The At Home/Chez Soi Project:

A Review of the Proposal Development and Planning Phase in Vancouver, BC

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PLANNING REPORT

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PARTNERS AND COLLABORATORS

Researchers:
- Providence Health Care
- Simon Fraser University
- University of British Columbia

Project Service Providers:
- Coast Foundation for Mental Health
- Motivation, Power & Achievement Society
- Portland Hotel Community Services Society
- RainCity Housing

Community Stakeholders:
- Atira Women’s Resource Society
- BC Housing
- BC Mental Health and Addiction Services
- BC Ministry of Health Services
- Canadian Mental Health Association
- City of Vancouver
- The Kettle Friendship Society
- Lookout Society
- Providence Health Care/St. Paul’s Hospital
- St. James Community Services Society
- Streets to Home Foundation
- Vancouver Coastal Health
- Vancouver Foundation
KEY MESSAGES

This report examines how a consortium of diverse stakeholders convened in Vancouver to respond to the Mental Health Commission of Canada’s Request for Applications for a research demonstration project on mental health and homelessness. It describes the challenges the local team faced and the sources of strength they drew on as they developed their response and proposal.

Qualitative methods were used to examine how the local consortium convened, developed, and planned the Vancouver site initiative. A semi-structured interview guide was created in consultation with the National Qualitative Working Group. Interviews with stakeholders were conducted from October 2009 through February 2010 and the sample consisted of 15 individuals (12 individual interviews and one focus group). Two research assistants (RA) reviewed all transcripts and prepared a detailed summary of responses by question. The RAs, along with two co-Investigators, then reviewed the summary and identified key themes.

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 mental health and other support services to an underserved, marginalized population. The collaborative approach the project encouraged was also embraced; many respondents recognized that working across disciplinary and institutional boundaries could enable the restructuring of the current hierarchical service model.

Respondents identified the project’s tight timeframe as a key challenge that limited opportunities for fully engaging stakeholders and people with lived experience. Time constraints also hindered creativity in proposal development and transparency in the decision-making process. In addition, many stakeholders found the Request for Applications both vague and rigid. As a result, the project vision was not fully developed and team roles were unclear. However, a few respondents noted that overly defined parameters can often lead to a narrowing of vision, creativity and innovation.

The group identified two primary ethical issues: the inclusion of a “treatment as usual” group and the sustainability of housing after the project ends. Several stakeholders noted that a better research design could have been used, one that did not include a “treatment as usual” group. As a result of disagreement over the research design, several stakeholders withdrew from the project.

Key themes that emerged from the application process included the importance of building trust and of working collaboratively. Some respondents felt that a lack of trust sometimes hindered the planning process, while many others felt that tensions were managed relatively well. Respondents noted that trust improved and power struggles diminished once lead service providers had been identified and the proposal was submitted. Although some tensions remain, respondents described a collective agreement to work through challenges as they arise and a collaborative spirit of give and take. As the project progresses, respondents aim to develop a reflective group practice and a strong commitment to transforming the system on multiple levels.
EXECUTIVE SUMMARY

This report examines how a consortium of diverse stakeholders, including community service providers and researchers, convened in Vancouver to respond to the Mental Health Commission of Canada’s Request for Applications (RFA) for a research demonstration project on mental health and homelessness. The report describes the challenges facing a large multidisciplinary team as members developed their research response and proposal (September 1, 2008 to January 30, 2009), and the strengths on which they drew to meet these challenges. The report also examines the planning phase of the project (February 2009 to October 13, 2009), during which research and service teams mobilized resources to begin recruiting study participants and coordinating service provision.

Qualitative methods were used to examine how the local consortium convened, developed, and planned the Vancouver site initiative. A semi-structured interview guide was created in consultation with the National Qualitative Working Group. Interviews with stakeholders were conducted from October 2009 through February 2010 and the interview sample consisted of 15 individuals (12 individual interviews and one focus group), all of whom were involved to some degree in the proposal development and planning phases of the project. Five individuals identified as researchers and 10 individuals identified as service providers. Two research assistants (RA) reviewed all transcripts and prepared a detailed summary of responses by question. The RAs, along with two co-Investigators, then reviewed the summary and identified key themes, which are summarized below.

Opportunities for change

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 ways in which those services are delivered. Most respondents saw themselves as part of unhealthy and fragmented service systems that they felt responsible for repairing. Overall, respondents expressed a sense of excitement, hope, and gratitude for their inclusion in a project with this philosophy and scale. Further, many described the importance of creating a unified voice across Canada to enable housing reform (e.g., a National Housing Strategy), and noted that the project provided an opportunity to break down the hierarchies that exist within the mental health and housing systems.

Relationship-building and shared learning

From the beginning, there was an attempt to create a collaborative working environment in which all team members were given the opportunity to contribute and participate. The project could have been carried out by a Health Authority or the research community alone; since it was not, those involved appreciated the redistribution of leadership roles and the creation of partnerships within and between groups. For many people, this appreciation was fully realized when the not-for-profit organizations were awarded the service leads. This move enabled stakeholders to see that clinical services do not have to be delivered through traditional models of care and it also demonstrated that the work of individuals who have been working with homeless and mentally ill populations for many years with few resources is highly valued.

Strong alliances and partnerships have developed through this project that will inform and support future endeavours. Overall, respondents felt welcomed into the process and supported regardless of historical positioning, and have acted with mutual respect despite tensions. In general, on the part of all project stakeholders, there is a progression toward relinquishing power and renegotiating relationships. An environment of shared learning is also being developed, drawing from the expertise at the table and sharing that knowledge within and between groups.
Timeframes
Respondents stated that some key aspects of project planning were missed due to time constraints. Several respondents stated that there was not time to be creative, in particular around service models and research questions. Further, a tight timeframe limited the ability to engage all the necessary stakeholders, specifically people with lived experience. Further, because some decisions had to be made quickly, many people felt left out of the decision-making process.

Inclusion of people with lived experience (PWLE)
The inclusion of PWLE was not fully realized during the proposal development and planning phase. Many respondents suggested that PWLE should have been involved from the project’s conception, and that an individual with lived experienced should have been hired along with the Site Coordinator. Full and meaningful inclusion of PWLE requires time and mentorship given the lack of consumer infrastructure in Vancouver.

Transparency and leadership
Overall, there was a lack of transparency and leadership with regard to the project vision, decision-making processes and roles within the local group, as well as between the local and the national teams. According to many respondents, decisions were often made without explanation. Many respondents found the RFA vague, which, combined with a tight timeframe, created significant anxiety.

Several respondents found the initial meetings confusing and unproductive, as well as hierarchical; according to respondents, researchers dominated the platform. Some felt that there was little opportunity for balanced dialogue in the early stages of the project; however, other respondents felt this was normal given the large and diverse nature of the consortium. The majority of respondents (predominantly service providers) stated that the appointment of a Site Coordinator was essential to navigating the proposal and planning process.

Redistributing power
Respondents discussed issues of power and control that arose at the beginning of the process. Researchers and service providers were perceived to be vying for power, as well as individuals within the research and service groups: “we’re all used to being in charge.” Most service providers noted that there were fewer struggles for power among agencies once the service leads were announced.

Trust and collaboration were key themes throughout the interviews. Some respondents described how a lack of trust hindered the process, whether it occurred between researchers and service providers, within the research and service provider communities, between service providers and larger funding bodies, or between the local and the national group. Tensions are still present between and within groups; however, the majority of respondents feel that these tensions are normal and are satisfied by efforts to develop trust and a more collaborative process. Significant progress has been made by following through on promises, showing respect, and being consistent and transparent. Overall, most respondents are very optimistic about the working environment as well as possibilities for real change in the system of care.

A number of recommendations emerged from the interviews.

Provide opportunities for cross-disciplinary education. Many respondents suggested that having more opportunities for sharing experience and expertise would have assisted in creating a less intimidating and hierarchical environment in the early stages of the project.
Define roles and decision-making processes. The majority of respondents stated that project parameters needed to be more clearly defined in the RFA. In addition, clear roles and decision-making processes at both local and national levels would have been helpful.

Develop an ongoing reflective practice. Given the size and complexity of the project, the opportunity to reflect on group interactions, decision-making processes, access to information, and other aspects of the project is critical to “doing things differently.”

Build capacity for co-creation. Given the cross-site structure of the project, there is a need for dialogue between sites. The complex and vital challenges we face cannot be addressed effectively by any one leader or organization or sector, and so we need to build our capacity for co-creation.

Make start-up funding available. It was suggested that start-up funds would have assisted stakeholders in managing workloads, particularly defining the interventions and developing budgets.

Communicate results. The majority of respondents requested that the results of these stakeholder interviews be shared locally and nationally.
INTRODUCTION

Over the past 30 years, homelessness has emerged as a significant social problem across Canada, growing in both size and scope in urban, semi-urban and rural communities (Laird, 2007). Adults who are homeless suffer disproportionately from high rates of serious mental health and substance use problems compared with the general population. Co-occurring physical health problems are also very common in this demographic (see Frankish, Hwang & Quantz, 2005). Although individuals with mental health problems constitute a minority of the homeless population, research has shown that they are likely to experience more frequent and longer periods of homelessness as well as require more support from health and social services than others experiencing homelessness.

Among other structural changes, the growth in the rate of homelessness has coincided with the deinstitutionalization of long-stay psychiatric institutions across North America. This significant downsizing in psychiatric care has been accompanied by inadequate investments in the expansion and integration of community programs that provide services for individuals with mental and substance use disorders, and reductions in welfare, criminal justice, and housing services. As a result, many cities across Canada, including Vancouver, have witnessed a significant increase in the number of homeless individuals with serious mental health and substance use problems. The housing and mental health-related needs of this population are not only diverse but are further complicated by physical health problems, trauma, and various social and occupational challenges.

While the research literature presents a complex relationship between homelessness and mental health, it is clear that untreated psychiatric and physical health conditions contribute to chronic homelessness. However, the services designed to address various psychiatric, addiction, physical and social issues are often segregated and inadequate. Mental health issues and addictions are most often addressed by diverse, community-based, not-for-profit organizations while physical health conditions tend to be treated in walk-in clinics and emergency departments where the continuity of follow-up care is limited. Not-for-profit agencies are often too ill-equipped to address the complex and concurrent needs of homeless individuals, and this inability often leads to incomplete care and further unmet needs. Given the high rates of behavioural and physical health problems among individuals experiencing homelessness and the inadequacy of services, there is a growing need for effective approaches that integrate housing with treatment and support services (Rosenheck et al., 2003).

A growing body of research demonstrates that supported housing has a positive impact on residential stability, regardless of the specific model of housing (Best, 2006; Rog, 2004). Recent research indicates that a Housing First approach, which provides permanent, independent housing that is dispersed throughout the community, is an effective approach for people who are homeless with mental disorders, including substance use (e.g., Tsemberis & Eisenberg, 2000). This model makes no treatment demands of clients but offers intensive support services to help individuals integrate into their community. Despite these findings, researchers have not thoroughly examined the impact of supported housing on outcomes other than those related to residential stability and hospitalization, and existing studies have not yielded consistent results.

Recent research has established many characteristics of effective interventions for individuals with psychiatric symptoms who are homeless, including the importance of perceived choice (Greenwood et al., 2005; Nelson et al., 2007). Assertive Community Treatment (ACT) is a model of care for people with severe mental illness in which a multidisciplinary team provides treatment and rehabilitation in addition to case management functions. An extensive body of research has shown that ACT is effective in reducing hospitalization and improving symptoms of mental illness as well as social functioning (see Ziguras & Stuart, 2000). Focusing on a subset of people with severe mental illness who are homeless, Coldwell and Bender (2007) used meta-analysis to assess the effectiveness of ACT versus standard
case management. Overall, clients who received ACT had a 37 per cent reduction in homelessness and a 26 per cent improvement in psychiatric symptom severity compared with standard case management. These results suggest that people with highly disabling conditions who are also homeless may best be served by a service model such as ACT.

Intensive Case Management (ICM) is another model of care for people with mental illness in which services are brokered to community agencies by a case manager rather than delivered by a team (as in ACT). The evidence base for ICM is not as strong as that for ACT. However, ICM has been shown to be effective in improving symptoms of mental illness as well as social functioning (see Dixon & Goldman, 2003). Despite the body of evidence in favour of ACT and, to a lesser degree, ICM, little is known about the effectiveness of different intensities of intervention for individuals who are homeless and have differing levels of need.

In addition to the increase in homelessness and diverse service needs, many cities face a substantial shortage in the availability of affordable housing units. In light of limits to housing availability, the implementation of scattered site housing, as modelled by the Housing First approach, may not offer the most efficient use of available service resources. Researchers have not adequately explored alternative strategies, including approaches that provide independent housing for individuals with severe mental illness who are homeless in congregate settings where neighbours would include other people living with severe mental illness (see He, O’Flaherty & Rosenheck, 2010; Walker & Seasons, 2002). Further, given the current economic recession, exploring the relative advantages and disadvantages of congregate housing arrangements on people with severe mental disorders is timely.

Over the past 30 years, researchers in medicine and, more recently, public health, have adopted a model of evidence-based practice (see Des Jerlais et al., 2004). The randomized controlled trial (RCT) is usually seen as the strongest method for assessing the efficacy of interventions (however, see Victoria et al., 2004 and Hawe et al., 2004 for a discussion of assessing complex interventions). Health Canada and the Mental Health Commission of Canada, the funding bodies for the At Home Project, determined that an RCT would be the underlying design of the study, in this way implicitly supporting the move towards complex policy trials and multi-site RCTs as primary methods for developing policy-related knowledge. In this context, certain constraints, such as the random assignment to intervention and control groups, as well as the lack of a clear sustainability plan, were inherent in the basic study design.

In light of the growth in both the size and scope of homeless populations and the increasing need for effective approaches that integrate housing with mental health and support services, as well as limitations in the research literature, it is essential to obtain a better understanding of how supported housing and services influence the broader context of individuals’ lives. An improved knowledge of homelessness and the service needs of individuals is necessary for the development not only of long-term, community-based solutions, but for the formation of well-defined health and social policies.
PURPOSE

This report examines how a consortium of diverse stakeholders, including community service providers and researchers, convened in Vancouver to respond to the Mental Health Commission of Canada’s Request for Applications (RFA) for a research demonstration project on mental health and homelessness. The report describes the challenges facing a large multidisciplinary team as members developed their research response and proposal (September 1, 2008 to January 30, 2009), and the strengths on which they drew to meet these challenges. The report also examines the planning phase of the project (February 2009 to October 13, 2009), during which research and service teams mobilized resources to begin recruiting study participants and coordinating service provision.

More specifically, this report focuses on the following:

• Ways in which the environment and stakeholder relationships affected planning and proposal development;
• The process of developing a vision and set of values for the project;
• Ways in which diverse groups of stakeholders were included;
• Leadership and decision making; and
• Contextual factors that shaped the planning of the project as a whole as well as specific interventions.

A future report will address the implementation phase of the project.
LOCAL CONTEXT

In Vancouver, the overlap between mental disorders, substance use, and homelessness has become a civic crisis. Compared with the rest of British Columbia and Canada, Vancouver is unique in terms of the heterogeneity, multimorbidity and concentration of its homeless population. Researchers have well documented the extent of chronic medical conditions, including infectious disease, among Vancouver’s homeless population (Acorn, 1993; Wood, Kerr et al., 2003). Furthermore, many individuals who are homeless in Vancouver are not connected to the formal health care system, and are thus at elevated risk of adverse medical outcomes, including drug overdose (Kerr et al., 2005).

The 2008 Metro Vancouver Homeless Count found 1,372 people who were homeless in the City of Vancouver. This number represents a 23 per cent increase from the previous count in 2005. Notably, between 2005 and 2008, the percentage of people who experienced homelessness for one year or more increased by 65 per cent, representing 48 per cent of people counted in 2008. In addition to the significant increase in the rate of homelessness, self-reported rates of mental illness and addictions have also increased significantly, by 86 per cent and 63 per cent, respectively. A 2007 provincial estimate of the population of adults with severe mental disorders (including substance use disorders) estimated that 1,800 adults in Vancouver are absolutely homeless and an additional 2,280 adults are at risk for homelessness (Somers, 2008). These reports suggest not only a significant increase in the rates and severity of homelessness in Vancouver, but that a substantial number of people are affected.

The Downtown Eastside (DTES) community, home to approximately 16,000 individuals, is unique to the Vancouver context. Many individuals in the DTES are homeless or live in unstable housing conditions, resulting in high rates of health and social service needs in the area. Vancouver Coastal Health (n.d.a.) estimated that 3,200 individuals in the DTES have significant health problems and an additional 2,100 have more substantive disturbances that require intensive support and services. Other estimates suggest an even greater level of need. For example, Eby and Misura (2006) estimated that 5,000 injection drug users in the DTES are infected with Hepatitis C or HIV/AIDS. Unfortunately, many individuals do not receive treatment for their conditions other than medical care through emergency departments (Kerr et al, 2005).

Although estimates vary widely of the clinical, social and housing service needs within the population of people who are homeless with mental disorders, it is clear that the variability and severity of needs within the homeless population requires interventions that respond to individuals with both high and moderate levels of need. In response to the growing levels of homelessness in Vancouver and related issues in health and social problems, several not-for-profit organizations have established housing and other supportive services, many of which are located in the DTES. However, while provincial ACT standards have been developed and a Provincial Advisory Committee has been established to implement ACT province-wide, there is currently only one ACT team in Vancouver (created within the past year), and only three province-wide. Vancouver therefore lacks basic service components (i.e., Housing First, ACT, ICM). This dearth of services may help explain the complexities of planning and implementing the At Home Project (i.e., not merely bringing people together around a common framework, but introducing key components of the framework at the same time).

The high concentration of Single Room Occupancy (SRO) hotels is also unique to downtown Vancouver. A considerable demand for low income housing is evidenced by the 0.5 per cent vacancy rate for bachelor suites in Vancouver. As a result, affordable housing is far beyond the shelter allowance of people receiving income assistance. The average rent for a bachelor apartment is $736 per month, almost double the $375 monthly shelter allowance. In general, housing in Vancouver for people living with substance use and other mental disorders has been in congregate settings, and this

1 The 2008 Metro Vancouver Homeless Count also identified an additional 1,037 individuals who were homeless in suburban areas adjacent to the City of Vancouver.
trend continues with the purchase and renovation of a number of SROs and the development of congregate housing on 12 city sites.

Growing civic commitment and public concern in Vancouver has been directed towards improving the health, autonomy, and quality of life among those who are homeless and have mental disorders. In November 2008, the Mayor of Vancouver, Gregor Robertson, created 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 and 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). If these initiatives continue, they will significantly improve the standard of “usual care” for people with mental disorders who are homeless in Vancouver.

In summary, the At Home Project addresses a critical gap in the research evidence about housing and services for a growing population of vulnerable individuals. While service agencies and institutions have struggled to overcome differences of organizational cultures, mandates and styles of work, the At Home Project has encouraged diverse stakeholder groups to come together and establish a common framework. The development of a philosophy of shared leadership among high performance teams that can transcend organizational boundaries is vital not only for the success of the project, but for the country to acquire the necessary knowledge to provide effective housing, health, and social services to individuals in need.
METHODOLOGY

The research team used qualitative methods to examine how the local consortium of diverse stakeholders planned and carried out the Vancouver site project. The team created a semi-structured qualitative interview guide in consultation with the National Qualitative Working Group. Consultation with the National Qualitative Working Group ensured that the interview guide was generally consistent across all study sites and that it adequately addressed planning and development issues. The interview guide provided the framework for both individual and focus group interviews. In addition, the research team used documents and minutes derived from planning and proposal development meetings held between September 2008 and September 2009 to gain further insight into the development of the project.

The team conducted interviews with stakeholders between October 2009 and February 2010. Stakeholders were contacted for inclusion based on the level of their participation and involvement in the initial meetings and subsequent project development. The sample consisted of 15 individuals, five researchers and 10 service providers. The ratio of females to males was 2:1 and the majority of respondents (87 per cent) indicated that they were between 25 and 54 years of age. All respondents self-identified as White or Caucasian with English as their primary language. On average, respondents had 21 years’ experience working in mental health and/or addiction services, in program development, as members of local committees and not-for-profit boards, or as frontline staff. Respondents also had considerable experience working with homelessness and housing issues through research initiatives and program development; 55 per cent of respondents had previous involvement with either a national or multi-site study. The majority of respondents (54 per cent) considered themselves to be actively involved in the project, while 23 per cent identified as key players, 15 per cent as peripherally involved, and 8 per cent as moderately involved. The team conducted 12 individual interviews and one focus group, with three service providers among the sample of participants. Two key informants declined to participate in the interview and four individuals were unable to attend a focus group session due to time constraints and prior commitments. An additional six individuals did not respond to several invitations to participate.

A trained research assistant, who was peripheral to the project, conducted, recorded and transcribed the interviews. Two research assistants reviewed and coded the transcripts. Drawing from the transcripts, each research assistant developed a list of key coding themes. In order to reach a consensus on the key themes, the research assistants held several meetings with the purpose of reviewing each other’s coding and negotiating interpretations and meanings. Once they had reached a consensus, they prepared a summary document of findings by question. This summary document served to protect the privacy of stakeholders and to ensure that no individual stakeholder could be identified. The summary document was then reviewed individually by the two research assistants along with two co-Investigators.

People with lived experience (PWLE) of mental illness and/or homelessness did not participate in these interviews because they were not directly involved in the planning and proposal development phase of the project. A series of six focus groups were conducted with PWLE prior to the development of the proposal, and the results of these focus groups are included in Appendix A.
RESULTS

Findings are summarized below by the topic areas that formed the interview guide, and are then summarized by overall key themes.

Impact of the project parameters and local context

Stakeholders were first introduced to the project by representatives from the national team in the summer of 2008. A broad group of stakeholders from the research and service provider communities was invited to an information session led by Jayne Barker in July 2008. A Site Coordinator was hired in late August, and the first official local consortium meeting was held on September 12, 2008. A draft Request for Applications (RFA) was circulated by the national team in mid-October and the final version was distributed on November 7, 2008. From mid-September until the proposal was submitted by the Vancouver consortium on January 30, 2009, researchers and service providers met separately, approximately biweekly, and convened as a larger group on a monthly basis.

Overall, the project was greeted with excitement by the community, primarily due to the scope and philosophy of the endeavour. Many respondents had been working with homeless populations for decades and recognized the need for large-scale structural changes to a system that was not working for many marginalized individuals. Both service providers and researchers were excited about implementing a well-resourced Housing First model of scattered site housing with the support of Assertive Community Treatment (ACT) or Intensive Case Management (ICM) teams.

While many respondents described initial cynicism regarding the need for another research project, most service providers expressed a need for action to increase the availability of housing and support for individuals with mental disorders who are homeless.

“If I had a dollar for every study...it’s not rocket science to know that if you give people housing and intensive supports, they’ll do well.”

After the first few meetings, many service providers developed a greater appreciation for an evidence-based approach to determine the most effective type of housing and service delivery model for specific subpopulations, and to create lasting policy changes at provincial and national levels.

Several respondents expressed concern about the lack of input that researchers and other stakeholders had regarding the research design and protocol. 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 shape of the local response and created some tensions between the national team and the Vancouver site. One researcher stated: “Although this is officially a grant, it feels like a contract.” Many researchers were concerned about the study design, particularly the random assignment of participants to “treatment as usual,” the apparent confound between intervention type and severity of needs, and the false distinction between “high” and “moderate” needs groups. A few respondents noted that the lack of input into the research design and protocol prompted some individuals from the research community to withdraw from the project early in the process.

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 hierarchical relationships that have long existed within the academic,
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Given that the RFA was distributed on November 7, 2008, and the proposal was due January 30, 2009, all respondents described the proposal development timeframe as tight and pressured. Some respondents stated that the tight timeline, combined with vague directives in the RFA, created considerable anxiety which may have hindered collaboration as well as the decision-making process:

“The pace at which decisions were being made [contributed to] the appearance of arbitrariness and unfairness.”

Some respondents viewed the timeframe as a potential barrier to the building of strong partnerships, and contended that opportunities for creativity were lost. However, several respondents also felt that, had the group been given more time, tensions would have arisen and meetings may have been less productive and effective.

Overall, the majority of respondents described the project parameters and expectations as unclear, particularly regarding the opportunity for local input. Service providers in particular expressed confusion early on with regard to the goals of the project and found the process of getting involved very complex. Other respondents normalized the lack of clarity and noted some advantages to undefined parameters:

“The MHCC allowed the local flavour, whether it was political or capacity or confidence, to evolve the way it should and allowed people to come in and take ownership of the project.”

Respondents voiced different opinions on the definition of key terms in the RFA. Some felt that definitions of homelessness and mental health were appropriately broad (e.g., no diagnosis required for mental illness, inclusion of precariously housed) and clear, while others felt that a more inclusive approach was needed to ensure that important subpopulations would not be excluded, specifically First Nations, women, families and ethnic minority groups.

**Stakeholder involvement**

A diverse group of stakeholders was involved from the initial information meeting, including the not-for-profit housing and services sector, municipal and provincial government representatives, the local Health Authority, representatives from police and community corrections agencies, as well as researchers from the University of British Columbia and Simon Fraser University. Individuals representing various service organizations and agencies were either contacted directly by the Site Coordinator, or were invited to attend initial meetings through less formal communications (e.g., word of mouth). Several respondents expressed concern that the strategy for engaging community players had not been more deliberate, while others felt that key sectors and organizations were well represented. A few felt that smaller organizations, those who may not have had the capacity to be involved in this type of project, may have been excluded from participating.

According to respondents, motivations for involvement generally revolved around the scope and philosophy of the project. Many described their interest in working on a national project that was adequately funded to provide good quality housing and support services to a population that has long been neglected. Others saw the potential for collaboration and shared learning across the country to shift policy on mental health and housing, particularly given the lack of a national housing strategy. Others were motivated by the opportunity to do intensive research on a population and issue that has been neglected in the academic literature.

Overall, respondents felt fairly included in the proposal development and planning phase. While many described initial project meetings as somewhat disorganized and dominated by researchers, most respondents perceived an openness
for discussion and sharing ideas. A few respondents felt that it was appropriate for research members to initiate and lead meetings since the project was research driven; however, others noted that joint leadership by a researcher and service provider would have been more effective. Some respondents felt that they did not have the expertise or knowledge to engage fully in discussions and that there should have been a greater effort to share expertise. Many respondents noted a lack of transparency around decision-making processes. Several respondents referred to “backroom deals” that were conducted outside the bounds of formal meetings, which undermined the development of trust, equality and collaborative effort.

“I think that communication within a project that has five sites as well as national and local leadership is bound to be complex and requires some group process. There is a need for ongoing clarification of the communication of the structure and processes.”

While the project parameters encouraged collaboration and promoted a level playing field, it was evident that some stakeholders were vying for power and control. Many respondents noted that funders were at the same table as funding recipients; therefore, organizations did not feel completely free to voice their opinions. However, even with these dynamics present, most recognized the potential that this project could bring to democratizing such a hierarchical structure as well as the broader system.

When asked if any stakeholders had left the process and why, the majority of respondents mentioned time commitment issues, the lack of input into the research design, ethical concerns related to the research design, and uncertainty regarding how their organization could contribute to the project. Some respondents suggested that certain stakeholders stopped participating once key roles had been allocated.

“I think people, in a gentle kind of way, figured out very quickly if they were interested or not, and some people decided they weren’t interested and they stopped coming and the people who kept coming became more involved. You know, it’s like you dance with the people who are at the dance sort of thing.”

Guiding vision, values, and principles

Stakeholders identified several key values and principles that guided the planning and proposal development. However, some respondents noted a lack of shared vision which may have hindered the process of identifying and benefiting from shared values and principles. Several respondents described the emergence of a common vision as the project evolved, and some considered this beneficial to the process since it encouraged collaboration. A number of respondents also noted that attempting to realize a shared vision was difficult given the number of stakeholders at the table, different agendas, and time constraints. A core principle that was missing from the perspective of some respondents was the specific inclusion of marginalized subpopulations (i.e., women, First Nations, ethnic minorities).

All respondents emphasized the critical need for good quality, affordable, no barrier housing in Vancouver. Some noted that the project’s emphasis on a Housing First model directly reflected both their organizational principles and personal values (i.e., client-focused, “fitting services to people instead of people to services”). As one respondent commented:

“We’re so used to having people earn their housing through complying with treatment. So this fits with our organization’s principles that you give people housing first.”

Most respondents referred to the Housing First model as the project’s guiding philosophy during the proposal development process. The urgent need for more affordable, low-barrier housing in Vancouver, as well as the belief that “housing is a right rather than something to be earned,” were the main reasons that many respondents became involved in the project. Several respondents appreciated initial discussions about what it means to be successfully housed and felt these conversations helped develop a common vision that was carried forward into project implementation.
“We supported the fact that actual housing was the centrepiece of this project. I think that all of us who work with this population understand that you need the wraparound services for success, but you can’t have the services without the housing....”

Stakeholders also identified the principles of inclusion, collaboration and openness as critical to the proposal and planning phase. Many respondents described the need to create space where individuals could share different perspectives and beliefs and feel respected and valued. As one respondent stated:

“We don’t have a strong culture of really understanding and valuing different kinds of expertise.”

Further, many respondents identified the need to move towards a unified position on homelessness and mental illness, both locally and nationally, and to do so “standing next to each other, not above or below one another”. Many respondents described such a breaking down of institutional and disciplinary boundaries as the start of real change in Vancouver, with the potential for long-lasting effects. In addition, many respondents articulated the need for ongoing reflection on the team’s work and the process of working together:

“It’s critical that we be open to recognize that everything isn’t perfect, that we don’t each individually have all the answers, and that we all have things to learn; and that we’ll be able to step back, and be open and accepting of that way of working which is different from what we’re used to.”

The involvement of people with lived experience (PWLE) was a guiding principle identified in the RFA. The majority of respondents described the value of including PWLE in the proposal development phase as well as in all aspects of the project as it progressed, but most recognized that this goal was not fully realized.

Ethical issues

Respondents identified several ethical issues that were the focus of initial discussions. Many respondents were uncomfortable with the research design, specifically the inclusion of a “treatment as usual” (TAU) group that offered neither housing nor support. Some respondents felt it was unethical to engage in such a research design and that an alternative, more ethical approach would have been equally effective. As a result, several stakeholders withdrew from the project.

Some respondents voiced concern about how participants would interpret assignment to TAU, since many of them would not understand the random assignment process. Given many homeless individuals’ experiences with waiting lists and arbitrary assignment to housing and other services, it is not uncommon for people to internalize disappointment as personal failure.

“It’s not just research ethics—it’s more about how human beings treat each other, how we live together in the same community.”

Stakeholders who remained involved in the project generally believed that participants in the TAU group would not be exposed to harm greater than they face in the current system. 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.”

Another ethical concern raised by many respondents was the sustainability of housing after the project ends. Many acknowledged that the sustainability of housing will be an ongoing issue that the project team will continue to work towards defining and promoting.
Several respondents also raised the issue of capacity to consent, questioning if people with severe mental illness who are homeless and live in desperate circumstances really have true choice. Others wondered whether a long interview process would exclude people who have severe mental disorders, particularly those who are paranoid. Several respondents noted that there is no perfect process that would include all homeless subpopulations and described the partnership between researchers and service providers as central to the issue of inclusion:

“...service providers are in frequent contact with the researchers so we can say, 'this is happening and how can we problem solve around this?' To have this interaction between the researchers and service providers, who've been doing this work and know the population...it's very valuable.”

Inclusion of people with lived experience (PWLE)

To engage PWLE in the proposal development, an outside consultant conducted a series of six focus groups in January 2009, each consisting of five to 15 people who were homeless or had previously been homeless. Some focus groups involved stakeholders from a specific population (e.g., women; individuals involved in the criminal justice system) and other focus groups were conducted in specific settings (e.g., supported housing; drop-in centres). The consultant archived the discussions and prepared a summary document (see Appendix A) which was included in the research proposal. Focus group discussions centred on ways to engage PWLE and included recommendations such as creating co-interviewer roles, finding participants for follow-up interviews, working with landlords, and encouraging participation in a reference group.

The majority of stakeholders agreed that PWLE were only marginally involved in the proposal development and planning phase. This was recognized by all respondents as a missed opportunity, primarily due to time and resources. Some respondents mentioned the lack of a strong advocate for PWLE; stakeholders were focused on their own roles and positions within the group and were facing significant workloads and time pressures. Several respondents described the lack of community infrastructure from which to draw consumers with the relevant experience. Some respondents suggested that training may be necessary to ensure that PWLE have an equal voice in discussions with other stakeholder groups:

“...training 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. What often happens is that they feel lost and are effectively silenced in large committees.”

One respondent suggested that the MHCC should have designated a role for a PWLE at each site to ensure that this stakeholder group was included in all aspects of project development. Several respondents felt that, while inclusion of PWLE was articulated as a guiding principle in the RFA, this was not demonstrated by the national team; PWLE should have been involved in all steps of project development, including the development of the research design.

Relationships among stakeholders

The majority of respondents described initial tensions among individuals and organizations as the result of pre-existing power dynamics and a fragmented system. Several respondents suggested that a lack of clarity about the initial process and a lack of leadership led to significant confusion. A number of respondents noted a clear separation between researchers and service providers:

“It might have helped from the beginning to have a service provider and a researcher co-chairing the meetings... I felt that service providers were comfortable speaking, but the discussions were very much dominated by researchers. The researchers were trying to be respectful and inclusive, but there was
still a dichotomy established right from the beginning – researchers leading the discussion, giving the presentations, and making key decisions...”

Several respondents described a struggle for “positioning” within the larger group. While stakeholders were encouraged to convene as “equal players,” many expressed feeling silenced by groups that have historically dominated discussions:

“At first there was a lot of positioning for power, whether it be researchers, NGOs, traditional health care providers...it was between and within all groups. But, over time, I saw more dialogue that seemed to consider evidence from more angles and perspectives. There was an evolution of realizing where we need to move off some of our positions.”

The project was announced at the beginning of an economic recession, and many agencies were concerned about budget cuts. Several respondents noted that the economic climate may have intensified the sense of competition among groups. In addition, some service providers perceived skepticism of and distrust for their involvement as service leads, roles that have historically been assigned to government agencies.

Overall, the majority of respondents noted that once lead research and service provider roles had been assigned, much of the struggle for power and group tensions diminished. Most respondents reported that there is greater equality and less tension between stakeholders now than at the beginning of the project, and the local project team continues to work toward this goal. For example, one respondent commented:

“We are all committed to a transformative process: we can’t predict the outcome...but we’ll weather whatever those transformations are, difficult or easy, and try to keep our eye on maintaining our relationships and the commitment to one another to achieve the overarching study goals...It was helpful that we agreed upfront that setbacks will happen and we’ll try and make sure that we emerge as stronger colleagues at the end of this than at the beginning.”

While all respondents agreed that there was no defined process for working through tensions and mistrust, most stated that meetings, both formal and informal, provided an opportunity for relationship building. Further, several respondents noted that trust is built over time, by “doing what you said you would do” and by being “consistent and transparent”. The majority of respondents noted that 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.” Some respondents also spoke about a collective commitment to work through challenges as they emerged and felt there was adequate room for dissent and a consistent effort to move away from a “blaming stance”.

Tensions between the local and the national teams were articulated by many respondents. Although the proposal development process was meant to be collaborative, some respondents perceived the national team as overly controlling. Several respondents also noted that lines of communication and decision-making processes were unclear between the local and national teams. For example, some respondents were uncertain whether national team members could be contacted directly. The majority of respondents stated that they perceived an overall lack of transparency both locally and nationally. A few respondents suggested that having a representative from British Columbia on the national team may have assisted in easing some of the tensions and promoting more open dialogue. Conversely, others described the relationship between the local and national teams as supportive and responsive. For example, the national team increased the housing subsidy in Vancouver in response to local concerns that the initial subsidy was insufficient.

Organizational structures

The majority of respondents stated that leadership by the Site Coordinator and the regular meeting structure were the
most critical components in moving the proposal development process forward. The lead researchers were identified in late fall 2008, followed by the lead service providers in late January 2009. Several respondents noted that the appointment of a Research Coordinator and a Field Research Manager were critical to the development of research protocols and the planning required to begin recruitment.

In general, respondents were not aware of a formal decision-making process. Some respondents felt decisions were “pushed through” without proper consultation. Several respondents reported that the writing of the proposal was dominated by the research team, with minimal consultation with service providers. A few respondents noted that the research team had more say in how services would be provided than service providers had in how research would be conducted. Nevertheless, most respondents recognized the tight timeframe that everyone was working within and that not all decisions could be made by consensus:

“There were issues that just couldn’t be deliberated and discussed in a timely fashion. It’s just one of the numbing consequences of the timeline. It’s not the individualness or openness or anything like that, it’s just that we had two years of work in four months.”

With regard to the process for determining the leadership of service provision, most respondents described the process as fair and transparent. In cases where more than one agency expressed interest, a small committee consisting of a researcher, a member of a not-for-profit agency, and the former CEO of a health authority made the final decision after reviewing the proposals submitted. While some respondents felt that this decision-making process was clear and provided an equal opportunity for all who were interested, others felt that the committee was not objective and that the internal process lacked clarity. For example, the larger group was not informed about why one group was chosen over another.

Development of intervention arms

The national team identified the inclusion of ACT and ICM (part of the core research design), which were further elaborated by local stakeholders. Local sites had considerable flexibility for designing their site-specific arm (congregate housing in Vancouver). In Vancouver, all four lead service providers (three intervention teams and one team dedicated to acquiring housing units) are not-for-profit organizations which have been working with homeless populations for decades. The majority of respondents noted that the selection of not-for-profit organizations as the service leads was a unique approach for Vancouver:

“Selection of service leads was based on who knows the population, who’s done the frontline work. It wasn’t about having a large HR department. It was about being street level, and having and practicing the right values around recovery...The focus was not so much on traditional health services, but what do people need and what organizations do they currently use and trust. So it was a big shift towards what people need versus professionalized health care and service delivery systems.”

Most respondents saw the awarding of the service leads to not-for-profit organizations as an opportunity to implement real change in how housing and support services are delivered in Vancouver:

“Non-profit organizations can be reliable, professional, accountable and forward-thinking organizations...When we got the project, a lot of non-profits said, ‘Good! Go! It’ll be good for us, too.’”

And:

“If you really buy into the values behind Housing First...it’s hard to have hierarchical interactions with your colleagues or other parts of the system. That’s what we have to reduce. It played out lovely: The non-profits are sitting at the table as full members, and the hand that feeds them is not at the table anymore. In fact, the non-profits were chosen over the hand that feeds them. That has a profound effect.”
Several respondents suggested that navigating the proposed intervention models, MHCC expectations, and researchers’ expectations was challenging as there were no clear directives. For example, the description of the ICM intervention was vague; however, there was an expectation that the Streets to Home model from Toronto would be implemented. Similarly, some described the ACT guidelines as unclear with little direction from the national team. The development of ACT intervention was based on current ACT programs in BC, ACT teams in Toronto and New York City, and the research literature. However, many service providers felt that there was inadequate time to examine other models and talk to other teams in Canada or abroad. A series of four meetings with research and intervention representatives, both internal and external to the project, was held during the summer of 2009 in an effort to further define the intervention arms. These meetings focused on the nature of services provided, given the complex needs of the population and what is known about best practices. Most respondents agreed that time constraints limited the full structuring of programs prior to implementation and that service models continue to be modified to fit the local context.

With regard to the contextual factors that shaped the interventions, many respondents described the unique and complex health needs of the homeless population in Vancouver. With a high percentage of individuals presenting with co-morbid conditions, including high frequency and severity of substance use and high rates of infectious diseases, programs would require modification to meet these needs. This modification includes additional research instruments and a greater focus on substance dependence within the intervention teams. The majority of respondents applauded the inclusion of a congregate housing arm which may better reflect the primary low-barrier housing model in Vancouver. Some respondents stated that it was necessary to explore current policy directives based on the belief that people with mental illness and/or substance use issues need to be housed in a single site. Other respondents stated that it was necessary to conduct research on the effects of creating a strong community within a congregate site that can support healing and recovery.

Financial and human resources

Many respondents commented on the diverse skills of and assets among team members. Primary attributes voiced by most respondents included passion, time and energy. Specific skills included group facilitation, clinical knowledge, experience with multi-site research projects, experience with the existing systems that serve people who are homeless and living with a mental illness, and facilitation and relationship-building skills.

The majority of stakeholders considered the appointment of a local Site Coordinator a critical component in the success of the project’s planning and development phase. According to respondents, the Site Coordinator assisted consortium members in navigating the proposal process and helped facilitate the building of relationships between the various stakeholder groups:

“Without [the Site Coordinator], we wouldn’t have been able to navigate the process. We had challenges in Vancouver. A lot of people didn’t think that non-profits could provide health services, so we had to have some discussions with the Health Authority. [The Site Coordinator] had to steer us through that as well as the process for putting a budget and proposal together for the national team.”

The majority of respondents approved of the overall budget for the study as well the allocation of 85 per cent of available funding to the intervention arms. Some respondents described the process of developing local budgets as unclear, and would have benefited from more guidelines from the national team. Some respondents noted that tight deadlines prevented budgetary discussions and creative thinking about the use of funding. Overall, respondents stated that there was little guidance, leadership or collaboration on how to develop local budgets:
“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.”

Overall, there were differing opinions about adequacy of funding. The majority of respondents felt that the study was sufficiently funded:

“I don’t feel that they cut corners...this feels adequately funded and I don’t see excessive waste.”

However, others disagreed, raising the concern that inadequate funds may affect project fidelity and the success of the interventions:

“...underfunding the interventions will come back to haunt us in the end...financial targets and payrolls will be strained and things left undone and there could be consequences.”

Several respondents suggested that a small amount of start-up funding would have helped during the proposal development phase. Many respondents stated that they spent a great deal of time on the project in addition to their regular workloads. Several respondents expressed concern that certain aspects of project planning, such as involving PWLE and thinking creatively about program design and measures, were lost because of inadequate resources and time:

“I think people were overwhelmed at the time and doing this kind of stuff off the side of their desk on top of all their other responsibilities. But no money was flowing yet ... I think that was tough for people at the beginning of the project.”

All respondents spoke about the issue of sustainability, both as an ethical concern and an ongoing challenge for the project. Some respondents described the need to first define sustainability: What would it look like? What would be feasible? There was also a need for the team to develop a common understanding and agreement about what the local project sought to achieve. The majority of respondents recognized that discussions around sustainability are ongoing; there was limited time during the proposal development phase to properly address the issue. A few respondents also noted that sustaining the project itself to its conclusion is an ongoing concern: keeping participants and staff engaged, sustaining collaborative partnerships, and securing and maintaining housing units and service delivery components. Ultimately, as one respondent stated:

“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 greater community, to engage all stakeholders as advocates for the issues. Most respondents were very positive about the direction that the project is taking and expressed optimism regarding its outcome.

Key themes

Opportunities for change

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 ways in which those services are delivered. Most respondents saw themselves as part of unhealthy and fragmented service systems that they felt responsible for repairing. Overall, respondents expressed a sense of excitement, hope, and gratitude for their inclusion in a project with this philosophy and scale. Further, many described the importance of creating a unified voice across Canada to enable housing reform (e.g., a National Housing Strategy), and noted that the project provided an opportunity to break down the hierarchies that exist within the mental health and housing systems.
All respondents spoke about the importance of working together across disciplines and institutional boundaries toward a common goal, boundaries that have been historically reinforced by structural and systemic factors. Several respondents described this approach as a way of “balancing the playing field” and valuing the different and overlapping expertise of consumers, not-for-profit agencies, the traditional health care system and academics.

**Relationship-building and shared learning**

From the beginning, there was an attempt to create a collaborative working environment in which all team members were given the opportunity to contribute and participate. The project could have been carried out by a Health Authority or the research community alone; since it was not, those involved appreciated the redistribution of leadership roles and the creation of partnerships within and between groups. For many people, this appreciation was fully realized when the not-for-profit organizations were awarded the service leads. This move enabled stakeholders to see that clinical services do not have to be delivered through traditional models of care and it also demonstrated that the work of individuals who have been working for many years with people who are homeless and living with a mental illness with few resources is highly valued.

Strong alliances and partnerships have developed through this project that will inform and support future endeavours. Overall, respondents felt welcomed into the process and supported regardless of historical positioning, and have acted with mutual respect despite tensions. In general, there is a progression towards relinquishing power and renegotiating relationships. An environment of shared learning is also being developed, drawing from the expertise at the table and sharing that knowledge within and between groups.

**Timeframes**

Respondents stated that some key aspects of project planning were left out due to time constraints. Several respondents stated that there was not time to be creative, in particular around service models and research questions. Further, a tight timeframe limited the ability to engage all the necessary stakeholders, specifically people with lived experience. Further, because some decisions had to be made quickly, many people felt left out of the decision-making process.

**Inclusion of people with lived experience**

The inclusion of PWLE was not fully realized during the proposal development and planning phase. Many respondents suggested that PWLE should have been involved from the project’s conception, and that an individual with lived experience should have been hired along with the Site Coordinator. Full and meaningful inclusion of PWLE requires time and mentorship given the lack of consumer infrastructure in Vancouver.

**Transparency and leadership**

Overall, there was a lack of transparency and leadership with regard to the project vision, decision-making processes and roles within the local group as well as between the local and the national teams. According to many respondents, decisions were often made without explanation. Many respondents found the RFA vague, which, combined with a tight timeframe, created significant anxiety.

Several respondents found the initial meetings confusing and unproductive, as well as hierarchical; according to respondents, researchers dominated the platform. Some felt that there was little opportunity for balanced dialogue in the early stages of the project; however, other respondents felt this was normal given the large and diverse nature of the consortium. The majority of respondents (predominantly service providers) stated that the appointment of a Site Coordinator was essential to navigating the proposal and planning process.
**Redistributing power**

Respondents discussed issues of power and control that arose at the beginning of the process. Researchers and service providers were perceived to be vying for power, as well as individuals within the research and service groups: “we’re all used to being in charge.” Most service providers noted that there were fewer struggles for power among agencies once the service leads were announced.

Trust and collaboration were key themes throughout the interviews. Some respondents described how a lack of trust hindered the process, whether it occurred between researchers and service providers, within the research and service provider communities, between service providers and larger funding bodies, or between the local and the national group. Tensions are still present between and within groups; however, the majority of respondents feel that these tensions are normal and are satisfied by efforts to develop trust and a more collaborative process. Significant progress has been made by following through on promises, showing respect, and being consistent and transparent. Overall, most respondents are very optimistic about the working environment as well as possibilities for real change in the system of care.
RECOMMENDATIONS

A number of recommendations emerged from the interviews.

Provide opportunities for cross-disciplinary education. Many respondents suggested that having more opportunities for cross-disciplinary education and for sharing experience and expertise would have created a less intimidating and hierarchical environment in the early stages of the project. The MHCC could have provided clearer guidelines around roles and leadership. It could have also provided service provider and consumer-based agencies with more information about the nature of the research design. Similarly, the research community would have appreciated more communication from the national team with regard to the rationale of the research design, as well as more opportunities to provide feedback on and critical analysis of the research design.

Define roles and decision-making processes. The majority of respondents stated that project parameters needed to be more clearly defined in the RFA. More clearly defined roles and decision-making processes at both local and national levels would have also been helpful. Many respondents described feeling confused about the expectations for the proposal (i.e., what were negotiable variables versus non-negotiable variables) and experienced difficulty in navigating the process. Discussion about the research design and measurement tools felt rushed and, as a result, was carried out in ways that many perceived to be hierarchical. Respondents would have appreciated more collaboration with local sites in this context. In addition, there was little time or resources for service providers to examine various housing and support intervention models across North America. The opportunity to visit and speak with other teams who have assembled ACT and ICM teams would have helped local team members further define and adapt the interventions to the local context.

Develop an ongoing reflective practice. Given the size and complexity of the project, the opportunity to reflect on group interactions, decision-making processes, access to information, and other aspects of the project is critical to “doing things differently.” Other respondents suggested that periodic group meetings that allow time for talking through tensions and reflecting on the team’s working relationships would be beneficial. A reflective practice would help the team pay attention to interests and differences while simultaneously fostering connections. Many respondents noted that the local team would not be able to avoid mistakes, but that it is more important to avoid stasis.

Build capacity for co-creation. Given the cross-site structure of the project, there is a need for dialogue between sites. The complex and vital challenges we face cannot be addressed effectively by any one leader or organization or sector, and so we need to build our capacity for co-creation. Several respondents viewed cross-site dialogue as an opportunity to share knowledge and experience on a macro level, to encourage a national movement for change, and to unite the power of multiple actors so they can realize local goals as well as the potential of the greater system of which they are part. Such a dialogue could be critical to promoting sustainability after the project is completed.

Some respondents suggested that a researcher and a service provider could have co-chaired the initial meetings to facilitate collaborative leadership. Such a demonstration of shared leadership may have also assisted in breaking down the hierarchical structure and power dynamics that were present between institutions.

Make start-up funding available. Some respondents suggested that start-up funds would have assisted stakeholders in managing workloads, particularly when they were defining the interventions and developing budgets. In addition, some respondents noted that the ACT teams are not fully funded; without full funding, the fidelity of the local project may be jeopardized.

Communicate results. The majority of respondents requested that the results of these stakeholder interviews be shared locally and nationally. Respondents also requested an opportunity to meet with the national team about these issues,
discuss the rationale for certain decisions, and reflect on how to improve communication. Sharing the results would show a commitment to transparency and demonstrate that stakeholder voices had been heard:

“I think there would be real value in some dialogue around the key themes that emerge nationally and/or locally...From my perspective, it’s important because it’s modeling reflective practice...I think it’s all about transparency and there will be concerns about how the MHCC nationally rolls something out...”

Several respondents commented that the questions were too broad and that more probes were needed to solicit detailed responses. Some found it difficult to distinguish between the proposal development and the implementation phases; more detailed questions may have assisted in creating a distinction. Other respondents suggested that questions be sent to participants prior to being interviewed because this would provide more time and opportunity for reflection and response. In addition, some individuals preferred to read the questions rather than receive them orally; therefore, it may be important to offer a variety of ways to engage respondents in the interview process.

Overall, the majority of stakeholders welcomed the opportunity to reflect on the proposal and program development phase, suggesting that it offered a chance to observe how the project is unfolding, to articulate challenges, and to celebrate successes:

“It’s not just about housing homeless people, but it’s about how we change the system. In order to do that, we have to work with what worked in the initial engagement. And I think so much has worked. Right from the beginning, a lot of us have been saying: ‘I hope that somebody will be taking notes and tracking this process’...I’m glad that it’s being tracked. I think it’s very important.”
SUMMARY AND CONCLUSIONS

Twelve individual interviews and one focus group were held with researchers and service providers who were involved in the proposal development and planning phases of the At Home Project in Vancouver. In total, these phases spanned approximately one year between September 2008 and early October 2009.

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 the project’s initiation, services such as Housing First, ACT and ICM were virtually absent from the landscape of care in Vancouver. 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.

Respondents identified the brief timeframe as a key challenge that limited opportunities for fully engaging stakeholders and persons with lived experience as well as for developing the interventions. Time constraints also hindered creativity and transparency in the decision-making process through both the proposal and planning phases. In addition, many stakeholders found the Request for Applications both vague and rigid. As a result, the project vision was not fully developed and roles were unclear.

Many respondents identified tensions between a large, nationally-funded project that had predetermined constraints and the need for local input and creativity. For example, ethical concerns related to the inclusion of a “treatment as usual” (TAU) group and the sustainability of housing and services after the project funding ends were the topics of many discussions. Several stakeholders noted that a better research design could have been used, one that did not include a TAU group. As a result of the research design, several stakeholders withdrew from the project.

Another key theme included building trust and working collaboratively. While tensions are natural in a large multi-stakeholder project, some respondents felt that a lack of trust hindered the planning process; however, many stakeholders felt tensions were managed relatively well. Respondents noted that trust improved and power struggles diminished once lead researchers and service providers were identified and the proposal was submitted. Although some tensions remain, respondents described a collective agreement to work through challenges as they arise and a collaborative spirit of give and take. As the project progresses, respondents have called for a reflective group practice and a strong commitment to transforming the system on multiple levels.
Introduction

The Mental Health Commission of Canada has set out a number of principles to guide the planning and implementation of the Canadian multi-site Research Demonstration Projects in Mental Health and Homelessness.

Two key principles have guided the Vancouver site as it informs people with lived experience (PWLE) about the demonstration project and invites their participation, voices and wisdom into the project-planning phase and throughout the life of the project.

- “Ensure people with lived experience are central to the planning and delivery of all supports and services and inform the research questions and methods utilized in the demonstration projects.”

- “Support the knowledge exchange component of the MHCC mandate.”

In the spirit of these principles, six roundtable sessions were held during the months of December 2008 and January 2009. The purpose of these initial sessions was to initiate the process of inviting PWLE to engage with the Vancouver site of the multi-city demonstration project. Specifically, these conversations served to inform the development of the application and to seek input on ways to engage PWLE throughout the life of the project.

The Vancouver site team is grateful to the organizations and people whose efforts created the opportunity for 58 individuals to learn about the demonstration project and lend their voices and wisdom to the next steps in its development.

Each of these 32 women and 26 men with lived experience gave generously of their time and graciously of themselves as they reflected on the project and shared their perspectives on areas for learning and how to continue to ensure that people with lived experience have an ongoing role in contributing to and enriching the Vancouver site research demonstration project.

The following summary outlines the main themes arising from the six roundtable sessions with groups of eight to 13 people with lived experience with homelessness, mental illness and/or addiction.

The process

In December 2008, a number of organizations representing NGOs, Health Care and Corrections were invited to create the opportunity for PWLE of homelessness and mental illness to participate in a 60- to 90-minute information session and dialogue. Organizations that volunteered to recruit PWLE and host the sessions were invited to discuss an appropriate honorarium and food provision for participants.

The purpose of the sessions was to inform participants about the project and the philosophy of a Housing First approach. Participants were then invited to join in a dialogue which would inform the development of the Vancouver site application and which would provide insight regarding the engagement of PWLE over the life of the project. Specifically, participants were invited to reflect on and discuss the following:

1. What questions about homelessness would you like to see explored or answered in this project?

2. What are some ways we can engage with and include people with lived experience with homelessness in this project?
   - Initial Engagement Sessions
   - Local and National Advisory Committee Membership
   - Research Assistants
   - Peer Specialists
   - Public Education

3. Can you think of other ways?

4. How can we best keep people (research subjects) engaged over the life of the project? (e.g., 2-hour interview twice a year for 2 to 3 years)

5. What would be fair compensation?

**Session format**

The sessions were designed to create a comfortable milieu that encouraged questions and comments and valued all opinions and ideas regardless of whether they were shared by everyone taking part.

The project information sheets provided to each participant formed the foundation of each session. The facilitator welcomed everyone and reviewed the plan for the session.

Participants were provided with their own copies of each sheet that outlined:

- the purpose of the session
- conditions of participation
- how their questions, comments and ideas will be used
- an introduction to the demonstration project and the Housing First philosophy
- areas for learning
- getting involved
- project contact information

Sessions provided time for questions and comments, and dialogue among participants was encouraged.
What people with lived experience have to say

The main themes arising from the sessions illustrate the key role that PWLE play in the development of research projects and the rollout of services. Many of the issues arising from these conversations aligned with the same issues the project team is exploring, while other issues emerging represent those unique and invaluable perspectives that come from the knowledge and wisdom acquired through lived experience.

The Conditions of Participation and Project Information Sheet provided a solid foundation for participants to further learn about the Housing First approach and the kinds of supports available through the project.

Participants’ questions and comments about the project and its underlying philosophy were instructive in that many of them aligned with the same issues the project team is currently exploring. Many of the following themes will be instructive for the Vancouver Project Team as they move from the application phase to the planning and implementation of the demonstration project.

Project Integrity

The issue of mistrust of new initiatives arose in a number of the sessions. From the perspective of some participants, there has been a “lack of local response” to homelessness and a history of resources not being used as mandated or promised to address homelessness. Others expressed disappointment at decisions that divert City resources away from social issues (e.g., Olympics, real estate development).

Participants stated that the Vancouver project team has a “big” responsibility to deliver on the philosophy underlying the demonstration project and to deliver on promises for both research participants and for PWLE who get involved in the project.

The issue of project process was raised, and specifically the integrity of the decision-making process to determine what organizations will provide the services. Aligned with the issue of fair process was the suggestion of the appointment of a Project Ombudsperson.

Housing First Philosophy

The Housing First philosophy received a resoundingly positive response. Words such as “hope,” “security,” “freedom,” “choice,” “independence” and “relief” reflect the optimism this project instills for PWLE of homelessness.

“This project is about freedom…”

In an effort to understand the “on the ground” realities of this philosophy, participants raised many questions such as:

• Will there be drug testing? What will be the restrictions/consequences on drug use or violence? Note: some participants feel there should be drug testing for those receiving housing.
• Will everyone just end up being housed all in one building?
• What will staff report to parole officers? What are our privacy rights with landlords and neighbours?
• How many mistakes can a person make before they are discharged from the project?

The importance of a home and the principle that housing is a basic right in society was impressed over and over in each session. Having a home was described as “foundational” for achieving all other goals a person may have (e.g., work, recovery, stability, dignity, happiness, privacy).
Access and Referral Process

Many participants in the sessions would like to be a recipient of the housing and services associated with the demonstration project. As such there were many questions and comments related to access and referral.

- Will the project be open to youth, people with children, people with a corrections history?
- There are more resources for women with children. Will the project accept women who are homeless but do not meet traditional definitions of homelessness and women who are single and using substances in conflict with the law?
- What is the referral catchment area? (Greater Vancouver versus Lower Mainland)
- Will there be a local office or drop-in site where people can self-refer?

Several people felt strongly that in the interest of fairness the project should provide access in equal numbers to persons experiencing homelessness with

- a mental illness
- a mental illness and an addiction
- an addiction

Demonstration Project Awareness

Raising project awareness with people experiencing homelessness, outreach workers, churches and other organizations supporting people with mental illness and addictions who were also homeless was viewed as a high priority for the project team. In each session, participants identified the important role PWLE can play in raising awareness among people on the street. Participants described the challenge of raising people's hopes by informing them about the project and the risk they faced of not getting in; however, participants contended that the value of knowing about the project outweighed the risk of not getting in or of getting in and being randomized to the TAU group.

Some people saw a benefit of raising awareness and building support for the project with locally-based federal and provincial politicians who have demonstrated a commitment to addressing homelessness.

Nature of supports for success

While participants in all sessions expressed a strong interest in and desire for the opportunity to experience a Housing First approach, they also expressed a sense of apprehension about the “on the ground” support and approach that an ACT or ICM team would be able to provide. Specific areas of concern include the following:

- Money management
- Developing new social networks
- Adequate housing subsidies
- Dealing with stigma and establishing a sense of safety in new neighbourhoods
- Building self-confidence and self-esteem
- Medication management and access to methadone clinics
- Patience on the part of the team and allowing participants with “adequate time” to rebuild self-esteem and meet personal goals
One participant stated:

“This project is excellent...it makes people think positively. To know you have a choice and to have a team help you in the community.”

Value of Involvement of People With Lived Experience

It is clear from the sessions that participants feel strongly that PWLE have tremendous value to add to the project. Participants described the value of their unique perspective and asked if PWLE would be hired as service providers on the ACT and ICM teams.

“We know the people.... appoint us to this project.”

Guidance for Researchers

There are a number of themes to explore during the project. Some themes are very project-specific and relate directly to the Housing First model and associated supports, while others are aligned with more general issues related to homelessness, mental illness and addictions.

Participants clearly stated that a project of this magnitude provides a key opportunity to explore the causes of homelessness and the impact of stigma towards people who are living with mental illness and/or addictions and are also homeless.

Homelessness: What are we talking about and why does it happen?

The participants feel strongly that there is still much to learn about the causes and prevalence of homelessness and the impact on children and family stability. Causes of youth homelessness and effective prevention strategies were highlighted as a priority area for additional research.

A key theme that arose in a number of the sessions was the definition of homelessness; it is clear that this term means different things to different people. In the context of this project, some participants expressed concern about definitions of homelessness and whether they would be involved in defining key terms. One participant stated:

“There is an issue of equality here...I want that looked at...What does it really mean to be homeless?...Some people choose to be on the street and some like me live in an SRO...but I had my own home 10 years ago so living in an SRO...I feel homeless. What priorities will be given to people who get to be in the project?...Will it be people off the street?”

Participants encouraged researchers to use the project as an opportunity to understand “the real reasons people are on the streets.”

Impact of Stigma

Participants expressed a desire to understand why, from their perspective, homelessness, mental illness and addiction appear to remain a low priority for government and society. One participant suggested a “walk a mile in our shoes” initiative that would encourage decisionmakers and the public to spend a day shadowing a person who is homeless to “get a glimpse of our world.”

Participants stated that the scope of this project and its Housing First philosophy provided an opportunity to engage the media throughout the life of the project. One participant suggested having project-related stories appear in the newspapers on a regular basis throughout the project and then assessing the impact on public awareness regarding the Housing First approach and attitudes towards people experiencing homelessness.
“You can rezone but cannot make long-term residents accept us who are homeless...who are used to the way we live.”

In the context of the project participants identified the following areas for learning:

- What supports do neighbourhoods need to overcome issues of stigma and successfully support individuals in the project? Are there differences regarding these needs in various areas of the city?
- What supports do landlords need to agree to provide housing opportunities to clients in the project? What specifically helps landlords to positively shift their attitudes about rent to people who are homeless and receiving social assistance?

Related Supports and Systems of Care

A number of participants suggested learning from the experience of project participants with other supports or systems of care. What can we learn about the alignment of Housing First, ACT or ICM with other current systems of care, supports, or societies (e.g., primary care, halfway and support recovery homes, the BC Schizophrenia Society)?

Impact of Housing First, Assertive Community Treatment and Intensive Case Management on Recovery

This issue arose in every session and was an area where there was considerable desire for learning. Participants differed in their opinions about Housing First and its impact on addiction and recovery.

“People need to be able to 'use'...so it is going to be interesting to see how this will work with Housing First.”

Many felt that a Housing First philosophy offered “hope,” “stability,” “a chance” and a sense of belief in individual success and that this would have a positive impact on recovery. Others wondered if factors like the pride of having a home and the presence of positive role models would increase housing stability. However, some participants wondered whether an individual would have to be “clean” to be successful at getting and keeping housing in a Housing First-oriented program.

Most participants expressed uncertainty about their own positions and many felt that substance use was a key research area for the project.

Impact of Change and Transitions

The Housing First philosophy was clearly embraced by all six focus groups. However, several participants were concerned about leaving current social and community supports in the Downtown Eastside and moving to a new neighbourhood.

Areas for learning include:

- What impact do low self-esteem and sense of worth have on one's ability to successfully transition to living alone in a new neighbourhood?
- What supports are most effective in helping people with this transition?
- How do people adjust to the significant transition from homelessness to instantly having housing and numerous offers of support and services?
- In a Housing First model, do people who live alone or with a roommate do better at achieving housing stability?
- What role do congregate housing environments play in preparing people to live alone?
Health, Wellbeing and Chronic Disease Management

The project is seen to play an important part in understanding and assessing program participants’ health and wellbeing. What is the impact of the demonstration project on individual physical, mental, spiritual and dental health? One participant wondered whether additional chronic diseases and the challenge of managing them (e.g., diabetes) would negatively affect housing stability for those in the ACT or ICM arms of the project.

Privacy and Anonymity

Participants raised the issue of privacy in each session. They discussed Housing First participant privacy vis-à-vis landlord and neighbour interaction with ACT or ICM supports. A key area for learning is establishing the optimum balance of individual privacy versus engaging with community support for individual goal achievement and success (e.g., neighbours, landlord). One participant stated:

“I don’t need to know what my neighbours are doing and they don’t need to know what I’m doing.”

Impact on Current Policies, Systems of Support and Emerging Innovations

All six groups stated that the Housing First philosophy (client choice) with ACT and ICM support represents a major change from the kinds of support and philosophies they have experienced. Many participants suggested looking at the Housing First philosophy’s impact on other non-project models of care and support services.

For example, will Housing First with ACT or ICM interact with emerging innovations (e.g., Community Court) to create additional or “middle options” for people whose current service options are limited to Forensics or Corrections?

Response to “Mistakes” or Hospitalization

Recognizing the uniqueness of the Housing First philosophy and the space it creates to learn from setbacks/mistakes/slip-ups,” many individuals commented on the sense of “safety” created by this approach.

However, some participants felt a false sense of safety and wondered if different ACT and ICM team members would maintain a Housing First approach and support learning from setbacks. Participants felt that it is important to examine individual staff response to participant setbacks and the impact of this staff response on individual outcomes, particularly for situations that involve hospitalization or breaches of parole.

Engaging people with lived experience (PWLE)

All participants emphasized the value of engaging PWLE beyond the role of research subjects. One participant stated:

“This project needs the voices of people with experience with homelessness.”

Some participants felt strongly that the project should engage a small group of PWLE and that their lived experience should be as locally based as possible. One participant stated:

“We know what the people in this project will need...We live here...We know this city.”

Session participants agreed that PWLE can and should engage with the project in the following roles:

• Advisory Committees: local and national membership
• Research Assistants: to enroll people in the project and conduct interviews
• Peer Specialists: to provide support
• Public Education: to show the face of homelessness and share success stories
• Project-related education and awareness: to help develop program material (e.g., pamphlets) and a website. Providing outreach on the streets throughout the life of the project to build awareness with people who are homeless and the community services they access.

Additionally, participants identified roles related to
• “visiting” project participants and supporting socialization
• supporting prevention strategies that target youth
• engaging the media in partnership with high profile public faces and speaking about the project philosophy

Some participants viewed the project as an opportunity to create paid employment opportunities for PWLE.

Maintaining engagement of research subject participation over the life of the project

Participants expressed a range of views about maintaining the engagement of research subjects. They noted that this motivation is deeply personal and may change over time or under certain conditions. Participants also identified compassion on the part of service providers and researchers and outreach as strong motivators for engagement over time, particularly the ability of support staff to meet participants on their own terms. Participants stated:

“The project has a big responsibility to be serious about the promises it makes. Too many people have lived with broken promises so the project needs to show its colours and demonstrate it is legitimate... that will keep people engaged.”

“Meet with people and have a good conversation: show empathy and be positive not negative and they will want to keep meeting with you.”

“If people feel a sense of power and belonging they will stay engaged.”

Many participants felt that some people would engage in regular research interviews throughout the project without financial compensation because they would be motivated by the chance to contribute to the project and help shape policy; others would contribute in return for housing and support. Participants felt that even those assigned to the TAU group would feel similarly motivated. One participant stated:

“...Some people are just more compassionate than others and they will just stay involved for nothing.”

However, other participants felt that it is important to compensate people financially for their time and sharing of self. One participant stated:

“People are living in poverty and receiving compensation is a strong motivator.”

There were some differing views on what people should and should not be given. Some participants felt it was “tricky” to give cash (or gift certificates that could be sold for cash) to individuals who have an addiction problem, while others felt “that lots of people on the street are used to quick money” and therefore should be offered cash as a choice.

There was much discussion among participants about the pros and cons of cash versus gift certificates but the general consensus was to ensure that where possible, people should be given a choice when it comes to honorariums.

Some individuals suggested dispensing any large cash honorariums over a period of time to assist with money management or to avoid making large sums of cash available to purchase drugs. The following were identified as ideas for compensation:

• Home essentials or improvements (e.g., “nice garden” at my Housing First apartment)
• Gift certificates for places of the person’s choice (Safeway, Future Shop)
• Cash
• Money designated for various needs (medications, food)

Participants suggested amounts for a cash or gift certificate honorarium for a two-hour research interview ranging from $15 to $200. Some individuals suggested amounts such as $50,000, prompting some humour in the groups.

The value of being invited to share the perspective of lived experience

At the end of each session, participants were asked if they had felt any value in participating in the session. Participants in all groups described the importance of learning about the project and being in a position to be able to “get the word” out to others. One participant stated:

“Everyone’s experience with homelessness is different...It is good to hear from everyone and their ideas.”

A few individuals remarked that they personally valued the opportunity to focus on a topic for over an hour and to work on having the confidence to contribute to the conversation. Others remarked that learning about the project and providing input left them feeling positive and optimistic, regardless of whether they participate in it. Many view the project as a useful and much-needed government investment. One participant stated:

“We never get to give our ideas so this was good.”

Staff who hosted sessions remarked:

“The women are never asked for their opinions...They are always told what to do so at first it is difficult for them when they are asked for their ideas. I liked that you made it okay for people to have different opinions than others in the room.”

“It was very powerful to look in and see the women all together...speaking with each other.”

Summary

It is clear that a project involving so many different stakeholders will be enriched by inviting people with lived experience to share their thoughts and ideas.

The individuals who shared their time and enthusiastically participated in these six sessions are a reminder of the commitment of people with lived experience as research participants and in other capacities alongside researchers and service providers in the planning, implementation and evaluation of this project.

The Vancouver site team is grateful to have such a rich resource on which to draw and team members are energized by the hope and determination that people with lived experience bring to this project.
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