From experimentation to mental health policy:
“Un chez soi d’abord” program
Implementation of an evidence based practice in France and
Construction of evaluation toolbox

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Key Words

Housing first, Assertive Community Treatment, Monitoring, Specifications, Recovery, Homeless
Introduction

As a departure from the ideological debate that has preoccupied French psychiatry since its inception, the French government has chosen for the first time in the field of mental health to implement an evidence-based intervention model incorporating powerful scientific research. The program is called *Un Chez Soi D'abord*, or Housing First, and indeed independent randomized evaluative research has shown that it is really effective in responding to a major public health issue. The positive results of Housing First has led the French government to pass legislation to sustain the program in the four cities already involved, and to introduce it to 16 more cities. Thus a crucial second step begins: To implement the program in 20 cities.

During the experimental phase, the evaluation of the services was the responsibility of the research team. Now, the process of assessment and monitoring has to be organized. Indeed, it is an axiom of program evaluation that an intervention is unlikely to be effective if it is not implemented appropriately. The effectiveness of any intervention depends in part on the quality of its implementation. This is particularly true for the Housing First model, where it has been proven that model fidelity is the main factor determining favorable clinical outcomes. This theme is the focus of the current thesis.

In the first part, a brief history of mental health in France will introduce an understanding of the phenomenon of homelessness among people living with psychiatric disorders, which appears to have increased in recent years. We shall also describe one of the solutions to this problem implemented by the French
government, namely the experimental programme *Un Chez Soi D’abord*, or Housing First.

The second part describes participation in different decision-making meetings and a survey of the clients, professionals and decision-makers, and focuses on the main question of this work: In order to appropriately implement a validated model after an experimental phase, which evaluation tools can be used to evaluate and monitor whether the intervention has been implemented as planned?

My participation in this work was multiple. First, during the trial phase, as medical coordinator of the program Housing First in Marseille, I coordinated the multidisciplinary team, but I was also at the interface between the research and support teams. Second, for the construction of specifications and the 'toolbox evaluation', I worked in a close collaboration with the national coordinator of the programme, collecting data, and was involved in different decision-making meetings.

1. Part 1: Mental health in France

The 2009 report on Health and Homelessness (*La Santé Des Personnes Sans Chez-soi*) provides an overview of the major health problems faced by people who are homeless, and highlights the fact that being homeless is a factor in mortality and morbidity in the field of mental and somatic pathologies.

The responses implemented so far in terms of public policies on social inclusion do not fully answer this challenge. On the one hand, medico-social services intended for people in situations of exclusion and suffering from mental disorder require prior guidance by a dedicated committee, and commitment to a caring approach; homeless people most often are, and have always been, excluded. On the other hand, the classical measures proposed in terms of the social emergency framework (so-called "staircase" model), require, as a prerequisite, access for all to self-contained housing, so that people can prove that they have the "capacity
to be housed". Self-dependent housing is often conditional on accepting medical treatment and being abstinent from psychoactive substances. "People who are cumulative of situations of vulnerability are most likely to return to the recurrent cycle of social emergencies and to turn social structures into health structures until they die." There is thus a conjunction of two negative effects: Poor recovery and a high consumption of services, which make the services not very effective, especially given the rate of discontinuity.

Faced with this situation, the state initiated an experiment called Housing First (Un Chez Soi D'abord), between April 2011 and December 2016, which aimed to radically change the support modality. Indeed, the program offered direct access to ordinary housing from the street, with sustained and multidisciplinary support at home, for people suffering from severe mental illness and eluding the conventional services.

Independent randomized evaluative research was conducted, which showed that the programme Housing First offered real effectiveness. The main results will be presented at the end of this section.

An evaluation committee, meeting on Tuesday, July 5, 2016, considered that the programme Housing First meets a real need in terms of the general aims of public policies for the target audiences, and that based on the results of evaluative research it added value compared to existing health, social and medico-social services. The committee therefore advocated "the sustainability of the experimental sites and the controlled deployment of the programme in the territory, based on a relevant assessment of the needs at the targeted sites while maintaining rigorous evaluation accompaniment during deployment".

From a budgetary viewpoint, and in view of the best performance of public spending, the Housing First programme is part of different action plans: The National Strategy for the Care of Homeless People or Poorly housed 2009/2012, "which is based on the belief that housing is a prerequisite and necessary for integration; the Multiannual Plan for Combating Poverty and Social Inclusion 2013-2017; the Territorial Mental Health Project; the regional health

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1 http://www.ladocumentationfrancaise.fr/var/storage/rapports-publics/074000208.pdf
programmes; and the Departmental Action Programme for Housing the Disadvantaged.

The first part of the next section will serve as a reminder of the major stages of French psychiatry, and will enable us to understand how a system of care, carried out by deinstitutionalization movements and the politique de secteur ("sector policy") aiming to guarantee access to local care for everyone, no matter where they live, has not been able to stem the phenomenon of homelessness or to prevent the entire phenomenon of sanitary exclusion. We shall see how homelessness represents a major public health issue, and how, through its principles of action and its main results, the research programme Housing First responds to this issue in a coherent way with mental health action plans and WHO recommendations.

1.1 Generality of mental health in France

1.1.1 From Insanity to the General conception of illness

Until the law of June 30 1838 organizing the care of the « insane », no hospital response was really offered to the mentally ill, who were often placed in prison when their behavior disturbed the social order. This law imposed the existence of one "insane asylum" by department. According to Marie-Rose Mamelet (Mamelet, 1978) it is because of the obligation made by this law that from 1838 to the end of the nineteenth century, most psychiatric hospitals currently exist in France.

Their edification however did not really take place until after 1870 (Coldefy, 2007). According to Georges Lanteri-Laura(Lanteri-Laura, 2001) this slowness can be explained by the paradigm shift during this period, from the alienation defined by Philippe Pinel and the asylum as an adapted institution to "The general conception of mental illness" by Jean-Pierre Falret(Falret, 1864). The notion of mental alienation proposed by Philippe Pinel in the 18th century
makes madness a disease only curable by "moral treatment" and isolation in exclusive institutions. As for Jean-Pierre Falret he emphasizes the plurality of diseases and their irreducibility to a single pathology. The paradigm of insanity was used to develop projects of institutions that did not come into operation until later but these institutions quickly found themselves unsuitable for new conceptions. According to Michel Audisio (Audisio, 1980), this slow implementation of the law can also be explained by the economic difficulties observed at the national level and the negative prejudices within the population: public opinion was not ready to accept the idea of spending large funds "to retain, keep and possibly treat fools deemed incurable".

1.1.2 Towards deinstitutionalization: "la politique de secteur" and its limits

In 1939, 18 departments were still devoid of any equipment. At that date, there were 100 establishments with 103,000 patients. Nearly 40% died before the end of the Second World War because of malnutrition (Vermorel & Vermorel, 2012). Awareness of the concentration camp horror and the questioning of the idea that the internment of the mentally ill in closed asylums is the only therapeutic instrument have been at the origin of the "desalienist" movement and deinstitutionalization. These evolutions were accompanied by an "unprecedented historical conjunction" (George & Tourse, 1994): the discovery in the 1950s of neuroleptics which multiply the therapeutic possibilities and allow the patients to move and exit; A more liberal mindset of psychiatrists, and more important means of providing services (Bernard, 2002) through the granting of state subsidies.

"Sectorization" the specificity of French psychiatry

It was in this historical context that the circular of 15 March 1960 setting up the sector policy was drafted. Each department must therefore determine geographic constituencies within which a medico-social team ensures

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2 Sector policy
prevention, early diagnosis, intra- and extra-hospital treatment and post-treatment of patients. Thanks to its good knowledge of the patient, his family and his environment and the use of the equipment at his disposal the healthcare team can thus ensure the long-term treatment of the patient and his insertion in the community. This is one of the main characteristics of French psychiatry. The fact that from the outset the "sectorization" has "docked" deinstitutionalization to a territorial reference has for a long time marked the innovative aspect of French psychiatry. From the outset, "sectorization" was based on a double division, territorial and demographic: a multidisciplinary team is responsible for ensuring the continuity of care, prevention and reintegration on a defined geographical area (the sector) of about 70,000 inhabitants. The search for a good match between a supply of care and the needs of a given population takes place within the boundaries of these "geo-demographic" spaces (Lopez, 2001). This model was taken up and implemented much later (1980-1990) in several European countries (Johnson & Thornicroft, 1993) (Johnson and Thornicroft, 1993). This division is in fact based on a very "hospitalo-centric" design, referring to the World Health Organization (WHO) standards for indices of beds per inhabitant. WHO therefore advocated a rate of equipment of 3 beds per 1,000 inhabitants in services with a maximum of 200 beds. This resulted in the creation of 200 bed areas with a population of about 67,000. Paradoxically the geographic framework that was supposed to mark the end of the asylum (and the reduction in the number of beds) was built in reference to the hospital.

The limits of "sectorization"

In 2003, France had 817 general psychiatric sectors in France responsible for the population over 16 years of age in a defined territory and 321 child psychiatry sectors for the population under 16 years of age. These areas were very heterogeneous in terms of population size and area. Indeed certain limitations of the sectorial division in psychiatry have frequently been put forward. First of all, the sectorial division may seem artificial and sometimes obsolete: it is not always based on the needs of the population and its evolution. This is the case, for example, with the "camembert shares" straddling rural and urban areas,
which are supposed to guarantee the attractiveness of the sectors for doctors. In addition there is often a lack of overlap with the health, social, medico-social or educational sectors which leads to difficulties in coordination with the various partners (including local elected representatives) and defeats the continuity of care. The question of the unevenness of the division is also frequently raised as the very large imbalance of resources (both in personnel and equipment) between sectors cannot be explained by a variability in needs of the same order of magnitude. Another limitation is that the private sector and liberal medicine are not integrated into the policy of the sector. Finally, one of the major failures of the sectorization is that care in psychiatry despite an outreach philosophy, promoting ambulatory care as the cornerstone of this new care organization has remained largely hospital-centered. The "ambulatory turn" could not be carried out as envisaged in the principle of action of the "politique de secteur" and this is largely explained by the financing. Indeed, only one envelope finances the hospital part and the ambulatory part. Hospital care, which is very costly and requires substantial and constant means continues to imbalance the balance and the savings are mainly made on the ambulatory part. Contrary to Italy or England, if this process was accompanied by the closure of a large number of beds in the psychiatric asylums there was no closure of these beds in France.

Nevertheless, these constraints and difficulties have sometimes been overcome through the organization of care policies (Coldefy, 2007). In particular, the sectors have been restructured according to logic of functionality and accessibility. There have also been attempts to bring the psychiatric sectors into line with the health sectors and some divisions have been able to benefit from greater flexibility in relation to population norms in order to limit for example the distances to be covered by teams and caregivers in sparsely populated rural areas. Finally, the fundamental concept of intersectorality, which has grown considerably in recent years has allowed us to go beyond territorial limits in order to offer targeted care for certain pathologies or populations.

The Sanitary Simplification Ordinance of 4 September 2003, through the unification of regional health organization schemes (SROS), modified the
organization of psychiatric care by subjecting it to the same planning principles as the general offer of care. The psychiatric sector is maintained in its functional dimension, but must integrate with the health territory. The aim of these territories is to retain, according to the nature of the care activities, the appropriate levels of division. The psychiatric sector may correspond to the level of proximity to responding to mental health needs. According to some authors (Vigneron & Masse, 2006), this ordinance can represent an opportunity to try to solve the adaptation problems that have accumulated in the territorial organization of psychiatric care. The first analyses of third-generation SROS show, however, that the specific characteristics of psychiatry are not taken into account in the search for a territorial coherence in the supply of psychiatric and somatic care.

1.1.3 Mental health in France, a public health challenge

a) Main Epidemiological data of mental health in France

One in four people develops a mental health disorder during their lifetime. 1.3 million patients over the age of eighteen were treated in France by the psychiatric care system in 2008.

Every year about 200,000 people commit suicide and 11,000 die as suicide is the number one cause of death for people between the ages of 25 and 34. So we are facing a real public health challenge.

A more detailed analysis shows that 1% of the French population suffers from schizophrenic disorders and 2% from mood disorders. In 2011, 280,000 patients were monitored in health facilities for depressive disorders. This finding is confirmed by the 2011 list of the main diagnoses that led to the use of psychiatric care in a health facility: episodes and depressive disorders are the most important, accounting for almost 18% of diagnoses followed by neurotic disorders. Which account for 17.6% of diagnoses, followed by schizophrenic disorders. And accounting for 14.3% of diagnoses. More worrying is the observed trend in the active file of patients supported in psychiatry from 1991 to 2003: a
62% increase in this active list for adults in general psychiatry and 82% for children in child psychiatry.

As a consequence of this high prevalence, the medico-economic cost, although imperfectly measured proves to be important. According to a study carried out by the Clinical Research Unit in Health Economics, Île-de-France (URC Éco), this cost, assessed both from a health and medico-social point of view, was estimated at € 18.5 billion in 2007. The Court of Auditors, for its part, estimated the economic and social cost of these diseases at around € 107 billion a year.

b) From Psychiatry to mental health

Databases, promoted by the first Psychiatric and Mental Health Plan 2005-2008 provide an overview of hospital care of psychiatric disorders and the populations supported. Dr Philippe Leborgne, a public health doctor in the Directorate-General for Health (DGS), acknowledged the need to work on the information system, as the data were currently not harmonized in the same way on the territory. "There is a need for cohesion on the analysis of these data to better define mental health policies." Moreover, the information system on the social and medico-social sector is insufficient. a survey conducts every four years on social care facilities and services for people with disabilities, it is difficult to identify structures devoted to people with psychiatric disorders from those dealing with intellectual disabilities. Nevertheless in view of the prevalence rates and the medico-economic cost, mental health is a health, social and economic issue at the same time. The perimeter of psychiatry having expanded to include mental health disorders. According to the World Health Organization (WHO), mental health is a state of well-being in which a person can overcome normal tensions in life, perform productive work and contribute to the life of the community. It is therefore a broad concept that encompasses a global approach to the person in his / her living environment.

Psychiatric illnesses, on the other hand, cover heterogeneous pathologies, such as schizophrenia, suicidal behavior or behavioral disorders. They are
multifactorial diseases defined by a genetic background and environmental factors triggering severe consequences that can lead to premature mortality and associated disabilities. The field of care for psychiatric disorders is in the medical field and covers the prevention, diagnosis and treatment of these disorders.

c) Mental health plans

The tables below shows the main ideas of the first 2 Mental health plans in France.

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Continued pathways of care</th>
<th>Actions in favour of patients, families and professionals</th>
<th>Development of quality and research</th>
<th>Implementation of 4 specific programs</th>
</tr>
</thead>
</table>
| Means      | - Developing information and prevention  
- Improving reception and care  
- Supporting the patient on his / her care path. | - Strengthening the rights of patients and their families  
- Improved professional practice. | - Promoting good practices  
- Improving information in psychiatry  
- Developing research. | - Depression and suicide  
- Health and justice  
- Perinatal care, children and adolescents  
- Vulnerable populations. |

Mental Health Plan 2005-2008

The objective of the first Psychiatric and Mental Health Plan 2005-2008 was to provide an inventory of hospital care of psychiatric disorders and the populations supported.
<table>
<thead>
<tr>
<th>Objectives</th>
<th>Principles of action</th>
<th>Axes</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Earlier diagnosis of pathologies</td>
<td>- Think jointly about prevention, care and support</td>
<td>- Preventing and reducing rupture during the life of the person: by allowing the different ages of life to every person to access the prevention, the care and the social and medico-social accompaniments, in a way adapted to his needs And those of their caregivers</td>
</tr>
<tr>
<td>- A more homogeneous management of patients throughout the country and a somatic follow-up</td>
<td>- Search for a therapeutic alliance</td>
<td>- Preventing and reducing disruption according to the public and the territories: by guaranteeing equal access to quality care and social and medico-social support</td>
</tr>
<tr>
<td>- A better understanding of the mental health needs of all actors</td>
<td>- Fighting stigma</td>
<td>- Preventing and reducing the disruption between psychiatry and its societal environment: by strengthening the dialogue between psychiatry and society, restoring its rightful place to psychiatry and recognizing mental health as an essential factor of social cohesion</td>
</tr>
<tr>
<td>- Greater integration of the sick in society, in particular through the housing.</td>
<td>- Ensuring a multidisciplinary and multi-professional</td>
<td>- Prevent and reduce gap in knowledge: by strengthening the development of knowledge, its diffusion, its transmission.</td>
</tr>
</tbody>
</table>

Psychiatric and Mental Health Plan 2011-2015
1.2 Mental health and homelessness

1.2.1 Generality

While the process of deinstitutionalization has appeared to be an important development in psychiatric care in the world, the outcome is not the same as the expectations because on the one hand it has sometimes been chaotic and on the other hand the development of residential facilities and the alternatives to hospitalization remained insufficient. There has been many hospital readmissions - revolving door syndrome - with a negative impact on the quality of life of patients and their families and a rejection of the most disadvantaged towards homelessness and criminalization (Florentin et al., 1995). For example many studies in different countries show that 30-50% of homeless people suffer from mental disorders, including formerly institutionalized patients who find themselves directly back on the street after hospitalisation. But beyond these extreme cases it seems that life outside the institution is not as simple as imagined because of loneliness, poverty and stigmatization suffered by people with severe psychological disorders. In addition to reducing hospital management in acute or crisis episodes, the psychiatric sector no longer provides - or not sufficiently - long-term follow-up, which is left to general social or medical actors or families. Finally, this phenomenon of deinstitutionalization occurred at the same time as profound changes in social organization with the break-up of families (divorces, geographical mobility, etc.) or the generalization of women's work (Novella, 2010). Also from the 1980s there will be a rise in unemployment and rents and a widening of social inequalities. The result is a growing presence in the public space of patients who are out of medical care and living on the streets over periods of several years (Damon, 2012).

Moving from an asylum care model to an open care model in the city, a change of status for the sick person has also taken place, moving from the status of "psychiatric patient" to "Mental health care service user". But this latter status
is far from being inclusive - as was the status of psychiatric patient - and the person still has to be a citizen but also a consumer, an employee, an elector, etc. whose freedom, rights and choices must be respected (Novella, 2010). To this end the care must be as close as possible to the living space of the person and not impede his participation as citizen. While this model of outpatient care is suitable for relatively socially integrated people with lighter illnesses, it is difficult to support patients who are socially disadvantaged and suffer from severe psychiatric disorders. This is especially true in France where despite the efforts of stakeholders of the development of “sectorial policy”, the latter stopped in the 1990s (many reasons are invoked: hospital-centrism, development of a private psychiatry, compartmentalization of professionals working in the field of mental health, etc.) with a distribution of alternatives to hospitalization unevenly developed into the country (Roelandt, 2010) (Coldefy, Le Fur, Lucas-Gabrielli, & Mousques, 2009), and in the end the psychiatric institution proves incapable of caring for homeless people who are out of medical care, often with addictive and somatic comorbidities, in addition to schizophrenia.

1.2.2 Housing policies

Another aspect explaining the phenomenon of exclusion concerns housing policies and the fight against exclusion and poverty which have not been able to provide an effective response to the growing number of people socially vulnerable. This phenomenon is observed in most high-income countries.

In France, social housing policies are unclear with a multiplicity of partners and a reluctance on the part of municipalities which hold the key to the development of constructible land supply by issuing building permits (Girard, Estecahandy, & Chauvin, 2010). The State guarantees the conditions for the financing of the construction and maintenance of social housing and guarantees the right to housing through its legislative entry since 5 March 2007 and by numerous measures including the prevention of evictions, insalubrity of the habitat, the
devices of assistance to the homeless. Yet "the record of the national housing policy is not up to the current situation" says the Abbé Pierre Foundation (FAP) in its latest report of 2015 with "a deficit of supply but also a quality of the proposed housing to the poorest who is being questioned ". It is 3.8 million people who are poorly housed and more than 12 million people affected by the housing crisis according to the FAP and 141,500 homeless people (INSEE, 2015). The policy against expulsions remains ineffective and 30% of those expelled from social housing are because of behavioral disorders(Girard et al., 2010).

In addition, the State is the guarantor of national solidarity and as such "pilots and coordinates policies to fight major social exclusion and (...) ensures (...) primary responsibility for the care of Homeless people. This primacy of the intervention of the State in relation to the territorial communities, in particular, is justified by a specific duty (...) in favour of persons who can not be attached to a local territory ". In 2007 a "Strengthened Action Plan for Homeless People" (PARSA) was adopted and above all an enforceable right to housing was instituted. On January 8, 2007, the Minister of Social Cohesion set a new principle in welcoming homeless people: "Everyone welcomed in an emergency shelter should be offered a perennial solution, depending on their situation, adapted and accompanied if necessary, in the public social park, in the private park, in a CHRS, a CADA, a LogiRelais (residential hotel with a social vocation), a relay house or a stabilization accommodation.

In 2009, the State Secretary for Housing launched the "National Strategy for the care of the homeless or inadequate housing 2009/2012" whose objective is to develop sustainable housing solutions rather than temporary accommodations. The three main objectives are (1) the creation of a centralized demand and supply orientation system in the territory (with a toll-free number 115), (2) a single referrer, and (3) priority to direct access to housing. This strategy radically changes the principles of anti-exclusion policy, with housing being the final outcome and not the starting point for support. In 2013 the "Multiannual Plan for Combating Poverty and Social Inclusion" with an annual investment of 1.3 billion euros, involves both an increase in the number of temporary reception
facilities and more structural measures favouring access and maintain in housing
- reduction plan for overnight stays, accommodation to and in accommodation,
rental mediation measures, etc. Yet, concretely and as in most European
countries, rather than direct access to housing, it is most often a so-called
"staircase" policy - where the person still has to prove she or he is ready to have
housing before having housing in different setting as temporary shelters for
homeless people (Busch-Geertsema, 2013).

1.2.3 Epidemiological data: Homelessness a public health issue

Homelessness, defined as the absence of customary and regular access to a
conventional dwelling or residence (Rossi, Wright, Fisher, & Willis, 1987), has
been recognized as a growing social and public health problem in developed
countries since the end of the 1980s. An estimated 100,000 people live on the
streets in France. The number of homeless people is expected to rise in the
current economic context of growing inequalities with potentially dramatic
effects on health (Frankish, Hwang, & Quantz, 2005). Indeed, homeless people in
most Western countries have limited access to appropriate care for their
complex health care needs. Adherence to treatment and continuity of care are
often poor (Henry, Boyer, Belzeaux, Baumstarck-Barrau, & Samuelian, 2010).
They also have a greater risk of engaging in health-damaging behaviours,
including tobacco, alcohol and drug dependence in particular (Kleindorfer et al.,
2006)(Wardle & Steptoe, 2003). In addition, it has been estimated that more
than one in four homeless people suffer from serious mental illnesses, such as
schizophrenia or bipolar disorder (Breakey et al., 1989)(Fazel, Khosla, Doll, &
Geddes, 2008)(D. P. Folsom et al., 2002)(D. Folsom & Jeste, 2002). Numerous
studies, including a meta-analysis of the scientific literature conducted between
1979 and 2005 (Fazel et al., 2008), show that the prevalence of psychiatric
disorders is high among people without personal housing and confirm the
problem of access and maintenance in housing for homeless people. The
prevalence of psychotic disorders was estimated at 12.7% and that of major
depressive disorders at 11.4%. Alcohol dependence was found in 37.9% of
people, and drug use in 24.4%. A French survey (Laporte, Le Méner, & Chauvin, 2009) confirmed a higher risk of social exclusion and street life for people with severe psychiatric disorders, especially schizophrenia (RR = 13), compared to the general population. This study also shows that these people with schizophrenia are more often verbally and physically assaulted than other homeless people; it has been estimated that more than one in four homeless people suffer from serious mental illnesses, such as schizophrenia or bipolar disorder (Breakey et al., 1989) (D. Folsom & Jeste, 2002).

Providing care to those homeless people with severe mental illness is particularly challenging (Shinn, Baumohl, & Hopper, 2001): they are more likely to remain homeless for longer periods of time and to require more health support (that is, they tend to be in poorer physical health and to have more substance abuse co-morbidity) and more social support (that is, they have less social support, they encounter more barriers to employment and they have more contact with the legal system) than homeless people who do not suffer from mental illness (Kuhn & Culhane, 1998) (Goering et al., 2011).

The care of these persons by health and social institutions is based on a model requiring the person to stop his consumption of toxic substances and to engage in psychiatric follow-up before accessing independent housing. It is the model: "Treatment First (TF)" or "staircase model" also called "revolving doors" and which has been strongly criticized because it does not allow the most fragile people to go through the different stages; they will "turn" between emergency services, hospitalization, incarceration and the street. As the Court of Auditors found in 2007 in a report on homeless people, it is "people who cumulate situations of vulnerability who are in the best position to return to the recurrent cycle of social emergencies and (to) turn a social structure into a sanitary structure until its death". In the 1990s emerged in the United States the proposal of an alternative solution called "Housing First (HF)". The model is based on access to

housing directly from the street and without condition of treatment, psychiatric care and abstinence.

Given the urgency of the situation of homeless people living with mental disorders, the French government decided to launch the experimentation "Un chez soi d'abord" which takes up the principles of action of the second action plan in health Mental health: think jointly about prevention, care and support; Search for a therapeutic alliance; Fighting stigma; Ensuring a multidisciplinary and multi-professional; Evaluate practices. In the next part, we present the principles of action of the research program " Un chez soi d'abord" ", the randomized trial design and its main results

1.3. "Un chez soi d'abord": the response of a public mental health issue

1.3.1 Housing first model

a) Housing service

By operating housing services in a manner that is consistent with what consumers identify as their first priority—housing—Housing First engages persons whom traditional supportive housing providers have been unable to engage. Housing First programs offer immediate access to permanent independent housing, without requiring treatment compliance or abstinence from drugs or alcohol. The goals of Housing First are not only to end homelessness, but also to promote consumer choice, recovery, and community integration. Thus, Housing First programs offer housing in the form of scatter-site independent apartments in buildings rented from private landlords. Such residential arrangements honour the preference of consumers for apartments of their own (Goldfinger & Schutt, 1996) (Tanzman, 1993) and afford people with psychiatric disabilities the opportunity to live in the community virtually indistinguishable from other residents, a fundamental aspect of recovery(Tanzman, 1993). To maintain this integration, the program does not lease more than 15% of
the units in any one building. Units are rented from private landlords. This immediate offer of an independent apartment is a very powerful tool of engagement and consumers begin to recognize that the program is responsive to their needs and preferences. Addressing the consumer's needs first is the guiding principle for all subsequent services that are offered and is the foundation for building trusting and supportive clinical relationships, an essential component of Housing First that maximizes housing retention.

b) The clinical support: Assertive Community Treatment model

Consumers will have access to integrated and comprehensive support, usually through multi-disciplinary Assertive Community Treatment (ACT) teams, with slight modifications. ACT teams are located off-site, but are on-call 24 hours a day, 7 days a week, and provide most services in a client's natural environment (e.g., apartment, workplace, neighbourhood) on a time-unlimited basis. Consumers are not discouraged, however, from visiting team members in their office. Teams are staffed with social workers, nurses, psychiatrists, and specialists in supported employment and peer counselling, and meet the national evidence-based practice standards for ACT. Teams use a recovery-oriented practice philosophy that includes consumer choice as well as a harm reduction approach to substance use and mental health treatment. Teams offer consumers assistance with issues including housing, health care, medication, employment, family relations, and recreational opportunities. Service plans are not based on clinician assessments of consumers' needs; rather individual consumers choose the type, sequence, and frequency of services and have the option of refusing formal treatment altogether without compromising their housing. Such a flexible, consumer-driven approach to clinical practice helps ensure that consumers remain engaged with the team, particularly during crisis, and facilitates open dialogue.

Though consumers can refuse formal clinical services, such as taking psychiatric medication, seeing a psychiatrist, or working with a substance use specialist, the
programs have requirements for a minimum of one visit per week by the team. The main purpose of the periodic apartment visits are to assure tenants' safety and well-being, to assess the condition of their apartment, and most importantly to keep open the channels of communication between the consumer and members of the team. A typical visit consists of observing the consumer's mental and physical state, following up on outstanding issues from the last visit, and offering assistance with any domain the consumer wishes to address, from apartment repairs to visiting families. The visits provide two essential forms of support: instrumental and emotional. The team often helps out with routine chores, but perhaps more importantly conveys to the consumer that he or she matters to the team. The team may just 'sit and chat' for a while but through it all they are empathic, compassionate, and purveyors of hope.

Consumers have their own lease or sublease and have the same rights of tenancy as other residents in their buildings. As tenants, consumers remain housed as long as they meet the obligations of a standard lease. As in most supportive housing programs, consumers have an obligation to pay 30% of their income towards rent (typically, 30% of their Supplemental Security Income). Further, by separating the criteria for housing from treatment, Housing First programs prevent re-entry into homelessness for this high-risk group. The adverse consequences of relapse into substance abuse or a psychiatric crisis are mitigated because relapse is addressed by providing intensive treatment or facilitating admission to detox or hospital to address the clinical crisis—not by eviction because the consumer is using or experiencing psychotic symptoms.

After completing treatment for their clinical conditions, consumers return to their apartments. Consumers in Housing First programs only risk eviction from their apartments for the same reasons as other building tenants including non-payment of rent, creating unacceptable disturbances to neighbours, or for other violations of a standard lease. To prevent such evictions, teams work closely with consumers and landlords to address potential problems in the early stages.
Principles of housing first

(1) Housing as a human right
(2) Respect, attention and compassion for all clients
(3) Commitment to follow the client as much as necessary
(4) Access to independent apartments in the city
(5) Separation of clinical and housing services
(6) Respect for choice and promotion of client self-determination
(7) Recovery-oriented support
(8) Principle of harm reduction applied to services (Gilmer, Stefancic, Sklar, & Tsemberis, 2013)

1.3.2 "Housing first" model Vs. "treatment first" model main international result

Over the last several decades, two main approaches have been investigated regarding treatment for homeless people with mental illness in the United States and Canada (Fitzpatrick-Lewis et al., 2011) (Hwang, Tolomiczenko, Kouyoumdjian, & Garner, 2005). The Treatment First model, also called Continuum of Care, requires that homeless people first address mental health issues and/or drug misuse, moving progressively up a 'staircase of transition' before finally accessing independent housing (Sahlin, 2005). In contrast to this model, which predominates in many European countries, including France, the Housing First model reverses this sequence.

Recent reviews of the literature suggest that in North American contexts, the Housing First model is particularly appropriate for homeless people with mental illness (Hwang et al., 2005). In 2010, studies compared the two models "housing first" and "treatment first". According to the study by Padgett et al. "Housing first" was accompanied by a greater decrease in relapses and the use of psychoactive substances. This same model was also associated with greater acceptability (less loss of sight and less program exit). The study by Henwood et al. (Henwood, Stanhope, & Padgett, 2011) confirms these results and shows that treatment first professionals are more preoccupied with the search for an
individual housing to be proposed at the end of the program, whereas professionals involved in "housing first" focus their efforts more on medico-social care. The study by Kyle et al.(Kyle & Dunn, 2008), suggests from a review of the literature that the provision of housing not conditioned by the care of the patient can promote the engagement of people in a global medico social support. To concluded, Compared to Treatment First or Treatment-As-Usual programs, Housing First programs report greater residential stability and fewer arrests, greater control over drug and alcohol use, better health outcomes and well-being, and lower residential and health costs (Tsemberis, Gulcur, & Nakae, 2004)(Clifasefi, Malone, & Collins, 2013; Greenwood, Schaefer-McDaniel, Winkel, & Tsemberis, 2005; Larimer et al., 2009; Padgett, Stanhope, Henwood, & Stefancic, 2011; Rosenheck, Kasprow, Frisman, & Liu-Mares, 2003; Stefancic & Tsemberis, 2007).

However, is the Housing First model applicable in European context(Atherton & Nicholls, 2008)? To our knowledge, no randomized studies have been done before « Un chez soi d’abord » project exploring the impact of the Housing First model in Europe. Given the important differences in health and social care provision (Rodwin, 2003; Verdoux, 2007), such models needed to be tested and evaluated in these highly generous care contexts, such as in France, before implementation on a larger scale. In line with international recommendations on poverty policies and programs(Duflo, 2004; Duflo & Kremer, 2005) and the French national report on health and homelessness(Girard et al., 2010) cited previously , the French Ministry of Health recommended the project “Un chez d’abord” applying rigorous techniques, such as randomized evaluations, to develop and test the Housing First model with real-world problems faced by the homeless in France.

1.3.4 « Un chez soi d’abord »: the randomized trial design

A prospective randomized trial in for cities has been designed to assess the impact of a Housing First intervention in comparison with Treatment-As-Usual (control group receiving existing supports and services in each site) on health
outcomes and costs for homeless people with severe mental illness. This project was supported both by private (less than 10%) funding sources and public funding sources, issued from different policymakers in charge of medical, social, housing and research services.

**a) Study objectives**

The primary objective is to assess the impact of a Housing First intervention in comparison with Treatment-As-Usual on the use of high-cost health services (that is, number of hospital admissions and number of emergency department visits) over a 24-month period by homeless people with severe mental illness in France.

The secondary objectives are: (1) to assess the impact of the Housing First intervention on the number of days in hospital and health outcomes (that is, mental health, physical health, alcohol and substance use, quality of life and recovery), adherence to medication, social functioning, housing stability and contact with legal services; (2) to measure the cost effectiveness and cost utility of the Housing First intervention in comparison with Treatment-As-Usual; and (3) to describe changes in professional culture and practices of the different stakeholders involved in the Housing First program, including policymakers, professionals and users, using qualitative research methods.

**b) Study site and population**

The study is being conducted in four major cities in France: Lille, Marseille, Toulouse and the capital city, Paris. The inclusion criteria are as follows: over 18 years of age; absolutely homeless or precariously housed; living in the city in question for more than six months and intending to stay in that same city for the coming two years; possessing a 'higher' level of need, defined as having a diagnosis of schizophrenia or bipolar disorder according to Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV-TR) criteria (DSM-IV-TR, 2000) and moderate to severe disability according the Multnomah
Community Ability Scale (score ≤ 62) (Barker, Barron, McFarland, & Bigelow, 1994; Barker, Barron, McFarland, Bigelow, & Carnahan, 1994) and meet at least one of the following three criteria: 1) having been hospitalized for mental illness two or more times in any one year over the last five years, or 2) having comorbid alcohol or substance use, or 3) having been arrested or incarcerated over the last two years; being covered by French government health insurance including free state aid; and speaking French. Exclusion criteria included the following: being considered unable to provide informed consent (Jeste & Saks, 2006); having dependent children; pregnancy; or a DSM-IV Axis I diagnosis other than schizophrenia or bipolar disorder.

c) Study design and procedure

The present study is a 24-month, prospective, randomized, controlled, open-label, and multi-site study, based on a mixed approach combining quantitative and qualitative methods. Subjects are referred from a wide variety of services including mobile outreach teams (Girard et al., 2012), community mental health services, general hospitals and access to health care and public services teams (Figure). Trained research assistants check eligibility criteria within 24 hours of referral. The results from the Mini International Neuropsychiatric Interview are given by a psychiatrist (Sheehan et al., 1998). The assistants describe the study, respond to any questions the candidates may have and obtain written informed consent. Participants are then randomly assigned to either the Housing First intervention (Group 1) or Treatment-As-Usual care (Group 2). Randomization is stratified by site and a computer-generated, randomized list is created using a permuted block design. Quantitative data are collected during face-to-face interviews by the trained research assistants at five different points in time: at randomization (baseline; T0) and then at 6 (T1), 12 (T2), 18 (T3) and 24 months (T4) after randomization.
Referents

Mobile outreach teams
Access to health care and public service teams (PASS)
Emergency departments and hospitals (somatic and psychiatric care)

Assessment of homeless for eligibility by clinical research assistants and psychiatrists

Age > 18 years
Absolutely homeless or precarious housing
High level of need, including diagnosis of schizophrenia or bipolar disorder

Randomisation of homeless individuals

Housing First with assertive community treatment (N = 300)
Treatment as usual* (N=300)

Follow-up evaluation at baseline, 6, 12, 18 and 24 months by clinical research assistants
d) « Un chez soi d’abord »: results

Quantitative result

Independent randomized evaluative research has shown that the "Un chez soi d’abord" program has real efficiencies at a lower cost on a two-year follow-up resulting in rapid access and maintenance in housing for 85% of people followed, by an overall improvement in the quality of life (more relevant for people with schizophrenia), a significant reduction in the use of the health care system (50% reduction in hospitalization times for people followed in comparison with the so-called "Witness") and structures dedicated to the homeless (structures of the social emergency). The entire cost of the "Un chez soi d’abord" program is offset by the savings potentially realized by the health care system and, to a lesser extent, by the (medico-) social system. This intervention therefore has a controlled return on investment.

We present below the main results in table form:

![Graph 1: Evolution of housing type](image1)

![Graph 2: Additional data](image2)
Qualitative result

The qualitative research focused on the different actors of the program "1 Chez Soi d'Abord", and more precisely:
- The evolution of the professional dynamics of the support teams
- The process of recovery from the point of view of the persons concerned
- Institutional and political dynamics

« 1 Chez Soi d’abord », a program of health promotion?

Numerous studies confirm the pre-eminence of the problem of housing in people with mental disorders. The literature indicates that the link between psychiatric disorders and homelessness is double: mental illness predisposes people to housing vulnerability, and housing vulnerability is associated with mental illness.

In France, the dominant representations in housing, mental health policies converge: psychiatric illness is considered a source of housing precariousness. The link between precariousness and mental health seems to be considered only on one way.

The philosophy imported by the program “1Chez Soi d'Abord” contradicts the dominant representations. The multiple definitions of recovery have in common the emancipation of the deficit, pathology, relapse, stabilization or healing approach to insist on the conditions of a personal, relational and socio-political process corresponding to a new way of thinking and of envisaging the future. As such, recovery conditions have more to do with health promotion, its claim to act on the social determinants of health and empower people.

"Un Chez Soi d’Abord", an intersectoral program?

Participants in “Un Chez Soi d’Abord » program have an intersectional identity. As street-involved and psychologically disturbed, they generally see the marginalization of their interests and their experiences in speeches designed to respond to one or the other of these dimensions (illness or street course).

The multidisciplinary support offered by the Un Chez Soi d'abord program should enable tenants to move away from a potentially stigmatizing one-
dimensional identity (of a patient, a disabled person, a homeless person, a drug addict) in order to recover a non-stigmatized plural identity (Artist, athlete, resident, parent / brother / friend, worker, etc.). The randomization trial revealed:
- theoretical and effective access to housing and care
- the principles of local justice declined towards the so-called "vulnerable" population whose "burden" must be distributed equitably, and with them the risk of one-dimensional identity assignment resulting from it. Implementation of the program reveals the difficulties of collectively thinking that the experience of the psychiatric illness of homeless people is different from that of non-homeless people, especially since historically the “recovery movement” has relied on a common experience of psychiatric services, regardless of class structures. Consequently, the proponents of the recovery do not have an interest in asserting social inequalities before a common experience of the disease. Qualitative research has restored the experience of psychiatric disorders in a multidimensional life experience by exploring the interplay of internal and external constraints faced by the users.

The use of science or the risk of depoliticization
The genesis of “1 Chez Soi d’abord” program began with squatters with strong intellectual and activist capital, convinced by user knowledge and the right to housing, one of whose strategies consisted of documenting and evaluating the most therapeutic value of access to the home; It ends with the untimely prioritization of a large-scale, randomized experiment resulting from internal negotiation with the State apparatus and optimized by the advent of experimentation as a method of evaluation of public action. What is remarkable is the way in which the actors belonging to the same coalition at the local level and in the central administrations have taken advantage of presenting their cause as capable of a technical solution validated by the scientific work improves health and the use of care, while some of them would gladly have given priority to the political argument (everyone has the right to have a roof / everybody has the right to receive care).
In practice, the concern for evaluation, which has become a strategy of actors, is claimed to be an effective tool for politicizing some form of injustice done to homeless people with severe psychiatric disorders. However, despite an explicit intention at the outset of the program, the opportunity to give the floor to the users and to involve them in the life of the program was very timid and had little impact on the functioning of a program embedded in a search protocol in predefined format. In the end, the participation of tenants weighs very much on the margin on the future of a program subjected to the balance of power opposing the major operators of care, social action and housing.

During the trial described above, I was the coordinator of the Housing First program in Marseille. I coordinated the multidisciplinary team, but I was also at the interface between the support team and the research team. For this reason I understood the research aspect of the program, and realized the relevance of strong collaboration between the support and research teams. The dynamic produced a snowball effect; each professional was involved to improve the quality of service and to recover their own practice. I was also in close collaboration with the sociologist who coordinated the qualitative research, in particular the support aspect (medical and social support, and management), and conducted some focus groups with him.
2. Part 2: Monitoring and Evaluation

The clinical trial of Housing First has permitted the scientific validation of the efficiency of this model in the French context. The second step is crucial: The implementation of the programme in 20 cities. It is an axiom of programme evaluation that an intervention is unlikely be effective if it is not implemented appropriately. If the effectiveness of any intervention depends in part on the quality of its implementation, this is particularly true for the Housing First model, where it has been proved that model fidelity is the main factor in terms of favourable clinical outcomes.

In this part, we shall focus on the main question of this work: In order to appropriately implement a validated model after an experimental phase, which evaluation tools can be used to evaluate and monitor whether an intervention has been implemented as planned? Secondary questions to be taken into consideration are the following: What are the factors promoting and limiting model fidelity during implementation?

We shall first analyze the creation of the specifications. This collaborative process, involving field professionals, users, funding agencies, control authorities and the DIHAL (Délegation Interministérielle à l'Hébergement et à l'Accès au Logement), is based on five years of experience, with the qualitative report as benchmark. I was not the leader, but I worked in close collaboration with the national coordinator of the programme. At the local level, I collected data from users and professionals (through a focus group and interview), and at the national level, I attended all the decision-making meetings.

These specifications have as a first consequence the necessity to create a medico social groupment which will be a point of departure for the second phase of Housing First: the sustainability step. We shall analyze this step from a local as well as a national perspective. Before starting the thesis, I wanted to analyse the setting up of the project at local level, in particular the political aspect. However, I had anticipated that the group would be created during the summer, but the project has been delayed and is still under construction.
Because the project is in an experimental phase, new requirements are emerging, in particular evaluation and monitoring issues, which until now have been outsourced to the research teams. We shall thus see how a toolbox can be developed based on the specifications and creation of the GCSMS, allowing these questions of evaluation and monitoring to be answered precisely with regard to two specific objectives: Respect for the intervention models, as well as maintaining the dynamic of appropriation of the programme by both professionals and users. The empowerment of both professionals and users is one of the drivers of this programme. For this part, I worked in collaboration with the national coordinator of the programme in charge of monitoring and evaluation. I collected some data using the methodology described below at the local level, and used the data as a basis for reflection. This work was supervised by one of the national evaluation agencies (ANSEM, cf. below).

2.1 Construction of specifications (guidelines) of “un chez soi d’abord”

« Un chez soi d’abord » programs are coordinated by the “DIHAL” an inter-ministerial delegation gathering ministries of health, housing and social cohesion.

Started in 2016 and largely based on the results of the qualitative research, the construction of specifications (guidelines) of “un chez soi d’abord is a collaborative work involving professionals, users and stakeholders. The final version was available in July 2016.

2.1.1 Methodology

The national specification defines the organizational and operational conditions applicable to the therapeutic coordination apartments “Un Chez-soi d’abord”;

4 Délégation interministérielle à l’hébergement et à l’accès au logement (Inter ministerial delegation for housing)
They shall also be subject to all the general provisions of the Social Action and Family Code (CASF) relating to social and medico-social services, including those relating to the evaluation obligations: "The establishments and services referred to in subparagraph Article L. 312-1 assesses their activities and the quality of the services they provide, in particular with regard to procedures, references and recommendations of validated professional practices or, in the case of deficiencies, developed (...) by the ANESM. The results of the evaluations shall be communicated to the authority that issued the authorization. Institutions and services report on the internal evaluation process undertaken."

From a methodological point of view, the creation of this specification is based essentially on the analysis of the qualitative research report (Cf part 1). 4 focus groups between June 2016 and April 2017, involving the field teams, funding agencies, directors and members of the DIHAL, based on the themes cited below, enabled the creation of a first set of specifications. All the stakeholders validated the final version during two meetings (June and July 2017).

Different themes addressed in the focus groups:

1- Principles of action (housing first model, recovery oriented care, harm reduction)

2- The public: definition of the public target (age, diagnosis, social condition...)

3- Organization
   - Area of Intervention
   - Management and head organization
   - Admission
   - Duration of support
   - Settlement Project
   - Partnership
   - Human resources
   - Training
   - Budget
   - Monitoring and evaluation

4- Missions and activities of the program
- Organization
- Modality of support
- Individual home
- Housing activity
- Medical and medico-social activity

In the next section, we will focus on the missions, the activities of the program and the care pathway of the users within this program. We will then describe the implementation of the control and management of the program. The last part will be devoted to monitoring and evaluation.

It should be noted that the users' positions was received indirectly during the research period in the form of a semi-directive interview and focus group. The teams of the 4 different cities have made a regular feed back to some users involved in the operation of the program.

An implementation guide based on the lessons of the experimental phase completes the specifications by offering detailed illustrations of the organization and professional practices resulting from the experience of the four experimental sites. These illustrations were made by small groups of 2-3 people involved more specifically on certain issues.

2.1.2 Result

Based on the 5 years of experimentation and its results, respecting the 3 models of intervention of this program (Housing First, Harm reduction and Recovery models), we now present the main elements that we find in the specification concerning the support of the users. We can see through this process how an evidence based practice validated in other countries could be adapted and validated again scientifically. The elements described below must be respected as closely as possible and the monitoring and evaluation tools described in the last part will aim to respect in particular this dimension of the program.
a) Missions and activities of the program “1 chez soi d’abord”

The program « Un Chez-soi d’abord operates without interruption 24hrs and 7 days a week, in particular by the implementation of a penalty or a telephone hotline for the people supported

Organization

Two main activities have to be organized:

- Housing activities It encompasses missions of capturing, rental management and support to housing

- Medical and medico social support: It will provide support to rights, care, habitat and citizenship.

General terms and conditions of support

Support is provided by a multidisciplinary team that offers intensive support with at least one visit per week to the home or to any place chosen by the person in the context of services oriented to recovery and offering a wide range of services. Support is maintained whatever the person’s residential journey, including during hospitalization or incarceration, in order to reduce breaks and promote citizenship. All the accompanying axes contribute to the recovery process. It is about working with people on their ability to act on the world as it is.

It will be proposed a support :

- Individualized realized in the environment of the person by professionals working preferentially in "multi-counselling" and in binomial,

- Based on people's choices

- Through a multidisciplinary team with a horizontal collaborative management that acts as a catalyst of the person's strengths and
potentials and ensures a perfect understanding of the information provided to the people supported,

- That guarantees respect for the right to private and family life of the persons supported.

People must be able to participate proactively, if they so wish, in all decision-making and policy-making bodies that concern them. An "Individualized Recovery Plan" will be developed with each person.

**Individualized Support**

The latter will aim at the person's entry into the program:

- To inform him/her of all the services and the modalities of its operation via a set of documents (welcome booklet, charter of rights, operating regulations and individual support documents).

- To identify its skills, strengths and potentialities and its wishes and expectations with regard to the system,

- To do with her/him an initial assessment of her rights

- To propose an assessment of their needs concerning support.

**Housing activities**

The latter, under the responsibility of the rental manager, will propose access to a dwelling and will implement measures aimed at preventing breaks and maintaining housing in close partnership with other actors of housing on the territory.

For the person's entry into the dwelling, the housing activity center must:

- Determine with her/him, the choices of housing diffuse in the city,
- Offer at least one housing corresponding to its choices within 8 weeks of its integration. If it is not suitable, another accommodation must be offered,
- Subscribe a rental or lease
- Ensure the proper installation of the person in his housing
- Ensure that the residual rent owed by the person does not exceed 30% of its resources,
- Open the rights to the personal allowance to the dwelling.

In the course of the move, the housing activity center in conjunction with the multidisciplinary team will:
- Ensure the rental management and the links with the owner,
- Ensure prevention and management of rental risks
- Propose a relocation if necessary according to the respect of the choice of the person,
- Guarantee the rights of the tenant with the owner,
- Accompany to a direct lease.
- There should not be more than 20% of apartments in a building that are dedicated to tenants of program “1 chez soi d’abord”.

Medico social support

Support to habitat and everyday life

The multidisciplinary team will work closely with the housing activity cluster to co-build with the person their housing project.

Support in this framework covers:
- The development and appropriation of its housing,
- The maintenance in the housing,
- Mediation with the environment.

It will consist in providing information, direct support that will be evaluated on a case-by-case basis, and finally strengthening individual skills (respect for dignity, reappropriation of daily life and fight against stigmatization).

Health support
In terms of health, the team has an overall objective of promoting physical and mental health. For this, it can mobilize the various dimensions that range from "cure" to "care". It support the person to the access to the care system and aims at their continuity both on the somatic and psychic aspect, the prevention, the detection and the harm reduction approach. Particular attention will be paid to the issue of psychological suffering. The team works in a multidisciplinary way and each professional participates in the improvement of the well-being of the person. Care should be part of the overall goal of recovery, placing the person as an actress and expert in his / her own health pathway. The question of respect for the dignity of the person, the limitations of each professional in the face of critical situations, refusals of care and lack of demand for care will be considered in regular reflection spaces. Support by peer mentors will be valued. On the dimensions of well-being and taking into account psychological suffering, the team will be particularly vigilant in situations of change (moves, employment, family or friendly situation, etc.). The aim is to allow the person to use the common law structures available in the territory (medical consultations, rehabilitation center, etc.). The support by the professionals of the program will be done in substitution or in complementarity with the common law taking into account the choice of the person, the assessment of his support needs and his state of health. These two modalities are not opposable and there is a gradient between the two according to the moments of the person's journey. It will be necessary with the agreement and the participation of the person to maintain cooperation between the different actors participating in his / her pathway of health.

Support to health concerns:

- Care and support for care: The services provided cover diagnosis, prescriptions, treatment, nursing, accompaniment to the consultation, monitoring and coordination of care. A medical evaluation will be proposed but in no case imposed in the first months when the person integrates the program.
- Health education, information, prevention and screening: this concerns all fields, in particular focusing on psychotropic treatments and their side effects, monitoring chronic pathologies, harm reduction and vaccination and screening in the general population or according to specific needs.

Support to relational life

The team will identify isolation situations, evaluate them and analyze their causes with the individual. Particular attention will be paid to identifying situations of vulnerability or violence suffered or acted upon by the person and not respecting his fundamental rights but also his duties.

Support to employment

In order to support vocational integration projects, a collection of training needs and access to employment in an ordinary or protected environment will be systematically proposed and support if necessary.

Support to cultural activities

It is a matter for the teams to create desire and encourage the person to move towards activities promoting social inclusion.

End of the support

The exit of the program is based on the examination with the person of a certain number of criteria. There is no provisional duration for the accompaniment but its relevance should be re-evaluated at least once a year with the person. At the time of the exit, the team will inform the actors participating in the accompaniment unless the person opposes it.

Although some elements of the specifications and its implementation guide should be respected as much as possible in order to guarantee better results, the
experimental phase also showed the importance of the appropriation of the intervention model by the teams. Indeed the issue of empowerment at the center of support for the users can also be a major element for the team building and the development of a common working culture. It is therefore important that this specification remains in a dynamic process allowing the teams to take ownership of it but also to stay in touch with the moving needs of the public. The program "1 chez soi d’abord" originates from the limitations of the systems of care and access to housing, which have become rigid and better adapted to meet the new needs of certain populations. It will be necessary to remain attentive to this dimension.

After describing the accompanying model, we will in the next section focus more on the organization and local management of the program.

2.2 Management of the program: Creation of a medico social cooperation group

During the five years of experimentation, each cities involved has developed a type of organization with different stakeholders in order to respond to the framework proposed by the DIHAL and to be quickly efficient considering the local context.

In order to sustain the program and develop it in a large number of cities, the Ministries of Health and Social Cohesion have asked that a type of administrative management program respectful of the program principles was defined. Many debates often heated between the different actors whose interests could be divergent concluded the creation of GCSM (Groupement de cooperation sociale et medico-sociale: medico social cooperation group).

Indeed, in each city, a medico social cooperation group has to be constituted with: a health facility, a housing organization, an addiction service and a users association. In Marseille this group has to be officially constituted in December
2017 and the main negotiations between participants and with financers (regional health and social cohesion agencies) has to be done in October 2017.

After briefly describing the process leading to the decision of the GCSM, this part will describe the GCSM in detail. We will also try to describe how this type of organization meets the requirements of the program "1 chez soi d'abord".

2.2.1 Methodology

On the same principle as the creation of the specifications, the choice of the grouping as management organism of "1 chez d'abord" and its method of governance comes from a work that is based firstly on the results of the 5 years of research and secondly a collaborative work involving all the directors involved in the experimental phase, the coordinators of 4 sites, and the heads of the health regional agencies of the 4 regions. The whole work was coordinated by the Dihal.

The methodology of this part is based on the analysis of the data collected in different contexts:

- Participation in different meetings (between potential group participants, with financers, with DIHAL)
- Interview with directors (or person involved) of different organizations
- Informal negotiation
- Email exchange

2.2.2 Result

The managing organism of the program "A Chez-soi d'abord" is a group of social or medico-social cooperation (GCSMS). It can not have any other object during
the three years following its creation and must include at least one organization falling into each of the categories mentioned in a) to c) below:

a) a health care institution providing psychiatric care, including a mobile psychiatric team for persons in precarious circumstances,

b) a legal entity authorized, for social, financial and technical engineering activities and for the sub-leasing activities

c) A center of addictology.

The managing organism concludes, unless they include among its members, a cooperation agreement with:

d) a health care institution providing somatic care and having a permanent access to health care,

e) an organization whose purpose is to combat the exclusion, integration or housing of disadvantaged persons,

f) an organization representing mental health users,

g) a body representing persons who are without housing

The managing body will be authorized for a capacity ranging from 90 to 105 places which are not scored on the territory.

We will try to understand how this type of innovative organization is particularly suited to collaborative and horizontal principles of action. It is little used until then in the sanitary and medico-social sectors. The choice of this type of grouping organization is the result of long national negotiations and difficult implementation at the local level.

The GCSMS constitutive convention will have to propose a balanced participation of all its members in order to decompartmentalize the different sectors of health, addiction, housing and social action.

Governance will aim to:

- The fluidity in the decision-making circuits in order to allow a reactivity in the management of the service,
- Horizontality in decision-making processes enhancing collaborative approaches with all stakeholders, including team members and people supported.

A pooling of skills and resources will be sought, in order to encourage the transmission of innovative practices implemented within the "1 Chez-soi d'abord" system to the other services of the GCSMS member structures.

The management organism should:

- Propose a clear organizational chart, making it easier for the people they welcome to use their support services and, if they so wish, investing in the decision-making bodies of the group,

- Participate in the dissemination of innovative practices in relation to the people welcomed. It will ensure the application of the reference texts in terms of compensation of people when they intervene (training, conference...).

The decision to choose as an administrative entity was therefore a lengthy process that sought to reconcile sometimes divergent views and interests. A number of factors have enabled this innovative solution to be found in the medico social field:

- The creation of detailed specifications: as mentioned above, these specifications were based mainly on the data obtained from the research work accumulated over 5 years. During the various meetings and exchanges, this specification has, on numerous occasions, allowed to refocus the debate which could sometimes be lost in institutional and / or local logics. In other words, this scientifically validated specifications allowed to be in a pragmatic logic and not ideological and partisan.

- The presence of members of the teams of the 4 cities and users at certain meetings: this allowed to respect the dynamics of horizontal management
and to promote proximity with the field. Indeed past experiments could show that once the experimental phase passed, the old dynamics regained the upper hand.

- National coordination of the DIHAL: incessant feedbacks between the national level and the local level under the aegis of a national coordination made it possible to extract the debate from local issues often tending to homeostasis.

A new phase of negotiations, only local in each city began in June 2017 under the responsibility of the ARS (Health regional Agency). The various stakeholders must constitute a GCSMS by December 31, 2017. At the first meetings and exchanges by email, we were able to see the interest of a national supervision of this work with support of the elements described above. Indeed, very quickly, the different actors have each expressed at their own level and in different ways, specific interests for their institution, which can be very far from the principles of "1 chez soi d’abord". For questions of timing, we can not in this thesis do the analysis of these negotiations but could be the subject of a future work.

2.3 “Evaluation and monitoring toolbox”

With sustainability the program "1 chez soi d’abord," it loses its definition from experimental status to become a medical social institution. Like any establishment and social and medico-social service, it will have to report every 5 years to the state. Indeed, the establishments and social and medico-social services are obliged to carry out external evaluations by an organization authorized by the ANESM (Agence Nationale de l’Evaluation et de la Qualité des Établissements et Services Sociaux et Médico-sociaux)⁵. In this section, we will

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⁵ National Agency for the Evaluation and Quality of Establishments and Social and Medico-Social Services: ANESM, created in 2007 in France, was born of the will of the public authorities to accompany social and medico-social institutions and services in the implementation of internal and external evaluation, instituted by the law of 2 January 2002. ANESM’s missions stem from the obligations imposed on the social and medico-social institutions and services, which are
present the results of a work carried out on the basis of the specifications with different stakeholders, which resulted in the creation of a set of assessment tools. These tools are, by definition, concerned with respect for the models of intervention and the quality of services.

2.3.1 Methodology

In Marseille, a qualitative survey was designed to develop monitoring and evaluation tools of the program “1 chez soi d’abord”. 4 Focus groups with professionals of the multidisciplinary team, 2 Focus groups with client following the main thematic and the recommendations of specifications (Cf tab) and 6 short open questionnaires with users (3) and professionals (3) focused on the same thematic have enabled them to define evaluation and monitoring tools.
<table>
<thead>
<tr>
<th>Housing activities (Capturing, rental management and support to housing)</th>
<th>Medico social support (Support to rights, care, habitat and citizenship)</th>
</tr>
</thead>
</table>
| **Housing condition**  
- Choices of housing diffuse in the city,  
- At least one housing corresponding to its choices within 8 weeks of its integration.  
- Subscribe a rental or lease  
- Ensure that the residual rent owed by the person does not exceed 30% of its resources,  
- Open the rights to the personal allowance to the dwelling.  
- Not be more than 20% of apartments in a building that are dedicated to tenants of program "1CSD"  

**Multidisciplinary team tasks**  
- Ensure the rental management and the links with the owner,  
- Ensure prevention and management of rental risks  
- Propose a relocation if necessary according to the respect of the choice of the person,  
- Guarantee the rights of the tenant with the owner,  
- Accompany to a direct lease. | **Support to habitat and everyday life**  
- The development and appropriation of its housing,  
- The maintenance in the housing,  
- Mediation with the environment.  

**Health support**  
- Care and support for care  
- Health education, information, prevention and screening  

**Support to relational life**  
**Support to employment**  
**Support to cultural activities,**  
**End of the support** |

Prior to the start of our surveys, we have defined the main parameters of the evaluation: the objectives of the evaluation, the questions to be answered by the evaluation, the recipients of the evaluation and the types of indicators based on a methodology defined below. We have summarized in tabula form all the data to
be collected at the person's entry into the service (M0), after 6 months (M6), 1 years (M12) and every year (M24, M36, M48...) as well as the data to be collected continuously.

The goals of the evaluation:

- Verify the effectiveness of the program, (maintain its effectiveness during deployment)
- Identify people for whom the model is not adapted
- Aiming at continuous improvement of the quality of services
- Communicate on the relevance of the program
- Communicate on the performance of the strategy

Questions to respond:

- Does the service target the expected population?
- Are the expected results present?
- Is the expected model applied?
- Are people satisfied with the services?
- Are the rights of individuals respected?
- Is the organization being implemented effective?
- Are the financial resources adequate?

Recipients:

- Teams, porters and users
- Health regional agency, the DIHAL and the central administrations
- Policy makers
- The social, medical and medico-social actor

Type of indicators:

- Results
- Process
- Structure
- Compliance
- Quality
- Respect for rights
- Satisfaction: tenants, landlords, neighborhood
- Financial management
- Alert / risk management

To define each indicator, according to the themes of the specifications we have followed the methodology proposed by ANESM summarized in the next table:

| To choose an indicator | An indicator is a selected information, a variable that helps to:
|------------------------|-------------------------------------------------
|                        | • examine one or more processes implemented to meet the support and care objectives and their effects for the users;
|                        | • trigger an evaluative questioning of the topic under study when this indicator indicates an insufficient quality of the measured effects or when its value varies from one measurement to another;
|                        | • measure the impact of the improvement plan established following the evaluation |
| To build an Indicator  | Data used to construct an indicator must be verifiable, quantifiable and easily retrievable. |
| To Take into account the data of the indicator with the others analysis elements | Even when an indicator gives precise information, it is always partial and really takes on meaning that is associated with other elements of analysis. |
| To Follow the indicators | The monitoring of the indicators allows the institution to have quantitative data on its activity and can be a starting point for questioning. The observations made on their evolution make it possible to enter into the process of internal evaluation or to continue it and to question professional practices. The evaluation helps to understand the findings, to analyze the discrepancies observed with respect to "oneself". The monitoring of the indicators makes it possible to measure the progress of the institution between two evaluations but does not aim at the comparison between establishments. |
The evaluation tools and recommendations were subsequently validated during several working meetings with members of the ANESM

2.3.1 Result

a) Parameters of evaluations

For the various objectives and the questions of the evaluation defined previously, we have in during the first step of the survey defined a series of items:

Goal of evaluation

Verify the effectiveness of the program, (maintain its effectiveness during deployment) at 12, 24, 36 and 48 months
- % of people who stay in the dwelling
- % of people lost to follow-up
- % of people who have signed direct leases
- Does the service target the expected population?
- % of people whose income / income stability has improved
- % of people with access to employment
- % of people with activities (including volunteer)
- Is the expected models applied?
- Model fidelity Scales

Identify people for whom the model is not adapted
- Typology of persons lost to follow-up
- Analysis of incident investigations

Aiming at continuous improvement of the quality of services
- Intern evaluation
- Quality services

Communicate on the relevance of the program
- Follow-up of requests for integration into the service

Communicate on the performance of the strategy
- Filling rate
- Housing vacancy
- Professional turnover
- Number of direct leases

Are people satisfied with the services?
- Satisfactory questionnaire
- Focus group, monthly meetings

Are the rights of individuals respected?
- Data deviation 0 and M12

Is the organization being implemented effective?
- % of people supported
- % of people housed
- Time to obtain an housing
- Governance
List of relevant data and the agenda are presented on the tables below:

<table>
<thead>
<tr>
<th>Demographic</th>
<th>Resources</th>
<th>State of health Needs level</th>
<th>Rights</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Gender</td>
<td>• Active Solidarity Income (RSA)</td>
<td>• Health status (CIRS)</td>
<td>• Social welfare 70%</td>
</tr>
<tr>
<td>• Birth date</td>
<td>• Adult Disability Allowance (AAH)</td>
<td>• Needs Level (GEVA⁶)</td>
<td>• Health Insurance</td>
</tr>
<tr>
<td>• Place of birth</td>
<td>• Salary</td>
<td></td>
<td>• Long Duration Disease 100%</td>
</tr>
<tr>
<td>• Nationality</td>
<td>• Unemployment insurance income (ASSEDIC)</td>
<td></td>
<td>• Without Social Welfare right</td>
</tr>
<tr>
<td>• Number of children</td>
<td>• Minimum old age</td>
<td></td>
<td>• Universal Medical Coverage</td>
</tr>
<tr>
<td>• Marital status</td>
<td>• Outgoing prison allowance</td>
<td></td>
<td>• Measure of protection: guardianship, curatorship</td>
</tr>
<tr>
<td></td>
<td>• Any</td>
<td></td>
<td>• ID</td>
</tr>
<tr>
<td></td>
<td>• Retirement</td>
<td></td>
<td>• Residence permit</td>
</tr>
<tr>
<td></td>
<td>• Other: in clear</td>
<td></td>
<td>• Other identification</td>
</tr>
<tr>
<td></td>
<td>• Debt</td>
<td></td>
<td>• Vital card</td>
</tr>
</tbody>
</table>

⁶ In France, the GEVA Guide to the Assessment of the Compensation Needs of Persons with Disabilities is provided for in article L.146-8 of the Code of Social Action and Families: "A multidisciplinary team assesses the needs of compensation for the disabled person and his or her permanent incapacity on the basis of his life plan and references defined by regulation and proposes a personalized disability compensation plan ... ". The GEVA purpose is to assess the needs of people with disabilities in order to give them appropriate answers. It makes it possible to gather all the elements necessary to determine the compensation needs of a disabled person and to adapt to this request the various criteria for access to the rights and benefits defined in the statutory instruments.
<table>
<thead>
<tr>
<th>Place of life</th>
<th>Time spent homeless</th>
<th>Complete diagnosis</th>
<th>Incarceration</th>
<th>Whole life hospitalization</th>
<th>Use of common law services</th>
</tr>
</thead>
<tbody>
<tr>
<td>In the last 6 months, how many days did you spend on the street? in Emergency shelter or stabilization? hosted (friend, family, other)? in squat (or caravan ...)? in social insertion center insertion? in prison ? in guesthouse? hospital or clinic? other (in clear)?</td>
<td>• Cumulative total time spent homeless (in months)</td>
<td>• Completed by the referring physician (psychiatric diagnosis, somatic comorbidities and addictions)</td>
<td>• Have you been incarcerated (whole life)?</td>
<td>• Were you hospitalized in psychiatry?</td>
<td>• Do you have a treating physician? Have you seen it in the last 6 months?</td>
</tr>
<tr>
<td></td>
<td>• Total cumulative time spent on the street (in months or days)</td>
<td>• At what age did you start having psychological problems?</td>
<td>• Total cumulative time spent on jail</td>
<td>• If yes, were you hospitalized without consent?</td>
<td>• Do you have a psychiatrist who follows you regularly? Have you seen it in the last 6 months?</td>
</tr>
<tr>
<td></td>
<td>• Age of the first time on the street</td>
<td></td>
<td></td>
<td></td>
<td>• Another specialist who regularly follows you (who)? Have you seen it in the last 6 months?</td>
</tr>
<tr>
<td></td>
<td>• Have you been followed by child social services</td>
<td></td>
<td></td>
<td></td>
<td>• A social referent? Have you seen it in the last 6 months?</td>
</tr>
<tr>
<td>MO Population profile</td>
<td>At 6 months (M6)</td>
<td>At 12 months (M12) Annually</td>
<td>Continuously</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------</td>
<td>------------------</td>
<td>-----------------------------</td>
<td>--------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Housing: number of relocations</td>
<td>Housing: number of relocations</td>
<td>Undesirable events</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Date of entry</td>
<td>Rights</td>
<td>Rights</td>
<td>Date of housing integration / relocations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Demographic</td>
<td>Resources</td>
<td>Resources</td>
<td>Access to services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Resources</td>
<td>Housing allowance</td>
<td>Employment</td>
<td>Participation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Health status</td>
<td>Solution before first housing</td>
<td>Health status</td>
<td>Team activity: contacts / contact patterns / contact location...</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Needs Level</td>
<td>Time for obtaining the first housing</td>
<td>Needs Level</td>
<td>Type of lease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Place of life in the last 6 months</td>
<td></td>
<td>Place of life in the last 6 months</td>
<td>Number of direct lease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Time spent on the street</td>
<td></td>
<td>People's Satisfaction</td>
<td>Nature of the lessor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Diagnosis</td>
<td></td>
<td>Solutions between relocations</td>
<td>Exit of the services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Incarceration</td>
<td></td>
<td>Hospitalization</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Hospitalization</td>
<td></td>
<td>Stay alive</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Use of common law services</td>
<td></td>
<td>Respect of the model ((Recovery Scale Assessment, Pathways To Housing Fidelity scale, ACT fidelity scale))</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Turn-over of professionals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Training of the professionals</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Process of data collection

<table>
<thead>
<tr>
<th>MO</th>
<th>Some data characterizing the population (demographic data et complete diagnosis) are required data in the admission file. The teams that address the client therefore collect them. It should be noted that an independent Admission Board was set up in April 2017 to ensure inclusion criteria and avoid a form of clientelism.</th>
</tr>
</thead>
<tbody>
<tr>
<td>MO - M6</td>
<td>The other data must be collected within the first 6 months of the support by the multidisciplinary team « un chez soi d'abord ».</td>
</tr>
<tr>
<td>M12, 24, 36...</td>
<td>After one year, then annually, the multidisciplinary team of the Housing First program will collect the quantitative data. The questionnaires indicating satisfaction will be administered by independent investigators, and a focus group with clients of the service will focus on the same topic. The evaluation of the practice and governance will be done annually with scales measuring fidelity to the model. This part will be developed latter.</td>
</tr>
<tr>
<td>Continuously</td>
<td>The multidisciplinary team will use activities of the various sites.</td>
</tr>
</tbody>
</table>

### c) Assessment of the models

**A cross-evaluation of programmes implemented in different cities**

In order to assess the three scientifically validated intervention models cohabiting within the Housing First programme, namely assertive community treatment, pathways to housing, and the recovery model, the fidelity scale should be completed each year. Considering that several Housing First teams exist or will be established, we thought of a system of partnering the teams of two different cities. Members of one team trained in assessment will annually evaluate the model fidelity of the team in the other city, and vice versa.
Fidelity refers to the degree of implementation of an evidence-based practice (EBP). A fidelity scale measures fidelity. Each scale assesses between 15 and 30 critical factors of EBP, based on the underlying principles and methods. The scale items provide concrete indication that the practice is being implemented as intended.

Why measure fidelity?

Several assumptions underlie the use of fidelity scales. First, a fidelity scale should adequately sample the critical ingredients of the EBP to differentiate between programs that follow the practice and those that do not. Research suggests that fidelity scale for assertive community treatment does accomplish this. Second, fidelity scales should be sensitive enough to detect progress in the development of a program from the start-up phase to its mature development. There is some evidence that fidelity scales achieve this goal as well.

Third, high-fidelity programs are expected to have greater effectiveness than low-fidelity programs in achieving desired consumer outcomes. Several studies comparing fidelity ratings to outcomes also support this assumption.

One key use of fidelity scales is for monitoring programs over the course of their development (and even after they are fully established). Experience by implementers suggests that routine use of fidelity scales provides an objective, structured way to give feedback about program development. This is an excellent method to diagnose program weaknesses and clarify strengths for providing positive feedback on program development. Fidelity scales also provide a comparative framework for evaluating statewide trends and outliers. The strategic use of repeated evaluations of programs using fidelity scales, either on an individual program or statewide level, is based on the general principle that whatever is paid attention to is more likely to be improved.

The 3 fidelity scales
1) ACT fidelity scale: DACTS (Dartmouth ACT scale)\(^7\) (annex 1)

The ACT Fidelity Scale contains 28 program-specific items. The scale has been developed to measure the adequacy of implementation of ACT programs. Each item on the scale is rated on a 5-point scale ranging from 1 ("Not implemented") to 5 ("Fully implemented"). The standards used for establishing the anchors for the "fully implemented" ratings were determined through a variety of expert sources as well as empirical research. The scale items fall into three categories: human resources (structure and composition); organizational boundaries; and nature of services.

The scale ratings are based on current behavior and activities, not planned or intended behavior. The scale is appropriate for organizations that are serving clients with severe mental illness and for assessing adherence to evidence based practices, specifically for an ACT team. The DACTS measures fidelity at the team level rather than at the individual or agency level.

2) Pathways to housing fidelity scale (annex2)

A multisite, randomized controlled trial (At Home/Chez Soi) in five Canadian cities included two assessments of 12 programs over two years shows associations between fidelity ratings and administrative data and participant outcomes. Greater program fidelity was associated with improvement in housing stability, community functioning, and quality of life. Variation in program fidelity was associated with operations and outcomes, supporting scale validity and intervention effectiveness. These findings reinforced the value of using fidelity monitoring to conduct quality assurance and technical assistance activities.

3) Recovery self assessment scale (annex 3):

The Recovery Self-Assessment (RSA, developed by PRCH (Program for Recovery and Community Heath) at Yale university is a 36-item measure designed to

\(^7\) DACT protocol online:
http://mha.ohio.gov/Portals/0/assets/Treatment/ACT/dacts-fidelity-scale-protocol.pdf
gauge the degree to which programs implement recovery-oriented practices. It is a self-reflective tool designed to identify strengths and target areas of improvement as agencies and systems strive to offer recovery-oriented care.

The RSA contains concrete, operational items to help program staff, persons in recovery, and significant others to identify practices in their mental health and addiction agency that facilitate or impede recovery.

There are four versions of the RSA targeted to different groups presented in annex 3:

- Person in recovery
- Family member/advocate
- Provider
- CEOs and Directors

Data analysis

An initial analysis of the data will be carried out annually by an public health worker on the different sites in France. Subsequently, work with a sociologist during monthly supervisions / focus groups with the multidisciplinary team, the users and / or the directors will allow a feedback of evaluations as well as the implementation of a process improvement of service. This method will also make possible to maintain the appropriation process of the program by the professionals and users so efficient during the research phases.
Conclusion

Housing First is a fairly new experiment in the mental health field in France, in particular because it applies public health methodology as described by the World Health Organization (WHO), in the WHO Mental Health Policy and Service Guidance Package. Indeed, the French government has adhered to the steps prescribed by the WHO in 2005 for governments to follow when developing mental health policy: (1) gathering information about the mental health needs of the population; (2) gathering evidence for effective strategies; (3) consultation and negotiation; (4) exchange with other countries; (5) setting the vision, values, principles, and objectives; (6) determining areas for action; and (7) identifying the roles and responsibilities of different sectors.

Despite the lack of consensus among leading experts and an unclear discourse among mental health professionals, using the Global Mental Health perspective, and in order not only to improve the health conditions of people living with mental illnesses but also the conditions of their caregivers, the French minister of health launched a randomized trial in order to respond to this real public health issue and to verify the adaptability of evidence-based practice. Many principles promoted by the WHO have been applied in terms of this experiment. Housing First is a community-based service for mental health care delivery (housing, employment and family support). It uses the “recovery” paradigm, and increases the participation of users and families. It strengthens the capacities of non-specialized health personnel. One of its goals is to reduce the “revolving door” syndrome, and reduce the number of long-stay beds in psychiatric hospitals.

The benefits of this programme are obvious for the populations concerned. We also see, through this programme, a unique opportunity to reform the mental health system through an oil stain effect. Many lessons for social issues beyond precariousness and homelessness could be drawn from this experiment, in order to promote an integrated service delivery system based on accessibility, comprehensiveness, coordination and continuity of care, effectiveness, equity,
and respect for human rights. This is one reason the issues of evaluation, monitoring and model fidelity are crucial, so that this powerful programme will continue to promote the "recovery" of professional practices in the field of mental health.
Bibliography


## Annexes

### Annex 1

<table>
<thead>
<tr>
<th>DACTS Score Sheet</th>
<th>Rater 1</th>
<th>Rater 2</th>
<th>Consensus</th>
<th>ACTUAL VALUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>H1</td>
<td>Small Coastal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H2</td>
<td>Team Approach</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H3</td>
<td>Program Meeting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H4</td>
<td>Prioritizing Team Leader</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H5</td>
<td>Continuity of Staffing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H6</td>
<td>Staff Capacity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H7</td>
<td>Psychiatrist on Staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H8</td>
<td>Nurse on Staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H9</td>
<td>Substance Abuse Specialist on Staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H10</td>
<td>Vocational Specialist on Staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H11</td>
<td>Program Size</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### HUMAN RESOURCES MEAN:

| O1 | Explicit Admission Criteria |         |           |              |
| O2 | Intake Rate |         |           |              |
| O3 | Full Responsibility for Treatment Services |         |           |              |
| O4 | Responsibility for Crisis Services |         |           |              |
| O5 | Responsibility for Hospital Admissions |         |           |              |
| O6 | Responsibility for Hospital Discharge Planning |         |           |              |

### ORGANIZATIONAL BOUNDARIES MEAN:

| S1 | In Vivo Services |         |           |              |
| S2 | No Drop-Out Policy |         |           |              |
| S3 | Assertive Engagement Mechanisms |         |           |              |
| S4 | Intensity of Service |         |           |              |
| S5 | Frequency of Contact |         |           |              |
| S6 | Work with Support System |         |           |              |
| S7 | Individualized Substance Abuse Treatment |         |           |              |
| S8 | Dual Disorder Treatment Groups |         |           |              |
| S9 | Dual Disorders (DD) Model |         |           |              |

### NATURE OF SERVICES MEAN:

| S10 | Role of Consumers on Treatment Team |         |           |              |

### TOTAL MEAN SCORE

* denotes items not included in original DACTS; do not include in score summary
### Annex 2

**Pathways Housing First Fidelity Scale (ACT version)**

<table>
<thead>
<tr>
<th>Item</th>
<th>Column 1</th>
<th>Column 2</th>
<th>Column 3</th>
<th>Column 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item</td>
<td>Description</td>
<td>Description</td>
<td>Description</td>
<td>Description</td>
</tr>
<tr>
<td>Housing Choice &amp; Structure</td>
<td>Participants have no choice in the location, decorating, furnishing, or other features of their housing and are assigned a unit.</td>
<td>Participants have little choice in location, decorating, furnishing, and other features of their housing.</td>
<td>Participants have some choice in location, decorating, furnishing, and other features of their housing.</td>
<td>Participants have much choice in location, decorating, furnishing, and other features of their housing.</td>
</tr>
<tr>
<td>Housing Availability (Intention to Move In)</td>
<td>Extent to which program helps participants move quickly into permanent housing units of their choosing.</td>
<td>Less than 55% of program participants move into a unit of their choosing within 4 months of entering the program.</td>
<td>55-69% of program participants move into a unit of their choosing within 4 months of entering the program.</td>
<td>70-84% of program participants move into a unit of their choosing within 4 months of entering the program.</td>
</tr>
<tr>
<td>Temporary Housing Tenure</td>
<td>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.</td>
<td>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.</td>
<td>There are standardized time limits on housing tenure, such that participants are expected to move when standardized criteria are met.</td>
<td>There are individualized time limits on housing tenure, such that participants may stay as long as necessary, but are expected to move when certain criteria are met.</td>
</tr>
<tr>
<td>Affordability</td>
<td>Extent to which participants pay a reasonable amount of their income for housing costs.</td>
<td>Participants pay 60-69% of their income for housing costs.</td>
<td>Participants pay 30-39% of their income for housing costs.</td>
<td>Participants pay 30% or less of their income for housing costs.</td>
</tr>
</tbody>
</table>

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*See last page for suggested citation, item examples, and references.*
Annex 3

RSA-R
Administrator/Manager Version

Please circle the number below which reflects how accurately the following statements describe the activities, values, policies, and practices of this program.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
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<td>Not Applicable</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D/K</td>
<td>Don’t Know</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Staff make a concerted effort to welcome people in recovery and help them feel comfortable in this program.
   - 1 2 3 4 5 N/A D/K

2. This program/agency offers an inviting and dignified physical environment (e.g., the lobby, waiting rooms, etc.).
   - 1 2 3 4 5 N/A D/K

3. Staff encourage program participants to have hope and high expectations for their recovery.
   - 1 2 3 4 5 N/A D/K

4. Program participants can change their clinician or case manager they wish.
   - 1 2 3 4 5 N/A D/K

5. Program participants can easily access their treatment records if they wish.
   - 1 2 3 4 5 N/A D/K

6. Staff do not use threats, bribes, or other forms of pressure to influence the behavior of program participants.
   - 1 2 3 4 5 N/A D/K

7. Staff believe in the ability of program participants to recover.
   - 1 2 3 4 5 N/A D/K

8. Staff believe that program participants have the ability to manage their own symptoms.
   - 1 2 3 4 5 N/A D/K

9. Staff believe that program participants can make their own life choices regarding things such as where to live, when to work, whom to be friends with, etc.
   - 1 2 3 4 5 N/A D/K

10. Staff learn to and respect the decisions that program participants make about their treatment and care.
    - 1 2 3 4 5 N/A D/K

11. Staff regularly ask program participants about their interests and the things they would like to do in the community.
    - 1 2 3 4 5 N/A D/K

12. Staff encourage program participants to take risks and try new things.
    - 1 2 3 4 5 N/A D/K

13. This program offers specific services that fit each participant’s unique culture and life experiences.
    - 1 2 3 4 5 N/A D/K

14. Staff offer participants opportunities to discuss their spiritual needs and interests when they wish.
    - 1 2 3 4 5 N/A D/K

15. Staff offer participants opportunities to discuss their sexual needs and interests when they wish.
    - 1 2 3 4 5 N/A D/K

O’Connell, Tondora, Kidd, Staymer, Hawkins, and Davidson (2007)
16. Staff help program participants to develop and plan for life goals beyond managing symptoms or staying stable (e.g., employment, education, physical fitness, connecting with family and friends, hobbies);

17. Staff routinely assist program participants with getting jobs;

18. Staff actively help program participants to get involved in non-mental health related activities, such as church groups, adult education, sports, or hobbies;

19. Staff work hard to help program participants to include people who are important to them in their recovery/treatment planning (such as family, friends, clergy, or an employer);

20. Staff actively introduce program participants to persons in recovery who can serve as role models or mentors;

21. Staff actively connect program participants with self-help, peer support, or consumer advocacy groups and programs;

22. Staff actively help people find ways to give back to their community (i.e., volunteering, community services, neighborhood watch/cleanup);

23. People in recovery are encouraged to help staff with the development of new groups, programs, or services;

24. People in recovery are encouraged to be involved in the evaluation of this agency’s programs, services, and service providers;

25. People in recovery are encouraged to attend agency advisory boards and management meetings;

26. Staff talk with program participants about what it takes to complete or exit the program;

27. Progress made towards an individual’s own personal goals is tracked regularly;

28. The primary role of agency staff is to assist a person with fulfilling his/her own goals and aspirations;

29. Persons in recovery are involved with facilitating staff trainings and education at this program;

30. Staff at this program regularly attend trainings on cultural competency;

31. Staff are knowledgeable about special interest groups and activities in the community;

32. Agency staff are diverse in terms of culture, ethnicity, lifestyle, and interests;

| Code: ______ |

Separate Section for Administrators Only

33. This agency provides formal opportunities for people in recovery, family members, service providers, and administrators to learn about recovery;

34. This agency provides structured educational activities to the community about mental illness and addiction;

35. This agency provides a variety of treatment options for program;

Participants (e.g., individual, group, peer support, musical, community-based, employment, skill building, employment, etc.).

36. Groups, meetings, and other activities are scheduled in the evenings or on weekends so as not to conflict with other recovery-oriented activities such as employment or school.

1 2 3 4 5 N/A DK

O’Connell, Tedora, Kidd, Stayner, Howells, and Davison (2007)
<table>
<thead>
<tr>
<th></th>
<th>1</th>
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<th></th>
</tr>
</thead>
<tbody>
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<td>Not Applicable</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D/K</td>
<td>Don't Know</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

1. Staff make a concerted effort to welcome people in recovery and help them to feel comfortable in this program.
2. This program/agency offers an inviting and dignified physical environment (e.g., the lobby, waiting rooms, etc.).
3. Staff encourage program participants to have hope and high expectations for their recovery.
4. Program participants can change their clinician or case manager if they wish.
5. Program participants can easily access their treatment records if they wish.
6. Staff do not use threats, bribes, or other forms of pressure to influence the behavior of program participants.
7. Staff believe in the ability of program participants to recover.
8. Staff believe that program participants have the ability to manage their own symptoms.
9. Staff believe that program participants can make their own life choices regarding things such as where to live, when to work, whom to be friends with, etc.
10. Staff listen to and respect the decisions that program participants make about their treatment and care.
11. Staff regularly ask program participants about their interests and the things they would like to do in the community.
12. Staff encourage program participants to take risks and try new things.
13. This program offers specific services that fit each participant’s unique culture and life experiences.
14. Staff offer participants opportunities to discuss their spiritual needs and interests when they wish.
15. Staff offer participants opportunities to discuss their sexual needs and interests when they wish.
16. Staff help program participants to develop and plan for life goals beyond...

O’Connell, Tondora, Kidd, Stayner, Hawkins, and Davidson (2007)
managing symptoms or staying stable (e.g., employment, education, physical fitness, connecting with family and friends, hobbies).

17. Staff routinely assist program participants with getting jobs.

18. Staff actively help program participants to get involved in non-mental health/addiction-related activities, such as church groups, adult education, sports, or hobbies.

19. Staff work hard to help program participants to include people who are important to them in their recovery/treatment planning (such as family, friends, clergy, or an employer).

20. Staff actively introduce program participants to persons in recovery who can serve as role models or mentors.

21. Staff actively connect program participants with self-help, peer support, or consumer advocacy groups and programs.

22. Staff actively help people find ways to give back to their community (i.e., volunteering, community services, neighborhood watch/cleanup).

23. People in recovery are encouraged to help staff with the development of new groups, programs, or services.

24. People in recovery are encouraged to be involved in the evaluation of this agency's programs, services, and service providers.

25. People in recovery are encouraged to attend agency advisory boards and management meetings.

26. Staff talk with program participants about what it takes to complete or exit the program.

27. Progress made towards an individual's own personal goals is tracked regularly.

28. The primary role of agency staff is to assist a person with fulfilling his/her own goals and aspirations.

29. Persons in recovery are involved with facilitating staff trainings and education at this program.

30. Staff at this program regularly attend trainings on cultural competency.

31. Staff are knowledgeable about special interest groups and activities in the community.

32. Agency staff are diverse in terms of culture, ethnicity, lifestyle, and interests.

**RSA-R Person in Recovery Version**

Please circle the number below which reflects how accurately the following statements describe the activities, values, policies, and practices of this program:

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Strongly Disagree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>Not Applicable</td>
<td>DK</td>
<td>Don’t Know</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Staff welcome me and help me feel comfortable in this program.  
2. The physical space of this program (e.g., the lobby, waiting rooms, etc.) feels inviting and dignified.  
3. Staff encourage me to have hope and high expectations for myself and my recovery.  
4. I can change my clinician or case manager if I want to.  
5. I can easily access my treatment records if I want to.  
6. Staff do not use threats, bribes, or other forms of pressure to get me to do what they want.  
7. Staff believe that I can recover.  
8. Staff believe that I have the ability to manage my own symptoms.  
9. Staff believe that I can make my own life choices regarding things such as where to live, whom to work with, whom to be friends with, etc.  
10. Staff listen to me and respect my decisions about my treatment and care.  
11. Staff regularly ask me about my interests and the things I would like to do in the community.  
12. Staff encourage me to take risks and try new things.  
13. This program offers specific services that fit my unique culture and life experiences.  
14. I am given opportunities to discuss my spiritual needs and interests when I wish.  
15. I am given opportunities to discuss my sexual needs and interests when I wish.  
16. Staff help me to develop and plan for life goals beyond managing symptoms or staying stable (e.g., employment, education, physical fitness, connecting with family and friends, hobbies).  
17. Staff help me to find jobs.  
18. Staff help me to get involved in non-mandatory health/education-related activities, such as church groups, adult education, sports, or hobbies.  
19. Staff help me to include people who are important to me in my recovery/treatment planning (such as family, friends, clergy, or an employer).  
20. Staff introduce me to people in recovery who can serve as role models or mentors.

O’Connell, Tondora, Kidd, Suymer, Hawkins, and Davidson (2007)
<table>
<thead>
<tr>
<th>Code:</th>
</tr>
</thead>
<tbody>
<tr>
<td>21. Staff caller to help me connect with self-help, peer support, or consumer advocacy groups and programs</td>
</tr>
<tr>
<td>22. Staff help me to find ways to give back to my community, (i.e., volunteering, community services, neighborhood watch/cleanup).</td>
</tr>
<tr>
<td>23. I am encouraged to help staff with the development of new groups, programs, or services</td>
</tr>
<tr>
<td>24. I am encouraged to be involved in the evaluation of this program’s services and service providers</td>
</tr>
<tr>
<td>25. I am encouraged to attend agency advisory boards and/or management meetings if I want</td>
</tr>
<tr>
<td>26. Staff talk with me about what it would take to complete or exit this program</td>
</tr>
<tr>
<td>27. Staff help me keep track of the progress I am making towards my personal goals</td>
</tr>
<tr>
<td>28. Staff work hard to help me fulfill my personal goals</td>
</tr>
<tr>
<td>29. I am encouraged to be involved with staff trainings and education programs at this agency</td>
</tr>
<tr>
<td>30. Staff listen and respond to my cultural experiences, interests, and concerns</td>
</tr>
<tr>
<td>31. Staff are knowledgeable about special interest groups and activities in the community</td>
</tr>
<tr>
<td>32. Agency staff are diverse in terms of culture, ethnicity, lifestyle, and interests</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>N/A</td>
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<td>N/A</td>
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<td>N/A</td>
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</tbody>
</table>

O’Connell, Tendler, Kadd, Stuyver, Hawkins, and Davidson (2005)
### RSA-R
**Family Member/Significant Other Version**

Please circle the number below which reflects how accurately the following statements describe the activities, values, policies, and practices of this program.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D/K</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. **Staff make efforts to welcome my loved one and help him/her feel comfortable in this program.**
   - 1: Strongly Disagree
   - 2: 3: 4: 5: N/A
   - D/K

2. **The physical space of this program (e.g., the lobby, waiting rooms, etc.) feels inviting and dignified.**
   - 1: 2: 3: 4: 5: N/A
   - D/K

3. **Staff encourage my loved one to have hope and high expectations for his/her recovery.**
   - 1: 2: 3: 4: 5: N/A
   - D/K

4. **My loved one can change his/her clinician or case manager if he/she wants to.**
   - 1: 2: 3: 4: 5: N/A
   - D/K

5. **My loved one can easily access his/her treatment records if he/she wishes.**
   - 1: 2: 3: 4: 5: N/A
   - D/K

6. **Staff do not use threats, bribes, or other forms of pressure to influence the behavior of my loved one.**
   - 1: 2: 3: 4: 5: N/A
   - D/K

7. **Staff believe that my loved one can recover.**
   - 1: 2: 3: 4: 5: N/A
   - D/K

8. **Staff believe that my loved one has the ability to manage his/her own symptoms.**
   - 1: 2: 3: 4: 5: N/A
   - D/K

9. **Staff believe that program participants can make their own life choices regarding things such as where to live, when to work, whom to be friends with, etc.**
   - 1: 2: 3: 4: 5: N/A
   - D/K

10. **Staff listen to my loved one and respect his/her decisions about his/her treatment and care.**
    - 1: 2: 3: 4: 5: N/A
    - D/K

11. **Staff regularly ask my loved one about his/her interests and the things he/she would like to do in the community.**
    - 1: 2: 3: 4: 5: N/A
    - D/K

12. **Staff encourage my loved one to take risks and try new things.**
    - 1: 2: 3: 4: 5: N/A
    - D/K

13. **This program offers specific services that fit the unique culture and life experiences of my loved one.**
    - 1: 2: 3: 4: 5: N/A
    - D/K

14. **My loved one is given opportunities to discuss his/her spiritual needs and interests when he or she wishes.**
    - 1: 2: 3: 4: 5: N/A
    - D/K

15. **My loved one is given opportunities to discuss his/her sexual needs and interests when he or she wishes.**
    - 1: 2: 3: 4: 5: N/A
    - D/K

16. **Staff help my loved one to develop and plan for life goals beyond managing symptoms or staying stable (e.g., employment, education, physical**
    - 1: 2: 3: 4: 5: N/A
    - D/K

---

O’Connell, Tendora, Kidd, Stayner, Hawkins, and Davidson (2007)
Fitness, connecting with family and friends, hobbies:

17. Staff insist my loved one with getting jobs:  
   1 2 3 4 5 N/A DK

18. Staff help my loved one get involved in non-mandatory health-related activities, such as church groups, adult education, sports, or hobbies:  
   1 2 3 4 5 N/A DK

19. Staff help my loved one to include people who are important to him/her in his/her recovery/treatment planning (such as family, friends, clergy, or an employer):  
   1 2 3 4 5 N/A DK

20. Staff introduce my loved one to others in recovery who can serve as role models or mentors:  
   1 2 3 4 5 N/A DK

21. Staff connect my loved one with self-help, peer support, or consumer advocacy groups and programs:  
   1 2 3 4 5 N/A DK

22. Staff help my loved one to find ways to give back to the community (e.g., volunteering, community services, neighborhood watch/cleanup):  
   1 2 3 4 5 N/A DK

23. My loved one is encouraged to help staff with the development of new groups, programs, or services:  
   1 2 3 4 5 N/A DK

24. Program participants are encouraged to be involved in the evaluation of this program’s services and service providers:  
   1 2 3 4 5 N/A DK

25. My loved one is encouraged to attend agency advisory boards and management meetings:  
   1 2 3 4 5 N/A DK

26. Staff talk with my loved one about what he/she thinks is important:  
   1 2 3 4 5 N/A DK

27. Staff help my loved one keep track of the progress he/she makes towards his/her personal goals:  
   1 2 3 4 5 N/A DK

28. Staff work hard to help my loved one fulfill his/her personal goals:  
   1 2 3 4 5 N/A DK

29. My loved one is or can be involved in facilitating staff trainings and education programs at this agency:  
   1 2 3 4 5 N/A DK

30. Staff listen, and respond, to my loved one’s cultural experiences, interests, and concerns:  
   1 2 3 4 5 N/A DK

31. Staff are knowledgeable about special interest groups and activities in the community:  
   1 2 3 4 5 N/A DK

32. Agency staff are diverse in terms of culture, ethnicity, lifestyle, and interests:  
   1 2 3 4 5 N/A DK

* For family only

33. Staff make efforts to welcome me and make me feel comfortable in this program:  
   1 2 3 4 5 N/A DK

34. Staff encourage me to have hope and high expectations for my loved one’s recovery:  
   1 2 3 4 5 N/A DK

35. Staff listen to me and respect my opinion about my loved one’s treatment and care:  
   1 2 3 4 5 N/A DK

36. Staff include me in my loved one’s recovery/treatment planning:  
   1 2 3 4 5 N/A DK

37. I am encouraged to help staff with the development of new groups, programs, or services.  & 1 & 2 & 3 & 4 & 5 & N/A & D/K \\
38. I am encouraged to be involved in the evaluation of this program's services and service providers.  & 1 & 2 & 3 & 4 & 5 & N/A & D/K \\
39. I am encouraged to attend agency advisory boards and management meetings, if I want.  & 1 & 2 & 3 & 4 & 5 & N/A & D/K \\
40. I am/ can be involved in facilitating staff trainings and education programs at this agency.  & 1 & 2 & 3 & 4 & 5 & N/A & D/K \\

As a departure from the ideological debate that has preoccupied French psychiatry since its inception, the French government has chosen for the first time in the field of mental health to implement an evidence-based intervention model incorporating powerful scientific research. The clinical trial of Housing First has permitted the scientific validation of the efficiency of this model in the French context. The second step is crucial: The implementation of the programme in 20 cities. It is an axiom of programme evaluation that an intervention is unlikely be effective if it is not implemented appropriately. If the effectiveness of any intervention depends in part on the quality of its implementation, this is particularly true for the Housing First model. In this work, we focus on this main question: In order to appropriately implement a validated model after an experimental phase, which evaluation tools can be used to evaluate and monitor whether an intervention has been implemented as planned? We first analyze the creation of the specifications. Then, new requirements are emerging, in particular evaluation and monitoring issues, which until now have been outsourced to the research teams. We shall thus see how a toolbox can be developed based on the specifications allowing these questions of evaluation and monitoring to be answered precisely with regard to two specific objectives: Respect for the intervention models, as well as maintaining the dynamic of appropriation of the programme by both professionals and users.

Key Words

Housing first, Assertive Community Treatment, Monitoring, Specifications, Recovery
Resumo

No sentido de construir uma saída para o debate ideológico que acontece na psiquiatria na França desde seu início, o governo Francês escolheu pela primeira vez no campo da saúde mental implementar um modelo de intervenção baseado em evidências, incorporando fortes pesquisas científicas. O ensaio clínico da experiência denominada Housing First permitiu a validação científica da eficiência deste modelo no contexto Francês. O segundo passo é crucial: a implementação desse programa em 20 cidades. Trata-se de um axioma da avaliação de programas a compreensão de que é improvável que uma intervenção seja efetiva se essa não for implementada adequadamente. E se a eficácia de qualquer intervenção depende em parte da qualidade de sua implementação, isso é particularmente verdadeiro para o modelo Housing First. Nesse trabalho, nós focamos nessa questão central: Para implementar adequadamente um modelo validado após uma fase experimental, quais ferramentas de avaliação podem ser usadas para avaliar e monitorar se a intervenção foi implementada conforme planejado? Assim, primeiramente, analisamos a criação das especificações. Em seguida, novos requisitos foram surgindo, em particular no que diz respeito às questões de avaliação e monitoramento, que até então têm sido terceirizadas para equipes de pesquisa. Dessa forma, nós podemos ver como uma caixa de ferramentas pode ser desenvolvida com base em especificações, permitindo que essas questões de avaliação e monitoramento sejam respondidas precisamente com relação a dois objetivos específicos: o respeito aos modelos de intervenção, bem como a sustentação da dinâmica de apropriação do programa tanto pelos profissionais, como pelos usuários.
Resumen

En el sentido de construir una salida para el debate ideológico que ocurre en la psiquiatría en Francia desde su inicio, el gobierno francés eligió por primera vez en el campo de la salud mental implementar un modelo de intervención basado en evidencias, incorporando fuertes investigaciones científicas. El ensayo clínico de la experiencia denominada Housing First permitió la validación científica de la eficiencia de este modelo en el contexto francés. El segundo paso es crucial: la aplicación de este programa en 20 ciudades. Se trata de un axioma de la evaluación de programas la comprensión de que es improbable que una intervención sea efectiva si ésta no se implementa adecuadamente. Y si la eficacia de cualquier intervención depende en parte de la calidad de su implementación, esto es particularmente cierto para el modelo Housing First. En este trabajo, nos enfocamos en esta cuestión central: Para implementar adecuadamente un modelo validado después de una fase experimental, ¿qué herramientas de evaluación se pueden utilizar para evaluar y monitorear si la intervención se ha implementado según lo planeado? En primer lugar, analizamos la creación de las especificaciones. A continuación, se plantearon nuevos requisitos, en particular en lo que se refiere a las cuestiones de evaluación y monitoreo, que hasta entonces han sido tercerizadas para los equipos de investigación. De esta forma, podemos ver cómo una caja de herramientas puede ser desarrollada en base a especificaciones, permitiendo que esas cuestiones de evaluación y monitoreo sean respondidas precisamente con relación a dos objetivos específicos: el respeto a los modelos de intervención, así como la sustentación de la dinámica de apropiación del programa tanto por los profesionales, como por los usuarios.