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ORIGINAL PAPER

Investigating the Impact of Housing First on ACT Fidelity

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Abstract This study examined the extent to which an ACT team employed within a Housing First program conforms to the fidelity standards of the ACT model. The aim was to specifically identify the extent to which accommodations have been made to suit the context and priorities of Housing First. Results indicate that some deviations from the ACT model could be attributed to the consumer choice approach inherent to Housing First. Other deviations may result from serving individuals that are more disconnected from social supports than other individuals with mental illness, with longer street histories, and greater involvement with substance use.

Keywords ACT · Fidelity · Housing First · Harm reduction · DACTS

Introduction

Assertive community treatment (ACT) is one of the most well defined (Allness and Knoedler 1998; Stein and Santos 1998; Test and Stein 2000) and researched (Mueser et al. 1998) community-based treatment models for persons with a mental illness. Since its development in the 1970s (Stein and Test 1980, 1985; Stein et al. 1975), ACT has been modified to reduce costs associated with this intensive service (Lachance and Santos 1995) and to serve certain high risk populations with serious mental illness (Dixon et al. 1995; Teague et al. 1995). These modifications have led researchers to identify vital elements of ACT (Bond et al. 2001; McGrew and Bond 1995; Witheridge 1991) that endure through adaptations of the model and instruments have been developed to measure a program's fidelity to these critical ingredients (e.g., the Dartmouth Assertive Community Treatment Scale; DACTS; Teague et al. 1998).

ACT has also been modified in order to integrate with a supported housing philosophy of treatment that "does not require tenants to take medication, participate in psychiatric treatment, or abstain from using drugs or alcohol in order to be eligible for housing" (Tsemberis 1999, p. 229). This "Housing First" model (HF) was developed to respond to the needs of homeless persons with substance use and psychiatric disorders who have been unsuccessfully engaged in other services (Tsemberis and Asmussen 1997). HF promotes immediate access to independent housing and program services attuned to consumers' priorities. Though the program has no treatment requirements; the model does employ ACT teams in order to make treatment and support services available to consumers.

Programs that adhere more closely to the ACT model are more effective in reducing substance abuse, hospital use and associated costs (McGrew and Bond 1995; McGrew et al. 1994; McHugo et al. 1999). Most research, however, has focused on an aggregate of program elements, such as those described in the DACTS and not on how different contexts or approaches (e.g., HF) could significantly alter adherence to ACT principles *within* the boundaries of conventional ACT fidelity standards. Although it has been asserted that HF uses ACT teams that meet fidelity standards (Tsemberis 2005, p. 1304), published studies of ACT fidelity have not included HF programs. Thus, the adequacy of the DACTS to consider the demands that may be placed upon ACT teams to

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support in independent housing dually diagnosed persons with a history of chronic homelessness remains largely unexplored. This descriptive study examines the extent to which an ACT team situated in support of a HF program conforms to prescribed elements of the ACT model. An additional aim is to describe (1) how the rationale underlying ACT principles specifically applies to the HF program and (2) how the ACT team's work to support housing impacts fidelity to the ACT model by specifically identifying the extent to which accommodations in the ACT model have been made to suit the context and priorities of a HF philosophy. The results can be used to inform possible adjustments to the DACTS that may be employed when assessing model fidelity in a HF context.

Harm Reduction and Consumer Choice

Integrated dual disorder treatment has been promoted as an effective treatment for persons with concurrent mental and substance use disorders (Drake et al. 2001). The harm reduction approach incorporates the dual disorder model and aims to decrease the consequences of substance use without requiring abstinence. The DACTS currently assesses implementation of harm reduction tactics as part of the approach to treatment of persons with dual disorders (Teague et al. 1998). However, anchors used for scoring the DACTS were based, in part, upon programs and literature (Teague et al. 1998) that did not focus on dual-diagnosed homeless persons and therefore may not adequately reflect the needs of this population. In addition, HF's "radical acceptance of the consumer's point of view" that "allows clients to choose the type and intensity of treatment services or to refuse them entirely" (Tsemberis and Eisenberg 2000, p. 489) may impact assessments of certain items of fidelity measures that reflect consumer choice (e.g., service intensity).

The DACTS tends to focus on structural rather than clinical aspects of treatment (Teague et al. 1998). Relationship building in a consumer-directed environment (e.g., HF) can lead to modifications of ACT that may be interpreted as efforts to enhance implementation of some of the basic principles of ACT like flexible, individualized, and time-unlimited services (Bond et al. 2001). For example, reduction in treatment demands may promote the development of therapeutic relationships and engagement in treatment at mutually agreed upon levels, which are both themselves underlying rationales for items measuring ACT fidelity (Center for Mental Health Services 2007). This, along with HF and ACT programs typically targeting clinically similar populations, leads us to expect that overall fidelity to the ACT model in a HF context will be high while items that reflect consumer choice are likely to be low.

Methods

Overview

The DACTS guided an empirical inquiry to investigate a HF-ACT team's degree of implementation of ACT principles using multiple sources of evidence (see Center for Mental Health Services 2007 for more information about the DACTS). The ACT team under study was part of a HF program called New Keys which was modeled largely after the Pathways to Housing program developed in New York (Tsemberis and Eisenberg 2000). The team had been in service for 3 years and was serving 62 clients at the time of the study, all of whom were dually diagnosed with mental and substance abuse disorders and had a history of long-term homelessness.

Measures

The Assertive Community Treatment Fidelity Scale (Center for Mental Health Services 2007) has been promoted as the tool for assessing fidelity of a treatment program to the ACT model. This scale is synonymous with the DACTS (Teague, February 9, 2007) developed by Teague et al. (1998). It is worth noting that the DACTS may undergo some revision from the form that was used for this Fidelity Study to reflect insights from current and previous use of the assessment tool. The DACTS contains 26 program-specific items. Each item on the scale is given a score ranging from 1 (*not implemented*) to 5 (*fully implemented*). Items fall into three categories: human resources; organizational boundaries; and nature of services. The DACTS comes with a set of "probe questions" that were used to elicit the critical information needed to score each fidelity item. Added to these probes were questions aimed at eliciting information specifically on (1) how the rationale underlying the fidelity assessment item specifically applies to the HF program (e.g., "To what extent do you think this rationale applies to New Keys and to your work with New Keys clients?") and (2) how the ACT team's work to support housing impacts the fidelity item being measured (e.g., "How does the work to support housing impact your thinking about [insert fidelity item]?"). Interviews were conducted with these questionnaires at the HF agency. Clients were interviewed once only; with no follow-up and no identifying information collected. Team members were interviewed multiple times depending upon the need for clarification of item scoring. After receipt of verbal approval from clients and signed consent from ACT team members, assessors recorded responses to interview questions with a digital voice recorder. Data on nature, frequency, location, and provider of service contacts were collected from ten charts selected at random. This process

was reviewed and approved by the University of Pennsylvania Institutional Review Board and the City of Philadelphia Health Department Institutional Review Board.

Analysis

The DACTS provides anchors that guide scoring of each item in the fidelity assessment. Content analysis of Team Leader, clinician, and consumer interviews, and chart reviews provided context for item ratings. An arithmetic mean score was calculated in each of the three categories ("human resources," "organizational boundaries," and "nature of services") to indicate the degree of implementation of ACT principles. Scores on the fidelity assessment were calculated directly from transcribed responses to interview questions and from paper chart-review instruments. In addition, the authors analyzed the transcribed responses to questions about the influence of the HF approach on the work of the ACT team.

Results

New Keys staff consistently indicated positively that the rationale underlying DACTS fidelity assessment items relating to the structure and nature of services of the ACT team applied to their HF program. Results of the fidelity ratings indicate that, in general, scores on fidelity items reflected the incorporation of these principles to a moderate degree (i.e., an overall score of 3.7 on a scale of one to five). The nature of services dimension had the lowest mean score (3.3) of the three categories, organizational boundaries the highest (4.1), and the human resources score fell between these two (3.8). Eighteen of the 26 items scored were rated either a 4 or 5. Items scoring below this level of implementation, with scores in parentheses, were: human resources: team approach (3), staff capacity (3), substance abuse specialist on staff (1); organizational boundaries: responsibility for hospital discharge planning (3); nature of services: intensity of service (3), frequency of contact (2), work with support system (1), dual disorder treatment groups (3), and measured but not included in scoring, role of consumers on the treatment team (1). Evidence from chart reviews, staff and client interviews of how the team's work to support housing influenced scores is provided below within the measure's three dimensions.

Human Resources

Client charts, the primary source of information for the item, "team approach" reflect that only 50% of clients had face-to-face contact with more than one New Keys staff members in the 2 weeks prior to this study. One case manager offers a twofold explanation,

> "[1] One of the challenges lately has been being CBH [Medicaid] billable. We need to do some stuff with individualized case managers. And so I think that is taking away to an extent of the team approach … [2] So I found that most of my interactions that are most meaningful have actually occurred in the office. I think one of the challenges is that in the community, there's always two people. And sometimes having a second person can get in the way of having difficult discussions" (case manager 2; CM2).

Another case manager sees a tradeoff between staff security and relationship building with clients when pairing-up for home visits, "I think that's a dichotomy, like providing support and security versus kind of changing the dynamic from a one on one contact" (case manager 1; CM1). Prioritizations are further evidenced in assessing the presence of a substance abuse specialist on staff.

New Keys was developed to provide case management services and supported housing to chronically homeless, street-dwelling individuals with diagnoses of co-occurring mental illness and substance abuse. Though team members were consistently supported in substance abuse services by a licensed substance abuse treatment provider, the team did not have as a member an individual with at least 1 year of training and clinical expertise in substance abuse treatment. Instead, the whole team served to enhance the motivation of clients to address their substance use or to provide referrals to traditional substance abuse treatment. For example, the team's two nurses had taken a lead role in actively referring clients to structured substance abuse treatment services while "[the rest of the team was] engaging clients around their substance abuse, that happens in their homes, it happens when it comes to their medical treatment, it impacts on the goals that they have in terms of education or employment" (CM2). Reflecting this pervasive influence of substance abuse in clients' lives, the team chose to focus on clients' goals in different domains and to enhance their motivation towards treatment by identifying how their substance use might interfere with achieving those goals. The New Keys team provided this motivation in a variety of ways and contexts reflecting housing, employment, or other identified goals:

> "Oftentimes, the goal is something else that the substance abuse may be providing a barrier to. And so that's kind of a backdoor approach to us addressing the substance-abuse issue … "OK, so you want to maintain housing. Let's talk about what happened with your last three apartments. We want to help you get a fourth and maintain that housing. But we need to talk about

what happened in these last three. Why do you think it is that you had so much drug traffic?" So the counseling is provided by the case managers, myself, and the nurses on the team. And the doctor as well. And takes the form of getting people to openly discuss their use … We try to be in constant dialog with consumers about their use in a non-threatening way. And sometimes that conversation, while it's very intentional on our part, may look like an informal query … We very much try to be non-coercive. But through motivational interviewing and other harm-reduction strategies, try and engage people in just discussion of their use." (Team Leader).

So while the team lacked a substance abuse specialist to provide traditional counseling, the approach employed here allowed for a highly individualized approach to addressing clients' substance use. This resulted in the fidelity item assessing the presence of a substance abuse specialist being rated as "not implemented," whereas the service item, "individualized substance abuse treatment" was rated much higher as this service was provided by the entire team. Thus, adherence to the HF philosophy allowed for high fidelity ratings on items that promote: the identification a client's readiness to engage, following the client's lead to provide or motivate treatment, and relating the use and purpose of substance abuse treatment to practical goals but a lower score on an item that called for a substance abuse specialist on the team.

Organizational Boundaries

Though team members recognize the importance of, and to a high degree implement, "full responsibility of treatment services," they also recognize their limits to provide it:

> "So we have competing needs … providing treatment services sometimes can get in the way of supported housing … because we don't have the time to provide all the services that they need in order to really have good quality of life in their apartment" (CM2).

Scores on the fidelity items can provide some evidence of how New Keys handles these "competing needs." Despite the rival demands between the provision of treatment services and housing support, the data reflected a high implementation of "responsibility for crisis services," and involvement with "hospital admissions," and "discharge planning." It is likely that, given ACT's record of reducing hospitalizations among its consumers, hospitalization was a rare occurrence among New Keys clients and that this infrequency allowed for full redress when it did occur. More routine treatment services, however, may be suffering as a result of attempts to provide clients all the support they need to achieve a "good quality of life in their apartment" or housing support may be given less attention at the expense of provision or treatment services. Low implementation of items assessing the nature of services could indicate housing support consumes an inordinate amount of the New Keys team's attention at the expense of treatment services.

Nature of Services

Both "frequency of contact" and "work with informal support system" were items on which the team scored lowly (2 and 1, respectively). The latter item assesses an area that, when given short shrift, could allow for the opportunity to provide more direct housing support. However, when "frequency of contact" is considered alongside the team's moderate score on "intensity of services" (3; a median 58 min per week), clearly face-to-face contact with clients did not reach the level of full implementation identified by the DACTS. As such it appears likely that neither treatment nor housing support services are provided to the extent that is asserted to be necessary by staff in the above quotation. Herein may lay the point. Support services provided in a HF context are not provided to the extent believed necessary by service providers rather; the recipients of the services govern the service intensity and frequency of contact. This consumer choice philosophy paired with clients who are likely to possess low-levels of motivation and readiness for treatment will result in low scores on items measuring service contact within a scale that has been anchored on the activities of ACT teams that do not incorporate HF's "radical acceptance of the consumer's point of view." It is likely that New Keys provides adequate housing and treatment support services when requested by clients. However, it may be that these services are not requested that often by clients. This would explain the high scores on hospitalizations admission and discharge planning (i.e., clients requesting and receiving staff support more when in crisis). So while the tensions to provide treatment or housing support services in the available time may be real, the time constraints are likely the result of clients choosing to limit their engagement with service providers. Indeed, aside from the intensity and frequency of service contacts, New Keys scored moderately to highly on items assessing the types of service provision. The glaring exception is "work with informal supports."

The low score on this item reflects the population targeted for this program; long-term street-dwelling homeless that have failed to engage in less intensive services. The "burned bridges" accumulated with such persons is well-documented (Fischer and Breakey 1985; Lehman et al. 1995). However, when clients do have relations, property

owners may limit the amount of contact between clients and such supports. As such, work with informal supports is limited and reflected in a low fidelity score for this item.

Discussion

Overall, the ACT team demonstrated a moderate degree of fidelity to the ACT model. However, within certain areas their ability to fully implement ACT components appeared limited by clients choosing not to access services or by the fact that clients lacked informal social supports (due to space limitations, we will not discuss the latter finding other than to state that behaviors that can be attributed to serious mental illness and substance abuse are likely to result in ostracism from social supports and that it is possible that clients' supports have chosen not to engage with New Keys that resulted in a low score on this item). Further, staff repeatedly reported a large share of their time spent with clients focused on providing assistance with upkeep and maintenance of clients' housing. While it has been asserted that the ability of clients in HF programs to retain residence for long periods of time "challenges long-held (but previously untested) clinical assumptions regarding the correlation between mental illness and the ability to maintain an apartment of one's own" (Tsemberis et al. 2004, p. 654), the competing demands between housing support and provision of treatment services identified by staff above indicates that this residential stability requires a considerable portion of the time staff spend with clients. Though this need for assistance with clients' adjustment to new residences was seen by staff as competing with service provision, it is our interpretation that limits on both assistance with housing and treatment provision are the result of clients' decisions not to request or accept staff support.

Reflecting consumer choice not to access treatment, persons served through traditional "treatment first" (i.e., where treatment is usually required) housing programs utilize more treatment services than those clients in HF programs (Padgett et al. 2006; Tsemberis et al. 2004). Similarly, the New Keys program, which selected for individuals who had a record of rejecting services, indicated low service utilization by clients even though services were available either through referral or direct provision. For example, while the program scored highly on its implementation of the dual disorder (DD) model in its approach to treatment and provided dual disorder treatment groups, attendance at these groups was low. Similarly, "individualized substance abuse treatment," which appears to permeate most interactions between clients and staff, is scored highly. However, these interactions are relatively brief and infrequent resulting in low scores on "intensity of service" and "frequency of contact."

Despite New Keys scoring highly on 18 of the 26 fidelity items, lower-scored items could suggest that ACT in support of HF is its own particular "brand" of ACT. However, the recovery-based service orientation of New Keys is, to some extent, already incorporated in the DACTS through an item assessing incorporation of a stage-wise, non-confrontational, DD approach to treatment. That this approach is not assessed through other program components (i.e., other items on the DACTS) may indicate a larger issue; the extent to which the conceptualization of ACT as reflected in the DACTS accommodates recovery oriented service generally, as opposed to just HF.

Though adherence to the ACT model has been shown to improve outcomes for clients served by ACT (Allness and Knoedler 1998; Bedell et al. 2000; Latimer 1999), McHugo and colleagues (1998) have suggested that individual-level factors such as willingness to maintain relationships and the working alliance between client and clinician may also effect outcomes from ACT. Indeed, the developers of the DACTS report that the instrument's focus on structural aspects of the ACT model has resulted in the omission of measurement of "clinical aspects that may be equally important to effectiveness but are harder to measure" (Teague et al. 1998, pp. 218–219). These clinical aspects appear to include the client's self-directed engagement in treatment services inherent to the recovery orientation of HF. Such omissions have consequences when assessing fidelity, as indicated in the present assessment, and are further evidenced by Anthony and colleagues' (2003) assertions that much of the research on evidence-based practices like ACT have failed to recognize the importance of the consumer–clinician relationship and rarely demonstrated a positive impact on recovery related outcomes like empowerment or client's own perceived progress through treatment. Supported housing's consumer-choice philosophy reflects a recovery approach in that the ability to choose housing and to engage in services provides an empowering setting for clients (Nelson et al. 2007) and may explain why an ACT team within a HF program may not fare as well against other ACT teams when assessed with a fidelity measure that has been developed based upon more traditional evidence. Though New Keys client outcomes were beyond the scope of this study, studies have shown HF to be successful with increasing both recovery-oriented outcomes such as client choice and more traditional outcomes like residential stability (Greenwood et al. 2005; Tsemberis et al. 2004). Thus, depending on the outcomes being sought with an ACT program, divergence from the ACT model may not be as detrimental to outcomes as previous studies have suggested. These divergences may represent enhancements in the service that build productive working relationships toward valued outcomes.

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