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A program implementation fidelity assessment of a Housing First program in Ontario

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by

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Abstract:

This research sought to assess the degree of fidelity to the Housing First model achieved by a new Housing First program in a mid-sized Canadian municipal region, and the factors that promoted or hindered fidelity therein. The program was delivering an adaptation to the Housing First model that prioritized access to housing and support services, which was assessed simultaneously. Fidelity ratings were gathered by a team of researchers during a site visit that included observation of a staff meeting, seven interviews with program leaders and staff, two focus groups with program participants, and 10 chart reviews. Overall, the findings show a high degree of fidelity with an average score of 3.55 on a 4-point scale, across 44 fidelity domain items. Results revealed high fidelity in the domains for service philosophy, separation of housing and services and the newly created domain of support and skills development used to assess the home-based support adaptation. Lower scores were found for housing choice and structure, service array, and program design. Challenges to program fidelity were found in housing availability and affordability, service continuation through housing loss, linking with employment and educational services, 24-hour coverage, and participant representation in the program. Factors that could account for these challenges include the low vacancy rates in the jurisdiction, prescriptive policy frameworks, and a slower pace of implementation than anticipated. This study demonstrates the use of a fidelity assessment to provide direct, actionable feedback for program improvement.

Contents

Introduction

In Canada, housing costs have skyrocketed in the past decade with a recent report by a major financial institution finding housing affordability to be at historic lows (Royal Bank of Canada, 2019). Those affected by the affordable housing crisis tend to be young people and/or those with lower incomes (Gaetz, Donaldson, Richter, & Gulliver, 2013). For many, the rising costs of living mean they are at a greater risk of experiencing homelessness, with 1 in 5 households experiencing housing affordability issues (Canada Without Poverty, 2020). The Canadian federal government has recognized this as a priority and committed to a significant investment in housing over the next 10 years (Canada Mortgage and Housing Corporation [CMHC], 2018).

One strategy that has come to prominence in North America in recent years is Housing First (HF), a model that provides housing without prerequisites for sobriety or psychiatric treatment (Tsemberis, Gulcur, & Nakae, 2004) to individuals experiencing homelessness. HF has proven to be a successful model to help people experiencing homelessness and mental illness find and retain housing (Goering et al., 2014; Gulcur, Stefancic, Shinn, Tsemberis, & Fischer, 2003; Tsemberis et al., 2004). Many Canadian cities are now actively working to implement HF solutions with an aim to eliminate chronic homelessness (i.e., greater than 180 days without a home in a year) (‘Region’, 2018). The HF Program (‘The Program’ hereafter) in this medium-sized Canadian municipal region (‘The Region’ hereafter) is one such solution which builds new elements onto the existing HF model by introducing skill building and home-based supports after people move-in to housing in order to help residents successfully retain housing. The Program was preceded by a pilot program in The Region that realized success with 95% of participants able to gain and retain housing over two years (‘Region’, 2018). The goal of this research is to

determine the extent to which The Program has been implemented in accordance with HF principles and initial program goals.

In order to properly assess this new program, it is important to understand the context surrounding housing and homelessness. Exploring the prevalence of homelessness in Canada, some of the root causes of homelessness and the many adverse effects homelessness can have on individuals and society will help define the Canadian context. Identifying strategies that have been employed to solve the issue helps to inform the history of homelessness policy. Finally, literature is presented on the role of program and fidelity evaluations in ensuring successful implementation and outcomes for programs and their application to Housing First protocols.

The available literature shows homelessness to be a significant issue in Canada at present, stemming from a wide range of intersecting causes and having a number of individual and societal-level effects (Gaetz, Dej, Richter & Redman, 2016; Echenberg & Jensen, 2012; Rech, 2019). Traditionally, the response to homelessness has been to manage the problem without addressing the root cause, through emergency shelters and programs that require abstinence from substance and psychiatric treatment, an approach that has yielded limited success in re-housing people (Gulcur et al., 2003; Rech, 2019). More recent strategies have focused on the Housing First (HF) model after successful trials have shown it to be a viable and effective strategy in Canada (Goering et al., 2014, Gaetz, Scott & Gulliver, 2013).

Fidelity assessments serve an important role in determining how faithfully a program is being implemented according to a set of standards (Centers for Disease Control and Prevention [CDC], 2012). Programs implemented with high fidelity to the HF model can demonstrate better participant outcomes (Durlak & DuPre, 2008). The specific context in which a program is being implemented can also affect participant outcomes (Durlak & DuPre, 2008), and for the purposes

of this research, context will be used as a lens through which results are interpreted. The increasing prevalence of fidelity assessments in Housing First evaluations is a result of the wide adoption of the model and reflects the importance of accurate implementation to program outcomes (Pleace, 2016; Polvere et al., 2014). We are conducting a process evaluation of The Program, that will measure to what degree it is adhering to HF principles and assess how the program's unique goal of delivering home-based supports are being met. This thesis focuses on the fidelity assessment as part of the larger process evaluation of The Program.

Literature Review

Background

Exploring the current state of homelessness in Canada reveals a significant problem that affects a diverse population. On a given night, there are approximately 35,000 people experiencing homelessness in Canada, which, over the course of a year, rises to 235,000 people (Gaetz et al., 2016). The demographics of homelessness have traditionally been single adult men, however since the mid-2000s, the population of people experiencing homelessness has become much more diverse (Gaetz et al., 2016). There is now a higher proportion of women, youth and families experiencing homelessness as well as people who identify as Indigenous, as newcomers to Canada or as LGBTQ2S (Gaetz et al., 2016). Additionally, the population of people experiencing homelessness is one that is disproportionately affected by mental illness (Echenberg & Jensen, 2012). In The Region in 2017-2018, 2,652 people stayed in a shelter bed and though that is a 3% decrease from the year previous, the length of stay for individuals in shelter increased by 24%, from 24 days to 42 days on average ('Region', 2018). This corresponds to 40% increase in individuals experiencing chronic homelessness and highlights the difficulty people have recovering from homelessness.

Addressing the underlying causes of homelessness can be difficult as there are many factors, both systemic and related to individual circumstances, that are responsible for people experiencing homelessness (Office of the High Commissioner for Human Rights, 2015). To understand some of the reasons homelessness exists, it is relevant to consider how government funding cuts and resource allocation has affected housing stability to create the problem that exists today.

For a period of around 20 years, beginning in the early 1980s, the federal government of Canada began withdrawing funding from affordable housing organizations and programs (Cohen, Morrison & Smith, 1995). In that period of time, the number of social housing units built annually through funding by all levels of government in Canada dropped precipitously, from 20,450 in 1982 to 1,000 in 1995 (Gaetz, Gulliver & Richter, 2014). It is estimated that these funds that were cut could have created up to 100,000 new affordable housing units in that time frame (Gaetz et al., 2014). Though funding for social housing has increased in the years since, including a commitment of $2.2 billion in affordable housing spending over two years in the 2016 Canadian federal budget, a significant lack of affordable housing units now exists, limiting housing options for people at-risk of or currently experiencing homelessness (Gaetz et al., 2016; Gaetz et al., 2014; MBNCanada, 2017).

A weakened social welfare support system also contributes to why people may experience homelessness. As funding for housing programs was being cut by federal governments in the 1980s, so too was funding for social welfare programs (Cohen et al., 1995; Gaetz et al., 2014). A 2012 review of risk factors for homelessness in Canada identified a significant gap between the level of social assistance benefits people receive and the high cost of rent (Echenberg & Jensen, 2012). Consequently, those who rely on social assistance programs

either cannot afford to enter the rental market or spend a disproportionate amount of their income on housing rent (Gaetz et al., 2013).

Economically, it is in society's best interest to find a solution to homelessness, rather than to manage the problem. The costs to society associated with services most often used by people experiencing homelessness (shelters, health care, policing) are exorbitant when compared with the cost to provide housing and support. A 2005 article by Pomeroy looked at different costs associated with homelessness across four Canadian cities (Toronto, Montreal, Vancouver and Halifax). They estimated that costs from institutional responses (correctional facilities and psychiatric hospitals) could range anywhere from $66,000 to $120,000 annually and costs associated with emergency shelters could be up to $42,000 annually, per person. For comparison, costs for supportive and transitional housing were found to be from $13,000 to $18,000 and affordable housing (without supports) to be up to $8,000 annually, per person. These kinds of economic results are echoed in a study by Goering et al. (2014), which found a significant cost savings for people in a HF trial compared to treatment as usual. A more recent analysis estimated the cost of homelessness to the Canadian economy at $7.05 billion (Gaetz, 2012). These studies demonstrate the financial burden society's traditional responses have incurred and make it clear that a new strategy is needed.

Problems finding, obtaining and retaining housing often arise for people leaving institutional care. As mental health institutions were closed down in favour of community care in the latter half of the 20th century (known as deinstitutionalization), proper support services were not in place to ensure adequate care for this vulnerable population (Belcher & Toomey, 1988; Canadian Population Health Initiative of the Canadian Institute for Health Information [CHPI], 2009; Martin, 1990; Niles, 2013). Former patients were often discharged into tenuous living

situations and without proper treatment and living support, many became homeless (CHPI, 2009; Niles, 2013). A high proportion of people experiencing homelessness have one or more mental health problems, reflecting a need for more specialized supports (Echenberg & Jensen, 2012; Goering, Tolomiczenko, Sheldon, Boydell, & Wasylenki, 2002; Lamb & Bacharach, 2001).

The effect of homelessness on individuals manifests in many ways. People experiencing homelessness regularly experience stigmatization and discrimination, which is often characterized by punitive government responses (Office of the High Commissioner for Human Rights, 2015; O'Sullivan, 2012; Parnaby, 2003). The criminalization of homelessness is common in North America, with the widespread use of laws that are designed to specifically target people living outdoors in a city (National Law Center on Homelessness and Poverty, 2014). These laws make simple acts of living difficult or illegal for those without a home and lead to social isolation and separation (O'Sullivan, 2012). Culturally, social narratives promoted by neoliberal ideas of individual responsibility (Taylor-Gooby & Leruth, 2018), say that people experiencing homelessness are inferior or somehow inherently different from the general population, which could also contribute to the stigmatization of an individual experiencing homelessness (Belcher & Deforge, 2012).

Individuals experiencing homelessness also have a much greater risk of physical health problems than the general population (Gaetz et al., 2013). This population has significantly higher rates of mortality, higher incidences of problems like seizures and chronic obstructive pulmonary disease and poor detection and/or inadequate care of existing health problems (Hwang, 2001). These problems arise, or can be exacerbated, by living conditions outdoors (inability to maintain adequate personal hygiene) or in shelters (overcrowding) or through

systemic factors like a lack of proper identification, which can impede one's ability to receive healthcare (Hwang, 2001).

The solutions that were originally created in the mid-1980s offered support in the form of emergency shelter programs and supportive and transitional housing for people experiencing homelessness (Rech, 2019). These responses however did not sufficiently respond to the more complex needs of many individuals who experience homelessness (e.g., substance use, mental illness) as their housing problems persisted and, in some cases, worsened (Gaetz et al., 2016). This is, in part, because of a requirement in many traditional shelter and treatment programs that people receiving housing and services achieve and maintain their sobriety and seek treatment for any addictions or mental health problems they have (Tsemberis, Moran, Shinn, Asmussen, & Shern, 2003). If a person were to breach these conditions, they could be evicted from their housing and removed from the program, returning to homelessness and shelter living.

Housing First

A new strategy was developed in the early 2000s called Housing First (HF) which takes a new approach. In this program, housing is the baseline of support given to people experiencing homelessness and mental illness, without requirements tied to sobriety or psychiatric treatment (Gaetz et al., 2013). Treatment supports to help people with substance use or mental health problems were offered and used as needed and as desired by participants, with no outcomes tied to housing support. Five core principles guide the delivery of HF programs: housing choice and structure; separation of housing and services; service philosophy (e.g., utilizing a harm reduction approach); service array (i.e., extent of community support services available); and eliminating barriers to housing access and retention (Nelson et al., 2014; Stefancic, Tsemberis, Messeri, Drake & Goering, 2013).

The HF model employs methods that promote participant empowerment. Empowerment, as defined by Zimmerman and Eisman (2017), is made up of a sense of control, a critical awareness of one's environment and the ability to pursue goals and affect outcomes. These three components are reflected in the HF core principles. In providing housing without any readiness requirements and stressing participant-directed program development and recovery, people in HF programs can regain control over their lives, and begin to make positive changes (Davidson et al., 2014; Tsemberis et al., 2004). Through direct and responsible engagement in program services and progress, participants can build a critical sense of the factors that have led them to experience homelessness and an ability to pursue positive outcomes (Kirst, Zerger, Harris, Plenert & Stergiopoulos, 2014).

Popularized in New York, NY, initial studies of HF found significantly better outcomes for those in Housing First programs compared to traditional supports (Gulcur et al., 2003; Tsemberis et al., 2004). Researchers found that a program that offered choice to the individual about the location and type of housing and which services they would like to use, and when, was preferred and led to better outcomes compared to working on a continuum where housing and services were prescribed (Stefancic et al., 2013; Tsemberis et al., 2004; Tsemberis et al., 2003). In a trial conducted with homeless individuals with mental illness and a history of substance use, the Housing First model was shown to significantly increase participants' perception of choice, their time spent stably housed and their use of substance-use treatment services compared to the standard of care (Tsemberis et al., 2004). Participants in that study showed an 80% housing retention rate over the 2-year study, demonstrating that a person's mental health is not indicative of their ability to remain housed.

The strength of the model was tested in the Canadian context in a large, multi-site, randomized control trial of HF called At-Home/Chez Soi. Conducted in five major cities, of different sizes and with different resources, the five-year study compared the HF approach against treatment as usual (TAU; using existing housing and support services in the community) for over 2,000 individuals experiencing homelessness and mental illness (Goering et al., 2014). For those individuals in the HF group, support was provided in the form of coordinated professional service teams to help individuals with mental illness and complex needs minimize hospitalization and enhance positive outcomes (Goering et al., 2014). The study reported better results for housing stability, participants' health and many other measures than achieved by the TAU participants (Goering et al., 2012; Goering et al., 2014).

An outcome evaluation of the five-year At Home/Chez Soi project found 62% of participants in the HF treatment group were housed all of the time compared to 31% for the TAU group, and only 16% of the HF group were housed none of the time compared to 46% for the TAU group (Goering et al., 2014). In concert with more stable housing outcomes, participants in the HF group spent less time in temporary housing, emergency shelter, institutions and on the street than did the TAU participants (Goering et al., 2014). Another finding of note from At Home/Chez Soi trial, mentioned briefly earlier, was the cost associated with implementing the HF model compared to TAU. Though support staff are expensive to provide, the cost savings for supplemental services (shelters, physician visits, police responses, etc.) decreased by over $21,000 per person for the highest needs participants (Goering et al., 2014). These positive findings and many others were echoed by participants in qualitative interviews conducted as part of the study (Kirst et al., 2014).

The Program

The Program began in 2018 and is being delivered by a local multi-service organization in The Region. The Program is designed to combine Housing First (HF) principles with greater home-based supports. This differentiates The Program from other HF trials by extending supports to aid participants in adjusting to their new housing (e.g., taking care of a home, financial planning, living independently). The Program has a specialized team that initially works with their participants to ensure necessary documentation and finances are in order to prepare individuals for moving into a home. Once a participant is deemed document ready, the team works to find suitable housing with the individual's input about the location and type of housing they would prefer. Once moved-in to their new housing, participants begin receiving support from the home-based support team who ensure a smooth transition into housing through ongoing support with housing retention, skill building (e.g. how to maintain a home and cook healthy meals) and linking participants to community services.

Support team members work with the participants through five essential and sequential stages of recovery from homelessness: stabilizing housing, individualized housing support coordination planning, promoting self-awareness, recognizing self-management, and reframe and rebuild (Housing Services, 2017c). All work with participants is meant to be trauma-informed and person-centered (Housing Services, 2017a). The five stages structure a home-based support worker's case management to create an individualized case plan, and help participants set recovery goals and critically reflect on their progress toward housing stability. Home-based support workers provide support for up to 18 months, depending on depth of need, with support scaling down as a participant progresses toward recovery (Housing Services, 2017c). After a participant is deemed able to maintain their housing stability and transition to independence, the supports from their home-based support worker scale down significantly but they remain ready

to re-engage supports if necessary (Housing Services, 2017c). Coordination between the initial intake system and the home-based support team, including how the stages are identified and actions to take with participants, are laid out in foundational frameworks created by the regional government (Housing Services, 2017a, 2017b).

Program participants are drawn from a Regionally-held list of individuals with high needs who are experiencing chronic homelessness. Level of need is determined using a standardized assessment measure, the SPDAT (Service Prioritization Decision Assistance Tool) (OrgCode, 2016), which is delivered to everyone who enters the housing system in the region. This measure assesses a variety of factors to determine level of need, including physical and mental health, substance use history, housing stability and self-management skills. Those who score highest on the SPDAT are deemed to be at the highest level of need and are prioritized for service on the intake list (Housing Services, 2017b), which is a central registry of people who have been deemed chronically homeless (>180 days spent homeless in the past year or 18 months over the past three years).

As with other HF programs, The Program is guided by a program theory that is a foundation for how it is meant to be delivered in The Region and how it will achieve the desired effect. Program theory is used to determine what a program needs to do to meet its desired goals and what additional impacts may arise from actions taken (Chen, 1990). Chen updated this definition (2005) to emphasize the role of the context and setting the program is occurring in and the implicit and explicit assumptions being made by the program. Beyond simply looking at the actions taken by a program, this theory incorporates the underlying factors that can affect a program's success. For The Program this includes the principles of HF, the added component of home-based support, the local organizations that contribute to the housing system in The Region,

as well as the region's community and governmental priorities. Broader contextual factors that affect this program and population include the increasing cost of living and as well as housing and social policies being pursued at each level of government. Considering this holistic approach will lead to a more complete and nuanced initial understanding of The Program's design and what factors, both within and outside of the program, may influence its ability to be implemented appropriately.

In its design, it can be said that The Program also incorporates theories of social support, community integration, and empowerment. Social support refers to the presence and content of personal relationships and the associated benefits to people that result from having those relationships (Turner & Turner, 2016). The presence of personal relationships refers to the social ties and network a person has and the content is the functional support one gets, emotionally, materially or through guidance (Saegert & Capriano, 2017). These concepts have been studied at length and have been demonstrated to provide many health benefits, including to both physical and mental health through mechanisms like stress-buffering (Chang, Heller, Pickett, & Chen, 2013; Kerman, Sylvestre, Aubry, Distasio, & Schutz, 2019; Saegert & Capriano, 2017). The Program makes social interaction and networking an essential component of the program's delivery, practices which are supported by this evidence. Participants are in regular contact with their support team and are connected with services throughout the community.

Community integration is a concept intimately tied to many housing programs as it stresses the building and maintaining of physical, social and psychological connections to the community (Wong & Solomon, 2002). These connections manifest through spending time in a community, having social interactions and building a social network, and by an individual perceiving membership in a community and having emotional connections with other

community members (Wong & Solomon, 2002). These authors propose that these facets of community integration are contingent upon the personal and local contexts within which the housing program is being delivered; that is the housing, behavioural, and support environments. These environments include the accessibility of community resources, the normalization of housing (housing that is located among the mainstream population), the degree of participant independence and the level of active support participants receive (Wong & Solomon, 2002). To help facilitate community integration for its residents, The Program aims to house people directly in community settings, stresses community interaction and works to help residents build life skills to further their independence (Housing Services, 2017a).

The Program emphasizes empowerment in the way it is designed, from person-centered recovery to community and social change. Power exists at various ecological levels, and hence empowerment can occur at the individual, organizational, community and societal levels (Keys, McConnell, Motley, Liao, & McAuliff, 2017). As power is gained at the individual level it may lead to the empowerment of organizations or community groups those individuals belong to (Keys et al., 2017). In this way, The Program not only aims to build empowerment for its participants, but through their increased power, could help foster empowerment of communities, organizations and the larger society. By providing a stable base of support (housing) and developing personal skills, communities can re-integrate formerly marginalized individuals who can contribute to organizations within the community for the betterment of the society.

The Program may focus on the individual but its impacts have the potential to be felt outside of the realm of their housing supports. The Program also promotes empowerment through the inclusion of peer support workers as housing support coaches on the home-based support teams (Housing Services, 2017a). These roles are filled by people with a lived

experience of homelessness who understand the challenges of becoming housed and navigating recovery from a personal perspective. Participating in peer support as either a provider or recipient increases people's empowerment, sense of independence and self-confidence by exploring new ways of thinking and engaging in a process of mutually developing solutions (Repper & Carter, 2011).

Fidelity Assessment

The demonstrated strength of the HF model in the U.S. and Canada has led to broad international adoption. Projects that use the HF model exist in many European countries, as well as New Zealand, and Australia (Australian Housing and Urban Research Institute, 2018; Housing First Auckland, 2019; Pleace, 2016). With different local histories, government priorities, and social welfare and housing systems, the implementation of HF in these new locations can take different forms. As HF is adopted in the new locales, implementation concerns arise that can lead to questions of program drift from core principles for implementation - that is, are the new programs faithfully implemented to the HF model or is there deviation which could affect results (Gaetz et al., 2013; Johnson, Parkinson, & Parcell, 2012; Stefancic et al., 2013)?

As HF targets a historically marginalized population with unique and complex needs, proper training of staff and adequate implementation are further complicated when adapting a model that originated in the U.S. (O'Campo, Zerger, Gozdzik, Jeyaratnam, & Stergiopoulos, 2015). With significantly different social and health care contexts as well as population and geographic differences, the adaptation of HF to The Region may encounter unique challenges (e.g. coordinating care and access between the cities and municipalities in the region). While there is concern about implementation in different regions, studies have shown that programs can adapt the HF model to specific contexts and populations while maintaining adherence to core

principles (Johnson et al., 2012; Nelson et al., 2014; Nelson et al., 2017; Stergiopoulos et al., 2012).

As a means of ensuring appropriate implementation, it is common to use implementation evaluations and fidelity assessments in order to assess how well a program is working and whether there is any deviation from the accepted model (CDC, 2012). An implementation evaluation is used in the early stages of a program, when information about program processes can help improve how it operates (CDC, 2012). The Program is currently in the early implementation phase and, as part of a fulsome implementation evaluation that will also assess other aspects of program functioning and stakeholder views, this work will focus on a fidelity assessment to determine how closely it is aligning with HF principles.

A fidelity assessment assesses the degree to which a program is implemented in accordance with a program model or set of standards (Bond, Evans, Salyers, Williams, & Kim, 2000), and tends to be one part of a larger implementation evaluation. The use of fidelity assessments in the implementation stages of a program helps to ensure consistency and correct errors in implementation at an early stage (Macnaughton et al., 2015). This enables programs to monitor implementation and adjust, as needed, in order to maintain theoretical integrity to the model and overall program quality (Saunders, Evans, & Joshi, 2005). Fidelity assessments can also help programs determine whether results of a program are due to the program model or some other confounding factor (Moncher & Prinz, 1991). They provide a rich source of information about strengths and weaknesses for specific design procedures and participant cases, beyond simple checks of whether a protocol was followed or not (Hogue, Liddle, Singer, & Leckrone, 2005).

For HF projects, the Pathways Housing First Fidelity Scale was created (Stefancic et al., 2013) to score program fidelity to the HF model principles on a scale of one to four (four being highest fidelity) (Nelson et al., 2014). The scale is comprised of 38 items categorized under five overarching domains: (1) housing choice and structure (reflecting choice in type and location of housing); (2) separation of housing and services (reflecting housing rights and responsibilities for program participants); (3) service philosophy (used to reflect underlying HF philosophy); (4) service array (used to assess the extent and availability of community support services); and (5) program structure (reflecting other good programming practices, e.g., low participant/staff ratio) (Nelson et al., 2014). Questions in each domain are specifically defined to ensure accuracy and consistency in scoring. This scale allows evaluators to assess all aspects of a program and provide specific feedback about the degree to which HF principles are being followed, rather than a dichotomous yes or no. The Pathways HF Fidelity Scale has been used in many fidelity evaluations, including in assessing programs of a similar geographical size (Tsemberis, Howard, & Vandelinde, 2016) and during early and later implementation evaluations of the At Home/Chez Soi study (Macnaughton et al., 2015; Nelson et al., 2014).

Another benefit to assessing program fidelity is the demonstrated link between fidelity in implementation and participant outcomes. Durlak and DuPre (2008) conducted a systematic review of nearly 500 studies examining the relationship between participant outcomes and program implementation fidelity in a variety of program types (e.g., drug prevention, mental and physical health promotion). The authors found extensive evidence that carefully implemented programs achieve better outcomes for their participants. Programs that achieved high fidelity tended to score well in areas of provider self-efficacy, program adaptability and organizational capacity. Effective programs were able to successfully negotiate model adherence to local

contexts, had a high-level of provider and staff buy-in to program philosophy and were able to provide a wide range of services to participants (Durlak and DuPre, 2008). These and other metrics are all captured in the Pathways Housing First Fidelity Scale that was used to assess The Program in this current research.

Evaluations by Macnaughton et al. (2015) and Nelson et al. (2014), used the Pathways Housing First Fidelity Scale to evaluate fidelity in the five sites of the At Home/Chez Soi study. Similar to the findings of Durlak and DuPre (2008), factors that contributed to good fidelity in the At Home/Chez Soi study included the growing expertise of staff and their comfort with the HF model and values, organizational capacity, and community partnerships (Macnaughton et al., 2015). These factors influenced the programs' ability to meet the needs of their participants on every level – from staff support, to organizational and community resources. With strengths in these areas, the At Home/Chez Soi sites maintained high-fidelity programs that worked to the benefit of participants (Macnaughton et al., 2015). Factors that were found to impede fidelity in the study sites included lack of support services for participants (e.g., mental health services), staff turnover, participant isolation and an inability for some participants to successfully adjust to being housed (Macnaughton et al., 2015; Nelson et al., 2014). In identifying these factors, the programs can develop strategies to address these deficiencies, which may involve better supports for staff and participants or developing more community connections.

A follow-up evaluation of each At Home/Chez Soi program site two years after the end of the study reported 75% of sites still active in providing treatment and maintaining a high level of fidelity (Nelson et al., 2017). Three of the five program locations had expanded their HF services, demonstrating the commitment to, and success of, the model. Nelson et al. (2017) identified several factors that influence sustainability including the amount of knowledge

dissemination the projects engaged in and the alignment between the HF model and government policy and funding. The outcomes of the fidelity evaluations are used to improve the program by identifying areas of implementation strength and weakness, and subsequently suggesting adjustments.

Results from previous fidelity assessments indicate common successes and challenges faced by other HF programs. Fidelity assessments of HF programs in different parts of the world have found that the domains of separation of housing and services, and service philosophy tend to score highly (Greenwood, Stefancic, Tsemberis, & Busch-Geertsema, 2013; Manning, Greenwood, & Kirby, 2018; Nelson et al., 2014; Samosh et al., 2018; Tsemberis et al., 2016). This indicates that many programs are developed with a strong foundation of Housing First principles and are cognizant of the importance of helping participants normalize and maintain their housing. Many programs experienced lower scores in the program structure and service array domains, with problems related to having participant representation in the program, adequate service coverage or providing employment and education services (Manning et al., 2018; Nelson et al., 2014; Samosh et al., 2018; Tsemberis et al., 2016). Though tools for fidelity assessments are being updated and adapted and the methods and measures between these assessments may have been slightly different, these common themes should be noted and examined for their applicability to The Program.

Research Aims

A fidelity assessment will provide a complete perspective of how The Program is operating according to the HF model and where it can be improved to better serve its participants. By understanding the theories that underlie The Program, recommendations for program improvement can be developed to address both technical and theoretical components. As such, this research strives to understand two main questions:

1) How is The Program being implemented with fidelity to the HF model and in accordance to relevant theories?

2) How is The Program being implemented with fidelity to the intended goals of the home-based support component of the program?

The final aim of this research is to provide concrete and actionable feedback to the community partner. As a community psychologist, it is vital that research conducted in community can be used to better those communities. As the evaluation process was highly community-engaged, key partners on the evaluation, such as the organization that is delivering The Program, will be provided with the fidelity scores, rationales for those scores, and consulted to determine the appropriate steps to improve their program as it develops with the goal of achieving the best outcomes for their participants.

Method

This research took place in a medium-sized Canadian municipal region in coordination with community partners involved in The Program. Mixed methods were used to develop an understanding of the adherence of The Program to the Housing First (HF) model in implementation and to intended program goals of home-based support. The previously developed Pathways HF Fidelity Scale (Stefancic et al., 2013) was used and adapted to include questions about the unique home-based support aspect of The Program. The result was the addition of a new domain, support and skills development, and six new items intended to capture the unique and critical elements of the home-based support aspects of The Program. The adaptation was done by myself, a master's student, and my PhD supervisor, and developed items were forwarded to the community partner for review and approval prior to use. This study has been approved by the Research Ethics Board (REB) at our host University.

Community Partners

Throughout the course of the research, we worked with local partners from The Region. This included the host organization for The Program, and the housing division of the regional government that provides oversight for The Program.

Initially, we developed a relationship with community partners to build trust and an understanding of common goals for the research project through the formation of an advisory group. The advisory group was comprised of the four members of the research team, two program leaders from the host organization as well as the program liaison form the regional government and met semi-regularly to discuss research timelines, progress and method. Having an advisory group ensures the incorporation of community partners' experience, perspectives and input throughout the research process (Newman et al., 2011). We then began familiarizing the advisory group with the protocols of the previously created fidelity assessment procedure and the associated materials (Aubry & Nelson, 2019), and gathered feedback on these materials. Continuous consultation with community partners occurred throughout the project and outputs were created that were specifically tailored to be useful for their organization (i.e. an executive report that outlined key learnings in addition to a full report that further detailed the research process).

Participant Recruitment and Data Collection

The bulk of data collection took place during a one-day site visit in September 2019 to the host organization in The Region. The research team for the site visit included a combination of faculty members and students, including myself. In accordance with the fidelity protocol designed by Nelson and Aubry (2019), a single site visit is all that is needed to gather the required information and helps minimize the burden the research may have on the host organization. Research team members took part in a training session prior to the site visit to review the process for the site visit day; how to gather information during the team meeting observation; how to deliver the scale in an interview setting; and how to score the scale. This training was delivered by Dr. Geoff Nelson (part of the research team) as he has taken part in this type of fidelity evaluation visit prior to this. The following figure (Figure 1) represents a graphical representation of the site visit protocol.

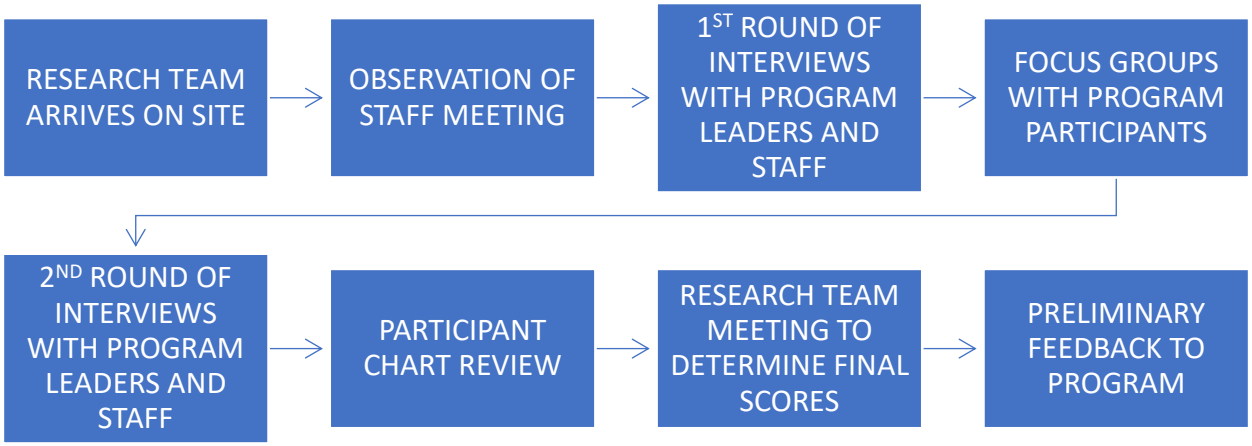

Figure 1. Fidelity site visit protocol.

All participants were recruited using convenience sampling from various levels of the program, including program leaders, staff and participants. Program leaders include a manager and team supervisors of The Program, of which we interviewed 3 during the site visit. Program staff are service providers involved with different aspects of The Program delivery and were

identified by program leaders. We interviewed 4 program staff, each in a different role in the program and thus able to provide a unique perspective. Both program leaders and service providers were recruited via email invitations sent out by the research team. Service providers were also asked to invite program participants, using a script provided by the research team, to participate in the focus groups. Using this method, we were able to recruit six program participants for each of the adult and youth focus groups. Compensation was provided for participants in the form of $25 gift cards to their choice of a local grocery store, general store or coffee shop.

The site visit began with an observation of a service provider team meeting in which members of the different branches of The Program (pre- and post-move-in support) briefly discussed each participant's current situation within the program and any challenges they may be encountering. Research team members were present in the same room as the service providers and took notes on the details discussed and the means by which the group navigated challenges for each other and participants. After the team meeting observation and throughout the course of the day, interviews with program leaders took place. Interviews took place with the program manager, team supervisors and Program staff. Interviewers took detailed notes during these interviews. A review of 10 program participant charts (picked at random and de-identified) was conducted by one research team member and assessed for details that map onto the fidelity scale, such as service choice and housing support. Finally, two separate focus groups with program participants were conducted, one with adult participants and one with youth participants. Both the interviews and focus groups were guided by the fidelity scale, with questions coming directly from the scale and answers being mapped onto the scale corresponding to the appropriate score. Interviewers sought clarification from interview and focus group participants whenever

necessary to ensure an accurate scale score was recorded. Audio recording devices were used to capture responses in the focus groups.

A preliminary discussion of findings was delivered by the research team at the end of the day with program leaders. Each research team member presented the fidelity results for a different HF domain(s) with both strengths and weaknesses being identified. A discussion of why certain results were found also occurred at this time, providing the first chance program leadership to provide context and other pertinent details that may impact results.

After the site visit was complete, interview notes were consolidated and focus group responses were transcribed, with both being analyzed to discover relevant themes related to program implementation. A full report of findings on fidelity was put together by the research team and distributed to program leaders for input and to help contextualize results.

Measures

The Pathways Housing First Fidelity Scale (Stefancic et al., 2013) was used to assess fidelity to the five domains of the HF model. The Intensive Case Management (ICM) version of the scale was used, as this version aligns most closely to the type of service model employed in The Program and has previously been successfully tested for validity and reliability (Stefancic et al., 2013). Stefancic et al. (2013) reported Cronbach's alpha coefficients ranging from acceptable, .71 for service array, to good, .92 for service philosophy, with the other domains scoring between the two. The domain of program structure was not assessed for reliability as it is comprised of a diverse set of items that reflect good practices in any program (Stefancic et al., 2013). This scale is composed of a series of 38 questions sub-divided into the five domains for HF fidelity (discussed above) to assess the program's ability to meet the criteria for HF implementation. One additional domain and six new questions were added to capture fidelity scores for the new home-based support component of The Program. The adaptation of the

fidelity scale was undertaken by reviewing the intended goals for home-based supports set out in the guiding frameworks (Housing Services, 2017a, 2017c) and modeling the new items after existing items in the scale. This method loosely follows the initial steps in developing fidelity criteria as described by Mowbray, Holter, Teague, & Bybee (2003) and Bond & Drake (2019) however the new items have not been tested for validity or reliability. These new questions were reviewed by The Program's leaders with their input being used to further refine items. All scale items are scored between 1 and 4, with half-marks being permitted (e.g. 3.5). The benchmark used for high-fidelity was a score of 3.5 or higher (Macnaughton et al., 2015; Nelson et al., 2014).

Table 1
Fidelity Scale Domains with Descriptions

Domain	Description
Housing Choice and Structure	Housing choice, affordability and belonging in community
Separation of Housing and Services	Ensuring same housing rights and responsibilities for program participants and program commitment to re-housing if needed
Service Philosophy	Ensuring mental health and substance abuse recovery orientation for the program and use of participant-oriented engagement strategies
Service Array	Reflect the breadth and depth of services the program offers
Program Structure	Reflect program processes and participant representation in the program
Support and Skills Development	Reflect program's implementation of stages of recovery set out in program frameworks

Research Design

I used a triangulation design for this project in order to capture a wide variety of data about the program. I employed the validating quantitative data model of triangulation design in order to expand on quantitative results with qualitative data (Creswell & Plano Clark, 2007). This design utilizes complementarity to provide a fulsome assessment of the program's implementation (Creswell & Plano Clark, 2007). In practice, this approach has research team

members use the adapted HF fidelity scale in interviews as well in focus groups, collecting primarily quantitative data from the interviews and primarily qualitative data from the focus groups. This method minimized burden on participants while still capturing the required data. Conducting a sequential mixed methods design could have worked but would have unnecessarily increased the time burden placed on the program and its leaders, staff and participants. A solely quantitative or qualitative method could also have been used however neither would have provided enough information to fully realize the goal of giving thorough, actionable feedback to the program.

For this research, I used a pragmatic paradigm in order to properly approach the research question and determine appropriate recommendations for our community partner. In its axiology, this paradigm asserts that knowledge is to be pursued in a utilitarian way, valuing evaluation as a means to an end rather than an end in itself (Mertens & Wilson, 2012). By using this approach, my research is grounded in tangible outcomes for the community partner and can yield practical outputs. The epistemological and methodological approaches espoused in pragmatism emphasize the importance of practicality, in both the partnerships that are formed in an evaluation as well as the methods employed (Mackenzie & Knipe, 2006; Mertens & Wilson, 2012). Focusing only on what partnerships will be needed and only using methods best suited to answering the research questions help ensure the research will be well placed to succeed in delivering actionable recommendations without over-burdening the host organization. By approaching this work through the pragmatic paradigm, I believe this evaluation is well positioned to deliver realistic solutions that our community partner can understand and act on, with the aim of enhancing the program itself.

Ethical Considerations

Participation in this study risked emotional distress and breaches of personal privacy and the research team worked to mitigate these wherever possible. If, during the course of interviews or focus groups, participants became emotional or had emotional difficulty with some of the questions or topics, the situation was approached with empathy. The participant was informed that they can stop the interview/focus group if they wanted or could take a break from the interview/focus group. Space was given whenever needed in order for the participant to feel comfortable throughout the process. A list of mental health resources in The Region was provided to ensure there is ongoing support for participants who did experience emotional distress.

To mitigate privacy concerns, we ensured proper consent and study information forms were provided for participants to review and sign. An oral explanation of the purpose and techniques that were used throughout the study was given and there was explicit time for questions or conversations before any interviews or focus groups began. For those participants in a focus group, they were made aware prior to the focus group that they will be in a room with other program participants who they may or may not know and who would be able to identify them. If they were uncomfortable with that, they could choose to either take part in a separate individual interview or could withdraw from the focus group process. Individual interview responses were to be de-identified in any report to help preserve anonymity though, with a small and concentrated participant pool, there remains a risk that individual responses could be identified. A further safeguard was to reach out to participants to verify whether it is alright to quote their response in a report, allowing them time to assess for themselves the suitability and anonymity of their quote. For service providers being observed in the team meeting setting, only meeting function information was recorded (level of detail discussed, how service provider or

participant challenges are addressed) with no identifiable information or quotes recorded, thus no consent forms were required from them.

After interviews and focus groups took place, participants were assigned codes by the research team and all identifiable data was replaced with the associated codes. All digital data files were stored on a password protected computer in a locked research laboratory. All hard copy data was kept in a locked research lab only accessible by research team members. These measures were enacted with strict adherence to ethical guidelines in order to ensure participant privacy concerns were allayed and to maintain the security of the data.

Data Analysis

Participant responses to scale questions, as well as chart review data, were mapped onto the four-point fidelity scale items. After interviews, focus groups and the chart review were completed, final scores for each item were determined through a consensus process undertaken by the four-person research team. Scoring by each team member was shared and discussed for each item until consensus was achieved (a similar approach was used by Macnaughton et al., 2015; Nelson et al., 2014; Torrey, Bond, McHugo and Swain, 2012). While scoring on some items varied between research team members, consensus was aided by cross-referencing interviewer notes and, ultimately, was not difficult to achieve. Results were then calculated again, off-site, by the research team and focus group responses were analyzed to add depth and context to fidelity scores.

Quantitative data were analyzed to determine program fidelity levels from mean scores of scale results from interviews, chart reviews and focus groups. All final scores (after consensus) on items in each domain were summed and a mean scored derived to determine final domain scores and overall fidelity scores. The benchmark for high fidelity was a score of 3.5 or higher (Macnaughton et al., 2015; Nelson et al., 2014). Qualitative data from focus group responses and

interviewer notes were analyzed using thematic analysis to identify specific themes and map responses onto those themes. With help from my supervisor, I used the six-step method for thematic analysis outlined by Braun and Clarke (2006) to analyze the data. Initially, I (1) read through transcripts multiple times to become familiar with them, and then (2) identified relevant coding labels in the data and conducted a coding of the data. Before proceeding, I reviewed codes with my supervisor to ensure their appropriateness and applicability. I then (3) identified themes in the data related to the codes and (4) reviewed themes for consistency and applicability. Finally, I (5) defined themes further in relation to their focus and scope within the research, and (6) wrote a cohesive examination of the themes that tied in the research aims. Themes extracted from qualitative results were cross-referenced against fidelity scores to either corroborate results or determine if there was disagreement between fidelity scale results and focus group responses or interviewer notes. In the case of a disagreement between the quantitative and qualitative data, or where certain fidelity scale items received a low score, contextual factors were examined, and the community partner was consulted to determine why that might have occurred. The qualitative themes were also used to identify any new and salient results related to fidelity that may have been missed by the fidelity scale.

Data quality was assessed through a member check-in - that is, through feedback and conversations with program leaders. Feedback from service providers and program participants was not used here as it was difficult to coordinate or would have proved too disruptive. As service providers are often off-site and program participants are scattered throughout the community, it did not seem realistic to ask everyone to reconvene to provide feedback, whereas program leaders are more regularly accessible. Feedback occurred initially, during the site visit, after scores were calculated on-site, as a way of providing immediate results and to guide a

discussion with program leaders about the early findings. The feedback from this conversation helped contextualize results and present different interpretations for why some items may have scored higher or lower. Further feedback was gathered after more analysis of the data took place off-site, with a preliminary report being issued to the community partner. The feedback from our partners, who have the knowledge and experience delivering the services, was used to further contextualize results and helped develop a more nuanced interpretation of results. By consulting with the lead organization several times throughout the process, practical and actionable recommendations were created to help address any shortcomings identified in the evaluation to aid in the implementation of the program.

Positionality

Being a student in the Community Psychology field, I believe it is important to know your values and make explicit your biases and the relationship to your work before starting a project like this. Having never experienced anything but stable housing and support throughout my life, I feel like somewhat of an outsider in this work. The emphasis on lived experience and peer support in many health initiatives reminds me regularly that I am not a member of this group I hope to help. However, it also reinforces the idea that this community must be fully integrated into the research if I am going to understand the human context of homelessness and what practical solutions exist. This evaluation project exposed me to views from the various levels at play in any homelessness strategy - the government workers, the staff from organizations delivering services and those who have experienced homelessness - and I believe it was a great opportunity for me to learn and connect with this issue. It is the belief that I am an outsider but can make a difference, that I have lots to learn and lots to give, that guided my values in this work. I made an effort to build relationships and trust within these communities and to create a positive working relationship among all parties. Situated as I am, I used my

mindset and willingness to facilitate this work in a way that listened to program participants and staff and helped strengthen the program for the betterment of the participants.

As a master's student in a Community Psychology (CP) program, I believe I am well positioned to conduct this research. As a student, I am granted certain privileges associated with belonging to a university. I am able to use the resources of the University to ensure ethical standards are incorporated into the work and the status of the University to gain access to the work itself. Protocols and resources are already in place at such an institution to be able to adequately prepare for, execute and analyze any research being done, which will ensure an easier means of completing the work. Funding and community connections come with membership at the University and the personnel that work there, which I have access to. In my work as a graduate student I have completed a 200-hour practicum in the housing services division of the governing body of The Region. There I developed a thorough understanding of the various facets and partners involved in the delivery and maintenance of the housing system in The Region.

My research supervisor for this work was Dr. Maritt Kirst. Dr. Kirst's background in the housing and homelessness research sector provided a strong foundation for my research. As a leader in the qualitative component of the influential At Home/Chez Soi project, Dr. Kirst is well-versed in HF strategies and the challenges to be anticipated in this work. Collaboration with Dr. Geoff Nelson, also of the CP program with a research background in housing, homelessness and the At Home/Chez Soi project, helped ensure a strong knowledge base to guide the fidelity assessment and navigate any challenges. Dr. Kirst also has a background in program evaluation which ensured the proper steps were followed and relevant program aspects recognized and analyzed as the process proceeded. Her expertise in mixed methods research, specifically in this

area, proved invaluable and provided an excellent learning experience for a young researcher such as myself.

Evaluating fidelity to the HF model and to intended program goals (for home-based support) was a part of the larger evaluation which looked further into how individuals at all levels of the program are experiencing the program. The evaluation as a whole was designed to help the program learn about the perspective of staff and participants and discover whether they feel the program is set up properly to achieve its goals. The evaluation helped determine the state of implementation for the program and suggest ways to refine aspects of it to best serve its participants, including and beyond fidelity to the HF model. The fidelity assessment, though an important component, is only one piece of the larger picture of the implementation phase of The Program.

This work is important in establishing a strong foundation for The Program in The Region. Though much work has been completed to set this program up for success, the implementation phase of any program is key to its ability to achieve intended goals. Ensuring strong implementation will position the program best to achieve its goals and be a solution to homelessness in the region. The adaptation of the Pathways HF Fidelity Scale provides another example of how to expand on a proven scale for fidelity assessments and will strengthen the literature on successes and limitations associated with doing so. The unique aspect of home-based support provides a perspective on what further refinement and expansion of the HF model can look like and the successes and challenges involved with its implementation. Appropriate fidelity at the implementation phase can help ensure any outcomes are properly attributed to the program's delivery and not an unseen factor.

This work is important in further demonstrating the importance of strong implementation and planning on program delivery. Having a model to follow and further evolve is central to new program developments in any field and this work makes progress toward demonstrating how that is possible in the housing and homelessness sector. Utilizing and adapting the HF fidelity scale further demonstrates the importance of following the HF model and how adaptations can strengthen that model.

The community collaboration aspect of this project is significant as well. In partnering with a community in the province to conduct the fidelity assessment, this project helped build community expertise and capacity for program planning and delivery. Also, as organizations work to end homelessness in the region, this program's delivery provides a significant building block toward that goal. If it is successful, it could mean a significant decrease in the number of people experiencing homelessness and can be a model for this region, and others, to follow.

Knowledge Translation Strategies

In order to make this project and its findings as useful as possible for the program, several meetings with program and community stakeholders have occurred. As mentioned earlier, feedback with the program staff and leaders occurred the day of the fidelity assessment to share initial results. A final report on the fidelity assessment, with an accompanying meeting, were shared shortly thereafter once results were compiled more thoroughly into one report for the program's use and dissemination. Further reporting for the program will take the form of a community report as well as a knowledge brief. As it pertains to research on fidelity assessments, an article will be written for publication to the wider research community in order to maximize the reach of the results. This work may be presented at various conferences as well, to discuss procedures and results as it pertains to increasing the knowledge base for providing fidelity evaluations. Two conferences where results could be shared are the Fourth International Housing

First Conference and the National Conference on Ending Homelessness, both happening in Toronto, Ontario, likely being postponed until 2021 due to the novel Coronavirus pandemic. Finally, the broader project of the process evaluation for The Program could lead to an outcome evaluation in the future that would be focused on assessing program effectiveness in achieving key outcomes. That would be of great benefit to the regional government, in determining the long-term effectiveness of The Program, as well as to the broader research community who may wish to adapt the model to their region and wish to understand factors contributing to successes and challenges of this kind of program. Through these means, the results of the fidelity assessment and larger process evaluation could be used to provide another example of the benefits and challenges associated with delivering these kinds of programs.

Results

Overall, The Program scored 3.55 on the 4-point fidelity scale, or 89%. The mean fidelity score according to the original Pathways Housing First Fidelity Scale, excluding the newly developed home-based support-centric items, is similar, with an overall score of 3.50 out of 4, or 88%. Any score of 3.5 or higher is considered high fidelity so these scores represent a strong adherence to the Housing First model for the program. The domains of service philosophy and support and skills development scored highest (3.85, range: 3-4 for both), indicating strength in program support for and engagement with participants. Service philosophy reflects the admission requirements for participation in the program and how program staff engage with participants. Support and skills development reflects the strength of the home-based support model implemented in The Program and the focus on building independence for program participants. Separation of housing and services was the next strongest domain (3.67, range: 2-4), demonstrating the program's adherence to a model that supports minimal barriers for participant tenancy and mobile supports. The domains of service array, housing choice and structure and

program structure scored lowest (3.25, range: 1-4 for each) for The Program. Good fidelity in service array reflects the myriad ways The Program provides support for participants, while the score for housing choice and structure indicates a commitment by the program to provide choice and stability in housing for participants. Program structure represents the ways the program is set up to ensure participants have adequate staff support and how it ensures the representation of people with an experience of homelessness in the program. All scores can be viewed in Table 2.

Table 2
Fidelity Scale Results

Domain	Item	Score and Scale Definition
Housing Choice and Structure	1. Housing Choice	**3.5**: Participants have much choice in location, decorating, furnishing, and other features of their housing.
	2. Housing Availability	**1**: Less than 55% of program participants move into a unit of their choosing within 6 weeks of having a housing subsidy or receiving a voucher.
	3. Permanent Housing Tenure	**4**: There are no expected time limits on housing tenure, although the lease agreement may need to be renewed periodically.
	4. Affordable Housing	**3**: Participants pay 31-45% or less of their income for housing costs.
	5. Integrated Housing	**4**: Participants live in private market housing where access is not determined by disability and less than 20% of the units in a building are leased by the program.
	6. Privacy	**4**: Participants are not expected to share any living areas with other tenants.
Separation of Housing and Services	7. No Housing Readiness	**4**: Participants have access to housing with no requirements to demonstrate readiness, other than agreeing to meet with staff face-to-face once a week.
	8. No Program Contingencies of Tenancy	**4**: Participants can keep their housing with no requirements for continued tenancy, other than adhering to a standard lease and seeing staff for a face-to-face visit once a week.
	9. Standard Tenant Agreement	**4**: Participants have a written agreement (such as a lease or occupancy agreement) which specifies the rights and responsibilities of typical tenants in the community and contains no special provisions other than agreeing to meet with staff face-to-face once a week.
	10. Commitment to Re-House	**4**: Program offers participants who have lost their housing a new unit. Decisions to re-house participants are 1) individualized, 2) consumer-driven, 3) minimize conditions that participants need to fulfill prior to receiving a new unit, 4) safeguard participant well-being, and 5) there are no universal limits on the number of possible relocations.

	11. Service Continuation Through Housing Loss	**2**: Participants are discharged from services if they lose housing, but there are explicit criteria specifying options for re-enrollment, such as completing a period of time in inpatient treatment.
	12. Off-site, Mobile Services	**4**: Social and clinical service providers are based off-site and are able to deliver services in locations of participants' choosing.
Service Philosophy	13. Service Choice	**3.5**: Participants have the right to choose, modify, or refuse services and supports at any time, except one face-to-face visit with staff per week.
	14. No Requirements for Participation in Psychiatric Treatment	**4**: Participants with psychiatric disabilities are not required to take medication or participate in formal treatment activities.
	15. No Requirements for Participation in Substance Use Treatment	**4**: Participants with substance use disorders are not required to participate in substance use treatment.
	16. Harm Reduction Approach	**4**: Participants are not required to abstain from alcohol and/or drugs and staff work consistently with participants to reduce the negative consequences of use according to principles of harm reduction.
	17. Motivational Interviewing	**3**: Program staff are very familiar with principles of motivational interviewing, but it is not used consistently in daily practice.
	18. Assertive Engagement	**4**: Program systematically uses a variety of individualized assertive engagement strategies and systematically identifies and evaluates the need for various types of strategies.
	19. Absence of Coercion	**4**: Program does not use coercive activities such as leveraging housing or services to promote adherence to clinical provisions or having excessive intrusive surveillance with participants.
	20. Person Centered Planning	**4**: Treatment/service planning fully meets all 3 services (development of formative treatment plans; conducting regularly scheduled treatment planning meetings; practices reflect strengths and resources identified).
	21. Interventions Target a Broad Range of Life Goals	**4**: Program systematically delivers interventions that target a range of life areas (range exists across the program and among participants).
	22. Participant Self-Determination and Independence	**4**: Program is a strong advocate for participants' self-determination and independence in day-to-day activities.
Service Array	23. Housing Support	**4**: Program offers both assistance with move-in and ongoing housing support services including assistance with neighborhood orientation, landlord/neighbour relations, budgeting, shopping, property management services, assistance with rent payment/subsidy assistance, utility setup, and co-signing of leases.
	24. Psychiatric Services	**4**: Program successfully links 85% or more of participants who need psychiatric support with a psychiatrist.

	25. Substance Use Treatment	**4**: Program successfully links 85% or more of participants in need of substance abuse treatment with agencies that provide such treatment.
	26. Employment and Educational Services	**1**: Program fully meets less than 2 criteria (criteria: engagement and vocational assessment; rapid job search and placement; job coaching; follow-along supports).
	27. Nursing/Medical Services	**4**: Program successfully links 85% or more of participants who need medical care with a physician or clinic.
	28. Social Integration	**3**: Program fully provides 2 services, or partially provides all 3 (helping participants develop social networks; helping participants develop social abilities; facilitating participation in social venues).
	29. 24-hour Coverage	**2**: Program does not respond during off-hours by phone, but links participants to emergency services for coverage.
	30. Involved in In-Patient Treatment	**4**: Program is involved in 85% or more of inpatient admissions and discharges.
Program Structure	31. Priority Enrollment for Individuals with Obstacles to Housing Stability	**4**: Program selects participants who fulfill criteria of multiple conditions, including 1) homelessness, 2) severe mental illness and 3) substance use.
	32. Contact with Participants	**4**: Program meets with 90% of participants at least 3 times a month face-to-face.
	33. Low Participant/Staff Ratio	**4**: 20 or fewer participants per 1 full-time equivalent staff.
	34. Contact with Participants – Minimum Threshold	**4**: Program meets with 90% or more of participants 3 times a month face-to-face.
	35. Frequent Meetings	**4**: Program meets at least 4 times a month (once a week).
	36. Weekly Meeting/Case Review	**2**: Meeting fully serves 2 of the functions, or partially 3 (high level overview of each participant; detailed review of participants who are not doing well; review of one success from past week; program updates and any health and safety issues).
	37. Peer Specialist on Staff	**4**: At least 1.0 full-time equivalent peer specialist who meets minimal qualifications and has full professional status on the team. No more than 2 Peer Specialists fill the 1.0 full-time equivalent.
	38. Participant Representation in Program	**1**: Program does not offer any opportunities for participant input into the program (0 modalities).
Support and Skills Development*	39. Connections to Community Resources	**4**: Participants are being connected to community resources that meet and exceed their needs.
	40. Participant Self-Awareness	**4**: Program is a strong advocate for participants' self-awareness.
	41. Promotion of Participant Self-Management	**4**: Program is a strong advocate for participants' self-management skills.
	42. Skills to Live Independently	**4**: Participants are building the majority of skills necessary to live independently.
	43. Training Availability and Accessibility	**4**: Training sessions are frequently scheduled and are at times and locations that allow the participant to attend regularly, with program staff aid whenever necessary.

44. Trauma-informed Care	**3**: The program has many aspects that are designed in a way that is trauma-informed.

*new items specific to The Program

Items Promoting Fidelity

The fidelity domains that had the highest scores were service philosophy and support and skills development, each scoring 3.85/4. For the domain of service philosophy, the items relating to having no requirements for psychiatric or substance use treatment, employing a harm reduction approach, using assertive engagement and person centered planning, not using any form of coercion, having interventions that target a broad range of life goals and encouraging participant self-determination and independence all scored 4 on the fidelity scale. When asked whether they were required to be in treatment for mental health or substance use issues to be enrolled in the program one participant said "*no, they never do that. They will definitely encourage treatment if it's necessary in any kind of case but they don't hold … any gun to your head to tell you, you have to do this; right*" (Fidelity focus group 2). One of the items most often cited by program participants as being strong was service choice, as stated by this focus group member, "*yeah, my workers will, they'll walk with me anywhere I want to go. Any path I want to go down. They offer me different services and like treatment centres and this and that but it's all up to me, like they don't push it on me, they don't force it. They accept me for the way I am, which is, it makes it a lot easier*" (Fidelity focus group 2).

The support and skills development domain also achieved a perfect score on nearly all of the items. The items for connections to community resources, participant self-awareness, promotion of participant self-management, promoting skills to live independently, and the availability and accessibility of training all scored 4. It should again be noted that the support and skills development domain and items were created for the specific purpose of evaluating the

home-based support side of The Program. Participants spoke about how the program promotes self-management and skills that will foster independence, with one saying:

> *They encourage you to budget just to make sure you have your bus pass and groceries for sure cause they know, like as great as it is to go over there and get like free food, they want you to be independent.* (Fidelity focus group 2)

This sentiment was echoed by several staff members who agreed that there are ongoing conversations with participants to help them build skills to live independently (Program staff interviews 1, 2, & 4). Another participant spoke about the motivation they found in having responsibility to continue working toward recovery with their worker:

> *I have an accountability to* [the host organization] *and to the people that have been working with me. They put all this time and effort into me so I got to mind my Ps and Qs right. It keeps me in line because I'm grateful right. Yeah, I can't emphasize that enough*. (Fidelity focus group 2)

Separation of housing and services was a domain that was also rated quite highly at 3.67/4. The items for having no housing readiness conditions (such as requirements of sobriety or undergoing treatment), no program contingencies of tenancy, having a standard tenant agreement, a commitment to re-house participants (minimizing barriers to rapid re-housing) and providing off-site or mobile services all scored 4. When asked about whether the program had any requirements for tenancy, one participant responded, "*nothing forced on me but they have helped me get into treatment centres*" (Fidelity focus group 1). This was a sentiment that was then echoed by other participants in that focus group as well as several program staff (Program staff

interviews 1, 2, 5, & 6), demonstrating the program's commitment to connecting participants with support without it being a requirement.

The domains with the lowest scores, 3.25 on the 4-point scale, were housing choice and structure, service array and program structure. For housing choice and structure, the items for permanent housing tenure, integrated housing and housing privacy all scored 4 on the fidelity scale, while the item for housing choice scored 3.5. These scores indicate that the program has been successful in providing choice in housing and communicating to participants the permanency of that housing. It also indicates that the program has been successful in locating housing that is integrated into neighbourhoods with the mainstream population rather than in a communal setting with other participants. When asked about choice in the type of housing they got, one participant said "*Yep, for myself there yeah, I didn't want to share accommodations with nobody…I'm very private*" (Fidelity focus group 2). This participant then agreed that they believed the program respected their preference for private housing and ensured that is what they received. Many of the program staff also expressed their agreement that the program provides plenty of choice in housing and ensures participants preferences are incorporated into housing decisions whenever possible (Program staff interviews 1, 3, 4, 7).

For the service array domain, scores of 4 were received for housing support, psychiatric services, substance use treatment, nursing/medical services and the program's involvement in in-patient treatment. Many participants spoke about how much help their worker had been in managing the relationship with the landlord and ensuring they were not being taken advantage of. One program participant said:

> *They stop the crosstalk in between people and landlords…They basically act like the Landlord [and] Tenant Board for people that don't know the laws on tenancies so if*

> *anything, they're very much useful in almost every respect for the most part.* (Fidelity focus group 1)

For program structure, the items that received a score of 4 were priority enrollment for individuals with obstacles to housing stability, contact with participants, low participant to staff ratio, frequency of staff meetings, and having a peer specialist on staff. These items, mentioned in several program staff interviews, represent the strength of the organizational structure and capacity, including the intake list which ensures people with the highest needs have priority access to the program and the ability of the program to ensure low participant to staff ratios (Program staff interviews 1, 2, & 7). Many program participants spoke of the frequent contact they had with their workers, and the importance of having staff with an experience similar to theirs. One participant said of the peer-specialist housing support coach:

> *In order to get their job they have to have life experience either in addiction or in trauma so that's why it's not so textbook-y and that's why they're actually able to get it because some of them actually walked [in] our shoes.* (Fidelity focus group 1)

Items Hindering Fidelity

While the domains all scored quite well, it is important to know what items scored poorly in each domain in order to determine appropriate recommendations. Any item that scored below the score benchmark of 3.5 was included here and identified as an area for program improvement. For service philosophy, the one item that scored less than 3.5 was motivational interviewing, which was scored a 3. Though this practice is present in the program, staff and program leaders cited a need for further training in this area to best use the technique.

The only item that did not achieve a perfect score for the support and skills development domain was the implementation of a robust trauma-informed care approach to case management,

which received a score of 3. Though staff had received training on trauma-informed care and were working to incorporate it into their case management, it was not fully integrated at the time of this evaluation.

The item that scored the lowest in the separation of housing and services domain was a score of 2/4 for service continuation through housing loss. Participants who lose housing for greater than 30 days are transferred from their home-based support worker back to a housing liaison. While this keeps the participant in the system, the case management provided by their home-based support worker ceases until further housing is found for them and it is possible that a program participant may return to homelessness. The way that the program is structured, the home-based support worker is there to help primarily with a participant in maintaining their housing rather than finding housing, which leads to the transfer from one worker to another under circumstances of housing loss related to eviction, hospitalization or incarceration.

The items that scored lower in the housing choice and structure domain include affordable housing, which received a score of 3, and housing availability, with a score of 1. These scores reflect the lack of affordable housing available in The Region that the program could utilize to house program participants.

The service array items that scored more poorly include social integration, 24-hour coverage, and employment and educational services, with scores of 3, 2, and 1, respectively. The low scores for social integration and employment and educational services indicates that the program is initiating limited connections to the community for participants in these areas. For 24-hour coverage, participants spoke about not being able to access their worker or adequate supports in the evenings after 5pm or on the weekends. Instead, they are given the phone number for a local 24-hour mental health support hotline or can access the hospital if needed. As this

participant stated, "*I get stuck* [without support] *the whole time on weekends. That's my weakness and I wish there was somebody I could call on the weekend right. Saturday, Sunday is a free-for-all. If I make it to Monday, hallelujah right. It's a real struggle, it's a real battle*" (Fidelity focus group 2).

The items that scored lower in the program structure domain were weekly meetings and case review, which received a score of 2, and participant representation in the program, with a score of 1. The weekly meeting and case review score was due to the lack of information provided during case reviews in team meetings. The score of 1 for participant representation in the program signifies that there are currently no means for participant representation for input into program development or decisions.

Discussion

The Program's score of 3.50 out of 4 for the five domains (excluding support and skills development) can be seen as a success for the program and corresponds to similar results from other Housing First (HF) programs that have undertaken a fidelity assessment using the Pathways Housing First Fidelity Scale. The Program's overall score is close to that of the five programs assessed as part of the At-Home/Chez Soi study's early implementation evaluation, who's scores ranged from 3.40 to 3.54 (Nelson et al., 2014). In other studies, a program in Ottawa also received a score of 3.50 (Samosh et al., 2018), while a program in Windsor received a score of 3.38 (Tsemberis et al., 2016) and a program in Dublin, Ireland scored 3.40 (Manning et al., 2018).

The Program also exhibits similar strengths and deficiencies in program fidelity compared with these other programs. Where the top-scoring domains for The Program were service philosophy and separation of housing and services, the same pattern was seen in the

scores for the sites reviewed by Nelson et al. (2014), Manning et al. (2018), and Samosh et al. (2018). These domains also made up two of the top three highest scoring domains for the Windsor program (Tsemberis et al., 2016).

The lower scoring domains that represent areas of improvement for The Program were for housing choice and structure, service array, and program structure. Lower scores in service array and program structure domains were also common to other programs, and was often similarly related to items of participant representation in the program, employment and educational services and 24-hour coverage (Manning et al., 2018; Nelson et al., 2014; Samosh et al., 2018; Tsemberis et al., 2016). The low score for The Program's service array domain could be attributed to the program being relatively new, as similar results were found by Greenwood et al. (2013) when comparing older, more established programs to those that were more recently implemented.

The domain of housing choice and structure is one where The Program scored lower than other programs that used that same assessment scale. The Program's score of 3.25 on housing choice and structure is lower than the scores from the Windsor program, 3.90 (Tsemberis et al., 2016), and from the five At Home/Chez Soi sites, averaged to 3.59 (Nelson et al., 2014). This can be attributed to lower scores in housing availability and housing affordability due to the challenging housing market within which The Program operates. This is evidenced by the very low vacancy rate in The Region and the fact that those units that are available can be unaffordable for program participants ('City', 2020; CMHC, 2019). The other programs assessed in Ottawa and Dublin, Ireland, used a different version of the fidelity scale for their assessments that, while very similar to the other four domains, differed more substantially for this domain and thus were not directly comparable.

The Program is guided by principles of Housing First (HF) and adds an intensive home-based support component to help participants maintain housing as they work to recover from their experience of homelessness. Several theories are present in the work being done in The Program including empowerment (Keys et al., 2017), social support (Turner & Turner, 2016), and community integration (Wong & Solomon, 2002). Each of these theories are applied in different aspects of The Program and are tied to the fidelity scale used to assess the program. When reviewed in conjunction with results from studies that have assessed program fidelity specifically, these help to determine some of the strengths and areas for improvement that can be pursued by The Program.

Empowerment is a theory that is highly relevant for The Program and that is reflected in the fidelity scale used for this study. Keys et al. (2017) describe several layers of empowerment, from the individual to the organization and the community. This program focuses their work on the individual but with the underlying assumption that this will empower the organization and the community thereafter. Fidelity items relating to building empowerment for participants are found in every domain of the fidelity scale, emphasizing the link between the Housing First model and empowerment. Good scores on items for housing choice and commitment to re-house indicate that The Program ensures participants have a voice in their housing decisions and that, if they have difficulty retaining their housing, the program will continue to work to find more housing for them. The item for participant self-determination and independence centres participant choice in determining the next step in their recovery and the links the program can make to support programs (psychiatric and substance use programs being items on the scale) ensures that when a participant is ready, those services are available to them. The ability of a program to link to appropriate support services in the community is also something that has been

identified as being a factor that contributes to building a high-fidelity program (Macnaughton et al., 2015). Other items that relate to building empowerment for program participants include having a peer specialist on staff, as this can serve as an example of recovery for participants (Repper & Carter, 2011), and building skills to live independently. All of these are items that The Program scored well on in the fidelity assessment and speaks to the work being done by the program to empower their participants throughout their engagement with the program.

Some items that relate to building empowerment that did not score well reflect areas where The Program needs to make improvements. The availability of housing, scoring 1 on the fidelity scale, is something that challenges the program's ability to find suitable housing and to expand their participant capacity. This is, in large part, outside of the program's control as the tight housing market in The Region, described earlier, means there are few available housing options the program can utilize, while those that are available can be prohibitively priced for program participants ('City', 2020). This impacts those who are waiting to enter the program as the longer it takes for the program to find additional housing units, the longer individuals remain on the waitlist to enter the program. The program is engaging in several strategies to find additional housing, including developing a relationship with landlords; however, housing availability remains a persistent obstacle to helping participants.

Other items that affect the program's ability to empower its participants are the lack of connections to employment and educational services and the lack of participant representation in the program. In not having more developed connections to employment and education services that could help participants recover from their experiences of homelessness, the program overlooks a significant area that can promote life stability and personal growth for participants. The program could utilize the existing employment and educational services offered by the host

organization however, at this time in the program's implementation, the program has been more focused on helping participants find and maintain housing and is yet to offer those services. Alternatively, the program could connect with other community resources to provide this service to participants. Missing community partnerships have been identified as a factor that can hinder fidelity to the HF model (Macnaughton et al., 2015; Nelson et al., 2014). By not having participant representation in the program, participants are unable to use their lived experience to help guide program implementation or affect decisions that pertain to their care. Gilmer et al. (2014) demonstrated that programs that achieve high-fidelity often have a significant amount of participant input, and while participants still have choice in housing and services as part of The Program, this additional avenue of input can help improve program design and empower participants.

Social support is the presence and content of personal relationships, and consists of emotional, material and guidance support (Saegert & Capriano, 2017; Turner & Turner, 2016). Though the relationship in the context of this program is between program staff and participant, social support remains a key driver of the work being done to help individuals recover from their experience of homelessness and is evidenced by the addition of the home-based support roles. Social support and supportive engagement by direct service providers have been found to help people with mental illness as they recover from an experience of homelessness (Kerman et al., 2019; Kerman & Sylvestre, 2020). The fidelity results suggest this is something the program does very well with the majority of items relating to this factor scoring quite highly. Items from the service philosophy domain such as assertive engagement, interventions that target a broad range of life goals and utilizing a harm reduction approach all received a score of 4 and all speak to the program's focus on providing different forms of guidance for participants. By providing

recovery options that are tailored to the individual participants and ensuring staff are able to work with participants in any stage of recovery, the program ensures that the emotional and guidance support are continually offered. From the service array domain, the items of housing support, involvement in in-patient treatment and providing medical and psychiatric services all scored 4 out of 4 on the scale. These items reflect the breadth of support available to program participants, from a person's relationship with their landlord, to their support through hospital treatment, or to any physical or mental health concerns they may have.

The content of personal relationships relates to the functional support between staff and participant (Saegert & Capriano, 2017) which is evident given the varied means of support participants have access to. In the program structure and support and skills development domains, the items that demonstrate strong social support include contact with participants, participant self-awareness and promotion of participant self-management. Ensuring consistent contact with participants maintains the presence of the social relationship whereas having staff advocate for participant self-awareness and promoting participant self-management ensures the content of the relationship provides guidance and emotional support. Finally, although it is not a fidelity scale item, material support is given or facilitated by The Program to participants, in the form of rent assistance and food support, among other forms.

The fidelity items that relate to social support that did not score well include service continuation through housing loss and 24-hour coverage. Service continuation through housing loss occurs for participants that have lost their housing for greater than 30 days and results in their primary worker changing from being a home-based support worker, to returning to a housing liaison. The distinction being that a housing liaison will help this participant find new housing whereas the home-based support worker helps participants manage their housing. The

challenge arises when a participant has built a relationship with the home-based support worker and, after eviction lasting greater than a month, is no longer able to work with that individual until they are housed again. Though the housing liaison does provide support, it is not the same level or depth of support provided by a home-based support worker, which can leave participants feeling unsupported at a time when they might be feeling more vulnerable. This could also lead to the participant returning to homelessness, which can have a significant detrimental effect on a participant's recovery. The lack of transitional or alternative housing for participants in this situation challenges the program's ability to remain in consistent contact with them or maintain any progress the participant may have made in the program already. The lack of available affordable housing further complicates these matters and could make the rehousing process last for an extended period of time. The change of worker is outlined by the program frameworks and helps to ensure participants remain in The Program's system of care, however more should be done to support these individuals and not risk the housing stability of the participant or the relationship built between them and their worker.

The other item that did not score well was 24-hour coverage. The program staff operate on a traditional work schedule, that is Monday to Friday, typically between 9am and 5pm. Several participants spoke about the challenges they face in evenings and weekends, when their worker is not able to be reached and they are experiencing some kind of distress. The program has been giving participants the contact information for a local 24-hour mental health support helpline that they can call to receive support or they can go to the hospital for care. Participants spoke about not wanting to call the helpline for mental health support as they do not trust they will receive the help they need. The inability for participants to contact their workers at vulnerable times is something that hinders the program's ability to support their participants

fully. The program maintains this process of referring to the helpline as they were originally set-up to broker services between themselves and community supports when they would be unable or unequipped to support their participants. Using a hotline to provide crisis support is something used by other programs as well, resulting in similar low scores for this fidelity item (Kertesz et al., 2017; Tsemberis et al., 2016). Though it is not reasonable to expect staff to be on-call for 24-hours a day, some form of program support could be beneficial during non-traditional hours to ensure participants have someone to turn to from a program they trust, that may be able to help them get the support they need. This could be in the form of a central resource center that is available throughout the night, as one Veteran's Affairs HF site in the U.S. has done (Kertesz et al., 2017), or a rotating on-call schedule for staff to provide after-hours support, as suggested in a fidelity assessment done in Windsor, Ontario (Tsemberis et al., 2016).

Community integration is another concept that is evident in The Program as it works to help reintegrate people with an experience of homelessness back into the community. Community integration refers to building and maintaining physical, social, and psychological connections to the community and are mediated by personal and local contexts (Wong & Solomon, 2002). This theory reflects several fidelity items that The Program scored well on. Integrated housing is one item that is integral to the HF model and ensures participants are placed into housing that is not differentiated from the mainstream housing around it, thus normalizing their housing. In that way, it can help participants avoid stigma that people may have regarding those with an experience of homelessness and it ensures the same access to the community as their neighbours enjoy, which works to build physical connections. The item for mobile services also scored well, indicating that participants are able to meet their worker out in the community, rather than at the host organization's head office. This helps to build their

physical and psychological connections to their community by spending meaningful time in their home space or out in public. This small but important act of travelling to the participant further normalizes the participant's housing and communicates a level of active support for participants that can help build psychological connections.

Community integration is further aided by the work of the program to build social integration, an item that scored a 3 in the fidelity assessment. This score represents that the program fully provides two or partially provides three of the following: help participants develop social networks; help participants develop social abilities; and facilitate participation in social venues (Stefancic et al., 2013). In providing these services, The Program emphasizes the social connections that are integral to community integration and that can increase social interactions and help individuals establish membership in their new communities. That the score for this item was not higher indicates that some work needs to be done to further develop this aspect of participant support. One other item that relates to program goals of helping participants re-integrate into the community is the connections to community resources item under the support and skills development domain. This item, specifically related to the home-based support component of the program, ensures a focus for workers on building connections for participants to community resources that meet and exceed their needs. This support can range from helping participants get food or clothing, to furnishing their new homes, to seeking out mental health supports or community support groups. The home-based support adaptation emphasizes community integration by building community partnerships to help support their participants, which is a factor identified as common to high-fidelity programs (Macnaughton et al., 2015).

Other items that indicate areas where the program could improve include motivational interviewing, weekly meeting and case review, and the use of trauma-informed care. Both

motivational interviewing and trauma-informed care received a score of 3 in the fidelity assessment. This indicates that these practices are not lacking significantly in any way but rather, as was confirmed in feedback sessions by program leaders, that the staff employing these techniques could use additional training on their use in order to deliver them effectively. Regarding the weekly meeting and case review item which scored 2, the research team felt that further detail should be discussed regarding each participant at these staff meetings. This could serve to better inform staff of the unique challenges and successes that participants are experiencing and ensure the program is sufficiently updated to provide a high-level of individualized participant support.

The ability of a program to implement properly and achieve its desired outcomes is always going to be mediated by the context in which that program is operating (Chen, 2005). A significant barrier mentioned by both program staff and participants was the tight housing market in The Region. As The Region undergoes gentrification and large technology companies continue to grow their local operations, the competition for housing has increased dramatically (Bueckert, 2017; Davis, 2019). Affordability and vacancy are very low in The Region which affects The Program's ability to house participants and effectively decrease the proportion of the population experiencing homelessness ('City', 2020; CMHC, 2019). This is a commonly encountered challenge by HF programs worldwide, from other regions in Canada to programs operating in the U.S. and Europe (Bernard, 2018; Greenwood et al., 2013; Kertesz et al., 2017; Manning et al., 2018; Nelson et al., 2014; Samosh et al., 2018). The widespread nature of this challenge is evidence of a challenge to the HF model itself, as housing availability is a key component. Several programs have cited some successes in navigating this challenge, with a HF program in Portugal building strong relationships with landlords to ensure adequate access to

housing (Greenwood et al., 2013) or a program in Spain using head-leasing strategies (where the service organization is the primary signatory on the lease, rather than the participant) to secure housing for participants (Bernard, 2018). The Program has developed strategies to engage landlords and continues to work to secure housing.

The Program is also constrained by the capacity of current Regionally-owned alternative housing stock, such as supportive or transitional housing ('City', 2020). When a program participant loses their housing, this kind of housing stock serves as an option outside of securing new housing units and can be a more suitable place for those with higher immediate support needs. However, the current alternative housing system in The Region has very little space available for new tenants, with a majority of people (79%) remaining in supportive housing for over a year ('City', 2020). This further contributes to the issue of rehousing participants and remains a barrier for the program that could lead to people returning to homelessness after having been evicted from housing found through the program.

Limitations

A limitation of the research design is that a representative sample was not recruited. The nature of the assessment and the time constraints of having all data collection taking place on one day limits the prospective pool of participants to those that are reasonably independent and able to participate without much support. This resulted in a sample that is not generalizable to the population of program participants as those with more severe mental health or addictions issues were not recruited. Further, the use of convenience sampling undertaken by the program itself could also have led to a biased sample, with the possibility that participants do not represent the full spectrum of views for the population of program participants. Reactivity bias could have been present during the team observation meeting, as the research team's presence could have influenced the behaviour of program staff at the meeting. Though the research team tried not to

disturb the regular meeting process and flow, there were times where clarification was needed and thus asked for, further asserting our presence in the meeting. Ideally our presence did not influence the actions of staff or content of the meeting however we cannot be sure. The focus group method used may not have allowed program participants to provide as much detailed information as they may have wanted to about the program as the group setting can limit explanations and time for individuals to speak. Additionally, the semi-structured interview and fidelity-focused interviews may not have allowed room for program staff and leaders to elaborate on aspects of the program, unrelated to fidelity or implementation, that they enjoy or do not enjoy and thus may have left participants with feelings of not being fully heard or their full perspective valued. This was mitigated in part, in the latter stages of research, as this project was a part of a larger program evaluation where participants were able to voice opinions and experiences with the program in individual interviews. The one-day site visit design could also have limited the depth and scope of data we were able to collect due to the inherent time constraints. Utilizing a sequential mixed-methods design with multiple days for data collection would have provided more time for interviews and focus groups and may have yielded further information about program strengths and weaknesses. The domain and questions added to the fidelity scale by the research team to assess the home-based support component of the program also presents a limitation as it was an exploratory undertaking with a specific focus on this particular program's adaptation. The new items were not tested for validity or reliability and may have had cross-over in topics with other scale items (e.g. connections to community resources). Our inability to conduct a member check about our findings with service providers or program participants is also a limitation as those groups could have provided valuable and varied feedback from program leaders. One other limitation is that this is a process evaluation and as

such, does not provide information regarding program effectiveness. Though results do reflect areas where the program could make improvements, they focus on implementation and do not reflect outcomes being realized by the program.

Conclusion and Recommendations

This fidelity assessment has proven valuable in identifying aspects of The Program that have been implemented well and those that need improvement. With respect to the HF model, The Program is being implemented well overall. Certain elements under each HF domain need improvement but the program has been successful in implementing the program as designed, within the constraints of the local housing context.

The home-based support aspect of the program has been well implemented, with program participants regularly identifying the support from their case workers as important to their success in the program. With regards to the frameworks that were written to guide the implementation of the home-based support component of the program, the host organization has been successful at implementing the home-based support framework and in keeping with its goals.

In order to provide useful feedback to the program, several recommendations have come out of the fidelity assessment for The Program to inform improvements in program implementation. These recommendations are:

- Continued support from the home-based support worker for program participants from The Program during housing loss and support in re-housing when housing is lost due to eviction or other circumstances
- Continue to work with the regional government to explore additional supportive and transitional housing resources

- More training of staff in motivational interviewing to better support program participants in setting and achieving goals
- Increased program coverage, and/or access to staff for program participants after-hours and during weekends (e.g. alternating after-hours staff coverage or extended hours resource centre)
- A greater focus on employment and education supports of program participants
- More detailed updates on participant progress in the program during team meetings to facilitate program participant support
- Greater involvement and representation of program participants in program planning and implementation
- More trauma-informed care training for all staff to facilitate greater adoption of trauma-informed care practices in the program

While these recommendations have come directly out of the fidelity assessment, we recognize the context within which the program operates. Implementing some of these recommendations requires more funding and resources, while others require re-examining the way The Program works alongside other service system partners. In making these recommendations, it is the sincere hope of the research team that The Program can continue to grow and learn from this work to ensure program improvements occur that better the outcomes for program participants as well as the broader community in The Region.

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Appendix A: TCPS-2 Certificate

PANEL ON RESEARCH ETHICS
Navigating the ethics of human research

TCPS 2: CORE

Certificate of Completion

This document certifies that

Steven Bigioni

has completed the Tri-Council Policy Statement:
Ethical Conduct for Research Involving Humans
Course on Research Ethics (TCPS 2: CORE)

Date of Issue: **30 August, 2017**

Appendix B: Adapted fidelity scale for evaluation of The Program

Name:	**Position:**		**Amount of time at agency:**		
Item	Criterion	1	2	3	4
HOUSING CHOICE & STRUCTURE: The first set of questions focus on housing choice, the process of moving into housing, and type of housing available to program participants.					
1.	**Housing Choice.** To what extent do program participants choose the location and other features of their housing?	Participants have no choice in the location, decorating, furnishing, or other features of their housing and are assigned a unit.	Participants have little choice in location, decorating, and furnishing, and other features of their housing.	Participants have some choice in location, decorating, furnishing, and other features of their housing.	Participants have much choice in location, decorating, furnishing, and other features of their housing.
2a.	**Housing Availability (*Intake to move-in)*.** To what extent does the program help participants move quickly into units of their choosing? How long does it take on average?	Less than 55% of program participants move into a unit of their choosing within 4 months of entering the program.	55-69% of program participants move into a unit of their choosing within 4 months of entering the program.	70-84% of program participants move into a unit of their choosing within 4 months of entering the program.	85% of program participants move into a unit of their choosing within 4 months of entering the program.
2b.	**Housing Availability (*Voucher/subsidy availability to move-in)*.** To what extent does the program help participants move quickly into units of their choosing? How long does it take on average?	Less than 55% of program participants move into a unit of their choosing within 6 weeks of having a housing subsidy or receiving a voucher.	55-69% of program participants move into a unit of their choosing within 6 weeks of having a housing subsidy or receiving a voucher.	70-84% of program participants move into a unit of their choosing within 6 weeks of having a housing subsidy or receiving a voucher.	85% of program participants move into a unit of their choosing within 6 weeks of having a housing subsidy or receiving a voucher.
3.	**Permanent Housing Tenure.** What is the extent to which housing tenure is assumed to be permanent with no	There are rigid time limits on the length of stay in housing such that participants are	There are standardized time limits on housing tenure, such that participants are expected	There are individualized time limits on housing tenure, such that participants can stay as	There are no expected time limits on housing tenure, although the lease

	actual or expected time limits, other than those defined under a standard lease or occupancy agreement?	expected to move by a certain date or the housing is considered emergency, short-term, or transitional.	to move when standardized criteria are met.	long as necessary, but are expected to move when certain criteria are met.	agreement may need to be renewed periodically.
4.	**Affordable Housing.** On average, what % of a participant's income is used to cover housing costs?	Participants pay 61% or more of their income for housing costs.	Participants pay 46-60% or less of their income for housing costs.	Participants pay 31-45% or less of their income for housing costs.	Participants pay 30% or less of their income for housing costs.
5.	**Integrated Housing *(Urban programs)*.** To what extent do program participants live in scatter-site private market housing which is otherwise available to people without psychiatric or other disabilities.	Participants do not live in private market housing, access is determined by disability and 100% of the units in a building are leased by the program.	Participants live in private market housing where access may or may not be determined by disability, and more than 40% of the units in a building are leased by the program.	Participants live in private market housing where access is not determined by disability and 21-40% of the units in a building are leased by the program.	Participants live in private market housing where access is not determined by disability and less than 20% of the units in a building are leased by the program.
6.	**Privacy.** To what extent are program participants expected to share living spaces, such as bathroom, kitchen, or dining room with other tenants?	Participants are expected to share all living areas with other tenants, including a bedroom.	Participants have their own bedroom, but are expected to share living areas such as bathroom, kitchen, dining room, and living room with other tenants.	Participants have their own bedroom and bathroom, but are expected to share living areas such as a kitchen, dining room, and living room with other tenants.	Participants are not expected to share any living areas with other tenants.
SEPARATION OF HOUSING & SERVICES: The next set of questions focus on conditions program participants need to meet to become housed and the process for assisting participants when they lose their housing.					
7.	**No Housing Readiness.** To what extent are program participants "required" to demonstrate being abstinent from substance use or having some stability in terms of mental health	Participants have access to housing only if they have successfully completed a period of time in transitional housing or outpatient/inpatient/residential treatment.	Participants have access to housing only if they meet many readiness requirements such as sobriety, abstinence from drugs, medication compliance, symptom stability, or no history of	Participants have access to housing with minimal readiness requirements, such as willingness to comply with program rules or a treatment plan that addresses sobriety,	Participants have access to housing with no requirements to demonstrate readiness, other than agreeing to meet with staff face-to-face once a week.

	symptoms to gain access to housing units?		violent behavior or involvement in the criminal justice system.	abstinence, and medication compliance.	
8.	**No Program Contingencies of Tenancy.** To what extent is continued tenancy linked to participating in clinical services or receiving treatment or social services?	Participants can keep housing only by meeting many requirements for continued tenancy, such as sobriety, abstinence from drugs, medication compliance, symptom stability, no violent behavior, or involvement in the criminal justice system.	Participants can keep housing with some requirements for continued tenancy, such as participation in formal services or treatment activities (attending groups, seeing a psychiatrist).	Participants can keep housing with minimal requirements for continued tenancy such as compliance with their treatment plan and meeting individual clinical or behavioral standards.	Participants can keep their housing with no requirements for continued tenancy, other than adhering to a standard lease and seeing staff for a face-to-face visit once a week.
9.	**Standard Tenant Agreement.** To what extent do program participants have the same type of legal rights as other tenants in Ontario? Are there any special provisions added to the lease or occupancy agreement?	Participants have no written agreement specifying the rights and responsibilities of tenancy and have no legal recourse if asked to leave their housing.	Participants have a written agreement (such as a lease or occupancy agreement) which specifies the rights and responsibilities of tenancy, but contains special provisions regarding adherence to clinical provisions (e.g., medication compliance, sobriety, treatment plan).	Participants have a written agreement (such as a lease or occupancy agreement) which specifies the rights and responsibilities of tenancy, but contains special provisions regarding adherence to program rules (e.g., requirements for being in housing at certain times, no overnight visitors).	Participants have a written agreement (such as a lease or occupancy agreement) which specifies the rights and responsibilities of typical tenants in the community and contains no special provisions other than agreeing to meet with staff face-to-face once a week.
10.	**Commitment to Re-House.** To what extent do program participants need to demonstrate housing readiness before they can access new housing after	Program does not offer participants who have lost their housing a new housing unit nor assist with finding housing outside the program.	Program does not offer participants who have lost housing a new unit, but assists them to find housing outside the program.	Program offers participants who have lost their housing a new unit, but only if they meet readiness requirements, complete a period of time in more	Program offers participants who have lost their housing a new unit. Decisions to re-house participants are 1) individualized, 2) consumer-driven, 3)

	having lost their original housing?			supervised housing, or the program has set limits on the number of relocations.	minimize conditions that participants need to fulfill prior to receiving a new unit, 4) safeguard participant well-being, and 5) there are no universal limits on the number of possible relocations.
11.	**Services Continue Through Housing Loss.** To what extent to do program participants continue receiving services from the program even if they lose their housing?	Participants are discharged from program services if they lose housing for any reason. (Services are contingent on staying in housing)	Participants are discharged from services if they lose housing, but there are explicit criteria specifying options for re-enrollment, such as completing a period of time in inpatient treatment.	Participants continue to receive program services if they lose housing, but may be discharged if they do not meet "housing readiness" criteria.	Participants continue to receive program services even if they lose housing due to eviction, short-term inpatient treatment, although there may be a service hiatus during institutional stays.
12a.	**Off-site Services.** To what extent do case managers provide services in location at participants' choice?	Social and clinical service providers are based on-site 24/7.	Social and clinical service providers are based on-site during the day.	Social and clinical service providers are based off-site, but maintain an office on-site.	Social and clinical service providers are based off-site and do not maintain any offices on-site.
12b.	**Mobile services.** To what extent do case managers provide services in location at participants' choice?	The program has no mobility to deliver services at locations of participants' choosing.	The program has limited mobility to deliver services at locations of participants' choosing.	The program is generally capable of providing mobile services to locations of participants' choosing.	The program is extremely mobile and fully capable of providing services to locations of participants' choosing.
SERVICE PHILOSOPHY: The next set of questions will focus on the philosophy and values guiding the delivery of services in the program.					

13.	**Service choice.** To what extent do program participants choose the type, sequence, and intensity of services they receive? How much does a case manager determine the services?	Services are chosen by the service provider with no input from the participant.	Participants have little say in choosing, modifying, or refusing services.	Participants have some say in choosing, modifying, or refusing services and supports.	Participants have the right to choose, modify, or refuse services and supports at any time, except one face-to-face visit with staff a week.
14.	**No requirements for participation in psychiatric treatment.** To what extent does the program require participants with psychiatric disabilities to take medication or participate in psychiatric treatment?	All participants with psychiatric disabilities are required to take medication and participate in psychiatric treatment.	Participants with psychiatric disabilities are required to participate in mental health treatment such as attending groups or seeing a psychiatrist and are required to take medication but exceptions are made.	Participants with psychiatric disabilities who have not achieved a specified period of symptom stability are required to participate in mental health treatment, such as attending groups or seeing a psychiatrist.	Participants with psychiatric disabilities are not required to take medication or participate in formal treatment activities.
15.	**No requirements for participation in substance use treatment.** To what extent are participants with substance use disorders required to participate in treatment?	All participants with substance use disorders, regardless of current use or abstinence, are required to participate in substance use treatment (e.g., inpatient treatment, attend groups or counseling with a substance use specialist).	Participants who are using substances or who have not achieved a specified period of abstinence must participate in substance use treatment.	Participants with substance use disorders whose use has surpassed a threshold of severity must participate in substance use treatment.	Participants with substance use disorders are not required to participate in substance use treatment.
16.	**Harm Reduction Approach.** To what extent does the program utilize a harm reduction approach to substance use?	Participants are required to abstain from alcohol and/or drugs at all times and lose rights, privileges, or services if	Participants are required to abstain from alcohol and/or drugs while they are on-site in their residence or participants	Participants are not required to abstain from alcohol and/or drugs, but staff work with participants to achieve	Participants are not required to abstain from alcohol and/or drugs and staff work consistently with participants to

		abstinence is not maintained.	lose rights, privileges, or other services if abstinence is not maintained.	abstinence not recognizing other alternatives that reduce harm OR staff do not consistently work to reduce the negative consequences of use.	reduce the negative consequences of use according to principles of harm reduction.
17.	**Motivational Interviewing.** To what extent do program staff use motivational interviewing in their interactions with program participants? Have program staff received training in motivational interviewing?	Program staff are not at all familiar with principles of motivational interviewing.	Program staff are somewhat familiar with principles of motivational interviewing.	Program staff are very familiar with principles of motivational interviewing, but it is not used consistently in daily practice.	Program staff are very familiar with principles of motivational interviewing and it is used consistently in daily practice.
18.	**Active Engagement.** To what extent does the program use techniques to engage difficult-to-treat participants such as motivational interventions, therapeutic limit-setting, and assertive engagement? Motivational interventions to engage participants? Therapeutic limit-setting as necessary? Assertive engagement if there is concerns about the well-being of the participant?	Program does not use strategies of assertive engagement.	Program uses very few assertive engagement strategies.	Program is less systematic in its use of a variety of individualized assertive engagement strategies OR does not systematically identify and evaluate the need for various types of strategies.	Program systematically uses a variety of individualized assertive engagement strategies and systematically identifies and evaluates the need for various types of strategies.
19	**Absence of Coercion.**	Program routinely uses coercive activities with	Program sometimes uses coercive activities with	Program sometimes uses coercive activities with	Program does not use coercive activities such as

	To what extent does the program engage in coercive activities towards participants to promote adherence to clinical provisions or engage in excessive surveillance of participants?	participants such as leveraging housing or services to promote adherence to clinical provisions or having excessive intrusive surveillance of participants.	participants and there is no acknowledgement that these practices conflict with participant autonomy and principles of recovery.	participants, but staff acknowledge that these practices may conflict with participant autonomy and principles of recovery.	leveraging housing or services to promote adherence to clinical provisions or having excessive intrusive surveillance with participants.
20	**Person-Centered Planning.** To what extent does the program engage in person-centered planning with participants that includes: 1) the development of treatment plans based on participant's goals and preferences, 2) conducting regularly scheduled treatment planning meetings with participants, and 3) engaging in practices focusing on strengths and resources identified in the treatment plan?	Program does not conduct person-centered planning.	Treatment/service planning FULLY meets 1 service or PARTIALLY meets 2.	Treatment/service planning FULLY meets 2 services or PARTIALLY meets all 3.	Treatment/service planning FULLY meets ALL 3 services.
21	**Interventions Target a Broad Range of Life Goals.** To what extent does the program systematically deliver or broker services that address a range of life areas (e.g., physical health, employment, education, housing satisfaction, social	Interventions do not target a range of life areas.	Program is not systematic in delivering interventions that target a range of life areas.	Program delivers interventions that target a range of life areas but in a less systematic manner. (range exists across the program but less diversity of areas among participants).	Program systematically delivers interventions that target a range of life areas. (range exists across the program and among participants).

	support, spirituality, recreation & leisure, etc.)?				
22	**Participant Self-Determination and Independence.** To what extent does the program increase participants' independence and self-determination by giving them choices and honouring day-to-day choices as much as possible?	Program directs participants decisions and manages day-to-day activities to a great extent that clearly undermines promoting participant self-determination and independence OR program does not actively work with participants to enhance self-determination, nor do they provide monitoring or supervision.	Program provides a high level of supervision and participants' day-to-day choices are constrained.	Program generally promotes participants' self-determination and independence.	Program is a strong advocate for participants' self-determination and independence in day-to-day activities.
SERVICE ARRAY: The next set of questions focus on the types of services that are made available to participants through the program.					
23.	**Housing Support.** To what extent does the program offer services to help participants maintain housing, such as offering assistance with neighbourhood orientation, landlord relations, budgeting and shopping?	Program does not offer any housing support services.	Program offers some housing support services during move-in, such as neighborhood orientation, shopping, but no follow-up or ongoing services are available.	Program offers some ongoing housing support services including assistance with neighborhood orientation, landlord relations, budgeting, and shopping but does not offer any property management services, assistance with rent payment, and co-signing of leases.	Program offers both assistance with move-in and ongoing housing support services including assistance with neighborhood orientation, landlord/neighbor relations, budgeting, shopping, property management services, assistance with rent payment/subsidy

					assistance, utility setup, and co-signing of leases.
24.	**Psychiatric Services**. What % of program participants who need psychiatric services are linked to a psychiatrist in the community?	Program successfully links less than 54% of participants who need psychiatric support with a psychiatrist.	Program successfully links 55-69% of participants who need psychiatric support with a psychiatrist.	Program successfully links less than 70-84% of participants who need psychiatric support with a psychiatrist.	Program successfully links 85% or more of participants who need psychiatric support with a psychiatrist.
25.	**Substance Use Treatment.** What % of program participants who need substance use treatment are successfully linked to these services in the community?	Program successfully links less than 54% of participants in need of substance abuse treatment with agencies that provide such treatment.	Program successfully links less than 55-69% of participants in need of substance abuse treatment with agencies that provide such treatment.	Program successfully links less than 70-844% of participants in need of substance abuse treatment with agencies that provide such treatment.	Program successfully links 85% or more of participants in need of substance abuse treatment with agencies that provide such treatment.
26.	**Employment & Educational Services.** To what extent are supported employment services available through or brokered by the program? Which services are made available to program participants? (1) engagement and vocational assessment; (2) rapid job search and placement based on participants' preferences (including going back to school, classes); & (3) job coaching & (4) follow-along	Program FULLY meets less than 2 criteria.	Program FULLY meets 2 criteria or PARTIALLY meets 3.	Program FULLY meets 3 criteria or PARTIALLY meets all 4.	Program FULLY meets ALL 4 criteria for brokering employment & educational services (see under definition).

	supports (including supports in academic settings).				
27.	**Nursing/Medical Services.** What % of program participants who need medical care get linked with a physician or clinic in the community? (documentation clearly evidences participant received services or program routinely attempted engagement within the last 6 months).	Program successfully links less than 55% of participants who need medical care with a physician or clinic.	Program successfully links 55-69% of participants who need medical care with a physician or clinic.	Program successfully links less than 70-84% of participants who need medical care with a physician or clinic.	Program successfully links 85% or more of participants who need medical care with a physician or clinic.
28.	**Social Integration.** What % of program participants receiving services from the program that focus on social integration? These services can include: (1) Facilitating access to and helping participants develop social networks within and outside the program, (2) helping participants develop social abilities to successfully negotiate social relationships, and (3) facilitating participation in social and political venues?	Program does not provide any social integration services.	Program FULLY provides 1 service or PARTIALLY provides 2.	Program FULLY provides 2 services, or PARTIALLY provides all 3.	Program FULLY provides all 3 services (see under definition)
29.	**24-hour Coverage.** To what extent does the program respond to	Program has no responsibility for handling crises after	Program does not respond during off-hours by phone, but links	Program responds during off-hours by phone, but less than 24 hours a day,	Program responds 24-hours a day by phone directly and links

	psychiatric or other crises 24-hours a day? How does the program respond when a participant experiences a crisis after hours?	hours and offers no linkages to emergency services.	participants to emergency services for coverage.	and links participants to emergency services as necessary.	participants to emergency services as necessary.
30.	**Involved in In-Patient Treatment.** To what extent is the program involved when a participant is hospitalized and works with inpatient staff to ensure proper discharge? What % of participants experience this kind of continued program involvement when they are hospitalized?	Program is involved in less than 55% of inpatient admissions and discharges.	Program is involved in 55-69% of inpatient admissions and discharges.	Program is involved in 70-84% of inpatient admissions and discharges.	Program is involved in 85% or more of inpatient admissions and discharges.
PROGRAM STRUCTURE: The last set of questions focuses on the structure and management of the program.					
31.	**Priority Enrolment for Individuals with Obstacles to Housing Stability.** To what extent does the program prioritize enrollment for individuals who experience multiple obstacles to housing stability? What are the criteria for prioritization?	Program has many rigid participant exclusion criteria such as substance use, symptomatology, criminal justice involvement, and behavioral difficulties, and there are no exceptions made.	Program has many participant exclusion criteria such as substance use, symptomatology, criminal justice involvement, and behavioral difficulties, but exceptions are possible.	Program selects participants with multiple disabling conditions, but has some minimal exclusion criteria.	Program selects participants who fulfill criteria of multiple disabling conditions including 1) homelessness, 2) severe mental illness, and 3) substance use.
32.	**Contact with Participants.** What is the minimum amount of contact per month for participants with case managers? What % of	Program meets with less than 70% of participants 3 times a month face-to-face.	Program meets with 70-79% of participants 3 times a month face-to-face.	Program meets with 80-89% of participants at least 3 times a month face-to-face.	Program meets with 90% of participants at least 3 times a month face-to-face.

	participants have this amount of contact?				
33.	**Low Participant/Staff Ratio.** What is the participant/staff ratio for the program?	50 or more participants per 1 FTE staff.	36-49 participants per 1 FTE staff.	21-35 participants per 1 FTE staff.	20 or fewer participants per 1 FTE staff.
34.	**Contact with Participants (Minimum Threshold).** To what extent the program has a minimal threshold of non-treatment related contact with participants?	Program meets with less than 60% of participants 3 times a month face-to-face.	Program meets with 69-74% of participants 3 times a month face-to-face.	Program meets with75-89% of participants 3 times a month face-to-face.	Program meets with 90% or more of participants 3 times a month face-to-face.
35.	**Frequent Meetings.** What is the frequency that program staff meets to plan and review services for each program participant?	Program meets less than once a month or does not meet as a team to plan and review services for program participants.	Program meets once a month.	Program meets 2-3 times a month.	Program meets at least 4 times a month (once a week).
36.	**Weekly Meeting/Case Review (Quality):** How frequent does the agency hold an organizational program meeting? What is the focus of these meetings? To what extent are the following the focus of these meetings: (1) Conduct a high level overview of each participant, where they are at and next steps, (2) a detailed review of participants who are not doing well in meeting their goals, (3) a review of one	Meeting serves 2 or fewer of the functions.	Meeting FULLY serves 2 of the functions, or PARTIALLY 3.	Meeting FULLY serves 3 of the functions or PARTIALLY all 4.	Weekly team meeting FULLY serves ALL 4 functions (see under definition).

	success from the past week, (4) program updates and discuss health and safety issues and strategies.				
37.	**Peer Specialist on Staff.** Does the program have one or more peer support workers on staff?	0.25 FTE to 0.49 FTE peer specialist who meets minimal qualifications.	0.50 FTE to 0.74 FTE peer specialist who meets minimal qualifications OR at least 1.0 FTE peer specialist with inadequate qualifications OR more than 2 peer specialists fill the 1.0 FTE.	0.75 FTE to 0.99 FTE peer specialist who meets minimal qualifications. No more than 2 Peer Specialists fill the 1.0 FTE.	At least 1.0 FTE peer specialist who meets minimal qualifications and has full professional status on the team. No more than 2 Peer Specialists fill the 1.0 FTE.
38.	**Participant Representation in Program.** To what extent are participants are involved in program operations and have input into policy? Is there a feedback mechanism for participants about the program? Are their opportunities for participant representation on any program committees?	Program does not offer any opportunities for participant input into the program (0 modalities).	Program offers few opportunities for participant input into the program (1 modality for input).	Program offers some opportunities for participant input into the program (2 modalities for input).	Program offers opportunities for participant input, including on committees, as peer advocates, and on governing bodies (3 modalities).
SUPPORT AND SKILLS DEVELOPMENT: The last set of questions will focus on particular skills and components specific to The Program.					
39.	**Connections to community resources.** To what extent are program participants being connected to relevant community resources?	Participants are not being connected to community resources.	Participants are being connected to enough community resources to meet some of their needs.	Participants are being connected to community resources that meet their needs.	Participants are being connected to community resources that meet and exceed their needs.

40.	**Participant self- awareness.** To what extent does the program promote participants' self-awareness about factors that contribute to homelessness.	Program does not promote participants self-awareness	Program promotes participants' self-awareness somewhat.	Program generally promotes participants' self-awareness.	Program is a strong advocate for participants' self-awareness.
41.	**Promotion of participant self-management.** To what extent does the program promote participants' self-management skills including control over housing, accountability and optimism in life.	Participants are not building any skills required to live independently.	Participants are building some of the skills required to live independently.	Participants are building several skills required to live independently.	Program is a strong advocate for participants' self-management skills.
42.	**Skills to live independently.** To what extent is the program helping participants build skills to live independently?	Participants are not building any skills required to live independently.	Participants are building some of the skills required to live independently.	Participants are building several skills required to live independently.	Participants are building the majority of skills necessary to live independently.
43.	**Training availability & accessibility.** With regards to training sessions on skills development, how often are these scheduled and how are they made accessible for participants?	Training sessions are scheduled infrequently and at times or locations that prevent the participants from attending.	Training sessions are scheduled regularly however they are at times or locations that prevent the participant from attending regularly.	Training sessions are scheduled regularly and they are at times and locations that allow the participant to attend regularly however program staff are not able to help with attendance when required.	Training sessions are frequently scheduled and are at times and locations that allow the participant to attend regularly, with program staff aid whenever necessary.
44.	**Trauma-informed care.** To what extent is the program trauma-informed in its design?	The program is not designed in a way that is trauma-informed.	The program has a few aspects that are designed in a way that is trauma-informed.	The program has many aspects that are designed in a way that is trauma-informed.	The program is designed in a way that is completely trauma-informed.