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Community partnerships: A case study of the Hamilton-Wentworth Supported Housing Coordination Network (Ontario)

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COMMUNITY PARTNERSHIPS: A CASE STUDY OF THE HAMILTON-WENTWORTH SUPPORTED HOUSING COORDINATION NETWORK

BY

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Abstract

Community partnerships are growing in importance as means of improving social service delivery (Boudreau, 1991; MacGillivary & Nelson, 1998; McCann & Gray, 1986; Nelson, Prilleltensky & MacGillivary, 2001; Wolff, 2001). Several research studies have identified them as effective means of intervention and for strengthening society (Nelson et al., 2001; Wandersman et al., 1996; Wolff, 2001). In this case study of the Hamilton-Wentworth Supported Housing Coordination Network, information was gathered from the participants in the partnership, documents and participant observation to reconstruct and analyze the partnership story. Current mental health housing policy in Ontario was also analyzed to determine its nature and influence on community initiatives for development. Findings revealed that the network's emergence was facilitated by a collective desire for change, which was expressed through enthusiastic participation and a favorable political climate. The motivations of those who initiated the process, factors that facilitated it and the challenges faced by the group are discussed. As well, the background and nature of current mental health housing policy and its influence on the emergence of the network are discussed.

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Dedication

I dedicate this thesis to my wife Mary A. Lomotey, my children Laureen Lomotey and David Ben-Lomotey. I also dedicate it to the memory of my parents, Nii Anang Lomotey I, and my mother, Madam Comfort Kooko Abbey both of who did not live to see this day.

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Introduction and Background

In this study, my aim was to find out how partnerships in social service delivery develop. The research was designed as a case study with particular reference to the issues of homelessness and housing for people with serious mental illness. Homelessness has always been a topic of interest to me as an individual because I view housing as a basic necessity of life for all human beings. Having grown up in a deprived community in a developing country, I have personal experience and awareness of inadequate housing. Till today, it is common practice in my community for an average family of six to eight members to share a single room, sometimes with members of the extended family. I was therefore happy to undertake this project in the hope that it will shed some light on community partnerships as means of social service delivery that can enhance housing for disadvantaged people in society such as poor people, people with disability and low income families. I also hoped that the findings of this research would have positive implications for collaboration in other social service areas these groups of people. The study, therefore, focused on the factors that bring different groups of people together to form non-profit partnerships for social service delivery, what makes such partnerships work and the role of government in community partnerships. This case study was based on Nelson, Prilleltensky and MacGillivary's (2001) definition of partnership as value-based relationships between professionals and people with disabilities.

The increasing importance of partnerships in the area of human service delivery has been identified by several researchers (Boudreau, 1991; Krogh,

1998; MacGillivary & Nelson, 1998; McCann & Gray, 1986; Nelson, Prilleltensky & MacGillivary, 2001; O'Donnel, Ferreira, Hurtado, Ames, Floyd & Sebren, 1998; Wandersman, Valois, Ochs, de la Cruz, Adkins & Goodman, 1996). According to Boudreau (1991), the concept of partnerships has taken such a strong hold on today's society that it has become quite an essential part of social-policy language. She observed that the word "partnership" has appeared conspicuously in social policy related issues in the media, on billboards, flyers and advertisement pamphlets with regularity. As Wandersman et al. (1996) observed, partnership by community agencies, institutions and concerned citizens as a way of strengthening society and improving health has become a very popular means of intervention. Thus by some unspoken consensus, "partnership" has assumed a lofty position in the field of human services. Boudreau (1991) traced the move of the concept of partnership from business to human services to an article by Goodbout and Paradeise (1988, as cited in Boudreau, 1991). In human services, the concept of partnership entails democratic participation and self-determination (Lord & Church 1998; MacGillivary & Nelson, 1998), power sharing, human diversity, social justice (Nelson et al., 2001), mutual understanding (O'Donnel et al., 1998), and trust and reciprocity (Ross, 2000), among others.

In order to gain deeper intellectual understanding of the issues related to the topic, I reviewed literature on inter-organizational collaboration, partnerships and coalitions to find out what factors other researchers have found as facilitating or inhibiting to partnerships. Furthermore, my literature review covered the

problem of homelessness and government policy on housing for people with serious mental illness to contextualize partnerships in this research.

Partnerships

Definition of Partnership

Partnership can be defined as an organization of diverse groups or individuals who are working together with their combined resources for a common purpose or to effect specific change which they cannot bring about independently (Krogh, 1998; McCann & Gray, 1986; Nelson et al., 2001; Wandersman et al., 1996). In research on collaboration, McCann and Gray (1986) defined partnerships or coalitions as "functional social systems" in society that are made up of actors joined together by a problem of common interest. This definition identifies the common interest or goal as the binding factor in any inter-organizational cooperation or partnership. The authors further described partnerships as a way of pooling together efforts and scarce resources towards the realization of a common goal, usually the solution of a local problem, which is too large and too complex for one group to tackle on its own.

New paradigms in the area of health and disability define partnerships more in terms of relationships between service-providers and disadvantaged people (Nelson et al., 2001; Nelson & Walsh-Bowers, 1994; Schwartz, 1992). Nelson et al. (2001) defined partnerships as "value-based relationships between researchers and/or human service-providers and disadvantaged people that strive to advance the values of caring, compassion, community, health, self-determination, participation, power-sharing, human diversity and social justice for

disadvantaged people" (p. 72). This definition identifies community psychologists, oppressed groups and other stakeholders as partners in the human service area.

Values Underlying Partnerships

Nelson et al. (2001) identified the values of caring, compassion and community as very important for ensuring that the disadvantaged members of a partnership enjoy a supportive environment, which promotes their health, well-being and integration with the community as a whole. They also identified stakeholder participation, self-determination and power sharing as other important values in partnerships, which promote equity between professionals and disadvantaged people in a partnership (see also Coe, 1988; Lord & Church, 1998; MacGillivary & Nelson, 1998).

The value of power sharing promotes empowerment or increased power for the disadvantaged relative to professionals and service-providers (Prilleltensky, 1994; Rappaport, 1987). Empowerment, which has become a key concept in community psychology, gives disadvantaged people greater control over resources thereby increasing their self-esteem and giving them greater control of their lives.

Stakeholder participation and self-determination (Lord & Church, 1998; MacGillivary & Nelson, 1998; Prilleltensky, 1994) play an important role in health and empowerment for disadvantaged or oppressed groups. The realization that it is empowering to provide opportunities for people with disabilities to have a say in matters that affect their lives has encouraged the participation of disadvantaged people in policy and decision-making in the human service sector.

Oppressed people sit on boards and councils in the health sector that decide what affects their lives. The stories of these people, their observations and descriptions of their life experiences add to our understanding of what they go through and further enrich the information bases for policy-making (Lord & Church, 1998; MacGillivary & Nelson, 1998; O'Donnel et al., 1998). Their participation, according to O'Donnel et al. (1998), is beneficial to all involved because it increases knowledge and understanding of their situation and facilitates decision-making that benefits them.

Prilleltensky and Nelson (1997) identified social justice as a fourth value, which is very important in partnerships. Social justice according to these authors pertains to an equitable distribution of both the resources and burdens of society. Such equity if ensured will give disadvantaged people access to the necessary resources that would enable them to achieve their desired goals and promote self-development. This is empowering and therefore important to the success of a partnership, as people without access to resources cannot meaningfully contribute towards the achievement of the collective objectives in a partnership.

Nelson et al. (2001) further identified the value of human diversity, which recognizes the uniqueness of all participants in a partnership. Each participant comes into a partnership with unique qualities, which can be harnessed and mobilized for the success of the partnership. Ross (2000) argued that trust and reciprocity are necessary for the success of any partnership involving people with disabilities, their families, communities and mental health workers. As people get together to work on a common goal, there is a need for them to trust each other

and avoid suspicion and mistrust which only engenders loss of focus and serves to impede the organization.

Why Groups Come Together to Form Partnerships

As Boudreau (1991) illustrated, groups that come together to form partnerships rarely share a common definition of partnerships or have similar understandings and expectations. These groups may, however, come together because they share a common goal or certain key values, which are pertinent to the area of interest. Groups may also come together to form partnerships to promote systems change and enhance community well being (Foster-Fishman, Berkowitz, Lounsbury, Jacobson & Allen, 2001). By pooling resources, partnerships gain advantage over individual constituents in terms of the amount of resources available to achieve their collective aim (Wandersman et al., 1996).

Resource mobilization theorists (Jenkins, 1983; Morris & Mueller, 1992, as cited in Nelson et al., 2001) described organization by communities for social change as political activity. Such activity, according to them, requires both internal and external supports, local organizational ability and public support to evolve. The presence of these factors promotes local organization for social change. According to Lord and Church (1998), the word "partnerships" suggests that each stakeholder group has something to contribute and something to gain from involvement. Ross (2000) identified stakeholder contributions in planning, delivery and evaluation in mental health as the most significant development in the mental health sector of the past century. These contributions by participants

in a partnership increase the resource base of the partnership. This, according to Ross (2000), is the most powerful implication of partnerships.

Partnerships also help in building social capital. Judith Maxwell (as cited in Ross, 2000) defined social capital as including institutions, patterns of behaviour and trust and reciprocity that enable citizens to solve problems and enhance personal growth. Social capital refers to the bond of trust, mutual understanding, and shared values and behaviors that create active connections among members of human networks and communities, which work together towards a common objective (Cohen & Prusak, 2001). This bond of trust was further emphasized by James Coleman (1969, as cited in Baron, Field & Schuller, 2000) who described social capital as a kind of resource inherent in family relations and which is very important for the cognitive and social development of children. Social capital is therefore very important for promoting collaboration and commitment (Cohen & Prusak, 2001), both of which are necessary factors for the success of partnerships.

Further, groups come together to form partnerships in order to attract public support and have political influence through joint action (Ross, 2000). This way, a partnership optimizes the power of individuals and groups in its ranks to bring about change. Moreover, the organization resulting from a partnership, with its combined resources, is able to take on broader issues which member organizations lack the ability individually to take on. We can therefore argue that partnerships are formed because it is mutually beneficial to collaborate with

others and also because more can be accomplished collectively than is possible by working independently.

Partnerships further reduce duplication of effort and services and also involve more diverse constituencies and interests. According to Wandersman et al. (1996), this makes partnerships potentially more representative of the communities in which they are formed and further creates more avenues for people to participate in them.

How to Build Partnerships

In an extensive literature review, Foster-Fishman et al. (2001) identified several capacities as necessary in the framework for building partnerships or coalitions. These include building members' capacity to collaborate, building attitudes/motivations for collaborative capacity, building access to member capacity, creating relational capacity, building organizational capacity and, finally, building programmatic capacity.

According to these researchers, member capacity is built by providing members with the skills and knowledge necessary for collaborative work. This is done through training, workshops and seminars usually for non-professional participants. There is also a need for positive attitudes and strong commitment to work in collaboration with other members of the partnership. Further, they noted that access to member capacity comes from member diversity. As people from diverse backgrounds with different skills join together in a partnership, the knowledge, skill and resource base of the partnership is increased. Relational capacity has to do with both internal and external social relationships. Positive

internal relationships are built through positive interactions among members whilst positive external relationships are fostered with the community and other agencies outside the partnership. According to Foster-Fishman and her colleagues, there is also a need for strong leadership with skills for communication, conflict resolution, resource development and administration to organize the group effectively. Finally, program initiation, development and implementation skills are required for any partnership to achieve its objectives.

Factors That Facilitate Partnerships

Several factors have been recognized as facilitative of partnerships. These include trust and mutual understanding (O'Donnel et al., 1997), the values of caring and compassion (Coe, 1998; Lord & Church, 1998), the value of listening (MacGillivary & Nelson, 1998) and effective leadership (Butterfoss et al., 1996; Lord & Church, 1998; O'Donnel et al., 1998).

According to O'Donnel et al. (1998), trust and mutual understanding are very important to partnerships. Oppressed people and community residents often lack trust in professionals who they believe use them to achieve their personal objectives but they still feel obliged to conform to their expectations. This notion causes what Lord and Church (1998) described as "partnership shock", a situation in which disadvantaged people within a partnership feel pressured to submit to the will of professionals. "Partnership shock," according to these authors, limits the effective participation of all members of a partnership. They suggested a need to understand the differences that exist between the members,

especially between professionals and people with disabilities, and a commitment to work across those differences.

The value of caring, compassion and community involves strong interpersonal relationships, which are characterized by mutual respect and a supportive environment. Such environments enable all participants to comfortably express themselves to others who are receptive to their ideas and opinions. This promotes the value of giving voice to weaker partners, which is another important factor that enhances the success of a partnership (Coe, 1988; Lord & Church, 1998; O'Donnel et al., 1998). Allied to this is the value of listening, another very important factor reported by MacGillivary and Nelson (1998). According to these researchers, consumer/survivors found participation in a mental health partnership very empowering because the agency would listen to them before anybody else. This made this disadvantaged group feel their contribution was valued and encouraged their active participation (see also O'Donnel et al., 1998).

Another factor, which has been identified as highly facilitative of partnerships, is effective leadership (Butterfoss, Goodman & Wandesman, 1996; Lord & Church, 1998; O'Donnel et al., 1998). Butterfoss et al. (1996) found that effective leadership was a very important factor in determining members' satisfaction with collective work. Lord and Church (1998) also identified the leadership question as one of the important issues that needs to be addressed at the onset, as the success of the group depends on this. According to them, good facilitation helps ensure good process and communication.

Besides these factors, certain activities have been associated with successful partnerships. These include, responding to community needs, recruiting through relationships, being open, creating standard goals, providing training needs of members (O'Donnel et al., 1998), networking and collaborative problem-solving (Coe, 1988). Other researchers have also found that successful partnerships are associated with making changes in the lives of people (Krogh, 1998; MacGillivary & Nelson, 1998), creating a supportive environment, and providing mutual benefits to both communities and agencies (Butterfoss et al., 1996).

Challenges to Partnerships

Several factors have been identified in the literature as inhibitive to partnerships (Boudreau, 1991; Krogh, 1998; Lord & Church, 1998; McCann & Gray, 1996). These include, power inequalities, inequitable distribution of financial benefits, lack of interpersonal skills, differences in culture and language, attitudes and personalities of professionals and role-expectations.

Partnerships between professionals and people with disabilities are characterized by power differentials, which if not addressed can seriously affect the effectiveness of the partnership (Lord & Church, 1998). Lord and Church advocate a "conscious shifting of power" by professionals as a way of reducing power differentials. According to these authors, the phrase "shifting of power" means "reducing the need for professional certainty without getting defensive" (p.119).

Power differentials also partly derive from financial disparity between professionals and people with disabilities. Lord and Church (1998) advocated a need to face the poverty of consumer/survivors by providing for their financial needs to enable them to participate in partnership activities. This helps to create an enabling environment for the less powerful members of a coalition to participate without feeling inadequate. According to Krogh (1998) people with disabilities are unable to participate fully when they feel their contributions are not valued. This makes their involvement superficial.

Rigid role-expectations also inhibit partnership development (Krogh, 1998; McCann & Gray, 1996). When professionals assume the roles of charitable givers or show excessive patronage and concern, people with disabilities are forced to assume a grateful stance, and this reduces their self-esteem and limits their ability to function as partners. Tied to patronage is the issue of self-determination. Paternalistic attitudes by professional and service-providers affect the sense of self-respect of people with disabilities and limit their aspirations to self-determination (Prilleltensky, 1997).

Boudreau (1991) also found the issue of role-definition very challenging to partnerships. She reported in her study of mental health partnerships in Quebec that stakeholders expected the ministry to assign clearly defined roles for them whilst at the same time complaining of excessive government involvement in their affairs.

Differences in culture and language between professionals and community members also serve as a challenge to partnerships (Krogh, 1998).

People with disabilities are often culturally conditioned to be dependent and conversely, many professionals tend to think that such people should only play limited or token roles in partnership decision-making and activities (Krogh, 1998). Furthermore, Krogh (1998) found that procedures adopted at meetings often require professional knowledge and training, which is usually lacking in community partners, especially people with disabilities.

The capacity of stakeholders to relate to the larger environment, rivalries among member organizations and convenor characteristics are also challenging to collaborative efforts (McCann & Gray, 1986). The capacity and legitimacy of the person or organization facilitating the partnership is a real challenge, which can seriously affect its successful functioning. Member groups need to have confidence in the organization, which convenes or facilitates the partnership. This reduces rivalries among individual members or member-organizations and enhances the organization's capacity to successfully achieve its objectives. Good leadership also promotes good relationships with the community and opens participation to more interest groups.

The literature reviewed on partnerships in this section has covered the general area of partnerships in social service delivery. To contextualize the current research, the next section will cover homelessness as a social problem.

The Problem of Homelessness and Housing for Homeless People

Homelessness Among People With Mental Health Problems

Homelessness is one of the most endemic social problems facing humankind today. The problem is not a new one. In the United States, Schutt

and Garrett (1992) traced homelessness to colonial times and noted that it worsened during the great depression of the 1930's. The late 20th century saw another upsurge in homelessness. A 1990 census put the number of homeless people in the United States at 228,372, although advocacy groups for the homeless believe the actual figure is between two and three million people (Glasser, 1994). Over a decade ago, it was estimated that more than a 100,000 people were homeless in Canada, with over 10,000 cases in Toronto alone (Ward, 1989). More recent statistics show sharp increases in these estimates. According to figures published in the Toronto Report Card on Homelessness (2000), annual admission to shelters in the city rose from 22,000 in 1988 to 28,800 in 1998, representing an increase of 30%. Figures released by the report indicated that homelessness is increasing at an alarming rate. For example, admission to the Out-of-the-Cold winter shelter program in Toronto doubled over a period of three years - 1996 to 1999 and was projected to reach 1000 in 2000. Most alarming were the demographics of the increases; the number of children using shelters increased by 120% from 2,700 in 1988 to 6,000 in 1998. The number of families with children using shelters was also found to be increasing rapidly with an average stay of 46 days, the longest compared to any other group.

In the world today, an ever-increasing number of children and adults live permanently on the streets. The United Nations estimates the number of homeless people in the world to be about a hundred million. They live in cardboard containers, huddle in doorways, sleep in street corners, under bridges,

in hallways, abandoned buildings, shelters and tents in refugee camps (Daly, 1996; Schutt & Garrett, 1992; Ward, 1989). Factors identified as causing this phenomenon include poverty, unemployment, de-institutionalization of the mentally ill (Daly, 1996; Schutt & Garrett, 1992), the lack of affordable housing, family disintegration, and alcohol abuse (Daly, 1996; Glasser, 1994). In most third world countries, generations spend their whole lives in urban slums and squatter settlements where several people often cram into little spaces to pass the night. The situation has further been worsened by conflict, war and poverty, which have rendered millions of people homeless (Glasser, 1994). The Toronto Report Card on Homelessness (2000) noted that among other things, lower incomes, an increasing gap between the rich and the poor, which is putting more families on social assistance, and lack of affordable housing in the system, are major causes of homelessness in the city.

People with serious mental health problems constitute a significant proportion of the homeless in industrialized countries. According to Schutt and Garrett (1992), studies have shown that the percentage of homeless people with chronic mental health problems is between 25 to 50 percent. This group possesses several characteristics, which distinguish them from other homeless people. Daly (1996) found that they are less likely to sleep in shelters and have been homeless for longer periods on the average compared to others. Most of these people actually become homeless only after release from institutions, and as Daly (1996) noted, the prospect of finding accommodation after release from a mental health institution is very limited in Canada. This is also true in most other

countries because such people rarely have the resources to rent homes. According to Schutt and Garrett (1992), homeless people have very limited resources to cope with residential and health problems. A survey by Gelberg, Linn and Leake (1988) found that most de-institutionalized individuals find themselves without families, any means of livelihood, or places to call home. Such people therefore just wander aimlessly about, swelling the ranks of the homeless.

Conceptual Approaches to Housing

In view of this problem, housing is an important and immediate need of de-institutionalized people. Since the policy shift from institutional care in mental health to community care, three main approaches to housing for consumer/survivors have evolved. These are custodial housing, supportive housing and supported housing (Parkinson, Nelson & Horgan, 1999).

Custodial housing. Custodial housing was first adopted when de-institutionalization began. This involved board and care homes established to house de-institutionalized individuals within the community (Carling, 1995). Board and care homes are run for profit, and merely serve as replacement for mental institutions. Residents are considered as clients and are provided with neither treatment nor rehabilitation services. Individuals in these homes remain under the strict care and control of staff and have no choice whatsoever of where to live or what services they need (Carling, 1995; Nelson, Hall & Walsh-Bowers, 1995). Examples of this model of housing are Second Level Lodging Homes, which are private for-profit residential care housing and Homes for Special Care.

Supportive housing. Supportive housing developed as an improvement over custodial housing to cater to the rehabilitation needs of people with mental health problems. The concept involves the provision of treatment and rehabilitation services to assist individuals with mental health problems to gradually develop the ability to live independently (Nelson et al., 1995; Tsemberis, 1999). This model, described by Tsemberis (1999) as Linear Residential Treatment (LRT), seeks to address the problem of homeless individuals with mental health problems through a sequence of steps beginning from transitional housing, through supportive group homes to independent living within the community. Rehabilitation services in these facilities are, however, linked with housing. Residents of supportive housing facilities therefore lack the power to choose their own lodgings or decide what services they need.

Supported housing. The concept of supported housing, as proposed by Carling (1995), focuses on encouraging self-help and empowerment of the individual consumer/survivor towards independent livelihood. This model does not only allow individual consumer/survivors to choose the type of housing they want but also involves them in decision-making that affects their lives as tenants of the housing facility (Nelson et al., 1995; Tsemberis, 1999). Supported housing programs also involve the provision of such support services as case management, crisis intervention and rehabilitation programs based on each resident's personal needs. In supported housing facilities, participation in these programs is not linked with housing. Individuals are therefore afforded the freedom to decide whether they need these services or not. Typical examples of

supported housing are units developed by the Hamilton Good Shepherd Inc. as part of the local Homelessness Initiative. In these units, residents are provided with 24-hour case management and are given freedom of choice of mental health services.

Partnerships for Creating Housing

Housing for homeless people with mental health problems involves several stakeholders namely: government (whose main role is that of policy-maker and funder), housing-providers, support service-providers, consumer/survivors and family members (Boudreau, 1991). These stakeholder groups could be regarded as partners working together towards the common goal of providing homes for homeless people with mental health challenges within communities.

In some cases, these partnerships have not been formally recognized and member groups work in isolation. In other cases, partnerships have formally evolved from single housing-providers who view themselves as separate organizations to broad-based coalitions with clearly defined goals, and in which each stakeholder group is accorded recognition and respect. One such example is Waterloo Regional Homes for Mental Health Inc., which began as a single group home but later developed into a full-blown partnership for service delivery for people with mental health problems. Such value-based partnerships develop to give all stakeholders the opportunity to participate in decision-making (MacGillivary & Nelson, 1998; Nelson, 1994).

Forging a partnership involves working with other people or groups with diverse interests and perspectives. Lord and Church (1998) suggested that it is important to address issues regarding these differences at the beginning of a partnership. They posed the following hard questions that need to be answered at the very beginning: "Who will benefit? Who will be harmed by the project? Is there a common goal? What beliefs about people and change are inherent in the project? How will differences be addressed? Who will control the process? How will the partners work together so that each partner's experience will be honored? How will participation be maximized? How will value resources be shared?" (p. 116).

The Importance of Policy in Mental Health Housing

Policy in the modern democratic world directs and regulates almost every aspect of life. In the social service sector, the role of policy is to create the context for the distribution of resources and to increase the likelihood that communities will address significant issues (Nelson, Lord & Ochocka, 2001). Since the interests of different groups are sometimes at variance, advocacy for policy change often meets resistance from politicians, as those who benefit from the status quo lobby for its maintenance. Advocacy for policy change therefore requires a favorable political climate and well-organized support base to succeed (Nelson et al., 2001).

De-institutionalization came as a major shift in policy as a result of research on community alternatives and sustained advocacy. Some writers also contend that governments adopt deinstitutionalization, more as a cost-saving

measure than for effective humane treatment of people with mental illness (Scull, 1977). Scull (1977) cited the closure of mental institutions in California and New York because of projected increases in the number of inmates and financial costs to buttress this claim. Mental health policy in the United States and Canada, according to Nelson et al. (2001), have focussed on reallocating resources to community-based programs (see also Boudreau, 1991). In the United States, the Community Mental Health Centers Act of 1963 (as cited in Flexer & Solomon, 1993) prepared the way for the release of patients of mental health institutions and initiated a move towards community-based mental health care. In Ontario, the Graham Report of 1988 (Ontario Ministry of Health, 1994) recommended a shift of resources to address the values of empowerment and community integration through community-based housing and services for de-institutionalized individuals.

The importance of policy in mental health housing stems from the fact that such projects often require government funding. A policy framework is required to redirect government spending on mental health institutions to community care. In the United States, the federal government took these bold steps by acknowledging its responsibility in providing homes for the homeless with the passing of the McKinney Homelessness Act of 1988 (cited in Daly, 1996).

Theoretical Basis

The theoretical basis of this research is social justice. Nelson et al. (2001) identified social justice and access to valued resources as one of the values of the empowerment-community integration paradigm in mental health (see also

Prilletensky, 1994; Prilletensky & Nelson, 1997). These researchers related social justice to equitable access to such resources as affordable and desirable housing, adequate income, education, and meaningful employment.

Founding a just society was the focus of John Rawls' philosophy. According to Rawls' theory of justice (Rawls, 1971, as cited in the Internet Encyclopedia of Philosophy), justice is the first virtue of social institutions. Rawls invoked "the original position" in which a group of people was asked to determine the scheme for governing society behind "a veil of ignorance" (unaware of the specific roles they would occupy in a society whose structure and processes they determine). He argued that under such circumstances where people do not know where the chips would fall, they would make fair decisions about the governance of society.

Social justice theory is based on the principles of equal worth, self-respect and personal autonomy, entitlement to basic needs and reduction in unjust inequalities for all people (Commission for Social Justice, 1998). These principles, which command equality and respect for human dignity, affirm the primacy of the individual's rights and freedoms in modern democratic contexts.

Social justice theories view equality as the basis for social life. These theories advocate the provision of equal opportunity and equal treatment for all members of society. In recognition of the fact that not all inequalities are unjust, they call for reduction in unjust inequalities rather than blanket elimination of inequalities. Miller (1969, as cited in The Internet Encyclopedia of Philosophy) endeavored to determine a basis for categorizing inequalities as just or unjust.

According to him, differences that result from an individual's personal effort and creativity are not unjust especially when there is equal opportunity for all. However, inequalities arising from social backgrounds and other demographic factors, disability, or other natural circumstances are unjust.

Unjust inequities exist in society mostly because people have unequal access to resources. Wealth is concentrated in a few hands and has become a tool for controlling governments and further influencing unequal allocation of resources. A most striking example of this is the force with which governments and multinational corporations are pushing the concept of globalization over the cries and protests of the poor masses. A small minority, by dint of luck of "high" birth are in positions of great wealth and advantage whilst the mass of people wallow in poverty. Until a fair redistribution of wealth occurs, care must necessarily be provided for the poor, the disabled and other unfortunates in society. According to Kneip (2002), unless we accept the collective burden of looking after these individuals, "powerful forces in the environment or social structure will maintain or exacerbate the inequities" (p. 1).

Constitutions of liberal democratic states guarantee people's freedoms and equality before the law. The freedoms thus guaranteed, according to the Commission for Social Justice (1998), should "amount to more... than the freedom to sleep on park benches and under bridges" (p. 41). Individual freedoms are associated with equal opportunity. In the view of the committee, people are restricted in what they can do with their rights if they are poor, ill or

lack education. It is the duty of society to care for its disadvantaged. People with mental illness fall within this category.

It is indisputable that support for people with disabilities is the responsibility of society. Social contract theories hold that although humans are born free agents, they surrender their sovereignty to rulers in exchange for protection. Thomas Hobbes (1588-1679), a 16th Century English philosopher, argued in *Leviathan* that human beings were motivated to end a state of life that was characterized by constant war and brutality by establishing moral laws to promote peace, and an agent (government) to enforce those laws. Another English philosopher, John Locke (1632-1704) believed that the state of human's life was guided by divine natural law and therefore moral. Social contract between the rulers and the ruled was therefore a means for preventing people from occasionally violating the law. The two philosophers approached the issue from opposite views of human nature. Hobbes viewed human nature as brutal and selfish, whilst Locke viewed humans as morally responsible beings. Both philosophers, however, agreed that humans surrender individual sovereignty to rulers in exchange for protection against threats to his life.

The threats against people's lives have been variously explained as threats of physical injury or to personal property from plunderers, marauders or invaders. A more extensive interpretation must, however, include protection from innocent suffering such as suffering as a consequence of poverty, disability and adversity. The disabled, the destitute and victims of natural disasters have a right to aid from society and from the state. According to Coll (1969, cited in Levine &

Perkins, 1997), "those in need had a right to receive aid and those better off had a duty to provide it as a matter of social justice" (p. 50). Levine and Perkins (1997) traced the responsibility of the state to provide care for the disabled to the Elizabethan poor laws of 1597-1601. The poor laws recognized that care for dependent persons was primarily a family responsibility, but firmly placed the responsibility on the community where the family is unable to support them.

According to the Commission on Social Justice, the state should necessarily provide resources or make available the means to acquire those resources that would enable individuals to meet their basic needs. Primary among those basic needs are education and health care. The commission places the responsibility of providing equal educational opportunities and equal access to health care for all citizens on the state.

For most people then, providing social services fulfils the prescript of social justice. Social justice for me, however, means more than merely providing services to the needy. It means ensuring that the services provided reach the people who need them, that the services so provided are effective in meeting their needs, and that they are provided in such a way as to empower them to take control of their lives. Thus finding the means for providing effective social services to needy populations is of great interest to me. I undertook the study of community partnerships with optimism that it may hold great prospects for people whose lives depend on the effectiveness of social services.

The Current Study and Research Questions

The current study was aimed at finding out how the partners in the mental health housing of Hamilton-Wentworth came together to form the partnership, the nature of the partnership, what worked in it and what were the challenges faced by the partners. It further aimed at determining the nature of current housing policy and how it relates to the formation of the Hamilton-Wentworth Supported Housing Coordination Network (HWSHCN) and government involvement in it.

The research questions will focus on three major themes:

1. The Partnership Story: Coming Together and Working Together

- Who are the partners and how did they come together to work on the homelessness initiative?
- How have the partners worked together?

2. The Partnership Story: Relationships, Challenges and Outcomes

- What are the relationships among the partners actually like?
- What should the relationships ideally be like?
- What could be done to make the relationship more ideal?
- What are the ideal outcomes of the partnership?
- What are the actual outcomes?
- What could be done to make the outcomes more ideal?

3. Analysis of the Relationship between the State and Community Partners

- What is the relationship between the state and the community partners?
- What should the relationship ideally be like?
- What is the nature of housing policy for people with serious mental illness?

- **How did the Phase I homelessness initiative come about at the level of the state?**

Methodology

Methodological Assumptions

This research is a case study and therefore requires in-depth investigation for thorough understanding of the inter-woven processes and relationships that form the fabric of the Hamilton-Wentworth Supported Housing Coordination Network (HWSHCN). It was therefore assumed that qualitative methods were best suited for vividly capturing the complex nature of people's feelings and experiences regarding the partnership (Patton, 2002). Such depth of information could not possibly be achieved using quantitative methods.

It was further assumed that using a participatory method of enquiry would promote a healthy interaction between the researcher and participants that would create an opportunity for learning and sharing of experiences. This assumption rested on the fact that participants were the experts regarding the experiences within the setting. Therefore they were consultants and the researcher the learner. Furthermore, a participatory approach would allow participants to maximize their participation in the research (Nelson et al., 2001) and enhance the chances that the process would empower them.

According to Patton (2002), naturalistic inquiry enables the study of real world situations as they unfold without manipulation or interference from the researcher. This is based on the assumption that the researcher's presence in the setting does not in itself constitute a manipulation of the setting by affecting the behaviors of its inhabitants. I therefore assumed that my presence in the

setting would not affect the behaviors of members of the HWSHCN in a way that would invalidate my observations.

Context

The HWSHCN is a partnership among staff of housing and support service agencies, consumers, family members and government. The groups came together in 1998 at a time when the mental health system in Hamilton-Wentworth was experiencing problems. Services were uncoordinated, ineffective and inadequate (Regional Municipality of Hamilton-Wentworth, 1988). They came together in 1998 in response to changes in the Ontario mental health system that decentralized funding for mental health housing and restructured hospital-based services. The group's main objective was to introduce "best practice" models of mental health housing and support services in the community. Believing they could achieve more by working cooperatively than by competing against each other, they took advantage of the devolution of mental health housing to the municipalities to work jointly on the HOMES project.

The Hamilton HOMES project is a provincially funded housing development project for people with serious mental health problems under the local Homelessness Initiative. The local Homelessness Initiative came at a time of housing crisis for people with disabilities and low-income families. According to an article posted on the website of Ontario Non-Profit Housing Association (ONPHA), the crisis was due to the withdrawal of funding by the federal and provincial governments from social housing in 1993 and 1995 respectively (ONPA, 2001). The article noted that the negative impacts of the withdrawal of

funding for social housing and a decline in the construction of new rental housing by the private sector are still very evident in most major Canadian cities. During the period of "no social housing", homelessness increased rapidly and became a national disaster (The Toronto Report Card on Homelessness, 2000). Research by ONPHA (1999) found that by 1999, one out of every four tenant households in most major cities in Ontario were at risk of homelessness due to the lack of social housing coupled with dwindling supplies of new rental housing. Hope was restored in 1998 when the Government of Ontario in a change of policy, downloaded housing responsibilities to the municipalities. The federal government followed suit with devolution of public social housing to the provinces. In both cases, however, devolution came without financial commitments for expanding existing social housing to accommodate more people. This severely constricted its potential impact on homelessness. In another policy change, the federal government launched the local Homelessness Initiative, which represented a switch from its previous position that it had no role in social housing. In this initiative, the federal government agreed to provide 50% of funding for affordable housing in the provinces and committed $680 million over a period of five years for this purpose in an agreement with British Columbia, Nunavut, Ontario, Quebec and the Northwest Territories (Government of Alberta, 2002). In its agreement with Ontario, the federal government promised half of $489.42 million required for 10,500 new affordable housing units (ONPHA, 2001). In reaction, the Government of Ontario announced over $100 million funding for a provincial homelessness strategy that year. The strategy allocated

$50 million for rent supplement housing for low-income families, $45 million for housing and supports for people with mental illness and $10 million for the Provincial Homelessness Initiatives Fund. It further earmarked $2 million to help families establish permanent residences and $1 million for ex-convicts' resettlement (Government of Ontario, 1999). In Phase I of the local Homelessness Initiative in Ontario, the government disbursed $24 million for 1000 new supported housing units for Ottawa, Hamilton and Toronto in 1999. Private non-profit agencies were awarded the contracts to develop these units. Phase II of the project followed in 2001 with $67.6 million for developing supported housing in all the regions of the province.

In Hamilton, the HOMES project began with about a 100 units of housing under Phase I in 1999 and has 54 out of 93 units completed under Phase II (Good Shepherd Non-Profit Homes Inc., 2002). Under the project, many existing housing units have also been converted to the supported model bringing the number of supported housing units in the community to about 450 units according to a key informant. The HOMES project is one of several being studied in the "Evaluation of Supported Housing Projects in Ontario", a research project funded by the provincial government to evaluate Phase I of the housing initiative for homeless people with serious mental illness. This evaluation study is being conducted by a group of community researchers on projects in Toronto, Hamilton and Ottawa. I learned of this project from Geoff Nelson (Ph.D.) and Lindsey George (M.D., M.E.S), who are both members of the evaluation team. The

HWSHCN therefore presents a very good opportunity for the study of community partnerships for social service delivery.

Participatory Action Research

Participatory action research methods were employed in this study to enable stakeholders to maximize their participation (Nelson, Ochocka, Griffin & Lord, 1998a). Nelson et al. (1998a) defined participatory action research as, systematic approach to data collection and analysis with full involvement of the people being studied towards action for change. This implies that the people who are affected by the problem of interest become partners in the research rather than subjects. The method strives to promote wellness of participants (Taylor & Botschner, 1998) by ensuring that the research outcome becomes a tool for addressing their concerns. In line with the participatory methods, I approached people from all the identifiable groups in the HWSHCN to serve as project advisers for this research. I also took steps at the designing stage to provide opportunities for all stakeholders to have their concerns addressed. This was done through a preliminary information gathering process during which I asked representatives of the subgroups to identify the concerns they would like the research to address and the benefits they expected from it. Furthermore, the classification of the membership of the network into subgroups ensured fair and adequate representation in the data-gathering portion of the study in order to capture the different perspectives of the partners.

The success of participatory action research involving disadvantaged populations depends upon the willingness and ability of the researcher to share

power with participants (Nelson et al., 2001). The process of engagement of consumer/survivors and family members in this research was therefore different from other groups in the partnership. I approached these groups with sensitivity to their circumstances by weighing items discussed to ensure that they were not likely to evoke painful emotions. Furthermore, in order for the process to be empowering for them, I helped these participants to understand the importance of their perspectives to the study and requested them to freely tell the story of the network from their personal points of view.

My personal involvement in the participatory action process was that of a facilitator and learner. I set up and facilitated four key informant and four focus group interviews. During the interviews I endeavoured to generate the enthusiasm of the participants by keenly listening to their responses and encouraging them to freely share their experiences. After the focus group session with family members, which was held at the home of the participating couple, the participants asked about my background. I was happy for this opportunity to share my life-story with them over a meal they generously offered and which I accepted with reluctance. Besides the interviews and focus groups, I conducted a naturalistic observation of the network process. For this part of the research, I attended five meetings of the HWSHCN between July 2001 and April 2002. During this period I had the opportunity to chat with members of the network and get acquainted with them. I also attended a housing workshop that was organized by the HWSHCN in December, 2001 to discuss "Future directions on housing for persons with mental illness in Hamilton." The workshop brought

together members of the community to discuss housing issues and this gave me further opportunity to meet more stakeholders and to discuss issues with them. Further, my involvement in the "Evaluation of Supported Housing in Ontario" as an interviewer brought me into contact with other people involved in the research at the Toronto Centre for Addiction and Mental Health for interviewer training. I interviewed 10 individual consumers using supported housing provided under Phase I of the HOMES project in Hamilton as part of the larger evaluation project. These instances and events gave me more opportunities for deeper involvement in the setting and enhanced my understanding of the issues.

Project Advisors

I needed people who were knowledgeable about the setting and capable of guiding the research process in a meaningful way that would make it useful to the partners. Fortunately, the person who initiated the process that evolved into the HWSHCN partnership agreed to be my field supervisor and also serve on the steering committee. This person also assisted me in identifying and approaching representatives of the various subgroups of the network who had the background and sufficient knowledge of the process to serve on the steering committee. These people represented some of the main stakeholder groups namely consumer/survivors, service-providers and the state (planners and policy makers). All four people I approached agreed to be on the committee. Unfortunately, after reading through the research proposal I gave them, the consumer informed me that he had too little knowledge of the technicalities of research to serve on the committee. I tried to persuade him that his personal

involvement and understanding of the setting were valuable knowledge that would be very helpful. He, however, insisted on not joining the steering committee, but agreed to assist in other ways. He assisted me in organizing the consumer-focus-group and participated actively in its discussion.

Distance and time constraints made it difficult to schedule meetings with the other members of the committee. I therefore decided to use the volunteers as project advisors instead of having a steering committee. I consulted with them at various stages of the research. I obtained their comments on the research proposal and interview guides. I also sent them copies of the results for comments and direction. The advisors also assisted me in obtaining documents on the network for review.

Participants and Sampling

Participants

17 people participated directly in the interviews and focus groups. Four were key informants whom I interviewed individually, and 13 were participants in focus groups. Two members of the steering committee doubled as key informants and one as a focus group participant.

Besides the above participants, the entire membership of the HWSHCN participated in the naturalistic observation. I attended five meetings with an average attendance of 20 people per meetings. Overall 27 different people attended meetings at different times.

Key informants. I used purposeful sampling methods for the selection of key informant interviewees. This method enabled me to identify individuals who

had been on the network for a considerable period of time and who could share in-dept knowledge of its beginnings, development and processes with me. According to Patton (2002), "the logic and power of purposeful sampling lies in selecting information-rich cases for study in-depth" (p. 169). My field supervisor was the ultimate "information-rich" case for studying in this setting because she initiated and led the process and was therefore the most qualified person to talk about what motivated her, her expectations, hopes and challenges. She agreed to participate as a key informant to share the story of the partnership and her experiences as an individual who had been so intimately involved in the process. I identified another pioneering member who had been a co-chair of the network at one point and who also agreed to be a key informant. Next, I approached two government representatives for interviews on government involvement and policy issues, both of whom accepted the invitation to participate as key informants. Attempts to schedule a meeting with one of them, however, proved futile because she was unavailable. I therefore had to approach a third person who agreed to participate.

Focus groups. For the focus groups I requested volunteers at a network meeting. Almost everyone at the table expressed an interest in participating and gave me their contact numbers. However, when I followed up with telephone calls to arrange the focus group meetings, time constraints prevented some of them from taking part. Four people participated in the focus group for housing-providers; four in the group for support service-providers, three in the consumers' focus group and two in the family members' group. The first three groups had

their discussions in the privacy of the boardroom of the Hamilton-Wentworth District Health Council (DHC). The only two family members on the network were a couple, who invited me to their home for the interview.

Naturalistic observation. I used opportunistic sampling, a method in fieldwork that involves on-the-spot decisions to take advantage of new opportunities that present themselves during data collection in the field (Patton, 2002). For this sample, members of the HWSHCN were informed that I would be meeting with them as part of my research to enable me to understand the issues. I explained my research objectives to them but refrained from telling them that I would make notes on their relationships and behaviors. I did this in full awareness of the ethical guidelines for naturalistic observation in order not to affect their behaviors. I had other opportunities to gather information in my interviews with supported housing residents as part of the "Evaluation of Supported Housing Projects in Ontario" project. Information these participants shared corroborated internal evaluation reports I reviewed. I did not, however, include their information directly in my report because I felt it would be unethical to do so without obtaining any form of consent from them for the purpose.

Information Gathering

Methods

To ensure that the information gathered had both depth and breadth, I used four different methods of qualitative data gathering. According to Patton (2002), using only one method for collecting data compromises the validity and credibility of the data collected in a qualitative research. Multiple methods were

therefore employed to guarantee the credibility of the data collected. The four methods I used were (a) key informant interviews, (b) focus group discussions, (c) examination of documents, and (d) field notes from participant observation. I employed multiple methods of data collection to make triangulation possible to enhance data credibility. Furthermore, I used an open-ended interview-guide to enable me to probe responses for clarification and to gain depth. According to Patton (2002), "Probes are used to deepen the response to a question, to increase the richness of the data being obtained, and to give cues to the interviewee about the level of response that is desired" (p. 324).

Table 1

Summary Data Collection

Method	Data source	Focus of data collected
Key informant interviews	• Interviewed 4 key informants (2 people from HWSHCN and 2 government representatives)	• Question 1. The Partnership Story: Coming Together and Working Together • Question 3: Relationships Between the State and the Community Partners
Focus group interviews	• Interviewed one group of consumers (n=3) • Interviewed one group of family members (n=2) • Interviewed one group of	• Question 2: The Partnership Story: Relationships, Challenges and Outcomes • Question 3: Analysis of

	housing-providers (n=4) • Interviewed one group of service-providers (n=4)	the Relationship Between the State and the Community Partners
Participant observation and field notes	• Attended 5 meetings of the HWSHCN • Attended housing forum • Interviewed supported housing residents	• Question 2: The partnership story: Relationships, Challenges and Outcomes • Question 3: Analysis of the partnership story: Relationships Between the State and the Community Partners
Document review	• Housing Development Group Reports (1999) • Minutes of the HWSHCN (1999-2002) • HOMES project report (2002) • Hamilton-Wentworth DHC housing documents (2001) • 4 provincial policy documents (1993-2000)	• Question 2: The Partnership Story: Relationships, Challenges and Outcomes • Question: The Relationship Between the State and the Community Partners

Prior to the interviews and focus group discussions I sent letters to identified key informants who had given me verbal assurances of their participation and also to potential participants for the focus group discussions

asking them to volunteer for the study. In fulfillment of the ethical guidelines, the letters of invitation provided them with information on the research objectives, the process, their rights as participants, their roles and what it would entail and the potential risks and benefits (see Appendix 1). The letters further assured them of confidentiality and anonymity. Participants filled out, signed, and returned consent forms, which were attached to the letters, to me for record keeping (see Appendix 2). I then scheduled a meeting with each individual or group to conduct the interview.

Key informant interviews. I held four key informant interviews. Three were conducted face-to-face and one by telephone. At the beginning of each interview, I thanked the participant for agreeing to participate in the study and asked his or her permission to take written notes and also to tape-record the discussion.

In the interviews with the two community members, I asked participants to tell the story of the partnerships, as they knew it from the beginning (see Appendix 3). I also asked them to share their personal experiences of the process. They further talked about the relationships among the partners, the outcomes and the challenges they had faced.

Key informants representing the government talked about housing policy, government involvement and relationships with the community partners as well as the state's expectations for the partnership (see Appendix 4). They also talked about what they perceived to be the role of the state in the community partnership and what they expected of the community members with whom they

partner. I tried to elicit responses from each informant regarding what he or she thought were the ideal relationships and ideal outcomes.

Focus group interviews. I facilitated four focus group discussions, one each for housing-providers, support service-providers, consumers, and family members. At the beginning of each focus group discussion I asked the permission of the participants to take notes and also tape-record the discussions.

The focus groups used the interaction method of information gathering (Posavec & Carey, 1997). People complemented each other's statements or reacted to them. They discussed the issues and reached agreement on some of them. My role as facilitator was to allow participants to discuss issues freely while at the same time providing guidance to ensure that they focused on the themes of the research questions.

During the discussions, I asked participants to identify their partners, and then to talk about the story of the partnership (see Appendix 5). Participants further talked about the relationships among members of the network and among their various agencies. They also discussed the outcomes and challenges the partners have faced and how they were resolved. In addition, they talked about issues of advocacy, government participation, and relationship with government on the partnership.

Document review. I reviewed the Ontario Ministry of Health policy documents related to housing for people with serious mental health problems. These included "*Putting People First*" (Ontario Ministry of Health, 1993), "*Making it Happen*" (Ontario Ministry of Health, 1999) and "*Mental Health Reform*

Guidelines for Housing and Support Services" (Ontario Ministry of Health, 1999). These documents provided me with information on the background of mental health housing policy in Ontario. They also gave me an insight into how mental health policy has gradually evolved over the past decade and the features of current mental health policy regarding housing for the severely mentally ill.

Other documents I reviewed were the Housing Development Group report (HDG, 1999), the minutes of the HWSHCN from 1999 to 2002 and the Hamilton-Wentworth District Health Council's background report on housing and support requirements for persons with serious mental illness. I also reviewed a booklet published by the Good Shepherd Housing Inc. on the Housing with Outreach, Mobile and Engagement Services (HOMES) project and the report of the regional task force on psychiatric care. These documents served as rich sources of information on the development of the HWSHCN, the stages it passed through, and the issues on which it has focused and the political environment within which it has operated.

Participant observation and field notes. Patton (2002) observed that taking field notes is fundamental to naturalistic observation. It enables the researcher to record descriptions of what he observes in the field and enhances qualitative analysis. As I became immersed in the setting and the issues, I took notes and wrote comments on the issues, processes and relationships among the partners during meetings of the HWSHCN. My notes, which were both descriptive and reflective, enabled me to compare my own observations with participants' statements.

Data Analysis

Data Organization

I transcribed the tapes from the key informant and focus group discussions verbatim. After the transcription I organized the data initially by pulling out the main points onto fact sheets. This method reduced the long transcripts into short precise pieces of information with quotations. I sent the fact sheets to the participants as feedback and requested them to check the accuracy of the information and to provide comments, corrections or add supplements wherever they deemed necessary or important. Participants returned the fact sheets to me with comments. Besides very minor changes suggested, they generally affirmed the contents of the fact sheets as representing the information they shared during the interviews. One participant flagged a piece of information he had shared and advised that I cross check with other people or records to determine its accuracy. Providing feedback to participants ensured data accuracy and helped to avoid the possibility of misrepresenting participants' views.

Key Informant Interviews

I used data obtained mainly from key informant interviews to reconstruct the story of the partnership from its inception to the present. I thoroughly read through the transcripts and fact sheets and identified and coded recurrent themes. I went thorough the data, checking back and forth and cross-checking again what one participant or group said against statements made by other participants and groups. I noted points of concurrence and difference among the various groups and made linkages in the data accordingly.

As I went through the coding process, I made notes of themes that blended together. From these groups of themes, I identified the factors that motivated the initiators of the partnership, the state of readiness of the community for intervention, the values that guided the development of the network, and the evolutionary process that it went through.

The key informant interviews with policy-makers yielded information on government policy, the state's involvement in the network and the impact of the network on new policy initiatives. The state representatives also talked about their relationships with the community partners and their roles on the network. Here again, I made linkages in the information for themes, which were blended into patterns for qualitative analysis.

Focus Group Interviews

I performed content analysis on the transcripts and fact sheets from the focus groups. Content analysis involves identifying, coding and categorizing recognizable patterns in the data (Patton, 2002). I coded information into themes then grouped them into discernible patterns to form the basis for qualitative analysis of the data; patterns here referring to themes that hung together in clusters.

The patterns identified helped to analyze the way the partners related to each other on the HWSHCN and also how they worked together. Some of the information was also used to verify information shared by the key informants on the relationships and the process. The focus group yielded rich information on the outcomes of the partnership in terms of its achievements and also its impacts on

individual participants, member agencies and the Hamilton-Wentworth community as a whole.

Document Review

I analyzed information from the network and HDG documents that I reviewed in the study by making connections in the records and forming themes from the connected items (Patton, 2002). This was used to reconstruct the path of development of the partnership and to identify notable incidents and landmarks. The themes from this source were used to check the information from focus group discussions and key informant interviews in a triangulation of sources. This process lent more credibility to interview information regarding the story of the partnership and the achievements of the HWSHCN.

The policy documents that I reviewed formed a major source of information on current mental health housing policy and its background because policy-makers who were interviewed appeared not to be very knowledgeable about the background of the policy. I used this information to construct the background of current mental health housing policy. Information from this source also enabled me to determine the role of the policy in government involvement in the HWSHCN.

Field Notes

I read over my field notes and searched for recurring themes and patterns. Next, I grouped related ideas and incidents together based on their similarity then connected the items to provide a descriptive summary of the partnership. The field notes threw much light onto the workings of the network and the relationships

among its members. I checked this information against information from participants regarding the processes and relationships. The data were then used for describing the partnership from my own perspective and also to make analytic statements about it.

Ethical Considerations

Throughout the research process I observed the ethical guidelines for community research. I upheld the principle of informed consent by providing participants adequate information regarding the research and explaining their rights as participants before requesting them to sign the consent forms.

In order to protect participants from unanticipated harm, I debriefed them at the end of the interviews to ensure that they had a clear understanding of the objectives of the study and also that they were not experiencing any discomfort. I also made means for addressing any perceived exploitation by providing them with the telephone numbers of my supervisor and the chair of the Laurier Research Ethics Board (REB) and advised them to contact any of these sources for assistance in case of any problem

I made extra effort to honor the dignity of the individual participants by being respectful and expressing my appreciation for their participation and how much I valued the information they shared. In constructing the interview guides I made conscious effort to avoid leading questions, loaded items, and ambiguous questions. I weighed items to ensure that they would not impinge on the individual's privacy or cause participant's discomfort in any other way.

Interviewing consumer/survivors and members of their families could be delicate because it could evoke difficult memories in them. For this reason, I approached the interviews with these groups with sensitivity to their statuses and the uniqueness of their situations.

Finally I upheld the principles of confidentiality and anonymity by keeping information they shared with me secure. I shared each group's information separately with them and also checked quotations with them in the feedback process to ensure that statement could not be traced to them if used in the final report. I maintained the principle of equality throughout the research by treating all groups equally in terms of the information provided and the respect with which the interviews were conducted.

Research Results

The results I present in this section are drawn from the four different sources of data: (a) key informant interviews, (b) focus group discussions, (c) field observations, and (d) document review. Information from one source was checked against information from other sources to ensure accuracy and data credibility.

Information from key informants selected from the community partners and information from the focus groups was used to answer Question 1, "The Partnership Story: Coming Together and Working Together." Participants gave an insight into how the partnership evolved, the groups that form the partnership and why they came together to form the network. Representatives of groups that joined the partnership after it had been founded shared the reasons why their organizations decided to join. The focus groups also provided information relevant to Question 2, "The Partnership Story: Relationships, Challenges and Outcomes." Participants in the discussions talked about the relationships among the partners and how they have worked with each other, the key values that hold the partners together and the outcomes and challenges they have experienced both as individuals and as groups. Planners and policy-makers who served as key informants talked about issues related to Question 3, "Analysis of the Relationship Between the State and the Community Partners." These insights are presented in this section with quotations to illustrate them. Moreover, information from field notes regarding issues, relational matters, participatory process, the interests and commitment of members was used to verify some of

the statements made by participants. The document review yielded information pertinent to Questions 1 and 3. Information from these sources helped to trace the landmarks of the HWSHCN from its inception to date and served as a back up for information provided by participants on the story of the partnership. The documents affirmed or corrected dates wherever doubts or contradictions existed. Policy documents served as the main source of information on current mental health housing policy and its background.

The Partnership Story: Coming Together and Working Together

Background

Hamilton is a large city with a medical school and a provincial psychiatric hospital. As far back as 1986, the Regional Municipality of Hamilton-Wentworth established a Task Force to review housing and services for people in the community with mental health problems (Regional Municipality of Hamilton-Wentworth, 1988). The task force report noted that families and relatives provided accommodation for a large number of the people with mental health problems. The rest were housed mainly in custodial care facilities that are called Second Level Lodging Homes. In 1986 there were 720 housing units for people with mental illness in the Hamilton-Wentworth district all of which were custodial housing. This was made up of 600 private for-profit residential care units and 120 public housing units in Homes for Special Care and hospitals. Most people with serious mental health problems in Hamilton-Wentworth lived in custodial care facilities. A housing survey conducted by the Hamilton-Wentworth DHC (DHC, 2001) showed that in 1999 there were 96 Second Level Lodging Homes with

2609 beds, six Homes for Special Care with 65 beds and only three supportive housing programs with 49 spaces. Services offered by custodial care facilities, which housed the majority of this population, were not rehabilitation focused. People were therefore left to stagnate in these facilities (Parkinson et al., 1999). Mental health services in the system were uncoordinated (Regional Municipality of Hamilton-Wentworth, 1988). One participant described the situation as follows:

> *"In the beginning you don't know which agency to call with a particular problem" (Housing providers' focus group)*

Housing-providers, support service-providers, consumers and family members in the community had become disenchanted with a system that relied heavily on a model that provided no opportunities for rehabilitation and therefore no hope for reintegration into society (Nelson et al., 2001). This was the background from which the Hamilton-Wentworth Supported Housing Coordination Network (HWSHCN) emerged.

In response to interview questions relating to Research Question 1 "The Partnership Story: Coming Together and Working Together," participants described the environment within which the HWSHCN emerged, and its evolution from a small discussion group to the current all embracing network that is striving to improve housing for people with mental health problems living in the Hamilton-Wentworth community.

What developed into the HWSHCN began as an informal discussion that one of the key persons in the development of the network started with a few professional colleagues in the SPRP in 1997. The discussions were prompted by

the inadequate conditions under which clients of the SPRP were housed and consequently centered on the housing needs of people with serious mental illness who were living in the Hamilton-Wentworth community.

At the time, there was very little happening regarding housing for people with severe mental illness in the Hamilton-Wentworth District. The approach to housing for the mentally ill in the district was mainly custodial (Regional Municipality of Hamilton-Wentworth, 1988). Supportive and supported housing models, which focus on rehabilitation, were very few and housed a very tiny percentage of the mentally ill, leaving the majority in custodial housing (HDG, 1999). The custodial housing model relies exclusively on medication, its residents are strictly controlled by staff and are neither allowed privacy, choice of services nor independent living (Nelson et al., 1995). The model therefore provides no opportunities for rehabilitation and gradual progress towards full independent community living. According to one key informant,

> *"A lot of the people (with mental illness) were living in lodging homes, they were sharing rooms, they didn't have privacy; they didn't have any freedom. It seemed [to me] like a very undignified place to live"*

This person said that because she believed that people with mental health problems should be helped not only to recover from their illness but also to move on with their lives through community living, her clients' housing conditions were of great concern to her. Drawing from her activist past, this individual started talking to some of her colleagues about the need for a change in mental health housing in the community. The group's discussions focused on the types of housing needed to adequately meet the needs of people with serious mental

illness, how to improve existing housing and also how to develop more housing units to meet increasing demand.

The Housing Development Group

In January 1998 the discussion group invited other stakeholders in the area of mental health to join them and constituted itself into the Housing Development Group (HDG) in anticipation of upcoming changes in the mental health system. Members of the HDG were consumers, family members, housing-providers including the Residential Care Association, which joined the group on its third meeting, and support service-providers. The changes envisioned involved restructuring of hospital-based services, shifting of housing responsibilities to different provincial ministries, and the downloading of some aspects of mental health housing to the municipalities. Those invited to form the HDG were members of consumer and family organizations and mental health housing and support service-providers (HDG, 1999).

The aim of this voluntary committee was to conduct a "needs assessment" to determine the housing needs of people with serious mental health problems and develop a plan for community housing that would meet the needs identified. The group received support from the DHC and the City of Hamilton and embarked on community consultations in the form of facilitated focus group discussions with stakeholder groups. There were 17 focus groups for consumers/survivors during which participants were asked to prioritize the characteristics of housing that would best meet their needs. Focus groups were also held for family members, and service-providers in the community to discuss

issues around the housing needs of consumers. The issues discussed included choice of housing, safety, privacy supports, social networks, autonomy, activities, and quality standards. As part of the research, the HDG organized a community forum to discuss and prioritize the findings from the focus groups.

The final report of the "needs assessment" identified choice of housing, privacy, safety and autonomy as very important issues for the stakeholders (HDG, 1999). The HDG published a report of its findings in 1999. The report recommended a shift in the housing system toward a supported housing framework with individualized support services to meet the unique needs of each service user (Parkinson et al., 1999). The report proposed improvements in existing housing to meet supported housing standards (Carling, 1995; Nelson et al., 1995) and the development of new housing units as a pragmatic way of meeting the housing needs of people with serious mental health problems.

Further, the report called for Second Level Lodging Home Reform to improve the living conditions of those in custodial care, including the creation of respite care, 24-hour crisis response and an increase in the number of crisis beds in the system. It also called for the provision of portable supports in the form of on-site support workers to give Assertive Community Treatment (ACT) and life-skills training to residents. ACT is comprehensive community-based supports provided to people with serious and persistent mental illness to enable them to maintain community living (HDG, 1999). Other recommendations of the report were building community partnerships to promote resource pooling, an increased use of volunteers to promote community involvement, and the development of a

central data base for disseminating information about mental health housing and services.

Finally, the report recommended the creation of a coordination network of planning bodies, funding agencies, service-providers and service-users to develop workable plans for the recommendations and coordinate their implementation. The HDG presented its report to the Regional Council of Hamilton-Wentworth, the City of Hamilton, the Hamilton-Wentworth DHC and the Regional Psychiatric Program (RPP). All these institutions accepted the HDG report as basis for improving the mental health housing system.

Hamilton-Wentworth Supported Housing Coordination Network

The acceptance of the report marked the end of the work of the HDG and the beginning of the Hamilton-Wentworth Supported Housing Coordination Committee (HWSHCN). The HDG metamorphosed into the HWHSCN to change its focus from "needs assessment" to program development and advocacy. As one key informant narrated it,

> *"...we took the report to the District Health Council, the City of Hamilton and the Regional Psychiatric Program. All of those groups supported the report. Out of that and with some support from the DHC and the city, we decided that rather than continue with the same group of people, what we needed to do was to bring a [more comprehensive] group of people together to implement the recommendations in the report."*

According to members of the HDG, they realized that the only way to avoid the report from gathering dust on a shelf was to push for implementation of its recommendations. To enhance the chances of implementation, fulfilling one secondary recommendation - the formation of a coordination committee was

important. The HDG had the necessary materials for such a committee. Thus, the members agreed to reconstitute the group into the coordination committee by involving more stakeholders in the community to make the committee more comprehensive. Consequently, new agencies were invited from the four main categories already forming the HDG to join.

The partners. The partners identified on the HWSHCN were housing-providers, support service-providers, consumers/survivors, family members, and three levels of government, namely provincial, regional and local governments. Membership of the group included Wesley Community Homes, Baldwin Housing Program, Good Shepherd Non-Profit Homes Inc., and the Housing Help Centre, which are all private non-profit housing-providers. Others are the Residential Care Association, the association of private "for-profit" housing proprietors, Schizophrenia and Psychosocial Rehabilitation Program (SPRP) - a support service-provider, the Canadian Mental Health Association, Schizophrenia Society and Mental Health Rights Coalition, all consumer and family help networks, and a local politician. Representing government are the City of Hamilton, the Hamilton-Wentworth DHC, the SPRP, the Ministry of Health and Long Term Care, the Ministry of Housing, and the Ministry of Community and Social Services. A member of the Mental Health Rights Coalition and individuals represent consumers on the network. Family members on the network joined through the Schizophrenia Society. According to them, when the invitation came from the network, people were asked at a meeting of the society whether they would like to join and they volunteered.

Some members of the network did not recognize certain groups as their partners. The consumers, for example, did not recognize the government as a partner on the network. They think of them more as observers than partners because, according to them, members of this group are too reserved at network meetings. The representatives of the government, however, view themselves as full partners. According to one of them, partnerships can be struck for different purposes and their partnership with the community groups was for support and information sharing. This participant said,

> *"Partnerships are formed for different reasons. Our partnership with the community groups is for information-sharing purposes. We are there to share information with them and support them in what they are doing for this community." (Key informant)*

Another participant, a housing-provider, said she did not conceptualize the network as a partnership because there was no formal signed agreement of partnership. She, however, acknowledged the presence of several little partnerships among agencies that became linked through the network. She said she recognized those as partnerships because the agencies involved have formal partnership agreements and are working actively together on projects in the community. Other participants, however, did not share this view.

The Residential Care Association, which participated actively in the community-consultations of the HDG and had remained a member of the HWSHCN, was not identified as a partner by any of the participants. According to participants, this group had recently stayed away from the network's meetings of its own accord. I made attempts to interview a representative of this group whom

I met at the Housing Workshop, but he was not available. It must also be noted that the Residential Care Association was different from all the other agencies on the network because it had different values and orientation towards the problem of homelessness. Its "for-profit" orientation was incompatible with the non-profit and rehabilitation focus of the other groups.

Parties' motivation for participation in the network. Individuals representing the various groups identified as partners on the network gave different reasons as to why they or their agencies got involved. Family members on the network got involved through their membership in the Schizophrenia Society, a group that comprises family members whose loved ones are suffering from schizophrenia and who organize to provide people suffering from schizophrenia with support in various ways. When asked why they joined the network, one of the family members said,

> *"We wanted better housing for our son who is suffering from schizophrenia, as well as for other people with the disease. And we believed that by joining the group and working together with the other people on it, we could achieve that [objective]."*

Consumers on the network joined the network through other self-help associations. One said,

> *"I think that somehow it had something to do with Second Level Lodging Homes Tenants Committee. We have been part of that group, which is now Residential Care Facilities. Yeah, and I think because I was [already] involved in the community, I was asked to sit on the network as a representative."*

Another consumer said,

> *"I have no idea how I got involved. It was by a kind of 'osmosis', which happened through joining all these committees."*

One other consumer said,

> *"I started during the last year due to my position on the Mental Health Rights Coalition. How it got started I haven't a clue."*

A representative of a planning agency who participated in the support service-providers' focus group said his organization joined the network to move forward the recommendations of the HDG. He said,

> *"The reason that [I think] we joined was to help see that the recommendations of the report were moved forward in the context of the Community Action Plan."*

Another participant in the same focus group said,

> *"We had people in our programs who didn't have appropriate housing so we wanted to make a proposal for them to be provided with adequate housing."*

And yet another said,

> *"We knew something had to be done about the housing situation. This initiative offered the opportunity to contribute towards that."*

Those representing the government said they joined to give support to the community partners by sharing information with them. According to one of them,

> *"The emergence of this group is a very positive occurrence in this community and we thought it was necessary to join them and give them the necessary support through information sharing."*

Besides the groups that were invited, several other agencies volunteered to join the network. A representative of one housing agency that opted to join said her agency joined because they believed they were stakeholders who had something positive to contribute to the network's efforts and therefore should not be left out. She said:

> *"We joined [the network] because we saw that we had an important role in supporting people in the community who have every degree of mental illness, and we certainly are preventing homelessness by being available to people and that's the key thing. And that is why we asked to be allowed to join. In fact, we should not have been left out of the process in the first place."*

The Residential Care Association, the association representing the Second Level Lodging Homes operators, was invited to join the group after the initial group had discussed the potential difficulties that it may involve. According to a key informant,

> *"Over the course of two meetings, we discussed the difficulties of involving them quite frankly. It was a difficult process in itself, but we [finally] decided that they needed to be involved."*

According to members, the decision to invite this group as participants was based on the fact that they qualified as housing-providers to the population of interest and therefore were stakeholders. They also believed that the participation of this group would make the network more comprehensive.

The network, as proposed by the HDG report (1999), was to advance the recommendations, develop plans for their implementation and implement those plans. In line with this, the HWSHCN's main objectives were to develop supported housing with individualized support services for people with severe mental illness. The aim here was to gradually shift the system from custodial to supported housing by developing more affordable housing consistent with the supported model. Another objective was to push for a review of Second Level Lodging Home Bylaws to emphasize rehabilitation and give residents more say in the running of the homes. In addition the group aimed at pushing for the

provision of interim community supports in the form of crisis beds, 24-hour crisis response and respite care. The network also aimed at promoting partnerships among the agencies to enhance resource sharing and coordination of services in the community and further to create and share information on housing within the community. Finally, it aimed to advocate on behalf of homeless people with serious mental illness. According to one of the participants, although advocacy was initially not one of the aims of the network, it became a very important part with the launching of the local Homelessness Initiative as a means for getting the needs identified in the community consultations into government policy.

Upon its formation, the network set up subcommittees or working groups to facilitate its work. These were information, rehabilitation, social housing, long-term support, and Second Level Lodging Homes working groups. These subcommittees put agencies with similar interests and operations together for work on the issues with which they mostly identified. Issues were referred to the working groups to deliberate upon and report back to the network. The working group format used was flexible and allowed other stakeholders who were not on the main network to participate. This highly enhanced the inclusive nature of the network. The subcommittees also served as recruiting grounds for membership of the network and people on them often ended up on the main network. One of the participants in the research said he got on the network through that process.

When asked what brought them together, participants gave various reasons for coming together to form the partnership. One of the pioneers of the

group said they did not want the efforts they had put into the report (HDG report of 1999) to be wasted. She said,

> *"We said, 'okay, we don't want this report to sit on the shelf like so many of them do.' So we brought this group together to push the recommendations further."*

Another key informant said that they came together because they believed that there was more power in collaboration than working independently. She summarized it thus:

> *"[It was] a commitment to change, a belief that we were stronger if we got together, that we could do things that we could not do individually, and that we were more powerful if we got together and could influence what was going on."*

According to her, members of the group also had a shared belief in supported housing as the best model for people with mental health problems and this did not only bring them together, but also united and sustained the network as a group to push for its ideals.

How they have worked together. In relation to part two of Research Question 1, "Working Together," participants said the group had worked very well together. It adopted a participatory process of decision-making at both the main network and subcommittee levels, which involved discussion and reaching consensus. Members contributed actively on issues and usually reach consensus with minimal discordance. According to participants, on occasions where no consensus seemed to be in sight, a vote was called.

The formation of the network coincided with the announcement by the Ministry of Health of the Phase I funding for Homelessness Initiatives in Ontario.

This presented the network with an opportunity to collaboratively implement one of the recommendations in the HDG's report. This was to develop supported housing with individualized services. As one key informant narrated it,

> *"...we had just finished our report in March and brought the network together in April for our first meeting, and in June, the Ministry announced over one million dollars funding for this community for Phase I of the Homelessness Initiative. And we saw this as an opportunity to implement one of our recommendations, which was to develop more supported housing."*

The issue was discussed at network meeting where the leaders posed a question whether individual agencies on the network should compete with each other for the funds or rather put in one proposal as a group. According to one of the leaders of the process,

> *"We brought the network together and posed the question: Do we want everybody to compete for the money or could we come together as a group and put in one proposal? And that was how the HOMES program started." (Key informant)*

The members supported the idea of putting in one proposal as a group to provide an opportunity for collaborative work on the project. According to the participants, they selected one of the non-profit housing agencies, the Good Shepherd Inc. to serve as the lead agency for the project because it had good credentials. They said that this agency had always provided good housing and case management to people with severe mental illness in the Hamilton-Wentworth district.

The network's proposal was successful and so the group began work on the HOMES project. One group, the Residential Care Association, was, however, unhappy that the funding was based on the condition that agencies putting in proposals ought to be non-profit. In an effort to work around this and make

everybody happy, the members of the network agreed to allocate part of the funding to rehabilitation programs in residential care facilities on the condition that those facilities had single private rooms. In the words of a participant,

> *"...earlier on we said we were going to provide some financing to provide rehabilitation and enhance programs in the lodging homes if we could find lodging homes that had single private rooms that were [consistent with] the recommendations of the original report."*

One of the main objectives of the network was to advocate on behalf of people with mental health problems. The main issue of advocacy has been the development of supported housing and improvement of support services for consumers. The network advocated for a shift to supported housing, which they hold as best practice and the establishment of new services for people with mental health problems. The network's advocacy involved presentation of the results of its community consultations and community forums to the City of Hamilton, the Hamilton-Wentworth DHC and the SPRP. It also lobbied the Hamilton-Wentworth DHC and the SPRP to de-link housing with mental health services and presented them with proposals for increasing crisis beds in the mental health system, providing 24-hour support and crisis intervention and establishing an Assertive Community Treatment (ACT) team in Hamilton. The HWSHCN lobbied the city to review Second Level Lodging Home bylaws to promote consumer involvement in decision making in those facilities. Also the network is currently pushing for the development of a local housing policy that will support people with mental health problems to live within the community. To this end, it has presented research reports showing the housing needs of people

with mental illness and the positive outcomes of supported housing to the city. To further raise awareness of the issue of inadequate housing for people with mental illness in the community, the network organized the earlier mentioned housing workshop in 2001.

The Partnership Story: Relationships, Challenges, and Outcomes

Relationships

Participants from all the stakeholder groups agreed that the members of the network have related very well to each other in spite of the unavoidable little tensions and misunderstandings that sometimes surround some of the issues. They all noted that working together has resulted in increased levels of collaboration among the agencies on the network. One service-provider described it this way:

> *"Generally the collaborative relationships have been really good, particularly in bringing together people who typically wouldn't work together such as the hospitals and the housing-providers. So I think, that has built some very good relationships and given some understanding around what some of the tensions are in housing, what people actually do and how much support they give to people in their programs." (Key informant)*

Participants also said that people have come to the network with a lot of goodwill and this has helped the process of the partnership. Agencies that under normal circumstances competed with each other were now working cooperatively with each other in a new, friendly environment that promoted healthy interrelationships among them. A participant expressed it this way:

> *"My feelings are that there are very positive interrelationships among the different agencies. They share information and share support so I feel more positive [about it]." (Service-providers' focus group)*

Relationships between consumers and other members of the network have also been very good. According to participants, consumers who attended the network meetings brought worthwhile questions to the table and made very useful contributions to the network. In some of the participants' views, their presence on the network is one important factor that has helped to keep the network focused on the issues. They said that consumers always felt welcome because other members were very friendly to them and gave them much respect. A family member said:

"They [Consumers] are made to feel that their opinions are valued."

Consumers confirmed this in their focus group discussion. They said that the good relationships they enjoyed on the network made them feel generally welcome. People always listened to what they had to say and treated it with importance. One consumer used the following words:

> *"I think we have worked very well as a community and I think we as consumers have a great voice in this community. We are respected and our voice is heard." (Consumers' focus group)*

Another added:

> *"There is no condescension [on the network] either." (Consumers' focus group)*

Consumers who participated in the research said they were very happy with the way people have related to them on the network because it made them feel valued.

Relationships with the Custodial Care Association's representatives have mostly been problematic. The problems began to surface after the initial period of

cooperation on the community consultations. The disagreements were triggered by the standards applied to the allocation of funds for the HOMES project, which kept the Custodial Care Association out. Agencies submitting proposals under the Homelessness Initiative were required to be non-profit, and although the network tried to accommodate them, none of the Residential Care facilities met its minimum standard of single private rooms. Further differences hinged on one of the HDG's recommendations, which had called for Second Level Lodging Home reform. According to a participant, relationships on the individual level began very well until the differences on the issues became more pronounced and then things sometimes turned *"really nasty." (Key informant)*

As previously mentioned, some participants also doubted the commitment of the government representatives because they viewed their participation as superficial. According to some participants, these people came to the table more as observers than as participants. One of the participants expressed it politely in the following words:

> *"Sometimes there are some people at the table and I don't know what they think because sometimes they listen more than they participate" (Consumers' focus group).*

Challenges Faced by the Partnership

The challenges. In response to interview questions pertaining to part two of Research Question 2, "The Partnership Story: Challenges," participants identified several challenges the network has faced as a group. According to both key informants representing the community partners, at one point, a staff person at the Hamilton-Wentworth DHC who was assisting the network left her post.

This made it difficult for the network to continue so they made up their minds to end it. In the words of one key informant,

> *"Initially we wanted to close the network group because the staff person left and we didn't have the resources to continue doing what we wanted to do."*

However, the network received assurance from the DHC and the city of Hamilton that they would support them with staff time. This reinvigorated the group, which at this point opened up to more members. According to the key informant quoted above,

> *"When we put the energy into pulling it back together, we just opened it up and anybody who had been involved and wanted to remain involved was welcome. It was not a tight membership. Those who wanted to be on it were invited."*

The challenge that participants identified as the most daunting was that of the Residential Care Association. Tensions with this group had been on and off from the time they joined the network. One key informant said about them,

> *"There have always been tensions with the Residential Care Association. Sometimes they are in with us and sometimes they are not."*

Participants said they believed that this group had an agenda that was at variance with the rehabilitation-agenda of the non-profit agencies at the core of the network. One described it this way:

> *"I mean, certainly, dealing with a group that has goals that are totally different from our vision and our goals was a big challenge." (Key informant)*

Resistance from the Residential Care Association to the recommendation for Second Level Lodging Home reform led to many more disagreements. Several issues became contentious and the process sometimes turned "nasty" to

a point where some members felt personally threatened. A participant described it this way:

> *" ... I'll like to say that personally for me, as one of the leaders of the process, it was at times very frightening." (Key informant)*

The antagonism escalated and went over and beyond the network to the political circles in which the Custodial Care Association was reported to have lobbied against proposals and recommendations the network presented to the City of Hamilton. They were alleged to have even mounted personal vendettas against some of the leaders of the process by applying pressure to have them removed from their jobs.

Another challenge was in pulling together in one direction by groups with different perspectives to the problem of interest. One participant hinted that there were little tensions around "people wanting to have bigger shares" of funding for common projects allocated to their agencies. She said:

> *"Within the care community there were also many agendas like 'we want more money for our services or for building services' and that kind of thing. It's almost truism that organizations want to make themselves bigger, but [the difference here is that] the drive is not profits." (Key informant)*

Another participant described this as a little bit of selfishness displayed initially by some members. According to him,

> *"There was a little bit of selfishness at first, mostly on the part of the Second Level Lodging Home operators, probably because they saw the problem their own way." (Family members' focus group)*

Another problem arising directly from differences in the organizational structures of member agencies was the difficulty of harmonizing salary structures

of different agencies with staff on the joint project. Seconded staff were paid from the funds for the project and the partners had to figure out the equivalence of various staff positions to determine salaries.

There was also an issue with high staff turnover of member agencies. This has made the network membership very fluid with new faces appearing at meetings all the time. According to one participant it was very frustrating when your partner agency has a high staff turnover because when you have developed rapport with people, and got to know them well, the next moment they are gone and then you have to start all over again with a new person.

Another challenge identified was the problem of getting consumers to the table. Participants said this posed a great challenge because although those consumers participating in the network's activities have found it rewarding, most of their fellow consumers have shied away from engaging in collaborative work. According to a participant,

> *"It is a big challenge getting consumers to the table. What happens too is that [it is] probably a handful of consumers, maybe the four consumers that I can think, of that are in everything." (Service-providers' focus group)*

Another added,

> *"In fact I think we find that we need more of them [consumers]. I know that at the social housing work group, it's been noted several times that we've lost some consumers, and that they needed to be there at the table and that they needed to be a strong voice in what we were doing." (Service-providers' focus group)*

They noted that there are only about three or four consumers who are actively involved in the community and those same faces were seen at almost every table in the city.

Consumers who participated in the research confirmed this but went on to identify the challenges they face as a group, which they believe, discourage their colleagues from active participation. One of them said that time demands on him were often overwhelming and also that the meeting process required "a very steep learning curve to follow." In his words,

> *"The personal challenge for any of us coming to this table is the amount of time and learning curve it takes to know who all the players are. It would be important to give some kind of orientation to people coming on, to enable them to understand the relationships. It requires a steep learning curve." (Consumers' focus group)*

Another said problems with memory made it extremely difficult for him to optimally participate. Finance was another issue that consumers found challenging. Although other people at the table are paid for meeting time and may even have their transportation and other expenses reimbursed, consumers receive no honoraria for participation and they have to bear their own transportation costs as well. Lord and Church (1998) recognized the need to confront the poverty of consumer/survivors directly by finding ways to share resources with them.

Another challenge the consumers talked about, and which I found very interesting, was what they viewed as a reluctance of the network to get tougher with the government over the issues. Though they were appreciative of the efforts of the HWSHCN and the results its efforts have achieved, they expressed the feeling that the pace at which change is coming to the mental health housing system is too slow. They would for instance like to see supported housing made accessible to all people with mental health problems without the condition of

being homeless or being at risk of homelessness as the mental health policy stipulates. As one participant advocated,

> *"I think another shift of goal will be in order. Around Phases I and II, it was only about homeless the way the ministry wanted it. They wanted to fund housing for the homeless and the only way to fund housing for the mentally ill is by attaching it to homelessness. Because that's a hot issue and an issue they want to get behind them. Well it's important to make things like the HOMES project accessible to people who are simply mentally ill not necessarily homeless. They shouldn't have to be homeless to get in. And that's where you need the government to say, 'We are going to fund housing for the mentally ill'." (Consumers' focus group)*

Besides these problems, participants talked about issues of funding for projects and an imminent leadership change as problems facing the network. Data gathering took place at a time when the HWSHCN was in a leadership transition. The then chairperson who had either chaired or co-chaired the network since its inception announced her desire to step down within three months and asked for a search to begin for a new chair.

How the challenges were resolved. The representatives of the Custodial Care Association have recently tended to stay away from the network's meetings, although they have not officially withdrawn from it. Probably because they felt outnumbered by their non-profit partners, this group found another way to oppose the agenda of the network by taking their differences into the political arena where they were reputed to have a lot of clout. Here were said to have consistently lobbied against the network's initiatives and tried to put as many obstacles in their way as they could.

Among the community partners, people for the most part, talk about their differences and work them through. According to a key informant, one of the

members who is particularly well connected within the community does a lot of behind-the-scenes mediation, which has been extremely helpful in working out differences on major issues before they got to the table. This role has been one of the greatest strengths of the partnership.

The network has moved into a new phase of operation where advocacy is the main focus. This has resulted in a significant decrease in tensions among the community partners. The issues around funding and resources have completely disappeared. This has made the work of the network much easier because people around the table are united on rehabilitation principles.

The challenge of leadership has since been solved with the election of two people in April 2002 to serve as co-chairs of the network. They have since assumed the leadership of the network. Members are very optimistic that the group will thrive under the new leadership. One of the members of the network actually described the leadership change process as a very exciting part of the partnership story.

Outcomes

Participants described their expectations of the partnership and the actual outcomes of the process. These are summarized on the following table.

Table 2

Summary of Outcomes for the Groups Forming the Partnership

Group	Expected Outcome	Actual Outcome
Consumers	• Increased availability and affordability of housing	• Increase availability of supported housing • Improved support services

		• Empowerment • Personal influence on housing development
Family Members	• Increased availability of housing • Improved services	• Increase availability of supported housing • Improved support services for people with mental illness • Influence on housing and support services
Housing Providers	• Change in system of to supported housing	• Movement towards supported housing • Increase in housing units under Phases I and II of the HOMES project • Collaboration on the HOMES project
Support Service-Providers	• Improved support services • Community education on homelessness	• Greater community awareness of the issue of homelessness • Networking
The State	• Policy implementation • Information sharing	• Successful implementation of new housing policy • New information for policy making • Information sharing

A comparison of outcomes for the identifiable subgroups of the network namely: consumers, family members, service providers and government on Table 3 revealed that the actual outcomes outweighed the expected outcomes.

Expected outcomes. Participants' expectations at the beginning of the partnership were not very focused because the network came together for one main reason: to provide adequate housing and supports for people with mental health problems (Nelson & Earls, 1986). One of the professionals who

participated in the research said her expectation was to make small changes to the Lodging Homes area and have better understanding of the concept of supported housing. It was not very difficult getting people to make the mind shift from custodial to supported housing because the professionals who led the process had background knowledge about the concept. Others expected improvements in the conditions under which consumers were housed, increased accessibility to housing for this population and education of the community on homelessness as it affects people with mental health problems.

Actual outcomes. The actual outcomes of the network are summarized at three levels namely: the individual, the organizational and the community level on Table 3.

Table 3

Summary of Outcomes at the Various Levels

Level	Source	Outcome
Individual	• Participation in network • Collaborative work	• Good feelings about selves • Personal empowerment • Increased access to housing • Personal recognition • Influence on housing development
Organizational	• Collaboration on joint projects	• Interagency cooperation • Increased number of housing units • Networking
Community	• Community consultation. • Collaborative work of the network	• Awareness of homelessness • Increased involvement • Building of social capital

Participants generally said that the network has created greater awareness of the problem of homelessness in Hamilton through its community consultations. The network has helped to focus greater attention on the issues around housing for people with serious mental illnesses and elevated those issues on the political agenda of the City of Hamilton. As a result there has been an increase in activity in the area of housing by the city and the formulation of a new local housing policy (in the works) for people with mental health problems.

Other outcomes of the network include the development of new supported housing units under the HOMES project. HOMES is the main housing development project designed collaboratively by the network under the Phase I funding for the local Homelessness Initiative. The program has added 154 out of 193 housing units earmarked under the funding for local Homelessness Initiative for Hamilton-Wentworth community (Good Shepherd Homes Inc., 2002). Information shared by a key informant who was one of the leaders of the partnership process indicated that the partners have also converted a number of existing housing units to the supported model bringing the number of supported housing units in the community to about 450. HOMES has increased access to housing for people with mental health problems and also improved the conditions under which they are housed through introduction of the concept of supported housing in the community. Residents of housing units under the HOMES program have privacy because they have their own apartments They are provided with 24-hour on-site support, and they have the freedom to decide

whether or not they want to participate in specific mental health services or activities. A participant in focus group discussions described it this way,

> *"I think the HOMES project is one of the most successful we can look at in terms of housing people because there is so much choice and so much support. It's what you need that you get. There is peer support I think it's the most effective model we could look at." (Consumers focus group)*

According to one family member, the housing units provided under the HOMES program have greatly improved living conditions for residents. An internal (network) evaluation of the HOMES project indicated marked improvement in social integration for residents and up to 50% reduction in hospitalization (Good Shepherd Non-Profit Homes Inc., 2002). According to the research, residents indicated that they were satisfied with their housing, and perceived increases in their personal independence and their quality of life in general. One of the participants in this research who provides peer support on the HOMES program described it thus:

> *"In the HOMES program, we provide social recreation and counseling just to invigorate people, encourage them and give them hope. One thing too that is amazing is that we don't have a big turnover of residents." (Consumers focus group)*

All participants in the research agreed that the HOMES project has contributed significantly to reducing homelessness in the City of Hamilton. This is witnessed by a significant decrease in the pressure on the shelters in the community. One participant attested to this when he said:

> *"I was meeting, the other day, with some of the emergency shelter providers who were saying that HOMES has reduced the pressure in the shelters substantially. So I think its impact in reducing homelessness among the hard to house in our community has been very good." (Support service-providers' focus group)*

Participants, however, generally acknowledged that homelessness among was still a problem in the city.

The HWSHCN has further enhanced mental health service delivery in the community by compiling information about available housing and services within the community, the agencies that offer the services and their locations. This information has been very helpful for both for interagency referrals and for people who need the services.

The network also collaborated with the Hamilton-Wentworth DHC on a study of mental health housing needs in the community. The group directed the study and assisted in interpreting the data gathered and making recommendations. According to one key informant, the network has since taken an active role in implementing some of the recommendations of that study. One of these recommendations was the creation of a central information system for mental health services in the district.

Participants in the interviews alluded to increased networking among member agencies. According to them, the agencies have developed links and worked cooperatively and collaboratively by sharing information and resources. They said this has improved referrals within the system because they have become more aware of what each other was doing. They also claimed to have also utilized the personal relationships they have developed with each other to enhance inter-agency collaboration. One of the participants said,

> *"One of the more recent interesting forms of collaboration or sharing is this, one of the staff at Hamilton Housing – the city's non-profit housing -*

got seconded to the DHC, and then one of the HOMES staff got seconded to her job at Hamilton Housing. People have actually taken on each other's roles and are learning a lot more about what each other does in the process. I don't think those opportunities would have been there if the project hadn't started. There is the community advisory board as well - that's different from this group - that brings all the folks together." (Key informant)

Furthermore, housing-providers and support service-providers confirmed that getting to know people at the personal level through the network has improved their relationship with governmental agencies and facilitated work with them. A participant described it in the following way,

"I think the way it's working is pretty good. You make some contacts face to face, you have questions on policy or different issues, you have somebody you can call and [if] they have concerns or questions they can call you. Once you meet face to face things are much easier to do." (Support service-providers' focus group)

Another participant said,

"I think the thing we all go on here is; we try to be as open and honest as we can when things are working and when things are not working. We clear them up right away, we have the connections to phone each other and say hey something is not working lets talk it through. If somebody for instance thought the HOMES program was not taking off well, [he/she] will phone and tell me. You know, that kind of openness is in our community now. It's all about the information sharing that D___ was talking about. Everybody knows what the rules are. It's pretty explicit. We agreed that the housing will be private rooms." (Housing providers' focus group)

The network has also actively collaborated on creating Crisis Outreach and Support Team (COAST), which provides 24-hour crisis intervention. Some of the partners are involved in the program for Supporting Communities' Partnership Initiatives (SCPI) and keep the network informed of its progress. Also some of the participants claimed that the network was instrumental in bringing an

Assertive Community Treatment (ACT) team to Hamilton. According to a key informant,

> *"One other positive thing was the subcommittee system. One of the subcommittees was looking at the importance of having an ACT team in Hamilton. We organized a half day workshop and brought consultants in and had people with different ideas. The idea translated into having an ACT team in Hamilton."*

When asked what new outcomes they thought would be ideal, the participants said the actual outcomes have so much exceeded their initial expectations that they did not know what more to ask (see Table 2).

Relationship Between State and Community Partners

Housing Policy for People with Severe Mental Illness

Background. Housing policy for people with serious mental illness in Ontario evolved gradually through a reform process that began with the Heseltine report (cited in Ontario Ministry of Health, 1994). The Heseltine report, *Towards a Blueprint for Change: A Mental Health Policy and Program Perspective,* was the first to bring into sharp focus the need to separate treatment from accommodation (Ontario Ministry of Health, 1994).

Following the Heseltine report, a community consultation process led by Robert Graham was started on mental health reform (Nelson, Ochocka, & Lord, 2002). The Graham committee report of 1988, *Building Community Support for People* (Ontario Ministry of Health, as cited in Nelson et al., 2002), recommended a shift of resources from institutions to community-based housing and support services. The report identified essential services necessary for re-integrating people into the community. One of these was housing in the community.

The Graham report set in motion a policy-making process which involved further community consultations by two sub-committees (Nelson et al., 2002). The work of these two committees resulted in *Putting People First* (Ontario Ministry of Health, 1993), which was a 10-year mental health reform plan with Case Management, 24-hour Crisis Intervention, Housing, and Family and Consumer Self-Help as the four main elements of reform. This plan had a vision of a comprehensive mental health system that provides an enabling environment for people with mental health problems within the community. The Ministry of Health, in collaboration with the Ministry of Housing, developed guidelines for implementing the housing element of the reforms (Ontario Ministry of Health, 1994). These guidelines formed the basis for implementing current policy for housing people with serious mental illness in Ontario.

The Graham report also influenced province-wide consultations that led to the report *Consultation Counts* (cited in Ontario Ministry of Health, 1994). *Consultation Counts* is a housing policy framework for Ontario with a people-centered approach to access. This framework focused on partnership between the Ministries of Health and Housing for promoting greater resident involvement in the planning and development of supportive housing.

Current policy. Current housing policy is built on the reforms advanced by *Putting People First* (Ontario Ministry of Health, 1993). The reform policy, which is rehabilitation focused, gives priority to enabling people with mental illness to live within their communities by providing them with adequate housing and supports. This principle is further elaborated in *Mental Health Reform*

Implementation Guidelines for Housing and Support Services (Ministry of Health, 1994). The implementation guidelines for housing and support services, which were jointly developed by the Ministries of Health and Housing, laid out directions for planning of housing and support services based on the principles of supported/supportive housing. These principles include security of tenure, integration of people with special needs, promoting individual choice in housing and support services and promoting independence of residents. A new bill, the Residents' Rights Bill was introduced in the provincial parliament to give tenants in private "for-profit" housing protection similar to that provided by the Landlord and Tenant Act, the Rent Control Act and the Rental Housing Protection Act. The current Tenant Protection Act (Ontario Rental Housing Tribunal, 2002) covers most landlords and tenants including people with mental health problems living in the communities. The range of housing covered by this act includes such rental units as apartments, houses, care homes, retirement homes and rooming, lodging and boarding houses. The current policy encourages stakeholder involvement in planning and identifies consumers/survivors, family members, housing-providers, local housing authorities and the regional offices of the Ministry of Housing as stakeholders who should participate in the planning process (Lord & Church, 1998; MacGillivary & Nelson, 1998; Nelson et al., 2001). It further proposes that planning should take place at the local level and gives the DHCs the role of coordinating the determination of the housing needs of the community as well as support services needed by consumers. The DHCs and Provincial Psychiatric Hospitals (PPHs) are also required under the policy to

jointly plan for deinstitutionalization by developing priorities for supportive housing.

The types of housing listed by the policy for utilization in the deinstitutionalization process were public housing owned by local housing authorities, rent-geared income housing owned by the Ontario Housing Corporation, private non-profit housing, private market rentals, family homes, supportive housing - mainly group homes in social setting, Homes for Special Care, Emergency housing (hostels), transitional housing - group homes for consumers, and private for-profit accommodation (Ministry of Health, 1994).

The most recent initiatives in mental health housing policy provide for an integrated approach to meeting the housing and support service needs of people with special needs (Ontario Ministry of Health and Long Term Care, 2000). The policy provides for a continuum of housing for people with special needs based on their levels of competence. The policy further instituted the Local Services Realignment (LSR) process to introduce changes in the roles of the various levels of government in the delivery of housing and support services to people with special needs. The new policy entails the development of new housing units and the provision of adequate support services for residents in both the new units and people in provincially funded residential care facilities across the province. As part of the policy, a provincial Task Force, which was set up to review mental health housing in Ontario, laid more emphasis on the supported housing model. The task force recommended reinstatement of provincial cost sharing of the domiciliary hostel system and giving greater responsibility to the municipalities in

housing. Consequently, the municipalities were given authority to enter into agreements with private housing operators to develop more supported housing units.

As part of the implementation of the policy, the province provided funding for the new supported housing projects to local authorities. The Ontario government disbursed $24 million for 1000 new supported housing projects under Phase I of the Homelessness Initiative for projects in Toronto, Hamilton and Ottawa. Out of this amount, about $1 million for 100 housing units was allocated to projects in Hamilton. Hamilton also received 93 additional housing units under Phase II of the initiative. Further, the province transferred the administration of 5000 supportive housing units to the Ministry of Health and Long Term Care (MOHLTC) and the Ministry of Community and Social Services (MCSS) to ensure that services are provided to residents in a coordinated fashion (MOHTLC, 2000).

State Involvement in the HWSHCN

Against this backdrop of the larger policy environment, stakeholders in the Hamilton-Wentworth community organized in the late 1990s to improve housing for people with serious mental illness. Formation of the HDG and subsequently the HWSHCN was facilitated by the Hamilton-Wentworth District Health Council (Hamilton-Wentworth DHC), the Regional Psychiatric Program (RPP), and the City of Hamilton. The Hamilton-Wentworth DHC served as its host institution and provided assistance with staff hours and office space in addition to its

boardroom, which the network uses, for meetings. Professionals with the SPRP initiated the process that culminated in the HWSHCN.

Formal state representation on the network is currently at three levels of government, local, regional and provincial levels. The City of Hamilton represents the state at the local level and the Hamilton-Wentworth DHC at the regional level. The Ministries of Housing, Health and Long Term Care and the Ministry of Community and Social Services represent government at the provincial level.

The City of Hamilton, which got involved after the presentation of the HDG report and the reorganization of the group to form the network, has two senior officials of the housing and social housing departments representing it on the network. The province is represented by senior bureaucrats from the Ministries of Housing, Health and Long Term Care, and Community and Social Services. The Ministries of Health and Housing were invited to join the network because they have direct responsibilities in the area of housing for the severely mentally ill under the mental health reform policy. The Ministry of Community and Social Services, however, opted for membership on its own because officials there believe they have something to contribute to the network's activities. At the initial stage, there was a local politician who got involved and unofficially represented the political sector on the group. This individual worked with the group until he moved on in his political career and is no longer available to continue.

Relationships between state and community partners. The relationship between the state and its community partners has been that of collaboration and information-sharing. The network maintains an independent status from the

government and is therefore able to criticize the government when the need arises. Participants, however, recognize that government participation is very necessary because it ensures the flow of important information in both directions.

Relationships with members of the HWSHCN representing the state have been mixed. Although some members of the network consider them as observers rather than partners, all participants in this study said that they have very good relationships with the state representatives on the network. They went on to describe some of the state representatives as very approachable. Further, they said that getting to know these people personally have facilitated their businesses with the government, not only at the network level, but also at the individual agency level. Participants also said they found some of those who came to the table representing the state very well informed about mental health issues and very understanding. According to one participant:

> *"People are excited to have them here, they do make contributions and keep us informed about new initiatives and how we can intervene effectively. Their participation has facilitated the network." (Housing-providers' focus group)*

Consumers who participated in the research said they find the participation of government representatives very helpful because they share useful information and give guidance on policy and procedural issues. They thought some of them are also very much aware of mental health issues. They, however, hinted that they are a little suspicious of their intentions because, *"In the end the bureaucrats have to toe the government line." (Consumers focus group)*

Challenges in partnering with government. Some participants expressed a little frustration over the lack of power to allocate resources to programs on the part of government representatives on the network. Others, however, thought the relationships were ideal as the government has no control over the network. Direct allocation of resources would require greater government control of the process and would turn the network into another government institution. One participant put it this way,

> *"I think for me we don't want too many of them at the table driving their own agenda because they already know what 'caucus' wants. But you want them on side when the report is done. You want them getting on side and saying, "yes, I actually read it and yes, I actually believe there is something in here and 'yes, I will actually take it to the legislature and talk about it and put pressure on it.' I am really not sure how much we want them sitting around the table because of their agenda. Because they already know what they want and we don't want them sitting around driving the results. But you do want them at the end of the process and especially their money – (laughter)" (Support service providers' focus group)*

Participants representing the government on their part identified time required for meetings outside busy office schedules as very challenging. They, however, thought the work of the network is very important and necessary therefore, time spent on it is worthwhile.

Ideal relationships with the state. The ideal relationship with the state, according to participants, is to maintain the independence of the network. It would be ideal to have representation from all levels of government, including the federal level. They also thought government representatives should serve more efficiently as a direct conduit for information from the network to policy circles.

They also believe people representing the state should be given some powers for resource allocation. According to one participant,

> *"For me the ideal will be to have representatives of the three levels of government at the table [who] would have decision making powers in terms of allocating some resources. I mean this is not to undermine people that are at the table, but I think we are at a point where we need a commitment of resources to move this froward. And I guess ideally I would love to be able to sit down and talk about these issues and have people nod their heads and then all of a sudden money starts to flow." (Support service-providers' focus group)*

Needed policy. Participants in the research emphasized the need for new policies that would develop of affordable housing, address poverty within the community, and increase incomes for people. Consumers specifically would like to see an increase in the Personal Needs Allowance for people on disability to enable them to access housing. They said although there is great improvement in housing in Hamilton, homelessness still remains a major issue that needs more action.

For people with mental health problems, participants advocated for a clear policy to effect a shift from custodial housing to "supported housing" to empower people to take control of their lives (Carling, 1995; Parkinson et al., 1998; Nelson et al., 1995). Another significant area that people identified was the need to set up regular channels for disseminating information within the community on services available to enhance accessibility.

Discussion

The Partnership Story: Coming Together and Working Together

Coming Together

Information gathered pertaining to Research Question 1, "The Story of the Partnership: Coming Together and Working Together" revealed that the formation of the Hamilton-Wentworth Supported Housing Coordination Network (HWSHCN) was an interesting evolutionary process. The process presents a story of a community that rose in defense of social justice and strove to improve the quality of life for one group of its members. Various writers have speculated as to the reasons why people come together cooperatively in response to a mutual need or to the needs of others. Some have described cooperation as a basic survival mechanism (Kropotkin, 1972, as cited in Levine & Perkins, 1997) whilst others have dubbed it a coping strategy (Hurvitz, 1976; Kurtz & Bender, 1976, both cited in Levine & Perkins, 1997). Kropotkin further linked response to the needs of others to a kind of social instinct that has developed in human beings over the years.

Irrespective of what pre-disposes humans to cooperation or collaboration, several factors have been found to be associated with the emergence of community coalitions and partnerships. These factors include: (a) community readiness, (b) existing leadership, (c) stakeholder organizations, (d) external support (Wolff, 2001b), and (e) an enabling political environment (Nelson et al., 2001). The story of the HWSHCN revealed all of these factors at play.

Readiness for change. The discussion started by the key professionals in the SPRP and the response it elicited from stakeholders were clear indicators of a community that was responsive and ready for change. According to resource mobilization theory (Jenkins, 1983, 1987, as cited by Nelson, 1994; Nelson et al., 2001), the readiness of a community for change depends on two factors, the presence of organizational bases of support within the community and favorable changes in the political climate. The initiation of the discussion was an expression of concern about the state of the mental health housing system and a desire for some action to improve it. The professionals who started the process said that they believed there was a need to change the system and had a strong conviction that the only way to do this was through collective effort and active advocacy. Consequently, bringing in other stakeholders gave the group a strong mix of people who were passionate about the issue of housing for people with mental illness. One of the participants identified having a mix of people who are powerful and people who are not so powerful on the network as one of its major strengths. This is recognized as an effective way of redistributing power within the community (Lord & Church, 1998; Nelson et al., 2001; Wolff, 2001b) and also for enhancing a sense of ownership of the process for community change among all members of the community.

Existing leadership. Indications were that the problems regarding mental health housing and services had been present in the Hamilton-Wentworth district for a long period of time (Regional Municipality of Hamilton-Wentworth, 1988). It is therefore interesting to ponder why the community did not get organized

earlier. Although the community was ready, it needed a facilitator or a person with leadership initiative to emerge. Someone with the ability to move and organize people. This emergent leadership role was played collaboratively by the key person who began the discussions and her colleagues. Evidence of this is the fact that the network adopted a system of co-chairs. In its three years of existence it has had three co-chairs. Chrislip and Larson (1994, as cited in Wolff, 2001b) identified four important characteristics of collaborative leadership as leadership that inspires commitment and action, leads peer problem solving, encourages participation and sustains hope and enthusiasm. According to the individual who initiated the process, she had always been an advocate on behalf of the disadvantaged in society. Besides this person, other leaders of the HWSHCN partnership had been involved in leadership roles in the community. One of them served on the Regional Task Force on Care for the Psychiatrically Disabled as far back as 1986. Several other professionals with whom the process began in the form of discussion were heads of various agencies and departments. These people got actively involved in the discussion and provided leadership on the various working committees that served as "breeding grounds" for new ideas and also as recruitment centres for membership. The leaders showed the ability to share power (Church, 1996; Lord & Church, 1998; MacGillivary & Nelson, 1998), facilitate group interactions, and effectively resolve conflicts (Wolff, 2001b) among the partners. Participants in this study acknowledged that the leaders have displayed these abilities. They cited a leader who was well connected within the community and who has dealt with most

potential conflict situations behind the scenes and prevented them from surfacing as open conflicts as an example.

Stakeholder organizations. As the initial discussions progressed, the group invited other people who had interest in the issue of housing for people with serious mental illness to join them in sharing ideas. These stakeholders who were mainly non-profit housing-providers, support service-providers and consumer and family self-help organizations brought more enthusiasm, energy and commitment into the process. Stakeholder participation has been identified by several researchers as very important for community development (Lord & Church, 1998; Nelson, 1994) The involvement of the stakeholder groups and agencies further emphasized the fact that the community was ready to organize itself to promote social justice by fulfilling a social need.

External support. External support is another important factor for the success of a coalition (Nelson et al., 2001; Wolff, 2001b) The group received support and encouragement from the Hamilton-Wentworth DHC and the City of Hamilton as well as the SPRP. The Hamilton-Wentworth DHC, which became the host organization for the group's activities, contributed immensely to its survival, development and consequently its success. By providing them with a meeting and office space the Hamilton-Wentworth DHC gave the group a centre of organization from where its operations were planned. It also gave the group a measure of recognition from the government and served as a source of encouragement for the participants to continue with their efforts. Both the

Hamilton-Wentworth DHC and the SPRP had also provided the group with staff assistance at various times.

Changes in the political climate. Signs of positive change in the political climate began to appear in 1998 with the Ontario government's decision to devolve the cost of housing to the municipal level and restructure hospital-based mental health services. The political environment was further enhanced by the federal government's devolution of public social housing administration to the provinces and the launching of its $680 million local Homelessness Initiative in 1999. It is, however, worth noting that the failure of devolution to come with financial commitments from these higher levels of government severely limited its impact on homelessness. Secondly, the amount of money promised for the local Homelessness Initiative was just a drop of what the government was capable of providing. According to the Toronto Disaster Relief Committee (TDRC), all levels of government in Canada spend $4 billion, just about 1% of their overall annual budgets on housing (TDRC, 2002). This organization and others have proposed in a campaign dubbed "the 1% solution" that if Canadian governments commit an additional 1% of their budgets to housing, the homelessness problem would be solved within 3 years. These shortfalls not withstanding, the changes in policy created the favorable political environment that played a key role in bringing the partners of the HWSHCN together. Evidently the policy change in Ontario had its foundation in previous initiatives in the mental health system beginning with the Graham report of 1988 and the mental health reform policy of 1993. Consistent with those initiatives, the current policy seeks to increase stakeholder

participation in planning of mental health housing and services. Under this new policy (Ontario Ministry of Health, 1993, 1994) the DHCs have an obligation to initiate community partnerships in the mental health sector. The support the Hamilton-Wentworth DHC provided to the network and the active participation of other governmental institutions in the network's activities give clear indication that the government was ready to actively join the effort to rectify the negative impacts of the "no social housing" era. The network interpreted these changes in government orientation and policy as an opportunity to influence housing development at the local level. This is consistent with resource mobilization theory (Jenkins, 1983 as cited in Nelson et al., 2001), which postulates that changes in the political environment serve as impetus for community mobilization for action to create change.

The aggregation of the effects of the factors discussed above was a strong internal impetus to organize for change in Hamilton-Wentworth. According to Wolff (2001b), an internal impetus for a coalition gives communities ownership of the process and enhances its chances of success. This assertion holds true for the HWSHCN partnership because the initiation of the partnership came from within the community.

Working Together: The HWSHCN

Himmelman (2001) differentiated between collaborative betterment and collaborative empowerment coalitions. According to him, collaborative betterment coalitions are first initiated by public or large private institutions who then seek the involvement of the communities. On the other hand, collaborative

empowerment coalitions are started by community members who establish mutually agreeable power relations and then invite government or large private organizations to participate. Applying Himmelman's (2001) concept to the HWSHCN identifies it as a collaborative empowerment partnership. The empowerment derives from the residual power that the process of development has left in the hands of the community.

Though all the partners agreed that the need for adequate housing for people with severe mental illness was central, there were few differences among the subgroups' objectives. According to Boudreau (1991) such differences in perspectives is characteristic of community partnerships. The differences in perspectives among the non-profit community partners were not so sharp as to create major problems as it did with the "for-profit" group. The professionals' desire to change the system of mental health housing to what had been demonstrated to be best practice, the consumers' eagerness to enjoy better housing and support-services, and the non-profit service-providers' desire to improve their services pointed in the same direction. Together, these groups recognized a need to collaborate in creating "a workable plan" for improving housing and support-services, and for strong advocacy to push for the plan's implementation. Government representatives also said they liked the prospect of working collaboratively with the community partners to fulfill their mandate and also ensure that the process was guided by policy. This harmonizing role was important because funding for mental health services comes from the government.

The aim of the HDG to bring together stakeholders to develop recommendations for the development of supported housing as a way of influencing housing development at the local level was consistent with the reasons Wolff (2001a) identified for forming coalitions. According to Wolff (2001a) coalitions are formed in response to endemic problems in public services in a bid to make them more available, effective and cheaper. Some are formed in response to policy changes that give greater responsibility and authority to the localities.

The HDG's adoption of a community consultation process was in itself a form of intervention for the community because it raised awareness of the problem of homelessness as it affects people with mental health problems (Lord & Church, 1998). The process ensured that the final document generated was representative of what the community believed were the housing needs of people with serous mental illness. Such representation engenders a sense of ownership and enhances collaborative effort on the program identified (Krogh, 1998; Lord & Church, 1998; Lord & Hutchison, 1993; MacGillivary & Nelson, 1998). The broad-based participation in the consultation process increased the likelihood that the decisions taken would be followed through with implementation (Taylor & Botschner, 1998).

Presentation of the HDG report to the City of Hamilton in 1999 was another important step in legitimizing the process and getting greater government involvement in it. Furthermore, the acceptance of the report as a guiding document for the development of housing under the devolution process was a

big success for the group, which generated further interest, and enthusiasm in its work and which led to the creation of the HWSHCN.

Reasons for Participation

One major reason why people participated in the partnership with high levels of enthusiasm was shared interest in the plight of people with mental health problems. Both the housing-providers and support service-providers were interested in improving the services they offered to their clients. This was in harmony with the professionals' interest in better living conditions for the people with whom they worked. Consumers and family members were naturally most concerned about the poor conditions of housing and had a vested interest in improvements. Interest in the efficiency and effectiveness of programs is shared by all funding agencies and government could be no exception. Since funding for mental health services come from the state, government, therefore had an interest in improving these services, even if only to justify budgetary allocations to the sector. Besides, the stated aim of the mental health reform policy to make the consumer "the centre" of the mental health system (Ontario Ministry of Health, 1994) gives clear indication that improvement in mental health services is of interest to the government. This convergence of interest in the problem on the part of the community members was important in bringing the groups together.

There was also a strong desire for changes in a mental health housing system. The custodial care model, according to participants, caused stagnation of residents because they lacked opportunities for moving on even when they had recovered enough and were capable of independent living. At the time of this

initiative, there were apparently no new initiatives in the mental health system to address these problems. That this was a desire shared by all people working in the mental health sector is witnessed by the enthusiasm with which agencies and individuals committed themselves to the network at its inception.

Limitations in service delivery systems is another reason for people to form partnerships (Wolff, 2001a). The failures of the mental health system as it was at the time played a key role in triggering the community organization for change. This is also consistent with resource mobilization theory. Nelson and his colleagues' (2001) rendition of the theory explicitly identified the organizational bases of support as important for social action to take place. Widespread concern generated by the limitations of the system account for the readiness of the community for action, which facilitated the emergence of the network.

Facilitating the Emergence and Work of the HWSHCN

Factors that promoted organization for change. From members' accounts of the story of the HWSHCN partnership, the metamorphosis of the HDG into the HWSHCN was expedited by several factors. The acceptance of its report brought the HDG to a natural and successful conclusion of its task. The next step would have been for it either to disband or find itself a new task to undertake. It was therefore logical that members of the HDG agreed not to "rest on their oars" but rather to continue to work for the implementation of their recommendations. The reconstitution of the HDG into the coordination committee was therefore a natural step because the report had identified this as very important for the implementation of the recommendations. It must be noted that the HDG had by

this time developed a great potential by bringing the various stakeholders together and generated so much interest, hope and enthusiasm. It would have therefore been a complete waste to disband the group and lose this potential.

The HWSHCN exemplified the definition of a partnership as an organization of diverse groups or individuals who are working together with their combined resources for a common purpose or to effect specific change, which they cannot bring about independently (Krogh, 1998; MacGillivary et al., 2001; McCann, 1986; Wandersman et al., 1996). The group also conforms to the new paradigm of partnership in the health and disability sector advanced by several writers (Nelson et al., 2001; Nelson & Walsh-Bowers, 1994; Schwartz, 1992) as working relationships between service-providers and disadvantaged people. The extensive participation in the HWSHCN by consumers, family members, support service-providers, housing-providers, and the state emphasized the diversity of support that can be assessed within a community for disadvantaged populations (MacGillivary & Nelson, 1998; Nelson, 1994). Further, the subcommittee or working committee system that the network adopted allowed member agencies to gravitate towards the issues about which they were the most passionate and also to maximize participation (Nelson, 1994; Nelson et al., 2001). The subcommittee format also enabled the partner agencies to create links among themselves and to enhance networking among mental health service agencies within the community (MacGillivary & Nelson, 1998; Wandersman et al., 1996). The working committee system also enhanced the growth of the HWSHCN and positively developed relational capacity both internally and externally. According

to Foster-Fishman et al. (2001), positive internal and external relational capacity is important for the development of community coalitions or partnerships because they enable the organization to relate well to the larger environment. The HWSHCN experience demonstrates that partnerships with strong external relational capacity exerts a "magnetic pull" on even the remotest of stakeholders and makes individuals and organizations yearn to join the process.

Factors that facilitated the partnership process. As identified by Coe (1998), the values of caring, compassion and community are very important in partnerships between professionals and disadvantaged people (see also Lord & Church, 1998; O'Donnel et al., 1998). These values played an important role in bringing about the initiation of the network. The professionals and interested people who started the whole process shared these values and for this reason, they were willing to spend their time and energy to make life better for a disadvantaged group in their community. For most of the initiators, the initial unpaid-for-time they spent to put this together was worthwhile because it satisfied those values in them.

Resource mobilization theory postulates that changes in the political environment promote community action for change (Nelson, 1994; Nelson et al., 2001). Devolution of social programs to local authorities has been identified as a factor that promotes the formation of community coalitions (Wolff, 2001a). The announcement of the downloading of housing to the municipalities by the Province of Ontario was a big factor in the consolidation of the group. This factor, perhaps more than any other, made the group realize the actual possibility of

influencing housing development and encouraged members to forge ahead. The timing, though a mere coincidence, was also a factor because the announcement probably came at the most opportune time.

Government involvement in the network was another favorable factor in the development of the HWSHCN. Members viewed this as an important factor because it provided essential resources in terms of staffing and office space (Wolff, 2001b), and also enabled the network to work in harmony with government policy. It has also facilitated work with the bureaucracy in the same direction. This happened because the government and the partners were always "on the same page." Government involvement also gave the group more legitimacy in the area of interest.

Furthermore, the shared values identified by participants held the network together as a group and led to its success. The values of mutual respect and being consumer centered are very important to partnerships involving consumers and professionals (Lord & Church, 1998). According to a participant in this study the value of being consumer centered has kept the network focused on its objectives. She said,

> *"Continuing to focus on what clients want and always trying to ask ourselves 'How is it going to benefit the people we serve?,' has helped us to stay focused." (Key informant)*

Representatives of all the main groups in the partnership also identified mutual respect as one of the most important values of the network. The consumers said they most appreciated the amount of respect they received as participants and the trust this has built among the members (Coe, 1998). Related to the value of

mutual respect is the value of listening (MacGillivary & Nelson, 1998). Consumers who participated in this study said listening to them made them feel their contributions were valued, and this encouraged them to continue participating. The value of listening promotes good communication among people and makes it easier to work things out whenever tensions arise, as is inevitable in any human organization of diverse perspectives. That the HWSHCN has benefited immensely from this value was evident from both what people said in the interviews and from my field observations.

Responsiveness to community need, a value identified by O'Donnel et al. (1998), also played a big role in the growth of the HWSHCN partnership. Both the initiators and those who joined the process later were responding to a community need. Representatives of agencies, which opted to join the network after its formation without being invited, said they wanted to be part of the process because they had a role to play in finding a solution for the housing problem in the community.

Another factor that facilitated the partnership was networking and collaborative problem-solving (Coe, 1998). All the participants agreed that there is an increase in networking among individual members and agencies on the network. They said this has improved referrals and created an enabling environment for both the agencies and the people they serve. Networking has also solidified relationships among people on the network as they worked together to assist the disadvantaged. Moreover, they said mutual understanding has gradually developed even among agencies, which would typically not work

together because they were in competition. This understanding is breeding mutual trust among member agencies of the network. Even members representing the state, a group usually viewed with suspicion, had consumers saying they were happy to have them on the network.

The capacity and legitimacy of the initiators of the network is another factor that was helpful to the partnership (McCann & Gray, 1986). The initiators of the network were professionals who have worked with the target population for an appreciable length of time. People listened to them because they had trust in them as professionals. This came through in some of the interviews as good reason to trust the process. Thus legitimacy derived from their professional qualifications and involvement in the field was an asset for the network.

The Partnership Story: Relationships, Challenges Outcomes

Relationships Among the Community Partners

Findings relating to part 1 of Research Question 2, "Relationships" revealed very healthy and cordial relationships among both individual members and agencies. These healthy relationships have been associated with social capital (Baron et al., 2000; Cohen & Prusak, 2001). Relationships between members of the community and consumers on the network has built confidence in consumers and helped to avoid what Lord and Church (1998) described as "partnership shock"; a phenomenon which limits the contribution of consumers at meetings. According to Lord and Church (1998), "partnership shock" results from formal procedural relationships, which enhance professionals' dominance over people with disabilities.

The sour point in the relationships on the HWSHCN, as reported by members, was with the Residential Care Association. This could not be observed directly in participant-observation because representatives of this group were not present at network meetings during data collection (Lord & Church, 1998; MacGillivary & Nelson, 1998). Participation by diverse stakeholders has been identified as a positive factor in community partnerships (MacGillivary & Nelson, 1998). This endorsement of the need to "cast the net wide" when building community partnerships could, however, result in groups joining the process based on perceived common interests, but whose real interests may be at variance with the core membership. It is therefore important to "cast the net wide" but with caution.

Challenges Faced and How They Were Resolved

Challenges. The most difficult challenge the HWSHCN faced was the clash of values that characterized relationships with the Residential Care Association. The difficult relationship with this group was a demonstration that groups whose objectives and perspectives are at variance cannot work together effectively. Although the inclusion of the Residential Care Association satisfied the need for a comprehensive network that included all stakeholders, the period of their active participation brought differences underlying the "for-profit" and "not-for-profit" perspectives into sharp focus. The contradictions in their perspectives made conflict inevitable. This is not to say for-profit agencies and a non-profit agencies cannot cooperate on projects of common interest (Mintzberg,

Dougherty, Jorgensen & Westley, 1996)), but when the interests are directly opposite, there is greater likelihood of conflict than cooperation.

Funding for projects, another challenge identified is common to all human institutions. People are said to have limited resources but unlimited wants. The problem of leadership change was transitory in my opinion because the network seems well endowed with leadership abilities. It appeared to be a problem only because the announcement came unexpectedly. The challenges posed by role confusion, different perspectives, and getting consumers to the table are, however, real and need to be dealt with to further enhance the network's success.

Resolution of challenges. When asked what attempts had been made to resolve the problem, participants said that the Custodial Care Association had stayed away from the network of its own volition. There had been few attempts to bring them back because people obviously thought the network was better off without them.

Role expectations, especially where it concerned the representatives of government, have been problematic for some members of the partnership. Some of the community partners expected the state to provide easy access to resources by giving its representatives the power to allocate resources to the network's projects. The expectations of the community partners contrasted sharply with what the state representatives viewed as their role; information sharing. In her study of mental health partnerships in Quebec, Boudreau (1991) discovered a problem with role confusion though in a different form. In Quebec,

the community partners expected the ministry to assign them roles and at the same time complained of excessive government involvement in their affairs. Clearly, roles and expectations of community partners are often assumed with negative consequences when such expectations are not met (Boudreau, 1991). This suggests that it will be helpful to discuss members' expectations and clarify their roles at the beginning of such partnerships.

One other problem was the difficulty in obtaining funding for projects. This is not a new problem for government funded sectors because allocation of resources in modern democracies is a matter of politics. This fact not withstanding, the experience of the HWSHCN indicates that community partnerships can be relied upon to deliver social services cost effectively and in accordance with government policy. A review by the Health Systems Research Unit of the Clarke Institute of Psychiatry recommended a single envelope funding managed by a regional authority for each area as a strategy for integrating the mental health system (Minister of Public Works and Government Services Canada, 1997). The review recommended a regional authority responsible for dispensing funds and organizing services for its area of jurisdiction. Citing the successes of mental heath authorities in New Brunswick, Vancouver, Kansas, Wisconsin and Washington, it suggested that mental health authorities have the promise of integrating the administrative, clinical and fiscal aspects of care delivery. This single envelope system has the advantage of enabling communities to decide their priorities and implement programs accordingly.

Power differentials, which have been identified as one of the major problems that characterize the relationships between professionals and people with disabilities (Church, 1996; Lord & Church, 1998), were not evident on the HWSHCN. According to the consumers who participated in the study, there is no condescension on the network, members are respected and their inputs are valued. All participants in the research confirmed this as true and likewise my own observations in the field.

Participants acknowledged that it was a challenge getting consumers to the table. Consumers who participated in this study identified economic factors as a major hindrance to participation. Consumers who participate on mental health boards and committees often face the problem of bearing the costs of transportation, baby-sitting, meals and others associated with participation (Valentine & Capponi, 1989; Lord & Church, 1998). Valentine and Capponi (1989) identified several barriers to consumer participation besides economic factors. These included incongruence between stated values and actual practice, tokenism, lack of representativeness, role strain and poor communication. These barriers result in perception of powerlessness on the part of consumers and make participation unattractive. These researchers offered several strategies for overcoming these barriers. They called on boards and committees to make their practices consistent with their stated values and eliminate tokenism by increasing consumer representation to make their participation meaningful. They further advocated for representativeness rather than mere representation of consumers, education of participants, improved communication and addressing consumers'

economic problems. Based on the findings of this research, I add my voice to the call on community partnerships to address consumers' economic problems by bearing the costs directly associated to participation as a way of encouraging consumer participation (Lord & Church, 1998). I also call on them to work in collaboration with local mental health associations to train and provide consumer/survivors with the necessary skills for participation, and educate them about the benefits of involvement (Foster Fishman et al., 2001; Nelson et al., 2001). This would bolster consumers' self-confidence and through that increase the possibility that they would participate.

Power in the HWSHCN was well distributed through its subcommittee system. According to Wolff (2001b), successful coalitions disperse and develop leadership among their members. This ensures that power is shared and not concentrated in the hands of one individual. The dispersal of power has served leadership-training purposes and made it easier for the replacement of a leader when the need arises. The election of two co-chairs in April, 2002 attests to this fact about the HWSHCN. Besides, one of the new co-chairs is a consumer and this further underscores the efforts of the network to address power imbalances.

Impacts of the HWSHCN

In this research, I found that the HWSHCN has had positive impact at three levels: (a) the individual level for members of the network, (b) the organizational level for the various groups, and (c) the community level for the community at large. The impacts of the network are therefore discussed at these three levels (Parkinson et al., 1999).

The individual level. At the individual level, participants reported positive personal outcomes. People said that they felt very good about themselves for being involved in something that was very beneficial to people with disabilities and to the community. Consumers on the network felt empowered because their voices were heard. Nelson et al. (2001) defined stakeholder participation and empowerment as "the process by which individuals participate with others while gaining control over their lives" (p. 21). Through the network, consumers were able to have direct influence on housing and services. According to one consumer, participation has brought him "self actualization," a term he explained as the feelings of "importance" and "fulfillment" that comes from doing something useful. This feeling was captured by Prilleltensky (1994) in his descriptive and prescriptive model of empowerment as developing through collaboration, democratic participation, distributive justice and self-determination. Several authors have identified participation as a means of empowering disadvantaged people and discussed the need to provide them with such opportunities as a way of enabling them to take control of their lives (Lord & Church, 1998; Lord & Hutchison, 1993; Nelson et al., 2001; Rappaport, 1987).

Furthermore, the empowerment-community integration paradigm advanced by Nelson et al. (2001) identifies access to such valued resources as desirable and affordable housing, adequate income, meaningful employment and education as important for social justice. The increased availability of housing to consumer/survivors and the opportunity for meaningful participation in the

collaborative effort have powerful implications for self-determination and empowerment.

Care, support and encouragement have been found to play a strong role in validating the dignity of disadvantaged people (Miller & Keys, 2001). Consumers on the network said they were happy with the support they have received from the network on the issues they are most passionate about and also identified the values of respect and listening on the network as very important to their self-worth. These values validate the dignity of consumers and also help to address power inequities on the network (Lord & Church, 1998; Lord & Hutchison, 1993; Nelson et al., 2001). The strong support for issues consumers brought to the table has an implication for power-sharing, a value MacGillivary and Nelson (1998) found to be significantly related to successful partnerships involving consumer/survivors.

Another participant, a professional who sought to play down the question, said she felt gratitude for the personal recognition she had gained for her work on the network. She also said the network has brought her good feelings and "self-integration" between the activist and professional parts of herself. In his conceptual framework for community partnerships, Krogh (1998) proposed that collective projects lead to personal transformation. As this study demonstrated, personal transformation occurs in both community members and people with disabilities. Other participants indicated that they have gained personal growth and development in various ways. This came through working with other people with different perspectives. Members had shared experiences, built collaborative

capacities and developed positive attitudes towards other people and therefore related to them in better ways. Overall they were now better endowed as individuals than before they came into the partnership. This outcome was indicative that some of the capacities identified by Foster-Fishman and her colleagues (2001) as necessary for building a partnership may actually develop from partnering with others. The capacity to collaborate, attitudes and motivation for collaborative capacity, relational capacity and access to member capacity has developed naturally in members of the HWSHCN through active participation.

The procedures and processes at both the network and subcommittee levels provided learning opportunities for people (Lord & Hutchison, 1993). People had learned new perspectives from other people with whom they worked. Participants also claimed that working together brought about improvements in inter-agency cooperation and support. Collaborative work on joint projects had enhanced the capabilities of the individuals involved. Participation in the network also encouraged selflessness in the members. This appeared to have resulted from the goodwill that people brought into the process. The experience of the HWSHCN showed that people were able to work through the difficulties presented initially because they came in with a fair amount of goodwill. Moreover, the goals for which they came together did not encourage self-seeking.

The organizational level. Participants in the study said that increased networking among member agencies has significantly improved services to people with mental illness who live in the community. The improvements were attributed to collaboration and cooperation among the member agencies. This

finding conforms with Krogh's (1998) "conceptual frame work for community partnerships" which holds that collective projects lead to broader social change. According to the people who participated in the research, people are now referred to services they need with greater ease because agencies have direct connections with each other. One member saw the network as a mosaic of several little partnerships because member agencies worked collaboratively on various joint projects outside the network. This finding has an implication for the expansion of organizational capacity (Foster Fishman et al., 2001). This is indicative that the positive outcomes of partnerships flow in two ways. As people and agencies partner to work together on projects, the positive outcomes do not remain restricted to the joint project; learnings from it further enrich the member organizations and enhance their capabilities.

The community level. The network has enhanced the capacity of the community agencies to relate to the larger environment. Increased networking has not only improved services but has also improved the speed with which services are offered to people with mental health problems. Although obtaining proof of this claim is beyond the scope of this study, such improvements have implications for well-being since it is less stressful to access services that are easily accessible. Improvements in social services have implications for the strengthening of communities (Wandersman et al., 1996).

Further, participants claimed that housing for people with mental illness, which is the main focus of the network, has improved dramatically in the City of Hamilton. The new projects undertaken by the HWSHCN under Phase I of the

homelessness initiative have increased housing availability for people with mental health problems in the community. Participants in the research observed that this has eased the pressure in homeless shelters in the community lending credence to the findings of Schutt and Garrett (1992) that people with serious mental illness form a significant proportion of the homeless.

According to participants, housing units under the supported housing concept offer improved services to consumers (Parkinson et al., 1999). They said that people living in these housing units are not only provided with such supports as case management and 24-hour crisis intervention but are, as a matter of policy and practice, allowed to decide what services they need and when they need them. This claim was confirmed by residents of the housing units whom I interviewed in the main research project, the "Evaluation of Supported Housing in Ontario." They hinted that although support is available to them whenever they needed, they have control over which services they want to use. Participants in the consumers' focus group described the kinds of services provided as designed to increase residents' self-worth, invigorate them and give them hope.

Participants in this research were also in agreement that even the bureaucrats on the network had become less bureaucratic in their relationships with them. This was perhaps one of the most interesting outcomes people alluded to in the interviews and focus group discussions. As I talked to people, I noticed how important it was for them to be members of the network and why everybody wanted to be part of it. They seemed to share a sense of power, the power of self-determination and the power to change things in their community.

Himmelman (2001) defined community empowerment as an increase in its capacity to control resources and expand self-determination. According to one of the participants:

> *"When people hear of this network and the amount of clout it has, they want to be part of it." (Support service-providers' focus group)*

The above quote suggests that the power of self-determination can be derived from membership of an active all embracing partnership. The perception of power was also evident in discussions with the consumer focus group in which participants expressed the belief that the network had and must use the power to take the government up on issues about which they felt very strongly.

Based on Zimmerman's (2000, as cited in Wolff, 2001b) definition of an empowered community as "one that initiates efforts to improve the community, responds to threats to the quality of life and provides opportunities for citizen participation" (p. 168), there is evidence of community empowerment from the activities of the HWSHCN. The partnership was initiated by members of the Hamilton-Wentworth community to improve the quality of life for one of the most disadvantaged populations within their community. By opening its doors to agencies and groups that are interested in the issues around housing for people with serious mental illness and creating more opportunities for participation through its working committees, the HWHSCN has greatly empowered the community.

Besides these impacts, the network has built considerable social capital in the community. The people and institutions involved in the network have

developed strong bonds of active interconnections (Cohen & Prusak, 2001) that enable them to easily provide or access support for themselves, their organizations or the people they serve. The bonds of active interconnections, shared values, mutual trust and understanding on the partnership have enhanced commitment to each other (Coleman, 1969 as cited in Baron et al., 2000). Further, the interconnectedness has increased people's sense of belonging and of community. Members of the network have therefore come to relate to each other more like family and show lots of interest in what is happening in the lives of other members. It was amazing listening to members discuss with a consumer his up-coming vacation with the keen interest one would expect from family members just before one network meeting.

Relationships Between State and Community Partners

Actual Relationships

Relationships between the state and the community partners have been excellent in terms of support and information sharing. Support has come from the Hamilton-Wentworth DHC and the Regional Psychiatric Program (RPP) in the form of staffing, office and meeting space. This has been very crucial for the sustenance of the network and is consistent with Wolff's (2001b) assertion that staffed coalitions have greater chances of success compared to unstaffed coalitions. The importance of these resources is underscored by the decision of the network to dissolve following the departure of the staff person who had been assisting with office duties. These supports from the state have been very helpful

to the HWSHCN for coordinating the work of its working committees, organizing meetings and conducting community consultation.

Access to such valuable resources as information has been identified as very important to the success of community partnerships (Kurland & Zeder, 2001). Information sharing between the community partners and the government has been helpful both ways in terms of communicating new ideas for programs from the network to policy makers and in return enhancing government's access to projects for monitoring purposes. Participants said that information government representatives brought to the table has helped guide the partnership to operate within policy and procedural guidelines in order to further access or retain existing financial support from the state. According to a key informant representing the government, the network's surveys and community consultation reports are being reviewed in a new housing policy formulation process. Thus the relationship could be described as symbiotic and beneficial for both government and the community partners.

Besides the benefits of this symbiotic relationship I have observed government representatives make helpful contributions at network meetings. Government representation could therefore be characterized as additional human resources that further enriched the partnership in terms of ideas and experience. This is consistent with MacGillivary and Nelson's (1998) finding that involving multiple stakeholder groups is beneficial to partnerships. Government representatives are also community members who are capable of contributing to its development. There is a general tendency to forget that a government official

actually wears two hats at the table; one as a state representative and the other as a community member. From my field observation, I could see that government representatives who have stayed on the network for longer periods are gradually slipping into the roles of concerned community-members because they are becoming used to the faces around the table. For the HWSHCN, although there have been recent changes of government representation, the relationships are warming up and people are already talking about how "great" it is to have them around. Naturally getting to know people personally puts a human face on bureaucracy. According to participants face-to-face meetings with government representatives have enhanced dealings between their agencies and government departments.

Ideal relationships

Participants were of the view that state representatives should have the power to allocate resources to facilitate programs. Politicians whose duty it is to allocate resources would totally disagree with this proposition, but the principles of social justice suggest that the community should have a greater say in shaping its future (Nelson et al., 2001). It is also most democratic for communities to be allowed to decide their priorities in utilizing budgetary allocations to sectors within them, especially when they present united fronts.

Participants were also of the view that state representatives should participate more actively without taking over the partnership. This brings into sharp focus the need for clearer role definition at the onset of partnerships (Boudreau, 1991). Active participation by state representatives is, however,

desirable because it can be helpful in reducing feelings of isolation and suspicion that has characterized relationships between consumers and government (Church, 1996). One may, however, argue that a laid back attitude would rather reduce the effect of the usual power differentials that exist between state representatives and community partners (Lord & Church, 1998).

Current Mental Health Housing Policy

Features. The current 10-year plan for mental health reform in Ontario has deinstitutionalization as its main focus. Under deinstitutionalization people released from mental institutions are to be housed and provided with needed support in the community. The policy identifies supported housing, local authority housing, rent-geared income housing, non-profit housing, private market rental, family homes transitional housing, emergency shelters and private for-profit accommodation as the types of housing to be utilized for people released from the institutions (Ontario Ministry of Health, 1993).

Careful analysis of the types of housing earmarked to be utilized in the deinstitutionalization process reveals a continuum of housing type including custodial, supportive, and supported housing. By implication, the policy recognizes that people differ in the level of support they require to live within the community and also the need to provide people with supports based on their individual competence level.

Private for-profit housing and special care homes typically provide custodial care for people with the least levels of competence. The reason for maintaining such facilities is the belief that some people need assistance to cope

with most everyday living activities. Although this was supported by members of the consumers' focus group, it is questionable because it leaves individuals housed in this type of housing out of rehabilitation efforts. With regards to individuals with higher levels of competence who need monitoring and peer support, the policy provides supportive housing for meeting their needs. Supportive housing in mainly group homes and transitional houses, however, fails to provide the privacy and independence that people often desire. Human beings are gregarious by nature and although everyone likes companionship, people prefer to have some privacy at certain times. People housed in this type of housing need to be given greater independence as they progressively acquire the skills for everyday living from the rehabilitation programs and ultimately moved to supported housing (Carling, 1995; Nelson et al., 1995).

The provision of supported housing under the current policy represents progress in housing reforms since the early 1990s (Ontario Ministry of Health, 1993). Supported housing gives consumers greater freedom including the right to choose both housing and services of their preference. The Mental Health Reform Implementation Guidelines for Housing and Support Services (Ontario Ministry of Health, 1994) clearly states that:

> *"A person's security of tenure will not be affected by his or her decision to accept or decline the supports offered." (p. 15)*

By this statement, the policy showed a clear break from past mental health policy in ensuring that consumers have greater independence in their daily lives.

Consumer independence, according to Carling's (1995) concept of supported housing, encourages self-help and promotes empowerment.

The policy also for the first time recognized the importance of active consumer and family member participation in planning and management of housing and support services. This provision ensures that people who use the service have a say not only in the kinds of services offered, but also in how they are offered. Consumer participation has been found by several studies to be a very empowering process (Lord & Hutchison, 1993; Lord & Church, 1998; MacGillivary & Nelson, 1998).

Further, the policy has a stated aim of creating an enabling environment to increase housing stability for consumers. It proposes to do this through increasing accessibility and affordability of housing, providing services that develop the necessary skills for independent community living and making services flexible to meet the changing needs of the consumer.

In addition, the policy provides legal protection of residents under the Landlord and Tenant Act, the Rent Control Act and the Rental Housing Protection Act. It further identifies a need for the consumers' security and safety and the importance of making services sensitive to such demographic differences as age, sex, sexual orientation and race.

The implementation guidelines for housing and support services further assign roles and responsibilities to the local, regional and provincial governments under the reform. At the provincial level, the Ministries of Housing and Health are to develop and distribute principles and guidelines for housing and support

services. They are further required by the policy to identify develop and coordinate strategies for increasing supported housing to enhance accessibility. Inherent in the policy is the two ministries' roles as funding organizations for projects under the reform.

At the regional level, the DHCs and Provincial Psychiatric Hospitals are assigned roles of identifying consumer needs for support services and developing priorities for supportive housing. The DHCs are required to establish regional plans for specialized and long-term treatment, integration of district mental health plans and the equitable distribution of resources among the institutions. This role gives the DHCs the task of harmonizing the regional health plans and ensuring a well-coordinated system of supports for the people with mental health problems who are living in the communities.

Partnerships. The policy provides for a limited partnership between housing-providers and support service-providers within the mental health sector in each community to be initiated by the DHCs (Ontario Ministry of Health, 1994). These partnerships are mainly to promote agreements between the agencies and the hospitals on housing and support services to harmonize the two aspects of the services. The DHCs are further required to set up the forums for consulting consumers and family members to determine needs and ensure their inputs in the planning of the housing and services to promote user-friendly access and referral services.

Policy implementation. Implementation of the reforms has been very slow until the devolution of housing to the municipalities in 1998. This has combined

government funding with private non-profit initiatives in the development of supported housing under the two phases of the Homelessness Initiative. Housing-providers have worked in partnership with support service-providers in communities across the province.

In Hamilton, the HWSHCN has conducted surveys to determine consumers' housing needs, clarified the concept of supported housing and led the implementation of the Homelessness initiative in the district. Its member agencies have collaborated in developing supported housing units under the HOMES project. The housing agencies as required under the terms of the funding have formed separate partnerships with service-providers creating what one participant described as "many little partnerships."

The policy, however, did not envisage the kind of broad-based partnership of the HWHSCN, which has brought together practically all the players in the mental health sector, including the government. This has actually demonstrated how much progress could be made through comprehensive community partnerships.

In contrast to the housing crisis that characterized in the period from 1993 to 1999, the current homelessness initiatives have led to dramatic improvements in housing and restored hope to the housing sector as a whole. According to ONPHA (2002), the local Homelessness Initiative has taken people off the streets and placed them in affordable housing. The success of the initiative is, however, limited since homelessness still remains a major national problem in Canada (The Toronto Report Card on Homelessness, 2000). The effects of the

long years of neglect are yet to be reversed and this can only be achieved through sustained and concerted effort.

Policy and state involvement in the HWSHCN. State involvement in the HWSHCN at the three levels of government is in line with the mental health reform policy guideline (Ontario Ministry of Health, 1994). Although the HWSHCN has benefited from high-level government participation it terms of the representation and number of government agencies involved, control has remained in the hands of the community partners. This relationship sets a very good example of how government can partner with community groups for development without controlling them.

Conclusion

This case study was designed to find out what brought the various groups in the HWSHCN together in a community partnership for improving mental health services. It further aimed at analyzing public policy on housing for people with mental illness and its influence in the emergence of the community partnership. As well the research intended to analyze the relationship between the state and the community partners to determine how well they have worked together and how the relationships can be improved.

To find answers to these questions, I studied the Hamilton-Wentworth Supported Housing Coordination Network by gathering information directly from participants in the partnership through interviews, from documents and through participant observation. I endeavored to identify what motivated the people who initiated the process, what brought the partners together, what values kept them

together and how they related and worked together. I further reviewed and analyzed public policy on mental health housing in relationship with the HWSHCN.

Based on the findings of this study, I conclude that people come together to form community partnerships for several reasons. These include a desire for change, responsiveness to community needs, good will, concern for people with disabilities, reaction to mounting problems in a specific sector of the community (Coe, 1998; Lord & Church, 1998, MacGillivary & Nelson, 1998; Nelson et al., 2001; Wolff, 2001a). Consistent with resource mobilization theory (Jenkins, 1983; Morris & Mueller, 1992, both cited in Nelson et al., 2001), changes in government policy that created opportunities for community participation served as an impetus for organizing for change. Many people joined the process because the network provided them the opportunity to make a difference in their community. Good leadership, shared values of mutual respect, decent communication, listening and respect for human dignity, external support and success kept the group together.

Like all other human institutions, the HWSHCN has faced a few challenges, the most daunting of which was a clash of values with the Residential Care Association. The experience according to a participant has served to strengthen the resolve of the other members. These difficulties notwithstanding, the network has made several impacts in the community by successfully introducing supported housing model to the mental health housing system in the Hamilton-Wentworth district. According to a key informant, taking both new units

(154) and previously existing housing that have been converted to the supported model into consideration, the network's efforts have increased supported housing units in the Hamilton-Wentworth community from 49 to about 450 between 1999 and 2002. The network has also promoted networking and collaboration among mental health service agencies and through that developed social capital within the community. According to Putnam (1995) social capital is very important for the wellbeing of communities. The enthusiasm of participants in the process and the "good feelings" they reported about involvement is indicative of empowerment for both consumers and the community as a whole.

Government policy for homeless people with serious mental illness has been progressively nudged towards supported housing by activists. As a result, there is slow movement towards this model and although the situation still leaves much to be desired, these positive developments are very encouraging. Participants also said they have observed significant reduction in homelessness in the community. Needless to say, homelessness is still an issue in the city, according to participants.

Although the design of this study does not permit generalization, the results nonetheless suggest that community partnerships offer much hope for eliminating problems associated with social service systems. The findings of this research therefore have positive implications for social services in general and are of particular importance to housing for low-income families, people with disabilities and other disadvantaged groups.

The strength of community partnerships derives from the widespread support they enjoy from community members. Besides making marked improvements to services of interest, people have found it rewarding to get involved and get connected to other members of their communities. This research is just one little contribution to a vast area of which we need greater understanding. It, however, has heuristic value of raising awareness and generating more research in the area.

Recommendations

The findings of this research indicate that community partnerships are empowering and effective ways for enhancing social service delivery. Based on the findings therefore I recommend that such professionals as community psychologists and social workers who work among communities should always endeavor to promote partnerships among the communities in which they work. For community psychologists in particular, partnerships offer the promise of extending the intervention to the whole community rather than restricting it to the population of interest. The empowerment that comes to the community as a whole provides a fertile environment for the gains of their individual programs to develop and take root.

I further recommend that at the beginning of a community partnership participating organizations should endeavour to clarify the roles of the partners. It would be very helpful if members negotiate the issues around their different interests and expectations during consultations before proceeding. This way, the partners can avoid the sort of role confusions that occurred in HWSHCN.

Partnerships should prepare guiding documents based on a collective understanding of the relationships and processes to be employed, the roles of members and the outcomes they expect at the very beginning.

Non-profit and for-profit groups can work cooperatively on projects especially where services of the two sides tend to be complementary rather than competitive. Partnerships are supposed to provide mutual advantage and meet the needs and expectations of all their members. And it is incumbent upon the leaders to ensure that it is possible for all groups involved to realize their expectations.

It is very important to have government participation in community partnerships (Kurland & Zeder, 2001). Being the main source of funding for social services, the state is an interested party in community processes. Its participation is therefore very necessary to ensure that needed resources are at the disposal of community partners.

Limitations of this Study

Twenty-nine people were expected to participate in this research. Of this number only 17 took part in the study. Small sample sizes reduce the validity of traditional research studies. In the case of qualitative research, however, the depth gained from collecting data from few but varied and very rich sources adequately compensates for the lack of breadth in small samples (Patton, 2002). In this research I obtained data not only from the interviews and focus groups, but also from documents and field notes to give the needed breadth. This allowed triangulation, which enhanced the credibility of the data.

The research did not include information from supported housing residents that could be treated as an outcome measure for assessing the quality of the services the network has helped to develop. I had to rely on statements made by participants and internal evaluation reports to infer the quality of the services. Here again, the consistency brought out by triangulation makes me confident of the accuracy of the statements on the outcomes, and this is adequate by all standards.

Being a case study, a partnership was identified and studied. There was no random sampling of groups or partnerships for study. The study was restricted to one partnership and therefore its transferability to other settings must be considered very cautiously. This limits my ability to make general statements about partnerships from my findings. According to Berkowitz (2001), partnerships that are selected for studies of this nature may not be representative of the universe of partnerships. This does not, however, devalue the findings of this study because an important factor of qualitative research is to identify a rich case for study to give in-depth understanding of the phenomenon under study. Besides, Berkowitz (2001) further noted that the universe of partnerships is not well defined and also that the outcomes of partnerships may vary over time. Like all other human organizations, a partnership may have ups and downs and its true outcome would be an aggregation over a long period, even if possible its life duration. This affects the reliability of judgements based on a one time study of this nature. For this reason a longitudinal research over a longer period would have been more desirable, time permitting.

Challenges I Met in This Research

The steering committee for my research was unable to meet together as a group. I therefore had to send information to the project advisors individually and receive their comments and suggestions separately. Due to this, I lost the advantages of the interactive method used by steering committees.

The consumer I invited to be a member of the steering committee declined after a long thought because he believed he didn't have the qualification and understanding to be helpful. I tried my best to make him understand how helpful he could be with his personal experience and understanding of the problem, the setting and the network but he insisted and I had to respect his decision. This left only three project advisors. I therefore lost the contribution of one of the most important groups on the committee. Fortunately, however, the individual agreed to be consulted on issues whenever necessary. I took him up on this offer and he made a substantial input in the study by helping to organize the consumer focus group.

Since the HWSHC meets quarterly, I attended five meetings in all from May 2001 to April 2002. Although my presence in the setting enabled me to study the participants in a natural setting and I collected a lot of data, it was not sufficient for me to gain as much in-depth understanding of the setting as I would have liked to. I was, however, able to supplement the data through involvement in the larger evaluation project, which took me to supported housing units in Hamilton on 10 more occasions to interview residents.

Some people who had been on the network and could have shared rich information were unavailable for interview. They had either moved to new positions at new locations or were too busy to participate in the research. Among these were a government official who was part of the network from the beginning, a representative of the Residential Care Association who seemed unwilling to share his experience on the network. I found it very regrettable that no representative of the Residential Care Association agreed to an interview because information from that group would have given me greater insight into the most challenging problems of the network and also balanced the information collected which was one-sided in that respect.

At one focus group meeting, my attempts to probe for depth caused irritation to one of the participants. This person reacted very sharply saying,

> *"I don't see this network as a partnership. And about this question of partnering with the government, we can beat this horse till it is dead, you can't get anything from me because you have me for only ten more minutes."*

This nearly marred the whole discussion but I managed to control the situation by moving on to a new topic. This most regretted incident may have sensitized me to excessive probing and probably reduced the depth of information I could have collected

Areas for Future Research.

Partnerships like any other social groupings take on lives of their own and therefore experience ups and downs (Berkowitz, 2001). The true and representative story of a partnership will be an aggregation over a considerable

period of time rather than a one-shot study when the opportunity presents itself. It will be interesting to conduct a longitudinal study of the HWSHCN. I believe that would promote greater understanding of community partnerships.

A study of people who initiate partnerships to identify what outstanding characteristics make them more likely than others to initiate organization for change will also be interesting. Studying these "movers" of people in society will give us an insight into the motivations and cues that cause them to say "it's time to get up and do something about the situation! Let's do it now!"

It will also be very interesting to study partnerships between for-profit and not-for-profit agencies in social service delivery. The experience of the HWSHCN clearly demonstrated that the sharp contrast between the values of the two types of organizations makes collaboration very difficult. It is my belief, however, that a thorough research will be able to identify ways in which for-profit and not-for-profit agencies can successfully work in collaboration.

A focus on partnerships that didn't survive for long strikes me as having the potential to reveal factors that militate against the formation of community partnerships and help avoid or eliminate them to pave the way for successful partnerships.

Appendix 1

Letter to Participants

Dear Participant,

My name is Jonathan Lomotey. I am a candidate for a Master of Arts (M.A.) degree in Community Psychology at Wilfrid Laurier University in Waterloo, Ontario. By this letter, I wish to invite you to participate in a case study of the Hamilton-Wentworth Supported Housing Coordination Network (HWSHCN). I am conducting this research under the supervision of Geoff Nelson (Ph.D.), for my thesis in partial fulfillment of the requirements for the M.A. degree. The study, which has been approved by the Wilfrid Laurier University Research Ethics Board, will form part of an on-going evaluation of supported housing projects in Ontario. The topic of my study is partnerships in social service delivery and it is titled, "Partnership in Social Service Delivery: A Case Study of the Hamilton-Wentworth Supported Housing Coordination Network." The aim of this study is to find out what brought the organizations and groups involved in the HWSHCN partnership together to work on the supported housing initiative. I will also look for factors that facilitate the partnership, its challenges and the role of government in community partnerships. I will gather information through key informant interviews, focus group discussions, document review and field notes for analysis. The findings will help the creation of successful partnerships for social service delivery.

Participation in this research will involve an interview or a focus group discussion. You will be requested to talk about your involvement in the

partnership, your expectations of the partnership, the actual outcomes of the partnership from your perspective, the role of government in it, the challenges it has faced and how they were resolved. I have a copy of the interview guide that I will use for the interview. Besides the above issues, I will welcome any further information or insights that you have regarding the HWSHCN partnership. Each interview or focus group discussion will be tape-recorded and will last for about an hour and a half. I will also take notes during the interview/focus group discussion. Your participation in this research is purely voluntary. Also, please be aware that you can choose not to respond to certain questions. Further, I will send you a copy of the interview transcript for you to correct or edict as you see fit.

You will be asked to talk about your experiences with the HWSHCN partnership. This is expected to be positive and there is very little chance that it will cause you any discomfort. The research will provide you an opportunity to share your experiences of the HWSHCN partnership with others. It will also attempt to address concerns of participating groups regarding the operations of the partnership and will also help in building knowledge about partnerships for social service delivery to enhance efforts to understand and find solutions to the numerous problems facing humanity through collaborative effort.

I will like to assure you that whatever information you provide in this interview/focus group discussion will be treated as strictly confidential and will be used only for the purposes of this research. For this purpose, only my thesis advisor and I will have access to the tapes and transcripts of the interviews and

focus group discussions. The tapes will be thoroughly erased after transcription and the transcripts will be kept under lock and key in my office to be shredded after I have compiled the results.

Your anonymity is assured and if I wish to quote any statements you make in the final report, your name will not be linked with them, and I will seek your consent first. Your participation in this research is completely voluntary and you have the right to refuse to respond to any question you feel uncomfortable with, or completely withdraw from the research at any time without any sanction. If this happens, data collected before your withdrawal will be completely destroyed and no part of it will be used in the research.

At the end of the research, I will give you feedback by sharing my findings with you either by sending you a summary of the results or having a feedback session with you. The final report will be printed, bound, and submitted to the Faculty of Graduate Studies, Wilfrid Laurier University. A version of the report will also be published in a community psychology journal as a way sharing the findings with other people.

Please if you have any questions or comments kindly contact me at the Department of Psychology, Wilfrid Laurier University, Wilfrid Laurier University, 75 University Avenue, Waterloo, Ontario, N2L 3C5. Tel. (519) 884-0170, ext. 2987 or (519) 880-9055. E-mail: lomo1578@mach1.wlu.ca. You may also contact my thesis advisor, Geoff Nelson (Ph.D.) at extension 3314. Also, if you should experience any problems after the interview, I will advise that you contact me, or contact the research office at extension 3171 immediately for assistance.

Also if you have any ethical issues regarding this research, contact Dr. Bill Marr, chair of the Research Ethics Board at Wilfrid Laurier University at (519) 884-0710, Ext. 2468.

Please if you agree to participate in this research, give your consent for participation by completing and signing the form attached, and return it to me in the enclosed return envelope. Thank you so much for your time.

Yours truly,

Jonathan Lomotey, M.A. Candidate

Community Psychology Program

Wilfrid Laurier University

Appendix 2

WILFRID LAURIER UNIVERSITY RESEARCH ETHICS CONSENT FORM

Title of Research: Partnership in Social Service Delivery: A case study of the Hamilton-Wentworth Supported Housing Coordination Network.

Researcher: Jonathan Lomotey - Candidate for M.A. in Community Psychology

Thesis Advisor: Geoffery Nelson (Ph.D.)

CONSENT FORM

Please acknowledge receiving and reading this information, and give your consent for participating in this research by completing this form. To ensure your anonymity, this consent form and the data collected in the research will be stored separately.

(Please circle "yes" or "no.")

I have read and understood the information provided in the letter attached.

Yes No

I agree to voluntarily participate in this research.

Yes No

I agree to have the interview tape-recorded.

Yes No

Please send me a copy of the summary result at the end of the study.

Yes No

Comments:

_____

_____

_____

Name of Participant_____

Signature_____ Date_____

Researcher's signature_____ Date received_____

Appendix 3

Key Informant Interview Guide

Main Question: What is the story of the partnership?

1. Who are the partners and how did they come together to work on the homelessness initiative?

- When was it initiated?
- Who are the partners?
- How was the partnership initiated?
- What brought them together?
- How have they worked together?

2. What are the relationships among the partners?

- How have the partners worked together?
- How do the partners relate to each other?
- What values are important to the partnership?
- What principles guide relationships in the partnership?

3. What were the challenges faced by the partnership?

- What challenges has the partnership experienced?
- How were they resolved?
- What do you think needs to be improved upon?

4. What are the outcomes of the partnership?

- What were the outcomes expected for your group?
- What were the partners' role expectations of one another?

- In what ways has the partnership been successful?
- What benefits have you gained as an individual involved in this project?

5. What relationship exists between the State and the Community Partners?

- How is the state involved in the operations of the partnership?
- What is the relationship between the State and Community partners?
- How has this relationship facilitated or hindered the partnership?
- What is the nature of housing policy for homeless people?
- What policies need to be initiated to facilitate housing for homeless people?

Appendix 4

Policy-Makers Interview Guide

Main Question: How did the housing initiative come into being and what role has the state played in the partnership?

1. How did the housing initiative come into being?

- What is the nature of housing policy for homeless people?
- How did the state get into partnership with the community partners?
- What is the role of the state in the partnership?

2. What would be the ideal relationship between the state and the community partners?

- What are the state's expectations of the partnership?
- What role should the state play in it?

3. What is the relationship between the state and the community partners?

- What has actually been the relationship between the state and community partners?
- In what ways has partnering with the community been successful?
- What difficulties has the state encountered in this partnership?
- How were they resolved?
- What new policies need to be initiated to facilitate housing for homeless people?

Appendix 5

Focus Group Interview Guide

1. What is the partnership story?

- How did the partnership start?
- Who are your partners in this endeavour?
- How did your group get involved?
- What brought the groups together?

  - What objectives?

  - What values?

- How have you worked together as partners?
- What is the level of commitment among members?

2. What are the relationships among the partners?

- How do the partners relate to one another?
- How are decisions made in the partnership?
- Who controls of the processes of the partnership?
- What is the level of cooperation among members?
- What has been the quality of leadership in the partnership?
- What should the relationships ideally be?
- What needs to be done to make the actual relationships ideal?

3. What are the outcomes of the partnership?

- What were your expectations of the partnership?

  - Adequacy of housing units.

- Quality of service provided.
- Benefits to your group.
- Personal independence (for consumers).
- Satisfaction with housing and services.

- Have these expectations been met?
- What are the actual outcomes of the partnership?
  - Adequacy of housing units.
  - Quality of service provided.
  - Benefits to your group.
  - Personal independence (for consumers only).
  - Satisfaction with housing and services.
- What needs to be improved upon to realize the ideal outcomes suggested?

5. What challenges has the partnership faced?

- What are the challenges regarding relationships in the partnership?
- What are the challenges regarding leadership?
- What are the challenges regarding funding?
- What are the challenges regarding partnering with people with disabilities and family members (professionals and staff)?
- How were these challenges resolved?
- What were the lessons from these challenges?
- What needs to be done to prevent recurrence of such problems?

6. What is the relationship between the state and the community partners?

- What is the role of the state in the partnership?
- How has the relationship between the state and community partners been?
- What should be the ideal relationship between the two?
- What is the nature of housing policy for homeless people?
- What new policies need to be initiated to facilitate housing?

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