Implementation Evaluation of a Housing First Program in a Small Canadian City

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ABSTRACT

This paper describes the implementation of Housing First in a small Canadian city. Given that the majority of Housing First research has been conducted in large American cities, providing a Canadian context in a small city contributes significant insights for similarly sized areas. The main objectives were to determine the adaptations made to the Housing First model and the contextual realities that affected implementation. Data were collected from two sources: (a) a fidelity assessment by an external team of experts; and (b) key informant interviews and focus groups with program staff and consumers. Results demonstrate that Housing First can be successfully implemented in a small city but with certain constraints and adaptations, notably more limited consumer choice of housing, challenges related to consumer access to transportation, and adaptations to program staffing. Implications for practice are discussed.

Keywords: Housing First, small city, implementation evaluation, fidelity assessment, program design

RÉSUMÉ

Le travail décrit l'implantation d'un programme de logement d'abord (*Housing First*) dans une petite ville canadienne. Une étude dans ce contexte contribue des nouvelles connaissances car la majorité des études sur le logement d'abord ont été complétées dans des grandes villes américaines. Les objectifs principaux de la recherche étaient de documenter les adaptations faites au modèle logement d'abord et les facteurs qui affectaient son implantation. Les données ont été collectionnées de deux sources: (a) Une évaluation de fidélité par une équipe d'experts externes au programme; et (b) des entrevues et groupes de discussion avec le

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personnel et les usagères et usagers affiliés au programme. Les résultats démontrent que le logement d'abord peut être implanté dans une petite ville mais avec certaines limites et adaptations, notamment des limites reliées aux choix des logements par les usagères et usagers, des défis associés avec l'accès au transport, et des adaptations reliés à la composition de l'équipe des intervenants et intervenantes. Les implications des résultats pour l'implantation des programmes de logement d'abord sont discutées.

Mots clés : Logement d'abord, petite ville, implantation, évaluation de fidélité, développement de programme

The Housing First (HF) model of rapidly housing homeless individuals with severe and persistent mental illness without any pre-conditions has emerged as a promising approach to addressing chronic homelessness. Much of this promise is founded upon the research outcomes of the *Pathways to Housing* HF program in New York City (Greenwood, Schaefer-McDaniel, Winkel, & Tsemberis, 2005; Greenwood, Stefanic, & Tsemberis, 2013; Stefancic & Tsemberis, 2007; Tsemberis, 1999; Tsemberis, 2010; Tsemberis & Eisenberg, 2000; Tsemberis, Gulcur, & Nakae, 2004). The program utilizes a HF model, also termed "supported housing" (Carling, 1995), which is guided by five central principles (Tabol, Drebing, & Rosenheck, 2010). These principles are: (a) normal housing (scattered-site, not congregate living); (b) flexible and portable supports; (c) separation of housing and services; (d) consumer choice; and (e) immediate placement into housing. The support services are provided through either Assertive Community Treatment (ACT) or Intensive Case Management (ICM), both evidence-based community mental health approaches (Nelson, Aubry, & LaFrance, 2007). HF consumers are also provided with a rent supplement and do not pay more than 30% of their income on housing costs.

Research studies on the Pathways program have found that participants remain stably housed despite having a chronic history of homelessness (Greenwood et al., 2005; Pearson, Montgomery, & Locke, 2009; Stefancic & Tsemberis, 2007; Tsemberis & Eisenberg, 2000). Upon comparisons to "treatment as usual" approaches, a review of HF research articles (Aubry, Ecker, & Jetté, 2014; Nelson et al., 2007) has demonstrated superior outcomes for HF participants in terms of improving housing stability and reducing homelessness, hospitalizations, and incarceration.

Despite these favourable outcomes, several contextual realities must be considered. Firstly, the majority of studies conducted on HF have occurred in the United States. This could limit the external validity of the previous research on HF given the differences in the health and social service systems of the United States and other Western countries such as Canada. A major difference in the delivery of healthcare between the United States and Canada is the universal coverage provided in Canada including in the area of mental health services; however, it is acknowledged that problems related to access of care exist in Canada. Since healthcare is universally covered in Canada, Canadian HF teams may have different priorities for assisting consumers with their healthcare needs than would American HF teams (e.g., not having to consider insurance plans).

A second contextual consideration is the size of cities in which these studies were conducted.[1] Homelessness is often viewed as a social problem that occurs predominantly in large urban areas. Census data in the United States support this view as over nine-tenths of all homeless individuals live in metropolitan areas with only 6% of individuals scattered across nonmetropolitan areas (Lee & Price-Spratlen, 2004).

Within these metropolitan areas approximately 20% of homeless individuals are located in densely settled suburbs. Unfortunately, comparable data on the homeless population do not exist in Canada.

Although fewer in number, it is prudent to recognize the potentially unique characteristics that homeless individuals living in smaller cities possess. Kales, Barone, Bixler, Miljkovic, and Kales (1995) investigated the prevalence of mental illness and substance abuse in homeless shelters located in lower-density population areas in Pennsylvania. They found that approximately 6% of participants met criteria for psychosis and approximately 25% met criteria for a diagnosis of major affective disorder. The authors stated that the rates of major affective disorder are similar to what is reported in the general literature on homeless individuals, regardless of the population size of the study locale; however, rates of psychosis were notably lower than what is reported in large urban settings. For example, within a homeless population assessed by a psychiatric outreach team in a large urban city in Ontario, 15% of individuals had symptoms of psychosis other than schizophrenia (Dealberto, Middlebro, & Farrell, 2011). Thus, homeless individuals in smaller cities may have different mental health needs than individuals in larger cities.

Two studies investigated homelessness in different-sized cities among specific populations—veterans and women. Gordon, Haas, Luther, Hilton, and Goldstein (2010) sampled homeless veterans who accessed veteran facilities in the U.S. They found that veterans residing in nonmetropolitan areas were more likely than homeless veterans living in metropolitan areas to have a medical problem, a psychological problem, or a history of past or current alcohol dependence. Nonmetropolitan homeless veterans were also more likely to have a history of employment or to receive public financial support. In terms of housing status, metropolitan homeless veterans were more likely to be homeless for over a year or longer.

Whitzman (2006) conducted focus groups with homeless female clients of health services in four different locales: downtown Toronto, a suburb of Toronto, a medium-sized city, and a small town. Several women in the non-downtown Toronto focus groups (i.e., suburb, medium-sized city, small town) spoke of concealing their homeless status to others, partly because exposing themselves as being homeless would be harmful to their children. Examples of harm included their children being stigmatized or picked on at school because of their housing status, or the fear of the child welfare system becoming involved and removing their children.

These results demonstrate that homeless individuals living in less densely populated areas share some similarities with homeless individuals living in densely populated areas, but also present unique, contextual-based issues. As a result, providing HF services in an area with a smaller population may require special considerations. In one of the only studies conducted in a small city, Stefancic and Tsemberis (2007) investigated the delivery of HF services in a suburban county. Two types of HF were provided. The first was the Pathways model, described earlier, and the second was the "consortium" model, which involved treatment and housing agencies with no prior experience operating HF. Their results varied depending on the HF model. For participants provided with the Pathways model of HF, close to 80% had retained their housing after a four-year period. The "consortium" model experienced slightly poorer results, as close to 60% of participants in this model retained their housing after four years.

Stefancic and Tsemberis (2007) attribute these differential outcomes to the implementation of a HF approach in a new locale and within existing agencies. With regards to the locale, the authors state that three challenges can exist. The first involves having sufficient resources to create a full-scale Assertive Community

Treatment team. The second involves the distance and travel involved in providing services. The third barrier involves the often limited housing stock available. Fewer housing options results in limited consumer choice, which is one of the major tenets of HF.

The current study describes the implementation of a HF program in a small, Canadian city in its early stage of development. It is a mixed-methods design, involving a fidelity assessment of HF services and a formative evaluation involving program stakeholders, program staff, and consumers of the program. This is the first such fidelity assessment and formative evaluation of a HF program conducted in a small city in Canada. It therefore provides a unique and valuable contribution to the literature, as there is very little published on the success of implementing the HF model (Nelson et al., 2007), particularly in a context other than a large city. The only published paper to date providing a detailed description of the implementation of HF focuses on the findings of fidelity assessments, and formative evaluations, across five locations including the locale of the current study (Nelson et al., 2014).

The purpose of the fidelity assessment was to assess how the HF program in Moncton was adhering to the principles and components of the HF model (Tsemberis & Asmussen, 1999). The purpose of the formative evaluation was to qualitatively assess how the program was functioning. Of particular importance for the current study were several questions guiding the study that focused on contextual issues related to delivering HF in small cities. These included: (a) What are adaptations made to a HF program in the context of a small city? (b) What are contextual factors affecting the implementation of a HF program in a small city?

The At Home / Chez Soi Project

The results from this paper are taken from the fidelity assessment and formative evaluation of the At Home / Chez Soi Demonstration Project located in the Greater Moncton Region and South-East New Brunswick. The focus of the present paper is on the findings as they apply to Moncton. A separate paper is being written for this special issue and will describe the application of HF in the adjoining rural region of South-East New Brunswick.

The Moncton site is one of five projects initiated across Canada by the Mental Health Commission of Canada (MHCC).[2] In addition to Moncton, the At Home / Chez Soi Demonstration Project is being implemented in Montreal, Toronto, Winnipeg, and Vancouver. It is part of a 5-year research demonstration project that tested HF programs in different regions of Canada and that intended to assist people with a severe mental illness who have experienced homelessness, typically of a chronic nature. The design of the research involved a randomized controlled trial that compared the effectiveness of the HF model to a "treatment as usual approach" as delivered in each of the sites. A detailed description of the methods of the study is presented in Goering et al. (2011).

Site Description

The catchment area for the Moncton site comprised the tri-city Greater Moncton Region made up of Moncton, Dieppe, and Riverview; and the adjoining rural region of South-East New Brunswick, notably the counties of Kent and Westmorland. The population of the Greater Moncton Region is approximately 130,000

(City of Moncton, 2011). The vacancy rate in the region at the time of the current study varied over the course of the study from 3.8 (2009) to 6.7 (2012) percent (Canada Mortgage and Housing Corporation, 2013).

A needs assessment of housing problems present in the Greater Moncton Region identified approximately 15,500 individuals as critically being in need of housing. These individuals were identified as living in substandard rental units. Additionally they were experiencing significant financial demands related to covering their basic shelter and living costs with approximately 50% of income dedicated to shelter/housing costs. Based on existing sources of data, the number of homeless individuals who used emergency shelters in the Greater Moncton area in 2012 was 720 (Greater Moncton Homelessness Steering Committee, 2013).

Description of HF Program

In line with the HF programs developed for the At Home / Chez Soi Demonstration Project in all the participating sites, the HF program in Moncton used a supported housing approach based on the *Pathways to Housing* model originally developed in New York City (Greenwood et al., 2005; Tsemberis, 1999; Tsemberis, 2010; Tsemberis & Eisenberg, 2000; Tsemberis et al., 2004). Specifically, the intervention included a combination of Assertive Community Treatment (ACT) and subsidized housing in the private rental market.

The staff of the ACT team was set at 10 full-time equivalent (FTE) positions representing a mix of mental health disciplines that includes a nurse practitioner, psychiatric nurses, occupational health therapist, home economist, social worker, human resources counsellor, physician Clinical Director, and consulting psychiatrists. The team also added in the later stages of the project peer support workers who were individuals with lived experience of mental illness and addictions. Additionally there was an Administrative Manager for the team with training in psychiatric rehabilitation who was available to deliver clinical services to consumers as needed. The ACT team provided clinical services for 100 consumers in the Greater Moncton area. The ACT services operated with a consumer to staff ratio of 10:1, which is the standard for ACT, allowing for the delivery of intensive services.

The ACT team worked closely with a Housing Coordinator to help consumers quickly find housing that they choose and could afford with the rent supplement. Although the Housing Coordinator was not a formal member of the ACT team, they worked closely together to assist consumers with selecting housing, negotiating with landlords, moving into housing, and adapting to the new living situation as a tenant. The Housing Coordinator was also involved in assisting consumers with mediating with landlords when housing problems were encountered.

METHODOLOGY

Fidelity Assessment

The data for the first fidelity assessment, which is reported in this paper, were collected over two days in August 2010, approximately 10 months after the program began. The Pathways HF Fidelity Scale was used to assess program fidelity (Nelson et al., 2014). A five-member fidelity assessment team, including clinicians, consumer representatives, housing experts, researchers who were external to the site, and experts in the Pathways HF model, travelled to Moncton to conduct the assessment in-person. The composition and

creation of the fidelity assessment tool for the At Home / Chez Soi project has been described in detail by Nelson et al. (2014).

The tool consists of five different domains with a total of 38 items. These domains include:

- Housing Choice and Structure: program participants choose the location and other features of their housing (6 items)
- Separation of Housing and Services: program participants are not required to demonstrate housing readiness to gain access to housing units (6 items)
- Service Philosophy: program participants choose the type, sequence, and intensity of services on an ongoing basis (10 items)
- Service Array: program offers services to help participants maintain housing, such as offering assistance with neighbourhood orientation, landlord relations, budgeting, and shopping (8 items)
- Program Structure: program prioritizes enrollment for individuals who experience multiple obstacles to housing stability (8 items).

Each item is scored out of 4, with higher scores indicating better program fidelity. The scale has demonstrated acceptable to good internal consistency for each of the domains (Housing Choice and Structure: $\alpha = 0.80$; Separation of Housing and Services: $\alpha = 0.83$; Service Philosophy: $\alpha = 0.92$; Service Array: $\alpha = 0.71$; and Program Structure: n/a) (Stefancic, Tsemberis, Messeri, Drake, & Goering, 2013).

For conducting the fidelity assessment, the team members observed the daily ACT team meeting at which cases were reviewed, conducted interviews with some program staff, and facilitated focus groups with other program staff and consumers. Based on the information collected, each member of the fidelity assessment team scored the program on 37 of the 38 standards. Because psychiatrists only recently joined the ACT team as consultants at the time of the fidelity assessment, the item on the availability of psychiatric consultation in the Service Array domain was not assessed. Subsequent to individual rating of standards, scores were discussed collectively and differences were conciliated until a consensus score on each of the items was reached.

Formative Evaluation

The data for the formative evaluation were collected over a 5-month period from October 2010 to March 2011, at which time the program was 12 to 18 months old and reached its caseload capacity in February 2011.

Sample

Staff members associated with the demonstration project at the Moncton site, and a select group of consumers of the program, were invited to participate in either a focus group (i.e., ACT team members and consumers), or a key informant interview (i.e., other project staff).

Two focus groups ($n = 6$; $n = 3$) were conducted with members of the ACT team. Given the bilingual make-up of the ACT team, one of the focus groups was conducted in English ($n = 6$) and the other was conducted in French ($n = 3$). A total of nine key informant interviews were completed with the physician

Clinical Director of the ACT team, Administrative Manager of the ACT team, Housing Coordinator, consulting psychiatrists (n = 2), personnel from the agency coordinating housing (n = 2), one of the co-lead researchers, and the Coordinator of the demonstration project site.

Two focus groups (n = 5; n = 4) were conducted with consumers living in Moncton. A group of select program participants were invited to take part in the focus groups with the intent of having diverse representation from the standpoint of sex, age, primary language, and level of functioning. Additionally, selected consumers were judged as being able to participate in a comfortable manner with peers in a focus group.

Procedure

Common protocols for focus group and key informant protocols for interviews developed by national research team members and site team members for the formative evaluations of the five At Home / Chez Soi sites were used (Aubry, Cherner, Ecker, Jetté, & Philander, 2011). Focus groups with ACT staff were approximately 90 minutes in duration. Focus groups with program participants were also approximately 90 minutes in duration. Interviews were 30–45 minutes in duration. All focus groups and key informant interviews were audio-recorded and transcribed.

Data Analysis

The data were analyzed using a modified *grounded theory* approach (Berg, 1989; Patton, 1990; Ryan & Bernard, 2000) to identify emergent themes in relation to the questions that guided the implementation evaluation. This approach was utilized because although there was a set of evaluation questions to answer, the interviews and focus groups involved semi-structured questions. Thus, a grounded theory approach allowed the research team to ensure that all themes were grounded in the data provided by the participants. The data analysis involved all members of the research team and took place in stages. The first step required the open coding of data which involved reading each transcript line-by-line and developing codes for segments of the data. *In vivo* coding was used as often as possible, since initial codes should accurately reflect the words and views of the participants (Charmaz, 2006). A constant comparison technique was utilized throughout the open coding stage, which involves the comparison of developed codes within each individual transcript and then across all transcripts. Disconfirming data were also continuously sought throughout this process in order to increase the validity of the developed codes (Maxwell, 1998). Following open coding, focused coding was completed. This type of coding allows for data to be synthesized and placed into meaningful themes and subthemes.

FIDELITY ASSESSMENT RESULTS

Overall, the Moncton site was assessed as having a high fidelity to the HF model. The unweighted average total score across 37 standards was 3.5 out of 4. As shown in Table 1, the program was assessed with scores of 3 or higher on 32 of 37 standards (86%). Of these standards, 21 out of 35 (60%) were judged to be at full implementation. The site scored particularly well on four of the five domains: Housing Choice and Structure (3.75); Separation of Housing and Services (3.90); Service Philosophy (3.50); and Program Structure (3.50). The only domain to have relatively lower scores was the Service Array domain (2.85).

Table 1

Fidelity Assessment Domain Means and Scores of Individual Items

Fidelity Domain	Domain Mean/Standard Score (Out of 4)
Housing Choice and Structure	3.75
Housing choice	3.5
Housing availability	3.0
Permanent housing tenure	4.0
Affordable housing	4.0
Integrated housing	4.0
Privacy	4.0
Separation of Housing and Services	3.9
No housing readiness	4.0
No program contingencies of tenancy	4.0
Standard tenant agreement	4.0
Commitment to re-house	4.0
Services continue through housing loss	4.0
Off-site services	3.5
Mobile services	3.5
Service Philosophy	3.5
Service choice	4.0
No Requirements for Participation in Psychiatric Treatment	4.0
No Requirements for Participation in Substance Use Treatment	4.0
Harm reduction approach	4.0
Motivational interviewing	2.0
Assertive engagement	3.0
Absence of coercion	4.0
Person-centred planning	2.0
Interventions Target a Broad Range of Life Goals	4.0
Participant Self-Determination and Independence	4.0
Service Array	2.85
Housing support	4.0
Psychiatric services	n/a
Substance abuse treatment	2.0
Employment and educational services	3.0
Nursing/medical services	3.0
Social integration	3.0
24-hour coverage	3.0

... continued

Table 1
(Continued)

Fidelity Domain	Domain Mean/Standard Score (Out of 4)
Involved in In-patient Treatment	2.0
Program Structure	3.5
Priority Enrollment for Individuals with Obstacles with Housing Stability	4.0
Contact with participants	4.0
Low participant/staff ratio	4.0
Team approach	4.0
Frequent meetings	4.0
Weekly meeting/case review	3.0
Peer specialist on staff	3.0
Participant representation in program	2.0

Issues noted in the fidelity assessment in the Housing Choice and Structure domain included the presence of a tight landlord network and a limited housing stock resulting in fewer scattered-site placements and clustering of apartments in certain blocks. The sharing of information among landlords was thought to potentially restrict the amount of choice consumers have in where they would like to live. Landlords were described as being aware that participants were part of the program and were inquiring as to consumers' prior histories with other landlords in the city. Areas identified as needing improvement in the Service Philosophy domain were the program staff's knowledge and abilities related to motivational interviewing, and the extent to which person-centred service planning had been implemented.

Related to the Service Array domain, the assessment identified the need for program staff to further develop skills in substance use counselling (i.e., stages of change, motivational interviewing, treatment interventions) and integrated dual disorder treatment (IDDT). The assessment also found that there was a gap with coordination of psychiatric care both in the community and when a participant was hospitalized. The program has just recently hired two psychiatrists who will provide consultation to the team. It is expected that their involvement will address the coordination issues since they have links to the local hospitals.

Finally, the fidelity assessment indicated that program consumers had limited opportunities to provide feedback and have input into program development and improvement.

IMPLEMENTATION EVALUATION RESULTS

Contextual Factors Affecting the Implementation of a HF Program in a Small City

Contextual influences on the implementation of the At Home / Chez Soi program at the Moncton site included factors related to: (a) the size of the community; (b) nature of homelessness in the community; (c) participants in the program; and (d) available community resources.

Size of the community. Key informants and program staff indicated that the small size of the community impacted the program and consumers in several ways. Staff noted that an advantage of the small size of the community was that they were already aware of services in the community available to program participants. As stated by one of the staff members, "We just started to plug into the community instead of trying to recreate [services]." Furthermore, the staff were able to be in regular contact with these outside agencies and develop relationships.

Several key informants noted that the small size of the community facilitated the spread of information about the program to other professionals, the general public, and potential participants. This spread of information occurred informally, often through word of mouth, which allowed for information to travel quickly. One key informant stated that Moncton "has always been a small city with a huge knowledge-sharing within the community. We used that to our advantage in terms of getting the program up and running. So we're able to disseminate information fairly easily."

However, key informants and program staff also viewed the small size of the community as a potential disadvantage, particularly for relationships with landlords. A key informant noted that "every landlord knows every other landlord." For example, in some cases, landlords shared information about difficult consumers in the network of landlords and it made it more difficult to house those individuals. The small size of the community also contributed to landlords sharing information about their experiences with the program, leading them, for instance, to negotiate for similar compensation related to repairs of property damage.

The landlord issue is an important one as key informants and focus group participants noted that landlords were one of the critical ingredients of the HF program in Moncton. One of the key informants identified a critical partnership the program had with a community agency as aiding in the development of good relationships with the participating landlords. This agency had extensive previous experience and connections in the private sector, something which the HF program in Moncton did not necessarily have.

Working with landlords was sometimes challenging, as one focus group participant stated that it was a "delicate dance." The majority of landlords were described as supportive, but it was acknowledged through several of the interviews with key informants that landlords scrutinized consumers more closely than they would scrutinize their other tenants. Focus group participants stated that there were attempts to educate the landlords, but some were still quick to judge the consumers. In contrast, one staff member recounted an interaction with a landlord regarding one consumer's late rent payments. The staff member explained the consumer's circumstances and upon hearing it, the landlord offered some alternative for the consumer to resolve the situation. Thus, landlord interactions involved both challenging and positive interactions.

Similarly, the small size of the community impacted relationships among consumers. A key informant thought that consumers were more likely to be in contact with other consumers of the program and share their experiences. Although this sharing can serve an important function for a consumer's recovery, a key informant emphasized the importance of the program for providing equitable kinds of services to consumers, and sending consistent messages to the consumers. It was feared that some consumers may feel like differential treatment was provided to other consumers, as stated by one key informant:

> The fact that, here in Moncton, if something is done with one participant, we have to be very aware that the lines of communication here are pretty tight. The uniqueness about our site is that we have to always be conscious that the messages we're sending are very similar.

Nature of homelessness. The lack of visible homelessness in Moncton was perceived as a contextual factor having some impact on the delivery of services. Staff members thought that the larger cities involved in the At Home / Chez Soi project were largely recruiting street-based samples into their programs, whereas Moncton did not have a visible homeless population. Due to this lack of visibility, some staff members thought that it was more difficult to determine the needs of their clients. For example, the lack of street-based homeless individuals in Moncton indicated that there was a larger population of individuals that could be considered the *hidden homeless*. A staff member believed that this group of hidden homeless presented with needs that were different from street-based individuals. This became an issue for outreach services since these individuals were more difficult to locate compared to the visible homeless population living on the street. A key informant further explained that the definitional criteria for homelessness were different from that of the other participating cities in At Home / Chez Soi: "One example they used was someone who had no fixed address, but was living from a friend's house to a friend's house, living on their couch and that [was described as homeless]."

Program participants. The key informants stated that the program was serving consumers that present a wide range of need levels. As a result, some individuals functioned at a much higher level than expected. In particular, some consumers were functioning fairly independently, demonstrated by their working full-time and their experiencing little difficulty in securing stable housing. Other cities in the At Home / Chez Soi project may not have had such high functioning consumers. For example, one key informant stated that "I've seen other Assertive Community Treatment teams have other stricter definitions of like chronic, persistent mental illness than you would see here."

Lack of public transportation. Program staff, key informants, and consumers identified the limited nature of public transportation as a significant issue that affects the mobility of consumers. The bus system in Moncton was perceived as particularly inadequate. Some consumers were viewed as being socially isolated due to this lack of transportation. A focus group participant stated:

> I don't think that [transportation] was considered as important as it actually is in the life of consumers because the main reason why they miss appointments or are not able to go to the food bank is because they don't have a drive. (translated from French)

Staff members also stated that providing transportation for program participants constituted a large portion of their work. The staff members were often asked by their participants for transportation to appointments and resources (e.g., food banks). As a result, some staff members expressed that they spent the majority of their time in their vehicles. It was noted that the provincial government was planning to implement a program for volunteers to drive program participants to the services that they require. The creation of this service would potentially ease the burden for transportation requests on the At Home / Chez Soi staff as demonstrated by the following quote from a key informant:

> Right now up to 50% of [staff] time is taken up driving them to doctors' appointments and driving them to different places, and some of them would be ready to go by themselves. Some of them that need us to go we would still be there. . . . It would give staff an enormous amount of time to do the work that they need to do with the tenant, whereas right now our time in transportation is a problem in urban as well as rural.

Lack of choice for consumers. Although a central value of the HF philosophy involves "choice" when it comes to their housing, all stakeholder groups noted that consumers in Moncton experienced limitations to

the amount of choice they experienced. This lack of choice often involved the type and location of housing and how to furnish it. It was stated that there was a limited selection of housing because of the relatively small size of the rental market in a small city. Moreover, if consumers wanted to live in certain areas or in the downtown core, there were few options. The furnishings were pre-selected and bought in bulk, so consumers did not choose much of their furniture. As stated by one key informant:

> Sometimes when you are trying to house people and you don't always have time to find the right place. I know that it's supposed to be choice, but in a small market you don't have that choice. You're limited by affordability, by whether the landlord is on board with the program, [and by where] participants want to live. So it's not always choice first. Sometimes it's practical.

And as stated by another key informant:

> I think you may get housed here more quickly than in other places. You don't have as much choice [in Moncton]. That's the absolute truth. You don't have the choice. If people want to live downtown, there are very few buildings downtown. Very few. Some are too expensive and some are not where we would like to put people, so that's part of the difference.

However, one key informant stated that offering consumer choice was a departure from the usual consumer processes followed by the provincial system, particularly with regards to housing where housing units, once they became available, were simply assigned to individuals without any choice.

Adaptations Made to an HF Program in the Context of a Small City

There were a small number of local adaptations to the Moncton At Home / Chez Soi project in the areas of services and staffing described in the focus groups and interviews. These adaptations centred on service delivery and staffing.

Service delivery.

Criteria for participation in the At Home / Chez Soi program. A key informant noted that the consumers in the Moncton project were eligible for participation in the program if they presented with either moderate or high level of needs. This was in contrast to the other cities of the At Home / Chez Soi program, where consumers needed to be assessed as having a high level of need to receive HF with ACT services. The Moncton site's inclusion of individuals with moderate needs was initiated for practical reasons, so as to ensure that there were a sufficient number of participants for the ACT team to reach service capacity (e.g., a ratio of ten clients for every ACT team member). As a result, participants' diagnoses in Moncton were more likely to be depression and/or Attention Deficit Hyperactivity Disorder (ADHD), rather than psychotic disorders.

Intensity of services. Due to the inclusion of individuals with varying levels of functioning and need, key informants noted that service delivery had to be adapted. In particular, the intensity of services was regulated in line with consumers' needs, with less intensive services being provided to moderate need participants. The varying intensity of services in Moncton was thought to differ from the larger cities involved in the At Home / Chez Soi program in how they provided ACT services. This sentiment is illustrated by the following quote from a key informant:

> It's having an approach that is more flexible where the same team that is an ACT team adjusts the intensity of services in line with level of need. Instead of having two teams who are treating the levels of need differently, the same team treats all levels of need. So there is a flexibility built in to the services. (translated from French)

Staffing.

Hours of staffing. A key informant explained that the ACT team staff in Moncton are not available 24 hours a day, which deviates from the HF model and the model of the other participating cities in the At Home / Chez Soi program. Instead consumers have access to a mobile crisis team and a crisis intervention centre located in Moncton from 10 p.m. to 8 a.m. The key informant stated that this modification was necessary due to the lack of staff available for around-the-clock coverage. There was also a concern that the staff would be unwilling to be on-call overnight, since this was not a requirement in the previous unionized positions of some staff members. For example, one key informant stated that the 24 hours a day, 7 days a week model was not common within a city the size of Moncton: "There was a sense that if we made a psychologist do on-call that we'd never get a psychologist. Same with some of the other positions. Like a social worker that's been in the system, not doing call for 18 years, is not going to want to move to that."

Psychiatric services. A key informant explained that the staffing of the ACT team differed from the traditional ACT model. The Clinical Director for the team was a family physician rather than a psychiatrist. The Clinical Director was partly chosen due to her extensive experience working with a homeless population. Although psychiatrists were recently added to the team, they served an auxiliary function and were available for consultations with the ACT team.

Staff composition. Program staff considered some of the professions on the multidisciplinary team as unique features for an ACT team. In particular, unique positions on the team included a home economist and a psychologist. Another innovation was related to the staffing of the ACT team positions. Staff were employed under the provincial government of New Brunswick in the Department of Health. This arrangement was viewed as essential for ensuring the sustainability of the program.

DISCUSSION

The results from the fidelity assessment and formative evaluation demonstrate that the implementation of a HF program in a small city is feasible; however, certain adaptations may be required. Adaptations stemmed from the characteristics of the consumers and contextual issues. The contextual issues parallel what Stefancic and Tsemberis (2007) report on the challenges of providing HF services in suburban settings. In particular, the availability of housing stock, and the travel involved for consumers accessing services, were difficulties identified by all of the stakeholder groups.

The fidelity assessment indicated that the program in Moncton has been implemented at a high level of fidelity. The results were similar to the other sites involved in the At Home / Chez Soi project (Nelson et al., 2014) which signifies that the implementation of HF in Moncton reflected some of the same strengths and faced some of the same challenges as much larger cities. It provides strong evidence that similarly sized small cities in Canada can provide HF services in their communities. The fidelity assessment data also indicate

that despite some local adaptations, HF principles can still be readily adhered to (Nelson et al., 2014). The biggest challenge identified in the fidelity assessment was equipping the program staff with the necessary abilities to integrate addiction treatment into the mental health services they are delivering.

Consumers of the program were described as presenting either medium or high levels of need. As a result, the majority of consumers had diagnoses of depression and/or anxiety disorders, rather than psychotic disorders. This lower rate of psychosis is similar to what Kales et al. (1995) found in their sample of emergency shelter users in a low-density city. Due to these differential diagnosis rates, the intensity of services provided to consumers varied and was individualized to respond to differential needs. This individualized service delivery plan is one of the several tenets of the HF model (Tsemberis & Asmussen, 1999). It may be particularly important for HF teams in smaller cities to recognize the varying complexities that each consumer will bring, since some consumers will not require intensive services. HF teams in smaller cities should therefore ensure that there are team members that can engage these higher functioning consumers in recovery-based areas such as education and employment.

The diverse profiles of each consumer also highlight the utility of applying HF to varying homeless populations. Despite HF being originally intended for street-based homeless individuals with severe and persistent mental illness (Tsemberis, 1999), results from the current study indicate that it can be successfully implemented with individuals with less intense housing and mental health needs. There is little research on HF that includes individuals without severe mental health issues. As a result, findings from this study aid in the generalizability of HF to other homeless populations. Further studies should be conducted on similarly sized cities.

In terms of contextual issues, Stefancic and Tsemberis (2007) state that participant choice in housing is often limited in non-metropolitan settings. Study participants confirmed this, as it was acknowledged that consumers cannot always live where they would like to. Although the vacancy rate in Moncton was relatively high at the time of the study (> 4%), there appeared to be at times limited options available in desired areas because of the small size of the city. The availability of affordable housing was an issue found within the other sites of the At Home / Chez Soi project (Nelson et al., 2014), indicating that inadequate housing markets are universal issues affecting the implementation of HF in both small and large cities.

Housing choice was also limited by the availability of supportive landlords from which to rent in the case where certain individuals had encountered problems in previous housing. Focus group participants, key informants, and the results from the fidelity assessment all stated that one of the disadvantages of operating HF in a small city was the knowledge-sharing about HF tenants that occurs among landlords. Landlords were thought to share information about troublesome consumers with one another and this may have resulted in certain consumers having greater difficulty in finding appropriate housing within the city. It was noted that attempts were made to educate the landlords on mental health and homelessness issues, but not all landlords were receptive. Despite the critical importance of landlords as partners for HF programs, the role of landlords in HF has not received much research attention to date. Only one study (Kloos, Zimmerman, Scrimenti, & Crusto, 2002) has investigated the subject and it demonstrated that engagement efforts with landlords promoted active problem-solving efforts among program staff and consumers. Further research on the perspective of this key stakeholder group for HF programs is needed.

Stefancic and Tsemberis (2007) also note that it is important to include a public relations and education campaign for community members when introducing HF to non-metropolitan areas. Interestingly, the program staff, key informants, and program consumers did not mention the need for these types of actions in Moncton. Instead, program staff stated that it was easy to transfer information about the program to the community. This ease in transmission was attributed to the smaller size of the city where information about a new program entailing a different approach can be quickly disseminated throughout the community.

On the fidelity scale, although the program did not receive a perfect score for housing choice, it did receive a perfect score for service choice. The consumers were able to choose, modify, or refuse services, and set their own goals. Service choice was respected by program staff, as they recognized that a varying intensity of services will need to be provided depending upon the client. The importance of service choice could also be linked to the availability of external—and familiar—services to the consumers. This comprehensive model of service delivery could be unique to small cities. Instead of having multiple agencies offering the same services, as is often the case in large cities, Moncton had only a handful of service agencies from to which to reach out. As a result, they were familiar with these agencies, and could foster and develop relationships.

Distance and travel times were regularly listed as concerns for study participants. This is congruent with literature on individuals accessing health and mental health services in smaller communities (e.g., Beardsley, Wish, Bonanno Fitzelle, O'Grady, & Arria, 2003; Fortney, Booth, Blow, Bunn, & Loveland Cook, 1995; Whitzman, 2006). Staff members noted that a substantial amount of their time was spent transporting consumers to appointments. This was due to the relatively large area that the program encompasses, combined with the lack of decent public transportation often found in a small city. Consumers felt that the lack of accessible transportation contributed to their feelings of social isolation. Social isolation has been a concern for HF consumers (Yanos, Barrow, & Tsemberis, 2004). The reliance on program staff for transportation may limit the consumers' development of autonomy; however, this was not discussed within the interviews and focus groups.

One way to mitigate the transportation issues is to provide subsidized transit tokens or shuttle services to consumers (Beardsley et al., 2003). The provision of a shuttle service, run by volunteers and organized by the provincial government, was something that the current program was hoping to develop. This innovation would reduce staff travelling commitments and help consumers to independently manage their appointments.

A further limitation that HF programs in non-metropolitan settings contend with involves properly staffing the ACT team (Stefancic & Tsemberis, 2007). Program staff and key informants in the current study listed some staffing variants, but also some innovations. Deviating from the ACT model, the program did not provide 24-hour services. Additionally, the clinical lead of the ACT team was not a psychiatrist, but psychiatrists were available for consultation. The program was able to include a home economist and a psychologist within the team. One way the Moncton HF program was able to compensate for service provision deficiencies was to access existing services in the community; this was also common among other sites of the At Home / Chez Soi project (Nelson et al., 2014). Accessing outside services is in-line with what Stefancic and Tsemberis (2007) note as one of the potential variations to the HF model for smaller communities.

Despite the few shortcomings of the program, a comprehensive set of services was provided to consumers. This may be largely due to the dedicated funding that was provided for the demonstration project,

and the partnership developed with the provincial government. Establishing relationships with government agencies, departments, and community organizations was also crucial among the other four sites of the At Home / Chez Soi project (Nelson et al., 2014). Partnerships are quite important for smaller municipalities, since they may lack the financial resources of larger metropolitan centres.

In summary, this study has demonstrated that HF services can be effectively implemented in smaller communities. To ensure successful implementation, similarly sized cities should focus on developing and fostering relationships with existing community agencies so as to support the unique differences and profiles of potential consumers. The main obstacles uncovered in the study include limited housing choice, adequate staffing, and transportation. Despite a relatively high vacancy rate in Moncton, consumers did not want to always live where there was housing available (e.g., outside of the downtown core). Therefore, program staff need to focus their efforts on developing a strong and varied housing stock which allows consumers some choice in where they would like to live, as well as nurturing relationships with landlords. The staffing composition and hours of availability may need to deviate from that of typical HF models, but providing choice in services can still be readily implemented. Lastly, it is expected that transportation issues will be present, so options such as shuttle services should be developed. In being mindful of these strengths and challenges, small cities can equip themselves with the necessary ingredients to implement HF services.

NOTES

1. Definitions of population size differ and are worthy of discussion. Statistics Canada (2014) provides definitions for three types of urban areas: (a) small population centres, with a population between 1,000 and 29,999; (b) medium population centres, with a population of between 30,000 and 99,999; and (c) large urban population centres, consisting of populations of 100,000 and over. The research literature does not use one specific definition when describing the size of city populations. Some researchers use urban, suburban, and rural classification schemes, while others use the terms metropolitan and nonmetropolitan. Within the context of the current study, the term "small city" is used. Although Greater Moncton, made up of the tri-cities of Moncton, Dieppe, and Riverview, with a population of approximately 130,000 (City of Moncton, 2011), would be classified as a large urban population centre by Statistics Canada, it is considerably smaller than other urban areas in Canada, for example: Toronto Metropolitan area with 5.91 million, Montreal Metropolitan area with 3.95 million, Vancouver Metropolitan area with 2.46 million, and Winnipeg Metropolitan area with 778,000 (Statistics Canada, 2013). Therefore, the authors believe it is justified to consider Moncton a small city.
2. For a description of the planning and development of the At Home / Chez Soi project please see Macnaughton, Nelson, and Goering (2013).

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