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Participant Engagement Strategies in a Housing First Randomized Trial

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Abstract

Conducting longitudinal Housing First research requires effective recruitment and engagement strategies to enroll individuals with prolonged homelessness histories who also have physical health and mental health vulnerabilities. In this article, we share our experiences working with participants in an attempt to conduct a randomized trial of single-site and scattered-site Housing First units in Seattle, Washington. We highlight considerations for the informed consent process, fostering participant agency, outreach strategies, issues with administration of measures, setting of boundaries, and ensuring participant safety. Our successes with participant engagement underscore the importance of a trauma-informed research philosophy, promoting a sense of choice for participants over the research process, and a perception of trustworthiness of the research team.

Introduction

Housing First is a model of permanent supportive housing in which individuals experiencing prolonged homelessness receive a rent subsidy and wraparound support services to promote their ability to attain and maintain housing (Tsemberis, 2011). Housing First programs operate by principles of providing housing without preconditions for compliance with treatment of psychiatric or substance use disorders or abstinence from substance use; however, variations on the structure of the housing exist. Most notably, Housing First may be configured as single-site housing (that is, buildings composed of all Housing First apartments with services provided onsite) or scattered-site housing (that is, Housing First apartments located in buildings throughout the community with services provided in the community). We embarked on an effort to conduct a randomized trial of single-site and scattered-site Housing First interventions for individuals experiencing chronic homelessness. Although the study terminated prior to completion due to pervasive barriers to implementation (Brown et al., 2020), we learned several lessons for effective engagement of participants in Housing First research.

Many ethical considerations are important when conducting research with individuals experiencing chronic homelessness (Runnels et al., 2009). Individuals in our sample experienced mental illness, substance use disorders, physical illness and disability, and cognitive difficulties, thus requiring engagement strategies that were sensitive to their needs and abilities. Furthermore, people who are homeless experience marginalization and often have negative or traumatic histories with homeless services and other institutions, so fostering trust among our participants was critical (Jost, Levitt, and Porcu, 2010; Kryda and Compton, 2009). This article highlights our approach to participant engagement in our research endeavor and the challenges we confronted therein.

Study Overview

Our study sought to examine person-environment fit in single-site and scattered-site Housing First models. That is, we aimed to identify characteristics and preferences of tenants that predicted positive housing and quality of life outcomes in each of the two housing models. The study was conducted in collaboration with Downtown Emergency Service Center (DESC), a large homeless service provider located in Seattle, Washington. Participants were randomly assigned to either single-site Housing First or scattered-site Housing First. The intended study enrollment was 450 participants. Participants were 18 years of age and older, spoke English or Spanish, and were currently experiencing homelessness—most of whom met U.S. Department of Housing and Urban Development (HUD, 2015) criteria for chronic homelessness. Vacancies in the Housing First programs drove the flow of participant recruitment; as DESC units became vacant, individuals who were next in line for housing were recruited and randomly assigned. The communitywide queue of Coordinated Entry for All (CEA) in King Country and the DESC internal housing referral channel provided referrals for the study. Both referral sources assessed, prioritized, and referred individuals to DESC-operated housing. Participants were administered measures[1] at the prehousing baseline and 6-month, 12-month, and 18-month followup interviews.

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[1] Alcohol Use Disorders Identification Test (Saunders et al., 1993), a background history interview developed for the study, Citizenship Outcome Measure (Rowe et al., 2012), Colorado Symptom Index (Boothroyd and Chen, 2008), Community Integration Scale (Aubry and Myner, 1996), Drug Abuse Screening Test-10 (Skinner, 1982), Housing Environment Survey (Kloos and Shah, 2009), Quality of Life Interview (Lehman, 1988), Residential Time-Line Follow-Back Inventory (Tsemberis et al., 2007), The Substance Abuse and Mental Health Administration (SAMHSA) Housing Satisfaction Scale (Tsemberis et al., 2003), SF-12 (Ware, Kosinski, and Keller, 1996), and a social network interview developed for the study.

Participant Recruitment and Followup

Anh-Dao Tran served as the study Research Coordinator (RC) and received the referrals to the study. The RC was a DePaul University employee who conducted her work out of DESC offices. On receipt of a referral, the RC conducted outreach to meet with potential participants for recruitment and consent to the study. Recruitment and consent meetings typically consisted of five parts: (1) reviewing information about the study and its relationship with DESC housing, (2) reviewing the consent form and obtaining informed consent, (3) completing a measure about the ideal housing preferences for the participant, (4) notifying the participants of their housing randomization, and (5) discussing the next steps for housing application and study participation.

Out of the 72 referrals we received between February 2018 and April 2018, nine potential participants declined participation. Declinations occurred for the following reasons: (1) individuals or their case managers had a strong preference for single- or scattered-site housing and so did not want to risk random assignment, (2) individuals did not want DESC housing, and (3) the time commitment of the study was too great. In addition, two potential participants could not be enrolled in the study because they were unable to provide informed consent due to disabilities. Demonstrating the complexity of the recruitment process, 10 referrals that CEA provided were returned to the community queue before recruitment could take place. In these instances, individuals could not be recruited because: (1) they did not meet low income or other requirements for DESC housing, (2) language barriers prohibited participation, (3) the RC was unable to contact the individual, or (4) the individual was incarcerated.

Once participants were enrolled in the study, the RC and a team of volunteer research assistants (RAs) conducted the prehousing baseline and followup data collections. Data collection consisted of a series of self-reported measures and structured interviews with individuals regarding their mental health, substance use, quality of life, social networks, perceptions of their housing environment, and their housing preferences and satisfaction. Taken together, data collection meetings were intended to take approximately 90 minutes.

Engagement Strategies in Service of Participant Wellbeing: Successes and Challenges

We incorporated study procedures to promote participant wellbeing and autonomy. Treating participants with dignity was at the heart of all interactions. Furthermore, in acknowledgment of the high prevalence of trauma histories among individuals experiencing homelessness (Sundin and Baguley, 2015), we drew on principles of trauma-informed care that have been implemented in homelessness services (Hopper, Bassuk, and Olivet, 2010) to guide our participant engagement strategies. Within homelessness services, trauma-informed care involves using a set of guiding principles to inform organizational policies, practices, and interpersonal interactions among staff and clients to promote a sense of physical and emotional safety (Hopper, Bassuk, and Olivet, 2010). The principles of choice (that is, promoting a sense of control by participants) and trustworthiness (that is, demonstrating clarity, consistency, and boundaries; Fallot and Harris, 2006) primarily guided our research activities. Specifically, we offered participants the choice and control over the logistics of their participation to the extent possible, and we promoted participant trust of the research team through transparency about the research procedures and reliable follow-through with scheduled interviews.

Considerations for Informed Consent

The informed consent process was essential to promote trust among potential participants and inform them of the purpose, methods, risks, and benefits of the research; the process allowed individuals the option to participate voluntarily. The RC provided a verbal overview of the essential elements of the consent form. Next, the participant independently read (or the RC read aloud upon request) the consent form in full. Participants had opportunities to ask questions. Finally, their understanding of the risks, benefits, and procedures of the study were assessed through a series of questions. Most participants were able to answer the informed consent questions without a prompt.

Importantly, the RC made concerted efforts to communicate to prospective participants that their ability to secure housing was not contingent on study participation; individuals would still receive DESC housing if they declined the study. Because housing and research were offered at the same time, however, the relationship between housing and research participation was often an area of misunderstanding. When this occurred, further review of the research consent information was prompted, and informed consent was demonstrated only after participants were able to show an understanding of the relationship between housing and research participation. The RC presumed that a few individuals chose to participate because they believed participation would accelerate or ensure their housing placement. Although these individuals communicated their understanding of the separation between research and housing, they may not have fully trusted that housing was guaranteed. In these instances, the research protocol could have been adapted to better ensure understanding by participants. In hindsight, we could have given participants more time to consider participation before signing the consent form, or we could have involved case managers to echo the information we provided about the independence of housing and research participation.

Fostering Participant Agency

To promote a sense of choice to participants, we met their preferences for meeting locations. The RC and RAs met with participants at the following locations: DESC offices, the offices of other service providers in the local community, shelters, or public spaces (coffee shops, libraries, parks, campsites, and so on). Due to confidentiality and safety issues of certain public spaces, meetings outside of private offices were less common and typically occurred only if potential participants requested them.

Case managers served a vital role in the study and fostered our ability to engage participants overall. We often used case managers to introduce us to participants and to help us locate participants in the community. Some participants preferred that their case managers be present during the consent process. During recruitment, however, some case managers declined participation on behalf of their clients or tried to influence the housing preferences of their clients during the consent meeting. Typically, case managers showed a preference for single-site housing for their clients, citing their perception of the service needs of their clients and a general preference for housing with more supportive services. Due to these occurrences, our research team implemented changes in our recruitment process to intentionally reduce our reliance on case managers during recruitment and to contact referrals directly when possible and when acceptable to participants. Doing so protected participant confidentiality and promoted agency in personal decisionmaking. Indeed, participants demonstrated their autonomy during interactions with the RC. They described choosing to participate because they wanted to contribute to change and make a difference for the homeless population in the future. Participants often communicated the importance of autonomy and choice in housing, expressing hope for a better system.

Outreach Strategies

We used a combination of outreach strategies for recruitment and followup data collections. These strategies varied depending on the availability of contact information and participant preferences. For recruitment, contact information and contact preferences for potential participants were typically available in the Homeless Management Information System (HMIS). If direct contact information (phone number or email) for the participant was available, that was typically the first method the RC and RAs used to reach out to participants. Participant contact information collected during previous interactions was used for followup timepoints.

When direct contact information was not available, the RC and RAs reached out to the support team for the participant, including housing support staff and case managers. For many participants, contact information frequently changed. We gathered updated information from the DESC internal database, housing support team, or other service providers. Therefore, the RC and RAs used either direct contact information or contact through support teams before visiting participants at their housing. Because participants often communicated their frustration for lack of privacy at their housing, especially in single-site housing, the RC and RAs used discretion when eliciting help from housing support staff or case managers, refraining from going to participant housing unless all other methods were unsuccessful. Outreach to potential participants on the streets, campsites, or public spaces was also sometimes necessary. Street outreach often involved going along with case managers during their outreach efforts or working with case managers to learn the whereabouts of an individual.

Timing and persistence were essential for outreach. For participants who had a pattern of being difficult to contact, the research team allotted more time prior to their expected followup timepoints for outreach. For some participants, the RC was able to rely on making contact within a day or two; for others, the RC would start outreach a full month in advance of interaction. Relationships between participants and the research team were critical for tailoring outreach and engagement strategies to the circumstances of each participant. For this reason, it was also vital to have consistent study personnel to build relationships and rapport with participants and other service providers.

The study design included three intermittent followup timepoints between data collections at 3, 9, and 15 months after enrollment. These intermittent followups enabled further opportunities to check in with participants, update their contact information, and maintain rapport. Through regular contact, the RC was able to develop a better understanding of participants, their situations, routines, and preferences to improve the effectiveness of outreach strategies. Strategies for contacting participants during the intermittent followups were similar to other timepoints, although they rarely involved home visits. These followups were less time-sensitive and not crucial for data collection; therefore, they were done with more flexibility. Because they were less crucial, and incentives were not provided, participants were also less responsive to intermittent followups. Every now and then, the RC would coincidentally encounter participants in public places such as on the streets, buses, and parks. If the timing was close to their intermittent followups, the RC would use those opportunities to complete them, highlighting the importance of sustained engagement within the community.

Balancing Rapport and Boundary Setting

Among members of the research team, the RC had the most consistent contact with study participants over time, which afforded her an opportunity to develop rapport with participants. She promoted trustworthiness by being reliable and consistent in her commitments to participants. Most participants clearly understood the RC role as a researcher and would only expect contact with her every 3 months. Some participants saw the RC as a source of support during times of desperation, however. Participants who contacted the RC outside of followup timepoints often expressed frustration with their housing and expressed lack of trust for their support team. Thus, relationships developed in the context of research inadvertently caused some participants to believe that the research team could help them with their housing problems and advocate for them. In these instances, setting boundaries and redirecting participants to their support team was necessary but also difficult. The RC addressed this tension through honest and persistent communication of her role and limitations. When necessary, participant support teams were also contacted to help redirect participants and ensure they received assistance.

Ensuring Participant Safety

A unique aspect of our study management was that the oversight of research activities occurred at a distance from Chicago, with only the RC and volunteer RAs working in Seattle. RAs were most often students from local universities seeking research experience, most of whom had limited experience working directly with individuals experiencing homelessness. As such, structures were put in place to ensure the Seattle-based team was equipped with the resources necessary to support participants in crisis.

The Principal Investigator (PI; second author) and Graduate Assistant (GA; third author) provided training and oversight of the RC and RAs via video conferencing and phone. The RC and RAs engaged in a rigorous training process that included attendance at virtual presentations on the study procedures, completing assigned readings of key literature, and shadowing and engaging in role plays with experienced RAs. They were quizzed on their knowledge of procedures before being allowed to interact with research participants.

We prioritized procedures ensuring participant safety. The research team received indepth training on suicide and homicide risk assessment should participants express ideation, intent, or plans to engage in harmful behavior on the Colorado Symptom Index or at any point during a data collection interaction.

We developed a series of actions to address the risk of harm that the DePaul University Institutional Review Board (IRB) reviewed and approved. First, the study consent form informed participants that confidentiality may be broken should they pose a risk of harm to themselves or others to ensure their awareness of the implications of disclosure. Second, we provided RAs with a script for assessing risk that included a decision tree for steps to take to ensure safety among participants at varying levels of risk of harm to themselves or others. At lower levels of risk (for example, participants reporting ideation about harm to self or others without intent or a plan to engage in harmful behavior), we provided participants with a list of local and national mental health and crisis resources and encouraged them to disclose their distress to their service team. At moderate- and high-risk levels, we instructed the RC and RAs to contact the PI or GA (one of whom was on call during all scheduled data collection meetings) for guidance. To promote a sense of choice, whenever possible, the research team worked collaboratively with participants expressing moderate risk (that is, participants endorsing ideation and a plan but no intent or means to carry out the plan) to determine how their support team would be informed about their risk of harm. At-risk participants were generally amenable to seeking support from their service providers, but the IRB approved that our team could notify DESC staff if necessary. Fortunately, we did not encounter instances of imminent risk (that is, participants reporting ideation, intent, and a plan to engage in harmful behavior), but emergency services would have been contacted in these cases. Taken together, our collaborative approach with participants in distress and our partnership with DESC, which allowed for a direct linkage to support services, enhanced our promotion of participant safety.

Noteworthy Issues with Data Collection

In an effort to align our study outcomes with the existing Housing First literature, we used a battery of measures that were largely used in previous Housing First studies (for example, Goering et al., 2011). Although we acknowledged the sensitive nature of questions about mental health and wellbeing, reactions to the measures by participants were notable. Although most participants were comfortable with discussing their personal information with the research team during data collection meetings, the sensitivity of the survey questions led some participants to choose not to respond to items. In other cases, participant responses appeared inconsistent with their observable presentation (for example, they denied mental health symptoms but showed signs of responding to internal stimuli/hallucinations or displayed signs that suggested the participant was depressed or anxious), suggesting they may have refrained from responding truthfully. Although it happened infrequently, participants occasionally answered questions hesitantly regarding their own substance use, criminal record, and substance use by people in their social network. In particular, questions about friends and family often triggered emotional distress. Participants often talked about not having friends or family or that their relationships were complicated. If the RC and RAs observed signs of hesitation, they reiterated information regarding participant confidentiality and remained neutral when sensitive information was disclosed. As it was made clear that participants could skip questions they did not wish to answer, we found that a large portion of participants chose not to answer the social network survey.

Although our battery of measures was similar in length to a national Housing First demonstration trial for individuals experiencing homelessness with mental illness in Canada (Goering et al., 2011), response bias may have occurred when participants were not fully engaged during data collection due to survey fatigue. Most participants were able to complete the interview within 90 minutes, but some individuals' answers were tangential and often needed more time regardless of redirecting efforts. Understandably, the length of the interview was too long for some individuals and created frustration. In these instances, we provided those participants with breaks or invited them to terminate the session and meet again at a later date to complete the measures. A combination of emotional and physical distress from study questions, the length of data collection, individual circumstances (for example, insufficient sleep, mental health symptoms, frustration with housing, and so on) also caused survey fatigue. In addition, information about specific dates and timelines was, at times, subject to recall bias when reporting previous living situations, especially when individuals experienced a substantial amount of inconsistency in their lives. Nevertheless, participants were generally able to discuss events of their lives in detail.

Conclusion

In sum, our commitment to the population we were studying facilitated our successes. The positive and trauma-informed interactions among participants and the research team fostered effective data collection. Responsiveness to participant needs and preferences was key to building their trust. Thus, flexibility in participant engagement strategies should be incorporated into Housing First research protocols wherever possible.

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