FINAL REPORT ON THE FINDINGS OF THE SECOND IMPLEMENTATION EVALUATION FOR THE MONCTON SITE OF THE AT HOME / CHEZ SOI PROJECT

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I. INTRODUCTION

This report presents the results of the second implementation evaluation of the At Home/Chez Soi project in Moncton completed from March to July 2012. The Moncton site is one of five projects initiated across Canada and funded by the Mental Health Commission of Canada (MHCC). In addition to Moncton, the At Home/Chez Soi project is being implemented in Montreal, Toronto, Winnipeg, and Vancouver. It is part of a 5-year research demonstration project testing programs intended to assist people with a mental illness who have experienced housing problems of a long-term nature.

The purpose of this evaluation was to examine changes in program fidelity as well as to better understand the reasons behind continued and emerging strengths and challenges in the implementation of the At Home/Chez Soi project. Early fidelity assessment and implementation evaluation conducted during the participant recruitment phase of the research (August, 2010 to April, 2011) are compared with a later fidelity assessment and implementation evaluation (January to July, 2012).

Description of the Housing First Program in Moncton

The Housing First program implemented at the Moncton site is a supported housing approach based on the *Pathways to Housing* approach originally developed in New York City (Greenwood, Schaefer-McDaniel, Winkel, & Tsemberis, 2005; Tsemberis, 1999; Tsemberis & Eisenberg, 2000; Tsemberis, Gulcur, & Nakae, 2004). Specifically, the intervention includes a combination of ACT and subsidized housing in the private rental market.

Assertive Community Treatment (ACT). The target population for ACT at the Moncton site are individuals with persistent mental health problems and with either moderate need or high need. The main objective of the ACT team is to provide consumers with needed treatment, rehabilitation or support services to facilitate their successful functioning in the community context.

Members of the ACT team are employees of the Horizon Health Network and Vitalité Health Network. For some positions, this has required transfers within the Health Authorities, from other public service departments, or the hiring of new personnel. The staff composition is set at 10 FTE representing a mix of mental health disciplines that includes a nurse practitioner, psychiatric nurses, occupational health therapist, home economist, social worker, human resources counsellors, physician clinical director, and consulting psychiatrists. The team also includes a team leader with training in psychiatric rehabilitation that is available to deliver clinical services to consumers as needed.

The ACT team is intended to provide follow-up clinical services for 100 consumers in the Greater Moncton area. The ACT services operate with a consumer to staff ratio of 10:1 which is the standard for ACT allowing for the delivery of intensive services. Members of the ACT team collaborate and support one another in the provision of daily services to consumers. This may include sharing common roles and functioning interchangeably with respect to execution of case planning and service delivery activities while still respecting areas of specialization and limitations associated with professional competencies. All team members have responsibilities

related to participation in delivery of core program services including outreach and consumer engagement, screening and comprehensive assessment, clinical treatment and counselling, case management and review, community service collaboration and consultation, and file management.

In addition, there are three rural service providers located out of the mental health clinic in Shediac who work in close collaboration with the ACT team in Moncton. The rural service providers provide services and support for 24 consumers living in the Southeastern New Brunswick region. Prior to being admitted for services from the rural service provider, consumers lived either in Special Care Homes, with their families, in rooming houses, or were homeless. Upon admission into the program, consumers in the rural region moved into their own housing to live independently.

The rural arm of the ACT team will operate with a consumer to staff ratio of approximately 8:1 which is a common standard for delivering ACT services in rural regions. Members of the rural ACT team collaborate and support one another in the provision of daily services to consumers. Each consumer is assigned a primary and secondary case manager from the rural ACT Team. The Physician Clinical Director located on the Moncton ACT team assumes primary responsibility for monitoring the status and response to treatment for the rural consumer.

In line with ACT delivered in the *Pathways* model, the Moncton and rural members of the ACT team are expected to deliver a complete range of services, including treatment of psychiatric and medical conditions, rehabilitation, crisis intervention, integrated addiction treatment (harm reduction approach), vocational assistance, as well as any other needs identified by the patient. The service approach is informed by recovery principles assisting consumers to adopt valued social roles and become integrated in the community. Although the ACT team assists consumers to access needed resources in the community, they assume primary responsibility and are expected to provide most of the mental health services they need.

Upon admission to the ACT program, a service plan is developed in collaboration with the consumer at the first meeting. The ACT team works closely with a housing worker to help consumers quickly find housing that they choose and can afford with the rent supplement. Although the housing worker is not a formal member of the ACT team, he or she works closely with the team to assist consumers with selecting housing, negotiating with landlords, moving into housing, and adapting to the new living situation as a tenant. The housing worker is also involved in assisting consumers with mediating with landlords when housing problems are encountered.

In line with the *Pathways* program, consumers are required to have a minimum of one visit per week from an ACT team member; however, they can choose whether or not they want to participate in treatment and a harm reduction approach to substance use is adopted as they are not expected to stay abstinent. Clinical services are organized around an individual's service plan developed in collaboration with the consumer to assist them in the direction of recovery.

Staff services are available from 8:30 a.m. until 10 p.m. seven days per week. Evening hours include provision of outreach and crisis response which are supported by the existing Mental Health Mobile Crisis Unit of the Regional Health Authority and the crisis intervention center. The ACT team office for the Greater Moncton area is located in close proximity to the downtown core. The selected site is in a convenient central location to facilitate team members' contact with consumers. The office for the rural service providers is located at the Shediac mental health clinic.

The ACT team holds daily organizational meetings to review consumers' progress and the outcomes of the most recent staff-consumer interactions including appointments, informal visits, or emergency after-hours responses. In addition, members collaborate to develop a team work schedule to coordinate key treatment and support activities for consumers. This organizational meeting is held at the beginning of each work day and lasts for approximately one hour. The daily team work schedule provides a summary of all consumer activities to be completed for the given day. Members of the rural team participate in these meetings through teleconference.

The organizational team meetings provide a daily opportunity for primary case managers to receive peer feedback, consultation and supervision from the full ACT team. In addition, the primary case managers are responsible for maintaining accurate consumer records, detailing information about the consumers' mental health condition (e.g. onset, course, diagnosis, target symptoms) current assessment results, treatment and rehabilitation plans, as well as support services provided.

Following the organizational staff meeting, team members depart into the community to fulfill their assigned support and treatment related activities. The ACT Team Manager is responsible for monitoring the work activities of the various team members and for modifying the schedule to address unplanned consumer needs or crisis type situations.

The Physician Clinical Director, in collaboration with the Team Manager assumes primary responsibility for monitoring the status and response to treatment for each consumer. In addition, they provide operational and clinical supervision of all team members.

Subsidized Housing. Consumers who are randomly assigned to Housing First Services are provided with subsidized housing. This service aspect is coordinated by a Housing Worker who is located at the United Way of Greater Moncton and Southeastern New Brunswick. In particular, the Housing Worker delivers this service component through the following steps: (1) identifying private market housing that meet the needs of consumers based on their personal preference, (2) accompanying consumers to visit available apartments, (3) negotiating lease agreements with landlords, (4) helping consumers move in and set up their apartments, (5) providing necessary support to assist consumers to adapt to their new living situation, and (6) serving as a mediator between landlords and tenants if problems are encountered. The Housing Worker also attends ACT team meetings as necessary to participate in service planning for tenants.

A key feature of the Housing First approach is the provision of a rent supplement to ensure that participants pay a maximum of 30% of their income for housing. Given the housing situation in Moncton that includes a relatively high vacancy rate and a long waiting list for social housing, all of the consumers of the program have moved into private market housing. The delivery of housing and support services is provided without any pre-conditions of housing readiness; however consumers must be willing to have a reasonable portion of their monthly income allocated directly to cover rent expenses. They must also agree to meet with an ACT team member program staff at least once a week to discuss their current housing situation and any areas of need or concern.

Evaluation Objectives and Questions

There were five main objectives of this evaluation:

1. to describe changes in fidelity assessment ratings from early to later implementation;
2. to examine the reasons for implementation strengths and challenges;
3. to better understand staff perspectives on the theory of change of Housing First;
4. to understand landlords' experiences with the program
5. to learn about sustainability issues faced by the program

The evaluation of implementation is intended to complement an assessment of the fidelity of the program conducted in August 2010 and October 2011 by an external team of evaluators that included Paula Goering (both fidelity assessments), Research Lead for the At Home / Chez Soi project, Ana Stefanic (1st fidelity assessment), Juliana Walker (both fidelity assessments), and Sam Tsemberis (2nd fidelity assessment), staff members from *Pathways*, Sue Goodfellow (both fidelity assessments), staff member from *Streets to Homes*, and Dean Waterfield, Welsey Urban Ministries. For the fidelity assessment, the team assessed the Moncton program with regard to its adherence to a set of standards developed by *Pathways* in collaboration with members of the National Research Team of the At Home / Chez Soi project.

The research questions guiding the second evaluation of implementation comprised of the following:

1. Fidelity evaluation questions
    a. Are there changes from early to later implementation in the fidelity ratings of programs as determined by the fidelity assessment tools implemented by the Quality Assurance (QA) team?
    b. What are the current areas of strength in fidelity?
    c. What are the current areas of challenge in fidelity?
2. Developmental evaluation questions
    a. What are the reasons for issues that continue to represent implementation fidelity strengths?

b. What are the reasons for emerging implementation fidelity strengths?

c. What are the reasons for issues that have emerged as apparent challenges to implementation fidelity?

d. What are the reasons for issues that continue to present an apparent challenge to implementation fidelity over time?

e. How is implementation proceeding with respect to challenges identified in first round fidelity reports or implementation evaluation reports? (delays in housing placement, barriers to location choice, challenges with rehousing, challenges with involving participants and persons with lived experience in program operations and research, staff burnout and retention)

3. Housing First theory of change questions

    a. What outcomes are seen during the first year and what outcomes are seen during the second year of the intervention?

    b. What are the characteristics of those participants who benefit most from Housing First and those who benefit least?

    c. What are the most important ingredients of the Housing First program at different time periods and for different groups of participants?

4. Questions about landlord/caretaker experiences

    a. What are landlord/caretakers' perceptions about what is working well with the programs?

    b. What are landlord/caretakers' perceptions about what is not working well with the programs?

5. Sustainability issue questions

    a. How are the concerns of the participants about the stability of their housing and program support being addressed?

    b. What are the concerns about sustainability and how are they addressed at the sites?

    c. What are the views about the legacy of the project and the lessons that have been learned?

Based on the findings, the report concludes with cross-cutting themes and a list of lessons learned.

II. METHODOLOGY

Description of the Sample

All staff members of the ACT team, the Physician Clinical Director, ACT Team Manager, Housing Lead, Site Coordinator, and a select group of landlords were invited to participate in either a focus group or interview. Data collection was conducted between February and July 2012.

Two focus groups were conducted with staff members of the ACT team, one in English (N = 6) and the other in French (N = 2). The French focus group was conducted twice because of technical problems with audio taping encountered after the first focus group. A total of four key informant interviews were completed, namely with the Physician Clinical Director, ACT Team Manager, Housing Lead, and the MHCC Site Coordinator. The audio-recording of a fifth interview with a consulting psychiatrist was also lost because of encountered technical problems.

A member of the housing staff selected a group of 32 landlords who had at least 6 months experience with renting units to program participants and who had not been interviewed as part of the first implementation evaluation. The selection of landlords was intended to reflect diversity from the standpoint of number of units rented to program participants, length of time involved renting to program participants, nature of experience with program participants, and location of rental units (i.e., Moncton or South-Eastern New Brunswick). Of the 32 landlords invited to participate, a total of 12 were interviewed.

Methodological Steps

Common focus group and key informant protocols developed by the national qualitative group for the five At Home / Chez Soi sites were used. Areas of focus in the protocols included: (1) to determine changes in fidelity ratings from early to later implementation, (2) to examine the reasons for implementation challenges and strengths, (3) to better understand staff perspectives on the theory of change of Housing First, (4) to understand landlords' experiences with the program, and (5) to learn about issues regarding program sustainability.

Researchers at the Moncton site developed the landlord interview protocol with input from the housing staff and members of the Local Advisory Committee. Landlord interviews focused on the perceptions of landlords of At Home / Chez Soi participants, perceived advantages and disadvantages to renting to program participants, experiences with program participants, and suggestions for improving communication between landlords and the program.

Research team members conducted the focus groups with ACT staff at the Manse (Moncton ACT team office). Focus groups with ACT staff were approximately 90 minutes in duration. Key informant interviews were conducted either in person or by telephone. The duration of key informant interviews was 30-45 minutes.

For landlord team interviews, research team members sent out a letter of invitation to selected landlords explaining the purpose and demands of the study. Landlords were told they would be interviewed by telephone. Subsequent to sending the letter, research team members phoned each of the landlords to determine interest and to schedule a time for the telephone

interview. All of the 12 landlords who accepted to be interviewed were interviewed over the phone. Consent forms, invitation letters to landlord, and interview protocols that were used with participants are presented in appendices at the end of the document.

Coding Analysis

All focus groups, key informant interviews, and landlord interviews were audio-recorded and transcribed. Research team members conducted thematic coding of transcripts intended to answer the aforementioned research questions guiding the evaluation of implementation.

Establishment of Quality of Data

Initial coding of themes related to most helpful program components on transcripts was conducted by two members of the research team. Subsequently, coded themes were compared and discussed until a consensus was achieved on a set of common themes. Following this initial process, the two research team members conducted thematic coding related to the research questions separately. To verify and establish the quality of the data, the two research team members compared the coded themes associated with each research questions and conciliated their results to a consensus.

III. FINDINGS

A. Developmental Evaluation Issues

The following section is based on the one-year follow-up fidelity assessment of the At Home / Chez Soi program in Moncton (i.e., comparing the October 2010 fidelity findings (FV1) to the January 2012 fidelity findings (FV2)). By examining the results from both fidelity visits, it is clear that there are several areas of consistent strength (i.e., areas that have consistently scored a 4 on both fidelity visits) and some areas of consistent weakness in the implemented program (i.e., areas that have consistently scored below a 4). In addition, there are areas that showed both positive change and negative change. These will be discussed in further detail below.

Criterion	FV1	FV2	Action	Recommendations
HOUSING CHOICE & STRUCTURE				
1. Housing Choice. Program participants choose the location and other features of their housing.	3.5	4	-There is a new housing specialist who has hit the ground running.	-The new team leader should receive proper training and support.
2a. Housing Availability (*Intake to move-in)*. Extent to which program helps participants move quickly into permanent housing units of their choosing.	Not Rated	Not Rated	No action	-Ensure that there is enough staff in order to maximize efficient move to available units. -Ensure that both housing personnel and the ACT team meet the participant in a timely fashion.
2b. Housing Availability (*Voucher/subsidy availability to move-in)*. Extent to which program helps participants move quickly into permanent housing units of their choosing.	3	Not Rated	No action	-Ensure that there is enough staff in order to maximize efficient move to available units. -Ensure that both housing personnel and the ACT team meet the participant in a timely fashion.
3. Permanent Housing Tenure. Extent to which housing tenure is assumed to be permanent with no actual or expected time limits, other than those defined under a standard lease or occupancy agreement.	4	4	No action	No recommendation
4. Affordable Housing.	4	4	No action	No recommendation

Criterion	FV1	FV2	Action	Recommendations
Extent to which participants pay a reasonable amount of their income for housing costs.				
5a. Integrated Housing *(Urban programs)*. Extent to which program participants live in scatter-site private market housing which is otherwise available to people without psychiatric or other disabilities.	4	4	No action	No recommendation
5b. Integrated Housing *(Rural Programs)*. Extent to which program participants live in scatter-site private market housing which is otherwise available to people without psychiatric or other disabilities.	4	4	No action	No recommendation
6. Privacy. Extent to which program participants are expected to share living spaces, such as bathroom, kitchen, or dining room with other tenants.	4	4	No action	No recommendation
SEPARATION OF HOUSING & SERVICES				
7. No Housing Readiness. Extent to which program participants are not required to demonstrate housing readiness to gain access to housing units.	4	4	-The team has started to place some boundaries on participants who have been re-housed numerous times. They ask these participants to be responsible for finding a new apartment. -They also have a new building (i.e., transition	-The "hard to house" building should be renamed to reflect something more positive.

Criterion	FV1	FV2	Action	Recommendations
			house; "hard to house" building) that does have several contingencies like no overnight guests and there is superintendent on-site.	
8. No Program Contingencies of Tenancy. Extent to which continued tenancy is not linked in any way with adherence to clinical, treatment, or service provisions.	4	4	No action	No recommendation
9. Standard Tenant Agreement. Extent to which program participants have legal rights to the unit with no special provisions added to the lease or occupancy agreement.	4	4	No action	No recommendation
10. Commitment to Re-House. Extent to which the program offers participants who have lost their housing access to a new housing unit.	4	4	No action	No recommendation
11. Services Continue Through Housing Loss. Extent to which program participants continue receiving services even if they lose housing.	4	4	No action	No recommendation
12a. Off-site Services. Extent to which social and clinical service providers are not located at participant's residences.	3.5	4	No action	No recommendation
12b. Mobile services. Extent to which social and clinical service	3.5	4	No action	No recommendation

Criterion	FV1	FV2	Action	Recommendations
providers are mobile and can deliver services to locations of participants' choosing.				
SERVICE PHILOSOPHY				
13. Service choice. Extent to which program participants choose the type, sequence, and intensity of services on an ongoing basis.	4	4	No action	No recommendation
14. No requirements for participation in psychiatric treatment. Extent to which program participants with psychiatric disabilities are not required to take medication or participate in psychiatric treatment.	4	4	No action	No recommendation
15. No requirements for participation in substance use treatment. Extent to which participants with substance use disorders are not required to participate in treatment.	4	4	No action	No recommendation
16. Harm Reduction Approach. Extent to which program utilizes a harm reduction approach to substance use.	4	3.5	No action	-The team needs to develop additional skills in the specific harm reduction techniques. -Participants should only be encouraged to enter detox or rehabilitation programs when they are in the action stage of change, otherwise staff should focus on helping participants use safely or reduce their use.
17. Motivational Interviewing. Extent to	2	2.5	-All staff were given the opportunity to receive a	-Regular training in motivational interviewing

Criterion	FV1	FV2	Action	Recommendations
which program staff use principles of motivational interviewing in all aspects of interaction with program participants.			full day of training on Motivational Interviewing in October 2011 and additional presentations from qualified staff have also been provided.	should be available to program staff. -Regular follow ups with current staff should be done to ensure that they are incorporating motivational interview practices in their work with participants.
18. Assertive Engagement. Program uses an array of techniques to engage consumers who are difficult to engage, including (1) motivational interventions to engage consumers in a more collaborative manner, and (2) therapeutic limit-setting interventions where necessary, with a focus on instilling autonomy as quickly as possible. In addition to applying this range of interventions, (3) the program has a thoughtful process for identifying the need for assertive engagement, measuring the effectiveness of these techniques, and modifying approach where necessary.	3	3	-Wellness Recovery Action Plans (WRAP) were developed with some participants.	-Wellness Recovery Action Plans (WRAP) should be developed with all participants. -Regular follow ups with participants should be conducted concerning individual progress in relation to their WRAP. -Special attention should be given to participants who are struggling with a worsening of their illness as they tend to withdraw from the team. -All efforts made by the team should be documented in the chart to facilitate future follow ups. -Therapeutic recreational activities should continue to be offered by the program to participants to encourage them to become engaged with program staff in less threatening environments.
19. Absence of Coercion. Extent to which the program does not engage in coercive activities towards participants.	4	4	No action	No recommendation
20. Person-Centered Planning. Program	2	2.5	-Point people (i.e., staff responsible for setting	-There should be a minimization of changes

Criterion	FV1	FV2	Action	Recommendations
conducts person-centered planning, including: 1) development of formative treatment plan ideas based on discussions driven by the participant's goals and preferences, 2) conducting regularly scheduled treatment planning meetings, 3) actual practices reflect strengths and resources identified in the assessment			goals with the participant and updating treatment plan twice a year) were identified for all participants. -A plan has been put into place where each team member is now responsible for 10 participants.	in point people in order to maximize continuity of services. -Goals should be systematically reviewed with participants twice a year. -A scheduled review time should be organized for each participant. -Goal plans should be updated for all participants in a participant's own language.
21. Interventions Target a Broad Range of Life Goals. The program systematically delivers specific interventions to address a range of life areas (e.g., physical health, employment, education, housing satisfaction, social support, spirituality, recreation & leisure, etc.)	4	4	No action	No recommendation
22. Participant Self-Determination and Independence. Program increases participants' independence and self-determination by giving them choices and honoring day-to-day choices as much as possible (i.e., there is a recognition of the varying needs and functioning levels of participants, but level of oversight and care is commensurate with need, in light of the goal of enhancing self-	4	4	No action	No recommendation

Criterion	FV1	FV2	Action	Recommendations
determination).				
SERVICE ARRAY				
23. Housing Support. Extent to which program offers services to help participants maintain housing, such as offering assistance with neighborhood orientation, landlord relations, budgeting and shopping.	4	4	No action	No recommendation
24. Psychiatric Services. In addition to providing psychopharmacologic treatment, the psychiatric prescriber serves the following functions in treatment: (1) typically provides at least monthly assessment of consumers' symptoms & response to medications, including side effects; (2) monitors all consumers' non-psychiatric medical conditions and non-psychiatric medications; (3) if consumers are hospitalized, communicates directly with consumers' inpatient psychiatric prescriber to ensure continuity of care; (4) provides medication education; & (5) conducts home/community visits.	Not Rated	3	-One psychiatrist offers services for participants at the hospital. -One psychiatrist comes weekly for ½ day, is accessible to the team during off-hours, and is open to doing home visits.	-Continue to forge relationships with psychiatrists in the community in order to maximize psychiatric care available for participants. -Continue to have at least one psychiatrist working directly with the team and available for home visits. -Try to maintain the same psychiatrists for participants in order to ensure continuity of care.
25. Integrated, Stage-wise Substance Use Treatment. Integrated, stage-wise substance use treatment is directly provided by the program. Core services include: (1) systematic and integrated screening and assessment;	2	2.5	-A member of the team has received provincial training in addictions. This team member is working with many participants on substance use issues. -All staff were given the opportunity to receive a	-The team member with training in addictions should also receive training in dual diagnosis treatment in order to assist participants in understanding how their mental illness and substance abuse problems

Criterion	FV1	FV2	Action	Recommendations
interventions tailored to those in (2) early stages of change readiness (e.g., outreach, motivational interviewing, accompanying consumers to treatment/meetings) and (3) later stages of change readiness (e.g., CBT, relapse-prevention).			full day of training on Motivational Interviewing and the stages of change.	interact and how to cope with both. -The entire team should receive some training in dual diagnosis and substance use. -"In house options" for substance abuse treatment should be promoted. -Formal ongoing screening and assessment of substance use should be implemented.
26. Supported Employment Services. Extent to which supported employment services are provided directly by the program. Core services include: (1) engagement; (2) vocational assessment; (3) rapid job search and placement based on participants' preferences (including going back to school, classes); & (4) job coaching & follow-along supports (including supports in academic settings).	3	3.5	-A full-time vocational coordinator has been hired to assist with vocational placement and job coaching, and holds weekly job fairs to review available jobs as well as assist with resumes and role-playing job interviews. -The occupational therapist is completing vocational assessments. -A co-op program has been created for participants.	-The team should continue to look for creative strategies to increase the vocational opportunities for participants.
27. Nursing Services. Extent to which nursing services are provided directly by the program. Core services include: (1) managing participants' medication, administering & documents medication treatment; (2) screening consumers for medical problems/side effects; (3) communicating & coordinating services with	3	3.5	-A smoking cessation course has been held for participants at AHCS with moderate success. -A walking club is now being held weekly by the team physician. -Various team members have assisted participants in obtaining a membership at the local YMCA.	-Nursing services offered by the program should find more time to allocate on health promotion for participants. -The proposed hiring of a part-time nurse by the program should ideally be someone trained in harm reduction and integrated concurrent disorders treatment.

Criterion	FV1	FV2	Action	Recommendations
other medical providers; (4) engaging in health promotion, prevention, & education activities (i.e., assess for risky behaviors & attempt behavior change)				
28. Social Integration. Extent to which services supporting social integration are provided directly by the program. 1) Facilitating access to and helping participants develop valued social roles and networks within and outside the program, 2) helping participants develop social competencies to successfully negotiate social relationships, 3) enhancing citizenship and participation in social and political venues.	3	3.5	-Participants are now being encouraged to participate in community activities to foster integration (i.e., great soup cookoff, community gardening project, attendance at the walk for international eradication of poverty, and participation at the housing forum for homelessness).	-Program staff should assist participants with becoming advocates in the mental health system, developing leadership skills, and linking them to opportunities in which their input has an impact on policy.
29. 24-hour Coverage. Extent to which program responds to psychiatric or other crises 24-hours a day.	3	3	-No action	-Someone has to be available to answer crisis calls after 10PM. -All participants should have access to phone numbers to call in the event of a crisis. -Follow up with participants to ensure they have the appropriate numbers to call.
30. Involved in In-Patient Treatment. Program is involved in inpatient treatment admissions and works with inpatient staff to ensure proper discharge as follows: 1) program initiates admissions as	2	4	-There has been the addition of one ½ day psychiatrist to the team and another psychiatrist offering to see program participants at the hospital.	No recommendation

Criterion	FV1	FV2	Action	Recommendations
necessary, 2) program consults with inpatient staff regarding need for admissions, 3) program consults with inpatient staff regarding participant's treatment, 4) program consults with inpatient staff regarding discharge planning, and 5) program is aware of participant's discharge from treatment.				
PROGRAM STRUCTURE				
31. Priority Enrollment for Individuals with Obstacles to Housing Stability. Extent to which program prioritizes enrollment for individuals who experience multiple obstacles to housing stability.	4	4	No action	No recommendation
32. Contact with Participants. Extent to which program has a minimal threshold of non-treatment related contact with participants.	4	4	No action	No recommendation
33. Low Participant/Staff Ratio. Extent to which program consistently maintains a low participant/staff ratio, excluding the psychiatrist & administrative support.	4	4	No action	No recommendation
34. Team Approach. Extent to which program staff function as a multidisciplinary team; clinicians know and work with all program participants.	4	4	No action	No recommendation

Criterion	FV1	FV2	Action	Recommendations
35. Frequent Meetings. Extent to which program staff meet frequently to plan and review services for each program participant.	4	4	No action	No recommendation
36. Daily Meeting (Quality): The program uses its daily organizational program meeting to: (1) Conduct a brief, but clinically-relevant review of all participants & contacts in the past 24 hours AND (2) record status of all participants. Program develops a daily staff schedule based on: (3) Weekly Consumer Schedules; (4) emerging needs, AND (5) need for proactive contacts to prevent future crises; (6) Staff are held accountable for follow-through.	3	3	-Participants are now being tabled more. -Goals are being identified as part of the contact review.	-Establish a system for the team to regularly follow-up on participants' goals. -Provide detailed notes about participants' progress in meeting goals in the charts.
37. Peer Specialist on Staff. The program has at least 1.0 FTE staff member who meets local standards for certification as a peer specialist. If peer certification is unavailable locally, minimal qualifications include the following: (1) self-identifies as an individual with a serious mental illness who is currently or formerly a recipient of mental health services; (2) is in the process of his/her own recovery; and (3) has successfully completed	3	2	-A participant has been identified to become a peer specialist. -However, there is no program for certification at the provincial level, thus the peer specialist has no training. -The feasibility of training the peer specialist is being investigated.	-A peer specialist should be provided with training.

Criterion	FV1	FV2	Action	Recommendations
training in wellness and recovery interventions. Peer specialist has full professional status on the team.				
38. Participant Representation in Program. Extent to which participants are represented in program operations and have input into policy.	2	3	-Participants are now actively being involved in the planning, design and implementation of the cooking and gardening projects. -Participants are now involved at the local advisory committee level. -Participants have also been involved in giving input to vocational projects and employers.	-A monthly or quarterly tenants' advisory board that provides input into the development and management of the program should be created.

a. ***Maintained and Emerging Strengths***

i. Description of strengths from the fidelity reports. For the group of standards falling under the *Housing Choice and Structure* criterion, the Moncton site was assessed as being at full implementation on five of the six standards reflecting areas of strength (i.e., also assessed at full implementation in the 2010 fidelity assessment). These five standards included the provision of *Housing Choice, Permanent Housing Tenure, Affordable Housing, Integrated Housing (Urban and Rural Programs),* and *Privacy*. There were no specific weaknesses in this section, although it was unclear if *Housing Availability* had changed since it was not rated in the second fidelity visit and it was rated as being partially implemented in the first fidelity assessment. The team was described in the fidelity assessment report as doing very well in this domain demonstrating a commitment to providing participants with housing choice and options.

The group of standards under the *Separation of Housing & Services* criterion demonstrates another area of noteworthy strength for the program in Moncton. Specifically, the standards entitled *No Housing Readiness, No Program Contingencies, Standard Tenant Agreement, Commitment to Re-House,* and *Services Continue Through Housing Loss*, represent consistent strengths in both fidelity visits. There were no specific weaknesses in this section, nor was there any negative change. Two areas were found to have improved from the first to the second fidelity visit, namely *Off-site Services* and *Mobile Services*. These areas were now assessed as being at full implementation. The team has been very dedicated to re-housing participants and offering a personalized approach to each participant. In addition, the team focuses on helping participants work on their difficulties that may have contributed to the need for re-housing so as to reduce the future need for re-housing.

Six of the 10 standards falling under the *Service Philosophy* criterion were assessed as being at full implementation in both fidelity assessments. The standards showing consistently full implementation comprised of *Service Choice, No Requirements for Participation in Psychiatric Treatment, No Requirement for Participation in Substance Use Treatment, Absence of Coercion, Interventions Target a Broad Range of Life Goals,* and *Participant Self-Determination and Independence*. The staff was viewed as being committed to the values guiding the Housing First approach as it relates to maximizing participant choice and autonomy in accessing services.

Among standards making up the *Service Array* criterion, only one of seven standards, namely *Housing Support* was judged as being at full implementation in both fidelity assessments. However, two program areas in relation to *Service Array* were noted as showing notable improvement in the second assessment, namely the provision of *Psychiatric Services* and *Supported Employment Services.* Overall, the fidelity team noted that the program had made progress in extending the range of services available to program participants.

Lastly, the *Program Structure* criterion was assessed as having multiple areas of strength. Specifically, *Priority Enrollment of Individuals with Obstacles to Housing Stability, Contact with Participants, Low Participant/ Staff Ratio,* and *Team Approach*, were assessed at full implementation in both fidelity assessments. Although *Participant Representation* in the program was not at full implementation, positive change in the area was noted in the second fidelity assessment particularly as it related to including a tenant representative on the Local Area Committee as well as through informal efforts at obtaining participant feedback on the program.

ii. Service provider perspectives on strengths. Overall, program staff and key informants described the housing and support delivered by the program to participants as being of a high quality and making a difference for a large majority of them. In relation to the consistent program strengths associated with the *Housing Choice and Structure* standards, key informants underlined the success at finding committed and understanding landlords as being a very important contributor.

For example, one key informant noted "*the biggest issue for us we thought would be landlords and it ended up that it was not. It was one of our qualities was being able to have the landlords come. So the landlords were really not a problem with us…..*" (KI2, 16-18). The good working relations between the two service teams (i.e., housing and ACT) were also indicated as contributing to the strengths of the program in terms of housing and support being available to participants.

According to one of the key informants, program strengths related to the *Separation of Housing* and to the provision of housing services more generally have been facilitated by the new location of the housing staff member in the offices of the United Way in the Peace Centre next door to the Manse. This change in location has freed the housing coordinator from spending an overabundance of time in the Manse while still allowing her to have the necessary contact with the program through communication with the Clinical Director whose office is in the Peace Centre or through contact with ACT staff when needed.

ACT team members and key informants viewed the program as having a better sense of participant's needs and having become more flexible in delivering services that addressed these needs. In particular, they described program services as evolving towards being more recovery-focused. As well, they noted being less reactive in their responses, shifting some of the responsibility for problem-solving on to the participants. The noticeable stabilization of participants over time noted by key informants and program staff is viewed as having contributed to these changes.

"We have a better understanding of what the needs are as well…. you know I have an idea who would prefer to work alone in this cleaning job, who would prefer to work…so you kinda know where to put people…..To have a success and know what their strengths are..... .So it's more client-centered on what their interests are." (FG1; 819-827; 847-850)

" On a eu des gens qui ont atteint une stabilité incroyable, ils ont été logés et qui ont reçu nos services, parce que c'est des services intensifs c'est certain que l'on a quelque chose qui n'est pas nécessairement offert par d'autres services. Alors, il y en a qui ont été capable de trouver un chemin vers le rétablissement, le fait que l'on a trois individus qui sont sur la route de devenir des pairs aidant officiels, c'est un résultat de cela." (KI1: 521-525)

ACT team members also perceived themselves as having developed a better understanding of their roles over time. As well, they noted that there was better communication within the team. Key informants reflected that there was stability in the make-up of ACT team and the housing staff. All these factors appeared to be contributing to the program's strengths identified in delivering services that are in line with the values and philosophy guiding a Housing First approach.

"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 they're [staff] not afraid to ask for training, they're not afraid to try new things, they're not afraid to have committees going…" (KI2: 88-90)

As indicated in the fidelity assessments, the provision of support to tenants that contribute to their housing stability has been a notable strength within the *Service Array* group of standards. As previously mentioned, the program has established good working relationships with its landlords and this has undoubtedly facilitated the provision of effective housing-related support.

Overall, the program was described by key informants and program staff as having greater capacity to deliver a wider range of services and support. The training provided to staff locally and nationally was perceived as contributing to this greater capacity. One of team members has received specific training in the area of addictions treatment with the goal that he would provide in-house training, consultation, and program development in this area. As well, the addition of staff and professional disciplines with different areas of expertise was cited as also contributing to the program delivering more effective support to participants.

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 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 program needs.

The addition of a dedicated vocational specialist to the ACT was described by key informants and program staff as a very positive development and an emerging strength in the program. In particular, the vocational specialist had successfully created employment opportunities for participants (e.g., the farm, moving services for program participants). As well, there was appreciation expressed for her advocacy and public education efforts in the community with potential employers.

It was noted that having a receptionist at the Manse has also increased service capacity as she has helped with brokering services in the community for participants as well as providing useful information to the ACT team for service planning purposes based on her regular contact with many program participants. Key informants and program staff indicated that the program had also increased it capacity through the successful creation of partnerships with community organizations that can supplement and extend the types of services delivered by the program. The positive reputation of the program in the community has helped facilitate these partnerships.

"L'on essaye aussi de créer de meilleur partenariat, une meilleure collaboration, avec les services de traitement et service de dépendance, pour voir si l'on peut, améliorer le service que l'on offre à tous nos participants qui vivent avec cette problématique. ..... Parce que c'est incroyable, ce que l'on a vu ici avec tout l'appui de la communauté envers notre projet c'est vraiment incroyable. Il y a vraiment une multitude d'autres partenariats que l'on peut créer. On a vraiment un bon appui positif de tous les ministères." (KI1: 99-102; 575-577)

Finally with regard to standards falling under *Program Structure*, key informants and program staff noted the improved clarity of roles for housing staff and service providers as well as the improved communication within the team. As well, they highlighted the richness of services that are being delivered to program participants because of the multidisciplinary make-up of the team.

b. ***Recurrent Challenges or Trouble Spots***

i. Description of challenges from the fidelity reports. As previously mentioned, the program was judged by the fidelity assessment team as being at full implementation on the standards falling under *Housing Choice & Structure.* As such, there were no challenges identified in this area. Similarly, the standards falling under *Separation of Housing & Services* were also found to be at full implementation at the second fidelity visit indicating that there were no challenges identified in this area.

The *Service Philosophy* criterion was found to have a few recurrent challenges at the second fidelity visit. Specifically, the *Assertive Engagement* standard was assessed as falling below full implementation in both fidelity assessments. The team was described by the fidelity team as applying significant effort to engage participants but the main issue was that very few documented their efforts in the chart, thus making it difficult for the fidelity team to determine how consistent and systematically interventions were being implemented in this areas. In

addition, it was noted that the ACT team should continue to develop more social activities for participants to overcome their reported feelings of loneliness and isolation.

Two areas showing some improvement within the *Service Philosophy* criterion but continuing to be judged as being at less than full implementation involved the ACT team engaging in *Motivational Interviewing* and *Person-Centered Planning* with program participants. ACT team members had received training in motivational interviewing but still lacked experience and general comfort using these techniques. At the second fidelity visit, it was noted that there seemed to be a lack of documentation of the participant's words in relation to service planning; rather the team was using their own interpretation. In addition, the chart notes provided good day-to-day details of the ACT team's work with participants but were lacking more long-term planning and recovery planning. There was also a perception that the rural team was more effective at goal-setting and recovery planning with participants due to the extensive experience of the service providers there. In addition, the rural team had developed a really good Recovery Action Plan template to be used with participants.

A number of standards falling under the *Service Array* criterion continued to be assessed as being at less than full implementation at the second fidelity visit. The standard related to the program providing *24-hour Coverage* to participants was found to be again at partial implementation as the program relies on local mobile crisis services to provide coverage overnight. The *Psychiatric Services* standard was not rated at the first fidelity visit because there were no psychiatrists on the team. There is one psychiatrist providing a 1/2 day of consultation to the program which was noted by the fidelity team as a significant improvement. However, there is also one other psychiatrist who is willing to see participants from the program at the hospital, though this location was viewed by the fidelity team as potentially presenting an obstacle for some participants.

There were a few program standards falling under the *Service Array* criterion that improved significantly but continued to be assessed at less than full implementation, including delivering *Integrated, Stage-wise Substance Use Treatment, Supported Employment Services, Nursing Services*, and supporting the *Social Integration* of participants. Certainly the hiring of a substance use specialist, an occupational therapist, as well as a dedicated employment specialist has contributed to this positive change in this area. Although a substance use specialist has been identified and trained, the fidelity team judged the program to need to continue to develop its capacity in this area.

Recurrent challenges were also noted on standards falling under the *Program Structure* criterion. The *Daily Meeting (Quality)* standard continues to represent a fidelity challenge for the program. The fidelity team viewed the program as requiring a system that would facilitate their following up on participants' goals. The *Peer Specialist on Staff* standard was judged to have experienced a small negative change since the last fidelity visit and continued to represent an implementation challenge. This is because the team has identified peers but no training had yet been provided to these individuals at the time of the second fidelity visit in January 2012. Finally, the program was judged as being improved on the *Participants Representation in Program* standard though it continued to be assessed as being at less than full implementation. The program had recently added a program participant to the local advisory committee and the fidelity team perceived this improvement as an excellent development.

ii. Service provider perspectives on challenges. Program staff noted that the lack of engagement in services by some participants has proven to be an ongoing challenge despite significant efforts on their part to establish a working relationship with these individuals. A number of reasons were cited for this lack of engagement on the part of participants. In some cases, the nature of their mental health problems contribute to them having difficulty trusting service providers. In other cases, severe substance abuse with clients considered at a pre-contemplation stage of change was described as being behind some participant's disengagement. For a small number of participants, they were only interested in receiving housing from the program as they perceived themselves as not needing ongoing services or support.

"One will be for their mental illness um, and ah, those would be sort of, I would think more the paranoid people that. First of all they don't recognize that they have an illness and then they're very suspicious of the team and… So it's hard for them to develop any trust…It's hard, really difficult, um we…we have tried very hard to engage them um, sometimes it just comes back to hospitalizing them and once they get treated for their illness to start to really work there and start once they're feeling better....." (FG1: 237-245)

"*.....the other people that have been difficult to engage have been the substance people that have had substance abuse and they just don't want to be found. They're quite happy in their housing, using it for doing their drugs and having their friends and having parties and they just aren't there every time we go and they're really…They're not on the same page and um yeah those are the ones we're having issues with, more issues around housing….*" (FG1: 251-260)

In general, program staff expressed frustration in the focus groups with clients who were not engaged despite their efforts over a significant amount of time. They wondered in some case in light of continued disengagement if the program was actually a poor fit for certain participants. In general, they expressed a commitment to persist with participants despite their lack of engagement. In a couple of cases, it was mentioned that after not having contact with participants for several months, the program had sent them letters indicating that they would lose their housing subsidy if they did not make themselves available for the weekly visit. They noted that the approach was successful in re-engaging these participants at least minimally.

A number of factors were identified by the program staff as contributing to their only partial implementation to date of person-centered planning. Specifically, they noted that in the earlier stages of the program, the focus of service planning with participants was on immediate needs and often crisis-centered. As well, related to this tendency, program staff noted the over-dependence of some participants such that they were not comfortable taking the initiative required to set their own longer-term goals.

Another contributing factor was the fact that initially there was a lack of consistency in goal-planning across disciplines. This problem was further compounded by the fact multiple staff members were involved with each participant. These issues were described as being mitigated recently with the introduction of a new goal-planning tool and a process wherein each team member was assigned the primary responsibility for goal planning with a similar number of participants. Interestingly, similar to the perceptions of the fidelity assessment team, a key informant noted that the rural service providers had been more effective in implementing person-centered planning than Moncton service providers.

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

"*.....so they can spot fake two miles away. So it's very, you gotta be yourself. So this internal change with the motivational interviewing, I think it's a great tool but I think, if we try to incorporate this too much as more of a counseling technique, they're gonna see right through it."* (FG1: 331-334)

"I've done a bit of training in motivational interviewing and saving (18:42) and I think there was something else that I had but sometimes I feel like I'm missing the clues, 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 like this kind of defined way of doing things I feel I kind of miss it." (FG: 301-304)

Key informants and program staff viewed the program as having insufficient psychiatric services relative to its needs. There was appreciation for it having access to one day of psychiatric consultation on site and having access to another psychiatrist at the hospital. However, it was noted by both key informants and program staff that providing consultation exclusively from the George Dumont Hospital was less effective than having an on site psychiatrist. For example, one of the service providers explained the *"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, case planning."* (FG1: 645-647)

A lack of internal program capacity was identified by key informants and program staff as the major factor contributing to the program as having only partially implemented the use of integrated, stage-wise substance abuse treatment. In particular, there was recognition that most of the program 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 and interest in receiving addictions treatment training and efforts by the program to date to provide this training were much appreciated.

The addition to the team of a designated addiction treatment specialist was viewed very positively by program staff as helping to address this program deficit. At the same time, it was noted that the shift work schedule of this individual presented some limitations on his availability to other staff as well as to his ability to develop and offer targeted in-house group treatment to participants for addictions. The very demanding schedule of team members was also cited as making it difficult to provide this kind of group treatment by the program.

A key informant described the difficulties experienced by participants in relation to changing their social network. In particular, becoming housed often requires them to leave their friends from their previous life when they were homeless. This was characterized by the key informant as being particularly important in order for them to overcome a substance abuse problem. As a result, program participants were described as frequently experiencing social isolation.

"....the person that is addicted um lives a life of loneliness... it's gotta be the worst part of getting off your addiction is that you lost your best friend and the true part is that you've lost your physical best friend also, because your friends are no longer around cause you can't be around your friends. So the drug is your best friend and then you lose your other friends and so .....an agency has to make sure that you can be there to complement that….. until they have been able and have had time to build new friends." (KI2: 152-162)

Program staff mentioned how some participants were supporting each after having met at a program activity. This exchange of support was viewed as helping participants combat their social isolation and loneliness. For example, a program staff stated the "*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 program. You know like people are babysitting each other's dog. If you have a cat and going to the hospital, somebody will come in and feed it.....not everybody but I'm noticing that people are starting to have that more.*" (FG1: 522-525)

Finally, although it remained an ongoing challenge faced by the program, improvements were noted in the fidelity assessment in terms of the program accessing participant feedback on services. A key informant explained that a tenant representative has recently become a member of the Local Advisory Committee for the program.

iii. Perspectives on moving forward to address recurrent challenges. The fidelity team provided a number of very specific recommendations to address recurrent challenges. These are presented next for each of the standards identified in the second fidelity visit as a recurrent challenge followed by any perceptions of key informants and program staff for moving forward.

Service Philosophy:

Motivational Interviewing. Fidelity report recommendations: (i) Regular training in motivational interviewing should be available to program staff; and (ii) regular follow ups with current staff should be done to ensure that they are incorporating motivational interview practices in their work with participants.

Assertive Engagement. Fidelity report recommendations: (i) Wellness Recovery Action Plans (WRAP) should be developed with all participants; (ii) regular follow ups with participants should be conducted concerning individual progress in relation to their WRAP; (iii) special attention should be given to participants who are struggling with a worsening of their illness as they tend to withdraw from the team; (iv) all efforts made by the team should be documented in the chart to facilitate future follow ups; and (v) therapeutic recreational activities should continue to be offered by the program to participants to encourage them to become engaged with program staff in less threatening environments.

***Person-Centered Planning*.** Fidelity report recommendations: (i) There should be a minimization of changes in point people in order to maximize continuity of services; (ii) goals should be systematically reviewed with participants twice a year; (iii) a scheduled review time

should be organized for each participant; and (iii) goal plans should be updated for all participants in a participant's own language.

In discussing the *Service Philosophy* criterion with program staff, they described that it would have been useful to receive training on how to goal plan with participants in a standardized way. They also described receiving more training in motivational interviewing.

"On a eu une formation sur l'entrevue motivationnelle, ça, c'est avant que j'arrive moi, ça a été offert à l'automne dernier. Puis on s'était mis comme objectif, ce n'est pas encore atteint, de revenir peut-être sur ces outils et de les utiliser de plus en plus dans notre quotidien. On n'a pas encore eu la possibilité, il va y avoir des formations dans la province pour former les gens qui sont dans le milieu public en santé mentale pour l'entrevue motivationnelle. J'ai demandé à ce que l'on ait des sièges pour participer à cette formation encore une fois pour augmenter notre expertise de se coté la,....." (KI1: 104-110)

Service Array:

Psychiatric Services. Fidelity report recommendations: (i) To continue to forge relationships with psychiatrists in the community in order to maximize psychiatric care available for participants; (ii) continue to have at least one psychiatrist working directly with the team and available for home visits; and (iii) try to maintain the same psychiatrists for participants in order to ensure continuity of care.

Integrated, Stage-Wise Substance Abuse Treatment. Fidelity report recommendations: (i) The team member with training in addictions should also receive training in dual diagnosis treatment in order to assist participants in understanding how their mental illness and substance abuse problems interact and how to cope with both; (ii) the entire team should receive some training in dual diagnosis and substance use; (iii) "in house options" for substance abuse treatment should be promoted; and (iv) formal ongoing screening and assessment of substance use should be implemented.

Supported Employment Services. Fidelity report recommendations: (i) The team should continue to look for creative strategies to increase the vocational opportunities for participants.

Nursing Services. Fidelity report recommendations: (i) Nursing services offered by the program should find more time to allocate on health promotion for participants; and (ii) the proposed hiring of a part-time nurse by the program should ideally be someone trained in harm reduction and integrated concurrent disorders treatment.

Social Integration. Fidelity report recommendation: (i) Program staff should assist participants with becoming advocates in the mental health system, developing leadership skills, and linking them to opportunities in which their input has an impact on policy.

In discussing how to address some of the recurrent challenges associated with the *Service Array* criterion, program staff described that more training would become available in how to better help participants with substance abuse problems.

"Au niveau de l'équipe, on s'est mis comme objectif d'aller chercher plus d'expertise au niveau des outils , au niveau de programme pour être capable de mieux encadrer les gens qui ont des problèmes d'abus de substance. Parce que, l'on a une personne qui a un vécu, et qui est un petit peu notre expert. L'on veut embellir, on veut augmenter ces outils, on veut augmenter son expertise, alors on veut essayer de mettre quelque chose en place." (KI1: 95-99)

Program staff also described wanting to create more partnerships in the community in order to diversify the types of addiction services offered to participants.

"L'on essaye aussi de créer de meilleur partenariat, une meilleure collaboration, avec les services de traitement et service de dépendance, pour voir si l'on peut, améliorer le service que l'on offre à tous nos participants qui vivent avec cette problématique." (KI1: 99-102)

Program Structure:

Daily Meeting (quality). Fidelity report recommendations: (1) Establish a system for the team to regularly follow-up on participants' goals; and (2) provide detailed notes about participants' progress in meeting goals in the charts.

Participant Representation in Program. Fidelity report recommendation: (i) A monthly or quarterly tenants' advisory board that provides input into the development and management of the program should be created.

In discussing how to address some of the recurrent challenges associated with the *Program Structure* criterion, program staff described that including peer specialists in daily meetings has been incredibly helpful in better understanding the challenges faced by participants with addictions.

"Les gens qui on le vécu, ils peuvent nous aider à voir cette perspective la plus claire, que quelqu'un qui n'a jamais marché dans ces souliers-là qui n'a jamais eu ces défis-là. Alors c'est continu puis il y a de la réfléchie, des raisons pourquoi que ces tellement important d'entendre leur voix et d'entendre leurs expériences, puis leur histoire puis tout leur vécu pour que l'on puisse apprendre de ça, ça aide aussi entre nous autres de créé cette entraide la, parce que même à ce matin à notre table de réunion il y en a un qui dit, ça prend un alcoolique pour être capable de faire comprendre à un autre alcoolique quoi faire pour s'en sortir." (KI1: 613-620)

c. Emerging Implementation Challenges or Trouble Spots

i. Description of challenges from the fidelity reports. The vast majority of fidelity standards on which the Moncton At Home / Chez Soi program were rated at less than full implementation represented recurrent challenges that were identified at the first fidelity visit. In fact, there were only two standards on which the program was rated as having a lower level of implementation at the second fidelity visit compared to the first fidelity visit.

In particular, the standard falling under Service Array related to the program following a *Harm Reduction Approach* was initially rated to be fully implemented at the first visit; however at the second visit it was found to have experienced a slight decrease in fidelity. The fidelity

team noted that although there was an increasing number of staff that have been trained in the harm reduction model, there remains a number of staff that continue to emphasize detox and abstinence to participants that may not be ready for this step. This emerging weakness may be partially accounted by the fact that as the program evolves the participants that are left needing the most support are found to be the most difficult to engage (i.e., most severally addicted and have concurrent mental illness).

In addition, among the group of standards in the *Program Structure* criterion, the program was assessed as showing a decrease in implementation on the standard related to having a *Peer Specialist on Staff.* At the time of the second fidelity visit, a participant had been identified as a potential peer specialist but no formal training to this individual had yet been provided.

ii. Service provider perspectives on challenges. Program staff noted that the success of adopting a harm reduction was contingent on having engaged and honest relationships with participants. One key informant perceived that there was variability among team members in terms of their comfort level and integration of harm reduction in their work with participants. Program 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 suggested that landlords needed to be informed about and comfortable with the program's use of a harm reduction approach.

"In terms of harm reduction, ...the thing you have to get [into] a little bit of a bind from the landlords as well..... in terms of harm reduction in the apartment's themselves, you're going to you know promote harm reduction. Then you have to get landlords on board that..... they [participants] can do injections in their houses as long as they keep their needles and sharps in a safe place and .....I'm not sure that we've really worked hard on that… but we don't have a good spectrum of opportunity so I don't think we've done that harm reduction approach with our landlords too much…" (KI3: 71-77)

A key informant described how the program had hired at the outset several people who were open about having had "lived experience". However, she noted that the program was not prepared or structured to support these individuals and 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 program 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 available in New Brunswick.

"We have hired a lot of peers, from the beginning we had ah I believe at one point, five, six peers out of all of our staff. That's…that's a lot of peers and that was probably a mistake. These are people with lived experience. They've admitted that they've had lived experience....we weren't, I think we should have been better prepared for what the expectations should have been....and again because we hire through the province when they are sick and they were unable to work and they took a lot of time off, we could not hire and replace them. So it created a tremendous amount of pressure for the, ah, the other staff. At Home- Chez Soi housing first ask a

lot of demands on a person, ask a person to not always have the support there that they need." (KI2: 408-419)

Although the lack of a peer specialist was identified in the fidelity assessments as an ongoing challenge for the program, program staff also described one of the focus groups their very recent efforts being made to add a group of peer helpers to the team. In particular, five program participants have been identified and have begun to receive in-house training organized specifically by the program. There was concern expressed by program staff that it was unclear whether or not the necessary resources for adding peer specialists to the ACT team would be available.

"Oui et l'on est en train de regarder à en mettre un en place cet été, parce que d'ici le mois de mai on a aussi des pairs aident qui vont se joindre à notre équipe. Avec la collaboration des cliniques médicales de soins primaire on a offert une formation pour cinq personnes pour devenir pairs aident parce que l'on n'avait pas mis le focus là-dessus encore. Ici l'on avait des gens avec du vécu qui faisait partie de notre équipe, mais ce n'était pas ça leur rôles principal, alors il y a une formation pour ça. Ces individus, de ces individus-là on a trois participants, de nos participants à nous. Alors c'est des gens qui sont tellement avancés qui ont tellement progressé .....Qu'ils étaient capables de prendre le rôle de pairs aidant." (FG2: 322-330).

iii. Perspectives on moving forward to address the challenges. The fidelity team provided a few specific recommendations to address the emerging challenges. These are presented next for each of the standards identified in the second fidelity visit as an emerging challenge followed by any perceptions of key informants and program staff for moving forward.

Service Philosophy:

Harm Reduction Approach. Fidelity report recommendations: i) The team needs to develop additional skills in the specific harm reduction techniques; and ii) participants should only be encouraged to enter detox or rehabilitation programs when they are in the action stage of change, otherwise staff should focus on helping participants use safely or reduce their use.

In discussing challenges associated with the harm reduction approach, program staff stated that they were receiving more training in order to effectively use the philosophy in clinical conversations.

"...the fidelity report showed that you wanted more of that and that we should have sent them for more training and they're doing that now and you were, and it was probably right for you to recognize that what we were doing wasn't enough." (KI2: 73-76)

Program Structure:

Peer Specialist on Staff. Fidelity report recommendations: i) a peer specialist should be provided with training.

In reference to the lack of training of peer specialists, they mentioned that they had recently acquired funds in order to be able to pay peer specialists for participating in training. In

addition, they described having found a training program for peer specialists, which was being offered to a small number of program participants.

"So we are bringing in someone from Halifax that studied in Georgia I believe and somewhere else and he's gonna come and do a full week. We've identified a few peers that we want to train, that would be interested in doing this kind of work so with, it's in the works." (FG1: 967-969)

The staff also described that they had successfully trained 5 peer specialists and that the program was now working on how to integrate them into the program so that they could assist other participants.

"Mhmm, sont vraiment heureux de faire partie de ça, ils se sentent fière, ils ont une fierté, ils se sentent comme ils aident les gens pis c'est vraiment une chose qu'y voulaient faire." (FG2: 844-845)

d. Other Emerging Implementation Issues (including barriers, adaptations, innovations, etc.)

i. Description of issues. The team has gone through some significant transitions. They have changed both the team leader and the housing lead staff members. The composition of the rural team has also changed. Additionally, several staff that were out on medical leave have not returned. The teams have met this challenge, but it has been noticed as a significant challenge by both the staff and participants. A significant challenge associated with these staff changes is that some of the newer staff did not receive the same information about housing first and the overall mission of the project. They seem to understand the ACT service model but are not as well versed in the Housing First philosophy.

Another emerging implementation issue that has been noticed by the housing team is that there is a small percentage of participants who needed more structure in their living situation. The program was able to purchase a building to meet this need. This more structured living arrangement is considered to be a transitional housing setting for participants who are considered not ready for independent housing. The building has a superintendent on-site and has more restrictions about conduct and having overnight guests than an independent apartment would. This has allowed several individuals who had experienced multiple evictions in the program to work on issues that has contributed to these evictions and experience stable housing.

ii. Perspectives on moving forward to address the issues. The fidelity report noted that the team leader at the time of the fidelity assessment in January 2012 was relatively new and still learning about housing first and the overall mission of the project. The report described the importance of the team leader position and that this person typically carries institutional knowledge about the program and creates the atmosphere for the values and philosophy to be carried on. Thus, it was encouraged by the fidelity team that the new team leader receives proper training and support. A key informant suggested that the new team leader had helped the team make progress on implementing a goal-planning process that was more consistent with recovery principles.

The acquisition and launch of a transitional apartment building was characterized as a positive innovation enabling the program in Moncton to better support individuals who had

experienced multiple evictions within the program. It was intended to assist these individuals to successfully move into a stable housing situation. Currently, the transitional building is called the "hard to house" building, which has negative connotations. The fidelity assessment team recommended that the name of the building be changed to something more positive. In addition, the team indicated in the report that while the transitional building has been a success, this type of housing should be seen a temporary situation while working with participants to move towards independent living.

Program staff described the transitional building as already having helped several individuals stabilize their functioning. They noted that the couple serving as superintendents in the building were much more tolerant and flexible in relation to the behaviour of tenants than a typical landlord. One key informant reported that the operation of the transitional building had been challenging because of the mix of tenants there resulting in conflict among them. The key informant perceived the transition house as being at an early stage of development as a program resource with the program still learning how to use it optimally.

"...we've had about 6 apartments in it so one for a super ,... three, four for, longer term housing .....some of the more, people have been in that building have a lot of behavior issues around and .....that's led them to get kicked out of housing. So a lot of loud activity, a lot of squabbling amongst themselves. So it's led to some challenges you know we've put them into these buildings, because again we're dealing with a small community, we all know each other, often they have you know these interpersonal conflicts. So it hasn't been used optimally ..... we've had an occupancy rate of 95%....it's a bit more of a challenge to get the right mix...(KI3: 456-478)

e. Issues Identified from First Implementation and Fidelity Reports (housing/rehousing; housing/clinical team relationship; involvement of PWLE, staffing issues)

i. Description of issues (successes, challenges). The issues identified from the first implementation and fidelity reports have thoroughly been discussed in earlier sections of the report in the context of program strengths and challenges.

ii. Perspectives on moving forward. Directions to address program challenges have also been discussed in earlier sections of the report.

B. Housing First Theory of Change

i. Learnings About What outcomes Occur During the First Year and the Second Year of Housing First

The results in this section are presented in a way that describes participant outcomes over time. Specifically, this section presents intermediate (first year) outcomes and long term (second year) outcomes.

a. Intermediate Outcomes

Participants have achieved stability:

The most pervasive theme to emerge from key informant interviews and focus groups with program staff was the stability that participants have achieved in their lives. This stability was a result of the consistent housing arrangements of the participants. This was presented as an outcome that occurred for most participants in their first year in the program.

Stable housing. The acquisition of housing was described as the catalyst for stability in the participants' lives. One key informant stated that some participants have been in the same housing since the beginning of the program. Alternatively, in other cases attaining stable housing has been more of a process for participants. It was explained by one key informant that some participants required three or four moves before they were able to get into housing that was a good fit and stable. These multiple moves were viewed as a learning opportunity for participants.

Attaining stable housing resulted in several positive outcomes for participants. As described by two focus group participants, program participants were said to be happy to have a place to call home and took pride in their housing. One focus group participant stated that some program participants shared with them that acquiring housing had a substantial impact on their lives and provided them with hope. Having stable housing also allowed for program participants to start focusing on other areas of their lives, as illustrated by this quote, "*I do think the housing for those people, just the supplement and the stability of a place allows them to relax and kind of focus and try to manage whatever the biggest problem is.*" (KI3: 542-543)

Improvements in program engagement and relationship building:

Key informants and focus group participants noted improvements in program participants' engagement in the program and trust with program staff as important intermediate outcomes.

Participation in program activities. Program offerings increasingly developed over time as the program matures and these offerings increased participant engagement. A key informant acknowledged that participants had to deal with whatever programming was being offered initially. As new program activities developed, participants gradually became more engaged. For example, focus group participants discussed how the cooking program was poorly attended, but as the weeks progressed more and more participants began attending. A focus group participant regaled how the class was able to engage one particular participant: *"Well we had one girl when she first started, just about every day she'd phone and she'd be crying and well then we haven't actually heard her phone a lot and yeah she's come to my cooking class twice and said this is cool..."*. (FG1: 1129-1131)

The availability of the different types of programming was especially important for those participants with varying degrees of goal-setting. One focus group participant noted that successful outcomes for some participants may not include becoming employed. According to this program staff member, attendance to programming can be a comparable measure of success to becoming employed.

Healthy relationships developed. One focus group participant was able to see a great difference in some of the program participants in terms of their development of positive relationships in their lives as demonstrated by this quote:

"Well a lot of the people that I've known from my past job there, a lot of them are in this program. They're not the same; they've completely changed in the way that they present themselves, the way that they speak to you, their communication. Um so from the time that they started in this program and to the second year being in here, they're more comfortable they feel like they have relationships and they can open up to people. I've had a few people open up to me that I've known for years that I've never heard their stories before but finally they're at that point where they can share all that." (FG1: 1102-1108)

Furthermore, a key informant stated the stability achieved from housing resulted in the ability for participants to focus on rebuilding their relationships with others.

b. Long-Term Outcomes

Vocational successes:

The attainment of employment and the focus on education was heralded as two of the more long-term positive outcomes to emerge as the program progressed.

Attainment of employment and/or education. As mentioned above, once participants were in stable housing they could focus on other areas of their lives such as employment or education. One focus group participant stated that several participants are working and that some have kept their jobs for a substantial period of time. It was also stated that some participants are attending school, with one participant finishing up his second year of college.

Employment opportunities developed by the program. The opportunity for participants to work at either at the farming initiative or the house cleaning initiative was an invaluable opportunity. A key informant spoke of the empowerment it provided to the participants involved and how it increased their skill development. It also allows participants the opportunity to work on their interview skills with the employment specialist. A second key informant spoke of the benefits of these two vocational programs, stating:

"Toutes les personnes, on a plusieurs personnes qui sont impliquées au niveau de nos projets d'emplois, on en a plusieurs-là qui travail presqu'à temps plein, qui font des bons travaille, on a des bon succès avec ces occasions-là. On a certainement une vingtaine de participants qui sont là-dedans puis que ça fonctionne très bien." (KI1 : 533-537)

Improvements in Participant Independence:

As the program progressed, key informants and focus group participants found that program participants were becoming more independent, particularly with regards to keeping appointments and transportation.

Participants keeping appointments. During the initial stages of the program, focus group participants noted that participants were having difficulties with keeping appointments and

notifying staff when appointments needed to be changed. As the program progressed, one focus group participant stated: "*And they, they call they'll let us know that they're not coming or they'll let us know or they'll cancel their home visits, never used to do that before, they'll pick up the phone now.*" (FG1: 1147-1150). One reason cited for this change was that participants were now able to afford a phone.

Decreased reliance on transportation from staff. Focus group participants reported that requests for rides to appointments dramatically decreased from year one to year two. At the beginning of the program, participants were calling some staff up to twenty times a day for rides. Recognizing that this was an issue, the staff began to let participants know that they could not continue providing rides all of the time and pushed for the participants to make their own travel arrangements, if possible. As a result of this strategy, focus group participants stated that participants are now arriving to appointments without travel assistance from the staff.

Improvements in Substance Use:

Some participants were successful in reducing their substance use. As stated by one key informant, some participants had stopped using substances at all whereas others were able to reduce their substance use. Once again, the acquisition of stable housing was linked to these positive outcomes.

ii. Learnings About Who Benefits the Most from Housing First and Who Does Not

a. Characteristics of Participants Who Benefit Most from Housing First

Focus group participants and key informants stated the participants that benefited most from the program were those who were ready to make a change in their lives and who had higher functioning levels.

Demonstrates readiness and motivation for change. The most common theme to emerge from interviews was the participants' readiness for change. One key informant stated the participants that are, *"really ready to deal with their problems, to deal with their addictions or whatever the case may be"* are the ones that benefit most from the program. Participants also have to be committed to changing their lives.

Goal setting was cited as important for participants. Participants that were able to set goals for themselves and dream of future possibilities were more likely to benefit from the program. A key informant stated that by having these goals and working toward their attainment, participants have achieved positive outcomes particularly in regards to their mental health.

Participants that are doing well in the program tended to have an appreciation of being part of it. One key informant stated that "*the folks that are doing really, really well in housing are just so thankful, so appreciative and they recognize that help is there and they take advantage of the services that are being offered to them. And that is all contributing to their success."* (KI4: 570-575). A focus group participant shared that one consumer told her that the program had saved his or her life and that before the program he or she had nothing.

Level of functioning. The functioning level of some of the participants was described as quite high. Focus group participants shared that some of the participants are living independent lives and do not require much assistance from the program. Other high functioning participants were said to have had supports within the community and therefore did not need to access many services from the program. The rural group of participants was thought to be a higher-functioning and more self-sufficient than participants living in Moncton.

b. Characteristics of Participants Who Benefit Least from Housing First

Focus group participants and key informants stated the participants that benefited least from the program were those who lacked readiness for change, abused substances, had poorer physical and mental health, were potentially violent, and felt isolated.

Not ready to engage in programming or accept support from staff. Key informants and focus group participants recognized that engagement in the program was a choice made by the participants. However, this can be challenging since some participants may feel ready to engage in program activities, but encounter difficulties once they begin with this engagement. One key informant also stated that the program can offer programming and provide support, but it is up to the consumer to decide whether this support is taken. For those participants that are not ready for change or not motivated to change, they will often not access these services.

Participants taking advantage of the program. Although not a common theme, there was mention of some participants taking advantage of the program. One key informant stated that some participants are just interested in receiving the subsidy for their housing and have little to no engagement with the program. For example, the key informant stated, "*There's a couple of individuals who only, only want the housing subsidy. And they will do, they've done what they've needed, at a bare minimum, to attain that*." (KI4: 582-583). Other participants were thought to only speak with staff when they wanted something.

Not prepared for independent living. The responsibilities involved with independent living were deemed as too stressful for some participants. A focus group participant shared that one consumer moved from an apartment to a rooming house because the consumer found it overwhelming to manage both the stressors in his everyday life and the stressors associated with having his own apartment such as bill payments.

Substance Abuse. For the participants with substance use issues, both key informants and focus group participants stated that it was difficult to engage with them. One focus group participant stated that the program is not working well for those with severe addictions. It is difficult to find them housing, as they engage in high-risk behaviours associated with their addictions. One key informant stated that: "*the other people that have been difficult to engage have been the people that have had substance abuse [problems) and they just don't want to be found. They're quite happy in their housing, using it for doing their drugs and having their friends and having parties...".* (KI3: 251-254)

Some individuals with substance use issues were able to achieve stable housing. However, their focus on recovery was viewed by program staff as being limited.

Physical and mental health issues. The poor physical health status of some participants made it difficult for program engagement to occur. It was stated by several focus group participants that managing the physical health needs of some participants took precedence over everything else. Due to this, the staff felt that they were not providing as efficient of a service to these participants. In terms of mental health, a key informant described the limitations in working with certain individuals with a severe and persistent mental illness. Engagement with these participants can be difficult, particularly for those with symptoms of paranoia.

Histories of violent behaviour. Participants with histories of violent behaviour proved to be challenging to the program. It was felt that these participants put others at risk and required the maximum amount of support that could be given. Some participants became legally involved during the course of the program due to violent behaviour.

Social isolation. Independent housing provided new challenges for some participants, particularly in their social relations. A focus group participant stated that upon the receipt of housing, participants can lose the social networks they developed from their previous living situation, whether it was on the street or in special-care homes. Due to this change, some participants feel very isolated in their new surroundings. For example, one focus group participant stated that:

"J'ai souvent ce commentaire là, « j'me sens tout seul, c'est trop grand icitte, l'appartement est trop grand, moi j'suis habitué de vivre dans une petite boîte de carton, pis j'étais bien là ». Il en a qui mon même dit que leur identité c'était là, il en a qui veulent même retourner là." (FG2 : 973-976)

Participants are unsure of what to do in such a different housing situation relative to what they have previously experienced.

iii. Learnings About the Critical Ingredients of Housing First (What Ingredients are Most Important for Whom During What Time Period)

Focus group participants and key informants listed several important ingredients of the Housing First program, including consumer choice, staff composition, housing, and quality of support.

Recognizing Consumer Choice and Interests: One of the critical elements of success in a Housing First program was the ability to offer participants activities that were meaningful to them. For example, one participant's passion was gardening and the program staff were able to link her with a community garden. She later told staff that involvement in the garden was one of the biggest reasons why she connected with the program and she flourished as a result. A second example includes a participant who complained of boredom, so the program staff worked with him and linked him with a day program at the local YMCA. This respect for individual choice is demonstrated in the following quote:

"Je pense que c'est un facteur de succès au niveau du programme, hum, de continuer à, de toujours considérer les besoins de chaque individu, et d'essayer d'avoir un standard au niveau de quel genre de service et de programme que l'on offre, mais de vraiment être focusé sur les besoins de l'individu et de répondre à ces besoins-là dans la mesure du possible. Peu

importe la façon, donc peut-être au niveau de rendre le service de façon, de peut-être reconnaitre l'individualité, pour chaque besoin de chaque individu. " (KI1 : 590-596)

Respecting participant choice was also important for housing. Since participants chose the housing they were living in, there was a certain amount of responsibility and ownership that came with their decision. As one key informant stated, the participants cannot say that staff members placed them in this housing. For participants experiencing several re-housing episodes, one key informant stated that the program is stepping back and placing greater responsibility on these participants to actively seek out their housing and find compatible landlords. This component of consumer choice allows for greater skill development.

Recognizing That Recovery is a Process: Since the Housing First program is not contingent upon abstinence from substances or housing readiness, participants must be given time to engage in their recovery. One key informant stated that program staff must not rush participants in their recovery and that the participants themselves not rush into things when they are not prepared. Smaller achievements must be recognized, such as participants participating in a program event or offering coffee to staff.

Staff Composition and Staff Relations:

Multidisciplinary team. The multidisciplinary team was lauded by both key informants and program staff. When problems arise, staff members can bounce ideas off of one another and provide a comprehensive plan for participants. As stated by one key informant, if it was a team with only one profession represented then the wealth of knowledge from other disciplines would not be available and the program may not be as successful. The availability of different perspectives on the team also allows for targeted responses to occur for participants with specific issues.

Employment specialist. The involvement of the employment specialist was an important development in the program. It was thought that without this program, the participants would have faced much greater barriers in entering the workforce. The programs developed by the employment specialist also allowed for the skill development of participants and increased their earning potentials.

Staff with lived experience. Another key ingredient of the composition of program staff was the involvement of staff with lived experience. One key informant stated that:

"Alors c'est continu puis il y a de la réfléchie, des raisons pourquoi que ces tellement important d'entendre leur voix et d'entendre leurs expériences, puis leur histoire puis tout leur vécu pour que l'on puisse apprendre de ça, ça aide aussi entre nous autres de créé cette entraide là". (KI1 : 615-620)

Having individuals with lived experience on the team provides a comprehensive system of support for participants of the program.

Effective communication. Staff members were also said to be effective communicators with one another. There were several opportunities through the week for staff members to meet

in person to discuss any issues that may have arisen. It was also stated that the staff members are enjoying being part of the program.

Housing:

Transitional house. The transitional house was considered an important development for the program. For those participants experiencing difficulty in settling into their own place, this house offered an opportunity to provide them greater stability. It particularly helps to stabilize mental health issues that participants may be experiencing. The on-site couple superintendents were playing an instrumental role in the success of the transitional house, as it provided a form of on-site support for the participants.

Right fit with landlords. As the program has progressed, it became increasingly difficult to find suitable new landlords for the program. Due to its size, both the rural and urban sites had limited housing resources available. Despite these limitations, the program has been able to develop positive relationships with a large number of landlords. The good landlords are described as very open to the program and having an understanding of its purpose.

Other landlords were more problematic for the program. One key informant stated that a particular landlord was very difficult to work with and this may have resulted from the landlord being misinformed about the expectations of the program. Other difficult landlords were said to have taken advantage of the program. As stated by one key informant:

".....we've been taken advantage of a few times by a few different landlords but what do you do? We've identified who those landlords are and we've identified all of us collectively that it would be a good idea to limit ah the number of participants not let any new apartments be rented." (KI4: 122-124)

Quality and consistency of support. A further critical ingredient of the program, for all participants and at all times, is the level of support that is provided by the staff. Program staff stated that one of the most important ingredients of the program is the consistent support that is offered. The program participants have staff members on speed dial and some speak with staff every day. One focus group participant felt that the staff and participants were like a family. It was suggested that there was also a sufficient number of staff members on the team, so that when a consumer is prepared to engage with someone there is a staff member available.

C. Questions about landlord/caretaker experiences

i. What's working well from the perspective of landlords

As a group, landlords expressed varying feelings about renting to program participants. Many of the interviewed landlords had experienced some difficulties with tenants from the program. Nonetheless, most remained open to renting to program participants. Out of twelve interviewed landlords, three indicated that they would no longer rent to program participants because of difficulties they had encountered. However, most landlords indicated that the program did provide good tenants or they were willing to assist participants to becoming good tenants. Similarly, most landlords indicated that the majority of tenants from the program were similar to their other tenants.

"Ah I wouldn't say they're about the same, there might… there might be a little bit ah, more severe but you know we have had our challenges with our regular clients as well." (LL10: 105-110)

Some landlords even described that program participants were better than most of their tenants. In fact, one of the landlords stated that one of his tenants from the program had taken on additional roles.

"I would say most of the tenants that were part of the program were better than some of my regular tenants." (LL9: 30-35)

*"I still have one of them , he cleans all the laundry rooms and rakes the lawn and just he's basically the superintendent now and everyone in the building like knows him and really likes him. And he just got in a car accident and a lot of the tenants in the building have personally visited him at the hospital." (*LL9: 37-44)

Landlords cited three major advantages to having participants from the At Home / Chez Soi project as tenants: (1) the rent is guaranteed by the program; (2) the program pays for any damages and cleaning of the property; and (3) the program can be contacted and can intervene when problems are encountered with program participants. In addition, landlords stated that the program was responsive to their concerns about rent payment and was able to solve these issues. Most landlords identified that they could contact the program to receive assistance from staff if they had specific issues. Similarly, a few landlords also mentioned that the program efficiently handled evictions of problematic participants.

Half of the interviewed landlords also noted they decided to rent to program participants, at least in part, for altruistic reasons. These reasons included wanting to assist people with mental illness because of having personal experiences within their family or through their work. Specifically, they reported feeling as though they were giving people who had major difficulties "*an opportunity to live on their own and get back up on their feet*" (LL11: 77), and contributing by giving something back to the community.

ii. What's Working Less Well from the Perspective of Landlords?

Landlords cited disadvantages to renting to program participants. In particular, some landlords felt as though they were taking a chance by taking a program participant because of their unpredictability with some participants working out better than others. Some landlords reported that some participants to whom they rented had abused substances, had behavioral problems, were inappropriate towards them or other tenants, caused significant damage to apartments, had other people moving in with them, caused additional traffic in and around the property and attracted undesirable people. Landlords stated that those difficulties had multiple consequence from the landlord's perspective, namely: 1) It led to an increase in work load; 2) it created noise and disturbances in the building; 3) it could impact other tenants (a landlord reported that he lost some good tenants as a result of problems with program participants); and 4) it could create a bad reputation for the building.

Landlords also reported that smoking in and around the property was at times problematic. In particular, landlords reported that heavy smoking tended to be a problem of

many program participants. This excessive smoking caused noticeable amounts of second-hand smoke in the apartment buildings that were meant to be smoke free.

*"I would say that would probably be the biggest thing. Most of our units are non-smoking and you know that would be the…the only rule that they seem to all break." (*LL9: 71-76)

One landlord reported feeling frustrated when he confronted a program participant about the smoking problem and he denied his implication and responsibility.

".....some of our tenants, they are regular tenants that smoke; sometimes [they] smoke in the unit too. Um I guess it's just solving of the smoking issue. I guess it was just easier with some of our other tenants cause they would acknowledge that they did it.....Whereas the At Home tenants they deny that it ever even happened." (LL9: 78-82).

Some landlords reported having problems communicating with the program while other landlords expressed dissatisfaction with the program's responsiveness to their concerns. Some landlords stated that they had concern about the amount of services that were provided to participants, as they did not have the impression that the program was supportive enough of tenants and they felt as though more home visits by program staff could have been helpful.

"I believe more support for the clients would definitely be helpful. Yeah I kinda feel like they're put there and until it's a case of us having to evict them that's the only time they really get involved." (LL10: 167-176)

Communication was a challenge for some landlords. Many landlords stated that the time frame they could reach program staff was not ideal and did not include 24/7 service. Many landlords reported being frustrated that they had to leave messages every time they called and that at times their messages were not returned. A few landlords seemed to be confused in terms of who to contact in the event of a problem with a program participant. One landlord reported that they would have liked to receive more information via email as it was an easier medium to communicate. Another landlord stated that it would have been helpful to receive more information about the program and the potential tenants so as to be able to be more prepared and have a greater understanding, but also to give them the opportunity to refuse a tenant based on prior history of evictions.

"I mean I do understand these people are coming in with more of a history than the norm....But I think if they were more honest about it and you know open maybe more landlords would be accepting of it." (LL12: 218-221).

Overall most landlords had the impression that the program was doing a good job despite the difficulties that they had encountered. Advantages were considered to outweigh disadvantages, since 9 of the 12 landlords were still renting to At Home/ Chez Soi participants and several would recommend participating in the project to other landlords.

"Oui, je le recommanderais a tout le monde même au propriétaire qui sont la uniquement pour faire de l'argent, parce que cette expérience de contribué à la communauté est importante." (LL8: 123-125)

D. Issues Regarding Sustainability and the Future of the Project

i. How the Sites Is Addressing Sustainability Concerns of Participants

The ending of the program has created some discomfort for both program participants and staff. However, program staff are providing support to try and alleviate these discomforts by being transparent and assuring participants that they will be supported.

Anxiety in Participants: Participants are sharing and being open about their concerns with program staff. Program staff detailed that the participants are worried that they will lose their housing once the program ends and potentially end up on the street. This has caused some program participants to have increased anxiety, panic attacks, and difficulties sleeping.

Transparency and Support: One of the main tactics to respond to participant concerns about sustainability has been truth and honesty. Participants have been informed that the ACT services will remain once the program has formally ended. In terms of housing, staff members are letting participants know that this issue has not been resolved yet, but they hope to have answers by the end of the summer. Despite the anxious feelings of participants, program staff and key informants commented that the program participants know they will receive support regardless of the status of the program. A key informant stated:

" Je pense, agit aussi en fonction de soulager que l'on fasse des choses, on est en train de mettre des choses en place pour ne pas les laisser tomber. Ça fait que tous ces éléments ensemble créé une petite sécurité, ou une moyenne sécurité pour certain, chaque individu interprète différemment." (KI1: 78-81)

Staff members are listening to participant concerns and welcome their comments. The staff is also putting measures in place and increasing their services to help participants cope with the uncertainty. One initiative that the program has started is the early planning of participant moves to more sustainable housing.

Participants Comfortable in Current Housing Situation: As mentioned above, there have been efforts made by the program to place some participants in more sustainable social housing offered by NB Housing. This would provide participants with housing not contingent upon the ending of the program. However, one key informant stated that some participants are hesitant to enter this new housing since they are happy and comfortable in their current housing situations. They like their landlords and would prefer not to move, even if the housing they currently have is not guaranteed.

ii. Sustainability Concerns and Strategies at Site Level

The main concerns about sustainability revolve around the uncertainty of housing for participants. This issue is being addressed through community partnerships, increasing participant independence, and support from the Site Coordinator.

Housing Uncertainty: Key informants and program staff all agreed that the loss of housing is the main concern in terms of sustainability. If this were to occur, it would be extremely detrimental to program participants. The loss of housing will place participants at risk

of losing the stability that they have achieved in the program. The program staff themselves also have anxiety about the possibility of this situation occurring.

Developing and Sustaining Partnerships: The program has thought of ways to address this housing uncertainty through the development of partnerships. One of the important partnerships the program can develop is with the Department of Social Development, since this is the department that handles housing in New Brunswick. It is thought that program participants could be transferred to housing programs offered by Social Development. One key informant also thought that the At Home/Chez Soi program could work within the system at Social Development and help program participants maintain their current housing.

Partnerships with other agencies and departments must also be created and sustained. A key informant stated that it is a matter of, *"how we fit in, how to complement what's already out there..."*. (KI3: 627)

Landlords: The importance of landlords to the sustainability of the program was stressed by several key informants. The program is trying to get one of their better landlords authorized with NB Housing so that the current tenants of the building could possibly stay once the program ends. In regards to this landlord, a key informant stated:

"Unfortunately, he is not currently an authorized NB Housing landlord. So we're trying to take some steps to make that happen. Because right now, he's got a list of half a dozen tenants that would be more than happy to stay with him and he'd be more than happy to make those units NB housing. But there's a lot of handcuffs and bureaucracy and red tape which you can imagine with NB Housing. There's just physically not enough units. You'd have to have those units be relinquished by another landlord in order for them to be passed onto another landlord." (KI4: 692-697)

The landlords themselves are concerned about the ending of the program because some will lose up to eight tenants in their buildings. The staff is addressing landlord concerns much in the same way as participant concerns in the sense that they are unsure what will happen to the housing but they are keeping landlords informed of the situation as it is evolving.

Support from the Site Coordinator: One of the key informants stated that the site coordinator tried to provide some normalcy amidst the fears of program termination. It was thought that the Coordinator wanted to demonstrate to the participants and the staff that the program is still running and should continue to run as if the program is not potentially ending. This included meeting regularly with the staff and ensuring that the program was still being implemented as it should be.

iii. Views about the Project Legacy and Lessons Learned

Legacy:

According to key informants and program staff, the program will leave many legacies within the greater Moncton area. These legacies include the employment program, the community collaborations, and the inclusion of peer support workers.

Employment program. Having the employment specialist and the new programs that were created as a result, were viewed as having an important impact on the community. The program has created meaningful partnerships within the community. As stated by one key informant, "*[le programme]* a *créé des partenariats dans la communauté, elle va chercher des subventions pour payer des opportunités d'emploi, pour créer de l'expérience pour nos participants."* (KI1: 363-364)

The program has also facilitated the education of potential employers on the various barriers that program participants face when entering the workforce. The employment specialist conducted several workshops for potential employers to discuss vocational challenges and barriers and how employers can help participants to overcome these challenges. Because of these endeavors, one focus group participant found that employers were able to work with the participants when problems arose as opposed to just dismissing them.

Community collaboration. Program participants have been encouraged to seek out resources in the community that extend beyond what is offered through the At Home/Chez Soi program. By doing so, new partnerships have been developed and the continuity of care has been further cemented. This collaboration can work both ways, as one key informant stated:

"Moi, je m'attends à ce que certains de nos groupes vont ouvrir la porte pour que d'autres gens viennent se joindre. Alors ça va encourager l'intégration communautaire de nos participants, ils vont faire des connaissances et il va y avoir de l'entraide entre les pairs." (KI1: 664-665)

By not limiting the program to only At Home / Chez Soi participants, the possibilities for collaboration are widened.

Peer support workers. The inclusion of peer support workers is a new endeavor for the program. At least five participants had received training to become peer support workers and they are going to be fully integrated as members of the support team. These participants are perceived by the program as being invaluable to both the team and other program participants as they will be able to relate to them on a level that other staff members could not.

Lessons Learned:

Key informants and focus group participants cited several opportunities for growth in the program and in their own personal development.

Substance use programming imperative. One key informant stated that the program could benefit from increased attention given to substance use. He or she felt that increased training on issues related to addictions would benefit all team members. The key informant also felt that better collaboration was required amongst the At Home / Chez Soi staff and addiction treatment services in the community. The key informant stated:

"J'aimerais aussi que l'on travaille plus près puis que l'on ait une meilleure collaboration avec nos services de traitement dépendance. Parce que le fait que l'on ne soit pas dans le même environnement, parce que nous autres on est plus en ville et eux autres sont plus à un autre point de la ville, l'on ne se croise pas physiquement régulièrement. L'on ne se

rencontre pas nécessairement pour nos réunions d'équipe. J'aimerais améliorer ce lien parce que je pense qu'eux autres on a une équipe d'expert, on a une personne. Je pense que si l'on pouvait collaborer avec cette équipe d'expert ça pourrait nous aider énormément." (KI1: 311-318)

Importance of Partnerships. As stressed throughout all of the key informant interviews and focus groups, establishing collaborations and partnerships is vital to program success. These partnerships spanned across municipal and provincial levels. New partnerships were continuously being sought, all to the benefit of program participants.

Having appropriate staff. Certain staff characteristics were listed as beneficial to the functioning of the program. One key informant stated that it was important to have staff members with backgrounds in mental health. It allowed for familiarity with the types of issues that program participants presented. A second key informant stressed that it was important for the staff members to create a positive atmosphere for participants and have dedication to their job. Furthermore, flexibility was important for staff members. As one focus group participant stated as an example of a dedicated and flexible staff member that a consulting psychiatrists is now planning to offer in-person services in the rural area.

Personal growth through involvement in program. One key informant discussed how he/she was able to learn more in this program than he/she thought he/she would ever learn in a lifetime. The key informant stated that:

"..it's been an incredible learning experience for me on a personal level. It's made me appreciate that there's a lot of mental illness in our community. There's a ton more homelessness than I would have ever imagined. I think the learning's are endless..." (KI4: 740-742)

Housing. Several valuable lessons were learned in terms of issues related to housing. One key informant stated that the program should enforce having the landlords accept the damage deposit, as opposed to paying for any damage caused by tenants. This often costs the program more than what the damage deposit was.

A second lesson learned was having a manageable number of housing placements per month. When the program initiated, they were housing up to eight people per month. This caused stress on the program and it was later determined that housing three or four people per month was much more manageable.

One focus group participant stated that sometimes the program needed to freeze a participant's rent subsidy in order to reengage them into the program. Although this was a drastic measure, it provided a means for the program to interact with participants where little contact was occurring.

IV. CONCLUSIONS

Overall, the findings of the second implementation evaluation highlight the continued successful implementation in large part of the At Home / Chez Soi program in Moncton and Southeastern New Brunswick. There was consensus among the members of the team conducting the second fidelity assessment, program managers, and program staff that the key ingredients expected of a Housing First program modeled on the *Pathways to Housing* program were present in the program. In particular, the program was viewed as implementing a program that assisted a large majority of its participants to establish stable housing and begin the process of recovery and community integration.

The second fidelity assessment indicated that the program 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 program. Notable program areas requiring further development included the integration of substance abuse treatment into services delivered by the ACT team, the use of individualized service planning focusing on recovery goals, and the addition of a peer specialist to the ACT team.

There was a shared perception among program managers and program staff about the program's theory of change. Specifically, they defined housing stability, service engagement, and improved social relationships as intermediate outcomes expected in the first year of participation. They defined longer-term outcomes as including achieving vocational success, improving personal independence, and reducing substance use. They also noted that participants showed a wide range of outcomes and required varying time in the program to achieve these outcomes.

Program managers and program staff perceived a readiness and motivation for change, an ability to set personal goals, and a higher level of functioning as important characteristics of individuals who benefited from Housing First services. In contrast, they identified a lack of readiness for change, a lack of engagement in the program, a lack of preparation for independent living, severe addictions, significant health problems, a history of violent behaviours, and social isolation as personal characteristics of individuals who had not benefited from the Housing First approach.

As a group, landlords expressed openness to renting to program participants. Many of the interviewed landlords had experienced problems with some participants they had as tenants; however, most remained open to renting to program participants. According to landlords, advantages to renting to At Home/Chez Soi participants included business reasons (i.e., rent was guaranteed, damage to apartment is covered) and personal reasons (i.e., opportunity to assist a marginalized group and assist the community). Perceived disadvantages included problematic behaviours and substance abuse of participants, which can lead to evictions, program participants causing damage to apartments, and attraction of outsiders to apartment.

Cross-Cutting Themes

Based on the evaluation findings, we identified the following cross-cutting themes and issues.

1. Overall, the second fidelity assessment conducted in January 2012 confirmed that the At Home / Chez Soi program is continuing to implement at a high level of fidelity a *Housing First* approach modeled on the *Pathways to Housing* approach. As well, the results of the second fidelity assessment reflect program development in the direction of improved fidelity in a number of areas particularly as it relates to the breadth of services offered to participants by the program. In general, the findings emerging from the second fidelity assessment corresponded with the perceptions of the program shared by key informants and program staff.
2. Despite this high program fidelity and successful program development and improvement, the second fidelity assessment identified a number of areas in which the program could be improved. Noteworthy program areas requiring further development included the integration of substance abuse treatment into the services offered by the ACT team, goal-planning with participants that would direct services to be more recovery-focused, and the addition of a trained peer specialist as a member of the ACT team. Key informants and program staff noted that the program had taken steps and was making progress in addressing these areas of deficit.
3. According to key informants and program staff, a large number of program participants are experiencing, many for the first time, a sense of stability in their lives. This stability has been the result of their acquisition of secure and comfortable housing, improvement in functioning, and support from the program. As a result of this stability, participants are achieving vocational goals, engaging in program activities, and developing new social relationships. Challenges do remain for some participants, particularly those with substance use issues and those with troubles adjusting to their new housing situations and experiencing social isolation.
4. Overall, a majority of interviewed landlords perceived the program positively despite having encountered difficulties with some participants as tenants. The main advantages that landlords cited were the economic aspects (i.e., guaranteed rent and responsible for damages) but they also cited altruistic benefits. Landlords reported having varying perceptions about the program's support of participants and the availability of program staff to respond to problems when they are encountered. Some landlords viewed the program as being very supportive in response to concerns or problems they encountered with participants as tenants. Other landlords reported a lack of responsiveness from the program when they reported problems encountered with program participants.
5. Program sustainability has created feelings of anxiety and uncertainty amongst participants and staff. Although participants have been informed that the ACT team will be sustained, the major concern is the continuation of housing subsidies. The program staff have been respectful of participants concerns around housing and are being transparent in communicating information about program sustainability. Although uncertainty exists, the Site Coordinator and staff have undertaken significant efforts to address the sustainability issues related to housing subsidies for program participants.

Lessons Learned

The following lessons learned refer to recommended actions intended to address the issues described in the previous section:

1. The second fidelity assessment, key informant interviews, and focus groups with program staff highlighted the continued need for the program to further develop program capacity in the area of addictions treatment. As suggested in the previous implementation report, it is recommended that the program work on implementing within ACT "integrated treatment strategies", an evidence-based approach that combines mental health and substance abuse services in one setting (SAMSHA, 2010a). As well, in line with developing program capacity in this area, it is recommended that training on motivational interviewing continue to be offered with staff and include supervision follow-up to this training that can assist staff to develop their skills in this area in working with participants.
2. Although the program was assessed as having improved its implementation of person-centered planning in the second fidelity assessment, it remains an under developed service area. Program managers and program staff are aware of the challenges encountered in this area and described having taken steps to address them. As recommended in the second fidelity assessment report, a service planning process should be taken to systematize the service planning process with participants so that it's feasible, individualized, and integrated into the services delivered to program participants. To assist the program to implement these recommendations, it may prove worthwhile for program staff to receive training and follow-up consultation on person-centered planning. As noted in the second fidelity assessment results, the service providers on the rural team have expertise in this area and have effectively implemented individualized goal-planning focusing on recovery with participants. As such, they are an important resource within the program from which to draw to address this issue.
3. The second fidelity assessment also identified the lack of a peer specialist position on the ACT team as an ongoing implementation deficit for the Moncton program. However, as described by the key informants and program staff, the program has made important progress since the fidelity assessment in January 2012 towards addressing this issue by identifying five potential peer specialists and providing them recently with training. It is recommended that the program now work towards developing the peer specialist role and integrating these trained peer specialists into the ACT team.
4. The second fidelity assessment highlighted the progress made by the program in the provision of vocational / educational support by having a vocational specialist as a member of the ACT team. This support has led to the development of a number of "in-house" vocational opportunities (e.g., moving and cleaning services) for program participants. As well, the vocational specialist was described by key informants and program staff as engaging in advocacy and public education in the community with the intent to create more of these opportunities in the competitive work force. As suggested in the first implementation report, it is recommended that the vocational specialist continue in the direction of implementing "individual placement and support (IPS) or supported employment" that includes supporting program participants to work in the regular job market (SAMSHA, 2010b). As noted in the first implementation report, the Montreal site of At Home / Chez Soi is implementing IPS with its program participants and it can continue to serve as a useful consultation resource for the vocational specialist on the Moncton team.

5. The addition of one 1/2 day of psychiatric consultation was assessed as a program improvement in the second fidelity assessment. Program managers and program staff noted the usefulness for the program to have access to psychiatric consultation. At the same time, they indicated that the amount of psychiatric consultation was insufficient relative to the needs of participants. As well, another psychiatrist was willing to see program participants but only at the hospital where she worked. Moreover, the fidelity assessment report suggested that home visits by psychiatrists would enhance the utility of their consultation services to the program. However, the amount of available consultation time by psychiatrists precluded them being able to do home visits. Therefore, it is recommended that the program work towards increasing the amount of psychiatric consultation available to the program and that the service be provided on site at the Manse.
6. As described in the second fidelity assessment report, the acquisition of a "transitional" apartment building has served as a way to engage and work more closely with participants who have experienced multiple evictions and difficulty living independently in their own place. The report noted that the introduction of transitional housing in a Housing First program can make it more difficulty to facilitate participant choice in term of their housing. In line with the direction suggested in the fidelity report, it is recommended that the program work with these individuals with the goal of assisting them to return to independent housing. It is also noted that it is possible that some of individuals in transitional housing will choose to live there on a more permanent basis and this choice should be respected. Given the complexity of integrating transitional housing into the program, it is recommended that a formative evaluation be conducted focusing on reviewing best practices regarding transitional housing in the mental health field, identifying the needs of the participants living in the program's transitional housing, and evaluating the extent transitional housing is responding to these needs.
7. Interviews with landlords suggest that the program has cultivated positive and committed relationships with a large proportion of them who are renting to program participants. At the same time, similar to the findings of the first implementation evaluation, landlord interviews identified a number of challenges that they had encountered. These challenges have included a lack of information about the program, difficulty contacting the program when encountering problems, and a perception that some participants are not receiving sufficient support. Given these challenges communicated by the landlords, it is recommended that the program continue to make efforts to educate and inform landlords about the program by continuing to hold regular meetings with them. These meetings can serve to provide information about program participants, harm reduction, recovery principles, and the Housing First approach. As well, they can provide an opportunity to discuss and troubleshoot problems encountered by landlords. It may be worthwhile to present to landlords at these meetings vignettes on program participants developed by the National Film Board. The model developed by Kloos, Zimmerman, Scrimenti, and Crusto (2002) for working with landlords and property managers can serve as a useful guide for this work. As well, it is recommended that the program develop a brief and common language information pamphlet on the program for landlords that include contact numbers of program staff that landlords can contact if necessary.

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APPENDIX I.C.1
PARTICIPANT OBSERVATION PROTOCOL

- Have two people take semi-verbatim notes of proceedings (after session, combine notes into one set of field notes)
    - *Note: it may be helpful to develop an identifying short form for each meeting participant (e.g. QA #1, #2 [for QA team members one, two, etc]; , LT #1 [local team member #1])*

- Explain purpose of participant observation to meeting participants as part of the mixed methods implementation/fidelity evaluation, we're conducting participant observation of this particular feedback session (and with the other teams) and we're taking field notes that will help us understand the reasons behind the fidelity ratings, and which will help the qualitative research team to prepare for the sessions that will be conducted with the teams and Site Coordinator in which we will further explore some of the issues that we're observing for today (as per below, we're looking at trouble spots and strengths, and getting a sense of the reasons for these, as well as any differences in perspective on them)

- In final field notes, make particular note of:
    - Fidelity items identified as trouble spots, areas of improvement or strengths
    - Perspectives regarding why particular fidelity items are viewed as trouble spots or strengths
    - Fidelity items where there is a discrepancy in perspective between QA fidelity team and site participants (or where there is a discrepancy in perspective amongst team members)
    - Reflections on other notable issues

- Provide copy of field notes to implementation evaluation focus group facilitator(s), and interviewer of Site Coordinator
- Facilitators and interviewers should also be familiar with contents of the written report provided by the fidelity visit team to the site

APPENDIX I.C.2
SITE COORDINATOR INTERVIEW GUIDE FOR LATER IMPLEMENTATION EVALUATION

Thank you for attending this interview. As you know, the purpose of this interview is for you to share your knowledge about key program components of the MHCC At Home/ Chez Soi project and their implementation. We believe that this is important in defining the key ingredients of this intervention, determining their fidelity, and understanding how Housing First impacts upon participants. The interview will take less than one hour.

Before we get started let's review the consent form. Then you can decide if you want to participate in the interview.

[Interviewer reviews the information letter and consent form, which can be adapted from the early qualitative evaluation of implementation, with the participant.]

What questions do you have before we begin?

[After questions have been asked and answered, the participant is asked to complete the consent form and give it to the interviewer.]

I am now going to start the audio recorder.

The purpose of today's interview is to focus on what has changed in the implementation of the MHCC At Home/Chez Soi programs over the past year since the first fidelity/implementation evaluation, to understand the reasons for ongoing and emerging implementation successes and challenges. Also, we would like to understand any discrepancies in perspective between the Quality Assurance (QA) team's ratings, and the team's own self-ratings (if those were done). Furthermore, we'd like to explore is what the project has learned about the theory of change of the Housing First program, in other words, what we're learning about the process of how the intervention does or does not have an impact on the lives of participants. A final issue that we want to talk with you about concerns the sustainability of the services for participants.

Fidelity Scale Questions

Note to interviewer: the term "trouble spot" as used below refers to a rating which is low (below 3 out of 4 on the fidelity scale), and "notable improvements" are issues where there has been a significant improvement in QA team fidelity ratings between first and second rounds. In preparation for the discussion for this first section of the interview, the interviewer should examine the participant observation field notes, available ratings from both the first and second fidelity visits, and, if necessary, work with the site to identify the issues that will be explored as trouble spots and notable strengths/improvements.

- Re: trouble spots (maintained from first round and/or emerging):

- What barriers are getting in the way of implementation? (probe and/or code for barriers related to structure, resources, relationships, strategy/process, etc.)
- How would you address these issues moving forward?

- Re: notable improvements from the first round:
  - to what do you attribute the improvement? (probe and/or code for facilitators related to structure, resources, relationships, strategy/process, etc.)

- Re: other notable strengths (maintained from the first round and/or emerging in the second round):
  - to what do you attribute this strength? (probe and/or code for facilitators related to structure, resources, relationships, strategy/process, etc.)

Issues Identified from First Implementation Evaluation/Fidelity Assessment

Note to interviewer: The issues listed below may already have emerged in the first section of questions. The interviewer should adjust the questions accordingly. The interviewer should also ask about any issues emerging during the participant observation session which haven't been discussed.

- Why, if at all, are there delays or barriers to housing some participants?
  - How can (or are) these delays be(ing) addressed moving forward?

- What are the difficulties or successes in obtaining the types of housing in the locations that participants want?
  - How can (or are) any challenges be addressed moving forward?

- What are the challenges or successes experienced in rehousing some participants?
  - How can (or are) any challenges be(ing) addressed moving forward?

- What are the challenges or successes with respect to the developing a coordinated working relationship between the housing and clinical teams?
  - How can (or are) any challenges be(ing) addressed moving forward?

- What have been the challenges or successes in involving program participants and people with lived experience in the operations and shaping of the service teams, and with research?
  - How can (or are) any challenges be addressed moving forward?

- What have been the challenges or successes with respect to staffing issues (probe re: leadership, cohesion, staff burnout/self-care, staff retention?)
  - How can any challenges be addressed moving forward?

- What other challenges or successes would you like to discuss? (e.g., issues identified from participant observation session, issues identified in the first round site implementation evaluation report, other issues arising)

- How can any challenges be addressed moving forward?

Questions about the Program's Theory of Change

- What changes or outcomes have been observed for participants during the first year of the program? What changes have been observed during the second year?

- What are the characteristics of participants who benefit most from Housing First? For those who benefit least from Housing First?

- What are the most important program ingredients or components for facilitating changes in recovery? For first year and second year? For different types of participants

- What has the project learned about the process of involvement of persons with lived experience and about its impact on the initiative?

Questions about the Sustainability and the Future of the Project

- How are the teams addressing the concerns of participants about the sustainability of the project? (probe: to what extent is this an issue? how are teams communicating to participants about this issue?)
- How do you see the project going forward in the future (probe: concerns/strategies re: sustainability, perspective on potential legacies of project on the surrounding mental health and housing systems and on strategies for achieving these)
- What have you learned about the impact (positive, negative or otherwise) on implementation of the organizational context surrounding the project (e.g. host service delivery agencies, health authorities, etc.) (probe re: leadership, climate/culture, goodness of fit, etc.)
- What are the main lessons that have been learned from this project?

Ending the Interview

Are there any other observations about the implementation of programs you haven't had a chance to mention that you would like to add before we finish?

As I bring this interview to a close I would like to know about your experiences (how you feel, what you are thinking) about having participated in this interview today/tonight.
Is there anything we could do to improve the interview?

I am now shutting off the audio recorder. What questions do you have of me?

APPENDIX I.C.3
KEY INFORMANT INTERVIEW GUIDE FOR LATER IMPLEMENTATION EVALUATION FOR MEMBERS OF THE QUALITY ASSURANCE FIDELITY TEAMS (to be done by national team)

Thank you for attending this interview. As you know, the purpose of this interview is for you to share your knowledge about key program components of the MHCC At Home/ Chez Soi project and their implementation. We believe that this is important in defining the key ingredients of this intervention and determining their fidelity. The interview will take less than one hour.

Before we get started let's review the consent form. Then you can decide if you want to participate in the interview.

[Interviewer reviews the information letter and consent form, which can be adapted from the early qualitative evaluation of implementation, with the participant.]

What questions do you have before we begin?

[After questions have been asked and answered, the participant is asked to complete the consent form and give it to the interviewer.]

I am now going to start the audio recorder.

The purpose of today's interview is to focus on what has changed in the implementation of the MHCC At Home/Chez Soi programs over the past year since the first fidelity/ implementation evaluation, to understand the reasons for ongoing and emerging implementation successes and challenges. Another issue we'd like to explore is what the project has learned about the program's theory of change, in other words, what we're learning about the process of how the intervention is impacting on the lives of participants. As part of this exploration, we'd like to understand your own experience, as an expert in Housing First implementation, or as someone with the national perspective on At Home/Chez Soi, about the Housing First logic model and theory of change. Finally, we want to know your thoughts about issues regarding the sustainability of the project.

Fidelity Scale Questions

Note to interviewer: the term "trouble spot" as used below refers to a rating which is low and there is agreement between Quality Assurance (QA) team fidelity rating and team self-rating, and "notable improvements" are issues where there has been a significant improvement in QA team fidelity ratings between first and second rounds. In preparation for the discussion for this first section of the interview, the interviewer should have a general sense of implementation strengths, improvements and trouble spots across the various sites.

- How would you characterize the experience for the sites and yourself of the fidelity site visits for this round compared with the first round?

- Speaking generally of all the sites, what are the common implementation trouble spots? (probe: issues remaining from first round? emerging in second round?):

  - What barriers are getting in the way of implementation? (probe and/or code: for barriers related to structure, resources, relationships, strategy/process, etc.)
  - How would you suggest that the project address these issues moving forward?

- Speaking generally of all the sites, what are the notable improvements in implementation from the first round?
  - to what do you attribute the improvement? (probe and/or code for facilitators related to structure, resources, relationships, strategy/process, etc.)

- Again, speaking generally of all the sites, what other notable implementation strengths have you observed? (probe: maintained from the first round and/or emerging in the second round)
  - to what do you attribute this strength? (probe and/or code for facilitators related to structure, resources, relationships, strategy/process, etc.)

- Are there any notable strengths specific to particular sites that the other sites could learn from? (Please describe)

Issues Identified from First Implementation Evaluation/Fidelity Assessment

Note to interviewer: The issues listed below may already have emerged in the first section of questions. The interviewer should adjust the questions accordingly. The interviewer should also ask about any issues emerging during the participant observation session which haven't been discussed.

- Why, if at all, are there delays or barriers to housing some consumers?
  - How do you suggest the project address these challenges moving forward?

- What are the difficulties or successes in obtaining the types of housing in the locations that consumers want?
  - How do you suggest the project address these challenges moving forward?

- What are the challenges or successes experienced in rehousing some consumers?
  - How do you suggest the project address these challenges moving forward?

- What have been the challenges or successes in involving program participants and people with lived experience in the operations and shaping of the service teams, and with research?
  - How do you suggest the project address these challenges moving forward?

- What are the challenges or successes with respect to the developing a coordinated working relationship between the housing and clinical teams?
  - How can (or are) any challenges be(ing) addressed moving forward?

- What have been the challenges or successes with respect to staffing issues (probe re: leadership, cohesion, staff burnout/self-care, staff retention)
  - How do you suggest the project address these challenges moving forward?

- What other challenges or successes would you like to discuss? (e.g., issues identified from participant observation session, issues identified in the first round site implementation evaluation report, other issues arising)
  - How do you suggest the project address these challenges moving forward?

Questions about the Housing First Theory of Change

- Thinking about the experience across all the At Home/Chez Soi sites, or about your experience with the Housing First model in general, what changes in outcomes do you expect to see for participants in the first year of the program? In the second year of the program?

- Thinking about the experience across all the At Home/Chez Soi sites, or about your experience with the Housing First model in general, what do you see as the characteristics of the participants who benefit the most from Housing First? What are the characteristics of those who benefit the least?

- Thinking about the experience across all the At Home/Chez Soi sites, or about your experience with the Housing First model in general, what do you see as the most important ingredients or program components for facilitating changes in recovery? For first year and second year? For different types of participants?

- Thinking about the experience across all the At Home/Chez Soi sites, or about your experience with the Housing First model in general, what have you learned about the process of involvement of persons with lived experience in Housing First and about its impact on Housing First programs?

Questions about the Sustainability and the Future of the Project

- What is your understanding of how the teams are addressing the concerns of participants about the sustainability of the project? (probe: to what extent is this an issue? how are teams communicating to participants about this issue?)
- How do you see the project going forward in the future (probe: concerns/strategies re: sustainability; perspective on potential legacies of project on the surrounding mental health and housing systems and on strategies for achieving these?)
- What have you learned about the impact (positive, negative or otherwise) on implementation of the organizational context surrounding the project (e.g., host service

delivery agencies, health authorities, etc.) (probe re: leadership, climate/ culture, goodness of fit, etc.)

- What are the main lessons that have been learned from this project?

Ending the Interview

Are there any other perceptions about the implementation of programs you haven't had a chance to mention that you would like to add before we finish up?

As I bring this interview to a close I would like to know about your experiences (how you feel, what you are thinking) about having participated in this interview today/tonight.
Is there anything we could do to improve the interview?

I am now shutting off the audio recorder.

What questions do you have of me?

APPENDIX I.C.4
FOCUS GROUP INTERVIEW GUIDE FOR LATER IMPLEMENTATION EVALUATION

Thank you for attending this interview. As you know, the purpose of this interview is for you to share your knowledge about key program components of the MHCC At Home/ Chez Soi project and their implementation. We believe that this is important in defining the key ingredients of this intervention and determining their fidelity. The interview will take less than one hour.

Before we get started let's review the consent form. Then you can decide if you want to participate in the interview.

[Interviewer reviews the information letter and consent form, which can be adapted from the early implementation evaluation, with the participant.]

What questions do you have before we begin?

[After questions have been asked and answered, the participant is asked to complete the consent form and give it to the interviewer.]

I am now going to start the audio recorder.

The purpose of today's interview is to focus on what has changed in the implementation of the MHCC At Home/Chez Soi programs over the past year since the first fidelity/ implementation evaluation, to understand the reasons for ongoing and emerging implementation successes and challenges. Also, we would like to understand any discrepancies in perspective between the Quality Assurance (QA) team's ratings, and the team's own self-ratings. A final issue we'd like to explore is what the project has learned about the the program's theory of change, in other words, what we're learning about the process of how the intervention is impacting on the lives of participants.

Fidelity Scale Questions

Note to facilitator: the term "trouble spot" as used below refers to a rating which is low and there is agreement between QA team fidelity rating and team self-rating, and "notable improvements" are issues where there has been a significant improvement in QA team fidelity ratings between first and second rounds. In preparation for the discussion for this first section of the focus group, the facilitator should examine the participant observation field notes, available ratings from both first and second rounds, and if necessary work with the teams to identify the issues that will be explored as trouble spots, notable strengths/improvements and discrepancies.

- Re: agreed upon trouble spots (maintained from first round and/or emerging):
  - What barriers are getting in the way of implementation? (probe and/or code for barriers related to structure, resources, relationships, strategy/process, etc.)
  - How would you address these issues moving forward?

- Re: notable improvements from the first round:
  - to what do you attribute the improvement? (probe and/or code for facilitators related to structure, resources, relationships, strategy/process, etc.)

- Re: other notable strengths (maintained from the first round and/or emerging in the second round):
  - to what do you attribute this strength? (probe and/or code for facilitators related to structure, resources, relationships, strategy/process, etc.)

Issues Identified from First Implementation Evaluation/Fidelity Assessment

Note to facilitator: The issues listed below may already have emerged in the first section of questions. The facilitator should adjust the questions accordingly. The facilitator should also ask about any issues emerging during the participant observation session which haven't been discussed.

- Why, if at all, are there delays or barriers to housing some consumers?
  - How can (or are) these delays be(ing) addressed moving forward?

- What are the difficulties or successes in obtaining the types of housing in the locations that consumers want?
  - How can (or are) any challenges be addressed moving forward?

- What are the challenges or successes experienced in rehousing some consumers?
  - How can (or are) any challenges be(ing) addressed moving forward?

- What are the challenges or successes with respect to the developing a coordinated working relationship between the housing and clinical teams?
  - How can (or are) any challenges be(ing) addressed moving forward?

- What have been the challenges or successes in involving program participants and people with lived experience in the operations and shaping of the service teams, and with research?
  - How can (or are) any challenges be addressed moving forward?

- What have been the challenges or successes with respect to staffing issues (probe re: leadership, cohesion, staff burnout/self-care, staff retention?)
  - How can any challenges be addressed moving forward?

- What other challenges or successes would you like to discuss? (e.g., issues identified from participant observation session, issues identified in the first round site implementation evaluation report, other issues arising)
  - How can any challenges be addressed moving forward?

Questions about the Housing First Theory of Change

- What changes or outcomes have been observed for participants during the first year of the program? What changes have been observed during the second year?

- What are the characteristics of participants who benefit most from Housing First? For those who benefit least from Housing First?

- What are the most important program ingredients or components for facilitating changes in recovery? For first year and second year? For different types of participants

- What has the project learned about the process of involvement of persons with lived experience and about its impact on the initiative?

Questions about the Sustainability and the Future of the Project

- How have the ACT and ICM teams addressed the concerns of participants about the sustainability of the project? (probe: to what extent is this an issue? how are teams communicating to participants about this issue?)
- How do you see the project going forward in the future (probe re: concerns/ strategies about sustainability and the perspective on potential legacies of project on the surrounding mental health and housing systems and on strategies for achieving these)
- What have you learned about the impact (positive, negative or otherwise) on implementation of the organizational context surrounding the project, e.g. host service delivery agencies, health authorities, etc. (probe re: leadership, climate/ culture, goodness of fit, etc.)
- What are the main lessons that have been learned from this project?

Ending the Interview

Are there any other perceptions about the implementation of programs you haven't had a chance to mention that you would like to add before we finish up?

As I bring this interview to a close I would like to know about your experiences (how you feel, what you are thinking) about having participated in this interview today/tonight.
Is there anything we could do to improve the interview?

I am now shutting off the audio recorder.

What questions do you have of me?

APPENDIX I.C.5
INFORMATION LETTERS AND CONSENT FORMS FOR LANDLORD/CARETAKER INTERVIEWS

Date
Dear ,

We are writing you as members of the research team from the University of Ottawa and the Université de Moncton that is conducting an evaluation of the At Home/Chez soi program currently being implemented in the Greater Moncton Area. The evaluation is part of a larger multi-city project sponsored by the Mental Health Commission of Canada.

We would like to invite you to participate in an interview with one of us as a landlord or property manager in this evaluation. In particular, we would be interested in hearing your experiences of the program and its participants to date. Your input will help us to understand the functioning of the At Home / Chez Soi program, specifically what is working well in the program and what aspects of it could be improved.

The interview will last 30 to 45 minutes and will be audio recorded. We will be phoning you the week of February 7th to see if you would be interested in participating and to answer any questions you may have. We will be conducting the in-person interviews during the week of February 20, 2011 at a time and location that is convenient for you.

Your participation will be confidential and only members of the research team involved in this particular study will have access to your data for analysis purposes. Study information will be kept in a secure location at the University of Ottawa. The results of the study may be published or presented at professional meetings, but the identity of individual participants will not be revealed. Please be aware that your participation in the study is completely voluntary. You do not have to participate if you do not want to. You are also free to withdraw at any time or decide not to answer any of the questions asked of you in the interview. Thank you for your time and we look forward to speaking with you.

Sincerely,

Tim Aubry, Ph.D., C.Psych.
Co-lead, Moncton site
At Home / Chezsoi
Director and Senior Researcher,
Centre for Research on Educational
and Community Services
University of Ottawa

Jimmy Bourque, Ph.D.
Co-Lead, Moncton Site
At Home / Chez soi
Directeur,
Centre de recherche de
développement en éducation
Université de Moncton

Date
Insérer l'adresse

Chère/cher ,

Nous vous écrivons en temps que membres de l'équipe de recherche de l'Université d'Ottawa et de l'Université de Moncton qui effectue actuellement une évaluation du programme At Home/Chez soi dans la région du grand Moncton. L'évaluation fait partie d'un large projet multi-site subventionné par la commission sur la santé mentale du Canada.

Nous aimerions vous inviter à participer à une entrevue en tant que propriétaire ou gérant de propriété. En particulier, nous aimerions nous entretenir avec vous à propos de vos expériences avec le programme et ses participants. Votre contribution nous aidera à comprendre le fonctionnement du programme At Home / Chez soi, plus spécifiquement ce qui fonctionne bien et ce qui pourrait être amélioré.

L'entrevue durera de 30 à 45 minutes et sera enregistrée par un système audio. Nous vous téléphonerons dans la semaine du 7 février pour connaitre votre intérêt à participer et nous répondrons à vos questions. Les entrevues en personne auront lieu dans la semaine du 20 février à un endroit et un temps qui vous conviennent.

Votre participation sera confidentielle et seulement les membres de l'équipe de recherche impliqués dans cet aspect de l'étude auront accès à vos données. Les informations de l'étude seront conservées dans un endroit sûr à l'université d'Ottawa. Les résultats de l'étude seront peut-être publiés ou présentés à des conférences professionnelles, mais votre identité individuelle en tant que participant ne sera pas révélée.

Votre participation à cette étude est complètement volontaire. Vous n'avez pas à participer si vous ne le souhaitez pas. Vous êtes également libre de vous retirer en tout temps ou de décider de ne pas répondre à certaines des questions qui vous sont adressées durant l'entrevue.

Merci pour votre temps et nous espérons vous rencontrer sous peu.

Sincèrement,

Tim Aubry, Ph.D., C.Psych.
Co directeur, site de Moncton
At Home / Chezsoi
Directeur et chercheur sénior,
Centre de recherche sur l'éducation
et les services communautaires
Université d'Ottawa

Jimmy Bourque, Ph.D.
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Study Funding
The study has received funding from the Mental Health Commission of Canada.

Introduction
Before you agree to participate in this research study, it is important that you read and understand the following explanation of the study. It describes the purpose, procedures, benefits, and risks associated with the study. If you have questions after you read through this form, ask your interviewer. You should not sign this form until you are sure you understand everything on it.

Purpose of the Research
The goal of this study is to compare the effectiveness of new services that include housing and support to regular services available in Moncton. For the study, we will be following a group of 200 people living in Moncton for a two-year period. Of this group,

100 people will be receiving the new services and the other 100 people will be receiving the regular services. The study is part of a national study in which different kinds of new services relating to housing and support are being examined in five different cities, including Moncton. The other cities are Montreal, Toronto, Winnipeg, and Vancouver.

WHAT IS MY ROLE IN THIS STUDY?

For this evaluation, we are asking you to participate in one in-person or telephone interview that will last approximately 30-45 minutes. The purpose of this interview is for you to share your knowledge about your experiences with the Housing First services and clients in the MHCC Homelessness and Mental Health project in Moncton. You will be asked a series of questions in the interview. The interview will be audio-recorded and the interviewer will also be taking detailed notes.

WHY SHOULD I PARTICIPATE?

We believe that your opinions are important because the findings of this research will inform other jurisdictions who are interested in planning similar initiatives. *We have also interviewed other people who played a key role in the implementation of the Housing First Program.*

ARE THERE ANY RISKS TO MY PARTICIPATING?

Participating in this research involves few risks. There is a possibility that some questions may make you uncomfortable, but please remember that you are not obligated to answer any question. Your answers will be kept private and confidential by the researchers. The main benefit of participation is the knowledge that you are contributing to the development of services for people with mental health problems experiencing homelessness. Please remember that you may end your participation at any time.

DO I HAVE TO PARTICIPATE?

No. You do not have to participate. Participating in this evaluation is ***voluntary***. You may refuse to answer any question. You may stop the interview at any time.

HOW WILL INFORMATION COLLECTED IN THE STUDY BE HANDLED?

Only members of the research team will have access to the data. No identifying names of persons or organizations will appear in any reports arising from this evaluation. As an additional precaution, consent forms will be stored separately from collected data.

To protect your confidentiality, all of the information you provide in the interview will be transcribed and then transferred to a secure computer server located in Ontario, on which the data from the five cities participating in the studies will be stored.

We will keep locally in our research office in Moncton your name and other identifying information on a separate form. Identifying information you give us will be kept on paper in a locked filing cabinet in the research office and only authorized research staff will have access to the information. Data bases created for the study and all records containing personal information whether in electronic or paper format such as consent forms will be destroyed 10 years after the completion of the study.

In reporting results, your answers will be combined with those of all the other people we will interview. If something you say in the interview is used, it will be reported in such a way that no one will be able to identify you. We will maintain the privacy of your answers by never using your name in reports written based on this evaluation.

WHO DO I CONTACT IF I HAVE QUESTIONS ABOUT MY RIGHTS AS A PARTICIPANT IN THIS STUDY

If you have any questions about your rights as a research participant, you may contact the Ethics Office or the Chair of the Social Sciences Research Ethics Board at the University of Ottawa at (613) 562-5841 or the Chair of the Research Ethics Board at the Université de Moncton at (506) 858-4310.

INFORMED CONSENT

I know that I can refuse to answer questions and may withdraw my consent at any time.

I have received a copy of this form for my own records.

I hereby consent to participate in the study.

_____ _____
(Signature of participant) (Date)

_____ _____
(Printed name of participant) (Date)

_____ _____
(Signature of Researcher) (Date)

APPENDIX I.C.6
Interview Protocol
Moncton Site Landlords/Caretakers

Thank you for agreeing to be interviewed. As you know, the purpose of this interview is for you to share your opinions about the At Home / Chez soi program and its clients. We hope that the findings of interviews with landlords/caretakers like yourself will help us improve the services that are being offered in this program. The interview will take 30-45 minutes.

Before we get started let's review the consent form. Then you can decide if you want to participate in the interview.

[Interviewer reviews the information letter and consent form with the participant.]

Do you have any questions about the interview before we begin?
[After questions have been asked and answered, the participant is asked to complete the consent form and give it to the interviewer.]

I am now going to start the tape recorder.

The purpose of today's interview is to focus on your perceptions of the At Home / Chez soi program and the tenants from the program to whom you are renting a unit.

1. How many of your tenants are participants from At Home/Chez Soi?

Probe: How long have each of them been your tenants?

2. In your view, what qualities make for a good tenant? To what extent have the At Home/Chez Soi tenants met or failed to meet these expectations?

3. As a landlord/property manager, have you had to treat tenants from the At Home / Chez soi program differently than your other tenants?

Probe: (If yes) In what ways have you treated them differently? Why?

4. What have been the advantages of renting units to At Home / Chez soi tenants?

5. What have been the disadvantages to renting units to At Home / Chez soi tenants?

6. If there has been a problem with a tenant from the At Home / Chez soi program, have staff from this program been helpful?

Probe: (If yes) Who did you contact? Have they been helpful?

Probe: (If no) How were they not helpful? How could they have responded differently?

7. Have you had to evict any participants from the At Home / Chez soi program from one of your units?

Probe: (If yes) How many? (percent of your At Home tenants? Can you compare this figure with your typical eviction rate?) For what reasons, have you evicted these tenants? Could anything have been done to prevent the eviction?

8. Do you have suggestions for improving communication between the At Home / Chez soi program and landlords?

9. What factors do you see as being the most significant in terms of participants having successful tenancies?

10.Have you rented to participants from other similar programs in the past? In what ways is the At Home/Chez Soi project similar or different?

11. To what extent has the At Home/Chez Soi program met or failed to meet your expectations?

12. Would you recommend participating in At Home Chez Soi to other landlords/property managers?

13. Are you interested in being involved in the program by serving on the Advisory Committee or in some other way?

14. Is there anything else you would like to add or say about the At Home / Chez soi program?

Thank you for your participation in this interview. It is greatly appreciated Your feedback along with that of others will be shared with the program staff of At Home / Chez soi.