

Research Report

Phase I - Planning and Development of the At Home/Chez Soi Project

Moncton and rural arm

In alphabetical order: Charles Gaucher, Linsay Flowers, Natasha Prévost, Wiebke Tinney



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### **Introduction**

This report documents the planning and development of the At Home/Chez Soi Project from May 2009 to June 2010, in Moncton and in the rural communities of South East New Brunswick. When the methodological or analytical process is the same, we include the site of Moncton and the rural arm. The differences are indicated by specifying the targeted site.

### **Methodology**

The team responsible for the planning and development phase used a qualitative approach including semi-structured interviews and a thematic analysis of the content. It has added to this approach a reflection on the chronology of events and the local organization chart from the gray literature and discussions with some key players.

However, we had to change some methodological parameters that the national team had proposed. On the one hand, the small size of Moncton is such that the players involved in committees and the agencies contributing to the planning and development of the project are few and often take several responsibilities, which reduces the possibility of having a multi sectoral documentation. For example, when we tried to form a focus group with the community players that were the most involved in the project, we found out that many of them had already been interviewed individually. On the other hand, governance structures, such as the Local Advisory Committee had not yet formally been put in place at the time of data collection. Also, the person responsible for organizing focus groups left suddenly, which caused delays.

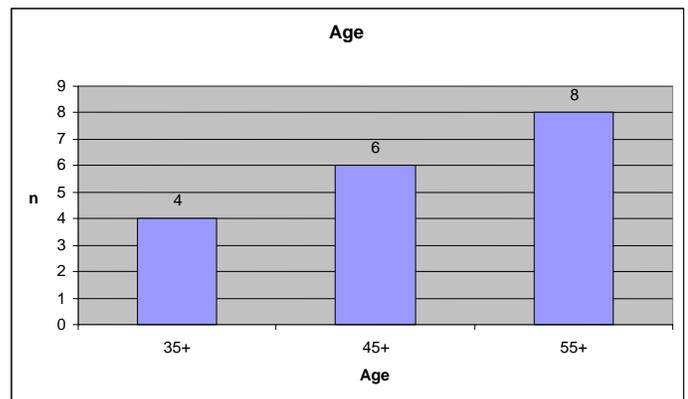
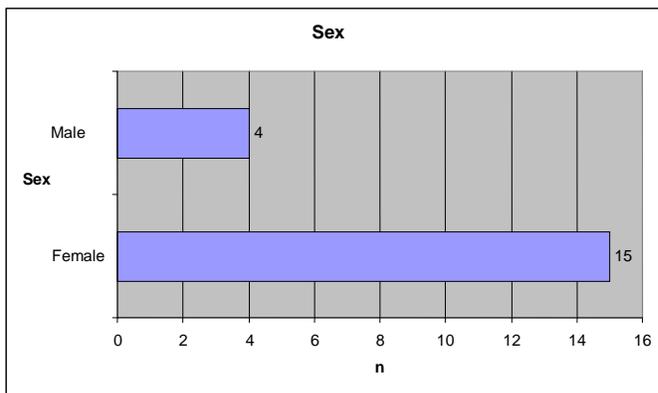
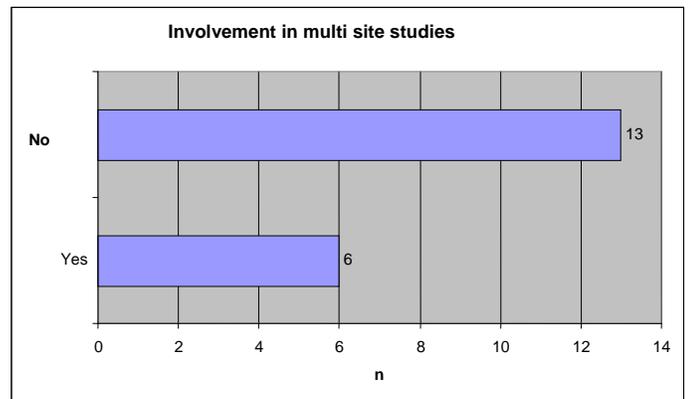
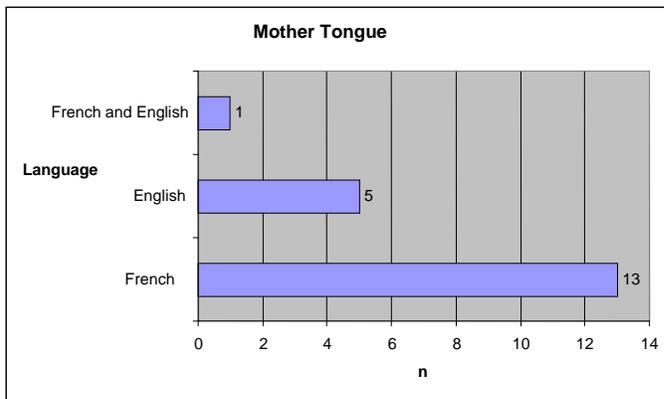
We decided, initially, to maximize the potential associated with proximity which characterizes the local context by multiplying opportunities for discussion and observations *in situ*. Subsequently, we concentrated our efforts on carrying out semi-structured interviews with players that had been involved in planning or developing the project in Moncton and in rural areas. As for the rural arm, the team has only conducted semi-structured interviews by administering the questionnaire proposed by the national team.

### **Sample Description**

In formal interviews, we met with 11 key players in Moncton (six of them being common to the Moncton and to the rural arm) and nine female key players in rural areas, for a total of 20 people. The selection was done using the « snowball » technique and using the Site Coordinator's suggestions. We then identified potential respondents and established a list that has allowed us to avoid overlap with the rural arm.

The list of key players for Moncton and its rural arm was comprised of 20 individuals from all the sectors involved in the planning and development of logistics management, implementation and coordination of both the service component and the research component. People from the non profit sector, the government and academia have been interviewed. We have kept a balance between women and men interviewed, and between Francophone and Anglophone. We also attempted to interview key players from different age strata, but the principal parties involved held senior positions that require some experience. Several representatives of the public service were interviewed, the project in Moncton requiring a strong collaboration of service providers of services coming under the authority of the provincial government. The size of Moncton is such that participants had criss-cross implications in the project, which the charts show concerning their link with the Commission and the links related to the nature of their involvement. Finally, we noted that all the interviewees did not identify themselves as key players (some saw themselves on the periphery of the project, despite the fact that they had been identified by many as key players).

***Schematic Synthesis of demographic characteristics of the sample***



### ***Relevant experience*** <sup>1</sup>

	Years	n	Years	n	Years	n	Years	n
Experience in the health and social services network (n = 12)	<b>0+</b>	0	<b>10+</b>	5	<b>20+</b>	6	<b>30+</b>	1
Experience in the Community network (n = 12)	<b>0+</b>	1	<b>10+</b>	4	<b>20+</b>	5	<b>30+</b>	2
Experience with the homelessness issue (n = 14)			<b>≤ 4</b>	5	<b>(5 - 10 years)</b>	3	<b>10+</b>	6
Experience in mental health (n = 11)			<b>≤ 3</b>	3	<b>10+</b>	6	<b>30+</b>	2
Experience in your current workplace (n = 13)			<b>≤ 6</b>	6	<b>10+</b>	4	<b>25+</b>	3

<sup>1</sup> Relevant experience has been collected only for certain key players that were part of the sample.

### **Detailed documentation of the research stages**

#### ***First data collection***

In the first part of data collection, we met people who had been involved in the research to develop a chronology of events and the organizational structure related to the project development. This phase of documentation has allowed us to become familiar with the gray literature related to the project and to understand the stages of its implementation and the local organizational structure, both formal and informal. This first phase in the reflection process, characterized by an effort to classify the sequence of events preceding the first participant's arrival in the project, served as a basis for training the interviewers. This training on the project implementation structure and implementation stages aimed at clarifying the planning and development process and organizational context to help the interviewers focus their questions on what to document rather than on the chronological and technical aspects.

#### ***Second data collection***

Following this training, C. Gaucher and a team of interviewers conducted the semi-structured interviews with the individuals that had been identified, which helped validate the information collected in the first phase and document the themes identified by the national team. The interview outline was adjusted as the project was evolving and in function of the clarification requests from the national team. These interviews were then transcribed according to the proposed transcription protocol in order to be analyzed; 375 pages of verbatim were compiled for both the Moncton site and the rural arm.

The Coordinator of the rural arm, N. Prévost, asked the Site Coordinator to identify persons that had been involved in the planning phase and development of the rural arm. She also participated in the interviews to better understand who the different players involved in the project were.

### ***Description of data processing and analysis process***

The research team compiled the preliminary information using a timeline and an organization chart. The compilation was done following an iterative process of observation, discussion and formatting data.

As for the second phase of data collection, the team conducted a thematic analysis by grouping the information according to the broad categories addressed during the interviews. This work has uncovered sub-themes of analysis. The QSR NVivo8 software was used to compile and codify data. Once the interviews were coded, we conducted a descriptive synthesis of the major categories basing ourselves on the emerging codes. As for the rural arm, L. Flowers made a first encoding for each theme without using software and then wrote a narrative synthesis.

As for the analysis, we conducted a cross-reading of the information contained in the chronology and organization chart with the interview data. This cross-reading allowed us to highlight the strengths of the themes, but also some inconsistencies or ambiguities which emphasize the subjective nature of some comments. Based on these matches and mismatches we have interpreted the data.

### **Limitations and challenges that have been encountered**

The main limitation encountered in Phase I concerns the project unfinished establishment of governance structures. The Advisory Committee being still in the process of being formed, the research team was faced with a twofold difficulty: first, a logistical obstacle that made it impossible to hold a focus group with players involved in implementing the project in the Moncton area. Second, it has been difficult to document the theme of governance because of insufficient data to analyze.

Another important limitation is the positive feeling that interviewed participants felt towards the Site Coordinator, C. Bradshaw. It is possible that this positive feeling, which has played a key role in the successful implementation of the project, has skewed the information collected. The research team did not feel that the key players applied censorship to themselves, but few critical comments have been collected. This limitation is insurmountable as it is part of the realities of small communities where people's care for good relations often exceeds that of criticism as constructive as it may be.

Second, we must emphasize that the original research team having declined our invitation to be interviewed, we do not have reliable data about the circumstances of their withdrawal.

Finally, the majority of the members from the non profit sector did not relate to issues related to the Commission, the call for tender, governance and financial resources, and in some cases it made them feel uncomfortable since they could not answer.

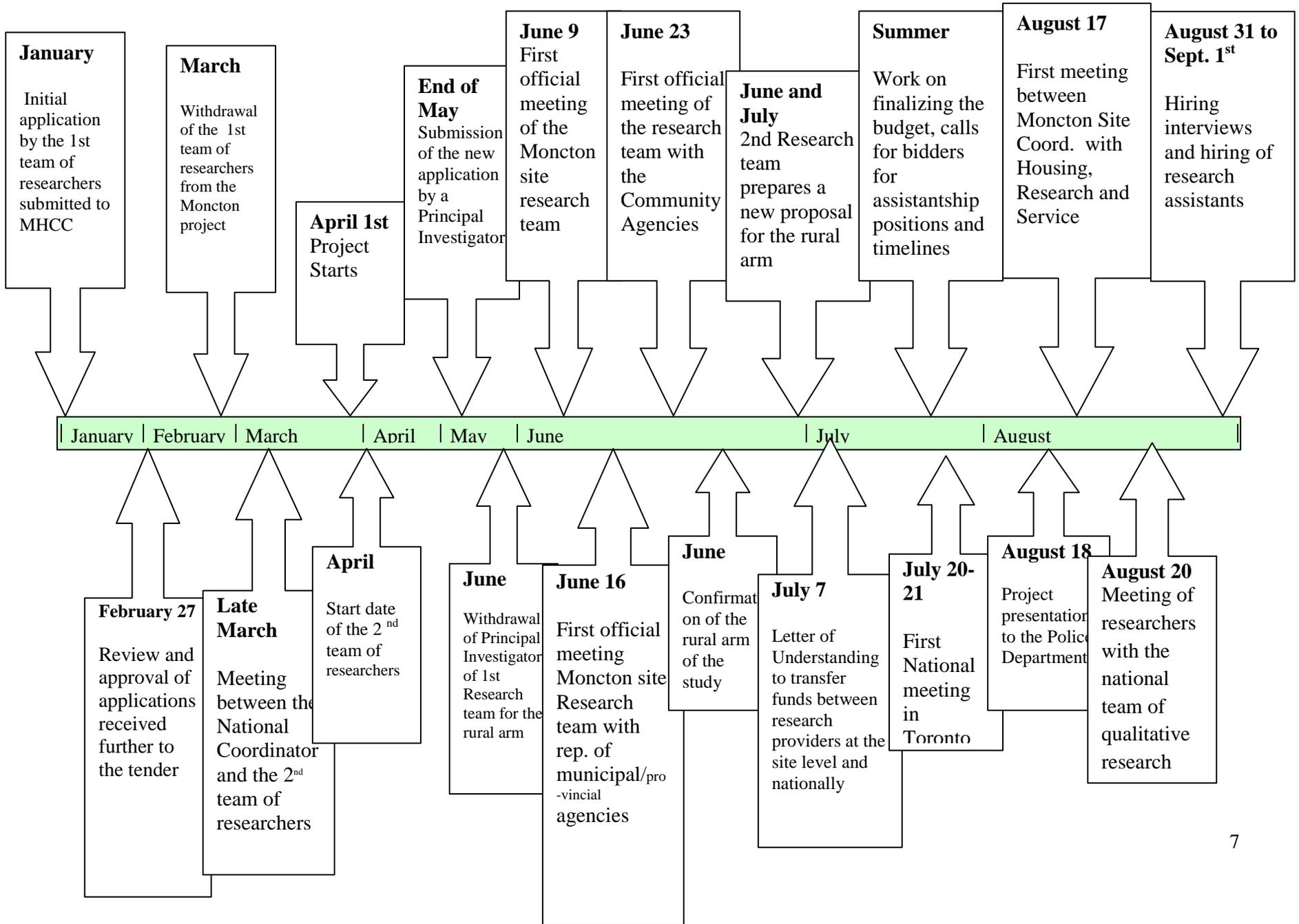
## **Data presentation and analysis**

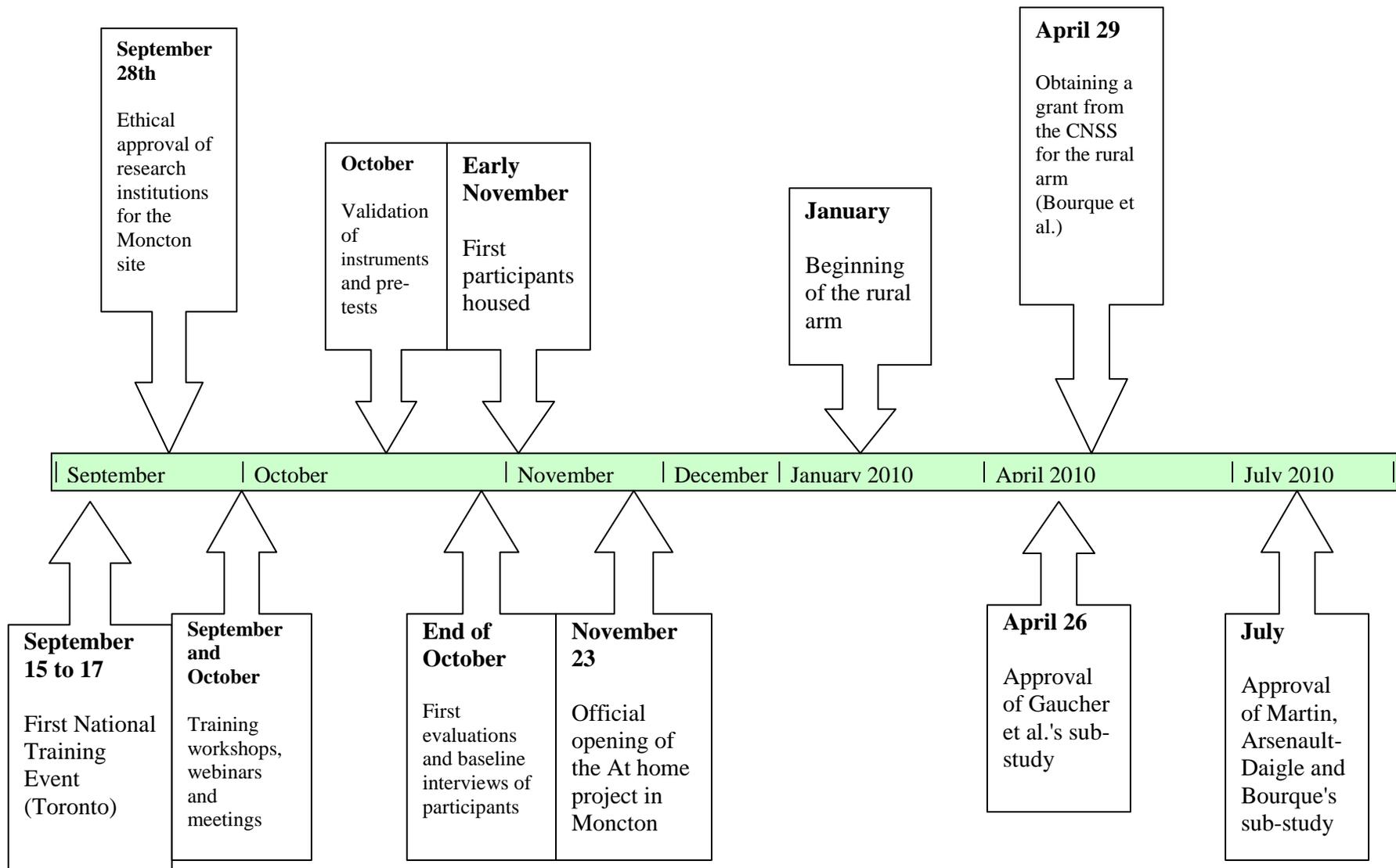
### ***Origin and development of the project: first data collection***

In April 2008, the At Home project was initiated in Moncton thanks to J. Barker and the Community Services of Greater Moncton, at a meeting organized by the Assistant Deputy Minister of Mental Health, K. Ross to discuss the development of the project. P. Goering approached an initial team of researchers, but because of discrepancies in methodology, that first team was replaced in April 2009 with a new team, whose research design better met the MHCC requirements. K. Ross and Mr. Murphy from the Health Department, contacted C. Bradshaw, who made the commitment to oversee the project in New Brunswick. The following timelines and organization charts summarize the stages and main events that have marked the project establishment.

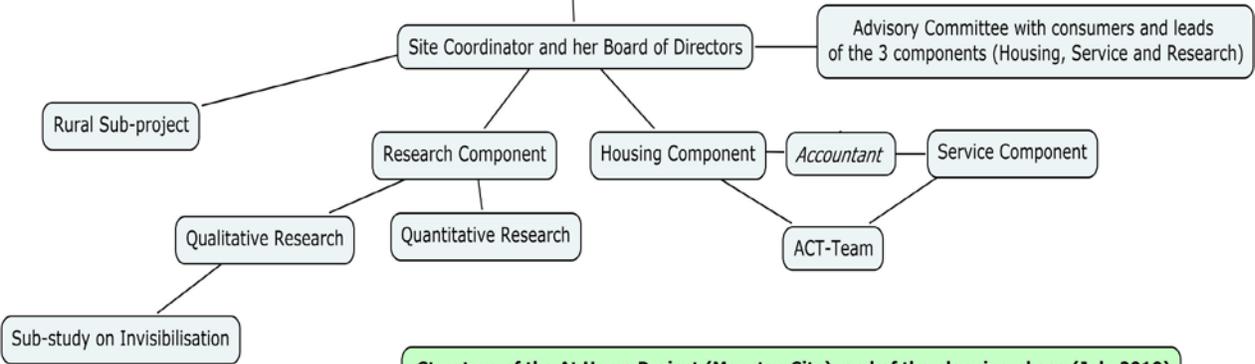
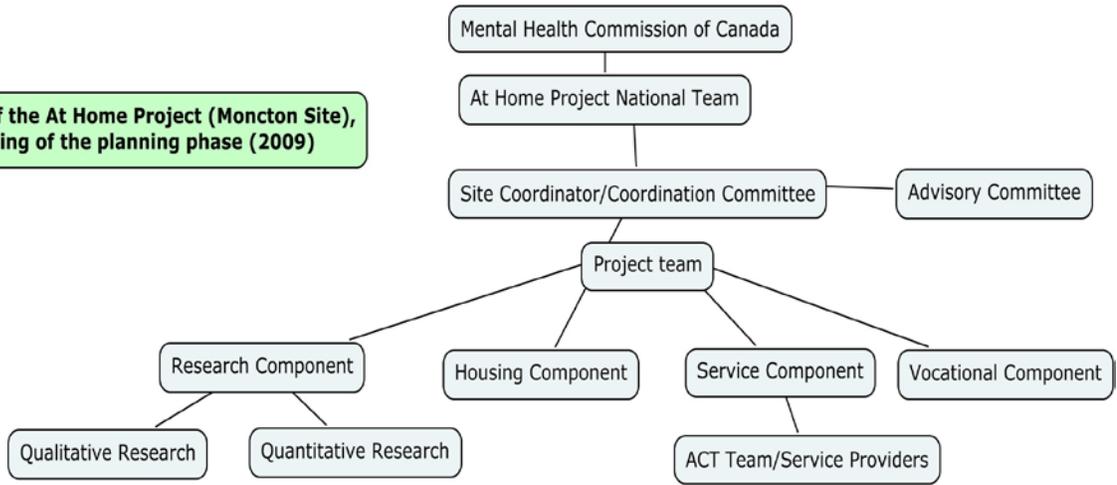
### ***The timeline and organization charts***

Regarding the project organizational model, the planning and development phase ended with results relatively close to the working hypotheses at the onset. With one exception, i.e. the inclusion of a third player doing the bookkeeping of the service and housing components of the project, the two organization charts, the anticipated one and the final one, match. A detail related to the players' final definition involved in committees differs as well: the composition of the Advisory Committee (named advisory committee in Moncton) includes representatives of the three components.





**Structure of the At Home Project (Moncton Site), beginning of the planning phase (2009)**



**Structure of the At Home Project (Moncton Site), end of the planning phase (July 2010)**

## *Presentation of data from semi-structured interviews: second data collection*

### **1. Influence of the national and local contexts**

#### *The influence of the parameters proposed by the Commission and the organizational context*

Participants stressed that the **budgetary flexibility** shown by the Commission made the setting up of the project easier. It is important to emphasize the key role of the Director of Mental Health and Addiction Services, Regional Health Authority A for what concerns the budget.

Moreover, the **extensive consultations** that the Commission has made in the community and especially their **collaboration** with government departments and non profit agencies have made the project planning and development easier. The lack of resources in rural areas has had an impact on the planning and development process. On the one hand, existing services - community and government services - must work together, which ensures that *"relations are already established when you already know the person, so you do not begin at zero."* [RM07]. In addition to this, there are efforts to ensure the success of the new service. Beyond the contributions made by several partners, the community's respect towards the Coordinator seems to have had the most significant impact: her political and community influences have greatly facilitated the development of the rural arm, among other things.

The **research component** has posed the greatest challenge during the planning and development phase. The initial team of researchers from the University of New Brunswick had prepared the ground by writing a first application, which was revised by the Commission. For a variety of reasons that are difficult to pinpoint specifically because of the refusal of the initial team to be interviewed, the team ended up by withdrawing after receiving feedback from the Commission. Because of the withdrawal, another research team had to submit a design to the Commission within a **very short period of time**.

The **use of an experimental design**, required by the Commission, has been a barrier for some key players: *"The clients actually go downhill after they are randomized to the control, they don't come out at the same level on the other side, they actually go downhill because of this whole process."\** [RM16]. There were also some reserves among the key players on the inclusion of a control group in rural areas for feasibility reasons. In fact, the rural arm began in January 2010 with no control group, the idea being that its feasibility would be evaluated after the recruitment of participants had been completed.

In regard to the quantitative section, the parameters were seen by some respondents as too flexible, which hampered the realization of the project: *"...with the national team it's that I don't know [what] they expect from our ACT-Team, [what] they're going to be wanting us to report. I don't have clear guidelines from them [...] we didn't have a concrete design of what they wanted to study and how it was done."* [RM16].

In general, the key players, however, appreciate the opportunity offered to their community to achieve **a study of this magnitude**.

\*\* Quotations that have been underlined are in English in the original text (Translator's note)

Regarding the **service component**, a female informant mentioned that some parameters were **too rigid** : "Local people didn't really have a good sense of what an ACT Team was. That was a very well defined criterion in the literature, that it wasn't something that we could make up." \*\* [RM16]. There were also negotiations between the Commission and key stakeholders concerning **choosing the type of services**: "*As for us, we wanted more to have that one from New York with a team that surrounds the client (...) [the] Commission was not always certain that they wanted us to have it. First, they found that it was very expensive (...) that is the one that we wanted because we thought that in a small community, (...) it was much easier to work that way instead of the other way (...) Resistance was not really coming from the community but rather from the Commission.*" [RM07].

Finally, looking for housing has proven difficult, firstly because of some **resistance from private landlords** and, secondly, because of a **lack of service providers**. Moreover, the availability of housing in rural areas has quickly proven a challenge.

### *The overall influence of the local context*

Several persons mentioned the major role that **existing linkages** and information sharing protocols already in place played in the cohesion and cooperation between non profit organizations, representatives of government and political decision-makers. Because of its size, we feel that in Moncton there is little bureaucracy and hierarchy and that **local decision makers are heavily involved**. On the other hand, one male interviewee noted that "there wasn't quite as much flexibility with the local government." [RM16].

In general, the consensus is that the involvement of political decision-makers and the links between partners have created a network of credible people who made the project implementation easier. All agree that the mobilization of this network was facilitated by **the Coordinator's enthusiasm**, C. Bradshaw.

Some local characteristics, such as low population, posed particular challenges. First, homelessness is **less visible** in low density urban areas : "It's just not that visible, we don't have a ton of people sleeping on the city streets, we don't have a ton of people panhandling and squeegeeing and loitering, and that is due to our by-laws of this city, that we're not allowed to panhandle, we're not allowed to squeegee and we're not allowed to loiter." [M23].

The **definition of homelessness** has also proved to be a challenge for the major players, because it does not correspond to the local reality. For example, homeless women who stay in relationships where they are abused, ill-housed families and individuals who could have lived independently with minimal support are to be found in nursing homes; all these are very

common situations in the region. The question of their inclusion or not in the project has created some problems during the planning and development phase. The issue of nursing homes and living with one's parents are the two aspects that the rural arm intended to address. Initially, the study of this aspect received support from some players, who agreed on the problem of definition: " ... sometimes they go to these nursing homes not because they needed to go there,

*but because they had no other place to go to. (...) Since they have mental health problems, they wander from nursing home to nursing home, they go in, they go out. (...) We must admit that there is homelessness in rural communities, but it is not necessarily the type of homelessness that people see.* " [RM07].

Moreover, the nursing homes' owners have not been consulted because one had little faith in their collaboration. The **lack of communication** resulted in **reactions that were often negative on their part**. In addition, **the parents of people in care homes did not favor the idea** to have their adult child enter a program in which s/he would not have access to care 24 hours out of 24. Several families were also anxious to see their 30-year old child move. Recruitment in rural areas has proved to be more difficult than had been foreseen.

Although the interviewees describe Moncton as a resilient community, some contextual elements presented challenges to key players. The population **with mental health problems**, both French and English, is **increasing rapidly**: *"Here we have the largest volume in the province in terms of service requests, then it's the region with the longest waiting list in the province."* [M08]. Project planning and development have had to take this factor into account in the development of services.

An important contradiction arose during the interviews. Some players had difficulty accepting that the government finances a research project whereas there were significant **gaps in funding the regular services**: *"hardest thing for the community to see is that it remains a research project, not a service delivery."* [RM16]. In addition, existing organizations **felt threatened** because they were not consulted or because of the competition from services that the project offered with their own services.

## **2. Key players / Collaborators**

Interviews with key stakeholders have identified five main contributors to the project planning and development process: the national team, the political decision-makers, the team of researchers, the community organizations and the Site Coordinator.

### ***Coordinator***

The most important facilitating factor that the respondents identified is the Project Coordinator's **networking expertise**. For 41 years, C. Bradshaw has been dedicated to strengthening the social sector, especially among the poor, which promoted the rapid and efficient development of a strong network of partners. She helped raise funds, identify needs and establish links between partners: *"This community has a lot of faith in Claudette in terms of her skills and abilities but more importantly, in terms of getting everybody together..."* [M21].

Many collaborators' influence on the planning of the rural arm, primarily that of the Coordinator, C. Bradshaw, is widely recognized. At a planning meeting for the Moncton project, she found out that the francophone rural areas outside Moncton were excluded. After receiving approval from the Commission to start the project, C. Bradshaw and the Regional Director of Social

Development, Y. Cyr-Sinstadt went into communities to identify their needs. We note that she made a lot of publicity and was always ready to answer questions. According to an informant, she was also the intermediary between services and research.

The Director of Mental Health for the Regional Health Authority A was involved early in the process of the rural project. One interviewee explains that she *"was not happy at not having been invited"* [R07] in a meeting organized by the Site Coordinator, attended by the Director of the Regional Health Authority B. It is partly thanks to this omission that the rural component took shape. J. Lizotte-Duguay has done a lot to establish more fluid relations and work with the Director of Regional Health Authority B. The nurse at the Richibucto Mental Health Community Center, G. Richard regularly attended planning meetings. The Centre Manager, P. Clark, and N. Cormier *"worked to bring together community agencies in this region for Claudette to meet them."* [R04].

The biggest challenge that was presented to the Coordinator was **her lack of experience with research**: *"Claudette is not from a science background so I think it's harder for her to see a study per se and having inclusion criteria..."* [RM16]. The problem of recruiting future participants in nursing homes and in families in rural areas is also a major challenge.

The development of the rural arm was led by the Site Coordinator until the Coordinator of the rural arm, N. Prévost, joined her. This component has not been given priority by the research team who had to catch up with the sites (due to the April 2009 change of team) and establish the research structure for Moncton. The Site Coordinator began herself recruiting participants, which led to a series of misunderstandings with respect to the recruitment criteria. N. Prévost, Coordinator of the rural arm, contributed greatly thanks to her expertise: *"She guided us and explained the details of the project (...) It's really Natasha that constituted a bridge as a researcher (...) Pauline did not have the answers. (...) We had Claudette's business card, but she too is busy. And then when Natasha came into the picture, she was able to answer our questions."* [R05].

### ***Researchers***

An initial proposal has been designed by the University of New Brunswick (UNB) team, then was reworked in a very short time by the principal investigators from the University of Ottawa and l'Université de Moncton. This transition, a consequence of the UNB team's withdrawal, delayed the project development. The rural arm suffered particularly from this delay. A few more weeks spent on examining its particularities in terms of participants, families, nursing homes, volunteers, recruitment criteria and even housing would have fostered communication, understanding and planning for this area of research: *"Well I mean it's really not clear that there is actually a study design there, I'm not clear that I've seen the exact study design, it seems*

that we're still trying to alter it to make it work. (...) so far the tensions have been around inclusion criteria and why can't we do this and why can't we do that. " [RM16].

Then, the teams of the Moncton site and its rural arm were formed: a team of researchers mostly from École de psychologie, having experience with quantitative research and able to render a clinical judgement and a team from the social sciences and education, interested in the qualitative aspect of the research. Initially, two coordinators were to divide between themselves the quantitative and qualitative aspects. However, the researcher approached to fill the position of Coordinator of the qualitative aspect chose instead to coordinate the rural arm. The resulting structure consisted of three coordinators: a research coordinator (S.R. LeBlanc), a field coordinator for Moncton (T. Monger) and a coordinator for the rural arm (N. Prévost).

The choice to organize the research team and the hiring of assistants in function of the required expertise proved wise, especially for the quantitative team, which gained time by training assistants already trained in mental health and administration of psychometric tests. However, researchers and assistants found it particularly difficult to announce to a participant that s/he was randomized to the control group. The first months of recruitment were particularly difficult. Debriefing sessions were introduced, but the fact remains that nobody is really prepared to announce this type of news to someone in need.

On another hand, the qualitative aspect of the Moncton site did not have a coordinator. To overcome the problem, the three phases of the qualitative aspect were distributed among different investigators, who are now responsible for maintaining the development rhythm of their phase and for organizing their own research team. In general, this new organizational structure works well. However, many researchers and assistants of the qualitative aspect were disengaged, which generated a certain vagueness in terms of organizing the qualitative dimension.

Finally, interdisciplinary relationships were more or less successful depending on individuals. Some service providers have a hard time grasping what a research project is all about. The fact that service and research teams are separated during national meetings does not facilitate the understanding of respective roles.

Collaboration with government departments requested a **Confidentiality Protocol** concerning the information circulating on participants, protocol which had to be amended on numerous occasions. The information-sharing has been especially problematic as some guidelines on research and coming from the national team seemed too vague. This became particularly evident in terms of recruitment criteria and opening of participants' files. The Moncton service team, which had two months' experience in establishing a recruitment of participants and in closing files with the Mental Health Community Center, had to change its procedure for the rural arm.

Prospective participants for the rural arm were reluctant to agree to participate. Some felt comfortable in the family home. The anxiety generated by the new possibility for the future participant and his family made several change their mind. This was the case for example of people living in nursing homes for years or who had been recently admitted; they felt they had

finally arrived safely, and then for those who participated in a vocational program, participating in the project meant a drop in income.

### ***Political decision-makers***

Recruitment of stakeholders and collaborators has been limited because of a **lack of financial resources and available manpower**. The loss of clinicians with extensive experience has also been a challenge for the regional health authorities : "*... recruitment to replace these people, it is extremely difficult. The waiting list of people waiting to see a specialist? For Moncton for mental health, right there, the waiting went from almost 3 months to 6-7 months.* " [R12]. Planning continued thanks to **the extension of government services**: "*The Social Development system will do two things for us: 1) They will ensure that our people will go on welfare and we will not have problems, then we will have a designated person, so we will not need to call 50 workers; 2) they will play an exceptional role with us in housing.* " [RM01].

### ***Political decision-makers and the Coordinator***

New Brunswick has **bilingual structures**, adding to the political decision-makers' challenges. On the other hand, the **Coordinator's initial lack of knowledge about the structure of provincial Health** generated some tension between the project players and those in Regional Health Authority A, all the more as future participants sometimes use the services of both Regional Health Authorities. In rural areas, the situation is complicated because of the distance between services. As such, many people in rural areas prefer to go to Moncton, which is closer to certain communities, rather than going to Richibucto.

This reality became particularly strong in terms of the recruitment strategy, which had to be amended several times; first because once the diagnoses were done, significantly fewer customers of the Richibucto Mental Health Community Centre were eligible, and because as a result of recruitment difficulties in nursing homes, the pool of potential participants was exhausted. One had to find service users other than those of Richibucto. Let's note that the communities of Cap Pelé and Shemogue are closer to Moncton than Richibucto and as a result, Richibucto nurses do not have their medical files.

Since we decided to simplify the selection process by not using the *screeener* to determine if a participant was eligible, we had to ensure that the referral was made by a nurse or a psychiatrist who could give their verdict on the future participant's diagnosis. As the volunteers in the community were neither one nor the other, we had to find another strategy: use the Single Entry Point (SEP) questionnaire, which determines whether a person qualifies to live in a nursing home, Level 1 and 2. This suggestion coming from the Site Coordinator, supported by S. Crouse, S. Patry and the principal investigators, was used as a recruitment strategy from April 2010

onwards. This way, from the Mental Health Community Center of Richibucto, Mental Health Community Centre of Moncton and from the psychiatrists working at Hôpital Georges-Dumont, we recruited participants before they entered a nursing home

### ***Community organizations***

All community organizations involved cooperated to start the project, especially in the implementation of the housing component. That did not come without difficulty: recruiting private landlords and negotiating the tenancy terms were difficult for the stakeholders. Community organizations have also contributed to planning fundraisers, identifying the needs of homeless people with mental health problems and referring participants to the project.

## **3. Vision / Principles / Values and Ethical Dilemmas**

### ***Vision***

The vision shared by the different partners involved in the project planning and development has been marked by **guidelines resting specifically on self-sufficiency**: *"Our vision was that within five years, those clients would be able to live much more independently than they did today. And bring them to their full potential as far as we could get them."* [RM07]. Stakeholders have planned to help homeless or poorly housed people **select and maintain a stable home** through the Housing First model. “

Participants have access to a range of services, but they are not required to use them. Several interviewees insisted on the participants' **right to choose**, although it was not always possible to find the apartment that the participant wished to have because of limited budgets and access to a sometimes limited pool of housing.

### ***Values***

The majority of players are willing **to denounce stigma** attached to homeless people living with mental health problems and they promote their integration into society. And yet, as mentioned by one female respondent, this stigma is often based on negative experiences related to the social support system: *"If you ask people about stigma, they'll say some of the worst stigma they experience is in the caring professions."* [RM14].

### ***Principles***

The majority of stakeholders agree with the principles of «Recovery oriented» and «Housing First». Deciding on the type of approach has been difficult because only one female collaborator has been able to visit the New York project, which has complicated the choice between the Assertive Community Treatment and the Intensive Case Management approaches.

However, there is a gap between how community and government stakeholders perceive the concept of self-sufficiency which is at the heart of the project principles: *"Self-sufficiency may be*

going to work, but also self-sufficiency is that the client is able to live on the social assistance check that is given to him every month." [RM02].

### ***Ethical dilemmas***

The presence of a **control group** posed an ethical dilemma for those involved in the research process. This important concern has disturbed, even questioned the people involved in the planning and development phase: "*I think the biggest ethical issue that came up really was around randomization. (...) That's really hard for everyone: (...) in their cognitive part of their brain, they understood the need for it but in their compassionate part of themselves, they felt as many of us do that it's just so hard to do.*" [M20].

The **confidentiality** of information related to participants is an ethical dilemma that has sparked many thoughts. To overcome this difficulty, one has made the decision of only disclosing examples and general statistics about people with lived experience.

### **4. Participation of Service users**

Regarding the participation of service users, opinions diverge. Some claim that people with lived experience **have not been consulted** and others that they **have always been involved** in the process. Some interviewees claim that they have never met **service users** as part of this project. Moreover, with the implementation of an interview template, the limited experience of some of these users would have **hampered the evaluation of the data collection instrument**.

The need to understand the homeless population's situation has been an important point in the project elaboration. One of the consumers has been able to make this understood through his sensitive speech and his lived experience. His commitment and knowledge have **helped the Moncton team** and have **made the other consumers' involvement easier**. His speech at the official opening of the project has deeply moved the audience.

It is certain that there are people with lived experience in the housing and service components, but the nature of their involvement remains unclear. It should however be noted that the positions in the project have never been explicitly reserved for people having mental health problems or having experience of homelessness, which has not prevented several persons from **spontaneously applying for jobs opening in the project**. This demonstrates how committed the users are towards all the facets of the program, and not only to the positions that are reserved for them in the governance bodies: "*there is a lot of people who had mental health experiences, and we didn't always go out looking for those people but it was evident when we were doing the interviews that people were bringing this up, that you know why were they passionate and why were they applying for this job, because they had a history.*" [RM16].

\*\* Quotations that have been underlined are in English in the original text (Translator's note)

## 5. Relations between Partners

Moncton has a long history of rivalry between the two language groups and the same applies to the Health Department. To properly serve everyone, the Department was split into two Regional Health Authorities (RHA): the Francophone Regional Health Authority A and the Anglophone Regional Health Authority B. Nevertheless, the tension was still there: *"There are all sorts of parochial backbitings that happen when you put these two groups together."* [R15]. To reduce this tension, half of the service team comes from the RHA A and the other half from RHA B. In addition, the two Regional Directors of Mental Health and Addiction decided to put the bickering aside to focus on the clients' needs. In the same vein, there have *"always been conflicts between Social Development and Mental Health because we have different priorities, ways of looking at things. (...) This is the first time we have really worked so well on a project."* [RM04].

Most of the time, the **cooperation** between the project collaborators has been described as very good, although not everyone agrees on the substance of that cooperation. Some see in it a continued partnership and ongoing communication. In contrast, others believe that some tensions between the government and community levels have posed a challenge to the planning and development. To prevent tension between the community and government agencies, one person has been assigned to communication in one of the departments. In addition, the Coordinator issued bulletins to inform the community agencies of the project progress.

The good quality of **communication** has been pinpointed as an element enhancing the planning and development process. However, some collaborators stress that communication with the national team was done mainly through the Internet; that led to some form of over-communication. Several researchers have had to participate in training sessions, conference calls, numerous committees, which led to a certain level of exhaustion. As well the volume of documents received regularly exceeded their ability to remain up to speed.

The **training sessions** offered to the caseworkers working for the project have also created some tension in that they put in interaction different intervention approaches. To resolve this problem, **additional training** was provided to key players of the service component.

## 6. Governance structures

Interviewees emphasize that the management mechanisms of the Moncton project were difficult to identify and understand. In general, the major players agree that the roles, responsibilities and decision-making mechanisms of the various committees were not clearly defined.

### *Users' and community groups' Involvement*

In a **relatively flexible** fashion, the Commission mandated the Moncton Site Coordinator to establish a team and a structure according to certain parameters which had to include, among other things, a local advisory committee. This committee called in Moncton *Comité avisieur* was

formed **informally** in the planning and development phase as a measure for people with lived experience to participate.

The Coordinator kept stimulating the involvement of community agencies by keeping them informed through **newsletters**, telephone calls and informal conversations. Finally, it should be mentioned that the local structure, to which was grafted an executive committee responsible for communications between the different project components, has appointed a person responsible for managing the meetings that involve consumers.

### ***Political decision-makers' and Research team's Involvement***

It is also important to mention that the cooperation of government departments has been significant in establishing management structures given the strong involvement of government authorities. The various departments involved have always contributed to the establishment of flexible structures. Some key players have attributed great power to departments in terms of expertise and information-sharing. The fact that the Coordinator has had to restore the structures of the research component because **the team had completely changed** posed a challenge to the planning and development process. The support provided by the **non-professional staff** facilitated the redeployment of the research component.

## **7. Components - local adaptation**

The housing component, the vocational component and the different types of support have been adjusted to take into account the context of Moncton, a decision that was made in consultation with collaborators, but especially by the Coordinator.

Although Moncton is the smallest of the five sites, a significant increase in its population has been noticed in recent years. Since there is very little **transitional housing** in the region, it has been necessary for the housing component to be implemented in order to immediately adopt a self-sufficient approach allowing each participant to have their own lodging. A payment system for subsidized housing had to be developed from the outset. This system relied on the one that was already in place, which helped **transfer funds directly to private landlords**.

Finding a psychiatrist has been problematic. The lack of professionals in Moncton, coupled with a demand already high and still growing, was such that responsibilities had to be divided between stakeholders and service providers to adhere to the guidelines of the ACT Team.

A second sub-ACT team made up of three persons was formed for the rural arm: "...the workers felt very strongly that we should try and advocate for an ACT team as opposed to an Intensive Case Management team, ICM. So that was one of the things that came out of that group, and it was felt by the local staff that we just had such a shortage of services, that the needs were extremely high in our population of homeless and mentally ill." [RM16].

In rural areas, given the quasi absence of services, people with mental health problems live with their families, in nursing homes, they are "couch-surfing" or they go and live in urban centers.

The definition of eligibility criteria for homelessness has been adjusted to reflect this reality. Existing services are already stretched to their limit, which requires increased supervision on the part of the service team. Since a quarter of participants are in rural areas, the service team has been limited to *"a nurse, a human resources counsellor and a social worker."* [R03].

The RCMP's cooperation in the project was crucial in the development process, since the existing proximity with the homeless has been beneficial in the distribution of services. The RCMP's involvement will reduce the number of undesirable situations, such as the unnecessary use of emergency services and imprisonment.

## 8. Resources

Since the very beginning of the planning process, the Coordinator and the key players made efforts to meet and discuss ways to finance the ACT team and to transfer money to participants. Then, the budget that enabled the implementation of the ACT model has been negotiated between the national team and the Moncton Site Coordinator. Other negotiations on wages and insurance have been necessary and agreements were made with the unions and hospitals.

Since September 2009, the **provincial Health Department and the provincial Social Development Department** pay the employees who work in the project and are reimbursed by the project. Similarly, the Social Development Department is reimbursed for the rental assistance that they pay. Also, the Health Department provides the infrastructure that is necessary for the ACT team.

During the planning phase, provisions had been made for a vocational component placed under the responsibility of a person from **Post-Secondary Education, Training and Labour**. Due to a lack of financial resources, this component has not been put in place.

Finally, one of the most important elements of the project is about **sustainability**. The role of the Site Coordinator was underlined by another interviewee: *"She was negotiating with the government right from the start to try to do sustainability, looking how it would work (...) she had sort of a larger picture of trying to have all these different government levels working together."* [RM16]. According to most collaborators, sustainability is a key objective of the project.

To promote continuity of the project, Department employees will not lose their seniority when their contract expires in 2013. The fact that the main players in the **housing component work with private landlords** also contributes to sustainability. Caseworkers make landlords aware of the life condition of homeless or precariously-housed people having a mental illness. As for the rural arm, one of its objectives is to demonstrate to the provincial and federal governments that the *Housing First* and the Assertive Community Treatment models prove to be less costly than the money allocated to nursing homes' residents.

## 9. Highlights

Of all the highlights described by interviewees, it is undoubtedly the official opening of the project, with the presentation of one of the consumers, who delighted the interviewees: " *He did it with finesse. There are guys with a Ph.D. who would never have even been able to do what he did there, no education, spent his entire life on the street and then he spoke a speech like that, that's what you call real life experience.* " [M22]. For the key informants of the rural arm, the highlight was when the Commission accepted the proposal for the rural arm.

The initial meeting with private landlords is considered by many as a **turning point** in the process. The meeting helped to educate landlords about the problems encountered by the project service users: "*That was a big turning point because if you didn't have that happen, you're in trouble because it's about housing. So that was pretty critical, and you know you don't get two chances to make a first impression and that was the first impression they could make on landlords in Moncton, that was a pretty critical meeting.*" [RM16].

Informants identified as a **downer** the period following the refusal of the first research proposal and when the first potential participant was eliminated because of the project criteria. One person has also experienced a "downer" when the Health Department admitted that there was almost no health services for the homeless or poorly housed people who have mental health issues. Also, most interviewees felt down when they realized that the participants randomized to the control group would only have access to treatment as usual, treatment which is so basic in Moncton that one could almost say it is nonexistent.

As for the rural arm, downers are about the lack of information to be communicated to applicants to the program and the recruitment criteria. Then, the often negative, even aggressive, reaction of nursing homes' owners regarding the project and how a wave of panic swept over the participants initially interested in joining the project and suddenly withdrew.

## Conclusion

The Site Coordinator's professional career has been instrumental in planning the project. Her experience in government and in the non profit sector has been an asset and in a short time rallied representatives from all levels; she convinced them to join forces. It also appears that the project was introduced at a time when the various government departments were ready to tackle a common challenge and work together as never before. A research project funded to take up this challenge could not be more timely; efforts, long hours, compromises were many from all sides to make the project happen.

However the new *Housing First* approach goes against a tradition of division into sectors. In the field, establishing a multidisciplinary team, establishing a leadership whose players have differing (and at times contradictory) disciplinary backgrounds and values attached to those backgrounds have created obstacles to the good will, communication and the desire to go beyond

what one has learned and practiced in one's professional life. It is a fact that the possibility of going beyond these obstacles often depends on each individual's motivation.

The transition from a research team to a second one affected the project planning and development, which accelerated to catch up with the other sites. Specifically, the second research team at the Moncton site began work about four months later than the other sites. The rural arm has been neglected, which resulted in problems in terms of recruitment. The service team and collaborators had difficulties understanding some choices that had been made, in particular the diagnostics that had been selected and the distribution between participants coming from nursing homes and participants coming from families, all the more as adjustments were constant. The service team whose members had been working in Moncton since the beginning of the project in November had to admit that the rural arm would not be a carbon copy of the Moncton project.

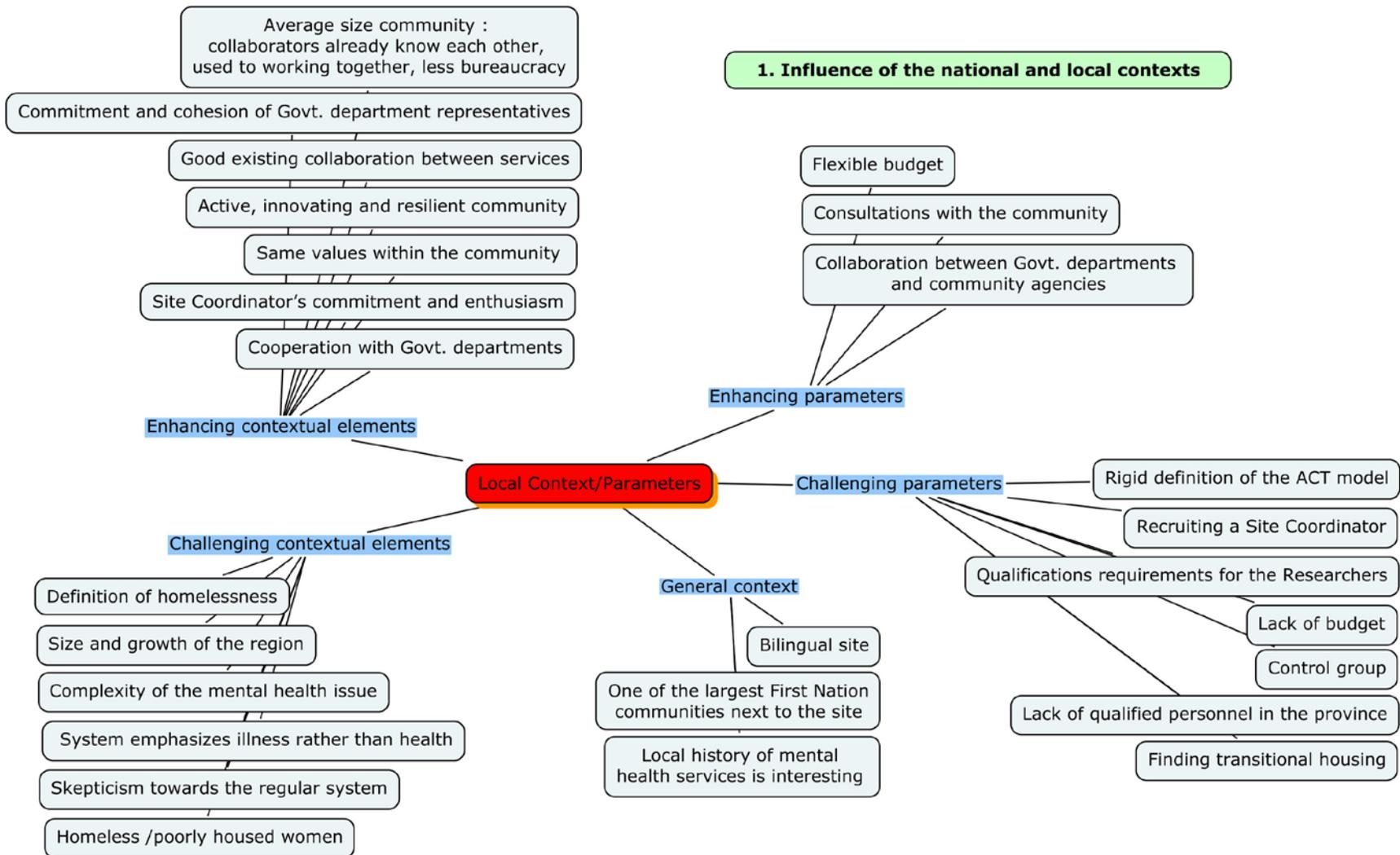
Finally the Moncton idiosyncrasies proved to be numerous and touch on fundamental aspects of the research, such as the very definition of *homelessness*. In a context characterized by a lack of services, setting up a control group was difficult to accept. In the same context, employees leaving mental health community centres and hospitals to form the ACT teams created also a crisis which, even though it had been anticipated by the two Regional Health Authorities Directors, has not been easy for the field staff to live.

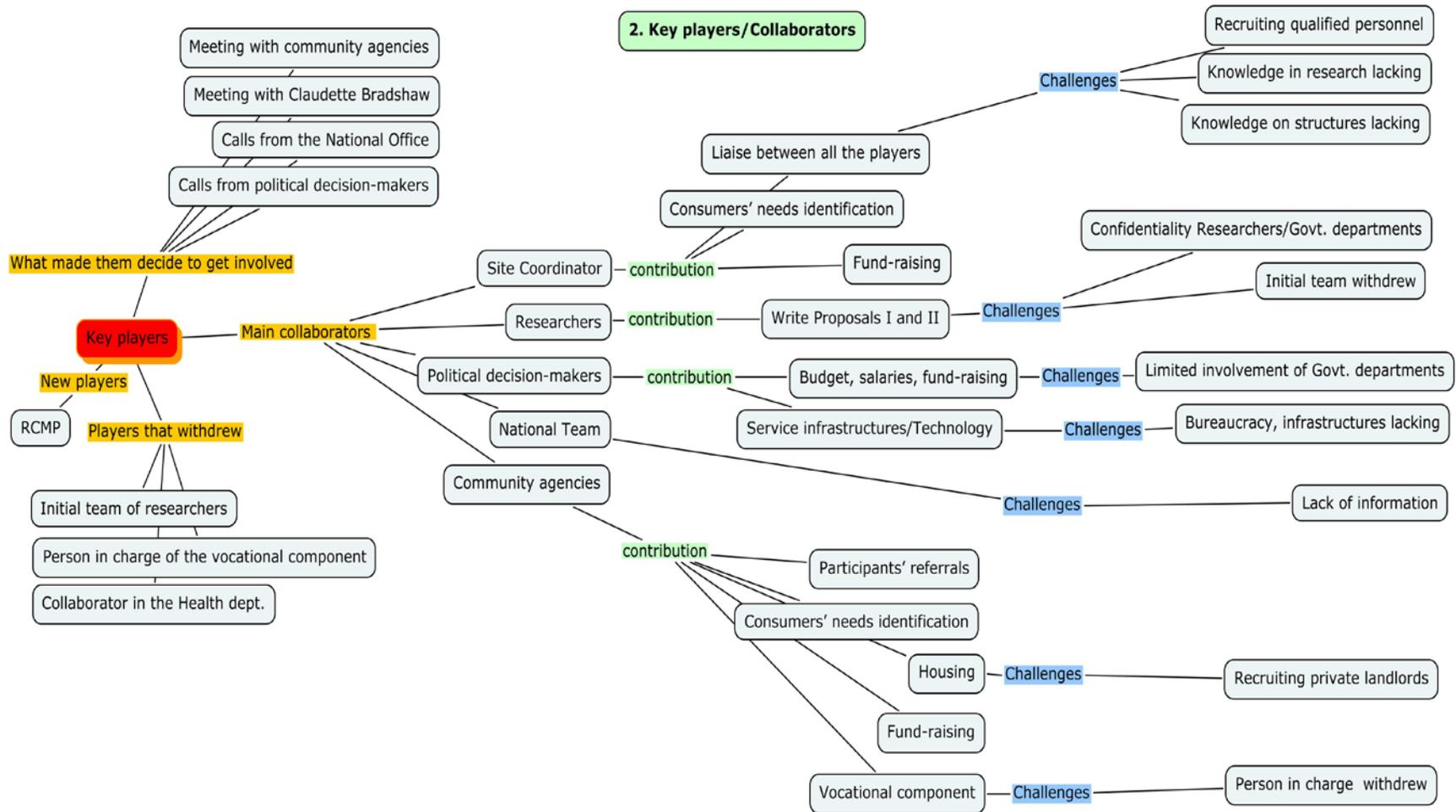
Nearly one year after the launch of the Project, we can say that together all the players, researchers, collaborators, partners and service teams have progressed tremendously; right now, in September 2010, recruiting for the rural arm is over and the Moncton site has caught up with the other sites.

One lesson that has been learnt and that will need to be applied in case the Project expands is how important it is to take the time to know the communities with which we will be working, and to have a team composed of the Site Coordinator, one researcher and one person from the ACT team to explain the various facets of the project to the main players involved, thus ensuring that the information that is being conveyed reflects the complexity of the project.

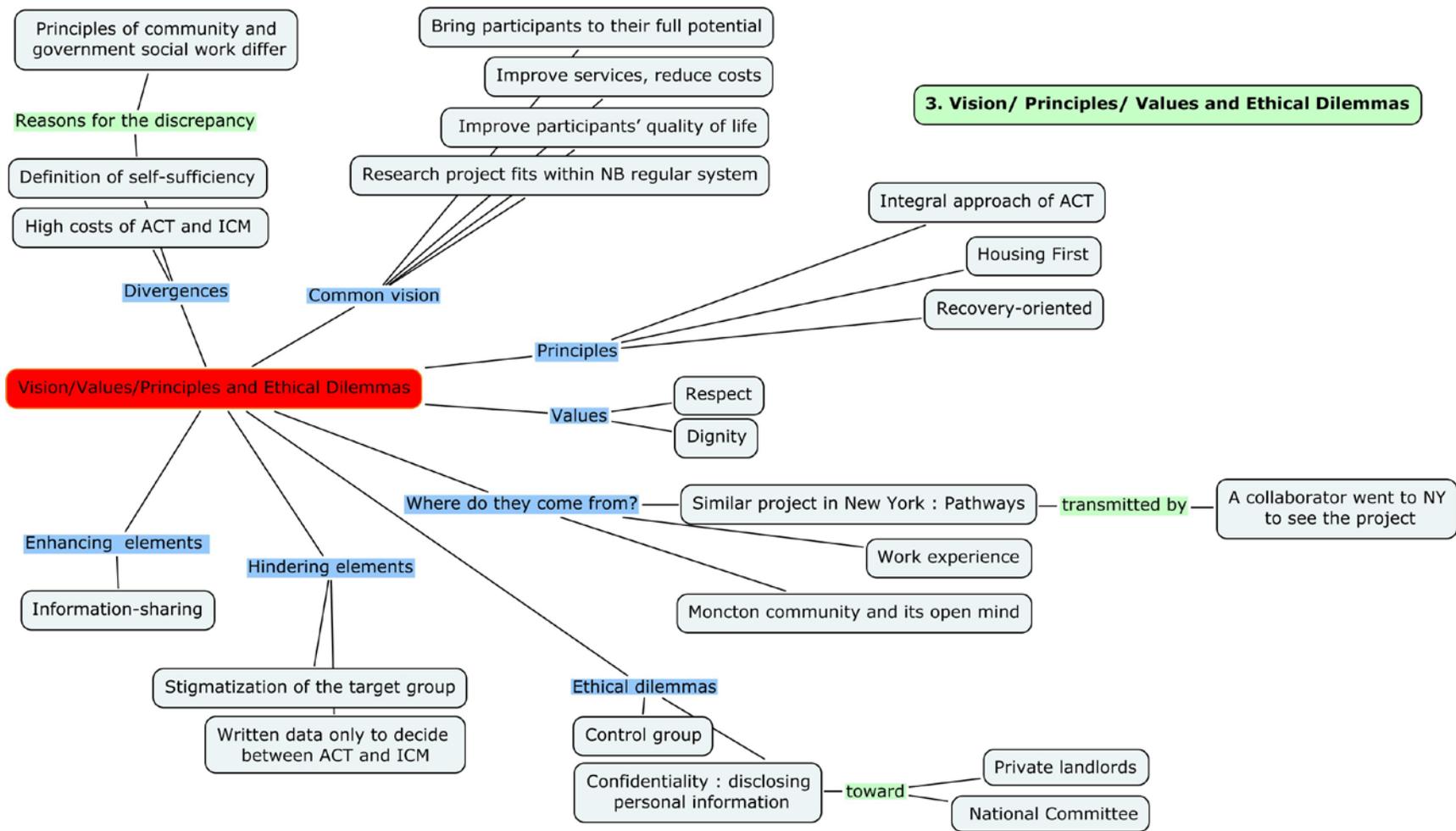


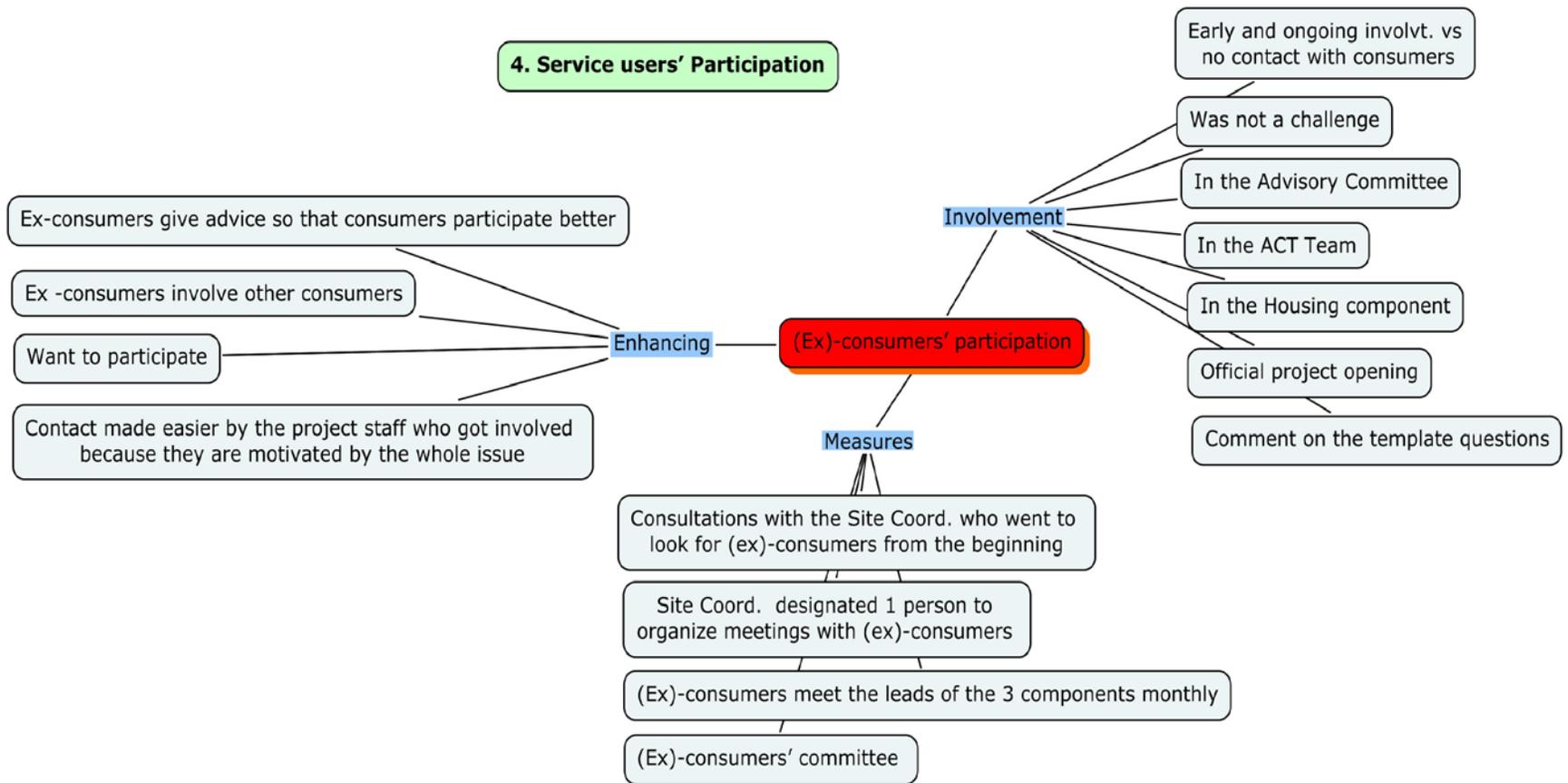
Appendix 1 – Conceptual Maps showing the data processing and analysis





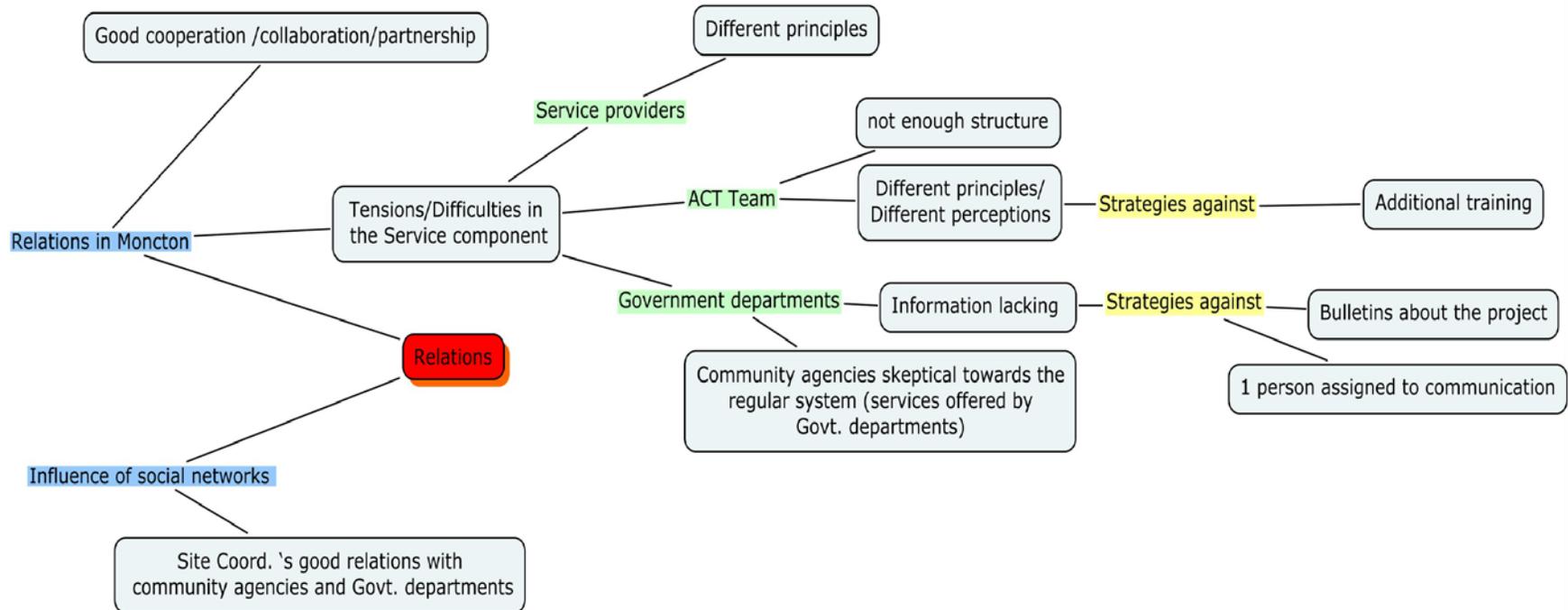
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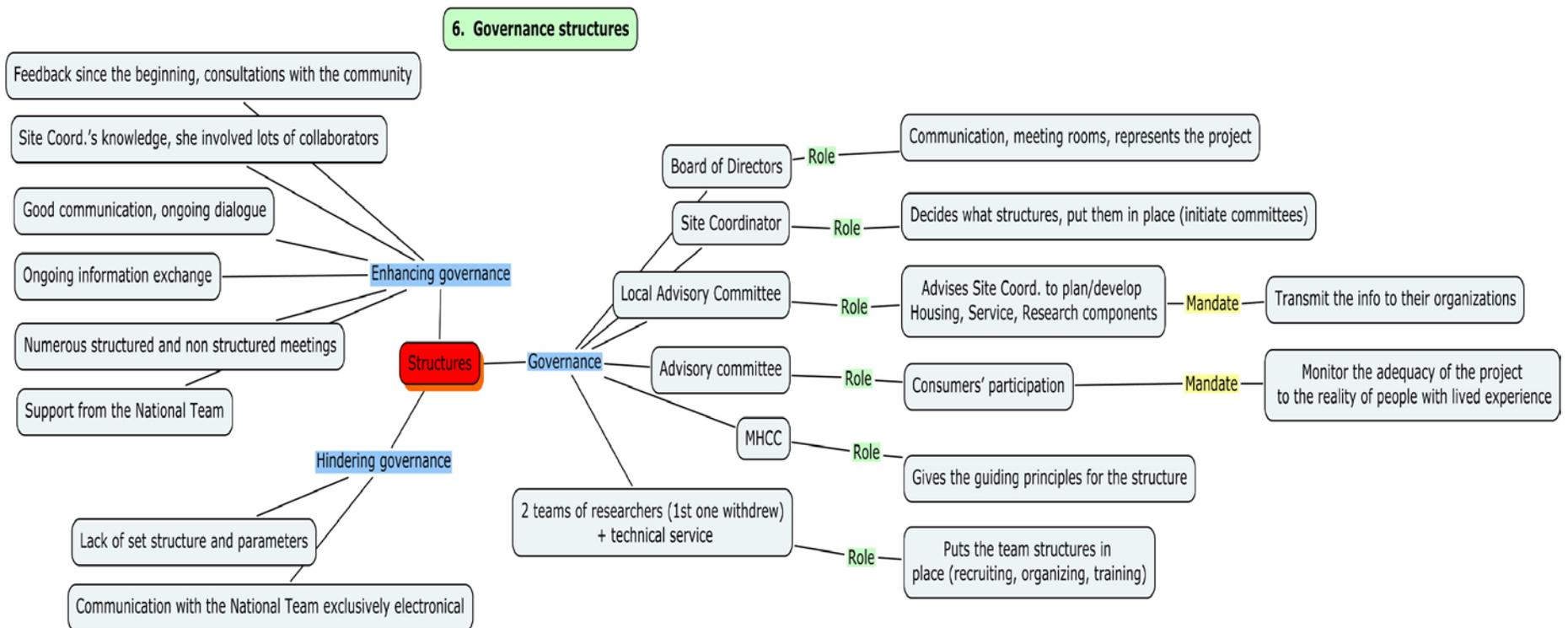


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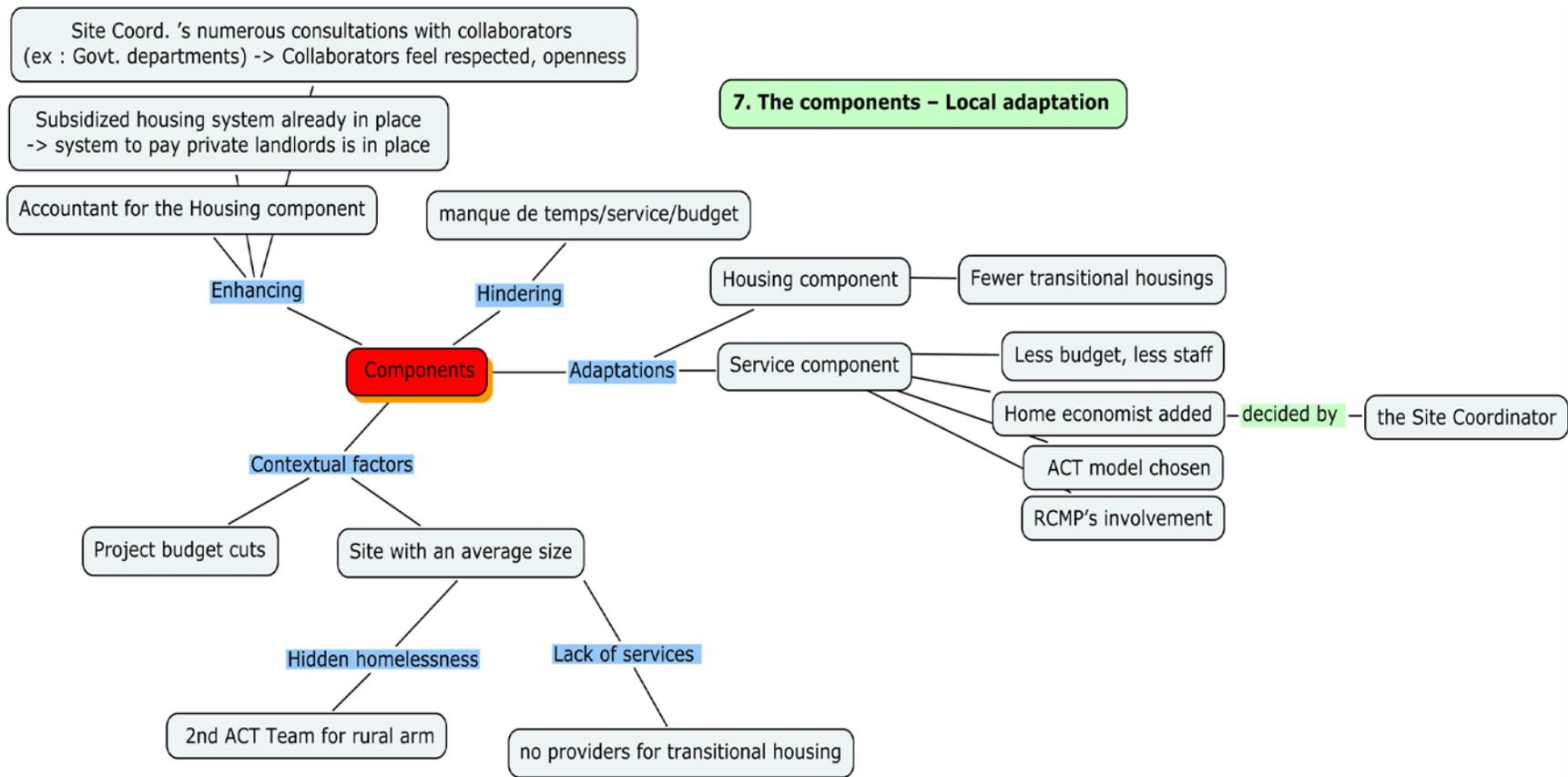
**5. Relations between partners**



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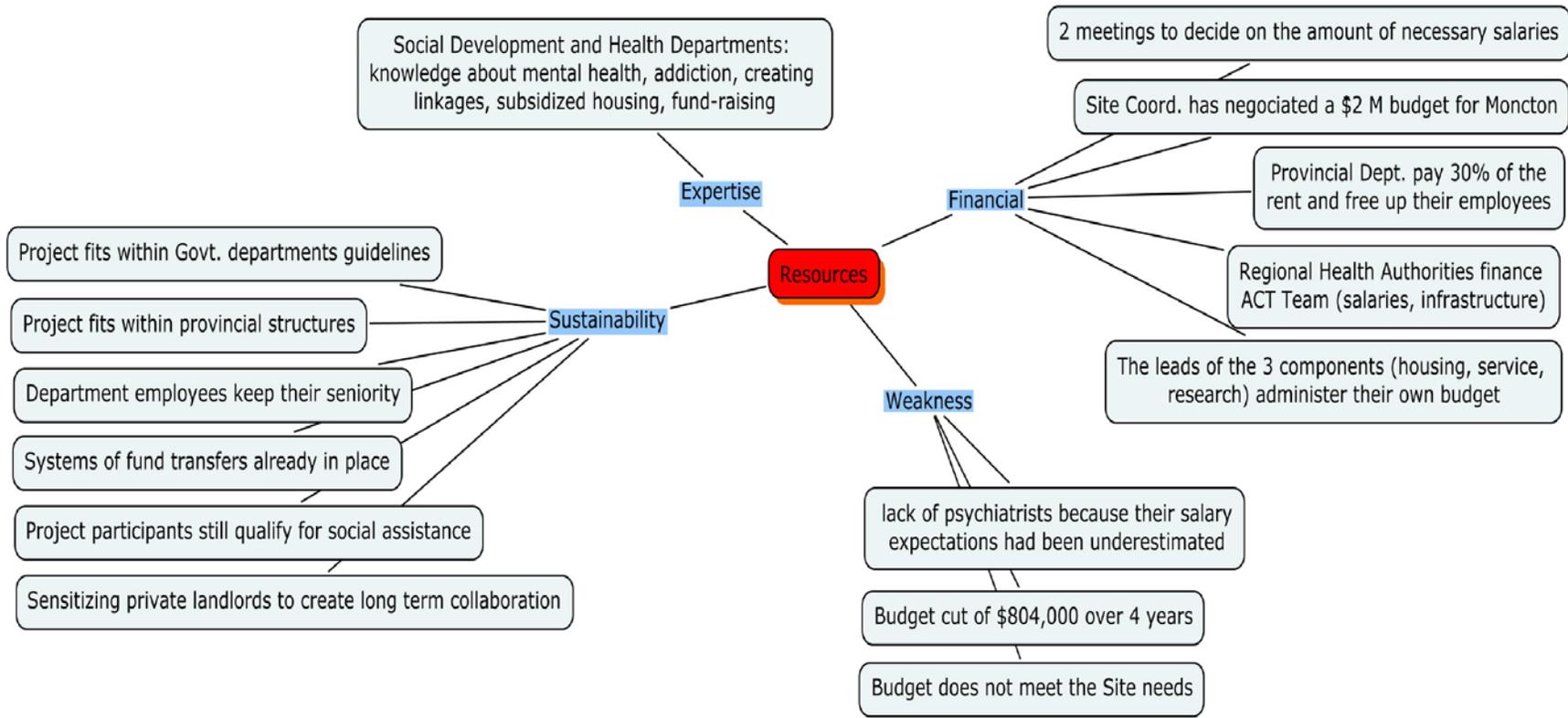


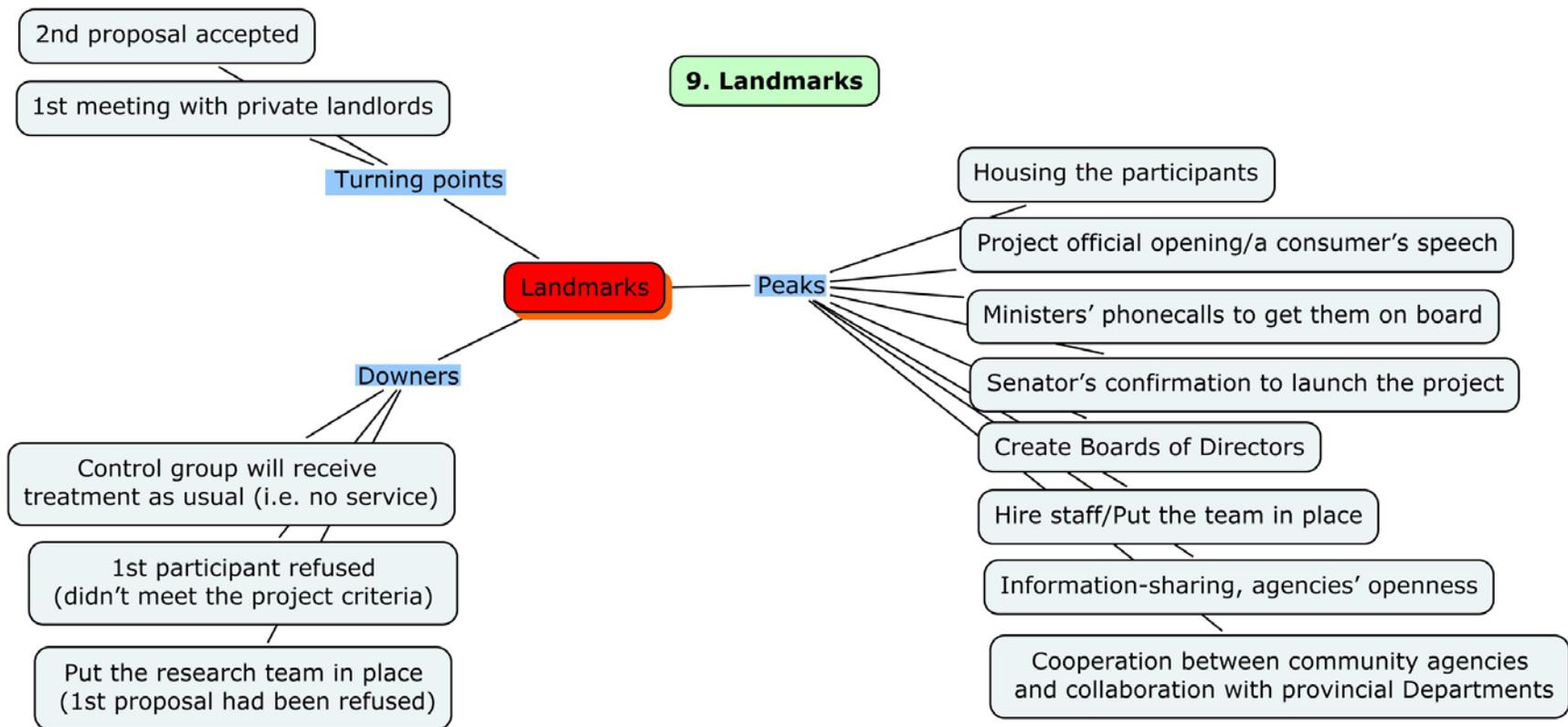
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**8. Resources**





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