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The role of advocacy coalitions in a project implementation process: The example of the planning phase of the *At Home/Chez Soi* project dealing with homelessness in Montreal

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ABSTRACT

This study analyzed the planning process (summer 2008 to fall 2009) of a Montreal project that offers housing and community follow-up to homeless people with mental disorders, with or without substance abuse disorders. With the help of the Advocacy Coalition Framework (ACF), advocacy groups that were able to navigate a complex intervention implementation process were identified. In all, 25 people involved in the Montreal *At Home/Chez Soi* project were surveyed through interviews ($n = 18$) and a discussion group ($n = 7$). Participant observations and documentation (minutes and correspondence) were also used for the analysis. The start-up phase of the *At Home/Chez* may be broken down into three separate periods qualified respectively as "honeymoon;" "clash of cultures;" and "acceptance & commitment". In each of the planning phases of the *At Home/Chez Soi* project in Montreal, at least two advocacy coalitions were in confrontation about their specific belief systems concerning solutions to address the recurring homelessness social problem, while a third, more moderate one contributed in rallying most key actors under specified secondary aspects. The study confirms the importance of policy brokers in achieving compromises acceptable to all advocacy coalitions.

1. Introduction

Over the past 30 years, there has been an increase and transformation of homelessness in Canada (Roy & Hurtubise, 2007). The homeless are getting younger and include more women, families, seniors, immigrants and Natives (Hwang, Stergiopoulos, O'Campo, & Gozdzik, 2012; Roy & Hurtubise, 2007). For example, in Toronto, a third of homeless people were immigrants (Hwang et al., 2012). The homeless population faces major concurrent health or substance-use disorders (Weinreb, Gelberg, Arangua, & Sullivan, 2005) and legal problems (Bellot, 2008). The multiplicity of problems affecting this population makes it increasingly difficult to implement adequate responses to homelessness.

Some studies have revealed that housing and support interventions are some of the best practices in the fight against homelessness (Tsemberis, Gulcur, & Nakae, 2004; Tsemberis, Kent, & Respress, 2012). A promising avenue for persons facing chronic homelessness and mental health problems is the "Housing First Model". Introduced in New York with Pathways to Housing in 1992 (Felton, 2003) and based on consumer-driven services (Nelson et al., 2014), this model allows homeless persons with co-occurring severe mental and substance abuse disorders to live in the housing

Abbreviations: ACF, Advocacy Coalition Framework; ACT, assertive community treatment; CM, case management; ICM, intensive case management; MHCC, Mental Health Commission of Canada.

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of their choice, and to have support through an assertive community treatment (ACT) programme providing close follow-up by a multidisciplinary team, including a psychiatrist (Goering et al., 2011). Unlike some other supervised housing programmes, housing in this model is not connected with an obligation of treatment. Users who also continued to abuse substances were not excluded from their housing (Tsemberis, 2004). The Housing First Model has been acknowledged as an evidence-based practice by nine randomized controlled trials (Nelson et al., 2014). In 2005, a modified version (Streets to homes programme) of the Housing First Model for homeless persons without severe mental disorders was implemented in Toronto (Canada) with variable community follow-up using an intensive case management (ICM) approach rather than ACT (Hwang et al., 2012). In ICM, the participant/staff ratio is about 20:1 versus 10:1 in ACT, and the follow-up is handled by a case manager only, usually once a week rather than several times a week with ACT (Goering et al., 2011).

In 2006, a report from a senatorial committee recommended the development of a national mental health strategy for Canada (Kirby & Keon, 2006). In February 2008, in an effort to identify potential solutions to the spread of homelessness among various groups, the federal government allocated $110 million to the Mental Health Commission of Canada (MHCC) for the development of the *At Home/Chez Soi* pilot project (Nelson et al., 2014). This 4-year project (2009–2013) provided access to three major services: (1) affordable and safe housing; (2) ACT programme for homeless persons with high mental health needs; and (3) ICM programme for moderate mental health needs. In the MHCC project, the recovery paradigm is also greatly promoted, where users' needs are at the centre of all decisions and interventions (Piat et al., 2009). Globally, the purpose of the *At-Home/Chez Soi* project was to faithfully reproduce this adopted Housing First Model (including ICM and the recovery paradigm) and it involved a quasi-experimental research framework. It thus required a high degree of standardization (top-down centralized governance), which had important effects in structuring the relationships between national and local stakeholders as well as between local stakeholders. Montreal was one of the five sites selected in Canada for the implantation of this pilot project, along with Vancouver, Winnipeg, Toronto and Moncton. According to the results of the pilot project, its sustainability at the end of its implementation could be assumed by their respective provincial governments.

The difficulty in implementing new public policies or programmes has often been described in the literature (Damschroder et al., 2009; Durlak & DuPre, 2008; Gagnon, Turgeon, & Dallaire, 2007; Weiner, Amick, & Shoou-Yih, 2008). However, most of the studies on policy processes are atheoretical and only a minority of them are based on a theoretical framework (Breton & de Leeuw, 2010). The Advocacy Coalition Framework (ACF) appears as a promising framework for the analysis of the implementation process of a public policy or a new programme (Bergeron, Surel, & Valluy, 1998; Fender & Klok, 2001; Gagnon et al., 2007; Schlager, 1995). Conceived by Sabatier and Jenkins-Smith (Sabatier & Jenkins-Smith, 1993), the ACF emphasizes the dynamics of coalitions of stakeholders, proponents or opponents involved in a new policy (Breton & de Leeuw, 2010). Used with success for the study of public health policy (Gagnon et al., 2007) and health promotion (Breton & de Leeuw, 2010), the ACF had not yet been applied to the analysis of a project implementation process. While the overall ACF process occurs over a time frame of about 10 years (Weible et al., 2011), this framework could also be useful for the analysis of a short time frame implementation process.

The purpose of this study was to analyze issues related to the planning phase of the *At Home/Chez Soi* project in Montreal (summer 2008 to fall 2009) with an adapted version of the ACF as part of the project implementation process and a short timeframe. Some concepts of the AFC were then used to identify the various phases of the planning process and the coalitions that emerged throughout, in order to better understand the planning implementation process of a pilot research project dealing with homelessness and mental health.

2. Site description

The study was carried out on the Island of Montreal, Canada's second-largest urban area with a population of approximately 1.9 million inhabitants (2006 census). In 2006, 32.3% of households were below the low-revenue threshold and 9.5% of the population received social welfare (ASSSM, 2009). In 2005, the number of individuals who were homeless at least part of the year was estimated at 30,000 (ASSSM, 2009; RAPSIM, 2008).

The network providing services to the homeless population in Montreal is difficult to delineate, mainly because there are no programmes specifically dedicated to addressing homelessness among those offered by the Quebec ministry of health and social services.[1] Other government departments play a key role, including the Ministry of municipal, regional and land affairs through the Quebec's housing agency, which is responsible for developing and supporting housing for persons in need, including the homeless. The Quebec's housing agency, in conjunction with the municipal housing board and the Montreal's agency for development and housing, manages an array of programmes designed to facilitate access to affordable housing. The City of Montreal, the Health and social services agency of Montreal-Centre, and community-based agencies (through the Montreal Single and homeless persons help network), cooperate in fighting homelessness. When the planning of the *At Home/Chez Soi* project began, there were already a broad range of structures for, and a strong history of, dealing with homelessness in Montreal. Over the past 20 years, there have been numerous concerted and community-based initiatives, many involving partnerships between the community and public sectors (ASSSM, 2009; RAPSIM, 2008).

For the *At Home/Chez Soi* project in Montreal, five organizations were key-actors during the planning phase: the MHCC, a Health and Social Service Center, a University Health Center, a Mental Health University Institute and a community-based organization. The MHCC was the most important actor at this phase, the major decisions concerning the project having been defined beforehand at the national level. The Health and Social Service Center had a regional mandate in homelessness and an expertise in research in this sector. It was responsible for the ACT team for homeless individuals with high mental health needs and one of the two ICM teams for homeless individuals with moderate mental health needs. The University Health Center was responsible for managing the psychiatric components of the ACT team. The Mental Health University Institute was responsible for the housing team and provided leading research expertise. Finally, the community-based organization, which was specialized in the follow-up of individuals with severe mental health disorders and homelessness problems, was responsible for the second ICM team.

[1] In Canada, the healthcare system is mostly public and managed by the provincial governments. In Quebec, healthcare and social services are amalgamated and managed by three levels of government (provincial, regional and local). General regulation and control over the province's healthcare are the responsibility of the Quebec ministry of health and social services (MHSS). Regional health agencies ($n = 18$) organize services in their respective territories (e.g. planning, budgeting, coordination). Finally, in 2005, the MHSS constituted a new governing body, referred to as local service networks (now: $n = 94$).