

**COLLABORATING ON HOMELESSNESS IN NEW WESTMINSTER BC:
ENHANCING COMMUNITY COHESIVENESS AND STREAMLINING SOCIAL
SERVICES TO ADDRESS CHRONIC HOMELESSNESS IN NEW WESTMINSTER,
BRITISH COLUMBIA**

by

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Abstract

This research is a community-based research study of a multiagency collaboration pilot project designed to improve outcomes for clients with high and complex needs who are currently unhoused or at risk of losing their housing. A group of community-based social agencies developed and piloted the collaborative outreach and support model for one year. The objective was to find out if working collaboratively would help streamline services and improve outcomes for these clients. Six out of ten clients completed the pilot program and have remained in long term housing with significant psychosocial improvements. Interviews with front-line staff and managers reveal that the collaborative project helped improve their sense of community and interagency communication, resulting in better outcomes for service recipients. The initiative demonstrates the effectiveness of consensus-based, community-driven collaboration in cultivating a better sense of community among social service workers.

Preface

This thesis is based upon a pilot project conducted by the New Westminster Homelessness Coalition (NWHC) between June 2009 and June 2010 in the City of New Westminster, in partnership with the School of Social Work, University of British Columbia (UBC).

The project development process outlined in Chapter 1 resulted from collaboration between me, Lynda Fletcher-Gordon, M.S.W. and Executive Director of the Purpose Society and Lorrie Wasyliw, Executive Director of W.I.N.G.S. and chair of the NWHC Services Sub-Committee, with input from members of the Services Sub-Committee. Lynda and I also co-presented material based on this thesis at the 2009 Annual BC Social Work Association Fall Conference. There was no conference proceedings published. All of the writings and figures were authored and completed by me, with editing support of the above mentioned collaborators.

Ethics approval was obtained from UBC's Behavioural Research Ethics Board for social science research as the study involved health service providers and clients. The approval the Certificate Number of the Ethics Certificate is H09-02930.

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Finally, I wish to express my gratitude to my family, friends and colleagues for their help and support, especially my mother Miriam Eguchi for her incredible support, particularly with academic writing and childcare.

Dedication

I dedicate this thesis to my children, Tyler and Kaylen Win, my mother, Miriam Eguchi and my late father Paul K. Eguchi.

1. Introduction

Given the number of factors contributing to the persistent problem of homelessness in North America, there is an increasing recognition of the importance of collaboration among those involved with different dimensions of homelessness. Despite this recognition, there is a paucity of research examining community-driven efforts to deliver collaborative services to unhoused individuals. The study presented in this paper was conducted in partnership with a community coalition consisting of organizations that provide direct services to people who are unhoused or at risk of losing their housing in the suburban community of New Westminster, British Columbia.

New Westminster is a small city; it is a suburb of Vancouver, British Columbia, with a population just under 60,000 (Statistics Canada, 2006). The city is part of a much larger urban context, with a large proportion of its population working in Vancouver. The population consists mostly of blue-collar working families with an average income just under \$30,000. About 70% of the population is Caucasian, with various Asian and mixed ethnic groups constituting the remainder. According to the 2008 Homeless Count (Metro Vancouver), 124 people were found to be unhoused in this city, a 35% increase since the last count in 2005.

The New Westminster Homelessness Coalition began to develop a collaborative framework and the blueprints of a one year pilot project in February 2009. The planning process involved staff members and managers from member agencies of the Coalition. As a practicum student from the Metro Vancouver Steering Committee on Homelessness, I agreed to assist with the development and implementation of the pilot project. We also formed an agreement that I would provide research support for the project, which will form the basis for

my Master's thesis for University of British Columbia (UBC) School Of Social Work. I therefore had a dual role of a project facilitator and academic researcher. I worked on formulating my research question during the process of assisting the New Westminster Homelessness Coalition with the development of the collaboration pilot project. Although the greatest need for unhoused clients was identified as housing, it was agreed that the objective of the pilot project was to support clients with high needs who require intensive interventions by a number of services and put into effect a model of integrated service delivery by participating agencies. (New Westminster Homelessness Coalition, 2009). The Coalition was also interested in developing a model of collaboration that was sustainable and that would lay the foundation for future collaborative projects.

The pilot project began enrolling clients in June 2009, with the goal of providing integrated services to ten clients. Shortly after the launch of the pilot project, I began conducting interviews with key project members for the purpose of collecting data for my master's thesis. I also regularly reviewed publicly available documents associated with the collaboration project. The New Westminster Homelessness Coalition and I jointly developed a client progress inventory for the purpose of measuring outcomes for the pilot project. These inventories were completed by case workers at intake and after one year to assess client progress over the pilot time frame. The purpose of this case study research was to document the process by which community agencies developed and implemented a collaborative framework (Chapter 2); and the perceived successes, drawbacks and community development benefits from the perspective of the service providers involved in the project (Chapter 3). My research question for my thesis is: What is the potential of

collaboration for improving the working relationship between organizations in the community?

The fact that a researcher is perceived as an insider by the community did raise some questions. I was viewed as having some interest in seeing the project succeed since I helped develop the project. In addition, some coalition members felt that only interviewing staff and managers involved in the project might result in everyone's praising the program they helped develop. To address this concern, I explained to key stakeholders at a New Westminster Homelessness Coalition meeting and Services Sub-Committee meeting that my research would function as an ongoing tool to help improve the program by identifying both its strengths and shortcomings. It was further clarified that the research findings and input from front line staff would be documented and reflected on the ongoing planning process. My master's thesis research was formulated and conducted through consultation with New Westminster Homelessness Coalition, and the feedback collected was shared at their monthly meetings in order to address barriers and continue to improve upon the collaboration process.

I begin with the conceptual context of the project, including statistical and demographic information and the scope of homelessness in the City of New Westminster. I will then elaborate on theories of homelessness, complex trauma and community development. Previous research and collaboration projects in other contexts will be reviewed, and gaps in the literature will be discussed. The project development and implementation process will be chronicled, by which community agencies negotiated a partnership and developed an integrated service model to deal with homelessness, a highly visible community issue. This will be followed by a description of the methods that were used to collect and analyze quantitative and qualitative data relating both to ongoing feedback from project team

members and to client outcomes. The quantitative results will be presented as project outcomes, followed by a qualitative thematic analysis and discussion. The implications and limitations of the project will be explored, concluding with recommendations for project improvement and future research.

Throughout this thesis, I will use the term "homelessness" to not only indicate the narrow dictionary definition of "people that are living without a home" (Webster's New World College Dictionary, 2010) but also encompassing a societal problem of inadequate access to housing in our society. The term "unhoused" will be used to describe a situation in which a person lacks regular access to housing. While the Webster's Revised Unabridged Dictionary (1913) simply defines 'unhoused' as "driven from a house"; many scholars prefer the term "unhoused" over 'homelessness,' as the latter has liberal Western connotations of a deficit in an individual rather than society (Finley & Diversi, 2009; O'Neill, 2010; Scanlon & Adlam, 2008).

1.1 Context

According to the 2008 Metro Vancouver Homeless Count, 2,592 individuals were found to be unhoused in Greater Vancouver, which is a 19% increase compared to 2005. While many studies and media attention are focused on inner city neighborhoods of large urban centers, little is known about homelessness in suburban cities. Gaining insight into the needs and challenges of a smaller suburban city is important since there are many such cities that have a substantial unhoused population but receive very little public and political attention.

1.1.1 Demographics

New Westminster is a small city; a suburb of Vancouver, British Columbia with a population just under 60,000 (Statistics Canada, 2006). The city is part of a much larger urban area, with a large proportion of its population working in Vancouver. The population is mostly composed of blue-collar working families with an average income just under \$30,000. About 70% of the population is Caucasian, with various Asian and mixed ethnic groups constituting the remainder. Based on the 2008 Homeless Count (Metro Vancouver), 124 people were found to be unhoused in this city, which is a 35% increase since the last count in 2005. Men comprised the majority (74%) of the unhoused, and over a quarter (27%) of the unhoused reported having aboriginal identity. In addition, 76% were between the ages of 25 and 44 years; 76% lived alone; 48% had been unhoused for a year or longer; 61% reported an addiction problem; and 33% reported a mental illness. A range of reasons were cited for being homeless; the number one reason cited was lack of income (25%), followed by the high cost of housing (19%) and addiction problems (17%). (Metro Vancouver Homeless Count, 2008)

1.1.2 Factors Contributing to Homelessness in New Westminster

The main factors contributing to homelessness in New Westminster are the high percentage of blue collar workers, the relatively low wage rate and the rising costs of accommodation. The city is being redeveloped rapidly with many new condominiums going up near the city centre, driving the rental prices up and reducing the number of units available for rental. The team of local social service agencies, which includes the emergency shelter, outreach workers, income assistance office and employment services, have been

relatively successful in helping people who have become unhoused suddenly due to unexpected circumstances. Based on interviews with front line service agency staff, most of the individuals who are temporarily homeless are connected rapidly to temporary (or permanent disability assistance) and housed within a month or two with some supports in place. But many of the chronically unhoused individuals have fallen repeatedly through the cracks. The reasons cited by the agencies for this include not wanting help, dislike of rules and conditions of service, repeatedly missing appointments, failing to follow through on plans, and unpredictable or aggressive behavior. At the same time, many front line workers noted that services are not accessible to many of their clients, due to long waitlists, restricted hours or locations that are difficult to access, refusing clients with addictions, or imposing certain behavioral or compliance expectations rather than meeting clients where they are at. While the mental health team works closely with the emergency shelter and transitional housing staff to care for persons diagnosed with serious mental illness, some people refuse to be seen by a mental health specialist and therefore do not have a diagnosis. Some people have a diagnosis, but refuse the suggested medication scheme. Concurrent Disorders is an emerging field of practice within Fraser Health, but in reality there is a lack of services for people with a dual diagnosis of substance abuse and mental illness. There is no sobering centre or detox facility within the community, and there is often a long wait and conditions of a period of sobriety to enter programs in neighbouring communities. These considerations suggest that organizations dealing with homelessness cannot thrive or survive if they do not relate to others whose jurisdiction and concerns affect the problem (Hesselbein & Whitehead, 2000).

1.1.3 The New Westminster Homelessness Coalition

The New Westminster Homelessness Coalition was founded in 2003. Its membership includes over 20 social service agencies, government agencies and politicians located in the city (For a list of agencies, see Appendix E). The coalition is co-chaired by the Community Services Manager of Lookout Emergency Aid Society and the Executive Director of Seniors Services Society. They have been meeting for nearly 10 years to address the service needs of those who are currently unhoused or at risk of losing their housing in the city. Over the years, they have developed a good working relationship with each other around homelessness through meetings and planning events such as the annual Homelessness Action Week. On average, fifteen agencies are represented at each meeting, and there are three active sub-committees, including the services sub-committee, Homelessness Action Week sub-committee and the governance and advocacy sub-committee. The collaboration project was spearheaded by the services sub-committee.

1.1.4 Emergency Shelters and Housing for Unhoused Individuals

At the beginning of the pilot project, the city had 63 emergency shelter beds, comprising 29 beds serving men only, 14 beds for families with children, 10 beds for single women and 10 for women and children fleeing abuse (City of New Westminster, 2009). There were 23 units of transitional supportive housing at the beginning of the project; but during the project four new supported housing developments have been completed in New Westminster, boosting the total number of supported housing units to 134. This includes 15 units for provincial and federal offenders on conditional release to the community (Ministry of Housing and Social Development, 2010), and 27 units of transitional housing for women and

children who are unhoused or at risk of becoming so. As housing plays a large role in the psychosocial well-being of persons experiencing homelessness (Coldwell & Bender, 2007; Muir, et. al, 2008), the increased availability of housing in the community likely boosted the positive psychosocial outcomes of many of the clients served by the community collaboration pilot project. While this may be a confounding factor in my thesis, the fact that collaboration clients got priority access to housing still speaks to the overall positive outcomes of the collaboration project.

1.2 Theoretical Perspectives

This section outlines the theories I used to develop the practice framework and principles of the collaboration pilot project and the research question for my thesis.

1.2.1 Theories of Homelessness

People who have fallen through the cracks of our “social system” live on the street without a home, food or basic necessities, in an environment that is often harsh, violent and degrading. There has been wide debate over what constitutes poverty and homelessness, and "homelessness" is defined in several ways. It was important for me to consider the definition of homelessness and the conceptual framework in which the New Westminster agencies delivered their service in order to formulate the theoretical framework for my thesis. What are the theories that guide the practice of the participating agencies, and how do they locate themselves in the greater social services community? The social construction of homelessness from the perspective of service providers affects how they perceive themselves

in relation to their clients, the power differential, and their social location in relation to the larger community.

The various attempts to define homelessness come mainly from government bodies and large social service organizations funded by the government that provide services to marginalized individuals. These definitions and understanding of homelessness become part of the general understanding of homelessness and shape the way smaller social service providers provide their services. For example, a 2008 report by the Parliamentary Research Branch conceptualized homelessness as a spectrum from absolute homelessness, defined as having no roof over one's head, to relative homelessness, which entails living in unsafe, overcrowded or unstable housing (Echenberg & Jensen, 2008). Scholars such as Fiedler, Schuurman & Hyndman (2006) point out that there is another category called the hidden homeless, which refers to people living in shelters and cars or staying at friends' homes, which is a population group that is particularly difficult to identify. For the purposes of the 2008 homeless count, the Metro Vancouver Regional Steering Committee on Homelessness identified individuals as 'homeless' if they "did not have a place of their own where they could expect to stay for more than 30 days and for which they paid rent" (Metro Vancouver, 2008). Lower income and fixed income Canadians, as well as renters, female lone-parent families, seniors, immigrants and Aboriginal households are particularly vulnerable to precarious housing situations and homelessness (Canada Mortgage and Housing Corporation, 2009). There is a general consensus in recent literature that those who end up on the streets are society's most marginalized and vulnerable, many of whom have a longstanding history of poverty, trauma, broken families, pain and addictions that go all the way back to their childhood (Masuda & Crabtree, 2010).

Although the belief that homelessness is caused by a character flaw or moral weakness still persists in some circles, there has been a gradual shift in thinking. This is reflected in the literature that conceptualizes homelessness as part of a societal process of social and material marginalization, rather than the shortcomings or disease of an individual (Buchanan, 2000; Dench, Gavron & Young, 2006; McNaughton, 2008). The societal process of marginalization is underpinned by structural forces such as capitalism, neo-liberalism and colonialism, which have become so entrenched in modern society that they are invisible to those who enjoy the privileges of such a process (Babones, 2009). Yet the most marginalized citizens in society are perpetually vulnerable to the forces that cause extreme poverty and human deprivation, referred to by some scholars as structural violence (Farmer, 2005). There is a large body of literature that demonstrates the link between marginalized social status with poverty, childhood abuse and neglect, family breakdown, interpersonal violence, trauma and addictions, all of which contribute to a person's risk of homelessness (Farley, Lynne & Cotton, 2005; Gaetz, 2010; Malos & Hague, 1997; McCreary Centre Society, 2002; North & Smith, 1992; Ryan, et.al., 2000). Furthermore, power differentials within households and the greater community will determine the likelihood of family conflict and violence, who the abuser is, and potential access to alternative housing (Novac, 2006). Given the power differentials across gender lines, women are more vulnerable than men to violence at home and on the street, and First Nations women are particularly at risk (Miller & Du Mont, 2000).

Canada has a history of investment in social housing; but the supply has decreased dramatically since 1993, when the government underwent a neo-liberal restructuring (Klein & Copas, 2010). The steady decline in affordable housing and the cutbacks to the welfare system have produced dramatic inequalities in housing, and have given rise to an epidemic of

homelessness across Canada. Despite the increasing visibility of homelessness on our streets, few ordinary citizens seem to think that they play a part in this problem. Most middle class citizens see their social status as a norm that everyone should experience, rather than entitlements and dominance granted to them by society, which must be maintained through the disadvantaging of others (Black & Stone, 2005; Kluegel and Smith 1986;). Black and Stone argue that this normative thinking results in the framing of social inequality as a failure on the part of disadvantaged groups to achieve the norm. This belief is underpinned by the myth of meritocracy, a belief that our society distributes resources in a fair manner according to the hard work and merit of individuals (McNamee & Miller, 2004). Based on this belief, the poor have earned their exclusion and oppression because of some personal defect, and that they could regain society's privileges if they tried hard enough and become more like the privileged group. The onus to fix the problem of homelessness is therefore placed on the individuals with the perceived deficits and social services agencies that are funded through 'public generosity' to help them. This tendency to view social problems as removed from their own reality is reinforced by the belief that the wealth accumulated through a capitalist free market will trickle down to the poor, raising everyone's standard of living (Seabrook, 2002). The numbers, however, tell a different story: the gap between the rich and the poor is widening (Ivanova, 2009), and homelessness is rising dramatically across Canada. Nationally, between 150,000-300,000 Canadians are considered homeless, which includes people sleeping outside, in their cars, on their friend's sofa, and staying in shelters (Canada Mortgage and Housing Corporation, 2009; Hulchanski, 2009).

The housing markets are an important domain in which structural violence is exercised, playing a significant role in the distribution of wealth and exercise of power relations (Dunn

& Hayes, 2000). These forces are infused in existing social hierarchies and operate virtually unnoticed and unquestioned, but their devastating consequences are in plain sight. The unhoused population has the highest rate of health complications and the highest mortality rate. Approximately 84% of the unhoused reported at least one health condition including addiction (61%), mental illness (33%) or physical disability (31%); and 53% indicated multiple health problems in 2008, a 47% increase compared to 2005 (Metro Vancouver, 2008). There is a significant body of research indicating that people without stable housing are at higher risk of suicide, accidental death and a multitude of illnesses ranging from seizures, liver and kidney disease, HIV/AIDS, Hepatitis C, chronic obstructive pulmonary disease, musculoskeletal disorders, diabetes, bronchitis, tuberculosis, and skin and foot diseases (Dent, et. al., 2003; Frankish, Hwang & Quantz, 2005; Hwang, et. al, 1997; Kushel, et. al, 2002; Wood, et. al, 1997). Unhoused people also face significant barriers that impede their access to health care (Frankish, Hwang & Quantz, 2005). Health conditions, including mental health and addictions, contribute to and are aggravated by living conditions. There is also a high likelihood of experiencing violence on the streets, as indicated by the high incidents of assaults on people who are unhoused (Homeless Count 2008). This is in addition to the extreme weather conditions, physical ailments, hunger and violence experienced by those on the street. As argued by Porter (2005), increasingly pervasive and severe poverty and homelessness among the most vulnerable and marginalized groups in Canada need to be acknowledged as a national human rights crisis.

1.2.2 Chronic Homelessness and Trauma Theory

Chronic homelessness is understood as a long-term condition in which a person does not have a stable housing situation, and has a long history of living outdoors or cycling in and out of shelters, hospitals, detox centres or jails (Willse, 2010). The United States Interagency Council on Homelessness defines a chronically ‘homeless person’ as: “An unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more or has had at least four episodes of homelessness in the past three years” (U.S. Department of Housing and Urban Development, 2010). In order to understand chronic homelessness and provide services to address it, it is important to understand the effects of trauma and social dislocation, and substance use as a coping mechanism. There is substantial evidence that the vast majority of people who are unhoused have experienced high levels of trauma both before and during their homelessness (Buhrich, Hodder & Teesson, 2000; Hopper, Bassuk & Olivet, 2010; Fitzpatrick, LaGory & Ritchey, 1999; Goodman, Saxe & Harvey, 1991; McNaughton, 2008). Goodman, Saxe and Harvey (1991) argue that the process of losing one’s housing is traumatic on its own, which includes the stress of losing a home, the circumstances leading to the loss of the home, the conditions of shelter life, and the increased risk of victimization on the streets.

I have repeatedly heard the terms “hard to house” and “hard to serve” being used by service providers across Metro Vancouver in reference to the chronically unhoused population. Hopper, Bassuk & Olivet (2010) argue that the perceived helplessness, resistance to help or inability to follow through with housing and treatment plans are a classic avoidance response for people with PTSD, especially after experiencing prolonged exposure to chronic stress and traumatic events. Many people who are unhoused have been

marginalized throughout their lives and have experienced multiple traumatic incidents both historically and through the loss of their housing. Continual exposure to trauma and chronic stress is linked to damage to this limbic system, which is connected to emotions and memory, as well as to the prefrontal cortex, which is linked to planning and decision making (Perry, et. al., 1995). Exposure to extreme and repeated stress may have irreversible effects on the development of the endocrine systems and central nervous system (Charmandari, Tsigos & Chrousos, 2005; Pervanidou, 2008). PTSD is also linked with higher cortisol levels, higher urinary adrenaline levels and higher dopamine and noradrenalin levels (Pervanidou, 2008). Previous exposure to trauma makes a person more vulnerable to subsequent traumatic events throughout the life course, and the risk of psychiatric impairment increases with the number and severity of traumatic events (Breslau, Chilcoat, Kessler, & Davis, 1999). These changes in the brain make it more difficult for a person to navigate the complicated social welfare system, application forms, appointments at different locations, various conditions for service, especially when they contribute to further stress and re-traumatization. The efforts of a client to avoid this stress and re-traumatization are often interpreted as resistance to service, creating further barriers to access housing and social services.

In addition to biological changes, trauma also changes a person's cognitive patterns and self image. Prolonged exposure to physical and sexual abuse is linked with critical thoughts towards oneself, micro-suicidal injunctions and dissociative behaviours (Firestone & Firestone, 1998; Van der Kolk, Perry & Herman, 1991; Zlotnick et al., 1996). According to Object Relations theory, unsupportive, unstable or abusive environments can create negative inner models and beliefs leading to verbal self-attacks and a generally negative attitude towards self and others (Firestone & Firestone, 1998). This predisposes people to alienation,

addictive patterns, self harming behavior, carelessness with one's body and finally physical attacks on the self. Within this framework, drug and alcohol use, risky lifestyle choices, resistance to help and inability to follow through can all be conceptualized as a continuum of symptoms resulting from the harm to the mind and body caused by ongoing exposure to chronic and severe traumatic life experiences. There is a considerable body of research demonstrating that substance use (both alcohol and drugs) is a significant factor in precipitating and perpetuating homelessness (See for example Johnson, Freeks, Parsons, & Vangeest, 1997; McNaughton, 2008; Orwin, Scott, & Arieira, 2005; Tyler & Johnston, 2006; Van Der Poel & Van De Mheen, 2006; Warnes & Crane, 2006). But it is important to understand that substance use is inextricably linked to trauma and dislocation, and substance use and homelessness lead to further traumatization and dislocation (Hopper, Bassuk & Olivet, 2010). People who are chronically unhoused are often trapped in this perpetual cycle of trauma, dislocation and addictions, with increasingly negative social, physical and psychological outcomes.

These latest research findings suggest that the problem of homelessness cannot be solved without addressing the underlying trauma that is intricately linked with the experience of homelessness. Historically, services were provided to unhoused individuals without explicitly acknowledging or addressing the effects of trauma. While much of the current focus is on housing, there is an emerging trend among progressive service providers to explore ways to address the longer-term healing required by these individuals (Hopper, Bassuk & Olivet, 2010). Vikki Reynolds (2010), a scholar and activist in Vancouver, asserts that healing does not simply refer to addressing individual client's problems. Rather, healing lies in the process of locating individual problems within the social context of oppression,

and addressing these problems together with our clients, with our colleagues and organizations, and in the greater society.

Reynolds (2008) points to the prospective of front-line work as a form of activism, through collective resistance to societal violence. Front-line workers bear witness to the devastation of structural violence embodied both physically and psychologically by their clients. Reynolds argues that workers who maintain that they are non-political simply lack the awareness of their own access to power and are more likely to replicate the power relationships within our society that resulted in the marginalization of the clients they serve. Social justice is a collective responsibility that requires front-line workers to use their power to bring about change, both within the realm of service provision and in the wider society. The collaborative framework is not only a prime opportunity to educate service providers about the societal forces of marginalization and the effects of chronic suffering and trauma; it is an opportunity to bring together fellow workers in social justice activism.

1.2.3 Community Development

Since the beginning of the twentieth century, there have been a number of community development theories targeting communities that are considered to be marginalized (Eriksson, 2010). These theories involve processes designed to improve the lives of individuals or groups, and present opportunities for communities to learn, act and reflect. Community organization, popular education and participatory action research are examples of these theories. Not all community development theories address structural inequalities, since they have developed out of several different theoretical positions.

The idea of community development in the Western world was originally developed in the late 19th century by the Colonial governments in order to encourage local cooperation and self-help, but also to raise public support for government action (Mayo, 1975). The largely top-down model of community development driven by governments and outside experts persists today in many arenas (Midgley et al., 1986; Cook, 1993; Vasoo, 2008). In the 1960s, a more radical notion of community development emerged, with a focus on participation, empowerment and social justice (van der Veen, 2003; Eriksson, 2010). This more radical version of community development is closely aligned with radical social work theory, which emphasizes empowerment and self-organization of marginalized groups (Ferguson and Woodward, 2009; Mendes, 2009; Mullaly, 1997). There is a clearer focus on human rights and social equalities, with more focus on social conflict instead of cooperation and consensus (Eriksson, 2010; Mayo, 2008).

Homelessness is one facet of extreme poverty, and largely results from the same structural forces of neo-liberalism and the capitalist free market that perpetuate poverty in our society (Seabrook, 2002). Critical social work and community development theory seek to empower marginalized individuals and communities in order to address structures of inequality that maintain poverty (Mantle & Backwith, 2010). While community development aims to address structural inequalities, it is embedded within existing socio-political structures and may serve to reproduce the existing social orders (Payne, 2005). As argued by Mendes (2009), many programs today are based on working within the systems rather than challenging them. A community-based intervention must originate from the needs of the community, and develop the capacity of the community to solve their own problems, seeking to change the community rather than the marginalized individuals (Pierson, 2008). However,

with the increased influence of neoliberal governmental policies, community organizations have returned to a more conservative approach to community development based on cooperation rather than conflict (van der Veen, 2003). While participation and a bottom-up perspective are encouraged, the process is often prescribed and closely monitored by government bodies (Eriksson, 2010). While my thesis is premised on a bottom-up community development model, it was important to keep in mind that many of the organizations receive funding from government agencies and their activities may be monitored and restricted by such agencies.

1.2.4 Collaboration

Collaboration has been increasingly mentioned in government discourse as the key to increased effectiveness of service delivery to the unhoused population (Auditor General of Canada, 2005; Howarth, 2008; Metro Vancouver, 2009; Treasury Board of Canada Secretariat, 2006). The rhetoric is that community issues such as homelessness have multiple and interconnected causes and effects, requiring partnerships between all stakeholders to achieve better results and build resilient communities (Gajda, 2004). Proponents argue that by working together, scarce resources can be pooled, and duplication of services can be minimized. Many services for the unhoused in Metro Vancouver are delivered by not-for-profit organizations, many which are partially dependent on government funding (Metro Vancouver, 2009). With increased pressure from government agencies to provide integrated services, many communities have formed local tables around homelessness, with different degrees of participation by non-profit organizations, community activists, governmental agencies, politicians and business groups. While collaboration across the health, social

services and not-for-profit sectors makes sense on paper, organizational and philosophical differences have prevented major collaborative action in many communities (Cargo & Mercer, 2008) including New Westminster.

This thesis attempts to identify the unique strengths and needs of the community and to encourage further community development. This is based on the potential of community based research to address social justice and human rights concerns by creating conditions that empower people, organizations and communities to gain mastery over issues that impact the community (Cargo & Mercer, 2008; Rappaport, 1987). Community development that focuses on empowerment of community organizations may promote the success of collaborative partnerships through continual dialogue and shared decision making (Fawcett, et al., 1995). Zimmerman and Rappaport (1988) suggest that grass-roots community organizations are a good starting point for empowerment research.

While I am personally aligned with the more radical ideas of community development that start with the marginalized individuals and question the status quo, I was invited into a situation where community organizations already have a planning structure in place. The New Westminster Homelessness Coalition is a group of mostly not-for-profit community service providers, with no direct representation of unhoused people. The group was eager to explore ways to better develop services, and political action was not on the fore of the agenda. Although I entered the research partnership with the understanding that I would work with the existing structure of the coalition, I believe that working towards gradual change and empowering local grass roots organizations is a meaningful endeavour. My focus in this research, therefore, is on inter-organizational collaboration as a means to community development.

Definitions and understandings of collaboration vary greatly, and there is no one agreed-upon definition. A classic definition that fits the context of the New Westminster project is provided by Wood and Gray (1991, p146): “Collaboration occurs when a group of autonomous stakeholders of a problem domain engage in an interactive process, using shared rules, norms and structures, to act or decide on issues related to the domain.” I would also like to note Bruner’s 1991 definition of interdisciplinary collaboration as an interpersonal process that facilitates the realization of goals that are difficult to achieve when individual professionals act on their own. Bazzoli and colleagues (2003) suggest that voluntary participation in collaborative initiatives facilitates the creation of trust and social capital among partnering organizations. They also view collaboration as the foundation for the community to tackle larger projects (Sofaer et al. 2003).

The population referred to as “homeless” is a diverse group of people who have experienced sustained poverty and oppression, violence, trauma and multiple physical and mental health problems. Traditionally, this population has been underserved by government-run health and welfare systems due to factors such as stigma, lack of identification, hygiene issues and mistrust of the system. Most governmental services require extensive collection of personal information and have various criteria for qualifying for service, a factor that has been a major barrier to serving this community. Many not-for-profit agencies and religious organizations in New Westminster have attempted to fill this service disparity by providing minimum barrier services such as outreach, counseling, food and shelter. For many organizations, this task has been especially challenging due to underfunding, resource constraints and the lack of service delivery models for this population supported by relevant research.

1.3 Previous Research

A literature review was conducted on collaborative social service delivery models in order to identify best practices that might be a good fit for the New Westminster community, and to identify themes that will help frame the research question for this thesis. Many communities have found innovative ways to maximize their local knowledge and resources through collaboration (Boettcher, Jakes & Sigal, 2008; Mares & Rosenheck, 2010; McGraw, et. al, 2010; Muir, et. al., 2008; Zakocs & Guckenburg, 2007). While there is very little research on community driven collaborative frameworks for homelessness, there is a rich body of literature on successful, evidence-based community collaboration models.

Jones, Crook and Webb (2007) conducted a meta-analysis of seventy-one articles published between 2000 and 2004 to examine community collaboration in the provision of human services. While there were no definitive results that cut across all studies, they found that environmental factors, organizational differences and interpersonal dynamics played a large role in the success or failure of any collaborative effort.

I also surveyed more recent literature to identify themes that appear frequently across the studies. The following ingredients for success emerged across the: Leadership, good communication; building and maintaining trust among collaborators; the roles, policy and procedures are clear from the beginning; and having an agreed-upon external goal or mission (literature (Bailey & Koney, 2000; Boettcher, Jakes & Sigal, 2008; Bronstein, 2003; Foster-Fishman, et.al, 2001; Ferguson, 2004; Gajda, 2004; Greenberg & Rosenheck, 2010; Heath, 2007; Jones, Crook and Webb, 2007; Mizrahi. & Rosenthal, 2001; Muir, et.al, 2008; Roberts & O'Connor, 2008; Wood & Gray, 1991).

Because collaboration meant many different things to different communities, we wanted to narrow down our choices to a few tangible and well researched collaboration models that we could use as a blueprint for our community. One of the Canadian examples that attracted our attention was the Inter-agency Services Collaboration Project, known as the Storefront Model, in Scarborough, Ontario (Roberts & O'Connor, 2008). The Storefront is a multi-service resource centre that provides many community services and programs in a “high risk” neighbourhood. Established through a bottom-up community consultation process, it is operated and staffed through a collaborative framework of diverse agencies and volunteers from around the city.

The wraparound service delivery model is another widely documented collaborative service delivery model. It is a family and community-centered, strength-based case conferencing model used widely for at-risk children and youth (VanDenBerg & Grealish, 1996; Walker & Bruns, 2006). The wraparound involves a series of client-directed case conferences with a collaborative team consisting of a client’s formal and informal support systems (Sparks & Muro, 2009). A more intensive and structured wraparound model, such as Assertive Community Treatment (ACT) (Burns & Santos, 1995), is used for clients with severe mental illness. ACT has a significant track record in reducing homelessness and promoting mental health stability (Bond, Drake, Mueser, & Lattimer, 2001; Burns & Santos, 1995; Coldwell & Bender, 2007). Although New Westminster does not have the funding and resources to implement a full scale ACT model, the NWHC embraced the idea of a multiagency team providing collaborative outreach and wraparound case management targeting hard to house individuals. In their ACT community case study, Scheyett, Pettus-Davis and Cuddeback (2010) found that the presence of the ACT team had a

positive impact on the community service systems. We anticipated that by working collaboratively as a team, a similar effect might be achieved without implementing the full scale ACT model.

Another idea that appealed to the NWHC group was Project Homeless Connect (2009), which is a service delivery model that has been proven effective in eliminating barriers to housing, employment, education and various other areas that contribute to homelessness. A Homeless Connect event is a one-day event where organizers rent a large venue and invite local services to provide unhoused individuals and families with direct services and supplies, all in one location. Services provided include access to housing, medical treatment, mental health services, income support, employment counselling, identification documents, veterans and aboriginal affairs, and more. Participants can also receive clothing, comfort kit items, haircuts and a nutritious lunch. Project Homeless Connect was first implemented in San Francisco in 2004, and has since been replicated in communities across North America. It has been promoted across the lower mainland by the Regional Steering Committee on Homelessness (Metro Vancouver, 2009).

In terms of a research component to developing a community collaboration model, community-based participatory research (CBPR) (Jones & Wells, 2007) was identified as the preferred research method to evaluate a community program. This research involves an ongoing community consultation process used in CBPR within a case study framework (Baxter & Jack, 2008; Stake, 1995) to develop community based strategies and promote knowledge and power sharing across diverse community and academic partners (Jones & Wells).

1.3.1 Gaps in the Literature

Much of the current literature (Bailey & Koney, 2000; Boettcher, Jakes & Sigal, 2008; Ferguson, 2004; Greenberg & Rosenheck, 2010; Hesselbein & Whitehead, 2000; Mizrahi & Rosenthal, 2001; Muir, Fisher, Dadich & Abello, 2008, Roberts & O'Connor, 2008) focuses on large communities with access to funding and resources, with very little information that would be helpful to smaller communities with minimal resources. While many communities are in some stage of collaboration around homelessness, there are few scholarly articles published about them. Within the body of academic literature, there is very little mention of secondary benefits of collaboration that are not directly linked to identified goals. Most studies aim to measure improvement in mental health and housing, and client satisfaction of programs. Studies that mention the development of personal connections, the increased willingness of clients to engage in the treatment process, and the feeling of connectedness to the community seem to be limited in scope and do not offer rich qualitative insights. Another area often overlooked is the personal growth and job satisfaction of the staff members involved in the collaboration process. Further research is also needed on the training opportunities made possible by the collaboration effort, and what kind of training would be most beneficial for the staff. The degree of involvement of front-line staff in decision making is another dimension that has not been explored much in the literature. Based on these identified gaps in current literature, my case study aims to further our understanding of collaboration in a smaller community with minimum resources. Through semi-structured interviews, this study aims to explore the personal experiences of both staff and clients around collaboration. This information will be useful for other small communities considering similar collaboration models, and will add breadth to the existing literature.

2. Project Planning and Development

Since 2003, the New Westminster Homelessness Coalition has developed a good working relationship around homelessness. The meetings are mostly attended by managers and directors of agencies, and the main focus has been on discussing community issues; exchanging information; supporting member organizations in increasing programs and services to serve unhoused clients; and planning events such as the annual Homelessness Action Week. There has been considerable discussion over the years among coalition members about the fact that large numbers of individuals use various services within the community, many of which overlap. The New Westminster Homelessness Coalition Services sub-committee has identified collaboration between service providers as essential not only for addressing the problems of individuals, but also for bringing about positive changes in the community and government policies. The outcomes of the following project development process have been crystallized into the Collaboration Model document (New Westminster Homeless Coalition, 2009), which states the terms of reference and the agreed-upon process, and has been signed by the core participating agencies.

2.1 Identifying and Mapping Community Needs

This project came about as a result of a growing sense of frustration among NWHC members, as many agencies felt that they were providing more and more services only to see homelessness increase in their city. A special services subcommittee meeting was called in March 2009, inviting managers from all the major front-line agencies. The purpose of the meeting was to re-visit the group's priorities, review existing services and review the gaps identified in a 2005 consultant's report. After the initial meeting to identify the current

model of service delivery, a series of meetings was held to hammer out a model of collaboration that fit the needs of the community. Through the course of the planning process, front-line workers were also invited to the meetings to provide their valuable insight into the realities of service delivery.

2.1.1 Identifying the Current Model of Service Delivery

The meeting was co-chaired by Lorrie Wasyliv, the Executive Director of Monarch Place Transition House, and myself. I participated in the planning process in my capacity as a practicum student from the Regional Steering Committee on Homelessness, which provides support to all the homelessness planning tables across the lower mainland as needed. Neither of us was considered a stakeholder by other organizations in the New Westminster Homelessness Coalition, as we were not involved in providing direct services to the unhoused in New Westminster. We held a planning session in advance of the meeting to discuss strategies of facilitating a focused, targeted discussion. In particular, careful thought was put into group dynamics, organizational cultures, individual personalities and the political landscape of the group, since these factors could significantly influence the course and atmosphere of the meeting (Toseland & Rivas, 2005).

The meeting began with the co-chairs stating the mandate of the group, which was to reach a consensus on a resource centre model. The expected outcomes were discussed, followed by a brief historical summary of the various discussions leading up to this meeting. Even though most group members knew each other well, we still asked each of the group members to give a very brief self-introduction and state their expectations for the meeting. We then requested each attendee to list the services they provide and the space, facilities, staffing,

volunteers and hours for these services. We also asked service providers to locate their services on a map. Flipcharts were used to list these services, and this information was compiled into a conceptual map of how the community services currently operated, shown in Figure 1. The current model was named "rotating cluster of services," since there were clusters of services concentrated at several geographical locations, with the primary services, operating individually on different days and times. Service users had to navigate the system to figure out where to go in order to have a meal or access a service; many were going site to site to access whatever they could, as much as they could. Since they had no clear map of how to get all their needs met, service users were initiating similar processes at several different agencies, such as initiating a Disability application or BC Housing application at multiple locations.

Many agency managers acknowledged that it would be difficult for an unhoused person to keep track of what service they had initiated, and when and how to follow up. One of the front-line workers described this process as a revolving door phenomenon, in which her clients were "spinning their wheels and the services spinning their wheels." Another front-line worker noted that the current system was forcing the client to fit the system, like "making a square peg fit into a round hole." The group agreed that we needed to start from the perspective of the client, and that all services should be accessible from whatever agency door a client walks through. Any point of contact, therefore, would open the door to all existing services, and the client would have a choice of which front-line workers they wanted as their primary case manager. This would require some pooling of resources and a system of information sharing, as well as central coordination.

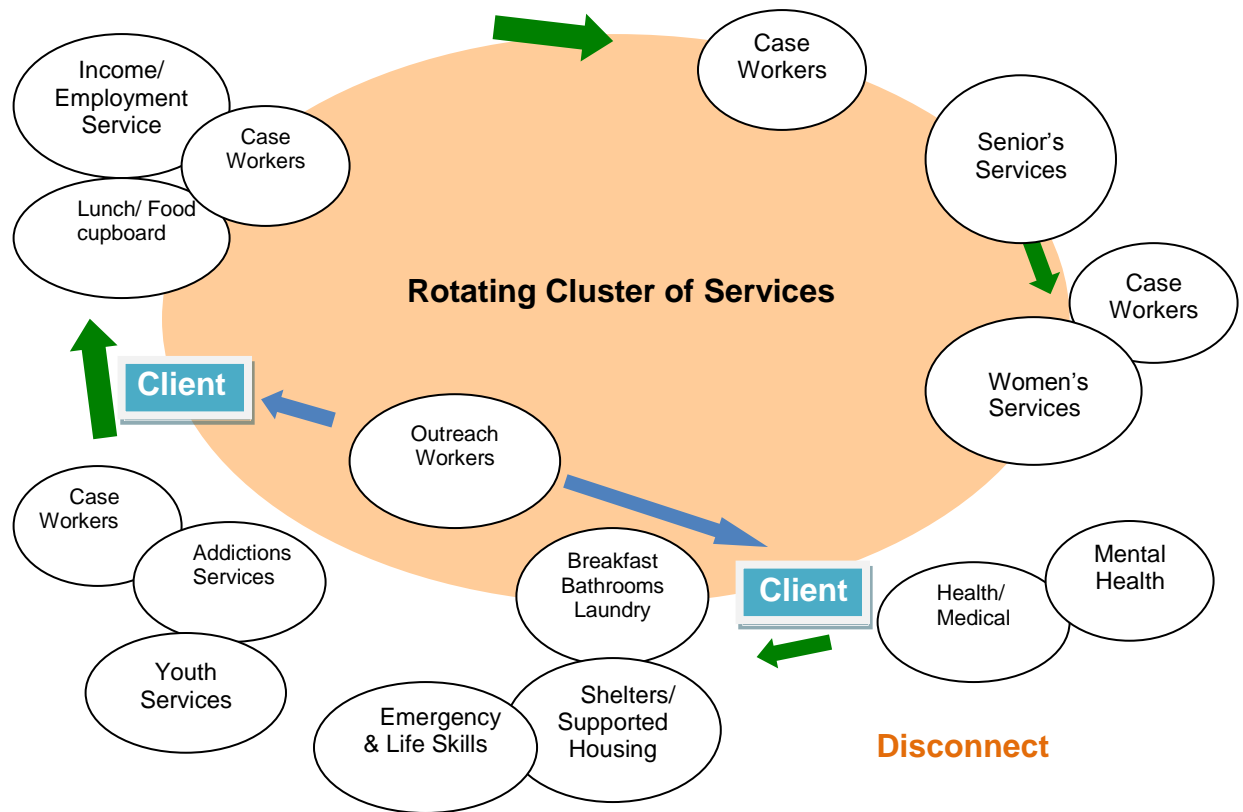


Figure 2.1 The Current Model: Rotating Cluster of Services

A couple of managers felt that services such as free meals, food banks and emergency assistance were not designed to get people off the street. Instead, they felt that they were helping their clients maintain life on the street, and that they were in “a vortex that endlessly required more and more resources without real results.” Many managers agreed that increasing the workload of front-line workers and allocating more resources into the current model was not the answer. Not everyone viewed their services as “maintaining people on the street”; however, everyone agreed that the current model was not sustainable for service providers and was insufficient in meeting the needs of service users. This mapping exercise gave everyone a good idea of where we were right now, and provided the group with a visual

tool that helped them to base their analysis and discussion on where they wanted to go from there.

2.1.2 Exploring a New Model of Service Delivery

The group then began exploring alternative models of service delivery in a whole community context. I asked the group the following questions:

- A. Can we improve on our current model?
- B. What are ways in which we can coordinate services or provide services collaboratively, and what can everyone contribute?
- C. If we choose to deliver services collaboratively, who will coordinate this effort?

The group agreed that there should be some sort of coordination between the different services offered in the community, and they began to develop some ideas about a model of community collaboration. To facilitate an informed discussion about various collaborative service delivery models, I researched different models from around North America and the world, and presented them to the Services subcommittee as outlined in the previous research section (Section 1.3).

One of the models that appealed to the group was the Project Homeless Connect (2009), a regularly scheduled event in which direct services are provided to unhoused individuals by multiple service providers in one location. Because the New Westminster Homeless Coalition had organized a Homeless Connect event during Homelessness Action Week (November 2008), the concept was familiar to all the group members. The group liked the idea of adapting this model to provide regular connect events more frequently out of different locations that were already providing some services to the unhoused population, such as local church meals. This would involve having agencies contribute their resources and staff on a

regular basis to provide one stop access to clients. While the one stop service delivery idea was appealing, the group felt that frequent connect events were not sustainable, and that services should be available every day. The Storefront model seemed ideal, as there is one permanent location that is open every day, and all the services could be accessed from this one location through collaborative service delivery. However, this was a large undertaking that did not seem feasible immediately. The New Westminster Homelessness Coalition had been in talks with the social planning department of the City of New Westminster and identifying a location for a resource centre was considered extremely difficult given the current political climate. Furthermore, the New Westminster Homelessness Coalition member agencies expressed that they were not ready to make such a large commitment of resources, since they felt understaffed and stretched already. Homeless Connect events were still seen as a good way to begin the collaborative process, since they would provide opportunities for front-line workers to work side by side, develop rapport and get to know each other's services.

Another idea that appealed to the group was the wrap-around service delivery model, since it was client centred and seemed relatively easy to implement. This approach seemed as if it would be the least burdensome to the agencies and staff, as the time commitment required for staff to attend meetings was minimal. Once the initial in-person case conference had taken place, the staff could work independently and work as a "virtual team" through regular telephone or email communication.

Consensus was reached on the new model, which combined a wrap-around type case conferencing model with weekly on-site direct service delivery by a team of front-line workers representing different agencies. It was further agreed that the structure, resources

and activities of the collaborative group would continue to evolve to meet the needs of the community without overwhelming its capacity. The new collaborative service delivery model envisioned by the group is depicted in Figure 2.

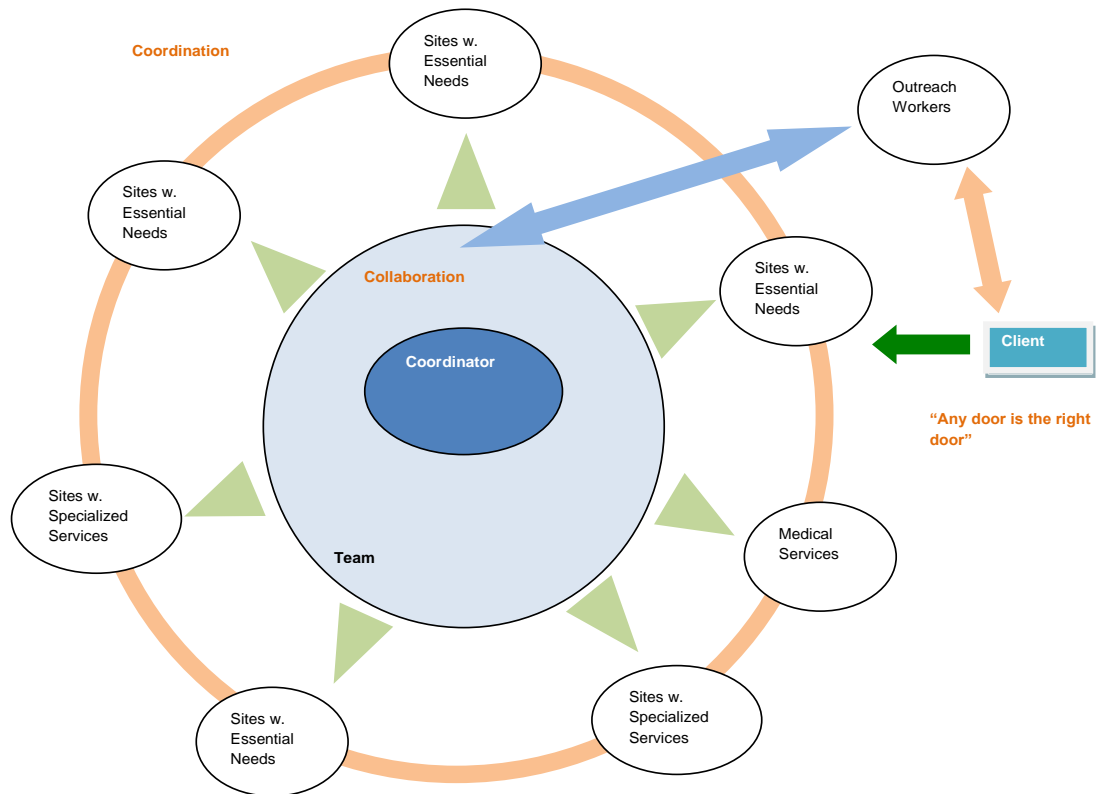


Figure 2.2 Graphic Representation of Collaboration Concept

2.2 Negotiating the Terms of Reference

Before hammering out the details of the collaborative service model, it was agreed that we needed to establish shared values and a clear objective. Through brainstorming and discussion, the following core values emerged and were agreed upon by all attendees:

- Honesty
- Safety & Security

- Client Centered
- Self Determination
- Empowerment
- Respect for the intrinsic worth and dignity of all persons
- Confidentiality and Privacy
- Incremental change (baby steps)
- Effectiveness
- Celebration
- Evidence-based and accountable practice

The objective of the project was defined as follows:

- To undertake a pilot project for supporting clients with high needs who require intensive interventions by a number of services, and put into effect a model of integrated service delivery by participating agencies. The initial number of clients will be about 10, but the number of clients may be adjusted over time, based on the staffing and resources available. The pilot period is 12 months, with a review after 6 months.
- To monitor and evaluate the outcomes for clients and agencies when all relevant agencies work together to achieve effective solutions using a wrap-around support & distributed site connect model.
- To identify, monitor/measure and record the barriers to integrated service delivery, and test possible solutions.
- To evaluate the outcomes for both clients and agencies involved in the pilot, based on evidence-based, measurable results; and to advocate for the need for systemic change.

(New Westminster Homelessness Coalition, 2009)

The desired outcomes for clients included improved access to services; more timely and better coordinated response from agencies needed to provide services to the clients; a decrease in the number of crises that occur; improved control of their own lives; improved

engagement with agencies and reducing the amount of services needed over time; and better quality of life across all domains, including housing, health, education, employment, financial management, and relationships. The desired outcomes for agencies that participate in the project included:

- Improvement in partnerships, collaboration and positive networking
- Increased understanding of the roles and capacities of other agencies
- Decrease in need for crisis management
- Increased learning from each other about what works well, creative responses, flexible approaches
- Improved referral outcomes
- A more consistent approach to service delivery
- Cost savings as a result of more effective use of resources
- Reduced stress and work load for staff

(New Westminster Homelessness Coalition, 2009)

2.2.1 Establishing the Working Model and Roles

The details of the working model of collaboration was discussed and accepted by participating agencies as elements that underpin collaboration. Participating agencies agreed to work together over 12 months to provide a range of support services to clients who were identified as chronically unhoused with multiple support needs. They also agreed to provide the required staffing to implement an integrated approach to service provision through joint case planning. It was agreed that priority would be given to the project so that staff could respond to each other's requests as soon as possible and the intervention would be timely.

The agencies agreed that for each client, the most appropriate person would be appointed to be the Primary Case Manager for that client. Where possible, the selection of the Primary

Case Manager would take into account: client preference; nature and extent of support required; skills / expertise required; and the existing case loads and availability of resources. In consideration of liability and accountability issues that may arise, it was agreed that only those team members who were covered by their employer's liability policy and had their employer's full consent may become a Primary Case Manager. The Primary Case Manager would be responsible for assembling a case management team for each client, calling case conferences and keeping other support agencies informed. Teams may include outreach workers, case workers, support staff of NWHC agencies and any volunteers or staff members from support agencies that entered into agreement with the NWHC. The agencies agreed to share the work load by ensuring that the role of Primary Case Manager was spread out evenly across participating agencies so that no one agency was overloaded. There was still great concern that this project would result in extra work for existing staff members. The quote below from one of the agency managers echoed the collective concern:

For other agencies, and for us to some extent, it is an issue of ok, we're taking someone off of other work to do this, right? We haven't acquired any new resources to say 'here you go, two more hours or four more hours a month, go to it.' So, for the most part it's people who are taken off of other work to do this, right? And the question is, 'is this the best use of their time?'

Based on these concerns, the nature of collaboration and the role of each participating agency was left to be identified on a case by case basis in order to keep the work of each worker in line with existing agency practices and procedures. In addition, it was decided that client files would be stored at the Primary Case Manager's office, and be kept strictly confidential, shared only with team members on a need to know basis.

It was agreed that a coordinator would be needed for overall planning, maintaining aggregate statistics and coordinating activities. The responsibilities of the coordinator were broken down into the following components:

- attend all NWHC Services Sub-Committee meetings;
- call team meetings and help assemble case management teams;
- monitor overall case loads, use of resources and training and support needs;
- coordinate regular connect events (sites & services);
- document client outcomes and track progress.

2.2.2 Protecting Client Rights

In consideration of the power differential between workers and clients, it was important to establish client rights and maintain a safe space for clients. This meant that all service providers would strive to provide a safe space to diverse clients, with particular safety considerations around gender, ethnicity, age, religious beliefs, sexual orientation and disability. This was explicitly included in the policy to ensure it had a central role in service planning. A common consent process had to be agreed upon by all participating agencies, to ensure that client' rights, confidentiality and privacy were protected. Privacy and confidentiality was the area of greatest concern for many agencies, who refused to participate until they were satisfied that the collaboration pilot project would adequately address their privacy and confidentiality concerns. One agency manager noted that they had clients “who have reasons not to let the government know where they are. So, that also creates a client trust issue.” Other agency managers expressed concerns about the possibility that sharing information about a client with a government agency might result in denial of eligibility, removal of services or penalties to agencies that were serving clients outside their program

mandate. The wording of the privacy and confidentiality policy and the consent form went through a number of revisions, based on input from several agencies.

The agencies agreed that before clients participated in the pilot project, it was important for them to be fully briefed about their right to choose whether or not they wish to participate, their right to freely withdraw from the program when they choose, their right to confidentiality and the limits to confidentiality. There was also consensus that clients should have the opportunity to participate fully in case conferences, and have a support person accompany them if they wish. Further, clients would have the right to view their file at any time and to request information to be added, and they may revoke any previous consent to service at any time. The agency managers also wanted to ensure that unintended consequences and risks to clients were thoroughly considered and identified as much as possible when referring a client, so that adequate precautions could be put in place. After much debate, it was agreed that the client would be treated as the client of the lead agency, which would assume liability for clients assigned to them as per their agency policy. The wording was added to the confidentiality policy that agencies should share client information only on a need to know basis.

Another area identified as a central issue by one of the participating agencies was to uphold the clients' right to make their own choices about responses to their needs, and to ensure that clients were well-informed about the choices available to them. The following was identified as the process to ensure that clients do not feel coerced into agreeing to the pilot project in order to receive the services they need.

- Clients will be provided with appropriate information about available options, the multiagency approach to providing support, the pilot project, and how data will be collected, stored and used.

- The client has a choice not to participate in the full program, and may choose not to sign the release for information. Clients are still entitled to any basic services available, and may select specific parties with whom they choose to share information. Signing any consent form is not a precondition to receiving food, hygiene, clothing, shelter, housing, medical services or any other services which do not normally require a release. Consent for service must be signed to participate in the case management program.
- Support will be offered in accessing any options offered.

A client handbook was developed to explain clearly the above client rights and the complaints process. Moreover, participating agencies agreed that access, entry and eligibility procedures would be flexible enough to address the presenting needs of clients seeking housing, especially clients with multiple support needs.

2.2.3 Intake Assessment and Review

To reduce redundancy, participating agencies would agree to accept information from an intake assessment completed by another NWHC agency and to build on that assessment as needed. If necessary, agencies will communicate with each other to update assessment information through an agreed process. It was recognized that assessment is an ongoing process and reviews will be conducted regularly as agreed upon by participating agencies. Reviews would also include feedback regarding the collaborative approach to service delivery and suggestions for improvements. It was agreed that items for review would be documented by individual workers and discussed during research interviews and Services Sub-Committee meetings. If any participating agency was unable to meet the required

support needs, this would also be documented so that evidence could be gathered about demand and unmet need.

2.2.4 Withdrawal of Service

The possibility of agencies withdrawing their services to a client was discussed, and it was agreed that any withdrawal of services should be discussed with participating agencies and the client before it occurs. Due to the united front approach of the collaboration team, there was great concern that the withdrawal of one service may jeopardize client trust of other agencies involved. Potential reasons for withdrawal of services were discussed, including: non-participation by client; services no longer required by client; agency believes it no longer has a role in providing services to a particular client; or unacceptable level of risk to workers or other clients. Participating agencies pledged to make every effort to provide support as long as needed, and to give adequate notice of withdrawing their service. It was further agreed that consideration would be given to the impact on other participating NWHC agencies before any withdrawal of services by an individual agency, and all agencies involved would be notified if a client declines an ongoing service. Furthermore, it was established that there would be no “burned bridges,” and that services would be open to a client seeking access in the future. All service providers agreed that if a service was discontinued, they would support the client in accessing other services or provide them with an appropriate referral, and would inform the client of their right to seek services in the future.

2.2.5 Referral and Criteria for Participation

It was agreed that the first criteria to qualify for referral to the pilot project would be that an individual was unhoused or at risk of losing their housing. Participants also needed to understand that this was a time-limited project (12 months), and agree to be part of the more intensive case management approach of this project. Priority would be given to those who are already involved with or require multiple service systems, or anyone in the community who has a history of disengagement from mainstream services. The members of the New Westminster Homelessness Coalition would be responsible for identifying clients from a range of member agencies to be part of this project. A multi-agency referral form with the list of all of the participating agencies was developed, as well as a client progress inventory, and these would serve adequately as the only paperwork required to address issues around client consent, confidentiality and consistency in tracking progress.

2.2.6 Ongoing Review and Evaluation

As a mechanism for review and evaluation of the pilot program, the partnership arrangement between NWHC and University of British Columbia (UBC)'s School of Social Work was discussed. I agreed to help facilitate the project, engage project members in ongoing evaluation and produce a final report of project results while collecting interview data for my Master's thesis.

Front-line workers were encouraged to discuss among themselves and keep notes on what they felt was working or not working and what needed modifying. Member agencies committed to regularly reviewing project data and front-line worker feedback by making the integrated service delivery a standing agenda item for services subcommittee meetings. This

enabled the regular collection of feedback and data, especially in relation to client outcomes, agency participation, unmet need and the impact of the collaborative support approach on agencies and clients. It was agreed that the effectiveness of the coordinated support approach would be reviewed quarterly and documented. The front-line workers agreed to seek and record client feedback regarding the effectiveness of the approach. A client progress inventory would be used at the beginning of service to record baseline information, and at the end of the service to record progress. Care must be taken to ensure that any data shared with external sources must be in the form of aggregate data or anonymous stories, without any personal or identifying information.

The action component of participatory action research was discussed, and it was agreed that the information brought forth from the front-line workers would be used in planning services. The outcomes of the pilot project would be presented to government agencies and potential funders for partnerships, funding and broader implementation.

2.3 Implementation

The terms of reference and necessary documents were completed in late 2008, in close consultation with community agencies. Five agencies initially signed on as primary partners: Lookout Emergency Aid Society, Seniors Services Society, Lower Mainland Purpose Society, Union Gospel Mission and the Hospitality Project. Several other community organizations expressed interest and agreed to provide peripheral support, but chose not to make a commitment at that time. Several local churches agreed to support the project by providing space and volunteers for the project at their community meals, including Holy Trinity Cathedral, Shiloh Sixth Avenue Church and St. Barnabas Church. Representatives

from the Income Assistance Office and Fraser Health indicated support for the project but did not sign on formally at the time. One of the staff members involved in the discussion noted that there would be a lengthy bureaucratic process for a health authority to sign on to such a project, and that it would be better to engage in such a process after a track record had been established.

The official launch of the project was held on June 4, 2009, with an inter-agency team of six front-line workers visiting a church breakfast and mingling with potential clients. The team agreed to begin their work at a community breakfast offered by a local church. The staff met 15 minutes in advance to do a check in with each other. Before the meal began, the team was introduced to the crowd, along with a brief overview of the project. Six workers, an agency manager and the coordinator attended the meal, with at least one worker representing each agency. The goal for the day was to announce the program and start working as a group, building relationships with other workers and community members, and get a feel of what services were working and what else we needed in the community. Staff were reminded not to share any client information until informed consent took place, but were encouraged to refer colleagues based on who could best help an individual. Several agencies gave away hygiene kits, blankets and other items to contribute to the event. A space was set up in the corner of the breakfast room as the home base for the team, and team members approached potential clients while they ate breakfast, to socialize and find out their needs. The staff kept track of how many people the team spoke to, and noted the general demographic information and trends about the clientele, but did not collect personal information. The staff set aside half an hour after the meal to debrief. All the staff felt that

the launch went well, and agreed to continue with the same service delivery format for the time being.

The team continued to visit different community meals once or twice a week on a rotational schedule, and provided services in the same format as the first session until 10 clients were signed on to the pilot project. During this time, they developed relationships, and assisted many unhoused individuals and individuals at risk of homelessness, regardless of whether they signed up for the pilot project. They also generated interest and momentum in the community.

The team held monthly meetings to discuss individual cases and the project. The services sub-committee was put in charge of steering and supervising the front-line collaborative team, in coordination with the team leader appointed by the sub-committee. In addition to the outreach and direct service component, the services sub-committee continued to work on developing community partnerships with other service providers, businesses and public sector stakeholders. During the pilot project, the collaborative team provided outreach and integrated case management services to individuals, known to many of the services, who were considered the most difficult to house.

3. Research and Program Evaluation

A case study is an in-depth investigation/study of a single individual, group, incident, or community (Shepard & Greene, 2003, p. 22). Case studies have become increasingly popular in the social sciences (Baxter & Jack, 2008; George & Bennett, 2005) as scholars are becoming progressively more critical of the heavy reliance on quantitative research. Baxter and Jack argue that case studies complement quantitative research by providing in-depth information about a particular program and context. The themes identified in this study, combined with previous studies, will increase the depth of the information available, and may provide valuable insight when designing new programs. This research will therefore be valuable for social work practitioners who are engaged in community development, as well as those who wish to improve interagency cooperation to better serve their casework clients.

My intention for this research was to assess the potential of collaboration for improving the working relationship between organizations in the community by drawing from and building on the latest body of research on community based collaborative projects. In order to do this, I first had to define what is meant by collaboration in this research and outline the process of developing and implementing a model of collaboration tailored to the needs of this particular community. Furthermore, my aim was to identify secondary benefits of collaboration that are often missed in results-oriented research. My ongoing involvement in facilitating collaboration through the New Westminster Homelessness Coalition provided me with the unique insider perspective of a social worker engaged in the collaboration process. I had access to insights and information that may not be available to an outside researcher, and I was in a position to readily engage the community in a community-based research process. While my position as an “insider” may be perceived as a conflict of interest, I am not an

employee or have any financial or other stakes in any of the agencies involved in the project. While I believe that discussing shared values and exploring collaboration is positive for the community, I have no vested interest in a “successful” outcome, since the results are mostly not tangible. If there were any problems in the course of the process, I would be interested in documenting the factors that contributed to a poor outcome. I believe that information about what did not work and what contributed to poor program outcomes is equally useful for the academic community and service organizations.

3.1 Methods for Project Evaluation

The methods used for project documentation and evaluation included in-depth interviews of selected informants, a focus group, a Client Progress Inventory (survey) to track client progress before and after the one year pilot project, field notes and a review of publically available documents related to the collaboration project, such as reports, publications and organizational websites. Since this research was designed up as a community based research, feedback and data was collected from participating agencies on an ongoing basis in order to continually evaluate the program. Before I began the research, I obtained a letter of permission from the New Westminster Homeless Coalition to engage in research with their members.

3.1.1 Client Progress Inventory

The Client Progress Inventory (Appendix E) was developed based on input from front-line workers about what kinds of progress and milestones they expected from the process. Workers noted that the process of building relationships and trust was often a slow process

which is difficult to measure as a tangible “progress.” There was a marked scarcity of tools available in scholarly journals to measure the psychosocial reintegration into society for unhoused persons with multiple service needs. An in-depth discussion with front line workers and managers about what constitutes progress resulted in the identification of three potential areas of progress: relationship building, overall health including physical and mental health and addictions, and life skills. After reviewing available scales, the NWHC Client Progress Inventory was developed by adapting the Homeless Engagement and Acceptance Scale (Park et. al, 2002); Community Living Scale (Smith & Ford, 1990); and the Life Skills Inventory (Washington State Department of Social and Health Services 2000).

There are many well established instruments for measuring improvements in life skills and community living skills (Dickerson, 1997; Patterson, Goldman, McKibbin, 2001; Wallace, Liberman, Tauber et al., 2000), but there are important differences between a housed mental health client and a chronically unhoused individual. The scales developed for mental health clients assumes that the client already has a good relationship with their service providers, is cooperative with the treatment plan and aspires to integrate into society. Those who have been chronically unhoused are often labelled ‘resistant’ because they are difficult to engage in services, and traditional measures of community integration may show very little success (Park, et. al, 2002). These individuals often have a history of being severely marginalized by the social services system, and do not trust the system.

In their pilot study, Park and colleagues found that the 3 month HEAS score is a significant predictor of service outcome at 12 months. Since its development in 2002, the Homeless Engagement and Acceptance Scale has been widely used and has demonstrated good psychometric properties such as reliability, predictive validity and internal consistency

(Killaspy, et. al, 2006; Killaspy, et. al, 2009; Park, et. al, 2002; Salkow & Fichter, 2003; Thornicroft, et. al., 2010; Tyrer, et. al., 2011).

The Client Progress Inventory was reviewed by the Services subcommittee and input was sought from front-line workers before finalizing the content.

3.1.2 Interviews and Focus Group

The invitation to participate in this case study research was distributed using the New Westminster Homeless Coalition mailing list. The invitation instructed the participants to contact the researcher if they were interested in participating. The inclusion criterion for my study was that participants must be involved in the collaboration pilot project, either as a service provider, manager or client. Anyone who was not directly involved with the collaboration project would not be able to participate in the study. (Due to ethical concerns, as explained in 3.1.5 below, it was eventually decided that the researcher would not interview clients directly, but that staff would seek feedback from clients when appropriate and include this information during their interviews.)

The research plan was explained at a New Westminster Homeless Coalition meeting, and the benefits of collecting on-going input to improve the program was stressed by the leadership of the coalition. The researcher stressed that there was no pressure on staff or clients of the collaboration project to participate in the research. The researcher explained the consent form to all those who responded and indicated their wish to participate in the research.

For the interviews and focus groups, participants were given a choice of which format they preferred: a semi-structured interview, a focus group, or both. This was because some

individuals may feel more comfortable doing the interview on their own, while others may prefer the presence of their peers and the potential for a lively discussion. In the case of front-line staff, the interviews were held at a quiet location close to their work places. A total of 11 members of the New Westminster Homelessness Coalition collaboration team were interviewed, including seven front-line staff and four managers. In three of the interviews, a front-line worker and a manager were interviewed at the same time; and three interviews were conducted one on one with front-line workers. One focus group, which took place after a services sub-committee meeting, was conducted with four managers, two front-line workers and a representative from the local mental health team. Each session lasted between 30 minutes and an hour. The total time commitment for each study participant was half an hour to two hours, depending on the length and frequency of interviews. The interviews were conducted several months after the launch of the project, at the end of the one year pilot period, and approximately six months after the end of the pilot period.

Areas of inquiry included: experiences with the collaboration team; changes in the quality of service after the implementation of the pilot program; policies, procedures or other aspects of services that support or hinder access and responsiveness to the needs of people experiencing homelessness; ideas about changes needed in services; age, gender, ethnicity, sexual orientation, profession, family, services and supports and any other background information that may be relevant to services. Participants were reminded of their right to decline to answer any questions.

During the interviews and focus groups, participants were asked about the benefits as well as those factors that detracted from the success of this particular collaboration project. Open-ended questions were used, such as: “Tell me about your experiences with the collaboration

project.” Some questions arose naturally during the course of the interview in response to what was said. At times the researcher would probe for more information with a question like: "Can you tell me more?" The wording of questions was not necessarily the same for all respondents. There was no risk anticipated based on the scope of the interview questions, but the researcher was available after the interview for follow-up support should it be needed. The interviews and focus groups were tape recorded and transcribed.

3.1.3 Rationale

This method of research was high in validity for this particular pilot program, as over half the people directly involved in the project development were interviewed, and the data collection method allowed for detail and depth. The interviews were tape-recorded and transcribed to increase accuracy, then analyzed for patterns and themes. The research is highly practical, since the interview locations were convenient for the participants and the interview format was easy to tape record. In addition, there was already an agreement with the host organization to provide an interview location and assist with recruitment of study participants. The semi-structured interview format allowed for the collection of qualitative information within a limited time. It also allowed for positive rapport between the researcher and the interviewees. The focus group had the added benefits of group synergy and additional information emerging through group interaction (Padgett, 2008, p100). In addition, the semi-structured format allowed interviewees to express themselves in their own words with little direction from the interviewer. The document review and field notes allowed the researcher to triangulate the data in different forms, thus providing a more

complete picture of the pilot project and helping to strengthen the findings (Muir, Fisher, Dadich & Sbello, 2008).

3.1.4 Limitations

The limitations of the research include the non-inclusion of project clients in direct interviews, and the skill of the researcher to ask effective questions and follow the interviewee's cue. The semi-structured interview restricts the freedom of the interviewee to decide what they choose to talk about, and the interviewer may unconsciously steer the conversation or give out cues that guide the respondent to give answers expected by the interviewer. The data will not be standardized, since the questions will vary from one respondent to another. The external validity is also low, as the sample size is small and limited to participants of one program in one geographic area. This means that the results cannot be generalized to other community and program contexts.

While a qualitative study provides rich, in-depth information about how a small number of participants perceive the collaborative project, it cannot be generalized and has a number of limitations. First, because the interviews involved members of only four agencies, it did not include all the members who participated in the planning and implementation. Additionally, the interviews and data analysis were conducted by a single researcher who is involved in ongoing relationships with study participants. While this relationship facilitates comfort and in-depth data collection, it is also prone to a number of biases such as confirmation bias and experimenter's expectation bias. On the other hand, some scholars (Morse, 1994; Janesick, 2003) argue that it is preferable for a single researcher to conduct the data collection and data analysis when the researcher is an insider. This allows for the researcher to integrate their knowledge of the community and participants into their analysis. In such cases, Gubrium

and Holstein (1997) stress that it is important for the researcher to state clearly her philosophical standpoint and biases. It is true that I am biased in the sense that I would like the collaboration project to succeed; but I am not a stakeholder in the community, and I would be interested in factors that both facilitate and hinder collaboration.

While this study serves as one example of a collaboration initiative for unhoused individuals, studies of similar initiatives in other communities would increase the breadth of knowledge and relevance of our findings. In addition, the interview data comes from service providers who may be invested in program success or who may wish to shed a positive light on their efforts, and is therefore subject to bias. Triangulation of the findings with data from clients and other community members who are not directly involved in the collaboration team would have helped increase the trustworthiness of the analyses. It would also be interesting to involve peer researchers in this type of evaluation to move towards community action research.

3.1.5 Ethical Concerns

The ethical concerns related to interviewing staff members and unhoused individuals differ significantly. The main ethical concern with staff is the protection of privacy, and conflict of interest. Due to the small and close-knit nature of the community, even anonymous sections of dialogue can potentially reveal an individual's identity to those who know them. Furthermore, there may be some fear on the part of the workers that refusing to participate or saying something negative about the program may reflect poorly on them or threaten their credibility. The first step to ensure privacy was to keep the names of the interviewees confidential and store any identifying information in a secure location. It was also important

to assure the interviewees that the researcher would not share any identifying information with peers or superiors. It was fully explained to all participants that some people may still be able to identify an individual based on parts of the dialogue.

For unhoused individuals, there are further considerations that need to be addressed. Of particular concern was the power differential. While free and informed consent would be sought from all research subjects, some scholars argue that individuals with mental health problems may have a diminished decision-making capacity and may therefore be considered vulnerable (Michels, 1999; Widom & Czaja, 2005). With this in mind, a number of measures were developed in relation to both the pilot project and the case study research to minimize the risk of coercion and exploitation of vulnerable individuals. A Consumer Handbook (Appendix F) was produced, which explains the rights of participants in the pilot project. Staff would be asked to go over this material with clients, and to explain the goals, risks and benefits of the research. It would also be explained to participants that every effort was being made to protect their privacy and anonymity. Interviews with clients would take place in a private setting near places where food and services are delivered, at a location chosen by the client and where she or he felt comfortable. It would be clearly explained to all participants that no identifying information would be used, that the researcher is not affiliated with any service provider, and that nothing said in the interview would in any way affect services they receive. Participants would also be informed that constructive criticism was welcome so that services could be improved. The research would be conducted in close cooperation with the front-line staff, in order to ensure the best interest of the participants (Runnels, Hay, Sevigny & O'Hara, 2009).

Despite these measures, however, there were further ethical concerns in relation to interviewing clients directly. Front-line staff pointed out that often clients were barely willing to engage with those staff members with whom they had developed a relationship, let alone with a stranger. The workers were concerned that while many of their unhoused clients were reluctant to meet strangers, some might comply with requests for interviews even if they were uncomfortable with the idea, in order to keep receiving the services they needed. Based on close consultation with front-line workers, it was finally agreed that the researcher would not conduct interviews directly with clients. However, there are ethical concerns around not including client feedback when designing programs to serve them (Abma, Molewijk & Widdershoven, 2009). In order to address this dilemma, the staff agreed to seek feedback from clients when appropriate, and to include this information during their interviews. In order to ensure that clients did not feel coerced to give positive feedback, workers agreed to remind clients that their feedback in no way will affect their services. Furthermore, all clients were provided with a client handbook (Appendix F) which explicitly stated their rights to service and complaint process. Furthermore, the following steps were taken to address ethical concerns in the context of research around homelessness:

- Interviews were conducted in simple language, and no personal information was included in the results or shared with participating agencies.
- No personal information was collected beyond demographic information directly relevant to the research, such as age range, sex and cultural background.
- Only the researcher has access to the original transcripts with identifying information, and such information is removed from the transcript when research is disseminated.

1.1 Results

The quantitative results presented in this section were obtained using the Client Progress Inventory, and the qualitative information was obtained through interviews and focus groups. The research results and implications will be discussed in this section.

3.2 Quantitative Results

Out of the ten clients who were initially signed up for the pilot project starting in June 2009, two left the project, and the remaining eight were provided with intensive support for one year by the collaboration team. All eight are housed and remain stable as of December 2010, six months after the completion of the pilot period. The Client Progress Inventory was completed both at baseline and completion for six of the clients ($n=6$) who completed the program. The inventory was completed by the lead case manager for each client from the case manager's perspective, and all questions were on a 4 point scale ranging from poor (0) to excellent (4). On average, there was significant improvement in the areas of engagement and acceptance of services (152%), health & basic living skills (177%) and community engagement and pre-employment skills (170%). The most significant improvements noted were in the areas of personal hygiene and appearance, meals and nutrition, addictions, and problem solving skills, all of which are fundamental to community integration.

The client demographics for the six clients are as follows: The average age was 54, with an equal number of males and females. All of the clients were Caucasian, except one client who self identified as Aboriginal.

3.2.1.1 Engagement and Acceptance

Given the multiple barriers and difficulty to engage, developing a relationship and preparing a client to accept help and move to the next level is crucial in this population. The pilot program has demonstrated its effectiveness in engaging and motivating the client. The average improvement in engagement and acceptance was 152%. Figure 3.1 shows the average score for each category of the engagement and acceptance scale at baseline and completion.

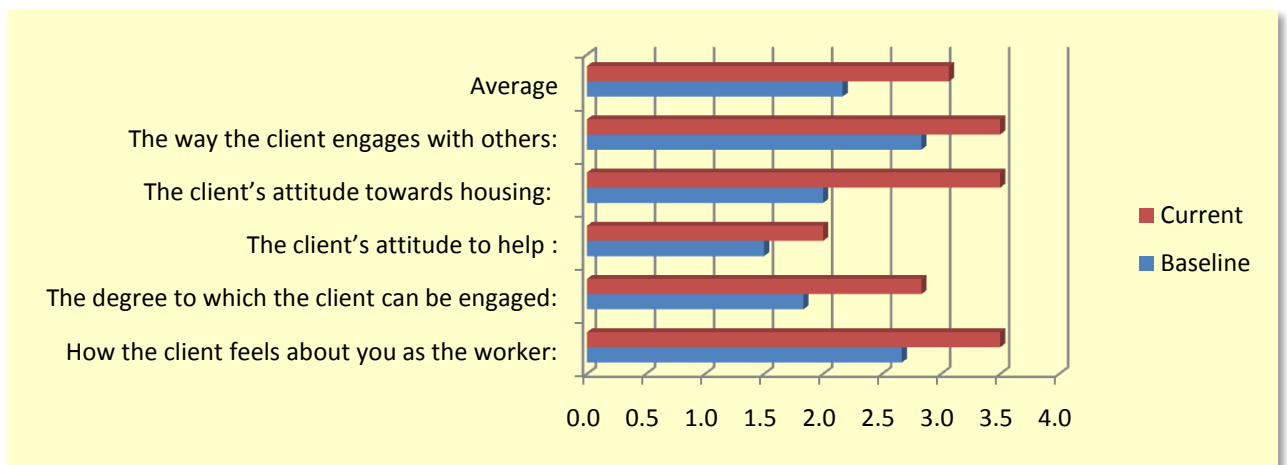


Figure 3.1 Engagement and Acceptance Scores

3.2.1.2 Health and Basic Living

The clients of the pilot project demonstrated improvement in overall health and well-being, with an average 177% improvement over the course of the project. While there was little change in physical health and medical conditions, there were significant improvements in the areas of personal grooming, nutrition, mental health and addictions as seen in Figure 3.2.

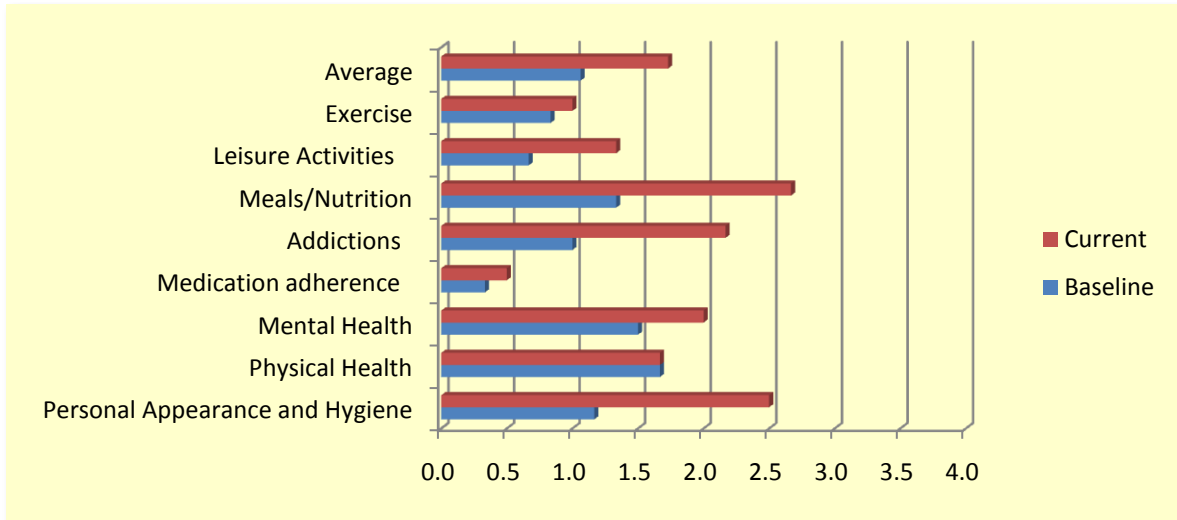


Figure 3.2 Health and Basic Living Scores

3.2.1.3 Community and Employment

There was a sizable gain in many areas of community involvement and life skills. Two clients have gained employment with New Westminster Homeless Coalition's the *I's on the Street* transitional employment program (elaborated in section 3.4.1), and all of the clients have improved their interpersonal and problem solving skills which are essential for employment preparation. The overall improvement from baseline to completion was 170 %, with improvements in individual categories shown in Figure 3.3.

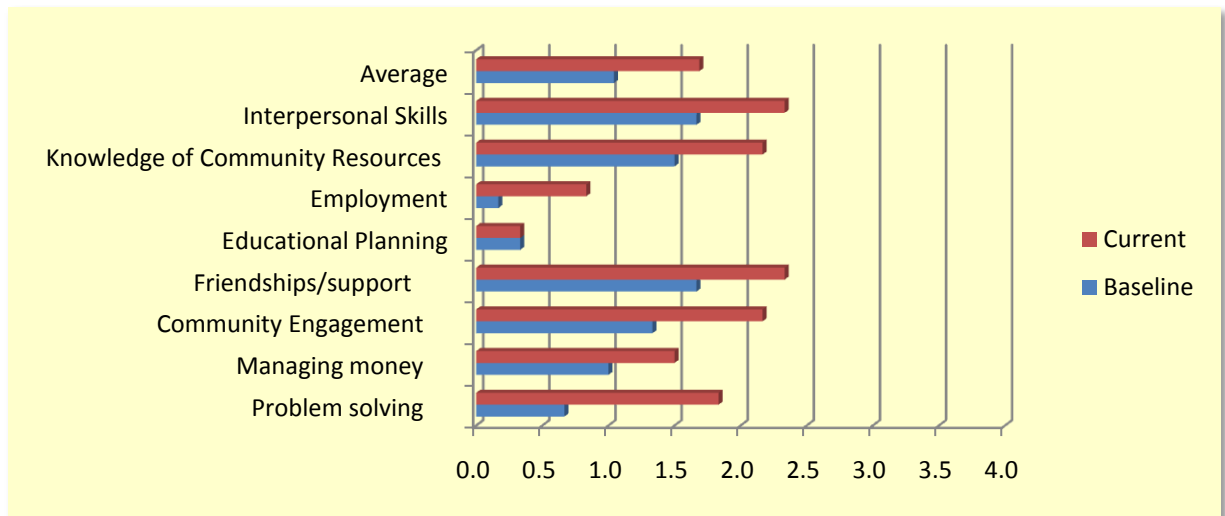


Figure 3.3 Community and Employment Scores

3.2.1.4 Other Supporting Data

The New Westminster Homelessness Coalition (2010) also released statistics they received from the health authority regarding a client of the collaboration program who was well known to hospital and police emergency services. This individual had visited the hospital emergency room 24 times and came into contact with the police 28 times between August 2008 and August 2009. Since enrolment in the collaboration program, this individual has not accessed the hospital or police emergency services (As of May 2010). These figures indicate that the collaboration model has proved to be successful in reducing crises for this particular individual. Based on the qualitative results, the NWHC concluded that the project was “extremely successful, and far exceeds local expectations.”

3.2.1.5 Limitations

The Client Progress Inventory is observational and highly subjective, since it is based on case worker observation and not on tangible evidence or client self report. Thus, results may differ greatly based on who made the observation and the worker’s subjective understanding

of each question. Furthermore, the construction of new supportive housing was completed and many of the clients participating in the project acquired housing during this period, which likely influenced and *conflate* the results. However, since the clients in the pilot project received some priority on the housing wait list, being part of the collaboration program did directly or indirectly contribute to the benefits occurring from being housed.

3.3 Qualitative Results

The qualitative component of the research aimed at gaining an insight into the experiences of the managers and front-line workers around the collaboration project. Based on a thematic analysis of the interviews and focus group transcripts, the following six themes emerged: (1) Fostering positive community relationships; (2) communication; (3) leadership and shared decision-making; (4) increased service effectiveness; (5) funding and time issues and (6) other limitations. The following is a summary of each category with illustrative quotes.

3.3.1 Fostering Positive Community Relationships

Most participants felt more connected to the community as a result of the collaboration project, although this was more noticeable for participants who had not previously communicated much with other organizations. Both front-line workers and managers from agencies located further from the city centre (where many of the services are clustered) reported a marked increase in their feeling of connectedness, knowledge of resources and access to other service providers within the community. Since agencies that were centrally located and geographically close to other agencies have always enjoyed a stronger sense of community connectedness, their workers tended to report little change in their own sense of

community connectedness. All the participants acknowledged the benefit of the collaboration project to the overall community in bringing agencies and people together.

Although only four agencies were consistent in their participation in the collaborative case planning component of the project, there were many other secondary benefits that could be linked to the development of positive community relationships. These included improved services for clients who were not enrolled in the pilot program and improved access to government and other community services that were not officially signed onto the collaboration. The following quote illustrates some of these benefits.

I get to have a better understanding of what my other resources are, what the other resources in New Westminster can do and where it best suits the client—and then as well for other people that I’m helping on the street, that have nothing to do with the collaboration... I can send them on to these different services because I have a better knowledge of what their capabilities are. Same when working with the ministry of housing and social development... they know that we are part of that collaboration, and I will tell them, this is what I am looking for, is there any possibility, and they are just more open.

This quote highlights the unanticipated benefits of the collaboration initiative: government agencies giving priority to collaboration clients based on the credibility and trust garnered through the collaboration partners.

On manager noted that he had noticed “subtle effects, which are more difficult to appreciate” which indicate stronger relationships between community agencies. He observed that:

Several of the front-line people now know each other personally, know each other face to face and I think more telephone calls are exchanged between people who are able to compare notes or get information from each other. So, we have the New Westminster Interagency and the Homeless Coalition and get to sit down with other

directors and just shoot the breeze, which is a form of recognition and support, even if it's not intended to be and I think the Collaboration Project offers that to staff; that chance to sit and shoot the breeze, talk about mutual cases or problems or whatever people want to talk about.

Several participants mentioned the development of partnerships among community agencies separate from the collaboration project, but building on the model. One participant noted that, as a result of their team's success, the team members have “taken on other projects like organizing homelessness action week and ‘I’s on the Street’. ‘I’s on the street’ is a social enterprise that was developed in partnership between the community mental health team and some members of the collaboration project. It is a program which offers employment to people who have been recently unhoused and/or are mental health clients, who work three mornings a week doing street cleanup in the New Westminster Downtown (Lookout Emergency Aid Society, 2010). The Lookout website calls the program a “collaborative solution,” since the program is operated by the New Westminster Homelessness Coalition’s collaboration team. Based on the success of the collaboration project, the team was able to request funding from the New Westminster Community Development Society and the local business improvement association to fund this street cleaning program for adults with significant employment barriers. As a result of the collaboration project, one of the key members of the collaboration project and the ‘I’s on the Street’ project felt that he was “more able to see the bigger picture, and more confident to take on these projects.”

3.3.2 Communication

Several interview participants spoke at length about the improvement in communication between participating organizations, which has been a “catch point” in the past. While the amount of communication did not change much for front-line workers who had always worked with other organizations, there was noticeable improvement for workers who did not previously communicate frequently with other organizations. One front-line worker noted that “it really helped in working with one of my clients, because she is in close knit with another service provider who is on board, and so we could quite often talk about what we were doing, who was doing what, and this helped move things along.” This sentiment was echoed by other workers who felt they were better able to help their clients because they knew what other workers were doing for the same client.

One of the surprising effects of enhanced communication within the community was its reach to other communities. Some of the organizations in the collaboration project have branches in other cities, and access to information in other communities. The following quote illustrates how the collaboration project expanded the scope of one agency’s communication: “My client was developing a habit of taking off to Vancouver every once in a while for periods of a few months at a time, and it was hard to keep track of his whereabouts; and so I used the other agencies that were on the team to keep an eye out as well, and if they had seen him, and it’s a pretty tight community downtown. So if you put the word out that you are wondering if Tom (name has been altered to ensure privacy) has been down at the meals, it’s pretty easy after you have developed a relationship with other organizations to get all this feedback of whether he was there or not, what’s his condition and stuff like that.”

3.3.3 Leadership and Shared Decision-Making

While the managers had a clear understanding that the Services Sub-committee was in charge of helming the project, many front-line workers were not clear on who was leading the project. Originally the project had a part time coordinator, who had to leave the project within the first few months, and this position was never replaced due to funding cuts to her organization. One of the outreach workers agreed to help coordinate the project, and continued to convene the meetings, but was not able to provide the amount of support originally intended due to limited time and resources. Most outreach workers commented on the lack of clear leadership, especially at the management level. There were some questions about accountability and who was monitoring the project; but most workers were content with reporting to their own managers, all of whom were members of the services sub-committee.

Many workers were happy to have a leader “who is not dominant,” and enjoyed the autonomy and shared decision-making model. One worker noted that “I think it is good that there is not one person dominating things, because it is a hard thing to coordinate, and sometimes people can’t make things, and it is good to have that kind of flexibility to simply step in and run a meeting, and that’s the way it’s been.” This quote suggests that this worker is not comfortable with an authority figure prescribing how things should be done. Another worker echoed this point: “I like the way things are because I don’t have somebody down my throat. Because to me, you cannot take a street entrenched person and give them a time line...so it wouldn’t do any good to put pressure on the worker to get your client from A to B in this amount of time, that just defeats the whole thing of having trust in a relationship with the person you are working with.” Several workers commented on the autonomy and

inclusion they felt in the group, noting that the leaders were “pleasantly inclusive ...it does feel like we are all running it.” While this horizontal structure and minimal supervision were viewed as helpful to the project, some participants felt that there was a strong need for a coordinator to “really keep things on track.”

3.3.4 Increased Service Effectiveness

Many workers noted positive benefits for the clients. Most of the clients who signed onto the collaboration project were housed and remain stable. Many workers noted how their clients used to go to several service providers “like a ping pong ball,” but often fell through the cracks because the services were not coordinated. Several workers also felt that it would not have been possible to provide service to their hard to house clients without the collaboration project. One worker felt that her clients “are seeing a positive sort of sense of community, because they know the people are working together on their behalf.” This comment suggests the worker’s perception that the collaboration is strengthening the client’s sense of community as well. Another worker noted that the collaboration team was better able to address relationship issues that clients had with each other: “Street mother, street father, boyfriend, friends, you know, it was pretty surprising how often people would cross over, like (one organization)’s client would be at odds with (another organization)’s client, and then it turns out that my client was the street mom of the two of them. So we were able to bring all of our client’s information together and anticipate where things are going to go.” The benefits of exchanging information highlighted by these comments are from the service provider’s perspective, and may differ significantly from the client’s perception.

3.3.4.1 Case Example

Brenda's case illustrates how a woman with complex needs who was falling through the cracks for years finally got all of her needs addressed through the collaboration project. One of the workers on her case noted that Brenda would not have got the same level of service, and that the collaboration project *"kicked everybody into gear to go, this is serious, people are falling through the cracks time and time and time again."* Below is Brenda's case, as described by her primary case worker. Client names have been changed to protect confidentiality.

Brenda had no teeth and needed eye glasses and needed her feet looked at and all the rest, and these issues just kept getting missed. You know, who is going to take her to the doctor's appointment or the dentist appointment, who is going to make sure she has her chest x-ray, blood work, all that before surgery. She needed help getting her with ID, getting a bus pass, employment, housing, dental, medical, mental health. In order to get dentures it required her getting a full physical done and also then updating her mental health status because she was originally diagnosed as bipolar about 20 years ago. (She met with the team) and she decided that Union Gospel Mission was going to look after her bus pass and helping her get her teeth done and I (Lookout) was going to look after housing and maybe some other stuff. So it did turn out well because we are so close with UGM so that any time I need something I just walked down the street. She went from being homeless to being in a woman's rooming house; from having no teeth to having surgery to get a full set of dentures. The collaboration of the two of us got that all in the works. She was denied BC housing because she claimed to be bipolar, and yet wasn't on any medication, and had no supports. I had been working with her probably a year or a year and a half and I had never seen a bipolar episode, so I made an appointment with mental health. She wanted me to go with her every single time, as she didn't want to go by herself. I went with her every single time.

3.3.5 Funding/Time Issues

Participants noted the decreased presence of some organizations that had been eager to participate at the beginning. Even organizations that contributed significantly to the project

had to cut back on some of their involvement, and everyone was “feeling the crunch.” The loss of members was attributed mainly to government budget cuts, particularly in the Health Authority and BC Housing, which hit some organizations harder than others. One outreach worker from a religious organization noted that because their funding came from private sources, it was not impacted as much by government cutbacks. A manager from another organization said that their funding came from both private donations and government grants, both of which are potentially precarious sources of funding that can be dependent on politics and the economy. One of the key participants of the collaboration project experienced a budget cut of approximately 60% during the collaboration project period, resulting in their having to reduce the services they offered almost immediately. Since this was the organization providing the coordinator, the collaboration lost its project coordinator within a few months into implementation. This highlights the impact of government decisions and funding cuts outside the collaborating group.

Some members indicated that they had noticed other members of the collaboration team becoming less available in subtle ways. One organization went from two outreach workers to one, started missing meetings occasionally, was much too busy with a heavier caseload and became “harder to get a hold of because of their funding cuts.” The time commitment was perceived as more difficult over time. A participant noted that “four hours a week seems pretty easy, but all of a sudden, just, yeah, not finding the time.” Another participant noted that that even though her agency had to pull back significantly from the project, they still use the collaboration team as a resource and “bug them for information.”

3.3.6 Other Limitations and Drawbacks of the Project

3.3.6.1 Need for More Organizations to Participate

In addition to budget cuts, all participants agreed that there is a need for more organizations to be involved in the collaboration to maximize the benefits. Most of the active collaboration team members were outreach workers from community organizations, with varying knowledge of addictions and mental health issues. Many participants emphasized the need for participation of the community mental health team and addiction services. Lack of housing and lack of access to detox facilities were also noted as limitations of the project. The following quote illustrates the rationale for having diverse individuals on the collaboration team: “One suggestion I would definitely have is to have a more diverse set of individuals, maybe the social workers from the hospital and/or the discharge nurses. Definitely mental health, definitely addictions, and maybe other social workers and the ministry (of Housing and Social Development), people who are involved at the government level for stabilizing finances and that kind of thing. Having any of those individuals to bypass the process because we all know there are processes that the outreach team is pretty good at wiggling their way through, but they experience blocks none-the-less. So being able to have sort of as many barrier free operations for them—they know how to do the job, they just need to have the barriers removed.” Most participants felt that the more organizations from the community that actively participated, the better the collaboration outcome would be.

3.3.6.2 Attrition and Time/Geographical Constraints

While some workers were content to end their case work when their clients got housed, other workers felt that the team would need to provide ongoing support in order to help the clients keep their housing. Another limitation is the willingness of the client population to stay with the pilot project during the one year time frame. Some clients disappeared from the community and were never seen again, while others refused contact or did not wish to continue contact after being housed. When none of the clients have a fixed address, it was sometimes hard to locate a client for a follow up appointment. A worker noted the example of one of the clients who started the program, “who was someone who has literally slept on the (agency’s) property. And I don’t know where he’s at because he’s slipped.” Many of the service providers originally expected a high attrition rate for the project, given “the nature of this population.” The fact that eight out of the ten clients remained in the project for one year and six agreed to a follow up assessment was considered extraordinary.

Several workers noted that the collaboration did not cover some areas of the city that were far away from most services, especially residential neighborhoods far from the downtown area.

3.3.6.3 Paperwork and Meetings

While some workers enjoyed attending team meetings, one worker felt that the meetings were not as useful as the time he spent helping clients directly, and feared that someone was getting turned away from the agency because he was in a meeting. The strong feeling of this worker is expressed in the following quote:

I hate seeing people get turned away. Someone's coming to the door and we're in a meeting and maybe it's a life or death situation. I've had that happen to me when I was out there, homeless, being a drug addict and going through all of that stuff, I know where they come from, so when they come through the door and they're hurting, I want to be there. I don't see enough stuff coming out of those meetings that would take priority over something like that.

Several front-line workers also expressed that the amount of extra paperwork increasingly became a burden. Although the project started off with only an intake form, confidentiality agreement and the client progress inventory, apparently the coordinator added additional paperwork which resembled a hospital chart, in which workers were asked to maintain a log of their activities. This was not vetted by the Services Sub-Committee, but was introduced into the process to improve accountability. Some workers felt that since they were required to keep records by their agency in a different format, this secondary paperwork was “redundant... it's just too much. I think it complicates things when you have all this paperwork.”

3.3.6.4 The Hidden Homeless

Another point that was raised repeatedly was the need to reach out to the “hidden homeless” who are not visible on the streets. This includes youth and adults who may be couch surfing, and families that lack stable housing or are living out of their vehicle. One worker noted that people in this population often fear stigmatization and do not want to be found, and that “it's a whole different relationship and it takes a very long time. Some of them are families – kids going to school, parents going to work and no one knows.”

3.4 Follow-up Interview

A follow up interview was conducted with one manager and the project coordinator in February 2011, 9 months after the official end date of the collaboration pilot project. The

purpose of this interview was to find out how the collaboration project impacted the clients, agencies and community in retrospect. The project coordinator reported that the collaboration team continues to provide services to the eight clients who stayed in the collaboration project. They are all still housed, and are displaying continued improvements in social skills, life skills and addictions. As of the time of the interview, only four to five staff members from three agencies were still involved in collaborative service planning. The project coordinator noted that it is increasingly difficult for many service providers to maintain their involvement given staff changes, increased workload and health issues. Even though the group is no longer selecting new clients for the project or conducting team meetings, the project coordinator noted that the relationships that were developed during the collaboration project are still strong, and the agencies still work closely together. The agency manager noted that there is a strong sense that the collaboration project “requires sustaining, and it also requires generating and mentoring young people.” Towards the end of the collaboration project time frame, talks had begun with the mental health team about their potential contributions to the collaboration efforts. While they did not officially join the collaboration team, staff from the mental health team has been visiting front line agencies on a weekly basis to provide direct services to agency clients.

Shortly after the completion of the collaboration project, a delegation from New Westminster Homeless Coalition presented the collaboration project results to Minister Rich Coleman, who was the Minister of Housing and Social Development at the time. The purpose of the meeting was to get the Minister to see how the collaboration operates and gain support for the agencies participating in the collaboration. Minister Rich Coleman showed interest in

coming to New Westminster and touring the agencies to see the collaboration project in action, but no date has been set.

The manager noted that he is observing similar collaboration efforts underway in neighboring municipalities such as Surrey, Burnaby and Coquitlam and that he has heard from several sources that New Westminster has been “a model of success” including acknowledgments by New Westminster City Hall and the Regional Steering Committee on Homelessness.

4. Conclusion

This study provides rich insights into the dynamics of a community driven collaborative partnership, the struggles and lessons learned, and how individuals and organizations utilized the collaborative protocol to fit their practice and the needs of the community. Many of the emergent themes demonstrate clear links to themes identified in previous research, such as leadership; shared decision making; relationship building; increased service effectiveness; funding issues and the need for the participation of diverse professionals. In order to avoid the common shortfall of forcing the data into pre-determined categories, the data was not compared to themes in previous research until all the interviews were completed (Bradley, Curry & Devers, 2007). Some issues that appeared frequently in past research, such as interpersonal dynamics, power issues and differences in organizational values, were not mentioned by the participants of this study. This may be due to the pre-existing relationships the organizations had with each other prior to the collaboration pilot project and the establishment of shared values at the beginning of the planning process. In addition, all the participating organizations supported harm reduction and had a similar organizational mandate and philosophy towards homelessness which reduced the chance of ideological conflict. It is notable that one major organization which declined to participate in the collaboration project may have done so partly because they were not comfortable working within a harm reduction framework.

The interview participants articulated a number of ways in which the collaboration project had catalyzed meaningful changes in their local communities' not-for-profit and public service systems. Prior to the collaboration project, community service systems were described as operating in silos: they were uncoordinated and clients were “going around and

around through revolving doors” according to one of the outreach workers. Individuals who were considered the hardest to house were known to many of the front-line workers for years, yet they continued to slip through the cracks. A small number of these individuals accounted for multiple hospitalizations and police contact incidents. Although the collaboration project involved relatively few resources, the impact on the community was dramatic. The collaboration project created an integrated system of communication and work load delegation that responded better to the needs of individuals who are unhoused and the providers who continue to struggle with resource shortages.

Services to the individuals improved as well, since the roles and responsibilities of each provider were clear in terms of who was providing what service to a client. For example, one pilot project client had been to the hospital emergency room 24 times during a one year period prior to collaboration, but did not visit the emergency room at all for the duration of the pilot project. Once the duplication of services was reduced, it enabled resources to be better focused on the needs of each client.

The positive impact on the sense of community emerged from a horizontal power structure and ongoing dialogic process led by the front-line workers. The front-line workers reported a sense of power sharing, since they were involved from the planning process through to the implementation and review processes. The establishment of shared values and a formal collaboration structure helped the workers stay focused, and informed the collaborative relationship. The workers were given autonomy to communicate and build relationships with each other and with other community resources, while protecting the clients with an agreed upon privacy and confidentiality clause. Most participants felt that the collaboration project enhanced their sense of community and access to other services, which in turn fostered

mutual trust and a desire to contribute to the community. Ongoing progress and outcomes were shared with all the NWHC members, including government agencies, and this became a catalyst for developing new programs and partnerships to serve clients better as a community system. Demonstrating a sustained, community-led collaboration team helped community organizations to have a stronger input in the development of government programs and funding. Many government agencies now consult the NWHC and the collaboration team before implementing new programs in the area. The collaboration team members and the NWHC recognize the collaboration project as a foundation for the development of future programs, and as an integral part of their long-term strategy to wade out funding crunches and tough economic times.

Participants emphasized the need for two elements to enhance program success: better funding and involvement of mental health and other key health professionals. There was a general recognition that mental health and addiction professionals in the public health system have more access to resources, which would have made a significant contribution to client recovery.

Although government agencies did not officially sign on to the collaboration, ongoing relationship building and communication mattered; the agencies provided better access to collaboration clients and helped speed up the paperwork process. Many managers noted the benefits to their agencies, in terms of access to resources for their clients, but also in terms of their younger workers gaining confidence. They see their younger workers “stepping up to the plate when it comes to taking initiative in community projects.” The collaboration project may thus be framed as a community driven systems change intervention, where relationships foster community belonging, and community connections foster system change.

This study suggests that community collaboration may improve the overall well-being of the client, as well as fostering a sense of community connection, improved communication and relationships among community agencies. Additional research is needed to further explore different types of community-led collaborative relationships with diverse participants from both not-for-profit and government organizations. There is also a need for a variety of quantitative and qualitative measures to identify both client and community-level outcomes, in order to better define ingredients for success.

While this study demonstrated client and community level improvements, further study is required to identify changes observed in the greater community outside of the immediate service providers. Future research must identify ways to incorporate government and other community stakeholders as well as clients to assess the impact in different areas of the community. Other questions also merit further exploration. It would be helpful to find out if particular agencies or segments of the community are more heavily impacted by community collaboration, and if particular collaboration strategies are more effective in creating lasting change. There is a need for further research to explore the impact of community service system changes on the outcome for individual clients. It would be interesting to determine if the collaboration model is effective in serving other clients groups as well, such as the hidden homeless, youth and families at risk. Further quantitative analysis on client health and well-being with a large sample size, as well as the cost effectiveness of collaborative services, will also be useful. This information will help community and government agencies improve the planning of their overall strategy and resource allocation.

If certain collaborative strategies can be identified as most effective in creating community change, there will be implications for staff hiring, training and resource allocation.

Individual agencies may consider the benefit to the team when hiring staff, and staff training may be delivered collaboratively. Agencies may consider the collaboration efforts in their budget, and include their participation and contribution on the collaborative team when submitting funding requests. Government and private funding bodies, in turn, may be able to get a better view of the bigger picture and benefits to the community as a whole when they are making their funding decisions. BC Housing, for example, has already indicated that they consider an agency's contribution to collaborative efforts when making funding decisions. Through collaboration and a unified measure of client progress, the community is better able to demonstrate the effectiveness of their efforts and plan for the future at a community level.

While the impact of collaboration on service effectiveness has been widely studied, there has been little focus on community driven collaboration and its effects on the sense of community. This study suggests that community collaboration has a positive impact on the overall community, which may in turn improve overall service delivery to individuals who are homeless, or to those who have multiple barriers and are at risk of homelessness. Community driven collaboration initiatives should continue to be studied not only as a vehicle for community level service improvement, but also as a community-building tool to create lasting change.

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Appendices

Appendix A: Consent Form

Consent Form **New Westminster Collaboration Pilot Project Evaluation**

Principal Investigator:

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Co-Investigators:

Leya Eguchi, Master of Social Work Student, School of Social Work
University of British Columbia

This study is part of a Master's thesis which will be submitted to an academic journal for potential publishing. No names or personal information will be included in the manuscript.

Purpose:

The New Westminster Homelessness Coalition has launched a one year pilot program to deliver collaborative services to unhoused and at risk residents of the city. The purpose of this study is to examine the effects of collaboration on the participants of the pilot program, including staff and clients.

Study Procedures:

You can choose between a private interview of approximately fifteen minutes to half an hour a focus group of approximately one hour. The timing and availability of a focus group will depend on the number of participants that sign up.

Areas of inquiry will include:

- Your experiences with the collaboration team
- Changes in the quality of service after the implementation of the pilot program
- Policies, procedures or other aspects of services that support or hinder access and responsiveness to the needs of people experiencing homelessness
- Your ideas about changes needed in services
- Your age, gender, ethnicity, sexual orientation, profession, family, services and supports and any other background information that may be relevant to your service needs
- You may decline to answer any questions
 - The interview will take place in a private setting near places where food and services are delivered
 - The interviews and focus groups are tape recorded and transcribed by a typist
 - You may view and request changes to the interview transcript upon request

Potential Risks:

There are no risks anticipated, but you may experience discomfort when being asked personal questions. You do not have to answer any questions that make you feel uncomfortable. You can also stop the interview at any time. The researcher and staff members of the collaboration team were available after the interview if emotional support is needed.

Potential Benefits:

Your voices will be heard and will be reflected in the planning process to improve service delivery. There is no guarantee, however, that your opinions will directly lead to a specific change in policies or services.

The final report will be available to all participating agencies, so you can also ask a collaboration team staff member to provide you with a copy of the report.

Confidentiality:

Your identity will be kept strictly confidential

Documents will be identified only by code number and kept in a locked filing cabinet; computer data will be password protected

You will not be identified by name in reports of the study

If you choose to participate in a focus group, we encourage all participants to refrain from disclosing the contents of the discussion outside of the focus group; however, we cannot control what other participants do with the information discussed

Remuneration/Compensation:

A choice of a non-perishable food item will be made available to you at the end of the interview.

Consent:

Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time without jeopardy to your entitlement to services or your employment.

Your signature below indicates that you have received a copy of this consent form for your own records.

Your signature indicates that you consent to participate in this study.

Subject Signature

Date

Printed Name of the Subject signing above

Appendix B: Invitation to Participate in the Study

An Invitation to Participate in a Study of:

New Westminster Collaboration Pilot Project Evaluation

What is the Purpose of the study?

The New Westminster Homelessness Coalition completed a one year pilot program to deliver collaborative services to homeless and at risk residents of the city. The purpose of this study is to examine the effects of collaboration on the participants of the pilot program, including staff and clients.

What's involved?

A private interview of approximately fifteen minutes to half an hour or participation in a one hour focus group
Areas of inquiry will include:

- Your experiences with the collaboration team
- Perceived changes in the quality of service after the implementation of the pilot program
- Your ideas about changes needed in services
- Basic demographic information such as your age, gender, ethnicity, sexual orientation, profession and other relevant background information
- You may decline to answer any questions
 - The interview will take place in a private setting near places where food and services are delivered
 - The interviews and focus groups will be tape recorded and transcribed by a typist
 - You may view and request changes to the interview transcript upon request

Who's Invited?

Participants of the pilot project (service recipients)

Service providers involved in the pilot project – front-line workers, managers

What about confidentiality?

- Your identity will be kept strictly confidential
- Documents will be identified only by code number and kept in a locked filing cabinet; computer data will be password protected
- You will not be identified by name in reports of the study
- If you choose to participate in a focus group, we encourage all participants to refrain from disclosing the contents of the discussion outside of the focus group; however, we cannot control what other participants do with the information discussed

Participation is voluntary. You can withdraw or refuse to participate without any jeopardy to your entitlement to services or your employment.

This study is part of a Master's thesis which will be submitted to an academic journal for potential publishing. No names or personal information will be included in the manuscript.

Appendix C: Interview Guide

Prior to the beginning of the interview, consent provisions will be discussed and an opportunity to sign the consent form will be offered.

To begin the interview, the purpose of the study will be outlined briefly. Then the participant will be guided in sharing his experiences as a service provider

1. Could you please tell me about any experiences in relation to the collaboration project you have had as a service provider.

Probes that will be used in exploring the participant's experiences:

- What was your role (e.g., in the planning process, as a team member, team leader, supervisor/manager, providing front-line services....)?
- How long have you been involved in the pilot program?
- What is your understanding of the collaboration pilot program?
- How has the pilot program impacted the services you provide to your clients?
- How has the pilot program affected the services of the member agencies and their staff?

2. Has the collaboration pilot program had any impact on how you perceive yourself in relation to the New Westminster community?

3. Has the collaboration pilot program enhanced your knowledge of services or other community resources?

4. Tell me about any aspect of the collaboration pilot program that you feel should be changed or enhanced.

- policies
- procedures
- forms
- professional education
- other aspects

5. Are there external factors such as government policies and procedures that help or hinder the collaborative services being delivered?

6. How would you change the service to make it better?

8. Tell me about your social positioning such as age, education, ethnicity and sexual orientation that may impact the way you provide services?

Appendix D: List of New Westminster Homelessness Coalition Members

1. NOT-FOR-PROFIT ORGANIZATIONS – DIRECT SERVICE

Union Gospel Mission
Lookout Emergency Aid Society
Canadian Mental Health Association
Elizabeth Fry Society of Greater Vancouver
FraserSide Community Services
Hospitality Project (Food Bank)
Lower Mainland Brain Injury Association
Monarch Place Transition House
Westcoast Genesis Society
Salvation Army
The Lower Mainland Purpose Society
Feed the Hungry Outreach, Westminster Foursquare

2. COMMUNITY ORGANIZATIONS

New Westminster Community Development Society
New Westminster Downtown Residents Association
Outreach Group
United Food and Commercial Workers Union, Local 247
New Westminster Business Improvement Association

3. PUBLIC SECTOR

Metro Vancouver Regional Steering Committee on Homelessness
City of New Westminster, Social Planning
New Westminster Mental Health Centre (Fraser Health Authority)
School District #40

4. POLITICIANS/CONSULTANTS

Bill Harper, Councillor, City of New Westminster
Betty McIntosh, Councillor, City of New Westminster
Lorrie Williams, Councillor, City of New Westminster
Dawn Black, MLA, New Westminster
Peter Julian, MP, Burnaby/New Westminster
Chuck Puchmayr (Previous MLA), New Westminster
Lorraine Brett Community Relations

5. CHURCHES/FAITH GROUPS

Holy Trinity Cathedral
Shiloh-Sixth Avenue United Church
St Barnabas Anglican Church
Will-Go-Ministries

Appendix E: Client Progress Inventory

Section 1: Demographic Information

Age _____
Gender: Female Male Transgender Unknown
Ancestry: Aboriginal Métis Visible Minority Caucasian Unknown
Household Type: Single Couple Dependent children Other: _____
Veteran Yes No Refused
Mental or physical disability _____

Section 2: Engagement and Acceptance

Circle the letter of the statement and enter the score for each item at baseline (start date) and present.

6. How the client feels about you as the worker:

- a) The client is well disposed towards me and looks forward to my visits. (4)
- b) The client is mildly positive towards me. (3)
- c) The client is neutral in attitude towards me. (2)
- d) The client is suspicious of my intentions or mildly hostile. (1)
- e) The client is overtly hostile and antagonistic towards me. (0)

Score: Baseline: _____ **Current:** _____

7. The degree to which the client can be engaged:

- a) The client goes to great lengths to avoid contact. (0)
- b) The client generally avoids contact and only occasionally agrees to be seen. (1)
- c) The client does not seek contact but usually agrees to be seen. (2)
- d) The client is easy to contact and reliable over appointments. (3)
- e) The client frequently initiates contact. (4)

Score: Baseline: _____ **Current:** _____

8. The client's attitude to help:

- a) The client is keen on being helped and is an active participant in making plans. (3)
- b) The client is prepared to accept help but there are difficulties in agreeing to a common plan. (2)
- c) The client claims not to need help but is prepared after some persuasion to accept some degree of intervention. (1)
- d) The client insists no help is needed and actively resists all attempts at intervention. (0)

Score: Baseline: _____ **Current:** _____

9. The client's attitude towards housing:

- a) The client wishes to accept any form of housing OR is already settled. (4)
- b) The client is wants housing but has specific realistic requirements. (3)
- c) The client appears to want housing but has unrealistic requirements. (2)
- d) The client's interest in housing is restricted to temporary placements. (1)
- e) The client refuses all offers of housing OR is unable to express a choice. (0)

Score: Baseline: _____ **Current:** _____

10. The way the client engages with others:

- a) Active hostility towards others. (0)
- b) Actively avoids most contact with others. (1)
- c) Passive avoidance of others, company usually tolerated silently. (2)
- d) Variable engagement: unpredictably withdrawn or friendly. (3)
- e) Appropriate social engagement with spontaneous conversation. (4)

Score: Baseline: _____ **Current:** _____

Total Engagement and Acceptance Score: Baseline: _____ **Current:** _____

Section 3: Health & Basic Living

Scoring:	Excellent (4)	Good (3)	Adequate (2)	Poor (1)	Non-existent (0)
----------	---------------	----------	--------------	----------	------------------

- | | | |
|------------------------------------|-----------------|----------------|
| 1. Personal Appearance and Hygiene | Baseline: _____ | Current: _____ |
| 2. Physical Health | Baseline: _____ | Current: _____ |
| 3. Mental Health | Baseline: _____ | Current: _____ |
| 4. Medication adherence | Baseline: _____ | Current: _____ |
| 5. Addictions | Baseline: _____ | Current: _____ |
| 6. Meals/Nutrition | Baseline: _____ | Current: _____ |
| 7. Leisure Activities | Baseline: _____ | Current: _____ |
| 8. Exercise | Baseline: _____ | Current: _____ |

Total Health & Basic Living Skills Score: Baseline: _____ Current: _____

Section 4: Community and Employment

Scoring:	Excellent (4)	Good (3)	Adequate (2)	Poor (1)	Non-existent (0)
----------	---------------	----------	--------------	----------	------------------

- | | | |
|-------------------------------------|-----------------|----------------|
| 1. Problem solving | Baseline: _____ | Current: _____ |
| 2. Managing money | Baseline: _____ | Current: _____ |
| 3. Community Engagement | Baseline: _____ | Current: _____ |
| 4. Friendships/support | Baseline: _____ | Current: _____ |
| 5. Educational Planning | Baseline: _____ | Current: _____ |
| 6. Employment | Baseline: _____ | Current: _____ |
| 7. Knowledge of Community Resources | Baseline: _____ | Current: _____ |
| 8. Interpersonal Skills | Baseline: _____ | Current: _____ |

Total Community Living Skills Score: Baseline: _____ Current: _____

Adapted from Homeless Engagement and Acceptance Scale (Park et. al, 2002); Community Living Scale, Smith & Ford, (1990); Life Skills Inventory (Washington State Department of Social and Health Services, 2000)

Appendix F: Consumer Handbook for Collaborative Services Pilot Program

Welcome to the New Westminster Homelessness Coalition Collaborative Services. This Handbook has been put together to make it easier for you to get the assistance you are looking for. Our team and agencies are committed to working with you to meet your goals.

OUR APPROACH

The member agencies of the New Westminster Homelessness Coalition realize that you are the expert about your life. This means that during the time you receive services from us, your goals come first. We are guided by what you say you want and/or need. Participating agencies have agreed to abide by the core values of honesty, safety, confidentiality, empowerment, celebration, respect for the intrinsic worth and dignity of all persons and evidence-based and accountable practice.

LOCATIONS AND HOURS

You can drop into any of the New Westminster Homelessness Coalition member services, or attend our scheduled events. We will also regularly have staff available at community meals and events. Most of our services take place during the day. If you need non-medical emergency assistance you can contact a Lookout Emergency Aid Society outreach worker at 604-523-9126 (ext 101). For medical or police assistance, please call 911.

THE TEAM (STAFF)

The New Westminster Homelessness Coalition Collaborative team are employees of member agencies, and are committed to providing excellent service. All participating staff have agreed to policies and procedures and professional codes of ethics to make sure you get the highest standards of professional behaviour and service.

CONFIDENTIALITY

Most things that you tell a staff worker will be kept in confidence. However, the following are some things that cannot be kept confidential.

If your safety or anyone else's safety is at risk, staff will report the situation to their supervisor.

We are required to report to the Ministry of Children and Family Development if a child is being abused or is seriously at risk.

YOUR RIGHTS AND RESPONSIBILITIES

As a consumer of the New Westminster Homelessness Coalition Collaborative Services, you have a right to expect that:

YOU WILL BE TREATED WITH TRUST AND RESPECT

- the work done will be in your best interest
- you will be treated with dignity and respect
- you will be safe in the place you come for service
- you will not be discriminated against on the basis of race, ethnic background, language, religion, marital status, sex, sexual orientation, age, abilities, socio-economic status, political affiliation, national ancestry or personal characteristics

YOU AND YOUR WORKER WILL DEVELOP A SERVICE PLAN

- the limits of service will be explained
- the service plan will be developed with you
- the expectations of the service plan will be reviewed with you
- the service plan will be signed by you

YOUR CONFIDENTIALITY WILL BE RESPECTED

- the limits of confidentiality will be explained to you
- confidentiality will be maintained except as required by local legislation or when someone's safety is an issue
- no information is given or received from others without your explicit consent except where required by law
- you will have access to your files according to the Freedom of Information and Protection of Privacy Act
- your file will contain only necessary and relevant information based on observation or fact

AS A CONSUMER OF OUR SERVICES, WE WOULD LIKE YOU TO MAKE AN EFFORT TO:

- act in a respectful way to staff and others
- play an active role in developing your service plan
- share facts and conditions that will affect the effectiveness of service
- be available for service and keep appointments or notify the agency if you are unavailable
- fully participate in the service during appointments
- be free of the influence of nonprescription drugs and/or alcohol during appointments
- be clear about what you wish to accomplish through the service
- be open with the service provider about what is helpful or not helpful

CONSUMER'S PARTICIPATING IN GROUP SERVICES

Some of our services may take place in a group setting. Confidentiality for anything said in a group setting is expected. Group members must not tell anyone what other people said in a group setting or at any other programs or activities. For formal group settings, the group rules will be explained to you before you join a group.

How to Make a Complaint

If you feel that you or anyone else receiving service from the Coalition has been treated unfairly or if you have concerns about any aspect of the service provided to you, you may make a complaint.

When you have a complaint about any of our services, you should first try to solve the problem with the staff person directly involved. If you are uncomfortable with this or if you are unhappy with the results, you can make a formal complaint. The formal complaint should be made to the Chair of the Homelessness Coalition in writing. You can also request to meet with the Chair of the Homelessness Coalition. If you make a complaint, you can still get service from the Homelessness Coalition.