Because the clients told us so

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Abstract

Purpose – *Eliciting client narratives and creating community-informed interventions have been effective methods of engaging those who are unstably housed in care. Previous studies have shown that these approaches foster client empowerment and provide insight as to the importance of creating community-driven solutions. However, few studies report the impact of these methods on homeless people living with HIV. The purpose of this paper is to describe methods used to engage consumers in sharing their stories, including formative focus groups, qualitative interviews, and feedback from peer staff.*

Design/methodology/approach – *Data for the case study were derived from program notes, board minutes, and feedback from founding board members of The Open Door. Two researchers who were involved with the program from its inception reviewed these data and then developed a schematic of the methods used to develop and inform the program itself. The authors determined that three methods were used to elicit client and community narratives to inform program decisions. These include a formative focus group that helped to structure and implement the program in its earliest stages; qualitative interviews, which helped to pinpoint effective program components and enabled the rapid expansion of the service delivery model; and feedback from peer staff, which has consistently allowed for the refinement and prioritization of services. Data were collected for the purposes of program development and improvement but since qualitative interviews were conducted by faculty affiliated with an academic institution, the institutional review board of that institution was consulted and the qualitative interviews were determined to be exempt from review.*

Findings – *The focus group informed the authors that they wanted to live in their own apartments but have on-site supports. They also indicated that traditional housing program rules such as abstinence were too restrictive for them to navigate. In the qualitative interviews, the clients reported an increased sense of community with peers and peer staff members, which helped to reduce stigma. Second, residents reported that supportive services helped them to connect to and maintain in HIV clinical care. Third, residents reported that the representative payee services were a key factor in helping them improve housing and financial stability.*

Research limitations/implications – *There are a number of limitations to this case study that demand the need for caution in interpreting results. Although the authors used several different methods to elicit client narratives and community feedback, sample sizes were small, control groups were not utilized, and data were specific to individuals receiving services through one housing program. Thus, results are not generalizable. In addition, the methods reported herein mix those conducted for the purposes of research (in-depth qualitative interviews) with others conducted specifically to inform program delivery and improvement (focus group and peer staff feedback). Thus, rigor is not equally applied across all methods. In addition, the individuals conducting research and authoring this paper were directly involved with the creation of the program and ongoing service delivery. Therefore, interviewer and reporting bias also present threats to validity.*

Practical implications – *There are many strengths involved in utilizing the narrative feedback of the residents and peer staff to inform the practice. One is that this method is an incredibly cost-efficient way to assess client and program needs to inform intervention development and improvement. The results are also very transparent and easily translatable to the agency's everyday work. These methods are practical in both their approach to clients and their ability to be easily incorporated into the daily work of clients and staff. These methods allow for rapid application as results are immediate and feedback can be implemented quickly.*

Social implications – *When seeking client and staff feedback, it is important to be cognizant of believing the client and recognizing that all people have their own personal perspectives, including their own version of the "truth." Eliciting this type of feedback puts individuals in a vulnerable place, so it is critical to guarantee their safety. All information solicited must be regarded in a positive light to inform improved service delivery and not as a means to receive information that "tells on" clients or peer staff. Feedback should be reviewed as an opportunity for learning and not as a mechanism for retaliation.*

Originality/value – *The clients and staff have been significantly marginalized in the society. It is possible that having providers be kind and respectful to them and asking for their opinions is a very new experience which might make them feel grateful and more likely to be favorable in their responses. Clients may feel loyal*

to the program and be much more likely to speak of it positively. Regardless of these potential biases, the quantitative results of improved health outcomes published elsewhere indicate that the clients may not just be being nice, but may in fact be receiving interventions that are working.

Keywords *Retention, Housing first, Homeless, Harm reduction, Representative payee, Client narratives*

Paper type *Case study*

Background

The use of client narratives has been shown to be an effective method of informing program development to improve outcomes for a range of vulnerable populations such as recipients of welfare, people who have experienced intimate partner violence, and the chronically homeless (Anucha, 2005; Keeling and van Wormer, 2012; Mulia and Schmidt, 2003; Todahl *et al.*, 2012). Client narratives can provide insight on critical life events while also fostering client autonomy and empowerment, since clients have control in choosing where to begin their stories, what to tell, and when to terminate the narrative process. Client narratives are a form of storytelling that empowers the client to give voice to his perspective on the history of an event and provide a unique insight as to the effectiveness and importance of service delivery (Greene, 2007).

Client narratives can be especially helpful in understanding the needs and experiences of marginalized populations, such as those who are chronically homeless. Anucha (2005) found that having chronically homeless participants tell their own stories allowed researchers to explore and understand the processes occurring during periods of both being housed and being homeless. In the Anucha study, hearing a client's history of homelessness allowed for an understanding of underlying factors that contribute to homelessness as well as barriers faced by this population, which preclude them from maintaining stable housing. Client narrative were utilized in a study of youth experiencing homelessness, which found that respondents recognized the social injustice of powerful institutions that created barriers to finding affordable housing (Toolis and Hammack, 2015). This study showed that youth were able to make positive meaning of their situation and recognize that we live in a socially constructed world that has placed negative attributes upon them for being homeless and for which they refuse to identify with.

Client narratives also present a rare opportunity to understand the subjective responses clients have toward services that are designed to aid them. By uncovering the themes that limit and promote an agency's service, program development and service delivery can be improved. The value of this approach was demonstrated in a study that utilized the narratives of formerly homeless psychiatric clients in order to enhance treatment engagement and retention factors in mental health recovery. Participants reported that barriers to service included program rules and regulations that were too restrictive, as well as the lack of individual "talk therapy" (Padgett *et al.*, 2008, p. 230). Participants also expressed that they were more likely to engage in and remain in services if staff were kind, the surroundings were pleasant and private, and the hope of someday obtaining independent housing was kept alive (Padgett *et al.*, 2008). Applying lessons learned in this supportive housing program may be particularly beneficial to clients who view restrictive environments as a barrier to service.

Narratives elicited from communities targeted for assistance from health and human service organizations can also be valuable methods of planning for effective interventions. Using a similar conceptual framework as client narratives, community-informed interventions focus on sharing information with communities about various social issues, understanding their interpretations of the situation, and then developing community-driven solutions to address these issues (Harvey *et al.*, 2007). Providers who gain insight as to the needs, experiences, and relationships of a target population can more effectively tailor community-based interventions to the specific resources, values, and traditions of the community they are seeking to empower and serve (Harvey *et al.*, 2007).

One community-informed intervention that aims to end chronic homelessness is permanent supportive housing (PSH). PSH is subsidized housing that is paired with, but separate from, ongoing supportive services for clients. This separation of services is consistent with a harm reduction model of care since tenants do not have to participate in mental health treatment or other services as a condition for maintaining housing. Many cities throughout the USA have developed community-driven plans to end chronic homelessness by expanding PSH, and it has been demonstrated that increased

community investment in PSH was associated with reductions in chronic homelessness over time (Byrne *et al.*, 2014). These findings further suggest the merits of using intentional methods of engaging community or client input and then supporting community-developed approaches to address social or public health issues. Clearly, client perspectives and community-informed solutions can be effective methods for empowering marginalized populations and developing services that are more likely to be successful in producing targeted outcomes.

This paper describes a case study documenting three ways in which a supportive housing program used client narratives to inform program decisions. The Open Door is an organization that was created to provide housing and supports to chronically homeless individuals living with HIV/AIDS. The majority of people served include active drug users, many of whom also have criminal histories and untreated mental illness. The Open Door operates a 15-unit apartment building where residents live independently in one-bedroom apartments within a community setting. Residents of The Open Door have their own apartments and pay rent, which are typically afforded through public entitlements including Supplemental Security Income (SSI) and Social Security Disability Income (SSDI). SSI and SSDI are public entitlements provided by the Social Security Administration (SSA), a government agency which decides whether individuals meet qualifying criteria related to disability and lack of income. Supportive assistance is provided to residents by peer resident monitors, who are themselves living with HIV/AIDS and/or in recovery from addiction.

In addition to the provision of housing and peer support, The Open Door serves as the representative payee for its residents. Representative payee is a service in which SSA appoints an individual or an organization to provide financial management for vulnerable individuals who are unable to manage their SSI or SSDI payments independently. The representative payee assists in the management of the assigned individual's income, helping them pay current expenses while budgeting and saving for future needs. The representative payee receives the check, assures bills are paid for the person they represent, and then disperses a spendable amount to the individual. A representative payee can be a family member or someone close to the individual needing the services, or the payee can be a qualified organization. Organizational representative payees can include social service agencies, institutions, and state or local government agencies (Social Security Administration, 2014).

The Open Door was founded on two basic principles. First, clients are valued as they are, and for everything with which they present. They are whole people, not in spite of historical challenges and problematic behaviors but because of them. Second, the program recognizes that housing is the way to keep people alive. The Open Door also builds on two primary service approaches. The first approach is harm reduction, a philosophy that encourages any positive change, even in the presence of continued risk behaviors such as substance use (Marlatt, 1998). Residents are supported in achieving personal health goals that often does not include reduction of substance use or involvement in mental health treatment. Clients of the housing program are most often interested in prioritizing their physical health by engaging in care for HIV. There is a growing body of literature detailing the incongruence between housing policies and the needs of persons who are homeless (Bowpitt *et al.*, 2011, 2014). Harm reduction prevents the housing agency from having conflicting priorities with clients because goals come from the clients and are supported by the agency.

The second service approach upon which The Open Door is built is the housing first model. Housing first is a consumer-driven model of care that prioritizes housing over all other treatment goals (Padgett *et al.*, 2006). The Open Door does not make the provision of housing conditional on treatment goals, engagement in mental health treatment, or abstinence from substance use. Housing is prioritized for people who are least likely to be served by traditional housing models, which often preclude services for active substance users with criminal histories. The only expectation placed on residents at The Open Door is that they aim to improve their HIV treatment outcomes. Specifically, residents must have an interest in seeking HIV clinical care, although services are not predicated upon success in care.

Both harm reduction and housing first are rooted in client-centered care, which is largely credited to psychologist Carl Rogers, and is hallmarked by complete and total acceptance of the client. In discussing this philosophy, Rogers (1961) wrote:

> By acceptance I mean a warm regard for him as a person of unconditional self-worth – of value no matter what his condition, his behavior, his feelings.

At The Open Door, this philosophy means that residents are not seen as individuals who must be made to conform to pre-conceived notions of treatment success, but rather as individuals who present with a set of experiences, behaviors, and self-identifiable goals. Only by working from the context and perspective of the client can he/she be helped to achieve optimal, yet feasible, health outcomes. In this sense, it can be seen that harm reduction and housing first are the application of the client-centered approach, which in turn is a values orientation of humanism. Given this emphasis on client-centeredness, soliciting client narratives and eliciting community feedback are methods of intervention development and refinement that are highly consistent with the program approach. This approach is consistent with previous studies that have demonstrated the importance of peers, who are "experts by experience" and can provide important information about how to best serve homeless populations (Barker and Maguire, 2017).

Though the methods used to elicit client feedback were iterative and applied for the purposes of program development and improvement, the significant clinical outcomes that our residents have achieved and the unique history of this organization have prompted us to share our results with the community in the hopes that others might consider replicating our model. The following case study describes the processes by which these methods were conducted.

Methods

Data for our case study were derived from program notes, board minutes, and feedback from founding board members of The Open Door. Two researchers who were involved with the program from its inception reviewed these data and then developed a schematic of the methods used to develop and inform the program itself. We determined that three methods were used to elicit client and community narratives to inform program decisions. These include a formative focus group that helped to structure and implement the program in its earliest stages; qualitative interviews, which helped to pinpoint effective program components and enabled the rapid expansion of the service delivery model; and feedback from peer staff, which has consistently allowed for the refinement and prioritization of services. Data were collected for the purposes of program development and improvement but since qualitative interviews were conducted by faculty affiliated with an academic institution, the institutional review board of that institution was consulted and the qualitative interviews were determined to be exempt from review.

Formative focus group

The earliest use of community feedback to inform program development occurred in 2005 in the form of a focus group comprised of homeless individuals living with HIV/AIDS. Because the focus group utilized a convenience sample, all members of the focus group were men, although the program has served both men and women throughout its history. Five individuals were recruited by a medical social worker affiliated with a local HIV clinical provider to participate in the focus group, and this social worker also facilitated the groups. These individuals were previously known to the social worker, who had helped them access housing and other resources in the past, and they shared their experiences with homelessness as well as with living in various housing programs and group settings. Participants were provided with a $10 gift card to honor their time. To protect confidentiality and engender participant trust, the focus group was not audio recorded; however, the facilitator took copious notes, supplemented by post focus group field notes, which were subsequently thematically analyzed (Moustakas, 1994). Results from this focus group, discussed below, were directly applied to develop the housing program, which began operation in 2006.

In-depth qualitative interviews

The second method of collecting feedback from clients occurred several years into the program. In 2012, we conducted qualitative interviews with residents of The Open Door in order to define "mechanisms of adherence," that is, program elements that were critical to helping residents achieve treatment success. Methods and findings are published elsewhere (Davis *et al.*, 2014), but briefly, we used a grounded theory approach to describe and build evidence for the implementation of mechanisms that could be refined to improve The Open Door's service delivery model, or used by other providers to improve clinical outcomes in similar unstably housed populations.

A total of 19 current and former male, female, and transgender residents of the program were interviewed for this study. In all, 11 participants were living at the program during the time of the study and 8 were interviewed after they had left the program, and each participant received a $10 gift card as thanks for their time. Interviews were audio recorded and coded manually using Microsoft Word, using contextualizing and categorizing strategies (Glaser and Strauss, 1967; Patton, 1990; Strauss and Corbin, 1990). First, four different coders reviewed the first two transcripts from each of the three interviewers and then reviewed the codes together to check for inter-coder reliability. Although there was a high degree of agreement among the coders, in cases where there was divergence, the codes were discussed until there was category agreement. The interviews were then recoded for consistency. Using the fully developed codes, two primary coders then coded all 19 interviews separately, and then reviewed once again for inter-coder reliability. Slight adjustments were again made to ensure consistent application of codes.

Active feedback from peer staff members

Our last example of the use of narratives and community-informed practice is through active feedback from the program's peer resident monitors who are paid staff members. As peers, they share many historical issues and challenges with residents including living with HIV and having substance use, homelessness, and mental health issues in their recent pasts.

Active feedback from peer staff members was facilitated in several specific ways. First, findings from in-depth qualitative interviews were reviewed with peer staff to interpret and triangulate results. Specifically, once thematic analysis was completed and a list of themes was developed as previously described, these themes were reviewed with peers in order to ensure that themes were being accurately described by the research team. The staff's interpretation of our results proved invaluable through all of our research processes, including recruiting residents for interviews, helping them feel comfortable with the process, informing the researchers of what incentives would be most valuable to the residents, and identifying critical questions to include in the interview protocol.

In addition to strengthening the qualitative research processes, peer staff members have consistently informed The Open Door's service delivery model. Since the inception of the program, the program supervisor met with staff on a monthly basis specifically to evaluate their work as well as to identify opportunities for program improvement. During these meetings, peer staff members were asked open-ended questions about residents' needs and experiences, as well as what needed to be changed, added, or deleted from the program. Also, every year peer staff members receive a two-page self-assessment that asks specific questions related to what they like the best about the job, what they like the least, and what they would like to change. Although peer staff members provide feedback informally on regular basis, these are two formal ways in which they evaluate the current services that are provided. While these processes align closely with standard supervisory methods in human service programs, what is unique about our processes of eliciting feedback from our peer staff members is that their experiences and convictions about program improvements led directly to shifts in our service delivery model.

Results

Formative focus group

Feedback from the initial focus group of homeless men living with HIV/AIDS was the impetus for The Open Door housing program. By hearing their narratives and experiences with reoccurring cycles of homelessness, we learned how to develop a program that was highly responsive to their needs. Specifically, this group informed us that they wanted to live in their own apartments but to be located within a larger building that had on-site support programs such as congregate meals and 24-hour staffing. In addition, they also indicated that traditional housing programs were too restrictive for them to navigate, since they required clients to be abstinent from substances for 90 days prior to move in. Focus group findings directly lead to the choice of building that was purchased, which enables residents to have their own apartments within a larger housing community. These findings also directed the harm reduction approach that is an integral part of the program.

In-depth qualitative interviews

Armed with these quantitative study results, we subsequently conducted qualitative research, again relying on client narratives to identify mechanisms that helped residents achieve treatment success. We conducted in-depth, semi-structured interviews where the first two questions were "warm up questions" about who were important people in their lives, which also provided some history of residents' lives prior to involvement with the housing program. The other eight questions were related to residents' experiences in the program as well as explorations of what aspects of the program were most important to them, what changed for them since being at the program, and how they perceived themselves in the past, present, and future. The whole of these results are published elsewhere (Davis *et al.*, 2014), but in summary, three themes emerged from this research as being critical to improved health outcomes. First, residents reported an increased sense of community, including connections with peers and peer staff members, which helped to reduce the stigma that is often associated with homelessness, substance use, and living with HIV/AIDS. Second, residents reported that supportive services such as clinical, practical, and emotional support helped them to connect to and maintain in HIV clinical care. Third, residents overwhelmingly reported that the representative payee services were a key factor in helping them improve housing and financial stability, both of which are linked to engaging in care (Davis *et al.*, 2014).

The fact that participant responses regarding the representative payee service were overwhelmingly positive was an unexpected finding. Residents credited representative payee with helping them to achieve financial independence, which seems somewhat counter-intuitive. However, individuals noted that being able to maintain rent and utility payments not only helped them reduce life chaos and stress, but also enabled them to build credit with utility companies. It is also revealing that although study participants reported that they were initially resistant to the idea of having a representative payee, most residents were eventually pleased with the service (Davis *et al.*, 2015). Most significantly, residents of The Open Door typically keep the organization as their representative payee even after leaving the program – even those individuals who leave the program under unfavorable circumstances.

Given that residents' responses to representative payee services were so positive, and once again relying on client narratives, The Open Door decided to expand its program to reach beyond individuals who are housed in the program, offering services to individuals who are living with HIV/AIDS and either homeless or unstably housed, but living in other environments. In 2012, we initiated an expanded client-centered representative payee program to serve a larger number of unstably housed individuals living with HIV/AIDS.

Active feedback from peer staff members

In order to understand the value of input from our peer staff members, it is important to understand the value of the peer staff members to our clients. In the qualitative interviews described above, many participants noted the importance of living in and being supported by a community of peers, which includes peer staff members (Davis *et al.*, 2014). Our findings showed that the emotional and practical support provided by peer staff was the foundation of our residents' adherence and housing success.

There are several specific examples that demonstrate the use of feedback from peer staff members to improve service delivery. Soon after the program began housing chronically homeless individuals, peer staff realized that there was a sense of community built not only among current residents but also with those who had lived there in the past. To strengthen this experience and ensure that those who graduated from our housing program could continue to benefit from it, our peer staff members started inviting former residents back for weekly and holiday functions. The qualitative interviews with our residents validate the importance of this tradition, as participants stressed the importance of being able to come "home" to "family" even when they no longer lived in the building (Davis *et al.*, 2014).

Peer staff also quickly realized that due to limited funds, our residents often did not have the monies to fit cleaning supplies into their budgets, so they created a monthly bingo game that involves winners receiving household cleaning supplies. These games are so valuable to residents that they

always have high levels of attendance. They also recognized that our residents were more likely to attend support events if there was food involved and that while some residents would only come to meetings for the donuts and coffee, they would often stay because of the topic or the comradery. Building from this, our peer staff has realized that many of the residents' only hot meals were coming from our program activities because they did not know how to cook. Therefore, our staff now provides regular cooking lessons, such as "how to make a meatloaf night."

Recently, one of our peer resident monitors developed a new way to work on goals with the residents. She reported that the usual treatment plans that are required for most agencies include monthly and yearly goals, which are too overwhelming for our residents. Residents had expressed that they needed help with more short-term goals such as daily and weekly "check-ins." From this feedback, she developed a journaling group and solicited donations so each resident was able to receive personalized journals. Our peer staff members were not at all surprised when residents started talking about how to help each other accomplish each other's goals. One such example is the resident whose goal was to not use substances every day during her birthday week because she wanted to start fresh. Other residents checked in on her daily and reinforced her goal. Our peer resident monitors recognized the fact that telling other people our goals is a good way to stick to them because, "Sometimes when you are not feeling strong enough, others can remind you of why you wanted to achieve that goal in the first place."

Another specific example of how we tailored services in response to input from our peer resident monitors is the way we handle "check days" in our representative payee program. As noted above, the representative payee service was greatly expanded in direct response to feedback from qualitative interviews with participants. As part of the representative payee service, residents all receive income from social security and get paid on either the first or third of the month. Peer staff intervened early in the representative payee process, informing us that we needed to separate this process from our housing program for the safety of the clients and the staff. As a result, we developed a process in which the person who handles financial transactions and disbursements is unknown to the clients. The value of separating this service from the housing program is that it creates clear boundaries for clients and reduces the power differential between staff and clients, since they know that the people who support their housing needs do not have control over their money. It is also consistent with our housing first approach in that our work with residents stays focused on stable housing. Through this shift, budgeting decisions are made by clients in partnership with their medical social workers, who are not a part of our program, and who also are the points of contact with the representative payee program. This change has not only eliminated unproductive conversations with our peer resident monitors but has also given residents good reasons to be visiting their social worker at their doctors' offices.

In addition to changing these logistical processes, the peer resident monitors have developed a strategy to ensure that our residents have the support they need to reduce crises and maintain stability on check days. The peer staff members are intimately knowledgeable about the crises that clients were going through on check days due to having limited funds and owing money to friends, relatives, drug dealers, leaving little left over for themselves. These check days can create overwhelming trauma in already stressful lives, and peer staff quickly ascertained that the presence of any other people on the premises during these days exacerbated the clients' levels of stress and increased their experiences of feeling unsafe. In addition to restructuring the way that residents obtain their checks, our peer staff members work differently with clients on check days. Rather than focusing on mid- or long-term goals, on these days the focus is on just getting through the day. While immediate crises are addressed, the peer resident monitors are intentional about not responding to crises that are temporary and likely to self-resolve in a day. They also limit programmatic activities on check days to create a calm atmosphere where clients can experience feelings of peacefulness in an otherwise chaotic environment.

Discussion

There are a number of limitations to this case study that demand the need for caution in interpreting results. Although we used several different methods to elicit client narratives and community feedback, sample sizes were small, control groups were not utilized, and data were

specific to individuals receiving services through one housing program. Thus, results are not generalizable. In addition, the methods reported herein mix those conducted for the purposes of research (in-depth qualitative interviews) with others conducted specifically to inform program delivery and improvement (focus group and peer staff feedback). Thus, rigor is not equally applied across all methods. In addition, the individuals conducting research and authoring this paper were directly involved with the creation of the program and ongoing service delivery. Therefore, interviewer and reporting bias also present threats to validity.

However, there are also many strengths involved in utilizing the narrative feedback of our residents and peer staff to inform our practice. One is that this method is an incredibly cost-efficient way to assess client and program needs to inform intervention development and improvement. The results are also very transparent and easily translatable to the agency's everyday work. These methods are practical in both their approach to clients and their ability to be easily incorporated into the daily work of clients and staff. These methods allow for rapid application as results are immediate and feedback can be implemented quickly.

The feedback elicited from program participants is consistent with findings from other studies and for other populations. Peer support in group settings or via individual providers is increasingly documented as an important resource for marginalized individuals. Peers can be important for role modeling, problem solving, and validating one's experiences. There is evidence that, for individuals who are addicted or have serious mental illness, peers can improve engagement into care, increase self-care, and even decrease levels of depression and psychosis (Davidson *et al.*, 2012). Furthermore, the feeling of belonging to a community has been positively correlated with improving health behaviors (Hystad and Carpiano, 2012). Finally, despite the fact that all of our participants are living with HIV, the issues of homelessness, substance use, and untreated mental illness are not specific to the population of people living with HIV. Though persons living with HIV come with their own set of unique challenges, HIV-specific challenges are not necessarily the ones that prevent them from the basic life needs of housing and health care. We believe that improving access to housing to all persons is a human rights issue, and safe and affordable housing should not be tied to criteria or eligibility guidelines that restrict access to anyone.

This type of methodology is not without its challenges, including the potential for client and staff bias. It is also possible that our clients and peer staff may not all have the critical thinking skills required for thoughtful self-inspection and therefore some of our results may fall on a very superficial level. Our clients and staff have been significantly marginalized in our society due to the very problems that make them eligible for our services, which can make them particularly vulnerable to a feeling of gratitude to the program. It is possible that having providers be kind and respectful to them is a very new experience for them, and if so, clients and peer staff may feel overwhelmingly loyal to the program and be much more likely to speak of it positively. Similarly, they may not have previous experiences of providers asking for their opinions about anything, which might make them feel grateful for even being heard and also more likely to be favorable in their responses. Regardless of these potential biases, our quantitative results of improved health outcomes published elsewhere indicate that our clients may not just be subject to response bias, but may in fact be receiving interventions that are working for them (Hawk and Davis, 2012).

Other providers considering this approach should be aware of several issues. When seeking client and peer staff feedback, it is important to honor the client's feedback and acknowledge that all people have their own personal perspectives, including their own version of the "truth." Researchers must recognize the epistemological privilege from which they start this process and the power differential between themselves and their marginalized clients and participants. Eliciting this type of feedback puts individuals in a vulnerable place, so it is critical to guarantee their safety, which includes ensuring that the information they share will not be used against them. All information solicited from clients and peer staff must be regarded in a positive light to inform improved service delivery and not as a means to receive information that "tells on" clients or peer staff. Feedback should be reviewed as an opportunity for learning and not as a mechanism for retaliation. Recognizing the challenges we identified, other providers implementing our recommendations may also want to consider providing training to clients and staff to enhance their ability to self-reflect and to reduce the potential for respondents to feel influenced by social desirability factors.

We described three methods of eliciting feedback from members of the target population and discussed program decisions and improvements that were made as a direct result of this feedback. Given that our program has demonstrated strong outcomes both in terms of clinical results and client satisfaction, it seems apparent that using client narratives to inform program decisions is highly effective. In addition to its utility in improving program outcomes, our commitment to eliciting feedback from members of our target population is consistent with our conceptual models of care, which include harm reduction, client-centeredness, and housing first. Actively engaging clients in sharing their narratives and providing feedback on our program extends these approaches because it is empowering, places the focus on client-developed goals, and improves opportunities for clients to remain engaged in care by being responsive to their needs. We have found success in having our practice inform our research and in turn having our research inform our practice. Our skilled staff and resilient clients have the most relevant knowledge of their own strengths and challenges and we have utilized their expertise to guide our research and then used the results of our research to guide our practice.

The methods used at The Open Door to hear the experiences of our clients and peer staff members may be useful for other programs to consider, especially since each of these processes is inexpensive and able to be conducted in a variety of program settings. In addition, the programmatic approaches described herein may be useful for other housing first models to consider. Additional research is warranted to better understand the impact of these methods on client outcomes, which may be used to extend the reach of homelessness services and inform policy to improve service delivery for marginalized populations.

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