Mental Health Commission of Canada

Commission de la santé mentale du Canada

Planning and Proposal Development for the Mental Health Commission of Canada's At Home/Chez Soi Project:

Cross-Site Report

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CROSS-SITE REPORT

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KEY MESSAGES

This report documents the planning and proposal development phase of the At Home/Chez Soi initiative. It also provides a cross-site summary and synthesis of individual site reports, and a qualitative analysis of key themes that relate to a number of relationships that were integral to developing the proposals.

With respect to the *national/site relationship*, the initial national plan was viewed by sites as presenting a tremendous opportunity to change practice and policy. The plan was also generally seen as allowing necessary adaptations to local context. However, it was not always clear which aspects of the strategy were negotiable, and the complexity and tight timelines of the planning process created some challenges.

Initial tensions regarding transparency of leadership selection tended to dissipate as the project moved towards implementation. Creating a cooperative proposal development process and hiring a Site Coordinator helped sites bring multiple stakeholders into the planning process quickly. In terms of *within site relationships*, the project was seen as an opportunity for collaboration and mutual learning within and among stakeholder groups. The challenge was to bridge multiple perspectives into a common approach, and to "make space" for less recognized players. What was particularly important here was selecting leaders with a commitment to inclusion and with credibility across the project's multiple spheres or cultures (research, service delivery, community engagement).

Bringing in disenfranchised communities (people with lived experience of homelessness and mental illness, Aboriginal communities, people from various ethno-cultural and linguistic backgrounds) was another key aspect of the proposal development process. Engagement worked best in situations where groups were ready to step forward, and where the project made a conscious effort to make space. The challenge here was to meet high expectations for ownership within tight time frames and the context of a research design that required a certain amount of standardization across sites.

There were several cross-cutting themes and lessons regarding the planning and proposal development phase.[1] The challenges of *integrating multiple cultures* into a single project suggest the importance of taking explicit steps to acknowledge and normalize differences. Similarly, some ongoing work is required to ensure that different parties arrive at *consistent expectations about what level of collaboration* is desired or possible in the context of a randomized controlled trial (RCT), and to ensure that opportunities are not missed.

Another lesson is the importance of *drawing in the right partners* (i.e., those who are skilled and committed to being inclusive and possess credibility across spheres); the importance of building in a position (the Site Coordinator) to work across spheres was evident here.

The penultimate lesson is the paramount importance of *working with a shared underlying vision*, as was suggested by the Housing First approach itself. Though a shared vision is important, the report also shows the *evolution of a shared commitment to the project's goals*, which include helping people who have experienced homelessness and mental illness improve their lives.

[1] Themes are identified in italics.

EXECUTIVE SUMMARY

This report documents the planning and proposal development phase of the *At Home/Chez Soi* initiative. Each of the initiative's five sites developed a report which documents and interprets the events in their respective cities. The current report provides a cross-site summary and synthesis of this material. It also provides a qualitative analysis of key themes that relate to a number of relationships that were integral to developing the proposals. These relationships include: national/site relations; within-site stakeholder relationships; and the relationship between each site as a whole and the disenfranchised groups that it sought to involve in the project (i.e., people with lived experience of homelessness and mental illness or PWLE; Aboriginal people and agencies; and people and agencies from various ethno-cultural backgrounds).

National/Site Relations

Opportunities and challenges. The national project was initially seen as a tremendous opportunity by each of the sites. In general, the strategy brought forward by the national team was seen as a well-resourced, innovative approach for addressing a serious social problem. The sites also saw the project as an opportunity to bring disenfranchised groups or less recognized players (e.g., housing/homelessness NGOs, landlords) into the mental health system to address homelessness in a coordinated way. The Housing First model was widely supported and the research came to be seen as necessary for influencing policy in the longer term. The challenge entailed bringing a number of stakeholders to the table in relatively short order to develop a locally relevant proposal for carrying out a complex strategy within an often complicated local terrain. Meeting the high expectations for control over the project by local players was also a challenge, given the short timelines and the reality that a randomized controlled trial (RCT) required a certain degree of standardization. There were also some concerns that research would dominate the service delivery aspect of the project, and specific concerns about whether the research would be disruptive to locally valued alternatives.

What worked well and what worked less well. In terms of what worked with respect to national/site relations, some site reports mentioned that the strategy of having each site develop a common proposal (as opposed to having a competitive process) enabled stakeholders to quickly forge relationships and develop a plan. Key informants from across the sites also suggested that the national team showed flexibility around the budgeting process that enabled them to develop proposals that responded to local conditions (e.g., allowing them to secure housing subsidies that responded to local rental markets). In general, the strategy of having a third arm (an intervention condition tailored to local conditions and needs) allowed sites to develop a model that responded to homelessness as it manifested itself within the local context. Specific instances of local/national negotiations also exhibited a helpful flexibility, for instance allowing adaptations that addressed the different realities of homelessness in smaller centres. The strategy of having a Site Coordinator helped facilitate these national/site negotiations in most sites.

While the "one proposal strategy" showed positive results, it also came with some drawbacks, leading to confusion and tensions about leadership selection decisions, although these dissipated once the project moved towards its implementation phase. Another challenge was that the flexibility in budgeting and program design identified above was not a unanimous experience across the sites. Sites did not always understand which aspects of the model were negotiable and which were not. Aspects of the approach were considered to be unclear by some. For instance, the Intensive Case Management (ICM)/moderate needs condition was perceived as vague, both with respect to the nature of the support model, and in terms of the reasons for its inclusion in the study. This suggested a need for clearer communication between the national and site teams about the nature of the research and the intervention(s) and about where opportunities existed for making adaptations.

Within-Site Relations

Opportunities and challenges. The site reports identified a number of strengths and opportunities that facilitated within-site relationships. In most sites, there were potential partners (research, service delivery, etc.) who had relevant and complementary expertise, and thus the project was perceived as an opportunity for collaboration and mutual learning. In some cases, there were previous positive working relationships that could be drawn upon. In terms of challenges, in some cases there were few obvious local partners ready to step forward initially. When capacity did exist, there may have been a previous history of competition or power differentials that had to be circumvented (e.g., between housing NGOs and the formal mental health system). Sites also needed to develop a process for defining project roles and leadership. A final challenge was the differences in perspective or ways of working, both within and between the various "worlds" (research, service delivery, communities), that constituted the project.

What worked well and what worked less well. In terms of strategies that worked, one common theme was the value of the Site Coordinator, both in terms of making space for the right partners to be involved and of helping bridge their various perspectives. The project was also able to find natural allies who could bring potential partners to the table and help them work together. In some cases, the sites were able to develop a helpful process for defining project leadership. In cases where this was more informal, what worked was when the leader who emerged was credible and inclusive of others who needed to be brought in. Most of the site reports mentioned that the Housing First model itself provided a bridging philosophy, and that a shared commitment to the people being helped by the project also emerged, particularly when the site turned its attention towards the implementation phase. Challenges emerged, particularly when the arena of interests within the site was particularly complex, and thus hard to navigate within short timelines. Some sites found it difficult to arrive at a clear workable process for deciding on leadership. While agreement about the Housing First philosophy generally helped bridge a potential "clash of cultures," there was disagreement about the model's merits within two sites. Finally, difficulties with finding an appropriate balance between service and research occurred within most sites.

Engaging Disenfranchised Communities

Opportunities and challenges. The opportunity to engage disenfranchised communities was facilitated by Request for Application (RFA) principles that placed a priority on working in partnership with PWLE. The initial RFA also placed a priority on working in a way that was sensitive to ethno-cultural diversity, to the needs of Aboriginal communities, and in general to communities that had been historically disenfranchised. In addition to this overall framework, at some of the sites there were potential partners that were ready to assume a role in the project. Challenges manifested themselves, especially where sites did not have the organizational infrastructure to facilitate consumer involvement. Challenges were also the result of historical relationships of mistrust or exploitation experienced by disenfranchised communities, which led to some initial cynicism.

What worked well and what worked less well. Engaging disenfranchised communities worked better in contexts where these groups were organized and visible (e.g., involvement of PWLE in Toronto). There were also specific examples where the project made conscious efforts to make space to bring disenfranchised groups into the project (e.g., in Winnipeg, hiring an Aboriginal Co-Site Coordinator, and basing the project in an Aboriginal health clinic, rather than in the formal mental health system). The time pressures (and realities of the research design) mentioned above also hindered opportunities for bringing disenfranchised communities into the project in a way that the groups initially expected. In retrospect, the project could have benefitted from clearer communication about where the opportunities for involvement did or did not exist, and more clarity about how that involvement would meaningfully impact the project.

Cross-Cutting Themes and Lessons

The challenges of *integrating multiple cultures* into a single project suggest the importance of taking explicit steps to acknowledge and normalize differences. Similarly, some work may need to be done to ensure that different parties arrive at *consistent expectations about what level of collaboration* is desired or possible in the context of an RCT design, and to ensure that opportunities are not missed. Another lesson is the importance of *drawing in the right partners* (i.e., those who are skilled and committed to being inclusive, and possess credibility across spheres); the importance of building in a position (the Site Coordinator) to work across spheres was evident here. The penultimate lesson is the paramount importance of *working with a shared underlying vision*, as was suggested by the Housing First approach itself. Though a shared vision is important, the report also shows the importance of the *evolution of a shared commitment to the project*.

ACKNOWLEDGEMENTS

This cross-site report is based on the reports from qualitative researchers from the five sites. We want to acknowledge and thank these members of our Qualitative Research Team for their thorough work in putting together the individual site reports and for their help in planning and conceptualizing this research. The five site reports are:

The At Home/Chez Soi Project: A Review of the Proposal Development and Planning Phase in Vancouver, BC (September, 2010) by Michelle Patterson, Diane Schmidt, and Denise Zabkiewicz, Faculty of Health Sciences, Simon Fraser University.

Report on Proposal Development at the Winnipeg Site: The Mental Health Commission of Canada's At Home/Chez Soi Project (September, 2010) by Michael Dudley with the assistance of Fereshteh Moradzadeh, Institute of Urban Studies, University of Winnipeg.

At Home/Chez Soi Project Planning and Proposal Development Toronto Site Report (November, 2010) by Maritt Kirst, Erin Christine Plenert, Deborah Wise Harris, Bonnie Kirsh, Stephen Hwang, Patricia O'Campo, and Vicky Stergiopoulos, Centre for Inner City Health, St. Michael's Hospital.

Projet Chez Soi Montréal – Projet de recherche et de démonstration sur la santé mentale et l'itinérance: Rapport d'évaluation de la planification et du développement du projet (été 2008 – automne 2009) (July, 2010) by Marie-Josée Fleury, Catherine Vallée, Roch Hurtubise, and Guy Grenier.

Rapport de recherche: Phase I – Planification et développement du projet Chez-soi/At Home Moncton et volet rural (September, 2010) by Charles Gaucher, Linsay Flowers, Natasha Prévost, and Wiebke Tinney.

The five site reports can be accessed on the website of the Mental Health Commission of Canada: http://www.mentalhealthcommission.ca/English/Pages/homelessness.aspx

Thanks also to each of the sites and to Jayne Barker for reviewing and providing feedback on an earlier draft of this report.

INTRODUCTION

This report presents the overall findings emanating from the planning and proposal development phase of the At Home/Chez Soi project.[2] This pan-Canadian project is funded by the Mental Health Commission of Canada (MHCC).[3] It is a five-year research demonstration project exploring ways to help the growing number of people who are homeless and have a mental illness. It builds on existing evidence and knowledge and applies it in Canadian settings to learn about what housing, service, and system interventions can best help people across Canada who are living with mental health issues and are homeless. The At Home/Chez Soi project is being implemented in five cities across Canada: Moncton, Montréal, Toronto, Winnipeg, and Vancouver. A more detailed description of the five sites is provided in Appendix 1.

This report focuses on the planning and proposal development phase of the study that spanned from the time the sites first heard about the project, up until the time of the formal launch of the project in October 2009. In October 2008, the National Team, which consisted of the Project Lead, the Research Lead, and members of the National Research Team of the At Home/Chez Soi, released a Request for Applications (RFA) to become one of the sites for this project. While the five communities were pre-selected, the particular partners who would offer the services and do the research were not. The terms of the RFA were that At Home/Chez Soi was to be a randomized controlled trial (RCT) of Housing First (Tsemberis, Gulcur, & Nakae, 2004) versus Treatment as Usual (TAU). Nested within each of these two experimental conditions were two groups of participants: those with high needs, who were to be served with Assertive Community Treatment (ACT) in the Housing First condition, and those with moderate needs, who were to be served with Intensive Case Management (ICM) in the Housing First condition. Additionally, sites had the option of developing a "third arm," or an intervention condition that was tailor-made to local conditions and needs. More information on the principles of Housing First can be found in Appendix 2.

The purpose of this report is to understand the story of how the five communities mobilized during the planning phase of this research demonstration project to develop a project and research proposal. The overall focus is to examine how the planning and proposal development process unfolded. The primary questions that we addressed were:

(1) What were the opportunities and challenges that the sites faced in the planning and proposal development process?

(2) What worked well and what worked less well for sites in the planning and proposal development process?

(3) What lessons were learned from the planning and proposal development process?

[2] The origins of the At Home/Chez Soi project and the selection of the five demonstration sites are detailed in the Qualitative Research Team's report Conception of the Mental Health Commission of Canada's At Home/Chez Soi Project (Macnaughton, Nelson, Piat, Eckerle Curwood, & Egalite, 2010).

[3] The MHCC is a national not-for-profit organization that was established to focus national attention on mental health. While it is funded by the federal government, it operates at arm's length from it. The work of the MHCC is currently focused on a number of key initiatives, including At Home/Chez Soi, as well as the development of a mental health strategy for Canada, efforts to end stigma and discrimination faced by Canadians with mental health issues, and the development of a knowledge exchange centre.

BRIEF METHODOLOGY[4]

RESEARCH APPROACH

Given the exploratory nature of this phase of the research, qualitative methods were used (Padgett, 1998). Moreover, we adopted a social constructionist approach to the research (Guba & Lincoln, 2005). That is, we do not suggest that the findings reported here reflect any singular "reality" or "truth" about such a reality; rather, we present findings that reflect the multiple constructions or experiences of people at the five sites who played a role in planning the At Home/Chez Soi project. One limitation of this report is that it focuses exclusively on the experiences and perspectives of the five sites in planning and proposal development and does not include the experiences and perspectives of the National Team members, who played a major role in working with the sites during this period. Because of their unique perspective, members of the National Team could have provided an additional insight into the planning and proposal development process.

SAMPLING AND SAMPLE

Sampling was purposeful: individuals who were identified as having played a key role in developing the proposal were selected and interviewed individually as key informants. Individuals involved in the planning, but to a lesser degree than the key informants, were interviewed in focus groups. In all, 75 key informant interviews and 10 focus groups with 56 participants were conducted by site researchers between October 2009 and February 2010.

DATA COLLECTION

Common key informant and focus group protocols were used across the sites that focused on: (1) the environment, (2) stakeholders/partners, (3) vision/values/principles, (4) participation of people with lived experience, (5) relationships, (6) structures, (7) focusing of the programs, (8) resources, and (9) high/low/turning points in the planning and proposal development process. A short demographic questionnaire was administered after each interview. Key informant interviews and focus groups were conducted, in either English or French, at the participants' workplaces or at the site offices. They were between 45-90 minutes in duration and were audio recorded and transcribed verbatim. Qualitative site researchers also reviewed relevant project planning and proposal development documents.

DATA ANALYSIS

The approach to data analysis at each of the sites involved thematic analysis (Morse & Field, 1995). Site researchers sought and identified "common threads" throughout the data, drawing out significant concepts that emerged from individual interviews along with concepts that linked interviews together. They also used the constant comparative method of making comparisons during each stage of the analysis to further develop themes (Charmaz, 2006). Each site went through a process of member-checking with people who were interviewed for the site reports to establish the trustworthiness of the data. Qualitative researchers at each of the sites produced site reports on the planning and proposal development process (Dudley & Moradzadeh, 2010; Fleury, Vallée, Hurtubise, & Grenier, 2010; Gaucher, Flowers, Prévost, & Tinney, 2010; Kirst et al., 2010; Patterson, Schmidt, & Zabkiewicz, 2010).

This cross-site report relied on the site reports as the source of data, rather than reviewing transcripts or other data from each site. Not working directly with the transcripts constituted a limitation in undertaking this secondary analysis.

[4] A more detailed description of the methodology can be found in Appendix 3.

Nevertheless, it provided the National Qualitative Research Team with the opportunity to check back with the sites; this serves as a strength for member-checking and validating the accuracy and completeness of these results. For the cross-site analysis, each member of the National Qualitative Research Team read the five site reports and took notes on themes. Following this, a teleconference was held in which the team members shared their impressions of the cross-site themes. From this discussion emerged three levels of analysis or types of relationships among project stakeholders: (1) relationships between the National Team and the local sites, (2) relationships among local-level stakeholders, and (3) relationships between local professional and research stakeholders with disenfranchised people (e.g., people with lived experience of mental illness). A matrix display was constructed with sites using these three levels of analysis. Relevant data from each of the sites were included in the cells of this matrix. Following this teleconference, the first author of this report then fleshed out a framework for looking at all of the three levels that consisted of opportunities, challenges, and what worked and what didn't work at each of the sites. During a second conference call, a consensus was achieved to use this framework. As well, a number of cross-cutting themes were identified during this teleconference (e.g., an evolution of a shared vision at the sites). Researchers from the sites were involved in a process of review wherein the National Qualitative Research Team shared the first draft of this cross-site report with site researchers, invited them to read it over along with their teams, and solicited their comments. Comments from every site were incorporated into the final version of this report.

FINDINGS

The findings are divided into the following sections: (a) the relationship between the National Team and the site teams, (b) local-level partnerships, and (c) engaging disenfranchised communities. In each of these sections, we first describe what happened at one or two sites with regard to the particular issue. We selected sites that we thought were particularly well suited to illustrate each of three broad levels of analysis noted above.[5] Next, we describe opportunities and challenges and what worked well and what worked less well in the planning and proposal development process across the five sites.

The Relationship Between the National Team and the Site Teams

The Moncton site. The Moncton project began in April 2008 with a meeting that was organized by the Province of New Brunswick's Assistant Deputy Minister of Health and involved the MHCC Project Lead and members of the Community Services of Greater Moncton. Following this meeting, a key person in the community was approached and agreed to be the Site Coordinator for the project in Moncton. As in other sites, there was a great deal of excitement about the possibilities that the project represented in Moncton, which had relatively little infrastructure for providing housing and support for people with mental illnesses who were previously homeless. There was particular excitement in Moncton given that it was the only smaller centre chosen to participate in the project.

While a proposal for the project was submitted in January 2009, the research team that was involved in the proposal withdrew its participation in March 2009. With the active support of the National Team, a new research team was formed and a new proposal was submitted in May 2009. French-English rivalries were also a challenge in Moncton, where the regional Health Authority is actually split into two divisions: one for French-speaking people and one for English-speaking people. The Site Coordinator became aware that, to be responsive to both communities, the project needed to be responsive to the more rural areas outside of Moncton. This posed a challenge: people with mental issues were not actually on the streets but were more likely to be living in institutional settings, such as nursing homes or with their families of origins. From the perspective of the national/site relationship, the issue was challenging because to deal with it would represent a shift in the way the overall project was conceptualized. Nonetheless, the site was able to make the case to the National Team, which showed flexibility in providing resources to address what became the "rural arm" of the project.

In spite of lack of experience with Housing First, stakeholders resonated with the values of this approach, which emphasize consumer choice, citizenship, and recovery. While the Moncton site does not have an extensive infrastructure for consumer participation on which to draw, the project has been a catalyst for project stakeholders to think about and begin taking steps towards consumer participation. Important in this regard is the fact that a consumer spoke at the official project opening, and the power and strength of his presentation signified an important symbolic beginning to the project.

Opportunities and challenges.

Opportunities. Across the five sites, there was initial excitement and stakeholders felt privileged to be a part of such a large-scale, innovative project, as the following quote from the Vancouver and Moncton site reports indicated. They valued the opportunity to be a part of this national project because they felt it had been articulated to meet local needs

[5] The selection of a site as a case example in no way implies that the illustrated theme was the dominant issue for the site in question. This cross-site summary highlights site-based issues for illustrative purposes. For a full description of planning and proposal development issues, please consult the five individual site reports.

and, in a sense, capitalized on the work they had done in their communities. This was one factor that helped foster positive working relationships between the National Team and the local sites.

> *Overall, there was a sense of excitement, hope, and gratitude as a result of being part of a project with this philosophy and scale. (Vancouver site report, p. 27)*

> *...The key players, however, appreciate the opportunity offered to their community to achieve a study of this magnitude. (Moncton site report, p. 9)*

A similar level of enthusiasm was initially apparent at the Montréal site, where stakeholders saw the project as a potentially important contribution to solving a major social problem.

> *Montréal's potential appointment as an At Home project site and its subsequent selection generated much enthusiasm and led to the progressive and sustained mobilization of many local players. At this early stage, though project objectives and players' potential participation remain undefined, there was a great sense of possibility. Several players believed that Montréal could only benefit from the project, which was perceived as a massive investment both in terms of improving conditions for the homeless population and consolidating services and/or research in the area of homelessness. (Montréal site report, p. 17)*

The Vancouver, Winnipeg, and Moncton sites saw the project as an opportunity to provide innovative services in communities in which such services did not previously exist.

> *Respondents saw their involvement not only as an opportunity to conduct research and provide essential services to an underserved population, but also as a chance to promote real change in the types of services offered and the way those services are delivered. Most respondents saw themselves as part of unhealthy and fragmented systems that they felt a responsibility to contribute to repairing...Overall, respondents expressed excitement and enthusiasm for the project, viewing it as an opportunity to implement the Housing First model in Vancouver and provide critical services to an underserved, marginalized population. Prior to initiation of the project, services such as Housing First, Assertive Community Treatment (ACT) and Intensive Case Management (ICM), were virtually absent from the landscape of care in Vancouver. (Vancouver site report, pp. 6 & 31)*

While Toronto has many services for people with mental illness and a relatively long history of supportive housing programs, Toronto stakeholders saw the project as providing a unique opportunity to develop culturally sensitive services to the neglected population of ethno-racial minorities who are homeless and have a mental illness.

> *Key informants involved in the proposal development were also encouraged by the level of flexibility in the RFA with respect to the development of a third intervention arm designed to meet some of each site's local service needs. Project stakeholders saw this as an important opportunity to develop an intensive case management intervention focused on the health and social support service needs of Toronto's diverse ethno-racial population. (Toronto site report, p. 6)*

The Winnipeg site expressed a similar sentiment with respect to the need to serve Aboriginal people, but also saw At Home/Chez Soi as:

> *...just one more means of responding to deep historical injustices against Aboriginal people and encouraging recovery on the part of individuals, families and the community and in the words of one stakeholder, "part of reclaiming Aboriginal identity." (Winnipeg site report, p. 9)*

The Vancouver site believed that the project provides an *opportunity for partners and systems to work more collaboratively*.

The collaborative approach of the project was also embraced; many respondents recognized that working across disciplinary and institutional boundaries could promote the restructuring of the current system on a number of levels. (Vancouver site report, p. 31)

Another hope was that the project would produce evidence that would be a catalyst for systems transformation and policy change regarding housing and mental health across Canada.

Motivations were therefore related strongly to what the stakeholders hoped would emerge from the project; in other words, what they held as expectations for success: that the Site would be able to "prove" the effectiveness of the Housing First model, and the long-term benefits would follow in the form of core funding and stable infrastructure for housing the homeless. (Winnipeg site report, p. 9)

Further, many expressed the need to create a unified voice across Canada in the hopes of creating housing reform (e.g., a National Housing Strategy), with the project providing an opportunity to break down power relationships that exist within the mental health and housing systems. (Vancouver site report, p. 31)

Challenges. The primary task during the planning and proposal development phase was the negotiation between the National Team and the sites of a proposal that specified both service and research components. While there were many challenges to the development of the proposals, the challenge that was most frequently mentioned across sites was tight timelines. A draft Request for Applications (RFA) was made available by the end of August 2008; the final RFA was posted in early November 2008; and proposals were due by the end of January 2009. In addition to writing the proposals, those who were involved in planning and proposal development at the sites had to assemble a team of researchers and service providers who would lead the project. The multifaceted and complex undertaking of planning and proposal development for At Home/Chez Soi was compacted into a very short time frame. Key informants at the sites experienced this time frame as stressful, and there were a number of consequences of this compact time frame that we discuss later. The Moncton site was particularly affected by the tight timelines because the original research team withdrew, a new research team had to be recruited, and this new team had little time to draft a proposal.

Key informants noted two challenges associated with the RFA itself. The first was the pre-determined nature of the interventions and the research. Respondents thought that this limited their creativity and input into the research, intervention, and population to be served.

...I would say the project description was already relatively complete. The design was...pretty much defined by the time we received it so our capacity to be responsive to other perspectives for appropriate research design and appropriate factors to evaluate was limited. (Key informant, Toronto site report, p. 6).

Although this is officially a grant, it feels like a contract. (Key informant, Vancouver site report, pp. 15-16)

Secondly, some key informants indicated that some aspects of the RFA were vague. This was particularly evident around the budget for the project sites.

Our first draft [budget] was much more expensive than what the MHCC was anticipating...So, we were told very specifically, "here's how much you have to play with." It would have been helpful to know those parameters right from the beginning. It would certainly have reduced unnecessary effort. (Key informant, Vancouver site report, p. 26)

Others described the parameters of the RFA as vague because they changed with the iterative nature of the consultation between the sites and the National Team. On the other hand, some key informants were more comfortable with this "back and forth" process between the sites and the National Team. Such flexibility on the part of the National Team was further exemplified by the inclusion of third arm projects.

Another challenge was how *local conditions impacted on sites' ability to carry out the RFA process.* This took several different forms. Some sites noted that it was challenging to complete a proposal because of the lack of a local infrastructure for housing and homelessness, leadership, service capacity, or human resources upon which to draw.

> *You can't research something that doesn't exist; there was no existing infrastructure, so it was created for this research project, it was created to be researched. (Key informant, Winnipeg site report, p. 24)*

> *Local people didn't really have a good sense of what an ACT Team was. That it was a very well defined criterion in the literature, that it wasn't something that we could make up. (Moncton site report, p. 10)*

At the other extreme were sites that had a well-developed infrastructure and leadership capacity, which posed different challenges. For example, the Toronto site was challenged by not having sufficient time to consult with the large number of other service providers that existed. In Montréal, there were concerns among some local stakeholders about adopting the Housing First model, and in Toronto there were concerns about comparing the existing Housing First program, Streets to Homes, to the much better resourced MHCC demonstration project.

> *There is also a strong movement and consensus in Québec in support of social housing. This orientation is endorsed by FOHM (Fédération des organismes sans but lucratif d'Habitation de Montréal) and RAPSIM (Réseau d'aide aux personnes seules et itinérantes de Montréal). These associations of community-based agencies have strongly opposed the use of private housing, which is perceived as a guiding principle of the At Home project in Montréal. This situation is due to a mention in the proposal suggesting that the project, which aimed to conduct an experimental comparison between subsidized private housing and social housing, was designed to demonstrate the superiority of the former over the latter. (Montréal site report, p. 16)*

A larger challenge to the planning and proposal development process was *cynicism and mistrust* over the project that existed in some cases. This was expressed in different ways.

> *The common narrative heard from almost all stakeholders was that the initial "buzz" about the MHCC research was quickly followed by alarm on the part of the Aboriginal community that this was going to be research about Aboriginal people, but without appropriate Aboriginal ownership of the research being done. (Winnipeg site report, p. 7)*

> *[A person with lived experience says] she gets folks that say...we're "pimping the poor," and...it's a huge risk but the risk that on the other side is to do nothing and we learned from this experience and I guess...we just want to make sure we don't hurt anyone along the way and...hopefully along the way like there's some good opportunities for people...(Key informant, Toronto site report, p. 13)*

> *The submission of the project proposal in late January 2009 marked the onset of this period by which point all local players within the consortium had had an opportunity to express their views and many of whom disapproved of the project in its present form. This period was characterized by mounting tension among the key players, revealing different cultures and diverging interests. Ensuing conflicts resulted in the departure from the consortium of major players in the areas of homelessness and delays in the recruitment of caregivers and service providers. (Montréal site report, pp. 17-18)*

The site reports indicated that the initial opposition to the RCT design and the TAU condition voiced by stakeholders had lessened through various means by the sites and the National Team. While some concerns and skepticism on the part of some stakeholders remain, the argument, for example, that services were being added and not taken away in each community helped elicit an appreciation for the value of the RCT.

Through discussions, stakeholders who remained involved in the project generally believed that participants in the TAU group would not be exposed to harm greater than what currently exists. As one service provider stated:

The federal system doesn't provide funding for housing. That's the ethical issue...we [non-profit housing] always have to figure out who to select and who not to select. Somebody is always left out...it's not the group selection that's the ethical problem, it's societal – we don't have enough affordable housing. So, I'm kind of used to this. (Vancouver site report, p. 20)

What worked well and what worked less well.

What worked well. While timelines were mentioned as being perhaps the most important challenge, some key informants also stated that the timelines and expectation of one proposal per site promoted teamwork and productivity.

> *With very little time to produce a proposal, the group had to gel into a team. The intensiveness of the work meant that partners got to know each other quickly. It was, as one key informant said, "like a cauldron and we were forged as a team." (Toronto site report, p. 10)*

> *Several respondents noted that the MHCC's request for only one proposal submission per site promoted a collaborative, inclusive approach. While this task was challenging, requiring a significant amount of time and effort to gather individuals, determine roles, and reach consensus, it encouraged the development of a collaborative, multi-disciplinary team. The majority of respondents referred to this creation of partnerships within and between stakeholders, who typically function independently, as a unique catalyst for change. Many recognized cross-agency and institutional partnerships as an opportunity to break down power relationships that have long existed within the academic, mental health and service provision sectors. Several respondents articulated the project's potential to shift the hierarchical service delivery structure in Vancouver, to form a "working with" instead of a "working for" partnership framework...Several respondents also felt that, had the group been given more time, tensions would have risen and meetings may have been less productive and effective. (Vancouver site report, p. 16)*

The overarching factor that helped the relationship between the National Team and the emerging site teams was the collaborative style of the National Team. The National Team exhibited responsiveness and flexibility to site concerns and preferences. Tangibly, this was expressed in several ways. For example, both the Vancouver and Toronto sites were able to successfully negotiate increases in the rent supplements that were to be provided to participants enrolled in Housing First.

> *...The City of Toronto made the case that it was impossible for us to provide the kind of services that we were required to provide unless we were able to provide a higher rent stipend which would mean that our overall budget would have to be increased...It was really a positive moment...when [the City] was able to make that case to the MHCC. I think it strengthened our team sense that we really do know what we're doing. (Key informant, Toronto site report, p. 8)*

The Moncton site also commented on the "budgetary flexibility shown by the Commission, [which] made the setting up of the project easier" (Moncton site report, p. 9).

Another example of this flexibility was the potential for sites to develop their own unique interventions or third arms. Each of the sites took advantage of this option. In Winnipeg, the National Team quickly engaged Aboriginal people when it realized that the population of people experiencing homelessness with mental illness was largely Aboriginal.

> *The Commission and those working to assemble the Winnipeg Site immediately corrected this oversight and then proceeded under the assumption of Aboriginal leadership and interest. The MHCC then hired the Site Coordinator and a Co-site Coordinator, the latter coming from the Aboriginal community, which allayed some concerns and helped to keep community groups engaged in the process. Then a "working committee" coalesced as the beginning of what would become the Advisory Committee, and they began developing a Terms of Reference. (Winnipeg site report, p. 7)*

Other sites were able to include previously neglected, but needy, populations, such as Francophones in the rural area around Moncton and ethno-racial populations in Toronto, through the development of third arms.

Moreover, to some extent, individuals who were involved in planning and proposal development at the sites saw the National Team as committed, responsive, and available to negotiate issues.

> *Everyone recognized how committed, mobilized, and available the National Team was. When presented with a problem, it responded promptly and never hesitated to come to Montréal to meet with local players and counsellors. (Montréal site report, p. 16)*

> *...The extensive consultations that the Commission has made in the community and especially their collaboration with government departments and non-profit agencies have made the project planning and development easier. (Moncton site report, p. 9)*

The cross-site training session held in Toronto in September 2009 was viewed as another vehicle for the promotion of collaboration and bonding across the sites.

> *The training session delivered in Toronto in September 2009, despite the criticism it attracted, was the event that officially launched the project. This was seen as a turning point, since it helped to create a sense of belonging around the project and of solidarity among the newly constituted teams. (Montréal site report, p. 21)*

What worked less well. There were, however, limits to collaboration. The National Team did set down some non-negotiable parameters in the RFA, such as the fact that At Home/Chez Soi was a research demonstration project with common service elements (Housing First, ACT, ICM), a common research design (an RCT comparing Housing First + ACT with TAU for participants with high needs and Housing First + ICM with TAU for participants with moderate needs), and a population of adults who are homeless with mental illness. These parameters created some tensions.

> *Some described the parameters set by the MHCC as a top-down approach, one that stood in opposition to the project's principle of collaboration. This approach limited the shaping of the local response and created some tensions between the National Team and the Vancouver site. (Vancouver site report, p. 15)*

While the tight timelines did motivate sites to work quickly and promoted team identity and bonding, key informants also noted that there were a number of negative consequences. One of the consequences was that there was insufficient time to engage people with lived experience or, in Toronto, members of ethno-racial communities in the development of the proposal.

> *I think too around the lived experience piece, it's always a big struggle in any project is how do you make sure the voice is heard, and I think in the [ethno-racial] third arm, maybe it wasn't heard quite as loudly as it was in the other parts of the project, and I think...part of that was the timelines, because we are not great at involving survivors yet in the field, and I think that's one of the learnings I hope we're going to take from this...(Key informant, Toronto site report, pp. 8-9)*

> *If there was one thing we could have done better it would have been that [engaging people with lived experience]. We tried, but it was probably minimal. We were so far behind, building the knowledge base, build[ing] these teams, we just didn't have the time or the capacity to do that to the extent that we probably should have. (Key informant, Winnipeg site report, p. 16)*

Another challenge that was associated with tight timelines was a lack of transparency in decision making. "The pace at which decisions were being made [contributed to] the appearance of arbitrariness and unfairness" (Key informant,

Vancouver site report, p. 16). At the Vancouver site, key informants perceived that the initial meetings were "dominated by researchers" (Vancouver site report, p. 17), while at some other sites there was a perception that decision making was concentrated in the hands of the Site Coordinator and the Principal Investigators.

Another problem that was noted between the sites and the National Team was poor communication. As was noted earlier, some stakeholders perceived a lack of clarity or vagueness of the RFA.

> *Having spent $5,000 to help someone, help me get this thing written, and then realizing that that isn't what they wanted and then so we're having to rewrite it, so it was just a nightmare 'cause we weren't getting clear directions of what they were looking for, so how do you clearly write a proposal?... The process wasn't set up good right from the very beginning...so yeah that was just a mess, it was horrible...they were making it up as they were reading stuff we sent them. (Key informant interview, Winnipeg site report,p. 8)*

It is important to note that this view that the RFA was vague was not shared by everyone, either within or across sites.

Difficulties in national/site communication over the nature of the proposal sometimes contributed to difficulties in creating an atmosphere of trust and transparency at the site level.

> *Several key informants discussed what they felt was a lack of communication and support from the National MHCC team during the planning and proposal development, and that this unfortunately led to a lot of "back and forth" and an element of mistrust between these stakeholders. (Toronto site report, p. 8)*

> *Well, during the proposal development phase, unfortunately the communication between the National Team was poor...We did all the engagement and this was another frustration because trying to manage writing the proposal and preparing the proposal and at the same time having to navigate a very rich community such as ours with so many stakeholders...It would have been a great help if at that stage some of that had been taken off our plate and actually been done by somebody neutral. (Key informant interview, Toronto site report, p. 8)*

Another communication problem concerned French-English language issues between the National Team and the French-speaking sites.

> *The language difference remained a source of major frustration: English-only documents or poor French translations were sent and few players at the national level spoke French, resulting in major communication challenges. (Montréal site report, p. 15)*

Local-Level Partnerships

The Vancouver site. In Vancouver, a diverse group of stakeholders convened to plan the At Home/Chez Soi project, including representatives of the non-profit housing and services sector, municipal and provincial government, the Health Authority, police and corrections agencies, and two local universities. While some stakeholders initially expressed cynicism about the need for a research project, saying, for example, "It's not rocket science to know that if you give people housing and intensive supports, they'll do well" (Key informant, Vancouver site report, p. 24), overall, the project was greeted with excitement, as the community recognized the need for large-scale, structural changes to a system that was not working for many marginalized individuals.

Initially, pre-existing power dynamics and a fragmented system created challenges for the Vancouver team. Perceptions of the initial planning meetings as disorganized, lacking leadership, and dominated by researchers also led to tension. Once lead research and service-provider roles were assigned, much of the struggle for power diminished, and tensions lessened. The hiring of a Site Coordinator who was committed to facilitating equality among group members and moving the project forward was also noted as key to improving group dynamics. Mutual trust has developed over time, facilitated by follow-through on commitments, demonstrations of respect among partners, and increased transparency of processes. Although some tensions are still present, team members indicate that they are optimistic about both the working environment and the possibility for real changes in the system of care.

The Montréal site. Early on, during the period preceding the emergence of the written proposal characterized by some as the project's "honeymoon phase", the Montréal At Home/Chez Soi site was able to mobilize key players in both the homelessness and mental health sectors. A large consortium was established and contributed to the Montréal At Home/Chez Soi project. Soon after, the proposal was drafted. Over 50 partners from community organizations, health care, and municipal government, and key players emerged on both the research and service sides.

Following this period of relative calm, some stakeholders described challenges and dissension that began to arise within the consortium, which they deemed to be the result of a "clash of cultures" (Montréal site report, p. 17). Some stakeholders asserted that the consortium was participatory in appearance only, and was really created simply to sanction the national project. Representatives of the social housing movement strongly opposed the use of private housing.

Other partners expressed dissatisfaction with the cumbersome nature of the process, the lack of transparency around decision making, and what was seen as an over-representation of researchers and an under-representation of service providers. Concerns over sustainability also fueled many stakeholders' objections to the project. These conflicts resulted in some major players in the area of homelessness choosing to leave the consortium, as well as delays in service provider recruitment.

These challenges were concurrent with increased activity by those partners who remained committed to the project, including increased mobilization of the consortium, greater efforts to find potential solutions to appease project critics, and attempts to jump-start local commitment. As in Vancouver, and other sites, the role of a credible Site Coordinator and other key stakeholders helped mobilize partners and defuse conflict. By the time that organizations involved in the local project signed contracts, conversation had shifted away from ideological debates and toward discussions of how to best operationalize the project to effectively serve the homeless population. A sense of belonging and commitment was noted among those players who remained directly involved in the project.

Opportunities and challenges.

Opportunities. Stakeholders across the five demonstration sites have noted that the At Home/Chez Soi project provides a number of rich *opportunities for collaboration*, local capacity-building, merging of the diverse strengths of local partners, and mutual learning across sectors. "On the one hand, existing services — community and government services — [have already] work[ed] together, which ensures that 'relations are already established when you already know the person, so you do not begin at zero'" (Moncton site report, p. 9). The history of local collaboration differed at each of the sites — in Winnipeg, for example, few stakeholders had experience in working on multi-sectoral projects of this nature, while in Toronto, there were some partnerships to build on, such as the pre-existing working relationship between the City of Toronto and the Centre for Research on Inner City Health.

Learning to move beyond disciplines and institutional boundaries to work towards a common goal has been recognized as an important step towards building community capacity to address complex problems. Sites noted, however, that this

process requires time and **intentional effort**. In Winnipeg, where it was necessary to *build bridges*, not only between sectors but also between the world views of different communities, one stakeholder describes how "Two days were set aside for teaching and sharing, [making] sure there was time and opportunity for people to come together and find out about each other's work" (Key informant interview, Winnipeg site report, p. 18).

The third arm of the project, in which sites were encouraged to develop and study a *locally-relevant intervention* in addition to the Housing First and TAU groups, was also seen as a rich opportunity for developing local partnerships. At the Toronto site, the development of a third arm proposal focused on providing culturally appropriate services to ethno-racial communities was seen as providing an opportunity to take advantage of the particular areas of expertise of different local agencies. A lead service agency was chosen to lead the ethno-racial arm of the project, supported by other groups with experience working in racialized communities. This lead agency brought credibility and respect to the ethno-racial arm, as well as bringing knowledge and skills in anti-oppression and cultural competency that were able to be shared with the larger team. In Montréal, the inclusion of Diogene, a well-known, community-based organization providing case management services to people experiencing homelessness with mental illness, is another example of building on the strengths of local involvement.

Challenges. Again, a major challenge noted across all project sites was the short timeline available for planning and proposal development. Sites had many things to accomplish in a short period of time, including deciding what partners ought to be brought to the table, defining partner roles and responsibilities, building relationships among people with different world views and paradigms, selecting service and research leads, hiring a Site Coordinator, and developing an organizational structure, site-specific interventions, and a common proposal—a series of tasks described by one stakeholder as "two years of work in four months" (Key informant interview, Vancouver site report, p. 23). The timeline issue posed the greatest problems for the Moncton site, where a new research team had to be recruited after the initial proposal was submitted.

All sites noted *initial tension* between individuals and organizations resulting from past experiences, competition around roles, differing priorities, and/or lack of familiarity with one another's work. Service providers and researchers often found themselves at odds—many service providers questioned the *ethics of using an RCT design*, and at the early stages of planning, service providers often felt that their voices were overwhelmed by those of researchers. Different groups also had *different definitions of some key project terms*, including "homeless." In Toronto, it was felt that the working definition of homelessness might not be appropriate for ethno-racial populations; similarly there were questions about the meaning of whether "lived experience" referred to experiencing homelessness, mental illness, or both. Some stakeholders at the Winnipeg site held that since Aboriginal people view themselves as embedded in a wider community, any Aboriginal person with a family member or friend who had experienced homelessness had themselves gained lived experience of the issue. And the Moncton site also had concerns about the definition of homelessness, given that due to the bylaws of the city "we don't have a ton of people panhandling and squeegeeing and loitering." (Moncton site report, p. 10). In a number of cases, the inability to effectively resolve disagreements between groups led to one or more partners leaving the project team. The Moncton site, as well as others, also noted initial resistance *from landlords as an obstacle*.

What worked well and what worked less well.

What worked well. Each site described strategies that helped their group to overcome challenges such as those described above, and to move forward collaboratively in the planning and proposal development process. First and foremost was the *development of a common vision* for the project, one that could be shared by service providers, researchers, and those with lived experience. While this was not an easy process, it was seen as critical for success. Many sites began by finding agreement around the Housing First model and the idea that "housing is a right rather than

something to be earned." The site with the most difficulties in developing a shared vision may have been Winnipeg, where the combination of Housing First principles and the values of many Aboriginal stakeholders has, according to local evaluators, resulted in a project developed around "two sets of assumed shared values, but with limited attempts at synthesizing them" (Winnipeg site report, p. i).

Sites also noted the necessity to *build relationships, develop mutual trust, and implement transparent processes*. Over time, consensus-building, open dialogues, and mutual respect allowed partners to develop a sense of belonging and commitment, which in turn created a strong foundation upon which to build. This not only happened with service providers, but with landlords as well.

A number of sites noted that *power struggles diminished* and the *clarity of communication increased* once the research and service leads had been designated and the Site Coordinator hired. The *role of the Site Coordinator* appears to have been a particularly important one in developing an inclusive atmosphere and forging multi-sectoral relationships.

> *Beyond the contributions made by several partners, the community's respect towards the Coordinator seems to have had the most significant impact: her political and community influences have greatly facilitated the development of the rural arm, among other things. (Moncton site report, p. 9)*

> *...the hiring of a coordinator in January 2009 was a major turning point...The coordinator helped bolster project leadership. Enjoying a high level of credibility in the housing and mental health care sectors, she was able to mobilize the various parties and reduce friction among project players. The coordinator played a key role in achieving the objectives set by the national team with respect to services and increased the number of contacts with local and provincial partners so as to ensure project success. (Montréal site report, p. 15)*

Toronto, which had to replace its Site Coordinator during the planning process, noted this as a particular challenge.

Sites also noted that the development of *site-specific, third arm projects was very helpful in creating local ownership and commitment*. In Winnipeg, the development of a holistic, Aboriginal-focused intervention worked to create buy-in from a community that had initially questioned whether a prescribed national approach could be considered "culturally safe" for Aboriginal people. In Montréal, the establishment of a social housing intervention group initially helped the project to more closely conform to local realities.

What worked less well. At the site level, many of the problems in the planning and proposal development process had their roots in the complexity, lack of transparency, and changing parameters that characterized the introduction of the project. Across sites, there was much *initial confusion* about the project's goals and parameters, particularly around the roles and the relative levels of importance of the service and research teams. Many stakeholders found early meetings to be disorganized and research-dominated. Despite the flexibility, communication was described by some as minimal, decision-making processes somewhat unclear, and there seemed to be little room for discussion or debate. Service providers often indicated that they did not understand what the researchers would be doing, or sometimes not even what they themselves were being asked to do.

All sites noted that the short time available for planning and proposal development negatively impacted their ability to effectively resolve these problems. The time needed to resolve communication difficulties and build positive relationships between stakeholder groups was not available. Sites uniformly noted that flexibility of timelines around planning and partner engagement is necessary to fulfill these functions in a way that is appropriate given local social, political, and historical realities.

Engaging Disenfranchised Communities

The Toronto site. The Toronto site developed a unique and focused approach to the engagement of people with lived experience of homelessness and mental health issues (PWLE). There existed in Toronto a high degree of commitment to involving consumers due to long-standing relationships with consumers and the agencies serving them. Correspondingly, expectations were high that the consumer community would be engaged in the project.

Partners included an extensive consultation process in their application and went "above and beyond" the mandate outlined in the RFA. As early as November 2008, PWLE were included in initial consultative meetings intended to introduce the project to the community at large; partners from the City of Toronto held a series of meetings at 11 different community-based agencies. Realizing that the site's vision demanded negotiation around the issue of resources, project members were successful in preserving the budget items related to the extensive engagement of PWLE. Since the project was funded, people with lived experience have participated in planning meetings concerning governance, research approaches, and strategic implementation (Toronto site report, p.3).

A community caucus was established, composed of approximately 22 individuals and representatives from community agencies, half of whom were elected by those who participated in the consultant-led focus groups and the other half of whom were selected by two paid consultants hired by the project. Once developed, the PWLE caucus established internal structures, instituted rules of order and began to function as a working committee that meets bi-weekly. Caucus members were represented on the project's decision-making bodies, including all working groups, the Site Operations Team (SOT), and the Local Advisory Committee (LAC) (Toronto site report, p.14). Although some conflicts and divisive issues arose between members of the caucus, team-building and conflict resolution were deemed essential in ensuring the development of a cohesive group. PWLE continue to strive for training, support, empowerment and meaningful participation in the project.

The planning of the innovative ethno-racial intensive case management (ER-ICM) third intervention arm in the Toronto site further constituted an opportunity to address disenfranchisement. It allowed a focus on mental health and homelessness, specifically within racialized communities in Toronto. Stakeholders planned an anti-racism/anti-oppression service delivery model that would respond to their particular service needs.

The Winnipeg site. In Winnipeg, engaging Aboriginal people emerged as a goal of paramount importance. As noted previously, the project was seen as an opportunity to address "deep historical injustices against Aboriginal people." Initially, there were high expectations about Aboriginal ownership of or control over the research. There was disappointment as it became clear that the research design would only allow a certain amount of flexibility. On the service side, however, the project made a highly conscious effort to make space for Aboriginal leadership, hiring a Site Co-Coordinator who is Aboriginal to develop a comprehensive community engagement strategy. The Coordinators were also clear with members of the formal mental health system that Aboriginal people would play a leadership role in the project. In a context of differing views of mental health and little previous experience of collaboration between Aboriginal people and mental services research professionals, a holistic, Aboriginal-focused intervention was developed.

Later in the planning and proposal development phase, the Aboriginal Cultural Lens Committee was established. It was formed to ensure that Aboriginal perspectives were included and that meaningful collaboration with Aboriginal people was realized. It was also intended to be a filter for looking at project information in terms of consistency with Aboriginal values through the seven sacred teachings. Project members recognized the need for cultural relevance in the site's programming, as well as adherence to OCAP principles (Ownership, Control, Access and Possession of knowledge by Aboriginal people) (Winnipeg site report, p.12). Along with the hiring of an Aboriginal Co-Coordinator, other efforts to engage Aboriginal people included initiatives to educate Aboriginal and service-provider partners about the At Home/Chez Soi project.

Opportunities and challenges.

Opportunities. Stakeholders across the five sites recognized the *importance of involving consumers* in the planning and proposal development of the research project. In the words of one stakeholder, PWLE "bring gifts that must be honoured" (Key informant interview, Winnipeg site report, p.15). They appreciated that the participation of PWLE was a guiding principle identified in the RFA as presented by the MHCC, and that sites were offered the flexibility to come up with their tailored approaches. The Toronto site, for instance, was able to draw on a rich history of engagement and activism of people with lived experience at the local level:

> *...What facilitated [the participation of PWLE] [was...] the fact that the people involved in this study were credible. I think several of us [...] that were leading the proposal development [...] phase have been working very closely in the community and with people with lived experience [...] I think credibility helped the fact that we had personal relationships with several groups in the community. (Key informant interview, Toronto site report, p. 14)*

Inclusion was deemed to be consistent with the values of Housing First. Consequently, efforts were made by other project members to understand PWLE throughout the planning of the project.

The At Home/Chez Soi project also gave sites the *chance to engage with a multitude of disenfranchised communities*. In Moncton, there long existed a rivalry between Francophone and Anglophone communities. Tension was defused by involving service teams from both Francophone and Anglophones health authorities *(Régies)*; project staff seized this opportunity to put their differences aside and work together. As the Moncton report says (p. 17) "the two Regional Directors of Mental Health and Addiction [Francophone and Anglophone] decided to put the [conflict] aside to focus on the clients' needs." The inclusion of Francophone communities under the rural arm was perceived as engaging people from resource-poor and traditionally disadvantaged environments.

Challenges. A consensus emerged among stakeholders at every site: *the involvement of PWLE was the weakest aspect of the planning and proposal development*. Many characterized it as a *missed opportunity* to not have consumers play a groundbreaking role in how At Home/Chez Soi was conceived in their respective sites. The engagement of consumers, in their view, was not fully realized. Several factors were cited as reasons for this: lack of time and the project's accelerated pace, lack of financial resources, and the need for more clarity about how consumers should be involved at sites or what their roles would be.

Another big hurdle encountered was the lack of *history of consumer participation and a community infrastructure from which to draw consumers*. Toronto profited from a local psychiatric survivor community that was active and more established, and Winnipeg had Aboriginal people participate in the project from the beginning. However, other sites did not benefit from the same presence and had trouble identifying individuals who could join the project. In Montréal, the research team first approached representatives of community-based agencies who already held a regional mandate with respect to local user participation (Montréal site report, p. 10). But when these agencies withdrew from the project, only one PWLE was left to act as a representative for all consumers. Concerns arose that this person took on a much too heavy workload and worked in isolation. Some key informants interviewed in Moncton went so far as saying that they had not met any PWLE during their tenure with the At Home/Chez Soi project.

Moreover, the very term *"people with lived experience" proved contentious*. Did this mean people with experience with homelessness or mental health or both? There were different interpretations of what constituted a person with lived experience in Winnipeg. For some, the participation of Aboriginal staff and researchers meant that they brought a dimension of lived experience to the project. As noted previously, this appealed to a world view through which individuals are embedded in a wider community and absorb others' lived experience. This view, however, was disputed by an Aboriginal stakeholder, who countered: "you can have a partner who has mental illness, or have a relationship with

an individual with the lived experience but you aren't that person" (Key informant interview, Winnipeg site report, p. 15). Such disagreement made consensus difficult to achieve about the extent of involvement of PWLE at this particular site.

What worked well and what worked less well.

What worked well. One of the strategies that proved effective in facilitating dialogue was the *consultation that took place through which the views of PWLE were solicited*. In Vancouver, a series of focus groups yielded valuable information in addition to the formulation of concrete suggestions and recommendations on the contribution of consumers such as "roles as co-interviewers, finding participants for follow-up interviews, working with landlords, and participation in a reference group" (Vancouver site report, p. 21). In addition to offering input on the engagement of PWLE, individuals weighed in on other issues related to the project, most notably ethical issues surrounding the treatment as usual group. Ongoing communication by PWLE of their experience enabled other project members to gain valuable insight:

> *We speak from lived experience; we attend subcommittees so I am always giving personal examples of what it was like when I was lived experience so that I can give recommendations of the services that needed to be provided, provided for people that are now receiving housing (Key informant interview, Toronto site report, p. 17)*

Stakeholders across all the sites also appreciated the *commitment to establish and support reference groups*. In Toronto, considerable attention was paid to the development of a structure of governance for the PWLE caucus. Two paid consultants were tasked with moderating the caucus, and providing leadership, administrative and logistical support. Caucus members were paid an honorarium for each monthly meeting attended; later on, they were also compensated for their participation in the project's ongoing governing groups. Across all the sites, stakeholders reported including members of reference groups in other committees and meetings. On the whole, they viewed other project partners as supportive of PWLE reference groups.

Such support was demonstrated by the fact that *PWLE were hired at every site*. In Moncton, one key informant conceded that the team had not sought consumers directly and that job postings were not explicitly reserved with experiences of mental health issues or homelessness, but stated:

> *There [are] a lot of people who had mental health experiences, and we didn't always go out looking for those people but it was evident when we were doing the interviews that people were bringing this up, that you know why were they passionate and why were they applying for this job, because they had a history. (Key informant interview, Moncton site report, p. 21)*

There was also the sense that there could be *more opportunities to take advantage of in the future*. This was perceived as a noteworthy sign of meaningful engagement of PWLE within the project.

What worked less well. Some stakeholders noted that *PWLE lacked the training* needed to ensure they could share their knowledge and views. One stakeholder, speaking of the need to ensure that PWLE had an equal voice in discussion with other groups, felt that consumers could have benefitted from guidance "in how to participate in committees and how the project is structured would help consumers come into the project with more comfort and confidence so they feel free to speak and share their knowledge" (Key informant interview, Vancouver site report, p. 21). There was also a sense that other stakeholders themselves needed to adapt their own behaviour or norms. Key informants further alluded to a *clash of cultures between "professionals" and PWLE*. This magnified differences, not only in communication styles (PWLE interviewed struggled with jargon and difficult terminology), but held implications related to power dynamics in meetings (who had the authority to speak) and expectations vis-à-vis representation (generalizations, determining who is a "true consumer").

Interviews with stakeholders in Winnipeg revealed feelings of marginalization and the sense that some project members demonstrated a lack of respect for the Aboriginal Lens Committee.

> *I don't think we were all that well-received...When we were first introduced as a committee...Why would we want a committee like that? What's the use of that?" I know for a fact that those questions were raised. Why would we want a cultural lens committee? An Aboriginal cultural lens committee? So I know the resistance is still there" (Key informant interview, Winnipeg site report, p. 10)*

Elsewhere, cynicism was expressed by some of the consumers interviewed. In Toronto, there were questions raised about the value and role of the caucus. Across all sites, skepticism among PWLE arose about the project itself, and more specifically about the research orientation of the project. While consumers appreciated their own reference groups, they at times felt alienated from the wider project.

Finally, *stakeholders repeatedly questioned whether consumers involved held real power or exerted significant influence*. It was feared that members of disenfranchised communities involved with the project only served to validate decisions that had already been taken, or that some individuals had been co-opted. In Montréal, consumers saw the National Team as the locus for project decision making. All in all, key informants interviewed would have appreciated feedback about how the contributions of PWLE affected the project.

CROSS-CUTTING THEMES AND LESSONS LEARNED

There were a few themes that cut across the different levels of analysis and relationships that we have described in this report.

Working with Multiple and Competing World Views

The At Home/Chez Soi project's planning and proposal development phase exemplified how a multi-stakeholder project can feature multiple "cultures" or "worlds" that require bridging. This particular project included researchers, policy makers, people with lived experience, people from Aboriginal and diverse ethno-cultural communities, as well as service providers. Partners brought different strengths and made different contributions; they had varying perspectives as to the nature of the project, the ways it should be addressed, and the people who should lead. To some extent, these differences tended to dissipate over time. For example, in Vancouver, as in other sites, there was an initial sense that the project was dominated by researchers, but as time went on, more attention was paid to the issue of "shared leadership", as well as discussion of concrete strategies for how this would occur (e.g., joint chairing of meetings). Their site report suggests that both the site and the project as a whole should keep moving towards:

> *The development of a philosophy of shared leadership among high-performance teams that can transcend organizational boundaries, [which] is vital for not only the success of the project, but for the country to gain the knowledge needed to provide effective housing, health, and social services to individuals in need. (Vancouver site report, p. 10).*

Differences in perspective that existed within these multiple spheres added another layer of complexity. For instance, in Winnipeg, Aboriginal groups from different sectors/organizations did not always hold shared views. Recognizing that the Aboriginal community was "not monolithic," the project made a conscious effort to take an eclectic approach to inclusion. In many of the sites, the service providers from the homelessness sector and the formal community mental health sector had different interests and perspectives, and lacked a history of working collaboratively. These agencies were accustomed to competing for funds, and they may also have had distinct philosophical views about supported housing, which came into conflict with views held by others in the project.

Many key informants recognized the project as an opportunity to bring groups from multiple worlds into the process and begin to foster a shared commitment to the project as a whole. As discussed further below, some of this shared commitment evolved naturally over time. The project also developed some explicit strategies and spaces for mediating between these different perspectives. However, some of these tensions remain, which suggests that a more explicit attempt to help stakeholders develop a "common language" could be beneficial going forward. As the Toronto site report recommended:

> *In order to avoid power imbalance and challenges related to trust…a commitment must be made to…the development of a common language so that all types of knowledge (e.g., academic and experiential) can be openly shared and understood (Toronto site report, p. 3)*

Balancing Collaboration with Competing Factors

Because of the multitude of players that must be involved, the At Home/Chez Soi project has proceeded with the expectation and spirit of collaboration. Within this report, the nature of this collaboration has been considered at various levels: the relationship between the national and local teams, the collaborations among the players at each site, and the degree to which each site included traditionally disenfranchised groups. A common theme running through

each of the site reports, however, is the challenge at each of these levels of balancing the principle of collaboration with other competing values.

Need to accomplish tasks and move the project forward. One of the most pressing competing issues was the need to get things done within tight time frames. As one of the Toronto respondents stated: "Balancing our desire to be inclusive and community focused and get rich input from stakeholders and then meeting the deadline were very, very difficult" (Toronto site report, p. 30). While these timelines in some cases helped to forge relationships quickly, the speedy context sometimes made collaboration difficult, given that time constraints made communication more challenging within sites, and between sites and the National Team. Lack of time also made it more difficult to build the necessary environment for participation of people with lived experience, or of involving other groups who were traditionally disenfranchised. Given time pressures, many sites found it challenging to establish formal processes for selecting which partners would be in leadership positions. Concerns about transparency were mitigated once funding decisions were made, especially when the identified group demonstrated an inclusive approach to involving a range of partners. Nonetheless, the site reports suggest that time pressures initially made establishing a collaborative climate more difficult. A passage from the Toronto report sums up the situation well:

> *The short timelines ultimately limited the project team's ability to sufficiently consult and engage service and consumer communities…However, interview data indicated that many of these challenges were resolved after the proposal was approved and the project was funded. (Toronto site report, p. 5).*

Randomized controlled trial (RCT). The other factor that challenged collaboration was the nature of the RCT research design. Adding a third arm to the study was recognized by the sites as a way by which they could ensure that the research took local context into account, and involved partners who otherwise might not have been involved. In Vancouver and Montréal, the third arm entailed testing locally-developed, congregate approaches to Housing First. In other sites, the third arm was a way of bringing in the Aboriginal, ethno-cultural, and rural communities that were an integral part of these sites. Within the main study arms, however, collaboration was difficult because the intervention was perceived as having less flexibility for making adaptations. Moreover, collaboration was challenged because the involvement of traditionally disenfranchised groups often came with high expectations about ownership that were also difficult to meet within the context of an RCT design. For instance, in Winnipeg, initial expectations that Aboriginal people could decide on the research approach (in a way consistent with participatory action research) gave way to an understanding, and disappointment, that the cross-site RCT design would not allow this flexibility. In Toronto, great strides were made with respect to involving people with lived experience, but questions remained as to how this involvement and input would translate into "ownership" of the project.

> *While the caucus had the expectation of having "equal participation" in project planning, and envisioned having "ownership", the partners seemed to look to the caucus for input, while also struggling with issues of ownership and feeling the weight of their own responsibility for the project and its outcomes. (Toronto site report, p. 21)*

Bringing in the Right People and Partners

One way that the project dealt with the challenges of mediating multiple world views and working collaboratively within tight time frames was by bringing in the right people and partners. These were partners and individuals who were committed to inclusivity, and who possessed certain key attributes. A key issue was the importance of having a Site Coordinator who was perceived as neutral, who could mediate within multiple worlds, and who was able to work between these in a way that helped the project as a whole build a shared understanding of what the project was about and move ahead. The Moncton report (p. 11) describes the importance of this position well:

> *The most important facilitating factor that the respondents identified is the Project Coordinator's networking expertise. For 41 years, Claudette Bradshaw has been dedicated to strengthening the social sector, especially among the poor, which promoted the rapid and efficient development of a strong network of partners. She helped raise funds, identify needs and establish links between partners: "This community has a lot of faith in Claudette in terms of her skills and abilities but more importantly, in terms of getting everybody together..."*

Another issue was the importance of having project lead agencies which were committed to working in partnership and who, along with the Site Coordinator, could bring in or make space for people and stakeholders with less power. As mentioned, in Winnipeg, the two Co-site Coordinators, one of whom was Aboriginal, were able to make space for Aboriginal leadership to emerge. The choice of the Institute of Urban Studies as a research partner was also identified as important, given its history of collaborative research with Aboriginal people. In Vancouver and Moncton, Site Coordinators were able to bring in members of the non-profit housing sector, and help these agencies work in partnership with each other and with the formal mental health system, with whom productive working relationships had not always existed. When the inevitable bumps occurred, it was the shared commitment to the vision of helping people who were previously homeless come off the street that maintained the climate of hope that the project needed to move forward. Another example that illustrates the importance of certain players in mediating world views and ensuring equality was in Vancouver, where "...complex relationships were managed and negotiated by the Site Coordinator, who was viewed as a key person in facilitating greater equality between team members and 'making things happen.'" (Vancouver site report, p. 20)

The Evolution of a Shared Commitment to the Project

Despite initially having multiple and often competing perspectives, the partners at each of the sites began to move towards a shared vision about what the project was all about, and as to what values and principles they held in common. Some of the factors that helped this shared vision come about have already been mentioned. For instance, bonds were sometimes forged by the shared activity of working up a project proposal under the pressure of meeting a deadline. Through their skills and credibility, the Site Coordinators and project leaders also helped foster an atmosphere of trust that allowed a shared vision of the project to emerge. Despite some concerns about lack of transparency of the process for deciding on project roles and direction, key informants across sites remarked that interests were dropped and commitment grew once leadership selection decisions were made and the project began to think more concretely about the implementation phase. Thus, as the prospect of actually finding homes for people became more of a reality, the project partners became more inclined to focus on this shared vision, and less inclined to dwell on previous differences.

Many key informants remarked that the Housing First model itself provided a shared vision for the project. While there was some disagreement about what some saw as the overly illness-oriented and potentially coercive aspects of ACT, there was universal agreement with the project's main tenets: that is, the fundamental importance of choice and housing to a person's mental health; and the importance of providing resources and an approach that fosters community integration and recovery in a wider sense. It was this broad vision that was a key ingredient of the glue that helped hold the project together.

As encapsulated by the Toronto report authors, overall the themes:

> *reflect the challenges and intricacies associated with planning a complex health intervention, but also the passion and commitment of its stakeholders to bring this important intervention to fruition, and to prove its effectiveness for improving the quality of life of individuals experiencing homelessness and severe mental health issues in Toronto [and in the rest of Canada]. (Toronto site report, p. 34)*

Ethical Issues

A final theme that cuts across all the site reports was how all the sites needed to work through some significant ethical issues, most particularly the ethical implications of conducting an RCT with a "treatment as usual" (TAU) group, and with the implications of being involved in a study where there were no hard guarantees of continued funding beyond the study period.

Randomized controlled trial (RCT) and Treatment as Usual (TAU). Stakeholders at all the sites expressed discomfort with the RCT design, with some participants deciding not to become involved when they learned about the nature of the design. Some stakeholders believed that the project valued research over service with its adoption of the RCT design. As well, the issue of proceeding with a TAU group that would not be offered any housing or support was seen as an ethical issue:

> *I think the biggest ethical issue that came up really was around randomization…That's really hard for everyone…in their cognitive part of their brain, they understood the need for it, but in their compassionate part of themselves, they felt as many of us do that it's just so hard to do…In a context characterized by a lack of services, setting up a control group was difficult to accept. (Moncton site report, p. 16; p. 21)*

Key informants questioned whether participants would understand the randomization process; the very researchers tasked with explaining it to participants described themselves as feeling uneasy if a subject was randomly assigned to TAU. Despite some continuing misgivings about the design, eventually sites collectively became more comfortable with the rationale for the RCT as principled arguments for proceeding were articulated (e.g., that the research was ethically sound, that the project as a whole was not removing resources from anyone and would bring a net gain of resources together with research evidence for continuing the approach and influencing future resource development decisions).

Sustainability. Similarly, the issue of sustainability was an ethical issue that arose as a concern during the planning and proposal development phase. The concern here was that, given the time-limited nature of the research, resources could be withdrawn from participants at the conclusion of the project. Addressing sustainability was in part seen as a matter of producing solid research evidence that the intervention worked, so that not only could funding be continued, but expanded into other jurisdictions. Sustainability was also seen as requiring a sustained strategic effort to identify and persuade key stakeholders of the project's merit, using effective knowledge translation approaches. Given the integrated knowledge translation approach of the project, a number of these stakeholders (including policy makers, community agencies) have been involved in the formation of the project. While some of the necessary relationships and strategies have been developed, a theme across sites was that sustainability required an ongoing effort that uses both evidence and advocacy.

> *"We had lots of conversations and we have a plan and we have some sustainable pieces, but it's nowhere near what we need. It's an ongoing task." Overall, respondents described the need for a united front, within the local project team and across the larger community, in order to engage all stakeholders as advocates for the issues. (Vancouver site report, p. 24)*

Summary and Lessons Learned

The five main themes are:

1. National/site relationship + within site relationships = Integrating multiple cultures
2. Build relationships, develop mutual trust, and implement transparent processes; opportunities for collaboration

3. Drawing in the right partners; bringing in disenfranchised communities
4. Working with a shared underlying vision; evolution of a shared commitment to the project's goals
5. Sustainability

Each of these key themes suggests a certain lesson.

1. The challenges of involving multiple cultures into a single research project suggest the importance of taking explicit steps to acknowledge and normalize difference, and to move closer to the community of practice ideal.
2. Similarly, some work may need to be done to ensure that different parties arrive at consistent expectations about what level of collaboration is desired or possible in the context of a RCT design, and to ensure that opportunities for collaboration are not missed.
3. This analysis also suggests the importance of drawing in the right people and partners (i.e., those who are skilled and committed to being inclusive, and possess the credibility to help the project work between its various worlds).
4. Another lesson is the paramount importance of working with a shared underlying vision, which, in this case, is suggested by the Housing First approach itself. When the inevitable bumps occur, it is the shared commitment to the vision of testing the effectiveness of Housing First, a promising approach for people who were previously homeless. It is this vision of using a research-informed approach to help people come off the street that maintains the climate of hope, bridges differences among stakeholders, and moves At Home/Chez Soi forward.
5. The last lesson is that it is important for the projects and the National Team to continue to direct their energies towards the sustainability of the project. There is a societal obligation towards continuing to provide evidence-based services to those in the intervention conditions, to extend to those in the TAU conditions, and to shift public policy so that no one with a mental illness in any Canadian community has to live a life of homelessness.

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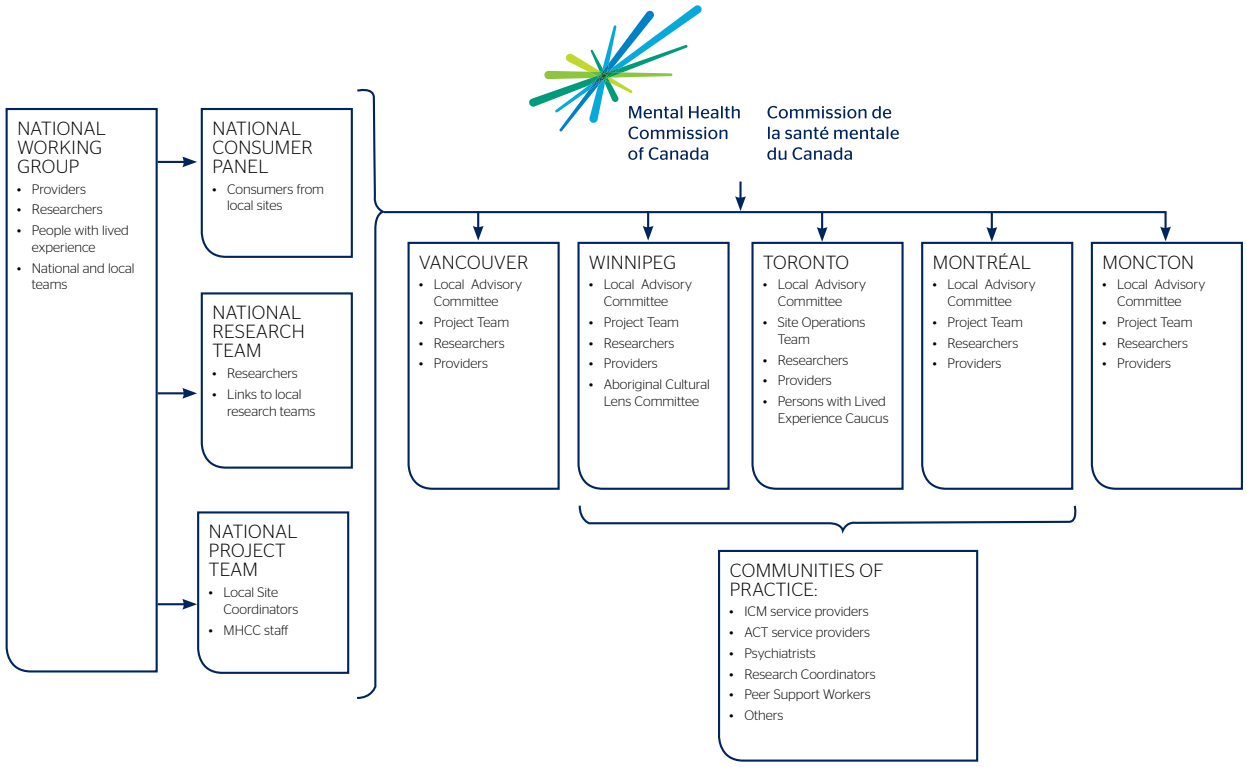
PROJECT STRUCTURE AND DESCRIPTION OF THE FIVE AT HOME/CHEZ SOI PROJECT SITES

FIGURE 1:
Structure of the National Research Demonstration Project in Mental Health and Homelessness



VANCOUVER

Located on Canada's west coast, Metropolitan Vancouver is Canada's third largest urban area with a population of roughly two million. While Vancouver boasts a reputation as one of the most livable cities in the world, Vancouver is also home to the infamous downtown eastside where homelessness, drug addiction and other health and psychosocial problems are rampant and highly visible. For example, it has been estimated that 5,000 injection drug users in this community are infected with hepatitis C or HIV/AIDS. People with serious mental illness in Vancouver are often co-morbid with addictions. "The 2008 Metro Vancouver Homeless Count found 1,372 people who were homeless in the City of Vancouver. This number of homeless individuals represents a 23 per cent increase since the previous count in 2005" (Vancouver site report, p. 12).

In spite of these significant problems, "best practice" housing and mental health services in Vancouver have been very slow to develop. Until the At Home/Chez Soi project, the Housing First approach was not evident in Vancouver. Instead, people with serious mental illness have been housed in congregate, custodial housing, such as single-room occupancy (SRO) hotels concentrated in downtown Vancouver. Moreover, housing is very costly in Vancouver, and the average rent for a bachelor apartment is close to double the shelter allowance that recipients of social assistance receive for their housing. Mental health services, such as ACT and ICM, have also not taken hold in Vancouver until the At Home/Chez Soi project. While the Vancouver Mental Patients Association (MPA) has been in existence since the 1970s, mental health consumer participation has not become part of mainstream practice in Vancouver either. Thus, treatment as usual (TAU) for people with mental illness and co-occurring substance use has tended to be a custodial and medical model in nature.

Recently, there have been initiatives to address the problems of homelessness, mental illness, and addictions and to improve housing and mental health services.

> *In November 2008, Vancouver's Mayor Gregor Robertson struck a Task Force to address the issue of homelessness. Numerous city- and province-led initiatives have recently addressed challenges related to homelessness, including reforms to the justice system (e.g., Community Court), expanded mental health services (e.g., Burnaby Centre for Mental Health & Addiction), access to income assistance (e.g., Homeless Outreach Teams), and investments to stabilize housing stock (e.g., purchase of SROs and development of additional supportive housing). (Vancouver site report, p. 13).*

WINNIPEG

With a population of more than 600,000, Winnipeg is the capital and largest city in the province of Manitoba, which is in the prairies of Western Canada. Winnipeg is home to the largest urban Aboriginal population, with roughly 7,000 people of First Nations ancestry residing in Winnipeg. While there has never been a census of homelessness in Winnipeg, it has been reported that there are at least 350 people living on the streets and 1,900 people who use shelters on a temporary basis.

There is a very low vacancy rate in Winnipeg, around 1 per cent, and roughly 40 per cent of the rental stock is concentrated in downtown Winnipeg, much of which is older and in need of repairs. "Prospective landowners and managers in the public market have the power to be particular in tenant selection. Some property owners and managers may avoid renting to tenants who are considered marginalized due to perceived drug and alcohol use and misuse, mental health issues and matters relating to affordability and institutional discrimination" (Winnipeg site report, Appendix 1, p. C). Racism and stigma are major obstacles to housing Aboriginal people with mental illness and/

or addictions. The shelter allowance provided through social assistance falls roughly $144 short of covering the costs of the average bachelor apartment in Winnipeg. Moreover, there are long waiting lists for social housing. Many low-income people live in rooming houses, residential hotels, or in shelters. Roughly 70 per cent of the shelter population is male and Aboriginal.

While there are some supportive housing (with live-in staff) and supported housing (with case management) programs available for people with mental illness, the Housing First approach was not implemented on a widespread basis until the At Home/Chez Soi project. In terms of mental health services, Winnipeg has only recently developed its first ACT program. Moreover, there has been little to no history of collaboration between mental health service providers and organizations serving the Aboriginal population.

TORONTO

Toronto is the capital of Ontario, Canada's largest province, which is located in central Canada. The Greater Toronto Area has the largest urban population in Canada of roughly 4.5 million. The demographic profile has changed a great deal in recent decades.

> *Almost half of Toronto's population are immigrants (Statistics Canada, 2001), and this group has been identified as vulnerable to homelessness and in need of targeted support services (City of Toronto, 2000). There is a lack of data on service utilization among immigrant groups, but what data exist indicate low general levels of access and satisfaction with services, and significant barriers to accessing mental health services in particular (Access Alliance, 2005). (Toronto site report, p. 2)*

Toronto has a significant homelessness problem.

> *Homelessness remains a significant social issue. The Street Needs Assessment conducted in Toronto in 2009 estimated that there were more than 5,000 homeless people in Toronto on that night, with about 79% living in shelters, 8% on the street, 4% in health care or treatment facilities, and 6% in correctional facilities (Toronto Shelter Support and Housing Administration, 2009). Approximately 30,000 different individuals use shelters in Toronto over the course of one year. Homeless people also often have complex mental health needs; about one-third of homeless individuals in Toronto have a serious mental illness such as schizophrenia, major depressive disorder, or bipolar affective disorder. Within the current system, a large proportion of these individuals do not receive the proper level of care for their mental health issues (Toronto Shelter Support and Housing Administration, 2006). (Toronto site report, p. 1)*

Dating back to the inception of the Toronto Supportive Housing Coalition in the 1980s, Toronto has a relatively long history of providing a range of housing options, including those based on the Housing First approach, to people with mental illness. The City of Toronto's Streets to Homes, which has been in operation since 2005, has as its goal helping people who are homeless access permanent housing. Toronto also boasts a relatively well-developed array of community mental health services.

> *There also exists a sizeable mental health service network serving homeless and housed individuals in Toronto, comprised of in-patient and outpatient care, case management, assertive community treatment, supported housing, supported employment, early intervention programs, court support services, crisis programs, and ethno-racial specific agencies, amongst other services. However, there is a significant unmet need for these services among homeless individuals in the Toronto area (Stergiopoulos, Dewa, Chau et al., 2008). (Toronto site report, p. 2)*

Toronto also has a relatively long history of consumer participation in mental health and consumer leadership, which dates back to the 1970s. Not only do consumers work in mental health agencies, they have played prominent roles in research, program governance, planning, advocacy, and policy making. Moreover, consumers in Toronto have operated their own businesses and peer-run organizations for nearly 30 years.

MONTRÉAL

Located in the province of Québec, Montréal is Canada's second largest metropolitan area with roughly 3.8 million people. It also has the second largest Francophone population in the world, after Paris. Montréal has a significant problem of homelessness and mental illness.

> *At last count, carried out in 1998 by Institut de la Statistique du Québec (Québec institute of statistics), 28,214 people had at one time used a shelter, a soup kitchen or day centre. Of this number, 12,666 had been homeless over the course of the past year (MSSS, 2008). For 2005, the number of people in Montréal who were homeless at least part of the year, was estimated at 30,000 ("Cadre canadien en matière de logement 2005," in RAPSIM, 2008). The profile of homelessness has undergone a major transformation (Roy & Hurtubise, 2007). There are more and more youths, women, seniors, and Natives living in the street. This population also faces major concurrent health problems. In particular, from 30 to 50% of homeless people have mental health problems, and 10% suffer from severe mental health problems. Over half of homeless adults with mental health problems may also have an addiction problem (Weinreb et al., 2005). In addition, an increasing number of homeless people have problems with the law (Bellot, 2008). The multiplicity of problems affecting this population makes it increasingly complex to implement adequate responses to homelessness. (Montréal site report, p. 2)*

Existing housing programs for people with mental illness include social housing (a congregate program for low income people), hostels, foster families, group homes, supervised apartments, and rooming homes. Moreover, although since 2005 provincial policy has called for the implementation of ACT and ICM teams across the province, when the At Home/Chez Soi project started, access to such programs was still relatively limited. When the At Home/Chez Soi project started, it coincided with provincial initiatives to address the growing problem of homelessness in Québec.

> *[In 2008], the government of Québec established a parliamentary commission on homelessness. Over 145 submissions were made and 104 persons or groups provided testimonials. A document titled L'itinérance au Québec – Cadre de référence (Homelessness in Québec: A Reference Framework) was issued a few months later. It targeted four priority objectives at the provincial, regional, and local levels to respond to the needs of the homeless population: (1) enhance prevention; (2) respond to emergency situations; (3) intensify intervention and social reintegration; and (4) improve knowledge, research and training (MSSS, 2008). The reference framework is the basis for the Plan d'action interministériel en itinérance 2010-2013 (interministerial action plan on homelessness, 2010-2013) made public in December 2009, which recommends identifying best practices in the fight against homelessness. It is worth noting that the action plan identifies the "Housing First" model as a promising avenue of exploration for persons facing chronic homelessness and mental health problems (Plan d'action interministériel en itinérance 2010-2013, 2009)…The Plan d'action en santé mentale 2005-2010 (mental health care action plan, 2005-2010), tabled in 2005, recommends consolidation of community services to help persons with mental health problems and to facilitate their social reintegration (MSSS, 2005). The action plan also presents specific targets for housing services with support from Assertive Community Treatment (ACT) teams and Intensive Case Management (ICM) teams. (Montréal site report, p. 1)*

MONCTON

While Moncton is a relatively small city, it is the largest city in New Brunswick and it is one of the fastest growing cities in Canada. Situated on the east coast in one of the Maritime Provinces, the geographical area is a central location within the Atlantic Provinces and is in close proximity to the TransCanada Highway, which links Halifax to the south, and Fredericton, Saint John, Québec and Ontario to the north/west/east. Greater Moncton includes the Cities of Moncton, Dieppe and the Town of Riverview. The Greater Moncton area population exceeds 126,000 with it having experienced a growth of 6.5 per cent between 2001 and 2006. The language composition of the population is approximately two-thirds Anglophone (62 per cent) and one-third Francophone (35 per cent) (City of Moncton, 2009).

The location of the rural arm of the Moncton site is in the southeast region of the Province of New Brunswick. The southeast region is within a 60-minute drive of Greater Moncton and covers an area stretching over 2,000 square kilometres. The region is made up of a variety of small municipalities and service districts that range in population from a few hundred up to four or five thousand. There are approximately 40,000 people living in the southeast region of the province. Adults with severe mental illness in this region have lived in custodial facilities operated by the private sector or with their families of origin.

Approximately 70 per cent of dwellings in the Greater Moncton region are owned with the remaining 30 per cent being rental units. With respect to core housing needs, there have been positive improvements noted in housing adequacy, suitability and affordability since 1991. In particular, the percentage of rental dwellings considered in "core housing need"[6] decreased from 33 per cent to 25 per cent over the 20-year period from 1991 to 2001 (Human Resources and Social Development Canada, 2007).

There have been some small, incremental financial increases in income assistance and minimum wage. One of the significant gaps in policy that continues to affect the living conditions of many renters is the absence of provincial standards to regulate the safety and suitability of rooming and boarding houses. The Community Plan Assessment Framework (2007) developed for Greater Moncton identified approximately 15,500 individuals at potential risk of homelessness in the Greater Moncton area (Human Resources and Social Development Canada, 2007). These individuals were identified as living in substandard rental units (in core housing needs), as well as experiencing significant financial demands related to covering their basic shelter and living costs (approximately 50 per cent of income dedicated to shelter/housing costs).

Based on existing sources of data, the number of individuals experiencing homelessness who received services from shelters in the Greater Moncton area in 2006 is 946 (Human Resources and Social Development Canada, 2007). This outcome reflects the annual number of individuals served by the two largest shelters (in the City) (689 male adults; 177 female adults; and 80 children).

Relative to the other sites, Moncton is the most resource deprived in terms of housing and community mental health services. There are two organizations in Moncton providing long-term supportive housing: (1) Alternative Residences Inc. which offers 30 units for mental health clients that can accommodate up to 76 individuals; twenty-six of the 30 units are apartments and the other four are 24-hour supervised residences; the maximum stay is set at two years; and (2) Future Horizons Housing Inc. which has 12 units (three two-bedrooms and nine three-bedrooms) available for clients of Headstart Inc. and offers a range of support services along with the housing (Greater Moncton Homelessness Steering Committee, 2008). The provincial Department of Social Development has 647 units of social housing available in

[6] A household is said to be in core housing need if its housing falls below standards in terms of adequacy, suitability, or affordability and it would have to spend more than 30 per cent of its before-tax income to pay the median rent of alternative local housing that meets all three standards. (Cooperative Housing Federation of Canada, 2007).

Greater Moncton. As well, it provides rent supplements for another 669 units in the private housing market. There are no supports tied to any of these units.

Publicly-funded mental health services are delivered in Moncton and in the adjoining rural region through community mental health centres (CMHCs), tertiary and secondary facilities, and psychiatrists in private practice. The tertiary and secondary facilities and psychiatrists in private practice are located in Moncton. These services are managed and operated by two regional health authorities, Regional Health Authority A and Regional Health Authority B.

CMHCs are the main source of services delivered in the community and these are organized under three core programs: (1) Acute services (i.e., 24-hour crisis intervention, short-term therapy prevention, consultation and service delivery coordination), (2) child and adolescent services (i.e., individualized assessment and treatment, service provision for all family members), and (3) adult long-term services (i.e., treatment, monitoring, psycho-social rehabilitation) (Health Systems Research and Consulting Unit, 2009). Types of services delivered by these programs include case management services, community support services, and rehabilitation services (Health Systems Research and Consulting Unit, 2009).

Addiction services deliver counselling and withdrawal management support for individuals with problem substance use. Programs available in Greater Moncton include a detoxification centre, outpatient counselling, health promotion, and wellness activities and school-based youth support services.

Housing First and ACT were new programs in Moncton and in the province of New Brunswick. TAU in Moncton consists of accessing the above services, all of which have long waiting lists.

In comparison with the other sites, housing and services available to people with severe and persistent mental illness are relatively sparse, with many individuals from this population receiving no services or infrequent services.

PRINCIPLES OF HOUSING FIRST

HOUSING FIRST MODEL

- Recovery-oriented culture
- Based on consumer choice for all services
- Only requirements: income paid directly as rent; visited at a minimum once a week for pre-determined periods of follow-up supports
- Rent supplements for clients in private market: participants pay 30 per cent or less of their income or the shelter portion of welfare
- Treatment and support services voluntary — clinicians/ providers based off site
- Legal rights to tenancy (no head leases)
- No conditions on housing readiness
- Program facilitates access to housing stock
- Apartments are independent living settings primarily in scattered sites
- Services individualized, including cultural adaptations
- Reduce the negative consequences of substance use
- Availability of furniture and possibly maintenance services
- Tenancy not tied to engagement in treatment

Sources:

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As outlined in *Request for Applications MHCC Research Demonstration Projects in Mental Health and Homelessness*, 2009.

DETAILED METHODOLOGY

SAMPLE

Sample selection was purposeful. The goal was to select a variety of different stakeholders who played a role in the planning and proposal development phase of the project. Individuals who were identified as having played a key role in developing the proposal were interviewed individually as key informants. Those who were involved in the planning, but to a lesser degree than the key informants, were interviewed in focus groups. In all, 75 key informant interviews and 10 focus groups with an additional 56 persons were conducted between October 2009 and February 2010. Table 1 presents the breakdown of interviews for each site. Key informants included Principal Investigators and Co-investigators, Site Coordinators, service providers, community organization partners, and persons with lived experience. Focus group participants included service providers, research staff, and persons with lived experience.

Table 2.1
Key Informant and Focus Group Interviews by Site

SITE	#KEY INFORMANT INTERVIEWS	# FOCUS GROUPS
Vancouver	12	(n=3)
Winnipeg	14	(n=24)
Toronto	10	(n=23)
Montreal	19	(n=6)
Moncton	20	-
Total	**75**	**10 (n=56)**

DATA COLLECTION

The National Qualitative Research Team, in collaboration with qualitative researchers from the five sites, developed two research instruments: (1) a Key Informant Interview Guide and (2) a Focus Group interview guide. Nine topics were explored in the interviews: (1) the environment, (2) stakeholder/partners, (3) vision/values, (4) participation of people with lived experience, (5) relationships, (6) structures, (7) focusing of the program, (8) resources, and (9) high/low/turning point stories. The interview guides were pre-tested and translated into French. A short demographic questionnaire was administered after each interview (See Appendices 3-11 for the materials used in the research).

Key informant interviews and focus groups were conducted at the participant's workplace, or at the site offices. They were between 45-90 minutes in duration and were audio recorded and transcribed verbatim. Qualitative site researchers also reviewed relevant project planning and proposal development documents.

DATA ANALYSIS

The purpose of the analysis was to "tell the story" about the planning and proposal development phase and to provide some analysis about the common themes embodied in the process. The analysis was not intended to evaluate the process or to test a specific theory of planning and proposal development, but to provide some insights that may help others who wish to embark on a similar initiative, and also contribute to the development of theoretical insights pertaining to the process of planning such an endeavour that may guide others in the future.

Site-level analysis. The main objectives of the analysis were to:

- identify themes according to the topics (or sensitizing concepts) asked about in the interview/focus group guide (see Table 3 below);
- identify any convergences or divergences in perspective between various stakeholder groups (PWLE, service providers, community groups, decision makers, researchers);
- identify themes pertaining to any unanticipated or locally relevant topics not identified in the interview guide, and that may have emerged during the course of the research; and
- identify cross-cutting themes or processes that thread their way through or go beyond the themes identified in the earlier stages of the analysis.

Table 2.3
Topic Areas or Themes: Sensitizing Concepts for Planning and Proposal Development

TOPIC AREA	
• planning environment	• focusing the programs
• stakeholders/partners	• resources
• vision/values/principles	• high, low, and turning point stories in the planning process
• participation of people with lived experience	• other important topics and issues
• relationships	
• structures	

The approach to data analysis involved constant comparative analysis as practiced in grounded theory and other analytic approaches and entailed the following:

- open or initial coding, which involved identifying and giving provisional labels (codes) to apparently similar portions of data that re-occur, and/or which appeared to be emerging as significant issues or themes;
    - note that the approach we followed is both "open" and "not open" in the strict sense, as site researchers identified codes within specific topic areas and, at the same time, looked for and potentially identified codes and themes that were not anticipated;
- focused (or thematic) coding, which involved developing more firm categories, and involved going back to re-code data, grouping them according to the emerging themes; if relevant, grouping themes according to stakeholder group; and possibly
- theoretical coding, which involved identifying how various themes interrelated, or involved identifying a larger process that goes beyond the individual themes.

Despite having a common approach, each site performed the analysis differently, but documented and developed a methodological description for inclusion in the final site report. Issues that were covered included:

- documenting how the questions were adapted in the course of carrying out the interviews or focus groups;
- documenting the variations taken to coding the data;

- writing memos describing the reflection or discussion process that went into the analysis (e.g., identifying why a certain category theme was chosen);
- describing who was involved in the analysis (some examples are listed below):
  - Was there a team approach involved in analyzing the data?
  - Were stakeholders involved in contributing to the analysis?
  - Were interviewers involved in the analysis? (If not, were hunches generated by the interviewers incorporated into the emerging analysis, or what steps were taken to keep the analysts "close to the data" as the analysis proceeded)?
  - Did the analyst have "insider" knowledge of the project, or was it someone who was fresh to the scene?
- identifying any theoretical orientation or personal experience that those analyzing the data may have brought into and employed during the analysis.

Cross-site analysis. The main objective of the cross-site analysis is to provide an analysis of both common and unique themes to the five sites. Each member of the National Qualitative Research Team read the five site reports and took notes on themes. Following this, a teleconference was held in which all team members shared their impressions of the cross-site themes. From this discussion emerged three levels of analysis or types of relationships among project stakeholders: (1) relationships between the national team and the local sites, (2) relationships among local-level stakeholders, and (3) relationships between local professional and research stakeholders with disenfranchised people (e.g., people with lived experience of mental illness). A matrix display was constructed with sites by these three levels of analysis. Relevant data from each of the sites were included in the cells of this matrix. Following this teleconference, the first author of this report then fleshed out a framework for looking at all of the three levels that consisted of opportunities, challenges, and what worked and what didn't work at each of the sites. During a second conference call, a consensus was achieved to use this framework. As well, a number of cross-cutting themes were identified during this teleconference (e.g., an evolution of a shared vision at the sites).

DATA VERIFICATION

Each site went through a process of member-checking with people who were interviewed for the site reports to establish the trustworthiness of the data.

INFORMATION LETTER AND CONSENT FORM FOR KEY INFORMANT INTERVIEWS – PLANNING AND PROPOSAL DEVELOPMENT

Mental Health Commission of Canada Research Demonstration Projects in Mental Health and Homelessness

Informed Consent Statement

You are invited to participate in a research study on the planning and proposal development of the Mental Health Commission of Canada Research Demonstration Project in Mental Health and Homelessness in [site name]. The purpose of this research is to understand the story of the planning and proposal development for the MHCC Homelessness and Mental Health Project in [site name], as you see it. The findings of this research will be used to inform other jurisdictions that are interested in planning similar initiatives. The principal researchers for this project are [insert name]. Altogether, between 400 and 500 people who were involved in the planning and proposal development phase across the five demonstration sites will participate in interviews or focus groups for this research. This includes approximately 6-10 people who were key to the development of the [site name] initiative participating in individual interviews, and another 50-70 participating in focus groups.

INFORMATION

This research is part of the Mental Health Commission of Canada Research Demonstration Projects in Mental Health and Homelessness, in which you have participated in the planning and proposal development in [site name]. This aspect of the research involves participation in an individual interview. The interview will be conducted by a member of the local site research team. The interview will be arranged at a time and place that is convenient for you.

During the interview, the Site Researcher will ask you a number of questions about the planning and proposal development for the MHCC Homelessness and Mental Health Project in [site name]. We will give you the questions in advance so you have a chance to think about them. You are free not to answer any question or to pass on any question that is asked. The interview will last for approximately one to one-and-one-half hours. With your consent, the Site Researcher will audio record the interview. There is no deception involved in the research.

RISKS

We do not believe that you will experience any significant risks to your well-being by participating in this interview. It is possible that if involvement in the planning and proposal development stage of the project was a challenging or emotionally intense experience for you, you may find yourself recalling such challenges and emotions.

BENEFITS

We do envision significant benefits to your participation in this study. You may benefit from the opportunity to reflect on your participation in the planning and proposal development of the MHCC demonstration project in [site name]. Your perspectives on the planning and proposal development phase of the project may be beneficial to other jurisdictions that are interested in planning similar initiatives. Finally, the results of this study will make a contribution to the research literature on the ways in which Housing First programs have been conceived, planned, and implemented in different community contexts.

CONFIDENTIALITY

Your responses to the interview questions will be held confidential by the researcher. That is, your name will not be associated with anything you say during the interview. We will keep everything you say confidential and private, and your name will not be associated in any way with your responses. A transcription of the interview will be identified by code number and stored in a locked filing cabinet to protect the confidentiality of your responses. Should you consent to the use of quotations from your interview, they may be used in write-ups and/or presentations on this research; however, the quotations will not contain any information that allows you to be identified.

All audio files of digitally recorded interviews will be stored on a secure (password protected) server provided by the vendor EHealth, which is accessible only to members of the local site research team and the national research team. Transcriptions of the interviews will be stored in a locked filing cabinet [add location – probably the office of the site researcher]. All audio files will be deleted and paper transcripts destroyed by December 31, 2016.

COMPENSATION

No compensation will be provided for your participation in the interview.

CONTACT

If you have questions at any time about the study or the procedures, or if you experience adverse effects as a result of participating in this study, you may contact the Site Researcher, [insert name and contact information]. This project has been reviewed and approved by the Research Ethics Board at [university name]. If you feel you have not been treated according to the descriptions in this form, or your rights as a participant in research have been violated during the course of this project, you may contact [insert name and contact information for local REB].

PARTICIPATION

Your participation in this study is purely voluntary and you have the right to decide that you do not want to take part in the research. Your decision to take part or to not take part will in no way affect your relationship to the MHCC Research Demonstration Projects in Mental Health and Homelessness. If you withdraw from the study, we will not transcribe any of your responses to the interview. You have the right to omit or withdraw your response to any question or procedure without penalty.

FEEDBACK AND PUBLICATION

A summary of the results of this research will be sent to you when the data have been analyzed, no later than [date]. Information from this research will be used to inform reports on the planning and proposal development process at each of the five demonstration sites, as well as a cross-site report developed by the national research team. Additionally, we plan to present the results of the research at professional and scientific conferences and to publish the findings in professional and scientific journals.

WHERE CAN I GET ADDITIONAL HELP OR RESOURCES IF I NEED THEM?

If you have any questions concerning the collection of this information, please contact:

[Site Researcher name and contact information] or [REB name and contact information for local university]

MENTAL HEALTH COMMISSION OF CANADA RESEARCH DEMONSTRATION PROJECTS IN MENTAL HEALTH AND HOMELESSNESS

Research Consent Form

I have received a copy of the INFORMED CONSENT STATEMENT. I have read it or had it read to me and understand it. It describes my involvement in the research and the information to be collected from me.

I agree to participate in an interview or focus group for this research.

- ○ Yes
- ○ No

I agree to have the interview audio tape-recorded.

- ○ Yes
- ○ No

I understand and agree that my quotations may appear in published reports.

- ○ Yes
- ○ No

I agree to have my name associated with quotations from my interview.

- ○ Yes
- ○ No

_____

Participant's signature Date

_____

Researcher's signature Date

KEY INFORMANT INTERVIEW GUIDE

For Planning and Proposal Development Research for the MHCC At Home/Chez Soi Project (October 13, 2009)

Thank you for attending this voluntary interview. As you know, the purpose of this interview is for you to share your knowledge about the planning and proposal development phase for the MHCC "At Home" project. We believe that this is important because the findings of this research will inform other jurisdictions who are interested in planning similar initiatives. We will also be interviewing other people who played a key role in the planning and proposal development process and conducting interviews with different stakeholder groups (e.g., service providers, researchers, people with lived experience) to gain their perspectives as well. The interview will take about an hour to an hour and a half.

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 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 facilitators.]

I am now going to start the tape recorder.

The purpose of the interview is to focus on planning and proposal development.

I want to start by asking you about the environment in which the planning and proposal development occurred.

Environment

How did the MHCC and the local environment influence the planning and proposal development process?

Probe Questions:

- What parameters set by MHCC in the Request for Applications facilitated the planning process? Challenged the planning process?
- What were some of the characteristics of the community context that facilitated the planning process? Challenged the planning process?

Now I want to turn to the stakeholders/partners who participated in the planning process.

Stakeholders/Partners

Please talk a bit about the stakeholders who were involved in the planning and proposal development process and how they contributed.

Probe Questions:

- Who were the stakeholders/partners who were involved in the planning process?
- How did they become involved?
- What contributions did stakeholders make to the planning process?
- What challenges did they experience in the planning process?
- Over time, did new stakeholders/partners join the planning process? If so, how were they added? Did any stakeholders/partners leave the planning process? Why was that?

I'd like to move now to your views about the vision, values, and principles of the planning process.

Vision/Values/Principles/Ethics

Please describe the vision, values and principles that guided the planning and proposal development.

What were the ethical issues that were the focus of discussion in planning and proposal development?

Probe Questions:

- Is there a common vision that the project aims to achieve? If so, what is it and how was that vision arrived at?
- What values/principles, if any, guided the planning process? How were these values/principles decided upon?
- What facilitated the use of these values/principles in the planning process? What challenged the use of these values in the planning/principles process?

Now I want to ask you about the participation of people with lived experience during the planning process.

Participation of People with Lived Experience

Please tell me how people with lived experience participated in the planning and proposal development process.

Probe Questions:

- To what extent were people with lived experienced involved in the planning process?
- What steps were taken to ensure that people with lived experience had a voice in the planning process?
- What facilitated the participation of people with lived experience in the planning process?
- What challenged the participation of people with lived experienced during the planning process?

The next question focuses on the processes and relationships among stakeholders during the planning process.

Relationships

Please tell how the relationships among different stakeholders influenced the planning and proposal development.

Probe Questions:

- How did the individuals and organizations involved in developing the proposal get along during the planning process?
- What strategies were used to work through any skepticism, mistrust, tensions, conflicts, or issues faced in the planning process?
- Did organizational politics hinder the development of the proposal in any way?
- Did the planning process improve the amount and quality of interaction between key stakeholder groups?
- Did stakeholders see their relationships as having practical value for them during the planning process?
- What was the relationship between the national group and stakeholders at your site during the planning process?

I'd like to switch now to ask you about the group or structures that were involved in the planning process.

Structures

What organizational structures were put in place during the planning and proposal development and how did they work?

Probe Questions:

- Describe the group or structure that guided the planning process.
- Who were the lead agencies and individuals involved in the planning process? And how were they decided on?
- How did the planning group decide who would be responsible for what?
- What roles did the different partners play?
- How were decisions made by the group? Was there a formal decision-making/organizing structure at any point during the development of the proposal?
- How did the group make decisions about issues such as project location, program components, etc.?
- What aspects of the group or structure facilitated the planning process? Impeded the planning process?

Next I'm going to ask you about the specific programs that were proposed.

Focusing the Programs

Please describe the specific programs that were developed.

Probe Questions:

- How was the planning of programs adapted to fit the local context?
- What contextual factors shaped the programs that were planned?
- How were decisions made about the form and function of the site-specific intervention arm?
- What organizations will be involved in operating what components of the programs?

Finally, I'm going to ask you about how resources were proposed to be allocated for the programs.

Resources

Please talk about financial and human resource issues that were faced during the planning and proposal development.

Probe Questions:

- How were funding resources allocated to the different program components?
- What human resources or strengths (e.g., knowledge, skills, experience, leadership) did the different stakeholders bring to the planning process?
- What resources, if any, were not sufficiently developed at the time of the planning process?
- How did the planning group address the issue of sustainability of the programs during the planning process?

High-Point, Low-Point, Turning Point Stories

- What was a high point for you in the proposal development and planning process?
- What was a low point for you in the proposal development and planning process?
- What was turning point for you in the proposal development and planning process?

In Closing

- 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 today/tonight. What was it like for you to participate in this interview?
- Is there anything we could do to improve the interview? I am now shutting off the tape recorder.
- What questions do you have of me?
- Thank you very much for your participation in this interview. I appreciate your willingness to share your experiences with me.

TRANSCRIPTION PROTOCOL
MHCC AT HOME/CHEZ SOI PROJECT

Key Informant Interviews Planning and Proposal Development and Implementation (October 28, 2009)

- File names should be in the following format: ID # XXX - MHCC Planning
- Files should be saved in .doc, .docx, or .rtf format.
- The first paragraph of each file should be in the following format: Focus group conducted (date) by (facilitator name); transcribed (date transcription completed) by (transcriptionist name).
- Please use 1 inch (left) and 2 inch (right) margins and Times New Roman 12 pt font.
- Pages and lines should be numbered. Page numbers should be inserted in the top right corner (in Microsoft Word, Insert -> Page Numbers). Line numbering in Microsoft Word can be inserted through Page Layout -> Line Numbers -> Continuous.
- If the interview follows a path that allows you to do so, please use the following headers in "Heading 1" style to divide the interview into sections:
    - Environment
    - Stakeholders/Partners
    - Vision/Values/Principles/Ethics
    - Participation of People with Lived Experience
    - Processes/Relationships
    - Structures
    - Focusing the Programs
    - Resources
    - High Point Story
    - Low Point Story
    - Turning Point Story
- In each section of the interview, please use italics to indicate interviewer speech and plain text to indicate participant speech.
- Please transcribe speech as naturally as possible, including "you knows", "ums", etc.
- Insert paragraph breaks after all obvious changes of topic.

- Other transcription conventions that may prove useful:

[descriptor]	Descriptors of speech or behaviours in square parentheses e.g., [sarcastically], [laughter], [P# laughs]
(2.0)	Extended pause (seconds)
'Aw...'	Extended sounds shown by colons in proportion to the length of the sound Word Underline shows stress or emphasis
Wor-	Hyphen indicates that a word or sound is broken off
WORD	Increase in amplitude is shown by capital letters
(word)	Parenthesis bound uncertain transcription, the transcriber's "best guess"
((incomp))	Incomprehensible

- File Management:

  Completed transcripts should be saved to the Health Diaries site in the folder "Site » Planning & Proposal Development » Key Informant Interviews » Transcripts" under the name "ID # XXX - MHCC Planning"

- Template:

  A template in MS Word format is attached to this transcription protocol.

Interview conducted (date) by (interviewer name); transcribed (date transcription completed) by (transcriptionist name).

Environment

Interviewer's speech in italics

Participant responses in normal text

Stakeholders/Partners

Vision/Values/Principles/Ethics

Participation of People with Lived Experience

Processes/Relationships

Structures

Focusing the Programs

Resources

High Point Story

Low Point Story

Turning Point Story

INFORMATION LETTER AND CONSENT FORM FOR FOCUS GROUPS – PLANNING AND PROPOSAL DEVELOPMENT

Mental Health Commission of Canada Research Demonstration Projects in Mental Health and Homelessness

Informed Consent Statement

You are invited to participate in a research study on the planning and proposal development of the Mental Health Commission of Canada Research Demonstration Project in Mental Health and Homelessness in [site name]. The purpose of this research is to understand the story of the planning and proposal development for the MHCC Homelessness and Mental Health Project in [site name], as you see it. The findings of this research will be used to inform other jurisdictions that are interested in planning similar initiatives. The principal researchers for this project are [insert name]. Altogether, between 400 and 500 people who were involved in the planning and proposal development phase across the five demonstration sites will participate in interviews or focus groups for this research. This includes approximately 6-10 people who were key to the development of the [site name] initiative participating in individual interviews, and another 50-70 participating in focus groups.

INFORMATION

This research is part of the Mental Health Commission of Canada Research Demonstration Projects in Mental Health and Homelessness, in which you have participated in the planning and proposal development in [site name]. This aspect of the research involves participation in a focus group. The focus group will be conducted by a member of the local site research team. The focus group will be arranged at a time and place that is convenient for you and other participants.

During the focus group, the Site Researcher will ask you a number of questions about the planning and proposal development for the MHCC Homelessness and Mental Health Project in [site name]. We will give you and the other focus group participants the questions in advance so you have a chance to think about them. Everyone will have a chance to speak to each question; however, you are also free not to answer any question or to pass on any question that is asked. The focus group will last for approximately 1.5-2 hours. There will be a break, if the group wishes. With your consent, the Site Researcher will audio record the interview. There is no deception involved in the research.

RISKS

We do not believe that you will experience any significant risks to your well-being by participating in this interview. It is possible that if involvement in the planning and proposal development stage of the project was a challenging or emotionally intense experience for you, you may find yourself recalling such challenges and emotions.

BENEFITS

We do envision significant benefits to your participation in this study. You may benefit from the opportunity to reflect on your participation in the planning and proposal development of the MHCC demonstration project in [site name]. Your perspectives on the planning and proposal phase of the project may be beneficial to other jurisdictions that are interested in planning similar initiatives. Finally, the results of this study will make a contribution to the research literature on the ways in which Housing First/Streets to Homes programs have been conceived, planned, and implemented in different community contexts.

CONFIDENTIALITY

Your responses to the focus group questions will be kept completely anonymous. That is, your name will not be associated with anything you say during the focus group. The Site Researcher will ask all participants to keep what is said in the group confidential. While we cannot guarantee complete confidentiality, as some participants may talk with others about their participation in the group, we as researchers will keep everything you say confidential and private.

A transcription of the focus group will be identified by code number and stored in a locked filing cabinet to protect the confidentiality of your responses. Should you consent to the use of your quotations, they may be used in write-ups and/or presentations on this research; however, the quotations will not contain any information that allows you to be identified.

All audio files of digitally recorded focus groups will be stored on a secure (password protected) server provided by the vendor EHealth, which is accessible only to members of the local site research team and the national site research team. Transcriptions of the interviews will be stored in a locked filing cabinet [add location – probably the office of the site researcher]. All audio files will be deleted and paper transcripts destroyed by December 31, 2016.

COMPENSATION

No compensation will be provided for your participation in this focus group.

CONTACT

If you have questions at any time about the study or the procedures, or if you experience adverse effects as a result of participating in this study, you may contact the Site Researcher, [insert name and contact information]. This project has been reviewed and approved by the Research Ethics Board at [university name]. If you feel you have not been treated according to the descriptions in this form, or your rights as a participant in research have been violated during the course of this project, you may contact [insert name and contact information for local REB].

PARTICIPATION

Your participation in this study is purely voluntary and you have the right to decide that you do not want to take part in the research. Your decision to take part or to not take part will in no way affect your relationship to the MHCC Research Demonstration Projects in Mental Health and Homelessness. If you withdraw from the study, we will not transcribe any of your responses to the interview. You have the right to omit or withdraw your response to any question or procedure without penalty.

FEEDBACK AND PUBLICATION

A summary of the results of this research will be sent to you when the data have been analyzed, no later than [date]. Information from this research will be used to inform reports on the planning and proposal development process at each of the five demonstration sites, as well as a cross-site report developed by the national research team. Additionally, we plan to present the results of the research at professional and scientific conferences and to publish the findings in professional and scientific journals.

WHERE CAN I GET ADDITIONAL HELP OR RESOURCES IF I NEED THEM?

If you have any questions concerning the collection of this information, please contact:

[Site Researcher name and contact information] or [REB name and contact information for local university]

MENTAL HEALTH COMMISSION OF CANADA RESEARCH DEMONSTRATION PROJECTS IN MENTAL HEALTH AND HOMELESSNESS

RESEARCH CONSENT FORM

I have received a copy of the INFORMED CONSENT STATEMENT. I have read it or had it read to me and understand it. It describes my involvement in the research and the information to be collected from me.

I agree to participate in an interview or focus group for this research.

- ○ Yes
- ○ No

I agree to have the interview audio tape-recorded.

- ○ Yes
- ○ No

I understand and agree that my quotations may appear in published reports.

- ○ Yes
- ○ No

I agree to have my name associated with quotations from my interview.

- ○ Yes
- ○ No

_____

Participant's signature Date

_____

Researcher's signature Date

FOCUS GROUP INTERVIEW GUIDE

Planning and Proposal Development MHCC At Home/Chez Soi Project (October 13, 2009)

Thanks everyone for attending this voluntary focus group session. As you know, the purpose of this interview is for you to share your knowledge the planning and proposal development phase for the MHCC "At Home" project. We believe that this is important because the findings of this research will inform other jurisdictions who are interested in planning similar initiatives. We will also be interviewing other people who played a key role in the planning and proposal development process and conducting interviews with different stakeholder groups (e.g., service providers, researchers, people with lived experience) to gain their perspectives as well. The focus group will take about one hour to one and a half hours.

I'd like you decide whether you would be most comfortable representing yourself or a specific organization with which you are affiliated or that you work for.

Before we get started let's review the consent form. Then you can decide if you want to participate in the focus group.
[Interviewer reviews the information letter and consent form with participants.]

What questions do you have before we begin?
[After questions have been asked and answered, participants are asked to complete the consent forms and give them to the facilitators.]

Let's begin by introducing ourselves to the rest of the group. [After introductions have been made.] I am now going to start the tape recorder.

The purpose of today's discussion is to focus on planning and proposal development. I will give everyone a chance to respond to each question. If you don't want to give your opinions or voice your experiences about the question, feel free to pass.

I want to start by asking you about the environment in which the planning and proposal development occurred.

Environment

1. What was your reaction to the MHCC Request for Applications? What was the reaction of your organization to the Request for Applications? What did you find appealing about it? What did your organization find appealing about it? What did you find challenging? What did your organization find challenging?
2. What specific aspects of the local community facilitated or impeded the planning process?

Now I want to turn to some questions about the stakeholders/partners who participated in the planning process.

Stakeholders/Partners

1. Can you describe your experience with participating in the planning process?
    a. What were your motivations for getting involved in the planning? What was the motivation of your organization?
    b. How were you invited to participate? How was your organization invited to participate?
    c. What helped you or hindered you from participating in the planning process?
    d. What helped you or hindered your organization from participating in the planning process?

I'd like to move now to your views about the vision, values, and principles of the planning process.

Vision/Values/Principles

1. Is there a common vision that the project aims to achieve? If so, what is it and how was that vision arrived at?
    a. What values/principles, if any, guided the planning process?
    b. How were the vision/values/principles decided upon?
    c. What facilitated or impeded the use of the vision/values/principles in the planning process?

Now I want to ask you about the participation of people with lived experience during the planning process.

Participation of People with Lived Experience

1. To what extent were people with lived experienced involved in the planning process?
    a. What steps were taken to ensure that people with lived experience had a voice in the planning process?
    b. What facilitated or impeded the participation of people with lived experience in the planning process?

The next questions focus on the processes and relationships among stakeholders during the planning process.

Relationships

1. How did the individuals and organizations involved in developing the proposal get along during the planning process?
    a. What strategies were used to work through any scepticism, mistrust, tensions, conflicts, or issues faced in the planning process?
    b. Did organizational politics hinder the development of the proposal in any way?
    c. Did the planning process lead to better relationships between you and other stakeholders?
2. What was your experience of the collaboration between the national group and your site during the planning process? What was the experience of your organization of the collaboration between the national group and your site during the planning process?
3. What was your experience of the process of designing the site-specific intervention arm in your community?
4. What was the experience of your organization of the process of designing the site-specific intervention arm in your community?

High-Point, Low-Point, Turning Point Stories

1. What was a high point for you in the proposal development and planning process?
2. What was a low point for you in the proposal development and planning process?
3. What was a turning point for you in the proposal development and planning process?

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 today/tonight. What was it like for you to participate in this interview?

Is there anything we could do to improve the interview? I am now shutting off the tape recorder.

What questions do you have of me?

Thank you very much for your participation in this interview. I appreciate your willingness to share your experiences with me.

TRANSCRIPTION PROTOCOL

MHCC At Home/Chez Soi Project Focus Group Interviews Planning and Proposal Development and Implementation (October 28, 2009)

- File names should be in the following format: Focus Group # XXX - MHCC Planning
- Files should be saved in .doc, .docx, or .rtf format.
- The first paragraph of each file should be in the following format: Focus group conducted (date) by (facilitator name); transcribed (date transcription completed) by (transcriptionist name).
- Please use 1 inch (left) and 2 inch (right) margins and Times New Roman 12 pt font.
- Pages and lines should be numbered. Page numbers should be inserted in the top right corner (in Microsoft Word, Insert -> Page Numbers). Line numbering in Microsoft Word can be inserted through Page Layout -> Line Numbers -> Continuous.
- If the interview follows a path that allows you to do so, please use the following headers in "Heading 1" style to divide the interview into sections:
    - Environment
    - Stakeholders/Partners
    - Vision/Values/Principles/Ethics
    - Participation of People with Lived Experience
    - Processes/Relationships
    - High Point Story
    - Low Point Story
    - Turning Point Story
- In each section of the interview, please use italics to indicate interviewer speech and plain text to indicate participant speech.
- Please transcribe speech as naturally as possible, including "you knows", "ums", etc.
- Insert paragraph breaks after all obvious changes of topic. Insert paragraph breaks between speakers, with the >> character to indicate a change of speaker.

- Other transcription conventions that may prove useful:

[descriptor]	Descriptors of speech or behaviours in square parentheses e.g., [sarcastically], [laughter], [P# laughs]
(2.0)	Extended pause (seconds)
'Aw...'	Extended sounds shown by colons in proportion to the length of the sound Word Underline shows stress or emphasis
Wor-	Hyphen indicates that a word or sound is broken off
WORD	Increase in amplitude is shown by capital letters
(word)	Parenthesis bound uncertain transcription, the transcriber's "best guess"
((incomp))	Incomprehensible

- File Management:

  Completed transcripts should be saved to the Health Diaries site in the folder "Site » Planning & Proposal Development » Focus Groups » Transcripts" under the name "Focus Group # XXX - MHCC Planning"

- Template: A template in MS Word format is attached to this transcription protocol.

Focus group conducted (date) by (facilitator name); transcribed (date transcription completed) by (transcriptionist name).

Environment

Interviewer's speech in italics

Participant responses in normal text

Stakeholders/Partners

Vision/Values/Principles/Ethics

Participation of People with Lived Experience

Processes/Relationships

High Point Story

Low Point Story

Turning Point Story

PARTICIPANT DEMOGRAPHIC FORM

Planning and Proposal Development MHCC At Home/Chez Soi Project (October 28, 2009)

Age

_____

Gender

- ○ Male
- ○ Female
- ○ Other
- ○ Decline to Answer

Race/Ethnicity

- ○ White or Caucasian
- ○ Black or African Descent
- ○ Aboriginal/First Nations/Métis/Inuit
- ○ Asian or Pacific Descent
- ○ Hispanic or Latino/Latina
- ○ Other
- ○ Decline to Answer

Primary Language

- ○ English
- ○ French
- ○ Other

Relationship to MHCC Homelessness & Mental Health Project (all that apply)

- ○ MHCC Staff
- ○ Research Partner
- ○ Service Delivery Partner
- ○ Consumer
- ○ Family Member of Consumer
- ○ Government Representative
- ○ Representative of Other Community Organization
- ○ Other: _____

How would you describe your involvement in the planning development of the MHCC proposal?

- ○ A Key Player
- ○ Actively Involved
- ○ Moderately Involved
- ○ Peripherally Involved
- ○ Not Involved

What did your involvement entail? (All that apply)

- ○ Contributions to research protocol
- ○ Contributions to service protocol
- ○ Planning meetings
- ○ Consultations
- ○ Other: _____

Describe your experience in mental health/the mental health system: _____

If working in mental health, years of experience: _____

Describe your experience with homelessness/housing: _____

*If working in housing, years of experience:*_____

Previous involvement with other national/multi-site study: ○ Yes ○ No

PROTOCOL FOR DOCUMENT REVIEW

Planning and Proposal Development MHCC At Home/Chez Soi Project (October 28, 2009)

Title of Document _____

Date of Document _____

Date of Document Review _____

Name of Person Who Reviewed the Document _____

TOPIC AREA	NOTEWORTHY DESCRIPTIVE INFORMATION	REVIEWER IMPRESSIONS / COMMENTS ANALYTIC
the planning environment		
stakeholders/partners		
vision/values/principles		
the participation of people		
with lived experience relationships		
structures		
focusing the programs		
resources		
Other noteworthy		
topics/issues		