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

Coralie Buxant

Coordinator of the Housing First Belgium experiment – Federal Public Planning Service Social Integration.

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

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

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Introduction

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

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

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

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

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

The Housing First Belgium experiment

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

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

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

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

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

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

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

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

The place of HF in the fight against the homelessness paradigm

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

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

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

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

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

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

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

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

Description of the Housing First Belgium experiment

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

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

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

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

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

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

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

(e) The housing tenure is independent of the quality/frequency of the support relationship.

(f) Except if the person prefers another approach which better suits his/her profile. Because of their age and/or specific vulnerabilities, certain tenants of the Housing First Belgium experiment occupy a room in a nursing home or within the framework of a sheltered housing initiative. The recommended rationale is as follows: the housing must be best suited to the person in question AND the housing must be permanent.

(g) Either directly via an Assertive Community Treatment team (multidisciplinary team) or through external channels, via an Intensive Case Management team.

(h) Both these recommendations aim to promote the key role of housing in the social resettlement/integration process. However, considering the difficulty of access to housing, these recommendations must be put into context.

The eight HFB pioneer services participated in the fidelity assessment process undertaken in Belgium within the framework of the larger international fidelity study (Aubry *et al*., 2018). Six of the eight services use an Assertive Commitment Treatment model (teams include psychologist, nurse, social worker, specialist educator); moreover, two of them include a peer worker[1], one a doctor, and one a job coach. The other two services use an Intensive Case Management model. The caseload is six to eight clients per employee. At the time of data collection, the professionals had worked within the HF model for approximately one to two and a half years. Five of the services used a mix of public and private market housing units, while two of them used only public housing and one service used only private housing. Due to the short, fixed two-year duration of the experiment, 75 clients were housed very quickly in the first year across the first six sites (and mainly in the first six months) and 45 in the second year (with the 2 new sites involved later in the experimentation). Currently about 30% of new clients are housed every year.

1 At the time participants filled in the Fidelity Scale, only one HF support team was working with a peer.

Method

The fidelity assessment

Procedure and sample

The self-assessment survey used for the research consists of 37 items (Gilmer *et al*., 2013). Six to eight items assess fidelity in five domains: (1) *Housing Process and Structure,* (2) *Housing and Services*, (3) *Service Philosophy*, (4) *Service Array*, and (5) *Team Structure/Human Resources*. Thirty-six of these items are used to calculate an overall fidelity score and domain scores.

The coordinators of the five French-language teams read and commented on the original wording of each item. Translation was discussed with French speaking colleagues, which resulted in minor wording modifications. The same final version was used by the French programme *Un chez soi d'abord.* A professional translation was provided to the three Dutch-speaking HFB teams, based on the French and English versions.

The national coordinator of *Housing First Belgium* (and author of the present paper) conducted the research. The fidelity survey was completed individually in the summer of 2016. All team members of these eight teams participated (30 people). In each site, the team coordinator then conducted a consensus meeting to reach agreement on each item in the measure. Quantitative results were presented to them at a collective meeting (5 October 2016).

Interviews with site coordinators

A qualitative assessment phase was then conducted by the national coordinator by means of email exchanges and phone calls with each of the eight site coordinators (October 2016).

Data analysis

For the quantitative results, the agreed answers to the survey for each of the sites were scored using a grid provided by the research coordinators. The scores for each item were converted to a 4-point scale, in which scores of 2.9 or lower are considered low fidelity, scores between 3 and 3.4 are considered moderate fidelity and scores of 3.5 or higher are considered high fidelity (McNaughton *et al*., 2015). A total fidelity score and a score for each of the five fidelity domains was calculated. The national coordinator of *Housing First Belgium* then calculated the average scores for the eight sites.

For the qualitative results, the different elements identified in the discussions and email exchanges with the team coordinators and other team members were coded according to the agreed upon common analysis framework (Aubry *et al*., 2018). Initially, factors identified in the interviews were classified as facilitators or barriers

to HF fidelity. Subsequently, after this initial dichotomization, they were coded in terms of ecological level, namely as being either systemic-, organizational- or individual-level factors.

Results

Quantitative findings

Table 2 presents the individual item scores, average domain scores, and average total scores for the eight programmes. The average global score for the eight sites was 3.4. The *Housing and Services* and *Service Philosophy* domains nearly achieved the maximum possible scores (*Ms*=3.9 and 3.8 respectively). Moderate fidelity scores were obtained for the *Housing Process and Structure* (*M*=3.2), *Service Array* (*M*=3.4), and *Team Structure/Human Resources* (*M*=3.0) domains (Figure 1). Despite some exceptions, mainly due to different configurations in the services (availability of public housing for items 4 and 5; or the existence of a peer worker in item 28), a great deal of consistency was observed across the eight sites. The lowest average scores per item related to clients' participation in the services (item 37, M=1.1; item 28, M=1.4), the proportion of income required for the rent (item 5, M=2.1) and the frequency of staff meetings (item 35, M=2.5).

Figure 1. Average Housing First Fidelity Ratings by Domain (Mean rating for the 8 sites)

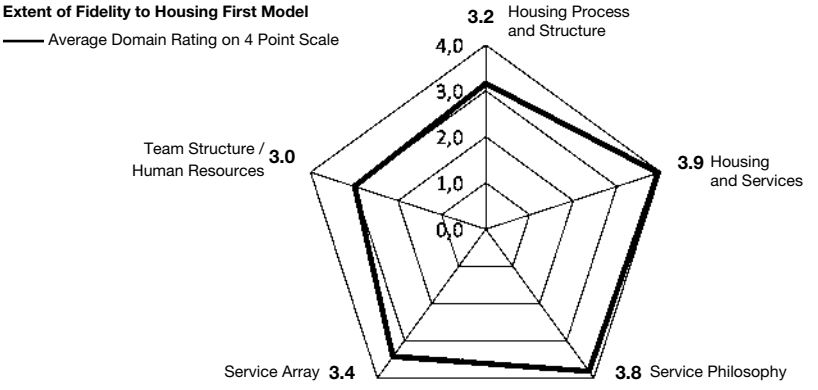

Table 2. Fidelity Assessment Item Scores and Domain Means per site and Average

Domain / Item	Domain Mean / Standard Item Score (Out of 4)								
	Site1	Site2	Site3	Site 4	Site 5	Site 6	Site 7	Site 8	Mean 8 sites (SD)
Housing Process and Structure	***3.1***	***3.6***	***2.7***	***3.3***	***3.9***	***3.0***	***3.0***	***2.7***	***3.2 (.42)***
1. Choice of housing	*3.0*	*3.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*3.8*
2. Choice of neighborhood	*4.0*	*3.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*3.9*
3. Assistance with furniture	*4.0*	*4.0*	*2.0*	*2.0*	*4.0*	*2.0*	*2.0*	*2.0*	*2.8*
4. Affordable housing with subsidies	*2.0*	*4.0*	*2.0*	*3.0*	*4.0*	*3.0*	*2.0*	*2.0*	*2.8*
5. Proportion of income required for rent	*4.0*	*4.0*	*1.0*	*2.0*	*3.0*	*1.0*	*1.0*	*1.0*	*2.1*
6. Time from enrolment to housing	*4.0*	*3.0*	*2.0*	*4.0*	*4.0*	*3.0*	*4.0*	*2.0*	*3.3*
7. Types of housing	*1.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*3.6*
Separation of Housing and Services	***4.0***	***3.7***	***3.9***	***4.0***	***4.0***	***4.0***	***4.0***	***4.0***	***3.9 (.11)***
8. Proportion of clients with shared bedrooms	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*
9. Requirements to gain access to housing	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*
10. Requirements to stay in housing	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*
11a. Lease or occupancy agreement	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*
11b. Provisions in the lease or agreement	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*
12. Effect of losing housing on client housing support	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*
13. Effect of losing housing on other client services	*4.0*	*2.0*	*3.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*3.6*
Service Philosophy	***3.6***	***3.7***	***3.9***	***3.9***	***3.9***	***3.8***	***3.9***	***3.7***	***3.8 (.12)***
14. Choice of services	*4.0*	*3.0*	*4.0*	*4.0*	*4.0*	*3.0*	*4.0*	*3.0*	*3.6*
15. Requirements for serious mental illness treatment	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*
16. Requirements for substance use treatment	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*
17. Approach to client substance use	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*
18. Promoting adherence to treatment plans	*3.5*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*3.5*	*3.9*
19. Elements of treatment plan and follow-up	*2.0*	*3.2*	*3.6*	*3.6*	*3.2*	*3.6*	*3.6*	*3.2*	*3.3*
20. Life areas addressed with program interventions	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*
Service Array	***3.4***	***3.5***	***3.3***	***3.3***	***3.9***	***3.4***	***3.4***	***3.3***	***3.4 (.19)***
21. Maintaining housing	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*
22. Psychiatric services	*3.0*	*4.0*	*3.0*	*3.0*	*4.0*	*4.0*	*4.0*	*3.0*	*3.5*
23. Substance use treatment	*2.4*	*3.2*	*2.4*	*2.4*	*3.2*	*2.4*	*2.4*	*2.4*	*2.6*

24. Paid employment opportunities	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*
25. Education services	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*
26. Volunteer opportunities	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*
27. Physical health treatment	*4.0*	*3.2*	*3.2*	*3.2*	*4.0*	*3.2*	*3.2*	*3.2*	*3.4*
28. Paid peer specialist on staff	*1.0*	*1.0*	*1.0*	*1.0*	*4.0*	*1.0*	*1.0*	*1.0*	*1.4*
29a. Social integration services	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*
Program Structure	***3.2***	***2.9***	***3.0***	***2.9***	***3.1***	***2.7***	***3.0***	***3.1***	***3.0 (.15)***
31. Client background	*3.3*	*3.3*	*4.0*	*3.3*	*3.3*	*2.7*	*3.3*	*4.0*	*3.4*
33. Staff-to-client ratio	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*
34b. Frequency of face-to-face contacts per month	*4.0*	*4.0*	*4.0*	*3.0*	*4.0*	*4.0*	*4.0*	*4.0*	*3.9*
35. Frequency of staff meetings to review services	*4.0*	*2.0*	*2.0*	*2.0*	*2.0*	*2.0*	*2.0*	*4.0*	*2.5*
36. Team meeting components	*2.7*	*2.7*	*2.7*	*4.0*	*4.0*	*2.7*	*4.0*	*2.0*	*3.1*
37. Opportunity for client input about the program	*1.3*	*1.3*	*1.3*	*1.3*	*1.3*	*0.7*	*0.7*	*0.7*	*1.1*
Total	***3.4***	***3.4***	***3.3***	***3.5***	***3.7***	***3.4***	***3.4***	***3.3***	***3.4 (.13)***

Qualitative findings

Systemic facilitators and barriers

Assistance with rental payments, (interest-free) loans for the rental deposit, and a (single) moving-in grant for any homeless person moving into accommodation from the street, were considered some of the types of public subsidies that facilitate access to housing for the most vulnerable people in Belgium. This help exists and is available independent from the HF programmes; as a result, it was thought to facilitate separation between housing and support that is promoted by the HF model.

However, these social benefits hide and try to compensate (all too often unsuccessfully) for the lack of investment in a more social housing policy. Access to affordable housing for a poor and stigmatized population clearly remains the major sticking point in the fight against homelessness (and poverty). The HF programmes in Belgium can even be considered as having more difficulties in accessing housing solutions, considering the stigmatization of the extremely fragile people they are designed for, which is reflected in the difficulty of achieving a higher score in the *Housing Process and Structure* domain of the fidelity scale.

At the time when the HF programmes in Belgium participated in the current study, they were still considered innovative pilot projects. They were developed within the framework of a fixed-term experiment, fully supported by the Secretary of State in charge of Fighting Poverty. As a result, the Regional Housing Ministers did not feel involved. To access the housing units, the HF programmes were autonomous and

powerless. Amongst the 11 HF programmes that currently exist in Belgium, only one of them has direct and priority access to public housing, and only four have a subsidy to cover late rental payments or small rental damages.

The moderate score in the *Housing Process and Structure* domain is mainly influenced by the item number 5 called "Proportion of income required for rent". Scoring high on that item means that at least 85% of the tenants should spend no more than 30% of their income on rent.

In Belgium, the Social Integration Income paid to homeless people with no other source of income is €835 per month. Accordingly, rent should cost a maximum of €250 per month, which could, in theory, be achieved in the public rental market, since income is taken into account when setting rental prices. Currently, however, there is a substantial shortage of social housing units and a long waiting list that increases each year. HF programmes negotiate access, but few of them have signed a formal partnership, so most negotiations are *ad hoc*. The obvious conclusion is unambiguous and disappointing: the policy to fight homelessness is not yet aligned with housing policy. Therefore, the average rent paid by the tenants in our HF programmes is unfortunately greater than 30% of their income (sites that work mainly or only with the private rental market – sites 3, 6, 7 and 8 – are most affected, this is reflected in item 5).

HF programmes (as do all housing-led programmes in Belgium as well as many European countries) require structural political measures such as the capping of rents, increased assistance with rent payments, refinancing of Social Estate Agencies, and the creation of new social housing (including pilot projects involving modular housing). During the launch of the experimental phase, it was important to remain optimistic, and the critical lack of housing was not considered an immediate obstacle. To maximize the duration of the longitudinal assessment within the allotted period, teams were hired and housing was found in record time. Although some teams found the pressure of the experimental study difficult to handle (see the individual obstacles mentioned below), it nevertheless provided a positive influence in the form of a catalyst. This pressure made the role of the housing department indispensable and allowed for a clear separation between housing and support, which facilitated fidelity in the *Separation of Housing and Services* domain.

All available routes to accessing housing were taken. These included: (1) collaboration with private investors who entrusted management of a renovated building to a Social Estate Agency; (2) use of a rolling rental agreement to negotiate with private and public owners and use of public funds to cover possible rent defaults or damages; (3) precarious occupation of public housing in need of renovation (with an agreement to ensure the transfer to suitable housing with a traditional rental contract); (4) feasibility study for the construction of low-cost modular housing; and

(5) long-term residences such as care homes and Protected Housing Initiatives. The only directives given by the experiment's general management team were that access to housing must be unconditional and the rental contract must be as traditional as possible (including in its duration).

As a social worker from one of our teams says: "I explain to them that the only thing we're asking them is to pay their rent, and to agree to meet with the team at least once a week. And that we're not going to ask them to undergo treatment or abstain from consuming" (Buxant *et al*., 2016; p.62). *Housing First Belgium* is a social laboratory for the entire "housing-led" sector. The huge amount of media coverage has contributed to the legitimacy of the practices tested and has reassured certain intermediaries (in particular, private landlords). However, despite this initial burst of energy from the HF teams, we have to acknowledge that, with more than 400 clients in housing, securing additional tenancies will be difficult.

The score on the *Housing Process and Structure* domain is also influenced by some poor-quality housing units. In the very high-cost and tight rental market, certain accommodation offers have been considered by some programmes as they could not be refused. As one social worker stated, "we had to start the experiment. There wasn't any housing available at the time and all of a sudden, we had 10 candidates and we had to use transitional housing, which does not fall within the HF principles". Testing the effectiveness of these different types of housing units placed the teams in a stronger position to negotiate with new housing providers because of their experience from which they could draw. In the HF implementation manual published at the end of the experimental phase, although we advise institutions looking to implement such practices to follow every lead to decent and sustainable housing, we also suggest they take the time necessary to prepare the project and build partnerships before they accept their first tenants.

Table 3. Systemic Facilitators and Barriers for Achieving Housing First Fidelity

Facilitators	Barriers
Rent supplements & move-in bonuses	High cost public rental market
Additional subsidies and interest free loans	Substantial shortage of social housing and long wait times
Separation between housing and support	Lack of funding
Collaboration with private investors	Coordination with other Agencies
Negotiation and partnerships with housing provider	Lack of structural political measures
Public and media support for the program	Yearly increases in cost of rent

Organizational facilitators and barriers

As previously discussed, the HFB programme was developed by the stakeholders themselves, who developed and piloted the project with support from (but under the control of) the Federal Public Service. Therefore, apart from some clear fundamental principles of the HF model, stakeholders were free to build the teams according to their local needs. Precedence was given, for example, to three organizations that combined their expertise to create the HFB teams integrated by specialized workers. These mixed teams favoured the development of the different skills needed to support clients and facilitated the integration of the HF practice throughout the whole HFB network. The challenge was, therefore, to ensure fidelity to HF principles while adapting to local needs. To do so required support team members to look beyond their respective institutional philosophies, which was not evident due to the lack of an initial shared training process, as well as the absence of strong leadership within some of these teams.

Whatever their composition, the HFB teams are at the core of local networks of community agencies and delegate to these agencies, helping to support clients' autonomy in the community. The HF teams physically accompany the tenant to these external services in the community providing a "warm handover". In some cases, the HF service provider delivers the support in collaboration with a colleague from another agency.

As one HF social worker explained: "We have different partners, each one is a piece of the puzzle in the fight against homelessness, but nobody is going alone. If we combine our means, work together, and are responsible together, we can have something to offer to people with complex problems who have nowhere else to turn. I think it's really important that a project starts from a field network" (Buxant *et al.*, 2016; p.29). Since the HF teams do not want to view themselves (or be seen by others) as being self-sufficient, they make use of existing networks as well as their clients' own resources.

The HF teams faced some barriers to achieving high fidelity in the *Housing Process and Structure* domain, especially purchasing furniture and decorating the apartment in ways that match the client's wishes. On one hand, the teams do not have the budget to carry out this type of purchase (not at the beginning of the experiment, in any case); on the other, this is a deliberate choice. The teams ensure the presence of furniture needed to meet basic needs, but the follow-up to these purchases becomes a part of the recovery process. In other words, the team does assist participants to find furniture in the community, such as through donations. From their perspective, they view HF teams as providing support to clients so they can capitalize on their own strengths and become more independent.

This explanation given by one of the HF social workers aligns well with this philosophy:

> I think that at one point we had, by default, taken the habit of saying that we would move them in using our own funds, but actually no, I think we also have to use the external resources that exist. Sometimes, the people themselves have a lot of resources. They have a friend who comes along, who can help out. We have to be able to ask them: "But what about you? How do you think you can do it?" It's also important not to fill all the spots too quickly (Buxant *et al*., 2016; p. 66).

> We have a check-list comprising all of the tasks and things that have to be done to enter housing. We also give this list to the tenants. A lot of them are able to manage things independently, but just don't think about it because they've never lived alone before (Buxant *et al*., 2016; p. 66).

On an organizational level, some choices that were made when the teams were first set up limit programme fidelity. However, we note that fidelity in many areas is still developing as the programmes mature. When they began, HFB teams had the opportunity to select the staff themselves, and they prioritized hiring team members with expertise they deemed indispensable for their own local projects. In the beginning, these team members did not yet have expertise in HF. They gradually developed their own practices, mainly at the national level meetings coordinated by Federal Public Service for Social Integration. Moreover, HFB teams support about 20 to 45 clients each (with an average caseload of six to eight clients per employee). They are, therefore, small teams with limited budgets and two to four FTE employees. These conditions made it difficult to integrate other HF components, such as peer support workers. In programmes with high fidelity, there must at least one 1.0 FTE peer specialist for every 100 participants. In Belgium, only two teams have peer workers, and they have not been hired from the start. And even now, one is employed, while the other is still working as a volunteer due to the lack of funding.

All the HFB teams are aware of the benefits that a peer support worker could bring, especially to delivering support around substance misuse and harm reduction. However, it must be said that some team members have concerns about integrating peer workers into the HF teams. They mainly explain that when starting a HF programme, all efforts and time are put into managing and training their HF support team in providing an innovative practice and convincing the local stakeholders about their legitimacy. They all talk about having to "fight" when implementing HF. Working with peers in the field was totally new in Belgium. Team members explained that it was impossible to implement all innovations at the same time, with such an insecure framework, as they received funding for the test phase, but without any

guarantee for the period after the pilot. Moreover, the Federal Public Service in charge of the piloting asked them to implement HF in such a way that they could fulfil it even if the financial support was to stop after the test phase. This involved networking and pooling their own resources.

It seems that the framework we gave them was not secure enough for all to receive peer support from the start. More than three years later, with more confidence in the future of their HF programme, they are working with peers or seriously thinking about it. Current subsidies remain very tight in some HF programmes and don't allow the employment of new workers. However, when asked, most HF team support coordinators answer that if any financial revaluation occurs, they will prioritize the fulfilment of the part-time contracts before thinking about working with peers. From our point of view, we all still need to overcome our prejudices. Some of the crucial questions heard from social workers during the discussions were: "How are we going to manage if he decompensates? How can we be confident about his recovery?" The HF support team who has the strongest experience in working with peers has started a training programme. It could be the first step to overcoming scepticism.

Working with volunteers was also identified as challenging. Two HF teams recently began working with volunteers. These volunteers are trained and supervised, so they can accompany clients who are further along their recovery journeys to leisure activities or other appointments. This allows the teams' professionals to focus on their primary responsibilities to their most vulnerable clients. This kind of partnership with volunteers aligns well with some individual clients' needs, which only appeared at the end of the second year of our experiment. These needs are linked to loneliness and a desire for more opportunities for meaningful daily activities. Even though there are positive benefits for all stakeholders to continue these partnerships, it is important to remember that including volunteers in a professional team requires time, coordination, training, and support from the HF support team, which is not always available at the beginning of a project. In the same way, despite the teams' desire to increase clients' participation in the programme, to do so effectively takes time, training and more experience (item 37).

Team members' part-time employment status is the final organizational obstacle identified by the key informants. Part-time work makes it difficult to hold daily meetings, share, and update client information, despite the assistance of some very practical tools. In the beginning, the choice was taken that teams would be multi-organizational and that team members would return to their original organizations to help expand HF in those areas. However, HF team members increasingly favour full-time positions on the HF teams.

Table 4. Organizational Facilitators and Barriers for Achieving Housing First Fidelity

Facilitators	Barriers
Program development by stakeholders	Absence of strong leadership
Collaboration between HF teams	Lack of shared training process among support workers
Adaptation to local needs	Lack of funding for hiring full-time housing and peer support workers and training of volunteers
Strong commitment among housing first workers	Novelty of the program and lack of experience
Use of external networks and client own resources	Part-time housing workers
Partnerships with volunteers	

Individual facilitators and barriers

It appears that very few individual elements functioned as either barriers or facilitators of HF fidelity. Effective daily practice is highly dependent on this individual element, both for the workers and clients. Motivation and trust are the two facilitating assets on both sides. HF teams have time and do not have pressure to deliver immediate results, which is particularly unheard-of in the sector. Motivation can therefore be generated and honed, and trust can be earned.

The unusual offer of housing was met by some chronically homeless and vulnerable potential clients with initial suspicion:

> We often hear very specific questions about money, payment: 'What am I signing up for?' Sometimes people ask, 'Why me?', so they're distrustful. I give them time to think about it. It's really a question of getting their heads around this strange idea that 'someone's just offered me somewhere to live!' It's a big shock. Some cry, they can't believe it, and some have intense feelings of guilt regarding others (…) (Buxant *et al*., 2016; p. 62).

Housing was difficult to find for this target population. Some were more interested in the offer of housing than the offer of assistance. Some quickly put an end to the assistance despite the contact the HF teams tried to maintain, though as a consequence of the strict separation of housing and support, they remained in their homes. As a social worker described it: "Some take up the housing, but don't want the assistance. When we explain to them that we'll have to meet with them regularly, to make home visits, they tell us 'But I don't need that'" (Buxant *et al*., 2016; p. 62).

In terms of how the team works, it has become apparent that strong leadership from the manager is necessary for multi-organizational teams to work coherently and to remind them of the fundamental principles of the model. Finally, the HF teams must also constantly fight against the prejudices that still act as major obstacles, including those coming from managers of public housing. Evidence that the risks are overestimated does not seem to allay these prejudices. Without a housing policy to provide impetus by officially prioritizing this target population, the expansion of HF will be limited.

One of the major individual obstacles is that some owners change their minds at the last minute or add conditions to access the housing, demonstrating their prejudices and jeopardizing the hoped-for collaboration:

> Generally speaking, it's when the housing was promised to us with a billed guarantee for a certain date, but something goes wrong, and we get it much later. Then, it is a nightmare, because the person is in dire need, as is the team. We get harassed on a weekly basis, and there's nothing we can do. (…) And sometimes it's the professionals around this person who are more stressed than the person him/herself, and then they get resentful (Buxant *et al*., 2016; p. 63).

Table 5. Individual Facilitators and Barriers for Achieving Housing First Fidelity

Facilitators	Barriers
Motivation and trust among support workers and clients	Skepticism of the program among vulnerable homeless individuals
	Stigma towards clients and program
	Last minute changes and added conditions of housing by landlords

Conclusion

Team members who completed the fidelity self-assessment reported that the experience allowed each team to gain common understanding of their own practice and put it into perspective. Further, they have a better understanding of the actions they need to take to address systemic barriers and improve model fidelity. One of the major challenges of HF in Belgium is, for example, to generate accountability and implement housing policies in the fight against homelessness.

However, at the same time, certain doubts and questions emerged as a result of completing the survey. Some answers, although associated with a high level of fidelity to the HF model, were seen as potentially contradictory to HF practice. Some remarks can probably be explained in part, by misunderstanding of some items that lost nuanced meaning through the translation process. For example, although the teams demonstrated high fidelity in the *Service Philosophy* domain, our attention was drawn to the item that states the programme must "systematically address [different issues] with specific interventions". For this item, the average score obtained by Belgian respondents was significantly lower than for other items in the same domain. In discussion, participants said that they do not have to *systematically* cover each of these fields with *specific* interventions. These two adjectives can probably be interpreted in different ways. Our respondents stressed the facts that support is always provided on an "as-needed" basis with a client-centred approach and that a HF team does not necessarily have to meet all of an individual's specific needs. As we illustrated with some concrete examples (e.g., furnishings), our view is that a HF team, targeting the autonomy of the client as an objective, should not be expected to accomplish it on its own.

A social worker interviewed described this "tailored" support very well:

> For example, a woman I assist. In the beginning, she clearly said to me: *'I'll take care of my children. You're already giving me so much help, there's no need to worry about that'. But now, she's asked me to accompany her to the youth tribunal. I simply notice that it has changed. But it might not have changed. Others are better placed to help her than I am* (Buxant *et al*., 2016; p. 80).

The lowest fidelity average scores were observed in the *Service Array* domain. Most of our respondents maintained that the range of services offered by a HF team should not lower fidelity estimates or be used as a basis for judging whether a programme should be given the HF label. In the specific area of employment, if the client wishes, a HF team can help them to look for a job and/or training and/or any other socio-professional integration programme, depending on the available services within the network. However, the role of HF employees is to make these partners aware of the special needs of the target population and to provide assis-

tance. The objective has always been to meet the client's needs and wishes through a common law offer, with as little stigmatization as possible from their former status as a homeless person. This "return to common law" is facilitated by the HF teams' reliance and use of external resources. The HFB teams' experiences show that employment relationships and socio-professional integration in general, rarely appear at the start of the recovery process, and is relevant only to a small segment of this vulnerable population.

HF teams clearly assume a motivational role and accompany the client to see a partnered expert service, but would rarely offer the full services themselves. A major factor that allows this to work is the extensive network of local services available to our clients. These services have been stakeholders for a long time and are organized into coordinated networks. As a reminder, the fidelity scale was developed into this specific context, where it was absolutely essential to have the largest service array possible in order to cover the complex needs faced by long-term homeless individuals.

This two-year longitudinal study showed that HF programmes are effective. Keeping in mind the potential for misunderstanding of certain scale items, we question how HF practices can be effective despite a moderate score on a fidelity measure. We formulate the hypothesis that some domain sub-scales would be more statistically discriminant and more directly associated with the effectiveness of HF practices – not only in Belgium, but perhaps in other European countries. In this case, these subscales could therefore be included in the core principles of the HF model

This may be the case for the *Housing and Services* and *Service Philosophy domains*. In other words, the separation of housing and support (assessed by the separate *Housing and Services* sub-scale) and the very philosophy of the support (client-centered, choice, harm reduction, etc.) may be domains that have greater influence on HF effectiveness, compared to other domains. For example, we argue that the number of meetings taking place per week within a HF team should not be weighted as heavily as clients' unconditional access to housing.

Organizations could adapt their HF programmes in order to better fit the model as assessed through this assessment scale and gain some points on this fidelity measure. But doing so, will they significantly gain effectiveness? We recommend further research to evaluate how specific modifications to the original model affect both fidelity and client outcomes. This research may result in the adaptation of the fidelity scale by weighting items or domains based on their impact on effectiveness, assisting practitioners and policy makers in the improvement of the services they deliver.

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