
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	
Limitations on “client choice” for type of housing and location.	Novelty of the program and lack of experience	
	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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