Report Date: 5 April 5, 2016

HOUSING FIRST FINAL FIDELITY REPORT: WINDSOR-ESSEX ICM

Members of the fidelity team completed a baseline Pathways Housing First ICM fidelity assessment of the Windsor-Essex ICM Program.

Site	Date	Fidelity Team	Time
Windsor ICM	2/9/2016	Sam Tsemberis, Whitney Joy Howard, Catharine Vandelinde	8:45am - 4:00pm

Data Sources: For ICM team

Program Meeting Observations: Team observed the weekly case review meeting
Staff Interviews: KC (Team Lead), Sue (Housing Locator), Tina (ICM/Aboriginal Housing Advocate), Michele (Peer Specialist), Matt (ICM), Colm (Outreach Coordinator), Susie (ICM) and the Executive Directors and Service Manager
Focus Group: Attended by Windsor-Essex ICM program participants
Chart Review: 6 charts were reviewed including latest treatment plans and progress notes for the month of January.

Fidelity Overview

This multi-agency collaboration is doing a remarkably good job of putting in place a program that adheres closely to the key principles of Housing First, particularly in the areas of consumer choice, commitment to rehouse, harm reduction, and recovery focused care. There is strong and competent leadership provided by the Team Leader and the team is composed of thoughtful and capable team members. The Team Leader has a firm grasp of the Housing First program model is both an excellent supervisor for her team as well as a powerful advocate for program clients in the larger community. In this way the Housing First program is making inroads into system change. The Windsor-Essex agency hosting the team is a very good fit for this program. The agency flexibility and core values are consistent with the Housing First program. Finally, the City of Windsor as the community entity has played a key role in this program's success. The CE understands the program and the unique needs that such an operation requires. The CE has a complex role of both assuring accountability and supporting the success of the team and achieved this is a very effective manner. The CE has understood when additional staff or other changes were needed to bring the program closer to optimal performance. Given that the team is still in its first year and in some ways still developing there are some areas where there is room for improvement and certain other areas to be mindful of as the program grows. But the program is under capable leadership both at the level of team and the CE and is well-positioned to grow and effectively serve more clients and address the challenges ahead.

Housing Choice and Structure:

The program excels in many areas of this domain and provides housing choices that are affordable, permanent, private and fully integrated into the community. The ICM and housing team are very supportive and committed to the need for providing housing as quickly as possible to program participants The program has achieved a very high percentage of participants moving into their apartments within the four-month intake-to-housed time frame at 82%. Of note is the fact that all team members are actively involved in locating units, meeting with landlords and taking clients to see properties. Since this a start-up year it is not surprising that many team members are focused on finding apartments. However, these activities take a significant amount of time and over time must be continually balanced by providing the level of support needed by those who have been housed. This is particularly

challenging because in the first year there is pressure to both house as many participants as possible in a short time and it is also when the needs for home visits of those who are housed is highest. The team has negotiated with the CE to have smaller caseloads and this will allow them to successfully juggle these competing demands. The question remains about how this balance will be managed as the caseloads grow over time. It does not seem that the team's current level of involvement in finding apartments can be sustained over time. The housing team (two Housing Locators) who currently assist in landlord engagement and housing-related financial operations will have to assume a more active role.

Recommendations:

1) Either expand the role of the Housing Locators, e.g., provide more support to team and participants by conducting housing searches with clients, or to find other ways to improve the front end efficiency on the housing search.
   For example, when an individual is admitted to the team, hold a meeting between the individual, a team member and a Housing Locator and discuss housing preferences. This will jump start the housing search process. The housing locators can also expand their role by taking clients to view available apartments.

2) The team and housing locators need to establish a method for prioritizing the housing needs list. One recommendation is to prioritize searches for those individuals who are newly admitted and are living on the streets or in unsafe situations. Requests for relocations would be a second order need. For participants who have very specific housing needs, if possible, it may be worthwhile to encourage the client to engage in their own housing search. You may also consider incentives such as finder's fees for finding your own place.

3) The team is committed to participant choice in selecting the location and other features of their apartment. While the team has been successful in moving people in quickly (82% of participants within four months of intake), about half of newly housed participants are currently looking for a different apartment. Some participants are looking to move due to risk of eviction, while others dislike their initial apartment, apartment building or neighborhood. Moves are labor intensive, expensive and disruptive to the individual and taxing for the team. You may want to consider ways to elaborate on that initial choice so you have a better fit from the start.
   One way to achieve this is to develop a protocol around finding housing that would provide for a thorough exploration of preferences and incorporate the first 2 recommendations. There should also be an explicit protocol to guide the process for moving in, planned relocations, emergency moves, and other rehousing. The program would do well to collect data on housing stability, especially the reasons participants identify for leaving or losing an apartment. This may help shed light on possible patterns and increase the team's understanding so that interventions to address these challenges can be developed. The program should continue to work with participants to identify why a move occurred, to explore what changes can be made to prevent (negative) moves in the future, and what strategies the participant can use to maintain their housing.

   4) A final recommendation in this housing choice domain is to expand avenues for acquiring a full furniture package, including a television and radio. Having a fully furnished apartment can promote a feeling of home. While there are some furniture resources available to participants moving into apartments, administration can seek out partnerships with the community and faith-based entities to formalize acquisition and delivery of furniture and other household items upon move-ins. The importance and value of creating a feeling of home may also be seen as a way of reducing moves and increasing housing retention.

Separation of Housing and Services

This factor is about maintaining service support even through housing relocation or loss. The team understands and implements almost all aspects of this domain. There was no reference to 'housing readiness' requirements as a condition for receiving housing and no treatment prerequisites or contingencies associated with housing or program participation. The majority of participants hold standard one year leases, with a small percentage choosing month-to-month rentals, and the team re-houses participants as needed.

The service team is very mobile, spending a lot of time in the community, making home visits, taking clients to appointments, and engaging in socializing activities with clients. At present, staff return to the office to write up case notes and service plans. As a program grows, balancing working with clients and appropriate documentation may prove challenging and time consuming.

As administration moves forward with a multi-agency data system that is aligned and integrated with operations, the agency could look into purchasing tablets with remote access to the data system so that staff can enter notes while in the field. This would also allow staff access to needed information and the ability to enter observations in real-time. Additionally, fully transitioning to a team approach would see one rotating staff member assigned to the office daily. This would provide a built-in time for documentation.

While less than a year into operations, the team has already re-housed several participants and understands that there will be a need to re-house some individuals in order for them to be successful in their apartments and supports clients in making these transitions as participants learn how to cope with the different challenges that they encounter. Based on the numbers provided by the team, the number of relocations for negative reasons is fairly low at this time, approximately 19% of housed program participants.

The team has had success in helping clients maintain housing by making behavioral changes and negotiating through difficult situations with landlords. The team is encouraged to be proactive around this issue and routinely, unobtrusively observe and check in with clients during home visits regarding how relationships with neighbors, property managers, and landlords are going and try and catch any emerging issues early on.

The Housing Locators can continue to be proactive with landlords, acting both as mediator but also as tenant advocate, especially in instances where landlords are infringing on tenants' privacy or rights. As participants desire to be re-housed, the team can also conduct a brief analysis of re-housings to determine causes of pre-emptive moves (or evictions) and to look for possible patterns or opportunities for developing further strategies for supporting clients in maintaining housing stability. The team is doing a very good job in addressing these underlying reasons for moves while continuing to provide a constructive and practical "harm reduction" approach to minimize risks to client, other tenants and landlords.

Finally, while services are generally continued through housing loss there appears to be some systemic challenges in continuing services during short-term inpatient treatment and detox. There have been repeated difficulties for the team to gain access to staff on the inpatient service of the hospital. While Housing First staff seek to provide continuity of care while a client is hospitalized, there is a need for advocacy or change in policy by the inpatient service. In other successful programs members of the Housing First team have met with hospital staff and administrators to complete the credentialing process required by hospitals so that staff can work collaboratively on behalf of their mutual clients. Similar administrative solutions are needed for the justice, addictions treatment, and other systems.

Service Philosophy

This factor concerns the teams' treatment and service philosophy. Staff interviewed for this report held values consistent with Housing First and had a comprehensive understanding of program practice and philosophy. In some instances, as with the Team Leader, there was a deep understanding of the Housing First model as well as a role of advocacy to have the model adopted widely throughout the homeless services community. Peer work is highly valued by the team and Team Leader, as was demonstrated by a strong presence from the peer perspective. The understanding and embracing of the program philosophy translates into a strong, consistent, and high fidelity program practice.

Staff are attuned to participant preferences and approach service delivery from the perspective of acceptance of the person with an awareness of their cultural background and needs. In line with this approach, they do not have treatment requirements, but are encouraged to pursue their well-being from a Recovery perspective. Participants have autonomy over service type and the team is committed to and effective in utilizing a harm reduction approach to address mental health, health and addiction. The team avoids coercive practices and supports clients to balance their needs for independence and self-determination with their need to feel connected to each other and to their communities.

Further training in motivational interviewing would be useful, including reflecting on its application in daily practice in team meetings to encourage staff to share creative techniques they are using. The agency might consider creating an orientation training on clinical operations, particularly around documentation and use of case notes, goal planning and WRAP reports.

During the start-up process, it can be difficult to focus on anything but placing participants in housing and attending to crises. Often, formal goal planning gets pushed lower on the priority list. The team will need to turn their attention to better documentation of person-centered planning, consistently documenting and updating stated goals, using these goals to structure visits with participants, and more comprehensively noting the services that are provided. During team meetings, staff should list goals the participant is working on so the entire team has goal and service planning as a focus of their discussion, review and work with the participant.

Another recommendation in this domain is to focus on diversifying the range of assertive engagement strategies used by the team. The team should continue to use weekly meetings (as well as individual supervision) to devise engagement plans for each individual they are having difficulty engaging. Input from the peer specialist and other non-traditional providers may serve well in these efforts. The program should also focus on ensuring that goals and strengths appear in participants' charts so that engagement and services can be rooted in the things participants want to work on.

Utilizing a shared caseload will also assist assertive engagement practices, so when one of the service workers is in a particular geographic region they can see all participants who live in that region and not just those on their individual caseload. Each team members is unique as is every client and there may be some new possibilities by changing the staff client composition. As the program grows, this approach will also ensure participants are being seen on a regular basis and that all team members will get to know all participants and can attempt different engagement strategies based on their respective interests, approaches and talents. The effectiveness of all these strategies should then be tracked during weekly meetings.

Finally, as the team transitions past start-up mode, attention should also be paid to the need for delivering a wider range of services. The program has already started to organize recreational activities, recently hosting a successful movie night out in the community. The program should expand upon its use of groups (focused on activities participants are interested in, e.g. cooking classes, art group, walking club, gardening, etc.) and recreational activities which are useful for building further engagement and rapport. Attention should be paid to participants' spiritual, social connectedness and employment needs and goals. Staff should consistently solicit and update participants' 'goals,' interests and aspirations and document the range of services they are delivering and participant responses to these efforts.

Service Array

The ideal in this standard is for the team to provide directly or to broker as many services and supports as those reflected in the needs and interests of their clients. The program provides many housing supports, such as move-in assistance and acquisition of furniture, landlord relations, budgeting, property management services, and assistance with rent payment/subsidy assistance where applicable. Clearly defining roles and responsibilities around housing for the team members and Housing Locators would streamline the housing process. As noted in the debrief, the team might consider the practice of having a mini-team assist with move-in and provide a meal or baked snack to celebrate the event. The program might also consider offering a basic orientation/group on tenancy (budgeting, cleaning, paying rent, landlord-tenant law, having guests, volume control, etc.) and a walking orientation of the neighborhood.

The program is seeking to develop a stronger and more collaborative relationship with the local ACT team, including ACT staff providing trainings on mental health and medication. Because there are participants with psychiatric and medical needs, the program needs to better facilitate linkages with psychiatric and medical services. The ACT team would also facilitate a direct relationship with the psychiatric inpatient service at the hospital.

A recommendation is to attempt to broker a relationship with the ACT team or with another psychiatric provider and/or try to connect with a medical and mental health clinic that is philosophically aligned with the program. The program could also look into engaging a part-time psychiatrist for consultation who on occasion would make home visits. While there is a nurse on-site at WEHC that program participants have access to, the nurse does not make home visits. As the program grows and expands, the program might consider running a health group or hiring a nurse part time to make home visits. The program should work to increase collaboration with other medical providers, particularly around continuation of services with inpatient service providers and around service provision for those in or just out of detox. Substance use treatment is another area of high need, but the team is limited in its ability to broker linkages given that there is a paucity of outside substance use treatment programs that meet the complex needs of their participants. If the team is unable to establish linkages with other providers, they may need to develop greater substance use counseling skills within the team.

Although the program is in an early stage, some participants have employment goals and there is already some activity in linking participants with educational and employment opportunities. Moving forward, the program should continue to expand links to employment and educational programs and opportunities. Staff should assess participants' needs and preferences regarding employment and education on an on-going basis and discuss these goals in weekly meetings. The program could look for training opportunities on Employment First.

While the program currently provides a 24-hour phone number for participants, in its present form the 24-hour coverage is not directly linked to a team member. It is strongly recommended that the team try to develop a main team number that can also serve as the 24/7 on call number and have a rotating coverage system in which each staff member provides the 'on-call' service in one week intervals.

The program has begun to facilitate social integration for their participants. As the team moves forward with the creation of other groups and organizing social events, they should be mindful of linking participants with the outside community and not focusing solely on building community around the program.

**It is highly commendable that even in the short interval since the fidelity visit the team has taken some of these recommendations to heart and acted on them and:

1) engaged the P/T services of a Nurse Practitioner from the Victoria Order of Nurses
2) is collaborating with the university and secured an internship for a disabilities studies student who is helping clients to map their neighborhood and community guided by client's interests and goals
3) increased the time available for their administrative assistant from half time to full time to better support the teams growing administrative needs.
4) The team has also made progress in adopting more of a team-based approach

This level of responsiveness and commitment to enact recommendations made a short time ago in order to provide excellent care for clients is reflective of the high quality services provided by this team and also shows the strong collaborative and responsiveness of the Community Entity.

Program Structure

The team operates in a cohesive manner and is already partially operating using a team approach even though they still formally utilize an individual caseload structure. Team members show familiarity with each other's clients, members are very supportive of one another, and there is a sense of 'having each other's back'.

In making the transition to a team model with fully shared caseload, we recommend introducing staff to participants who are initially more open to working with other staff or participants who have already met several members of the team. For participants who have built strong rapport with one individual worker, a team approach could be introduced gradually over a longer period of time, with the primary individual worker maintaining their lead role.

For morning meetings, the team could either designate an individual that regularly leads the meeting or can choose to rotate staff being a lead facilitator who takes responsibility for coordinating the discussion and triaging. The team meeting started on time, everyone was focused, and began by addressing urgent issues first. There was clear structure and organization, clear lines of leadership and decision making, and clearly expressed plans for follow up. There is room for improvement in the areas of keeping the conversation focused with less detail and it should be stressed that the morning meeting is a place to read the notes written from the day before not a verbal report. At the end of the 'roll call' the rest of the meeting should be utilized to plan and assign the day, with staff being assigned work by region or task. Also after the meeting, mini meetings can be used for a few team members to huddle and discuss particular issues.

Program meetings occur on a weekly basis and convey in depth information, or problem solving opportunities that allow input from all staff. The weekly meeting also allows for all staff to develop familiarity with each other's caseloads, learn from each other's insights and experience, and brainstorm strategies for any challenges they face.

Another great asset for the team is that they have a full-time peer support staff member who provides services to participants. The team frequently visits with clients and have the ability to be flexible around the number of times a participant is seen, based on their needs. While this flexibility is excellent, we recommend, more visits when clients are first housed and over time to have no less than a once a month visit in their home. The team should constantly evaluate whether the intensity of services needs to move up or down.

Beyond the Team

The team works in the context of a larger community. Currently there are several unresolved issues surrounding the prioritization for clients served by the team. The community adopted an instrument that is not as effective as it needs to be to accurately identify individuals with a history of chronic homelessness and mental illness. We recommend that the community prioritization process try and salvage this problematic process by allowing for input from the various agencies that work in homeless services and allow for their observations and experience of the participants to influence the prioritization process. If the goal is to focus on the chronically homeless with complex mental health and addiction needs the selection of clients prioritized for this program should be based on those actual criteria; what is actually known about the individual not what is scored by a quick and cursory assessment.

The team has been working with the community to better understand eligibility for the Housing First program. We encourage the team to continue to meet with the community to present on eligibility, as well as clearly define eligibility (perhaps, in addition to chronic homelessness, criteria around severe and persistent mental illness and/or addictions) so the team ensures fit between program and participant and that housing is going to those most vulnerable. Finally, the team can also expand opportunities for participant representation and input into the program including starting a client's advisory council. We appreciate how welcoming, accommodating, open and forthright the ICM team members were during the fidelity visit. We compliment them for their commitment to supporting participants given the various difficulties that they are facing. We look forward to providing any assistance we can to support their continued growth.

The findings are as follows:

Overall Fidelity Score: *Pending*

Fidelity Domain	Program Score	Notes
Housing Choice & Structure	3.9	
Separation of Housing & Services	3.9	
Service Philosophy	3.5	
Service Array	2.5	
Program Structure	3.1	

For inquiries or comments regarding this report, please contact:

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***See last page for item sources and references.**

Item	Criterion	1	2	3	4
	HOUSING CHOICE & STRUCTURE				
1.	**Housing Choice.** 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)*.** Extent to which program helps participants move quickly into units of their choosing.	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. 3.5**	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)*.** Extent to which program helps participants move quickly into units of their choosing.	Less than 55% of program participants move into a unit of their choosing within 6 weeks of having a hosing subsidy or receiving a voucher.	55-69% of program participants move into a unit of their choosing within 6 weeks of having a hosing subsidy or receiving a voucher.	70-84% of program participants move into a unit of their choosing within 6 weeks of having a hosing subsidy or receiving a voucher.	85% of program participants move into a unit of their choosing within 6 weeks of having a hosing subsidy or receiving a voucher.
3.	**Permanent Housing Tenure.** Extent to which housing tenure is assumed to be permanent with no actual or expected time limits, other than those defined under a standard lease or occupancy agreement.	There are rigid time limits on the length of stay in housing such that participants are expected to move by a certain date or the housing is considered emergency, short-term, or transitional.	There are standardized time limits on housing tenure, such that participants are expected to move when standardized criteria are met.	There are individualized time limits on housing tenure, such that participants can stay as long as necessary, but are expected to move when certain criteria are met.	**There are no expected time limits on housing tenure, although the lease agreement may need to be renewed periodically.**
4.	**Affordable Housing.** Extent to which participants pay a reasonable amount of their income for 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.**

Item	Criterion	1	2	3	4
5a.	**Integrated Housing *(Urban programs)*.** Extent to which 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.**
5b.	**Integrated Housing *(Rural Programs)*.** Extent to which program participants live in scatter-site private market housing which is otherwise available to people without psychiatric or other disabilities.	<60% of participants live in bldgs. that satisfy the following criteria: 1-3 unit bldg=1 partcpt 4-6 unit bldg=2 partcpts 7-12 unit bldg=3partcpts	60-69% of participants live in bldgs. that satisfy the following criteria: 1-3 unit bldg=1 partcpnt 4-6 unit bldg=2 partcpnts 7-12 unit bldg=3 partcpts	70-79% of participants live in bldgs. that satisfy the following criteria: 1-3 unit bldg=1 partcpnt 4-6 unit bldg=2 partcpnts 7-12 unit bldg=3 partcpts	80% of participants live in bldgs. that satisfy the following criteria: 1-3 unit bldg=1 partcpnt 4-6 unit bldg=2 partcpnts 7-12 unit bldg=3 partcpnts
6.	**Privacy.** Extent to which program participants are 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				
7.	**No Housing Readiness.** Extent to which program participants are not required to demonstrate housing readiness to gain access to housing units.	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 violent behavior or	Participants have access to housing with minimal readiness requirements, such as willingness to comply with program rules or a treatment plan that addresses sobriety, abstinence, and medication compliance.	**Participants have access to housing with no requirements to demonstrate readiness, other than agreeing to meet with staff face-to-face once a week.**

Item	Criterion	1	2	3	4
			involvement in the criminal justice system.		
8.	**No Program Contingencies of Tenancy.** Extent to which continued tenancy is not linked in any way with adherence to clinical, treatment, or service provisions.	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.** Extent to which program participants have legal rights to the unit with no 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.** Extent to which the program offers participants who have lost their housing access to a new housing unit.	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 supervised housing, or the program has set limits on the	**Program offers participants who have lost their housing a new unit without requiring them to demonstrate readiness and has no set limits on the number of possible relocations.**

Item	Criterion	1	2	3	4
				number of relocations.	
11.	**Services Continue Through Housing Loss.** Extent to which program participants continue receiving services even if they lose 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. 3.5 This score is reflective of the team's inability to gain access and to provide service through hospitalizations**	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.** Extent to which social and clinical service providers are not located at participant's residences.	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.** Extent to which social and clinical service providers are mobile and can deliver services to locations of participants' choosing.	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				
13.	**Service choice.** Extent to which program participants choose the type, sequence, and intensity of services on an ongoing basis.	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.** Extent to which	All participants with psychiatric disabilities are required to take	Participants with psychiatric disabilities are required to participate in	Participants with psychiatric disabilities who have not achieved a	**Participants with psychiatric disabilities are not required to take**

Item	Criterion	1	2	3	4
	program participants with psychiatric disabilities are not required to take medication or participate in psychiatric treatment.	medication and participate in psychiatric treatment.	mental health treatment such as attending groups or seeing a psychiatrist and are required to take medication but exceptions are made.	specified period of symptom stability are required to participate in mental health treatment, such as attending groups or seeing a psychiatrist.	**medication or participate in formal treatment activities.**
15.	**No requirements for participation in substance use treatment.** Extent to which participants with substance use disorders are not 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.** Extent to which program utilizes 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 abstinence is not maintained.	Participants are required to abstain from alcohol and/or drugs while they are on-site in their residence or participants lose rights, privileges, or other services if abstinence is not maintained.	Participants are not required to abstain from alcohol and/or drugs, but staff work with participants to achieve abstinence not recognizing other alternatives that reduce harm OR staff do not consistently work to reduce the negative consequences of use.	**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.** Extent to which program staff use principles of motivational interviewing in all aspects of interaction with program participants.	Program staff are not at all familiar with principles of motivational interviewing.	**Program staff are somewhat familiar with principles of motivational interviewing. 2.5**	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.	**Assertive Engagement.**	Program does not use	**Program uses very few**	Program is less	Program systematically

Item	Criterion	1	2	3	4
	Program uses an array of techniques to engage consumers who are difficult to engage, including (1) motivational interventions to engage consumers in a more collaborative manner, and (2) therapeutic limit-setting interventions where necessary, with a focus on instilling autonomy as quickly as possible. In addition to applying this range of interventions, (3) the program has a thoughtful process for identifying the need for assertive engagement, measuring the effectiveness of these techniques, and modifying approach where necessary.	strategies of assertive engagement.	**assertive engagement strategies.** **2.5**	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.	uses a variety of individualized assertive engagement strategies and systematically identifies and evaluates the need for various types of strategies.
19	**Absence of Coercion.** Extent to which the program does not engage in coercive activities towards participants.	Program routinely uses coercive activities with participants such as leveraging housing or services to promote adherence to clinical provisions or having excessive intrusive surveillance of participants.	Program sometimes uses coercive activities with participants and there is no acknowledgement that these practices conflict with participant autonomy and principles of recovery.	Program sometimes uses coercive activities with participants, but staff acknowledge that these practices may conflict with participant autonomy and principles of recovery.	**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.** Program conducts person-centered planning, including: 1) development of formative	Program does not conduct person-centered planning.	**Treatment/service planning FULLY meets 1 service or PARTIALLY meets 2.5**	Treatment/service planning FULLY meets 2 services or PARTIALLY meets all 3.	Treatment/service planning FULLY meets ALL 3 services (see under definition).

Item	Criterion	1	2	3	4
	treatment plan ideas based on discussions driven by the participant's goals and preferences, 2) conducting regularly scheduled treatment planning meetings, 3) actual practices reflect strengths and resources identified in the assessment				
21	**Interventions Target a Broad Range of Life Goals.** The program systematically delivers specific interventions to address a range of life areas (e.g., physical health, employment, education, housing satisfaction, social support, spirituality, recreation & leisure, etc.)	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)
22	**Participant Self-Determination and Independence.** Program increases participants' independence and self-determination by giving them choices and honoring day-to-day choices as much as possible (i.e., there is a recognition of the varying needs and functioning levels of participants, but level of oversight and care is commensurate with need, in light of the goal of enhancing self-determination).	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	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.**

Item	Criterion	1	2	3	4
		supervision.			
	SERVICE ARRAY				
23.	**Housing Support.** Extent to which program offers services to help participants maintain housing, such as offering assistance with neighborhood 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. 3.5**	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**. Extent to which the program provides has strong linkages, provides active referrals and conducts follow-up for the provision of psychiatric services. Specifically, the program: 1) has established formal & informal links with several providers, 2) assesses participants to match needs & preferences to providers, 3) assists participants in locating, obtaining, and directly introducing participants to providers, and 4) conducts follow-up including communicating/providing	Program FULLY meets less than 2 criteria.	**Program FULLY meets 2 criteria or PARTIALLY meets 3. 2.5**	Program FULLY meets 3 criteria or PARTIALLY meets all 4.	Program FULLY meets ALL 4 criteria for brokering psychiatric services (see under definition).

Item	Criterion	1	2	3	4
	consultation with other providers regarding services on a regular basis and coordinating care.				
25.	**Substance Use Treatment.** Extent to which the program provides has strong linkages, provides active referrals and conducts follow-up for the provision of substance abuse services. Specifically, the program: 1) has established formal & informal links with several providers, 2) assesses participants to match needs & preferences to providers, 3) assists participants in locating, obtaining, and directly introducing participants to providers, and 4) conducts follow-up including communicating/providing consultation with other providers regarding services on a regular basis and coordinating care.	Program FULLY meets less than 2 criteria.	**Program FULLY meets 2 criteria or PARTIALLY meets 3. 2.5**	Program FULLY meets 3 criteria or PARTIALLY meets all 4.	Program FULLY meets ALL 4 criteria for brokering substance use treatment services (see under definition).
26.	**Employment & Educational Services.** Extent to which the program provides has strong linkages, provides active referrals and conducts follow-up for the provision of employment & educational services. Specifically, the	Program FULLY meets less than 2 criteria.	**Program FULLY meets 2 criteria or PARTIALLY meets 3. 2.5**	Program FULLY meets 3 criteria or PARTIALLY meets all 4.	Program FULLY meets ALL 4 criteria for brokering employment & educational services (see under definition).

Item	Criterion	1	2	3	4
	program: 1) has established formal & informal links with several providers2) assesses participants to match needs & preferences to providers, 3) assists participants in locating, obtaining, and directly introducing participants to providers, and 4) conducts follow-up including communicating/providing consultation with other providers regarding services on a regular basis and coordinating care.				
27.	**Nursing/Medical Services.** Extent to which the program provides has strong linkages, provides active referrals and conducts follow-up for the provision of nursing/medical services. Specifically, the program: 1) has established formal & informal links with several providers, 2) assesses participants to match needs & preferences to providers, 3) assists participants in locating, obtaining, & directly introducing participants to providers, & 4) conducts follow-up including communicating/providing consultation with other	Program FULLY meets less than 2 criteria.	**Program FULLY meets 2 criteria or PARTIALLY meets 3. 2.5**	Program FULLY meets 3 criteria or PARTIALLY meets all 4.	Program FULLY meets ALL 4 criteria for brokering nursing/medical services (see under definition).

Item	Criterion	1	2	3	4
	providers regarding services on a regular basis & coordinating care.				
28.	**Social Integration.** Extent to which services supporting social integration are provided directly by the program. 1) Facilitating access to and helping participants develop valued social roles and networks within and outside the program, 2) helping participants develop social competencies to successfully negotiate social relationships, 3) enhancing citizenship and participation in social and political venues.	Program does not provide any social integration services.	**Program FULLY provides 1 service or PARTIALLY provides 2. 2.5**	Program FULLY provides 2 services, or PARTIALLY provides all 3.	Program FULLY provides all 3 services (see under definition)
29.	**24-hour Coverage.** Extent to which program responds to psychiatric or other crises 24-hours a day.	Program has no responsibility for handling crises after hours and offers no linkages to emergency services.	**Program does not respond during off-hours by phone, but links participants to emergency services for coverage.**	Program responds during off-hours by phone, but less than 24 hours a day, and links participants to emergency services as necessary.	Program responds 24-hours a day by phone directly and links participants to emergency services as necessary.
30.	**Involved in In-Patient Treatment.** Program is involved in inpatient treatment admissions and works with inpatient staff to ensure proper discharge as follows: 1) program initiates admissions as necessary, 2) program consults with inpatient staff regarding need	Program FULLY provides 2 or fewer services, or PARTIALLY provides 3 or fewer.	**Program FULLY provides 3 services, or PARTIALLY provides 4.**	Program FULLY provides 4 services, or PARTIALLY provides 5.	Program FULLY provides ALL 5 listed services (see under definition).

Item	Criterion	1	2	3	4
	for admissions, 3) program consults with inpatient staff regarding participant's treatment, 4) program consults with inpatient staff regarding discharge planning, and 5) program is aware of participant's discharge from treatment.				
	PROGRAM STRUCTURE				
31.	**Priority Enrollment for Individuals with Obstacles to Housing Stability.** Extent to which program prioritizes enrollment for individuals who experience multiple obstacles to housing stability.	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.** Extent to which program has a minimal threshold of non-treatment related contact with participants.	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. 3.5**	Program meets with 90% of participants at least 3 times a month face-to-face.
33.	**Low Participant/Staff Ratio.** Extent to which program consistently maintains a low participant/staff ratio, excluding the psychiatrist & administrative support.	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. **4.0**
34.	**Team Approach.** Extent to which program staff function as a multidisciplinary team;	Fewer than 20% of participants have face-to-face contacts with at least 3 staff members in	**20-49% of participants have face-to-face contacts with at least 3 staff members in 4**	50-79% of participants have face-to-face contacts with at least 3 staff members in 4 weeks.	80% or more of participants have face-to-face contacts with at least 3 staff members in 4 weeks.

Item	Criterion	1	2	3	4
	clinicians know and work with all program participants.	4 weeks.	**weeks.**		
35.	**Frequent Meetings.** Extent to which program staff meet as a team to plan and review services for program participants.	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):** Serves the following functions: 1) Conduct a brief but clinically relevant review of ½ caseload 2) Discuss participants with high priority emerging issues in depth to collectively identify potentially effective strategies and approaches 3) Identify new resources within & outside the program for staff or participants 4) Discuss program-related issues such as scheduling, policies, procedures, etc.	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).
37.	**Peer Specialist on Staff.** Peer Specialist on Staff. The program has at least 1.0 FTE staff member who meets local standards for certification as a peer specialist. If peer certification is unavailable locally, minimal qualifications include the following: (1) self-identifies as an individual with a serious	0.25 FTE to 0.49 FTE peer specialist per 100 participants who meets minimal qualifications.	0.50 FTE to 0.74 FTE peer specialist per 100 participants 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 per 100 participants peer specialist who meets minimal qualifications. No more than 2 Peer Specialists fill the 1.0 FTE.	**At least 1.0 FTE peer specialist per 100 participants who meets minimal qualifications and has full professional status on the team. No more than 2 Peer Specialists fill the 1.0 FTE.**

Item	Criterion	1	2	3	4
	mental illness who is currently or formerly a recipient of mental health services; (2) is in the process of his/her own recovery; and (3) has successfully completed training in wellness and recovery interventions. Peer specialist has full professional status on the team.				
38.	**Participant Representation in Program.** Extent to which participants are represented in program operations and have input into policy.	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).

***Several items were taken directly or modified from other sources as follows:**

Items 4, 5, 7, 8, 9, 12, 31: Permanent Supportive Housing KIT, fidelity scale.
Citation: Substance Abuse and Mental Health Services Administration (SAMHSA, 2010). *Permanent Supportive Housing: Evaluating Your Program.* DHHS Pub No. SMA-10-4509, Rockville, MD: Center for Mental Health Services, SAMHSA, U.S. Department of Health and Human Services.

Items 29, 30, 32, 34, 35: Assertive Community Treatment Fidelity Scale.
Citation: Substance Abuse and Mental Health Services Administration (SAMHSA, 2008). *Permanent Supportive Housing: Evaluating Your Program.* DHHS Pub No. SMA-08-4344, Rockville, MD: Center for Mental Health Services, SAMHSA, U.S. Department of Health and Human Services.

Items 18, 20, 21, 22, 24, 25, 26, 27, 36, 37: Tool for Measurement of Assertive Community Treatment.
Citation: Monroe-DeVita M. B., Teague, G. B., Moser, L. L., et al. (unpublished, 2008).*Tool for Measurement of Assertive Community Treatment (TMACT)*
Teague, G.B., Monroe-DeVita, M., & Moser, L. (2009). *Enhancing ACT fidelity assessment: Introducing the TMACT.* Presented at the Annual Assertive Community Treatment Conference, Arlington, VA, June 4–6.

Items 3, 13, 14, 15, 23: Program Characteristics Measure
Citation: Williams, V. F., Banks, S. M., Robbins, P. C., Oakley, D., & Dean, J. (2001). *Final Report on the Cross-Site Evaluation of the Collaborative Program to Prevent Homelessness.* PRA: Delmar, NY.