Findings from A Fidelity Assessment of a Housing First Programme in a Small Canadian City

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› **Abstract**_ *This paper presents the findings of a second fidelity assessment of a Housing First programme in a small Canadian city. The evaluation included two components: a) a fidelity assessment by an external team of experts; and b) key informant interviews and focus groups with programme staff to identify contributors to programme areas of high fidelity and low fidelity. Findings from the second fidelity assessment indicated that the programme in Moncton had effectively addressed a number of issues raised in the first fidelity assessment. However, the second fidelity assessment also identified the presence of a number of challenges that continued to be faced by the programme. Notable programme areas requiring further development included the integration of substance abuse treatment into services delivered by the Assertive Community Treatment (ACT) team, the use of individualized service planning focusing on recovery goals, and the addition of a peer specialist to the ACT team. The findings from the fidelity assessment are interpreted in the context of information collected from key informants and programme staff. Recommendations coming out of the assessment for addressing programme areas of low fidelity are discussed.*

› **Keywords**_ *Housing First, Assertive Community Treatment, fidelity assessment, homelessness*

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Introduction

The *Pathways* Housing First model represents a shift in the traditional service philosophy for homeless individuals with severe and persistent mental illness (Tsemberis, 1999; Tsemberis and Eisenberg, 2000; Tsemberis *et al.*, 2004; Greenwood *et al.*, 2005). Homeless individuals are rapidly placed in the housing of their choice, provided with a rental subsidy, and offered support through an Assertive Community Treatment (ACT) team (Tsemberis, 1999; Tsemberis and Eisenberg, 2000). The model has demonstrated superior outcomes, particularly with regard to housing retention, compared to traditional residential continuum models (Aubry *et al.*, 2014). Because of the success of the model, Housing First programmes are now being implemented in communities across Canada (Goering *et al.*, 2011), the United States (Stefancic *et al.*, 2013) and Europe (Greenwood *et al.*, 2013).

Due to the rapid uptake of the Housing First model in various locales, a new wave of research regarding programme implementation has emerged (Stergiopoulos *et al.*, 2012; Stefancic *et al.*, 2013; Fleury *et al.*, 2014; Gilmer *et al.*, 2014; Nelson *et al.*, 2014; Macnaughton *et al.*, 2015; O'Campo *et al.*, 2015). This type of research, which can help guide the development of Housing First programmes, is important, as the model is based upon several core concepts, and improper implementation may diminish the programme's ability to produce the expected positive housing outcomes (Stefancic *et al.*, 2013). Research has shown that Housing First programmes with high fidelity demonstrate better outcomes for their participants in relation to housing stability, community functioning and quality of life (Gilmer *et al.*, 2013; Davidson *et al.*, 2014; Goering *et al.*, 2015).

In recognition of the importance of adherence to the Housing First model, this article presents findings from a fidelity assessment of a Housing First programme in Moncton, New Brunswick – a small Canadian city. The city was one of five participating sites of the At Home/Chez Soi demonstration project (Goering *et al.*, 2011).The assessment included two components: a) a fidelity assessment conducted by an external team with expertise in the delivery of Housing First; and b) a qualitative evaluation of factors contributing to programme areas of low and high fidelity. This article provides a significant and new contribution to the literature, as it presents the findings from fidelity assessment of a Housing First programme three years after its launch in a community with no prior experience administering Housing First services. It also describes the mixed methods undertaken to assess fidelity and provides unique insights into improving the programme fidelity of Housing First programmes.

Critical ingredients of Housing First

Housing First is guided by principles of the supported housing model. Although supported housing is a well-known model, there has been considerable variation in its implementation (Aubry *et al.*, 2014). Several review articles have been published to try to determine the critical ingredients of supported housing (Rog, 2004; Wong *et al.*, 2007; Tabol *et al.*, 2010). After a review of the literature, each of these cited articles identified a set of ingredients that encompassed supported housing models. These ingredients fit into the following categories: 1) use of regular housing; 2) separation of housing and services; 3) delivery of flexible supports; and 4) facilitation of choice. Tabol *et al.* (2010) also included immediate placement into housing as a critical ingredient.

Based upon these critical ingredients, the review articles then compared these criteria to supported housing models presented in the literature. Rog (2002), Wong *et al.* (2007), and Tabol *et al.* (2010) all found substantial variation in the adherence of the programmes to these five critical ingredients, with some programmes demonstrating strong fidelity and others meeting few of the critical ingredients. These findings demonstrate that it is important for new and existing Housing First programmes to monitor their programme implementation to ensure that they have fidelity in line with the tenets of the model. In recognition of this, the At Home/Chez Soi demonstration project in Canada used mixed methods to evaluate how well the participation sites across five cities were adhering to the Housing First model (Macnaughton *et al.*, 2012; Macnaughton *et al.*, 2015).

Mixed methods and fidelity

Mixed methods designs are common in programme evaluation. Greene, Caracelli, and Graham (1989, p.256) defined mixed methods designs as those that 'include at least one quantitative method (designed to collect numbers) and one qualitative method (designed to collect words), where neither type of method is inherently linked to any particular inquiry paradigm.' Mixed methods can serve several functions, with triangulation being perhaps the most common; however, mixed methods can also function as a means of complementarity.

In these types of studies, 'qualitative and quantitative methods are used to measure overlapping but also different facets of a phenomenon, yielding an enriched, elaborated understanding of that phenomenon' (Greene *et al.*, 1989, p.258). This type of analysis differs from triangulation as the quantitative and qualitative methods do not counteract one another. The At Home/Chez Soi demonstration project used the complementarity mixed methods approach to evaluate the fidelity of the programs in the different sites (Macnaughton *et al.*, 2012). In particular, a fidelity assessment

by an external team (evaluation on a quantitative measure) and discussion of the fidelity results with programme stakeholders (in-depth qualitative focus groups and interviews) were used as complementary measures.

Fidelity assessments provide a systematic manner by which to evaluate programme implementation. They are important tools, as programmes with strong adherence to the philosophy of established models demonstrate better outcomes than programmes with poor adherence (Durlak and DuPre, 2008). Goering and her colleagues (2015) showed a positive relationship between programme fidelity and the housing stability, community functioning and quality of life achieved by the programme participants. Fidelity measures also 'reduce the chance that outcomes, positive or negative, will be misappropriated to a model never fully implemented in practice' (Watson *et al.*, 2013, p.2).

The At Home/Chez Soi demonstration project in Canada

The At Home/Chez Soi demonstration project was a multi-site randomized controlled trial that examined the effectiveness of Housing First services relative to treatment as usual in five Canadian cities (Moncton, Montreal, Toronto, Winnipeg and Vancouver) (Keller *et al.*, 2013). The design and methods of the project have been described in detail in previous publications (Goering *et al.*, 2011) and therefore only a brief synopsis is provided here. The Housing First services followed the Pathways to Housing model (Tsemberis, 2010). In Moncton, Housing First consumers were provided with subsidized housing in the private rental market and with Assertive Community Treatment (ACT) services. The ACT services operated with a consumer to staff ratio of 10: 1, which is the standard practice for ACT. Staff members of the ACT team represented a mix of mental health disciplines that included a nurse practitioner, psychiatric nurses, an occupational health therapist, a home economist, a social worker, human resource counsellors, a physician clinical director and consulting psychiatrists. The Moncton site also provided Housing First services to individuals living in a rural region adjacent to Moncton. The city had only limited community mental health services in place and no previous experience implementing a Housing First programme or ACT.

As part of the mixed methods analysis, an early implementation and a follow-up implementation evaluation were conducted. As previously mentioned, this included a fidelity assessment using the Housing First Fidelity Scale (Stefancic *et al.*, 2013) and a qualitative evaluation of program implementation. Previous articles have presented the fidelity scores and implementation evaluation findings aggregated across the five sites of the At Home/Chez Soi project (Nelson *et al.*, 2014; Macnaughton *et al.*, 2015) and from the Moncton site (Ecker *et al.*, 2014). When averaging the domain scores across the five sites, 71% of the Fidelity Scale items were rated as higher than three on the four-point scale (i.e., interpreted as high

fidelity) at the early implementation phase, conducted approximately one year after programme launch (Nelson *et al.*, 2014). At the follow-up implementation, conducted between two and two and one-half years post programme launch, 78% of items were rated as higher than three (Macnaughton *et al.*, 2015). These percentages indicate that the five programmes were demonstrating high levels of fidelity in both time periods. Moreover, improvements were made across four of the five domains when examining all five sites together: *Separation of Housing and Services, Service Philosophy, Service Array* and *Programme Structure* (Macnaughton *et al.*, 2015). The score for *Housing Choice and Structure* showed a high level of fidelity in the first fidelity assessment and remained the same thereafter.

The fidelity scores of the five At Home/Chez Soi sites demonstrated several sustained and improved strengths, as well as some challenges from early implementation to later implementation. Strengths included separating housing and support services, providing permanent and affordable housing, and providing choice in housing (Macnaughton *et al.*, 2015). There were specific challenges uncovered by the fidelity assessment that were faced by the Housing First programmes, which reflected continued low levels of implementation; these included the availability of housing, the provision of person-centred planning, the provision of motivational interviewing, meaningful representation of consumers within the programme, the availability of psychiatric services, the provision of substance abuse treatment, the provision of employment and educational services, the encouragement of the social integration of consumers, and the provision of 24-hour coverage (Macnaughton *et al.*, 2015).

The follow-up qualitative evaluation of implementation also uncovered several strengths and challenges that impacted the implementation of the Housing First programme in the five cities. Strengths included staff commitment to the programme, improvement over time of staff expertise, the leadership of site leaders, the organizational culture, the local partnerships that were developed, and the training and technical support provided (Macnaughton *et al.*, 2015). Challenges that arose included staffing concerns regarding job security, ensuring peer specialists were meaningfully integrated into the programme, providing vocational support to the consumers, the availability of quality housing, and a small minority of consumers unwilling to engage with the programme or having repeated episodes of housing instability (Macnaughton *et al.*, 2015). The results from the fidelity assessment and the qualitative evaluation of implementation presented above demonstrate the utility of mixed methods analyses. Significant overlap occurred between the results of both types of analyses; however, unique strengths and challenges were also presented within each. As such, the goal of complementarity was achieved.

Fidelity assessment at the Moncton site of the At Home / Chez Soi project

The early fidelity assessment and implementation evaluation of the Moncton site of the At Home/Chez Soi project demonstrated high fidelity to the Housing First model, but certain challenges did arise given the unique context of the city (Ecker et al., 2014). The site scored particularly well on four of the five fidelity dimensions: *Housing Choice and Structure*; *Separation of Housing and Services*; *Service Philosophy* and *Programme Structure*. The one domain to score lower on fidelity was *Service Array*. Particular challenges noted in the fidelity assessment were the small landlord network, the limited housing stock available, the need for staff training in motivational interviewing and substance abuse treatment, and the lack of meaningful involvement of the Housing First participants in the programme. The implementation evaluation also uncovered a small number of challenges and modifications that resulted from operating a Housing First programme in a small city. Challenges included rapid information-sharing within the community, a lack of adequate public transportation for participants, and limitations to offering participants choice in their housing. Modifications included not providing 24-hour care, having limited psychiatric services, and the inclusion of participants with moderate needs.

Study objectives

The remainder of this article provides a site-specific account of the second quantitative fidelity assessment and related qualitative evaluation of the Housing First programme in Moncton as part of the At Home/Chez Soi research project. The quantitative fidelity assessment was intended to identify changes in fidelity ratings since the first fidelity assessment, programme areas with high fidelity, and programme areas with low fidelity. The qualitative evaluation of implementation, conducted after this second fidelity assessment, was intended to explain the contributors to programme areas of high and low fidelity from the perspective of key informants and Housing First programme staff.

Method

Mixed methods approach

We used a mixed methods approach in which a quantitative fidelity assessment was conducted by an external team to evaluate the fidelity of the programme on a set of standards. This was followed by a qualitative evaluation of implementation that used protocols informed by the results of the fidelity assessment with the objective of identifying factors perceived by key informants and programme staff as contributing to programme areas of high fidelity and low fidelity.

Fidelity assessment

Fidelity measure

The team assessed the Moncton programme with regard to its adherence to the standards set out in the 38-item Pathways Housing First Fidelity Scale developed by Stefancic *et al.* (2013). The scale was developed through a literature review, an assessment of similar fidelity scales, and consultation with a selection of Housing First programmes and experts in Housing First. Following these three steps, the key ingredients were validated through consensus-based procedures.

Five domains of the scale emerged, with a specific number of items within each: 1) *Housing Choice and Structure* (6 items); 2) *Separation of Housing and Services* (6 items); 3) *Service Philosophy* (10 items); 4) *Service Array* (8 items); and 5) *Programme Structure* (8 items). A 4-point rating scale is used for each criterion, with higher scores indicating greater fidelity. Half-point increments are used in the scale and a score of 3.5 out of 4.0 represents 'high fidelity'. The items making up the subscales for each of four domains other than *Programme Structure* demonstrated acceptable to good internal reliability based on Cronbach alpha coefficients (Stefancic *et al.*, 2013). As well, it has been shown to have discriminant validity in differentiating Housing First programmes from programmes that did not follow the Housing First model in the domains of *Housing Choice and Structure, Separation of Housing and Services, and Service Philosophy* (Gilmer *et al.*, 2014).

Procedure and sample

An external team of evaluators made up of experts in the delivery of Housing First services (i.e., a programme manager, a service provider and a researcher) conducted the fidelity assessment. The fidelity assessment was completed in January 2012 at which time the programme was 27 months old. The data for the fidelity assessment came from observations of the daily ACT team meetings, interviews with key informants, focus groups with programme staff and consumers, and chart reviews. Based on the collected information, each member of the fidelity assessment team scored the programme on the standards itemized in the fidelity measure (Stefancic *et al.*, 2013). Once each team member had scored the individual items of the scale independently, they discussed them collectively and conciliated differences until they reached a consensus score on each item.

Data analysis

Analyses for the fidelity assessment involved calculating an overall average across the 38 items and averages for each of the domains. In addition, we examined the scores of individual items on the scale. These averages and individual item scores of the second fidelity assessment were compared to those from the first fidelity assessment conducted in August 2010, ten months after the launch of the programme (Ecker *et al.*, 2014).

Qualitative evaluation of implementation

We conducted the qualitative evaluation between February and July 2012, at which time the programme was approximately two and a half years old and operating at full capacity in terms of the number of service recipients (i.e., approximately 100).

Sample

For the qualitative evaluation of implementation, we interviewed the Physician Clinical Director, the ACT Team Manager, the Housing Coordinator and the At Home /Chez Soi Research Site Coordinator individually. We also conducted two focus groups with staff members of the ACT team – one in English (n = 6) and one in French (n = 2).

Procedure

For the individual interviews and focus groups, we used the common protocols developed by the national qualitative group for the five At Home/Chez Soi sites. The protocols included questions focusing on programme strengths and challenges revealed in the fidelity assessment. The questions were open-ended and included a series of probes to engage participants in a discussion. The protocols were semi-structured, in that the interviewers had a specific list of questions but could deviate from the script depending upon the responses provided by interviewees. Given that the programmes across the five sites were diverse, a semi-structured protocol was important.

We interviewed key informants in person. The duration of key informant interviews ranged from 30 to 45 minutes. We conducted the focus groups with ACT staff at their team office. They lasted approximately 90 minutes. We audio-recorded and transcribed the key informant interviews and focus groups.

Data analysis

Five research team members conducted thematic coding of transcripts intended to identify factors contributing to programme areas of high and low fidelity as revealed in the fidelity assessment. The researchers used a thematic coding paradigm as outlined by Padgett (2012). The analysis took place in stages. The first step involved the open coding of the data, which involved reading the transcripts line by line and developing codes for segments of the data. In vivo coding was used as often as possible, since codes should stick closely to the data (Charmaz, 2006). Following open coding, a process of focused coding was completed. In this stage, codes were synthesized and developed into meaningful themes.

Members of the research team were put in pairs to code at least one of the research questions. Each member of the pair independently coded the transcripts and followed the two-step coding process. Subsequently, the two coders compared their themes and discussed them until a consensus was achieved on a common

set of themes. Through this initial process, the quality of the data analysis was established. Members of the research team were then assigned individual research questions and began to code independently. Once all of the research questions were coded, the team reviewed all of the themes and sub-themes that were created. This last step served as a verification process.

Results

Fidelity assessment

Table 1 presents the average scores for all of the items and for the items in each domain of the scale as well as the individual item scores from the first and second fidelity assessments. The second fidelity assessment found high levels of fidelity (i.e., 3.5 or greater) on 78 percent of the items. In contrast, the first fidelity assessment rated the programme as having a high level of fidelity on 65 percent of the items. Overall, the average score for individual items increased from 3.47 at the first fidelity assessment to 3.74 at the second fidelity assessment. A comparison of the individual item scores for the two fidelity assessments showed continued high levels of implementation in several programme areas as well as continued low levels of implementation in some programme areas. In addition, there were areas that showed both improvements and deterioration in terms of adherence to fidelity standards.

The second fidelity assessment found improvements in the programme, which were evident across four of the five domains of fidelity standards. Specifically, the five rated fidelity standards in the *Housing Choice and Structure* domain (i.e., choice, permanence, affordability, integration and privacy) were all assessed as being at maximum implementation (i.e., average of 4.00), demonstrating the programme's commitment to providing participants with choice regarding accessing regular housing of good quality. Improvements in fidelity to offering participants choice in their housing was evident in comparing the first and second fidelity assessment.

The fidelity ratings in the *Separation of Housing and Services* domain also demonstrated noteworthy strengths. It was assessed as being at the highest level of fidelity possible on all of the seven items in this domain (i.e., average of 4.0). Moreover, two areas in this domain improved from the first to the second fidelity assessment – namely the access that participants had to off-site community services and to mobile services. These improvements were due to the success of the programme in developing partnerships with community programmes. The staff were focused on helping participants to access these services to help them work through difficulties that may have contributed to their need for re-housing.

Table 1. Fidelity Assessment Domain Means and Individual Item Scores

Domain	Domain Mean / Standard Score (Out of 4)		Difference
	Fidelity Assessment 1	Fidelity Assessment 2	
Housing Choice and Structure	**3.75**	**4.0**	**0.25**
Housing choice	3.5	4.0	0.5
Housing availability	3.0	n/a[2]	n/a
Permanent housing tenure	4.0	4.0	0.0
Affordable housing	4.0	4.0	0.0
Integrated housing	4.0	4.0	0.0
Privacy	4.0	4.0	0.0
Separation of Housing and Services	**3.9**	**4.0**	**0.10**
No housing readiness	4.0	4.0	0.0
No programme contingencies of tenancy	4.0	4.0	0.0
Standard tenant agreement	4.0	4.0	0.0
Commitment to re-house	4.0	4.0	0.0
Services continue through housing loss	4.0	4.0	0.0
Off-site services	3.5	4.0	0.5
Mobile services	3.5	4.0	0.5
Service Philosophy	**3.5**	**3.55**	**0.05**
Service choice	4.0	4.0	0.0
No requirements for participation in psychiatric treatment	4.0	4.0	0.0
No requirements for participation in substance use treatment	4.0	4.0	0.0
Harm reduction approach	4.0	3.5	-0.5
Motivational interviewing	2.0	2.5	0.5
Assertive engagement	3.0	3.0	0.0
Absence of coercion	4.0	4.0	0.0
Person-centred planning	2.0	2.5	0.5
Interventions target broad range of life goals	4.0	4.0	0.0
Participant self-determination and independence	4.0	2.5	0.0
Service Array	**2.85**	**3.38**	**0.53**
Housing support	4.0	4.0	0.0
Psychiatric services	n/a[1]	3.0	n/a
Substance abuse treatment	2.0	2.5	0.5
Employment and educational services	3.0	3.5	0.5
Nursing/medical services	3.0	3.5	0.5
Social integration	3.0	3.5	0.5
24-hour coverage	3.0	3.0	0.0
Involved in In-patient treatment	2.0	4.0	2.0
Programme Structure	**3.5**	**3.5**	**0.0**
Priority enrolment for individuals with obstacles with housing stability	4.0	4.0	0.0
Contact with participants	4.0	4.0	0.0
Low participant/staff ratio	4.0	4.0	0.0
Team approach	4.0	4.0	0.0
Frequent meetings	4.0	4.0	0.0
Weekly meeting/case review	3.0	3.0	0.0
Peer specialist on staff	3.0	2.0	-1.0
Participant representation in programme	2.0	3.0	1.0
Total	**3.47**	**3.74**	

1. Not scored as programme was in process of negotiating the addition of psychiatric consultation services.

2. Information available to the external team was insufficient to make this rating.

The majority of the items in the *Service Philosophy* domain were also assessed as being at full implementation in both fidelity assessments (i.e., average of 3.55). The staff were committed to the values guiding the Housing First approach as it relates to maximizing participant choice and autonomy in accessing services, promoting harm reduction, and focusing on a wide range of life areas with clients. Despite these strengths, several continued challenges in this domain were observed. The extent to which staff used motivational interviewing and adopted person-centred planning in working with participants showed improvements from the first fidelity assessment; however these areas, reflecting how staff work with participants, were still judged as being at less than full implementation. ACT team members had received training in motivational interviewing but still lacked experience and general comfort in using the approach in interactions with clients. Also, based on a review of participants' charts, there was a lack of documentation of participants' perspective in relation to service planning; rather it seemed service planning was based more on programme staff's perspective. In particular, the fidelity assessment indicated that there was still room for the ACT team to improve its long-term and recovery planning with the participants.

Another area in the *Service Philosophy* domain in which the programme fell short of full implementation involved the extent to which programme staff engaged in an active and assertive manner with participants who were not participating in treatment or accessing support. Although programme staff reported applying significant effort to engage participants, it was not being systematically documented in participants' charts, thus making it difficult for the fidelity team to determine how consistently or frequently interventions were being implemented in this area.

In addition, related to this item, the second fidelity assessment noted the need for the ACT team to continue developing social activities for participants to help engage them and overcome their reported feelings of loneliness and isolation. The programme showed a decrease in the fidelity score related to its adoption of a harm reduction approach. In scoring this item, the fidelity assessors noted that although there was an increasing number of staff who were trained in the harm reduction model, there remained a number of staff that emphasized detox and abstinence to participants who may not be ready for this step.

Among the eight items making up the *Service Array* domain, only two items were judged as being at full implementation in the second fidelity assessment (i.e., average of 3.38). In particular, the programme was rated as continuing to provide a high level of support to programme participants related to their housing. Also, the involvement of the programme in in-patient treatment when participants were hospitalized was assessed as having improved to full implementation from the first

to second fidelity assessment as a result of the addition of psychiatric consultation services being provided by two hospital psychiatrists. Other areas showing notable improvement in the second fidelity assessment, though still short of full implementation, were the provision of psychiatric services and supported employment services to programme participants.

Despite these strengths, a number of items in the *Service Array* domain continued to be assessed as being at less than full implementation at the second fidelity visit. Although a substance use specialist had been identified and trained, the fidelity team judged that the programme needed to continue to develop its capacity in this area. Furthermore, the utilization of an integrated, stage-wise substance use treatment approach to working with participants within the programme was assessed as being at less than full implementation in both fidelity visits. As well, the second fidelity assessment rated the extent to which the programme provided participants with 24-hour coverage to be only partially implemented as it relied on an external local mobile crisis services to provide this coverage overnight.

Lastly, the programme was rated in the second fidelity assessment as having multiple areas of strength in the *Programme Structure* domain (i.e., average of 3.5). Specifically, five of the eight items in this domain were assessed as being at full implementation – namely the extent to which the programme gave priority to assisting individuals facing obstacles to achieving housing stability, the amount of contact with participants (i.e., at least once per week), the low participant/staff ratio (i.e., 1: 10) and the adoption of a team approach with programme staff sharing service responsibilities for participants.

Although the involvement of participants in programme decision-making was rated as being at less than full implementation, an improvement in this area was evident from the first to the second fidelity assessment; in particular, there was now a tenant representative on the Programme Advisory Committee and there were informal efforts made at obtaining participant feedback on the programme. Other areas in the *Programme Structure* domain in which the programme was still not at full implementation were the extent it held weekly case reviews for all participants and having a peer specialist as a staff member.

The fidelity team viewed the programme as needing a system that would facilitate their following up on participants' goals in order to improve the frequency of their case reviews. The peer specialist standard was judged to have experienced a small negative change since the last fidelity visit and continued to represent an implementation challenge. The team had identified peers as potential peer specialists but had not as yet provided training to these individuals.

Qualitative evaluation of implementation

The results of key informant interviews and of focus groups with programme staff are presented next, starting with their perspectives on programme areas of high fidelity, followed with their views of programme areas of low fidelity.

Contributors to programme areas of high fidelity

Overall, in line with the fidelity assessment findings, key informants and programme staff described the housing and support delivered by the programme as being of high quality. In relation to the programme strengths associated with *Housing Choice and Structure* fidelity standards, key informants underlined success in finding committed and understanding landlords as being a very important contributor. The good working relations between the Housing Coordinator and the ACT team was also indicated as contributing to the strengths of the programme in terms of the positive nature of the housing and support being available to participants.

Key informants and programme staff considered that the programme was developing, over time, a better sense of participants' needs and a greater flexibility in service delivery. In particular, they described programme services as evolving towards being more recovery-focused. They noted that staff were less reactive in their responses and had become more comfortable with shifting the responsibility for problem-solving on to participants. The noticeable stabilization of participants over time was viewed as having contributed to these changes. A key informant stated:

> We had people who have achieved incredibly stability. They were housed and received our services. Because they are intensive services, we need to be sure that we have something that is not necessarily offered by other services. Then there are some who have been able to find a path to recovery. The fact that we have three individuals who are on the road to becoming peer-helping officials, it is a result of [their recovery]. (Translated from French)

Programme staff also perceived themselves as having developed a better understanding of their roles over time. They noted that there was better communication within the team. Key informants also explained that there was now stability in the make-up of ACT team. All these factors appeared to be contributing to the programme's strengths, identified in delivering services that are in line with the values and philosophy guiding a Housing First approach, as illustrated by the following quote:

> And now that we're settling in a bit and we've done staff changes that we needed to do, the stress level has gone down tremendously and [the staff are] not afraid to ask for training; they're not afraid to try new things.

Overall, the programme was described by key informants and programme staff as having a greater capacity to deliver a wider range of services and support. The local and national training provided to the staff as part of the demonstration project was perceived as contributing to this greater capacity. As well, the addition of staff and professionals with different areas of expertise was perceived as contributing to the programme's ability to deliver effective supports. For example, programme staff noted that one of the ACT team members received specific training in the area of addictions treatment with the goal that he would provide in-house training, consultation and programme development in this area.

A key informant suggested that the addition of a home economist to the ACT team facilitated the housing stability of tenants because she helped them to develop abilities in such practical areas as shopping, cooking and housekeeping. The addition of one-half day of psychiatric consultation since the last fidelity visit was also considered part of this additional capacity even though it was described as being inadequate in relation to programme needs. Key informants and programme staff highlighted the richness of services that are being delivered to programme participants because of the multidisciplinary make-up of the team.

As well, the addition of a dedicated vocational specialist to the ACT team was described by key informants and programme staff as a very positive development and an emerging strength in the programme. In particular, the vocational specialist had successfully created employment opportunities for participants. Related to this point, key informants and programme staff indicated that the programme increased its capacity through the successful creation of partnerships with community organizations that can supplement and extend the types of services delivered by the programme. The positive reputation of the programme in the community helped facilitate these partnerships. This point is emphasized in the following quote:

> We also tried to create better partnerships, better collaboration with the treatment services and addiction services, to see if we could improve the service we offered to all our participants… Because it is… amazing, what we saw here with all the support of the community towards our projects.

Contributors to programme areas of low fidelity

Programme staff stated that the lack of engagement by some participants was an ongoing challenge despite significant efforts on their part to establish a working relationship with these individuals. In some cases, the nature of the participant's mental health problems contributed to them having difficulty trusting service providers.

One staff member stated: 'the more paranoid people… don't recognize that they have an illness and then they're very suspicious of the team.' In other cases, disengagement was the result of severe substance abuse. For a small number of participants, they were only interested in receiving housing from the programme, as they perceived themselves as not needing ongoing services or support.

A number of factors were identified by the programme staff as contributing to their only partial implementation of person-centred planning. Specifically, they noted that in the earlier stages of the programme, the focus of service planning with participants was on immediate needs and often crisis-centred. As a result, some participants became over-dependent on the staff and were not comfortable taking the initiative required to set their own longer-term goals.

Another contributing factor was the initial lack of consistency in the goal-planning across disciplines. This problem was compounded by the multiple staff members involved with each participant. These issues were described as being mitigated through the introduction of goal-planning tools and a process wherein each team member was assigned the primary responsibility for goal-planning with a similar number of participants.

A lack of training and experience was cited by programme staff as contributing to the ongoing challenges of integrating motivational interviewing into their work. Key informants and programme staff stated that they had received some training but they had not yet succeeded in applying it effectively in their own counselling:

> I've done a bit of training in motivational interviewing… but sometimes I feel like I'm missing the cues, the cues to actually do it and of course the more you do it, the better you get at it and maybe I'm doing more than I think I am, but as for this kind of defined way of doing things I feel I kind of miss it.

Key informants and programme staff viewed the programme as having insufficient psychiatric services relative to its needs. There was an appreciation for having access to one half-day of psychiatric consultation on site and having access to another psychiatrist at the hospital. However, it was noted by both key informants and programme staff that providing consultation exclusively from the hospital was less effective than having an on-site psychiatrist.

For example, one of the service providers explained that, 'when the psychiatrist was here we could know more about the situation, we could have conferences. You know, she could give her feedback, we could involve her more with the team [in] case planning.'

A lack of internal programme capacity was identified by key informants and programme staff as the major factor contributing to the programme having only partially implemented the use of integrated, stage-wise substance abuse treatment. In particular, there was recognition that most of the programme staff had not received training on addictions treatment as part of their initial professional training as mental health service providers and had had limited experience in the area in their work to date. At the same time, there was openness to and interest in receiving addictions treatment training.

Programme staff noted that the success of adopting a harm reduction approach was contingent on being able to develop honest relationships with participants. One key informant perceived variability among team members in terms of their comfort levels with, and integration of harm reduction in their work with participants. Programme staff viewed the designation of the role of an addiction specialist on the team as helping them become more familiar with harm reduction as well as addictions treatment more generally.

A key informant described how the programme had hired several people who were open about having 'lived experiences (of mental health problems)'. However, she noted that the programme was not prepared or structured to support these individuals or define manageable roles for them on the team as peers. As a result, several of them encountered difficulties that resulted in long periods of sick leave.

This situation created problems for the programme because it was not possible to replace them on the team during their leave and the team was required to function short-staffed. A significant factor contributing to the lack of an identifiable peer specialist role on the team was the fact that training for this role was not yet available in the region in which the programme was located.

Lastly, a key informant described the difficulties experienced by participants in relation to their changing social network and social isolation once they leave homelessness. In particular, becoming housed often requires them to leave their friends from their previous life when they were homeless. Programme staff mentioned that some participants started supporting each after having met during a programme activity. This exchange of support was viewed as helping participants combat their social isolation and loneliness.

For example, a programme staff member stated that, 'we even have clients that will help each other, which we didn't have initially… I'm noticing that people are helping each other out. It's become a little community inside our programme. You know, like people are babysitting each other's dogs.'

Discussion

The discussion section is organized according to the five fidelity domains, interpreting the results of the fidelity assessment in the context of the information collected from the qualitative evaluation. In addition, it presents the recommendations made to the programme for improving its fidelity in the programme areas in which it was assessed as being low.

Housing Choice and Structure

The Housing First programme in Moncton demonstrated continued strengths in the *Housing Choice and Structure* domains. The Moncton site scored higher than the four other At Home/Chez Soi sites in this domain at both the early and later fidelity assessments (Nelson *et al.*, 2014; Macnaughton *et al.*, 2015). The community context may play a role in this result, as Moncton had a higher vacancy rate compared to other At Home/Chez Soi sites such as Toronto, Winnipeg or Vancouver (Goering *et al.*, 2014) thereby facilitating choice and the availability of housing for its participants.

The improvement in offering housing choice to participants over time in the programme was also possibly the result of the maturing of the programme. Programme staff were perhaps better able to facilitate choice when looking for housing with participants because of greater knowledge about the housing market and the development of good working relationships with more landlords. It is important for Housing First programmes to have a stock of ongoing housing options, as some participants can be expected to experience multiple moves (Aubry *et al.*, 2015). In addition to facilitating choice, the housing subsidy provided to all participants in the demonstration project aided access to private market housing of good quality as well as contributing to the permanence of their housing because of being able to afford the rent (Tsemberis, 2010).

Separation of Housing and Services

The fidelity assessment judged the Moncton programme to be at maximum fidelity on all of the items in the *Separation of Housing and Services* domain. From the outset, the programme had demonstrated high fidelity in this area with no preconditions placed on individuals before being housed, no expectations regarding engagement in treatment to stay housed, and a commitment to re-housing when housing is lost. There were a small number of participants in the Moncton Housing First programme who experienced multiple evictions after relatively short stays in their housing. As a result, the programme had developed a 'peer supportive housing programme' comprising of a six unit apartment block. The superintendents were a

couple with 'lived experience' and being in this programme required individuals to follow certain rules particularly as it related to visitors (see Yamin, *et al.*, 2014 for a description of this programme).

It is important to note that staff in the Moncton programme had never worked previously in a Housing First programme. In fact, most of them had worked in traditional roles in office-based outpatient mental health services and psychiatric day programmes and the community mental health system in Moncton and in the province of New Brunswick more generally was under developed (Province of New Brunswick, 2013). As a result, they experienced a steep learning curve in terms of their roles and how to deliver services in the community in line with ACT standards (Teague *et al.*, 1998). The fidelity rating related to providing mobile services to participants at locations of their choice had improved from the first to the second fidelity assessment, suggesting that they had successfully adapted to this aspect of the role of service providers in the context of Housing First.

Service Philosophy

The second fidelity assessment suggested that the service providers making up the ACT team in Moncton had fully adopted the *Service Philosophy* of Housing First in terms of affording participants maximum choice in terms of the type of treatment (e.g., type, sequence, intensity) in which they accessed. One area of *Service Philosophy* in which service providers were rated as being at less than full implementation involved the adoption of a harm reduction approach, a particularly important part of the Housing First approach (Tsemberis, 2010). The fidelity assessors noted that some service providers on the ACT team appeared partial to encouraging participants to enter detox and rehabilitation programmes. Like in many jurisdictions, it was only recently (i.e., in 2005) that mental health and addiction services became integrated in New Brunswick, and harm reduction practices are still at an early stage in this newly integrated service system (Province of New Brunswick, 2013).

Other areas of *Service Philosophy* in which the programme was at less than full implementation were aspects of service delivery, namely the use of motivational interviewing, assertive engagement and person-centred planning with participants. Deficiencies in fidelity in these areas were related especially to the fact that programme staff on the ACT team had not had previous training focused on them. The use of motivational interviewing was new for most of the staff and the programme had arranged for training in this area but, as indicated by programme staff, more ongoing training seemed needed. The members of the fidelity assessment team recommended the adoption of Wellness Recovery Action Plans (Copeland, 2014) as well as having regular follows-ups and organizing therapeutic recreational activities with participants to encourage their engagement (Aubry *et*

al., 2012). The fidelity assessment team also recommended the identification of a primary service provider from the ACT team for each participant to conduct goal planning and review on an ongoing basis.

Service Array

Although there was notable improvement from the first to the second fidelity assessment in the *Service Array* domain, it still remained at less than full fidelity. In fact, the items from this domain had the lowest average overall compared to the other fidelity domains. This pattern of improvement along with continued lower fidelity for the *Service Array* domain than for other domains was also evident in the programmes at other At Home/Chez Soi sites (Macnaughton *et al.*, 2015). This is not surprising given the relatively early stage of development of the programmes, even at the point of the second fidelity assessment. In particular, programmes were still in the process of developing capacity in a context where delivering a Housing First programme entailed new roles for service providers.

The ACT team in Moncton was led by a primary care physician whose practice focused on the participant population. Psychiatric consultation services were provided to participants at the programme site (i.e., one-half day) and at the hospital on a per need basis. The fidelity assessment highlighted the importance of having these services and recommended that efforts be made to increase them, allowing for some home visits by the consulting psychiatrists (Aubry *et al,* 2012). As previously mentioned, the programme was continuing to increase its capacity in substance abuse treatment by adding an addiction specialist to the team and providing training to other ACT team members in this area. The goal was for the ACT team to be able to provide 'integrated substance abuse treatment strategies' in their work with participants, an evidence-based approach that combines mental health and substance abuse services in one setting (SAMSHA, 2010a).

The second fidelity assessment also noted improvement in the programme's provision of vocational /educational support to participants through having a vocational specialist as a member of the ACT team. This support had included the development of a number of 'in-house' employment opportunities (e.g., moving and house-cleaning services) for programme participants. As well, key informants indicated that the vocational specialist was engaging in outreach to organizations and companies in the community with the intent of creating work opportunities in the competitive work force. In this vein, it was recommended that the vocational specialist consider implementing – 'individual placement and support or supported employment, with the goal of assisting participants to work in the regular job market' – (SAMSHA, 2010b).

Programme Structure

Specific programme areas related to the *Programme Structure* domain that continued to fall short of full fidelity in the second fidelity assessment were the quality of the daily meeting, the addition of a peer specialist on staff and participant input to programme operations. In line with the aforementioned need to improve person-centred planning with participants, it was noted in the fidelity assessment that there was a need for the team to regularly review participants' recovery goals and document the outcome of these reviews in the participants' charts.

An important aspect of programme structure in Housing First programmes is the integration of the equivalent of a full-time peer specialist as a member of the ACT team, who delivers community support to participants (Tsemberis, 2010). Although individuals had been identified as meeting the criteria for becoming a peer specialist in the Moncton programme at the time of the assessment, there was no formal training available for preparing these individuals to assume this role. Subsequent to the assessment, arrangements were made for these individuals to receive training and the process of defining the role was underway so peer specialists could join the ACT team (Aubry *et al.*, 2012).

Finally, the fidelity assessment team recommended that an advisory board of participants and programme staff be developed, which would meet on a monthly or quarterly basis to provide input into the development and management of the programme.

Conclusion

This article provides a detailed account of the results of a second fidelity assessment and associated evaluation of implementation of a new Housing First programme in a small Canadian city with no previous Housing First experience. The results provide insights for communities in similar positions with regard to challenges faced with developing new Housing First programmes as well as suggestions for addressing these challenges in order to improve programme fidelity.

In addition, the article demonstrates the use of mixed methods to conduct a formative evaluation of a Housing First programme. An external team of experts conducted the fidelity assessment. The assessment was supplemented with qualitative data collected from key informants and programme staff. Although the cost of conducting this kind of programme evaluation is relatively modest, it is likely that some Housing First programmes will not have the resources to afford a fidelity assessment by an external team. A self-assessment fidelity measure for Housing First programmes was recently created (Gilmer *et al.*, 2014). For Housing First programmes with limited resources, carrying out a self-assessment of fidelity combined with a qualitative evaluation similar to the one in the current study is an alternative worthy of consideration.

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