choice and a tight housing market, and how this sometimes led to delays in finding housing for clients or being able to engage them in treatment services (Samosh *et al.,* 2018).

Another key informant from the Pathways to Housing Washington, DC programme explained how difficult it was to maximize low-functioning clients' choice when some of their actions could result in housing loss or harm. He said: "*you're concerned about their well-being, and their hygiene and it's bordering on self-neglect, and we want to keep the housing, well then those are the clients who are not getting much say…. you end up back at not giving them choice, in order to keep them housed*" (Rae *et al.,* 2018, p.121). This same informant also highlighted the problems with quid pro quo transactional relationships that sometimes developed

between programme staff and clients, such as offering food, cigarettes, or access to cheques in exchange for attending a medical appointment, taking medication, or meeting with staff.

However, some key informants found the transactional approach to be quick and effective "*because without it we wouldn't be able to see people at times… I don't in any way think that anyone abuses it*" (Rae *et al.,* 2018, p.121). However, other key informants believed that transactional approaches are manipulative, and referred to the "*moral struggles*" or "*ethical issues*" that arise from using transactional tactics that could "*tarnish our ability to be clinical with clients because we're using that power so freely*" (Rae *et al.,* 2018, p.121).

Supporting clients with complex needs, with histories of criminal convictions and evictions, made it difficult for some programmes to fully commit to the HF core principle of client choice. Complex client characteristics as well as stigma and stereotypes were identified as systemic barriers to convincing landlords to rent to their clients. Several key informants described how discrimination from neighbours in their new communities undermined their clients' community integration (Bernad, 2018; Duarte *et al.,* 2018; Manning *et al.,* 2018; Rae *et al.,* 2018; Samosh *et al*., 2018). Difficulties building partnerships with landlords were commonly cited as a barriers to fidelity in the *Housing Process and Structure* domain. A key informant from Ottawa explained how some landlords were reluctant to rent to clients, especially those with histories of evictions (Samosh *et al.,* 2018) and another key informant from the Pathways to Housing DC programme described how landlords would not rent units to their clients because of their criminal convictions (Rae *et al.,* 2018).

Other clients were described as having significant cognitive impairments that made it difficult for them to manage guests in their apartments, which then caused problems with neighbours. Some clients repeatedly caused significant damage to their housing units, which raised ethical questions for some team members. For example, one key informant from the Sandy Hill HF programme in Ottawa described the *"ethical concerns related to people who may have repeatedly trashed units, and/or who may have been threatening towards superintendents… they can be challenging in terms of offering them housing"* (Samosh *et al.,* 2018, p.71). Key informants from this programme suggested that more could be done to maintain relationships with landlords as such as covering property damages caused by clients and creating dedicated positions within the programme that focus on cultivating relationships with landlords on a regular basis (Samosh *et al.,* 2018).

No common barriers were found at the individual level across programmes; however, individual factors overlapped with both systemic and organisational elements. Some individual barriers in specific programmes included some staff members expressing a lack of commitment to or finding it difficult to adapt to HF

values, which affected fidelity in the *Service Philosophy* domain. For example, one informant in Italy stated: "*social workers in the team have difficulty to find a new mentality and a new approach with the different type of service"* (Gaboardi *et al.,* 2018, p.175), while other key informant of the Hábitat programme in Spain, described challenges created by 'blurred' client/staff relationships: *"the line between personal and professional in this programme is weak, and that is emotionally exhausting"* (Bernad, 2018, p.101).

Other individual-level impediments to fidelity in the *Programme Structure and Human Resources* domain were identified by key informants in several programmes. These included employee burnout, administrative burden, and low salary, as well as scepticism expressed about the programme by clients, landlords and external services. Key informants from the Hábitat programme in Madrid quoted sceptical clients saying: *"This cannot be forever, I am starting to get tired of these visits"* or *"Since I do not have to report you on anything I wouldn't like to, I am not telling you not to come, but… why do you come?"* (Bernad, 2018, p.101). They also quoted sceptical professionals from external services: *"Well, then if there are no requirements for clients, what will you do with them?"* and described situations such as that of a family doctor who refused to provide medication to clients who were not abstinent (Bernad, 2018, p.101).

Adaptations to the HF model

Most programmes made at least minor adaptations to fit the model to their local contexts. Some programmes augmented the model with additional features. For example, Ireland's HF programme includes a street outreach team (Manning *et al.,* 2018). Members of the HF outreach team work with rough sleepers to build trust in the programme. When someone who is rough sleeping is ready to engage with the team, the outreach team member serves as an important source of continuity. In this way, the outreach team has been instrumental in overcoming the mistrust and scepticism that kept rough sleepers from engaging with HF during the first years of the demonstration programme.

Some adaptations added or combined new skills to the HF team. For example, Norway's team included a carpenter who was also a trained social worker (Fjelnseth, 2018) and one HF team in Belgium included a job coach (Buxant, 2018). The Belgian programmes' 'capteur de logement', the Dublin team's 'accommodation finder', and the Sandy Hill Community Health Centre and Habitat programmes' housing support workers are key staff members responsible not only for sourcing accommodation, but also for creating, maintaining, and improving relationships to private landlords and approved housing bodies (Buxant, 2018; Manning *et al.,* 2018; Samosh *et al.,* 2018).

Other HF teams collaborated with other social services or organisations in ways that augmented or strengthened the kinds of services they could make available to their clients. For example, in Lisbon, AEIPS, the agency delivering the Casas Primeiro HF programme has a formal partnership with the public social services delivered by the City of Lisbon to people who are homeless. This partnership facilitates the referral of clients from the city's outreach team and helps HF participants access income support benefits (Duarte *et al.*, 2018). The AEIPS HF team is also linked to a supported education and employment programme that assists participants to access work, schooling, and volunteering opportunities. The programme has also created partnerships with universities that facilitate continuing professional development opportunities in areas of evidence-based programmes and provides staff opportunities to participate in evaluation and research (Duarte *et al.,* 2018).

Finally, some HF programmes provide access to congregate housing accommodation. For example, congregate housing provision in one of the Italian programmes was justified based solely on high rental costs (Gaboardi *et al.,* 2018). Barcelona's Arrels Foundation runs several kinds of programmes in addition to HF. One of these is called "Flat Zero", an emergency night shelter. It is flexible and low-threshold, available to HF participants who "fail to adapt to the HF model" (Boixados *et al.*, 2018, p. 136). Although we know based on previous research that a very small number of people who enrol in HF will repeatedly experience housing loss, and eventually leave the programme, we also know that it is not possible to predict who these individuals will be, based on any of their characteristics (Volk *et al.,* 2016).

This very small slice of the chronically homeless population may reverse back down the staircase, until they find the type of accommodation that is must successful for them, before they choose to try independent accommodation again. Residences like Flat Zero are important housing resources for this small group of individuals. It is, however, important that programmes respect clients' choices and are extremely careful not to overly rely on these types of housing, to assume they can predict who cannot 'make it' in HF, or that someone who 'repeatedly fails out of HF' will never be capable of maintaining independent, private accommodation.

Programme and Policy Recommendations

The categorisation of the qualitative findings of the fidelity assessment into systemic, organisational and individual factors (Aubry *et al.*, 2018) helps to organise future directions in programme and policy development that can address factors that impede the achievement of programme fidelity in HF programmes. Systemic factors relate to contextual elements that are external to the programme that should be addressed through advocacy efforts. Organisational factors relate to elements within HF programmes, such as values, staffing, training, resource management and networking. At this level, organisational barriers to achieving fidelity in HF programme could be addressed through organisational development and changes in HF programme structures and services. Individual factors refer to the personal attributes and relationships among people involved in HF services, such as clients, programme staff, and stakeholders. Individual factors that serve as impediments to programme fidelity can typically be addressed through staff selection, staff training, and technical support. Using this framework and based on the findings of the fidelity assessment of the participating programmes, we propose a set of recommendations for policy makers and service providers involved in the development and delivery of HF programmes.

Systemic-level recommendations

One of the main barriers to HF fidelity identified by programmes across the nine different countries is the lack of access to affordable housing caused by high rental costs, limited private or public housing availability, or lack of housing subsidies. In this context, policy makers, especially those responsible for housing policies, need to find a way to grow affordable housing in both the public and private sectors and to provide more generous income support that can overcome these barriers to housing in major European and North American cities.

Several organisations also described the difficulties they encountered with landlords when clients attempted to sign their own leases. Stigma, discrimination and lack of stable housing subsidies or other income sources were identified as barriers to clients leasing their own apartments. In these cases, the programmes served as the lessees, which solved the problem of access to housing but created others. For example, subletting from programmes undermines clients' independence because of their reliance on the programme to maintain and renew their leases. Champions are needed to advocate for policy changes that that guarantee the right to housing, especially for those who have more complex support needs or are the target of stigma and discrimination.

In many countries, the "silo approach" to service delivery, in which housing, health, and social services operate separately and independently, makes it difficult for HF programmes to deliver both housing and community support. In this context, it would seem that health and social service departments in many countries find themselves responding to homeless people's health and social needs while being unable to help them access the very resource they need most: affordable housing.

The lack of adequate programme funding mentioned by some of the programmes in the international study is a significant barrier to programme fidelity and growth. There is clearly a need for HF programmes to have enough resources and reliable funding to facilitate participants' access to adequate housing and community support of sufficient intensity to meet their needs. It is important to note that economic research on HF programmes has shown the costs borne by these programmes are offset by reductions in HF participants' use of health, social, and justice-related services (Ly and Latimer, 2015).

HF programme participants have complex needs and have experienced significant long-term marginalisation. HF programmes alone are unable to adequately respond to these needs. Health and social service systems need to make available the array of services that complement and extend the support provided by HF programmes, and eliminate common barriers to those services. Collaboration and coordination between HF programmes and community agencies are needed to effectively deliver person-centred community supports. As detailed in our study, doing so would increase model fidelity for HF programmes that do not have sufficient resources to provide the wide service array prescribed by the HF model.

Taken together, based on these findings, we encourage policy makers to elaborate integrated strategies that holistically tackle the multiple contributors to homelessness, including lack of housing, barriers to health care services, unemployment, and social marginalisation. There is also a need to reduce the stigma expressed by the broader society towards homeless adults. This will require efforts on the part of relevant stakeholders, including policy makers, landlords, the media, and the general public. For example, broader community awareness and support of HF programmes can help facilitate community integration and recovery. Policy makers should consider developing public education campaigns that address the stigma associated with homelessness and communicate the positive findings associated with research on HF programmes. Among other stakeholders, NGOs responsible for HF programmes and university researchers should collaborate on public education initiatives that can contribute to informing the public about the effectiveness of HF in ending homelessness and policy changes.

Organisational recommendations

The tensions between HF participants' complex needs and the value placed on client choice can sometimes create difficult situations for service providers who have to find a balance between fostering self-determination and preventing harm. The value HF practitioners place on client choice can put them at odds with the values orientations of other services in their communities. As a result, HF programmes can find themselves at risk of drifting away from the HF model by adopting the more traditional prescriptive approach to delivering services that minimize client choice. For example, service providers may attempt to resolve a conflict with neighbours by forcing a client to comply with mental health treatment in order to maintain the lease and protect relationships with landlords. It is important for the HF programme's home organisation, its leaders, and programme staff to fully support the HF philosophy and principles even in the face of external pressure and risky situations. Ongoing discussion among HF team members of how to uphold HF values when faced with ethical dilemmas in service delivery is important.

A number of HF programmes noted that a lack of funding served as an obstacle in terms of achieving programme fidelity because, in some cases, it prevented programmes from hiring a full complement of staff. For example, as a result of this situation, a common area of low fidelity across the HF programmes in the study was the lack of peer support workers on teams. According to key informants in these programmes, the long-term consequences of this lack of resources for training and proper staffing can be staff burnout and turnover. In response, organisations need to mitigate against the workplace features that contribute to burnout and turnover, such as poor communication and decision-making processes. This issue was identified by a number of programmes as contributing to lower fidelity in the *Programme Structure* and *Human Resources* domain. HF programmes need to ensure that their programme structures include proper team coordination and communication processes that include regular staff meetings so that staff are able to support each other in their work with programme participants.

Many of the European HF programmes that participated in our study represented the first generation of HF programmes in their country and their staff had no previous experience with the HF model. In this context, regular training and technical support are especially important to address the lack of experience in HF implementation and professional practice, and to assist programmes to achieve fidelity in the different domains. Programme staff from a number of HF programmes in our study perceived the lack of training as negatively affecting programme fidelity, particularly in the *Housing Process and Structure* and *Programme Structure and Human Resources* domains (Buxant, 2018; Fjelnseth, 2018; Manning *et al.,* 2018). Collaboration and knowledge exchange between HF programmes through communities of practice within and across countries can address this issue.

HF programmes in Belgium, France, and the United States relied on Assertive Community Treatment (ACT) for supporting their participants in the community (Buxant, 2018; Estecahandy *et al.,* 2018; Rae *et al.,* 2018). In line with the ACT model, these programmes provided multidisciplinary wrap-around services. In contrast, the other HF programmes delivered Intensive Case Management (ICM) to their participants, requiring them to rely more heavily on finding and brokering services in the community (Bernad, 2018; Boixados *et al*., 2018; Duarte *et al*., 2018; Fjelnseth, 2018; Gaboardi *et al.,* 2018; Manning *et al*., 2018; Samosh *et al*., 2018). HF programmes that used both types of community support approaches assessed themselves as having low to moderate fidelity in the *Service Array* domain and noted how a lack of partnerships in the community contributed to lower fidelity in this area. This finding highlights the importance for HF programmes to negotiate formal partnerships with community organisations to which participants can be referred for access to health care, supported employment and education opportunities, and other social services.

Individual level recommendations

At the individual level, the commitment to HF values has been identified by most of the programmes as a critical facilitator of programme fidelity in the Programme Philosophy domain. Based on this finding, it is recommended that when hiring new staff members, HF programmes identify individuals who are comfortable with the HF approach and whose values align with the HF model. A number of programmes highlighted the importance of hiring individuals with the experience and expertise to build strong relationships with clients (Bernad, 2018; Boixados *et al*., 2018; Duarte *et al.,* 2018; Rae *et al.,* 2018; Samosh *et al.,* 2018). In particular, it was noted the importance of developing an alliance with clients that is respectful of client choice and promotes self-determination. It is recommended that training and supervision offered to programme staff focus on facilitating these positive working relationships with clients.

Limitations and Future Directions

Although this cross-national project produced important insights into the factors that facilitate and impede programme fidelity to the HF model, it is important to recognise some limitations to the study design. Perhaps the most important of these are the limitations associated with self-assessments of programme fidelity. Staff members were asked to rate their own programmes on the five fidelity dimensions and, to the extent that they were motivated to present their programmes in a positive light, their scores may be inflated. However, the conciliation process should have tempered, at least to some degree, any inflated scores.

Moreover, across the participating programmes, respondents appear to have been quite willing to identify and discuss the various factors, both internal and external to their programmes, which made it difficult for them to achieve high fidelity in various domains. Across the programmes, there was substantial consistency in the identification of access to affordable and appropriate housing, supporting clients with very complex support needs, and low or no involvement of service users in programme management activities as significant challenges to model fidelity. This pattern of similarity across programmes in different contexts, with different implementation histories, is a source of confidence in the validity of our findings, even if the actual scores may be somewhat inflated by social desirability motives.

A second limitation noted by many authors in the special issue was the challenge of translation of the self-assessment instrument, not only to another language, but to a different context. In fact, the English self-assessment measure was translated into five different languages (i.e., French, Italian, Norwegian, Spanish, Portuguese). The self-assessment instrument was developed in North America, where the structure of social services is quite different from many or all of the European programmes that participated in this project. These translation challenges were often the focus of extended discussions in the consensus meetings. Some authors raised questions about whether country-specific measures should be created (Bernad, 2018), and whether the five fidelity domains should be differentially weighted (Buxant, 2018). These concerns highlight the challenges involved in creating one reliable instrument that can be used to directly compare programme fidelity in different international contexts.

Finally, we should note that service users' perspectives were not included in this fidelity study. External partners and policy makers were not consulted either, in examinations of facilitators of and barriers to programme fidelity. Perspectives of all these groups of stakeholders would provide a more complete perspective on factors that affect programme fidelity.

Despite these limitations, we conclude that this cross-national study has yielded important insights into systemic, organisational, and individual factors that affect HF programme fidelity. We also believe that the self-reflection process engaged by programmes in conducting the self-assessment of fidelity will contribute to their improvements. As next steps, we encourage programmes to work together to perform external fidelity assessments that also consider service users' perspectives. In doing so, they may address the concerns about inflated domain scores and gain additional information that an outsiders' perspectives may provide. Comprehensive external programme reviews include not only focus groups with service users, but also chart reviews and site visits (Nelson *et al.*, 2014; Macnaughton

et al., 2015). The International HF Network could support training workshops to facilitate development of skills and knowledge of best practices required for these kinds of enhanced external reviews.

As these programmes grow and mature, it will be important to learn how they overcome existing challenges and what new challenges arise. We encourage all programmes to engage in periodic review to ensure effective services in line with best practices. Across place and context, regular programme review is a key ingredient in well-run HF programmes and is integral to supporting clients' recovery from homelessness. The research is pretty clear: HF programmes that achieve higher fidelity produce better outcomes for their participants (Davidson *et al.,* 2014; Gilmer *et al.,* 2015; Goering *et al.,* 2016).

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