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 =.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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